DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION
SANTA ANA SECTION

REPORT ON THE MEDICAL AUDIT OF ORANGE COUNTY ORGANIZED HEALTH SYSTEM DBA CALOPTIMA 2024

Contract Number: 08-85214

Audit Period: February 1, 2023 – February 29, 2024

Dates of Audit: March 18, 2024 – March 29, 2024

Report Issued: August 16, 2024

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I. INTRODUCTION

CalOptima Health Plan (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 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 members residing in Orange County. As of January 31, 2024, the composition of the Plan membership was as follows:

- Medi-Cal: 916,772 Medi-Cal members for low-income individuals, families with children, seniors, and people with disabilities.
- OneCare (Medicare Advantage Special Needs Plan): 17,380 Medi-Cal members who also have Medicare.
- Program of All-Inclusive Care for the Elderly: 453 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 review audit for the period of February 1, 2023, through February 29, 2024. The review was conducted from March 18, 2024, through March 29, 2024. The audit consisted of document review, verification studies, and interviews with the Plan personnel.

An Exit Conference with the Plan was held on July 30, 2024. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the audit report findings. On August 14, 2024, the Plan accepted all the findings and did not provide additional information after the Exit Conference.

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

The prior DHCS medical audit, for the audit period of February 1, 2022, through

January 31, 2023, was issued on August 17, 2023. The deficiencies identified in the audit report and the implementation of the Correction Action Plan were reviewed.

Findings denoted as repeat findings are uncorrected deficiencies substantially similar to those identified in the previous audit.

The summary of the findings by category is as follows:

Category 1 – Utilization Management

The Plan is required to follow a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated. The Plan did not ensure consistent application of its UM written criteria for adjudicating Gender Affirming Care (GAC) related to Prior Authorization (PA) requests.

The Plan is required to send standard PA decision within five business days. An expedited service authorization decision is required to be sent within 72 hours of receipt of the request. The Plan did not send PA NOA letters to members and providers within the required timeframes outlined in APL 21-011.

The Plan is required to implement and maintain procedures to allow members to file a grievance when they disagree with the Plan's decision to extend the timeframe for resolution of an appeal or expedited appeal. The Plan did not inform members of the right to file a grievance after denial of a request for expedited resolution of an appeal.

Category 2 – Case Management and Coordination of Care

The Plan is required to ensure network providers provide oral or written anticipatory guidance to the parents or guardians of a child member. At a minimum, the anticipatory guidance must include information that children can be harmed by exposure to lead and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age. The Plan did not ensure the provision of oral or written blood lead anticipatory guidance were provided to the parents or guardians of a child member starting at the age of 6 months and up to 72 months.

The Plan is required to document and appropriately follow up on BLS results. The Plan did not ensure that the network providers ordered or followed up with the BLS test results for child members at 12 months, 24 months, and up to 72 months of age.

The prior audit found that the Plan did not ensure that an Initial Health Appointment (IHA) was performed by the member's Primary Care Physician (PCP), perinatal care providers, and non-physician mid-level practitioners. The Corrective Action Plan (CAP) was not closed until December 29, 2023. There were insufficient samples to review for the new correction action process that was implemented. Thus, a desk audit review was conducted without selecting verification study samples.

Category 3 – Access and Availability of Care

The Plan is required to establish acceptable accessibility standards and communicate, enforce, and monitor providers' compliance with these standards. The Plan did not ensure primary and specialty providers complied with appointment wait time standards.

The Plan is required to ensure that the Non-Emergency Medical Transportation (NEMT) services are a covered Medi-Cal benefit when they are prescribed in writing by a physician, for the purposes of enabling a member to obtain medically necessary covered services. The Plan did not ensure that the health care professional signature on the PCS forms can be legibly identified.

The Plan is required to ensure all necessary written consent forms are collected prior to arranging transportation for an unaccompanied minor and cannot arrange NEMT or Non-Medical Transportation (NMT) services for an unaccompanied minor without the necessary consent form. The Plan did not ensure a procedure to verify minor consent letters are collected prior to arranging NEMT and NMT services.

The Plan is required to monitor and oversee the transportation brokers to ensure that transportation brokers who provide transportation services are enrolled in the Medi-Cal

program. The Plan did not ensure all individual NMT providers are enrolled in the Medi-Cal program.

Category 4 – Member's Rights

The Plan is required to review written record of grievances periodically by the governing body, the public policy body, and an officer of the Plan. This review is required to be thoroughly documented. The Plan's governing body (Board of Directors) did not review the grievance and appeals written records.

Category 5 – Quality Management

No findings were noted for the audit period.

Category 6 – Administrative and Organizational Capacity

No findings were noted for the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS Contract and Enrollment Review Division conducted this 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

The audit was conducted from March 18, 2024, through March 29, 2024. The audit included a review of the Plan's contracts with DHCS and other authorities, the 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, staff, and delegated entities.

The following verification studies were conducted:

Category 1 – Utilization Management

PA Requests: 38 medical PA requests (14 routine, 15 expedited, nine retrospective) and Post Stabilization Authorization (PSA) 16 were reviewed for timeliness, consistent application of criteria, appropriate review, and communication of NOA results to members and providers.

PA Appeals: 24 appeals (19 standard and five expedited) were reviewed to ensure that required timeframes were met and appeals were appropriately routed and adjudicated.

Delegated PSA and Claims: 17 non-contracted PSA samples were reviewed for timely decisions.

Category 2 – Case Management and Coordination of Care

IHA: No verification studies were conducted.

Blood Lead Screening (BLS): 15 BLS records were reviewed to verify the anticipatory guidance on blood lead was provided at each periodic health assessment starting at six months of age, and the BLS was ordered and performed at ages 12 months and 24 months.

California Children's Services (CCS) Whole Child Model: 15 CCS Whole Child Model records were reviewed for appropriate care coordination.

Category 3 – Access and Availability of Care

Timely Access Standards: 20 non-compliant providers (nine PCPs and 11 specialists) were reviewed for timely requirements.

NEMT: 16 records were reviewed for timeliness and compliance with NEMT requirements.

NMT: 25 records were reviewed for timeliness and compliance with NMT requirements.

Category 4 – Member's Rights

Quality of Care (QOC) Grievances: 25 QOC grievances (16 standard, seven expedited, and two declined) were reviewed for processing, clear and timely response, and appropriate level of review.

Category 5 – Quality Management

No verification studies were conducted.

Category 6 – Administrative and Organizational Capacity

No verification studies were conducted.

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

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management

1.2 PRIOR AUTHORIZATION REVIEW REQUIREMENTS

1.2.1 Prior Authorizations

The Plan shall ensure that its Prior Authorization, concurrent review, and retrospective review procedures meet the requirement to have a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated. *(Contract, Exhibit A, Attachment 5, (2)(B))*

The Plan shall comply with all existing final Plan Letters (PLs) and *All Plan Letters (APLs)* issued by DHCS. *(Contract, Exhibit E, Attachment 2(1)(D))*

When analyzing transgender service requests, MCPs must consider the knowledge and expertise of providers qualified to treat gender dysphoria (including the member's providers) and must use nationally recognized medical/clinical guidelines. One source of clinical guidance for the treatment of gender dysphoria is found in the most current "Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People," published by the World Professional Association for Transgender Health. *(All Plan Letter (APL) 20-018, Ensuring Access to Transgender Services)*

The Plan's policy, *GG.1535 Utilization Review Criteria and Guidelines (revised*

January 1, 2023), states that the Plan shall ensure that criteria and practice guidelines and UM activities and decisions are based on reasonable local and national medical evidence, or a consensus of health care professionals in the particular field.

The Plan's policy, *GG.1508 Authorization and Processing of Referrals (revised*

August 1, 2023), stated that Plan shall ensure the authorization process for Covered Services is consistently applied to medical/surgical, mental health, and substance use disorder services and benefits. Plan shall make utilization management (UM) decisions based only on appropriateness of care and service, and existence of coverage.

The Plan's policy, *GG.1517 Transgender Services (revised December 1, 2023)*, stated that the Plan will use internationally recognized medical and clinical guidelines, such as the World Professional Association for Transgender Health (WPATH), in reviewing requested

covered services for transgender members and shall apply those standards consistently across the population. The Plan will analyze transgender service requests under both the applicable medical necessity standard for services to treat gender dysphoria and will consider the knowledge and expertise of providers qualified to treat gender dysphoria (including the member's providers).

Finding: The Plan did not ensure consistent application of its UM written criteria for adjudicating Gender Affirming Care (GAC)-related PA requests.

A verification study of 11 PAs, the Plan's inconsistent application of its UM criteria for GAC services resulted in four incorrectly adjudicated PAs. The Plan denied covered services and services that met medical necessity or reconstructive surgery criteria.

For example:

- Prior authorization for masculinizing chest gender affirming surgery was denied incorrectly for the lack of a supporting mental health professional letter; however, a letter from a mental health professional is not required in this case since the PA request came from a qualified provider with experience in transgender health care.
- Prior authorization for pre-operative hair removal prior to gender affirming surgery denied incorrectly as a non-covered benefit; however, pre-operative hair removal prior to gender affirming surgery is a core service as noted in APL 20-018. The APL 20-018 guidance was based on identified services in the field of transgender health care by nationally recognized medical experts.

In an interview, the Plan stated that the cause for inconsistent and incorrect GAC-related PA adjudication was primarily due to lack of training. As a result, the Plan stated that it is using internal trainings and WPATH provided modules for education and has established a Working Group for GAC. However, the Plan could not substantiate how it is maintaining oversight or effectiveness of the training programs as these interventions were ineffective in ensuring decisions related to GAC were made consistently. For example, the Plan used superseded APL 16-013 (October 6, 2016), instead of the current APL 20-018 in the adjudication of two denied PA requests. Furthermore, the Plan did not show evidence of reviewing GAC-related appeals to determine if PA denials were correctly adjudicated based on APL 20-018 guidelines.

Inconsistent application of the Plan's UM written criteria can lead to incorrect PA adjudication. As a result, members may not be able to access medically necessary GAC.

Recommendation: Implement policies and procedures to ensure consistent application of the Plan's UM written criteria for adjudicating GAC-related PA requests.

1.2.2 Notice of Action Letters

The Plan shall 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) by providing a written notification NOA to members and/or their authorized representative, regarding any denial, deferral, or modification of a request for approval to provide a health care service. This notification must be provided as specified in CFR, Title 42, section 438.404, and Health and Safety Code (HSC) section 1367.01. *(Contract, Exhibit A, Attachment 13(8)(A))*

The Plan must send standard authorization decision within five business days. For an expedited service authorization decision, send within 72 hours of receipt of the request. *(Contract, Exhibit A, Attachment 14(4)(A))*

The Plan shall comply with all existing final Plan Letters (PLs) and APLs issued by DHCS. *(Contract, Exhibit E, Attachment 2(1)(D))*

Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. (*HSC 1367.01(c)(3))*

Decisions to approve, modify, or deny [standard] requests, must be communicated by the Managed Care Plan (MCP) to the provider within 24 hours of the decision and to the member within two business days using the appropriate NOA template. *(APL) 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates, August 2022)*

The Plan's policy, *GG.1507 Notification Requirements for Covered Services Requiring Prior Authorization (approved May 1, 2023)*, states that the Plan shall send a NOA or coverage decision letter in a timely manner as specified in *APL 21-011*, and a culturally and linguistically appropriate manner.

The Plan's policy, *GG.1508 Timeframes for Medi-Cal Decisions and Notifications (approved December 31, 2023)*, specifies compliance with notification timeframes for routine and expedited NOA letters as per *GG. 1507*, congruent with *APL 21-011*.

Finding: The Plan did not send PA NOA letters to members and providers within the required timeframes outlined in APL 21-011.

In a verification study of 38 PA samples, 7 provider NOA letters and 8 member NOA letters were not sent within the required timeframes.

For example:

- One routine PA was submitted on a Friday and adjudicated the following Thursday. Provider NOA was faxed timely same day as resolution. However, the Member NOA was mailed seven weeks later.
- One expedited PA was adjudicated the day after receipt. Provider NOA was faxed within 24 hours. However, the Member was NOA mailed 3 business days after resolution.
- One expedited PA was submitted on a Friday and adjudicated on the following Monday. Provider NOA was faxed on Thursday of that week, 72 hours after resolution. However, the Member NOA was mailed on Friday of that week, four business days after resolution.

In an interview, the Plan stated the medical director provides oversight for compliance with timely submission of NOA letters. A supervisor monitors a "pending" report as well as a denial worklist to ensure timeliness compliance. However, the verification study indicated untimely notifications were primarily due to staff error throughout the audit period indicating that the Plan processes were inadequate to provide appropriate oversight.

Members and providers may not be able to exercise their right to file a timely appeal or grievance if they do not receive notification of an adverse benefit decision within the specified timeframes.

Recommendation: Implement a process to ensure that adverse benefit decision notifications are sent to providers and members within required timeframes.

1.3.1 Member's Right to File a Grievance

The Plan shall implement and maintain procedures to allow members to file a grievance when they disagree with the Plan's decision to extend the timeframe for resolution of an appeal or expedited appeal. (Contract, Exhibit A, Attachment 14, (2))

If the Plan denies a request for expedited resolution of an appeal, it must follow the requirements in CFR, Title 42, section 438.408(c)(2). (CFR, Title 42, section 438.410(c)(2))

If the Plan extends the timeframe of an appeal, it must give the member written notice of the reason for that decision and inform the member of their right to file a grievance if they disagree. (CFR, Title 42, section 438.408(c)(2)(ii))

The Member Handbook must contain information that enables members to effectively use the Managed Care program. This includes grievance, appeal, and fair hearing requirements, procedures, and timeframes. The right to file grievances and appeals must be included. (CFR, Title 42, section 438.10(g)(2)(xi)(A) and (B))

The Plan's policy, GG.1510 Member Appeal Process (revised November 1, 2022), stated that the Plan will maintain an expedited review process for appeals when the members requests or the provider indicates that the service involves an imminent and serious threat to the health of the member, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function.
Finding: The Plan did not inform members of the right to file a grievance after denial of a request for expedited resolution of an appeal.

A verification study revealed that 5 out of 24 appeals were expedited requests by the members that were downgraded to routine. The Plan downgraded all five expedited requests (100 percent) to routine requests without informing members of the right to file a grievance if they disagreed with the decision.

The Plan did not have procedures to inform members of the right to file a grievance after denial of a request for expedited resolution of an appeal.

The Plan's policy, GG.1510 Member Appeal Process (revised November 11, 2022), and the Plan's procedure 1.3.1 GARS Expedited Member Appeals Desktop Procedure, both lacked the above process to inform the member. In addition, the Plan could not substantiate that they had informed the member to file a grievance if the expedited appeal is deescalated to routine.

During the interview, the Plan stated that they were not aware that the policy and procedures did not include the contract requirement referenced above. The Compliance Director was not aware and had not disseminated the policy to Appeals and Grievances Committee. The current Plan process is deficient in identifying, updating, and integrating contract requirement and language into policy and procedures.
When members are not advised of their right to file a grievance, they are not able to make well-informed decisions about their health. This may delay care of medically necessary services.

Recommendation: Revise policies and procedures to ensure members are informed of their right to file a grievance after denial of a request for expedited resolution of an appeal.

COMPLIANCE AUDIT FINDINGS

Category 2 – Case Management and Coordination of Care

2.1 BLOOD LEAD SCREENING

2.1.1 Anticipatory Guidance

The Plan shall cover and ensure the provision of a BLS test to members at ages one and two in accordance with California Code of Regulations (CCR), Title 17 Division 1 Chapter 9, commencing with section 37000. *(Contract, Exhibit A, Attachment 10(4)(D)(1))*

The Plan shall comply with all existing final Plan Letters (PLs) and APLs issued by DHCS. *(Contract, Exhibit E, Attachment 2(1)(D))*

The Plan must ensure the network providers provide oral or written anticipatory guidance to the parents or guardians of a child member. At a minimum, the anticipatory guidance must include information that children can be harmed by exposure to lead and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age. The parent or guardian must be provided this anticipatory guidance at each Periodic Health Assessment (PHA), starting at 6 months of age and continuing until 72 months of age. *(APL 20-016 (revised), Blood Lead Screening of Young Children)*

The Plan's policy, *GG.1717 Blood Lead Screening of Young Children (revised January 1, 2023*), stated that PCP shall provide oral or written anticipatory guidance to the parents or guardians of the child member. At a minimum, the anticipatory guidance must include information on lead exposure and risk of lead poisoning in children starting at 6 months of age to 72 months of age. The anticipatory guidance shall be documented in the child member's medical record. The Plan shall monitor the provision of BLS and anticipatory guidance in accordance with the DHCS Medical Report Review and the Plan policy, *GG.1608 Full Scope Site Reviews (revised August 1, 2023)*.

In addition, the Plan's policy, *GG.1608 Full Scope Site Review (revised August 1, 2023)*, indicated that the Plan shall conduct the medical record review on ten records in the preventative care area if a PCP site has only pediatric members at the PCP site for the number of PCPs of one to three. The Plan shall select medical records randomly from all PCPs at the site.

Finding: The Plan did not ensure the provision of oral or written blood lead anticipatory guidance to the parents or guardians of a child member starting at the age of 6 months and up to 72 months.

In a verification study, 8 out of 15 member records did not document the provision of the oral or written blood lead anticipatory guidance to parents or guardians of child members.

In the CAP to the 2022 audit finding 2.1.1, the Plan began using the DHCS MRR Tool during the Facility Site Review (FSR), which contained pediatric prevention criteria to determine if blood lead anticipatory guidance was provided. During the interview, the Plan stated they utilized the 2022 Medical Record Review (MRR) Tool to periodically review the anticipatory guidance for blood lead level during the Facility Site Review process in monitoring the network providers' compliance with the provision of anticipatory guidance. However, the Plan's MRR standards were not updated to include any required criteria for anticipatory guidance.

The Plan's process also included a monthly BLS testing report that showed missed BLS testing at 12 months or 24 months of age which are sent to the health networks and the providers. However, the Plan stated that they did not include anticipatory guidance in the report. The Plan likewise acknowledged that they do not have any other process to ensure that the blood lead anticipatory guidance is given to the parents or guardians of child members from the providers.

If the anticipatory guidance is not provided to the child's parents or guardians, then the child may be at risk of lead poisoning.

This is a repeat of the 2022 audit's finding 2.1.1 – Anticipatory Guidance for Lead Exposure.

Recommendation: Implement a process to ensure the provision of age-appropriate blood lead anticipatory guidance to the parents or guardians of pediatric members.

2.1.2 Provision of Blood Lead Screening of Young Children

The Plan shall document and appropriately follow up on BLS results. The Plan shall make reasonable attempts to ensure BLS test is provided and shall document attempts to provide the test in the member's medical record. Documentation shall be entered into the member's medical record to indicate the receipt of BLS testing and test results, or voluntary refusal of these services. (*Contract, Exhibit A, Attachment 10, (4)(D)(2))*

The Plan must ensure the network providers order or perform BLS on all children in accordance with the following: at 12 months and 24 months of age, and when the health care provider performing a PHA becomes aware that a child 12 to 24 months of age has no documented evidence of a BLS test taken. *(APL 20-016 (revised), Blood Lead Screening of Young Children)*

The Plan's policy, *GG.1717 Blood Lead Screening of Young Children (revised January 1, 2023),* stated that a PCP shall order or perform BLS at 12 months and at 24 months of age and when the PCP performing the periodic preventative health assessment becomes aware that the child member who is 12 to 24 months of age has no documented evidence of a BLS taken at 12 months of age or thereafter.

Finding: The Plan did not ensure that the network providers ordered or followed up with the BLS test results for child members at 12 months, 24 months, and up to 72 months of age.

In a verification study, 8 out of 15 child member records showed no documentation of the BLS test results (six had a BLS test ordered but lacked documented results and two did not have BLS test orders or results).

The Plan developed the Health Network/Delegate Attestation Form in 2023 for the health networks to attest that they have received and reviewed the monthly BLS testing reports. The monthly reports that were distributed to network providers showed child members who missed BLS testing at 12 months or 24 months of age. However, during the interview, the Plan stated that this attestation form procedure is not intended to ensure network providers order or make reasonable parental, or guardian outreach attempts to complete the BLS test order. The Plan did not have any other process to ensure that network providers were giving age appropriate BLS testing or following up with the BLS testing results.

If the BLS test is not provided to the child member, the child may be at risk of lead poisoning which could result in harming his or her growth, development, behavior, and learning ability.

Recommendation: Implement a process to ensure the provision and follow up of BLS tests for pediatric members by network providers.

COMPLIANCE AUDIT FINDINGS

Category 3 – Access and Availability of Care

3.1 APPOINTMENT WAIT TIME STANDARDS

3.1.1 Appointment Wait Time Standards

The Plan shall establish acceptable accessibility standards in accordance with CCR, Title 28, section 1300.67.2. The Plan shall communicate, enforce, and monitor providers' compliance with these standards. *(Contract, Exhibit A, Attachment 9(3))*

The Plan is required to document and implement prompt investigation and corrective action when compliance monitoring discloses that the Plan's network is not sufficient to ensure timely access and network adequacy as required by this rule. Plan's quality assurance process shall ensure the Plan takes all necessary and appropriate action to identify the cause(s) underlying identified timely access and network adequacy deficiencies and to bring the network into compliance. Plan shall give advance written notice to all network providers affected by a corrective action, and shall include a description of the identified deficiencies, the rationale for the corrective action, and the name and telephone number of the person authorized to respond to provider concerns regarding the Plan's corrective action. *(28 CCR section 1300.67.2.2 (d)(3))*

The Plan's policy, *GG.1600 Access and Availability Standards (revised 12/01/2023),* stated that the Plan shall identify providers not complying with timely access standards and shall communicate to the provider when they are not compliant with timely access standards and track and escalate corrective action for providers with continued non-compliance. Providers with two consecutive instances of non-compliance shall receive a warning. Providers with three consecutive instances of non-compliance shall be referred to the Member Experience Sub-Committee for review and further action in consideration of member access to appropriate services.

Finding: The Plan did not ensure primary and specialty providers complied with appointment wait time standards.

In a verification study, 9 of 20 primary and specialty providers were non-compliant with appointment wait time standards. In correspondence with non-compliant providers, the

Plan requested a response to correct the other access standards within a due date but not the particular appointment wait time deficiencies in question.

In an interview, the Plan stated that the Member Experience Sub-Committee met quarterly to monitor the corrective actions for member access standards. However, this sub-committee overlooked the CAP proposed letter for the nine non-compliant providers who did not address the appointment wait time requirements. In addition, during the interview, the Plan stated they prioritized resolving the Emergency Room or 911 access issues over timely access standards. The Plan confirmed there is currently no formal escalation process to address the appointment wait time deficiencies for the providers with continued non-compliance as described in Plan policy, GG.1600.

If the Plan does not address appointment wait time standards for non-compliant providers with corrective actions, this may result in members not receiving timely access to care which can lead to delayed medical interventions and possible poor health outcomes.

Recommendation: Develop a process to ensure corrective actions are implemented for primary and specialty providers who did not comply with appointment wait time standards.

3.2.1 Physician Certification Statement Forms

The Plan shall comply with all applicable requirements specified in federal and state laws and regulations. *(Contract, Exhibit E, Attachment 2)*

NEMT services are a covered Medi-Cal benefit when they are prescribed in writing by a physician, dentist, podiatrist, mental health provider, substance use disorder provider, or a physician extender, for the purposes of enabling a member to obtain medically necessary covered services or pharmacy prescriptions authorized by Medi-Cal Rx. *(APL 22-008, Non-Emergency Medical and Non-Medical Transportation)*

The medical record standards required that medical record documentation must have all entries signed, dated, and legible. Legibility means the record entry is readable by a person other than the writer. Signature includes first initial, last name, and title of health care personnel providing care, including medical assistants. *(APL 22-017, Medical Record Review Standards)*

The Plan's policy, *GG.1505 Transportation: Emergency, Non-Emergency, and Non-Medical (revised December 21, 2023),* stated that NEMT Authorization Request Form must be

fully and accurately completed by the physician, dentist, podiatrist, physician extender, mental health, or substance use disorders providers before NEMT can be provided.

Findings: The Plan did not ensure that the health care professional signature on the PCS forms can be legibly identified.

In a verification study, 9 out of 16 member records did not have legible and identifiable signatures on the PCS form prior to providing NEMT services.

During the interview, the Plan stated the medical technicians received and reviewed the PCS forms in accordance with the Plan's policy and procedures. However, the Plan did not have a procedure to ensure the health care professional signature is legibly identified as indicated in the APL 22-017.

If the signature on the PCS form is not legible and verifiable, the Plan cannot determine if the NEMT services provided was a medically necessary service prescribed by a health care professional.

Recommendation: Implement a procedure to ensure that a health care professionals' signature on the PCS form is legibly identified and verifiable.

3.2.2 Transportation Minors Consent Forms

Contractor must ensure all necessary written consent forms are collected prior to arranging transportation for an unaccompanied minor and cannot arrange NEMT or NMT services for an unaccompanied minor without the necessary consent form. (*Contract, Exhibit A, Attachment 3, (I)(4))*

MCPs must provide NEMT or NMT for a parent or a guardian when the member is a minor. With the written consent of a parent or guardian, MCPs may arrange NEMT or NMT services for a minor who is unaccompanied by a parent or a guardian. MCPs must provide transportation services for unaccompanied minors when applicable state or federal law does not require parental consent for the minor's service. *(APL 22-008, Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses)*

The Plan's policy, *GG.1505 Transportation: Emergency, Non-Emergency, and Non-Medical (revised December 31, 2023),* stated that with the written consent of a parent or guardian, the Plan, or a health network may arrange for NEMT or NMT for a Medi-Cal member who is a minor and is unaccompanied by a parent or guardian. The Plan policy further indicated, that contracted transportation vendor shall provide a fully and

accurately completed signed minor consent form from the members parent or guardian and submit it to the Plan.

Findings: The Plan did not ensure a procedure to verify minor consent letters are collected prior to arranging NEMT and NMT services.

In a verification study, three minor member records (one received NEMT service and two received NMT services) did not have parental or guardian consent forms.

During the interview, the Plan stated that the transportation broker is required to obtain records of minor consent for the transportation services. However, the Plan confirmed they do not have a procedure to ensure that the minor consent form is received from the individual transportation broker as required by the Plan policy, *GG.1505*.

If the Plan does not ensure minor consent is obtained prior to arranging transportation services, then minors' guardian/parents may not understand the minor's risk of traveling alone.

Recommendation: Implement a procedure to ensure that minor consent forms are collected and verified prior to arranging NEMT and NMT services for minor members.

3.2.3 Medi-Cal Enrollment of Non-Medical Transportation Providers

MCPs are responsible for monitoring and overseeing transportation brokers to ensure that transportation brokers are complying with the requirements. Monitoring activities may include, but are not limited to, enrollment status of NEMT and NMT Medi-Cal providers. *(APL 22-008, Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses)*

Transportation brokers are not required to be enrolled in the Medi-Cal program. However, the MCP must demonstrate that the transportation broker(s) are only conducting administrative activities such as scheduling rides. If the broker is providing rides to members, the broker must be enrolled as a NEMT or NMT Medi-Cal provider.

(APL 22-008, Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses)

The Plan's policy, *GG.1505 Transportation: Emergency, Non-Emergency, and Non-Medical (*revised *December 21, 2023*), stated the Plan shall establish and maintain a monitoring and oversight process of NMT and NEMT. The Plan does not delegate monitoring and oversight activities to the contracted NMT and NEMT vendors including enrollments of NEMT or NMT as Medi-Cal providers.

Finding: The Plan did not ensure all individual NMT providers are enrolled in the Medi-Cal program.

In a verification study of 25 NMT services, three individual NMT providers were not enrolled in the Medi-Cal program.

During the interview, the Plan stated that the main contracted transportation broker, Veyo LLC, is required to verify Medi-Cal enrollment for individual transportation providers. However, according to the Plan policy GG.1505, the Plan does not delegate to Veyo LLC for monitoring and oversight activities of Medi-Cal enrollment. In addition, the Plan did not have a procedure to ensure individual transportation providers are enrolled in the Medi-Cal program.

If the Plan does not ensure individual transportation providers are enrolled in the Medi-Cal program, then members may not receive transportation services in accordance with Medi-Cal requirements.

Recommendation: Ensure all individual NMT providers are enrolled in the Medi-Cal program.

COMPLIANCE AUDIT FINDINGS

Category 4 – Member's Rights

4.1 GRIEVANCE SYSTEM

4.1.1 Grievance and Appeals Written Record

The Plan shall have a system in accordance with CCR, Title 28, section 1300.68. The Plan shall follow grievance and appeal requirements. *(Contract, Exhibit A, Attachment 14, (1))*

The written record of grievances shall be reviewed periodically by the governing body, the public policy body, and an officer of the Plan. This review shall be thoroughly documented. *(CCR, Title 28, section 1300.68(b)(5))*

The grievance and appeals written record must be reviewed periodically by the governing body, the public policy body, and an officer of the Plan. The review must be thoroughly documented. *(APL 21-011, Grievance and Appeal Requirements)*

Finding: The Plan's governing body (Board of Directors) did not review the grievance and appeals written records.

The Plan policies, *HH.1102 Member Grievance* (*revised July 1, 2023*) and *GG.1510 Member Appeal Process (revised November 1, 2022*), state that aggregate and detailed grievance and appeals data will be submitted to the Quality Assurance Committee (QAC) quarterly. These policies did not include a procedure to ensure that the grievance and appeals written records were submitted to the governing body for review.

The Plan stated that the Grievance and Appeal Resolution Service submits a summary of data to the QAC quarterly, which is then shared with the Board of Directors at the next meeting. However, the Board of Directors meeting minutes could not substantiate that the grievance and appeals written records were reviewed by the governing body as contractually required.

Lack of review of the written record by the governing body could lead to missed opportunities to improve the grievance and appeals system and adversely affect QOC.

Recommendation: Develop and implement policies and procedures to ensure review of the grievance and appeals written records by the governing body.

DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SANTA ANA SECTION

REPORT ON THE MEDICAL AUDIT OF ORANGE COUNTY ORGANIZED HEALTH SYSTEM DBA CALOPTIMA 2024

Contract Number: 08-85221 (State Supported Services)

Audit Period: February 1, 2023 – February 29, 2024

Dates of Audit: March 18, 2024 – March 29, 2024

Report Issued: August 16, 2024

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I. INTRODUCTION

The report presents the audit findings of CalOptima (Plan) compliance and implementation of the State Supported Services Contract No. 08-85221. The State Supported Services Contract covers abortion services for the Plan.

The audit was conducted from March 18, 2024 through March 29, 2024 and covered the audit period from February 1, 2023 through February 29, 2024. 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 30, 2024. There were no deficiencies found for the audit period.

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 is 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 eight State Supported Service claims were conducted to determine appropriate and timely adjudication of claims. There were no compliance issues identified during the audit period.

RECOMMENDATION:

None.