DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SAN DIEGO SECTION

REPORT ON THE MEDICAL AUDIT OF ORANGE COUNTY HEALTH AUTHORITY DBA CALOPTIMA HEALTH
CALENDAR YEAR 2025

Contract Number: 23-30235

Audit Period: January 1, 2025 — December 31, 2025

Dates of Audit: February 9, 2026 — February 23, 2026

Report Issued: July 17, 2026

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I. INTRODUCTION

Orange County Health Authority 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 10 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 March 2026, the composition of the Plan membership was as follows:

- Medi-Cal: 818,624 Medi-Cal members for low-income individuals, families with children, seniors, and people with disabilities
- OneCare (Medicare Advantage Special Needs Plan): 18,430 Medi-Cal members who also have Medicare
- Program of All-Inclusive Care for the Elderly: 554 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 January 1, 2025, through December 31, 2025. The audit was conducted from February 9, 2026, through February 23, 2026. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on June 19, 2026. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On July 6, 2026, 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 Program, Population Health Management and Coordination of Care, Network and Access to Care, Grievances, Appeals, and Member Rights, Quality Improvement and Health Equity Transformation Program, and Plan Administration and Organization.

The prior DHCS medical audit for the period of February 1, 2024, through January 31, 2025, was issued on May 20, 2025. This audit examined the Plan's compliance with the DHCS Contract and assessed the implementation and effectiveness of the Plan's prior year 2025, Corrective Action Plan.

The summary of the findings by category follows:

Category 1 – Utilization Management Program

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

Category 2 – Population Health Management and Coordination of Care

The Plan is required to complete a Comprehensive Assessment and develop an individualized Care Management Plan (CMP) for all members enrolled in Enhanced Care Management (ECM). This includes identifying clinical and non-clinical needs, engaging the member and their support system in a person-centered planning process, and incorporating identified needs, goals, and preferences into the CMP. The Plan must also ensure the CMP is regularly reviewed and updated under appropriate clinical oversight.

Finding 2.25.1: The Plan did not consistently document CMP clinical oversight, which resulted in not following ECM provisions that require identified gaps in care to be incorporated into the CMP, using member input to assess risks and develop recommendations for service needs.

The Plan must develop and maintain policies and procedures to ensure members do not experience undue delays pending the authorization process for Community Supports. Finding 2.26.1: The Plan did not have a documented policy and procedure addressing the prevention of undue authorization delays for Community Supports.

Category 3 – Network and Access to Care

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

Category 4 – Grievances, Appeals, and Member Rights

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

Category 5 – Quality Improvement and Health Equity Transformation Program

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

Category 6 – Plan Administration and Organization

The Plan is prohibited from employing, paying, contracting, or maintaining a Medi-Cal contract with providers that are excluded, suspended, or ineligible to participate, either directly or indirectly, in the Medicare or Medi-Cal programs. Finding 6.15.1: The Plan paid claims to providers who were ineligible for payment under Medi-Cal requirements during the audit period.

The Plan is required to notify DHCS of any identified or recovered overpayments made to a provider due to potential Fraud, Waste, or Abuse (FWA). The Plan must notify DHCS within 10 calendar days of the date that the Plan identifies such overpayment, due to FWA, regardless of the amount. Finding 6.15.2: The Plan did not notify DHCS within the required 10 calendar days of identifying overpayments to providers who were ineligible for Medi-Cal reimbursement due to potential FWA.

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 February 9, 2026, through February 23, 2026, for the audit period of January 1, 2025, through December 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 Program

Prior Authorization (PA) Requests: Fifteen PA requests were reviewed for timeliness, consistent application of criteria, appropriate review, and communication of results to members and providers.

Delegated PA Requests: Ten delegated PA requests were reviewed for appropriate and timely adjudication.

Category 2 – Population Health Management and Coordination of Care

Initial Health Appointment: Eighteen medical records were reviewed for completion and care coordination of services.

ECM: Fifteen medical records were reviewed for care coordination and completeness to evaluate service performance.

Community Supports: Eighteen medical records were reviewed to evaluate the administration and timely provision of Community Supports.

Pregnant and Postpartum Members: Fifteen medical records were reviewed to ensure medically necessary services were provided to pregnant and postpartum members.

Category 3 – Network and Access to Care

Timely Payments: Nine family planning and nine emergency service claims were reviewed for appropriateness and timeliness.

Category 4 – Grievances, Appeals, and Member Rights

Grievance Procedures: Thirty-five standard grievances (10 quality of care and 25 quality of service), 8 expedited grievances, 3 exempt grievances, 2 provider grievances, and 8 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).

Appeal Procedures: Fifteen appeals (eight routine, five expedited, and two downgraded from expedited to routine) were reviewed for appropriateness and timeliness of decision-making.

Confidentiality Rights: Eight Health Insurance Portability and Accountability Act/Protected Health Information breach and security incidents were reviewed for processing and timeliness requirements.

Category 5 – Quality Improvement and Health Equity Transformation Program

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

Category 6 – Plan Administration and Organization

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

Suspended, Excluded, and Ineligible Providers: Eleven providers were reviewed for completion of required monthly screenings against federal and state exclusion databases and for compliance with prohibitions on employing, paying, or contracting with excluded, suspended, or otherwise ineligible providers.

COMPLIANCE AUDIT FINDINGS

Category 2 – Population Health Management and Coordination of Care

2.25 Enhanced Care Management

2.25.1 Enhanced Care Management Plan

The Plan must follow all provisions in the ECM Policy Guide, in addition to provisions outlined in the Contract. *(Contract, Exhibit A, Attachment III, 4.4.1 (A))*

The Plan is required to conduct a Comprehensive Assessment and CMP, which must include, but is not limited to:

- Identifying necessary clinical and non-clinical resources that may be needed to appropriately assess member health status and gaps in care, and may be needed to inform the development of an individualized CMP
- Developing a comprehensive, individualized, person-centered CMP with input from the member and their family members, legal guardians, authorized representatives, caregivers, and other authorized support persons, as appropriate, to assess strengths, risks, needs, goals, and preferences to make recommendations for service needs
- Incorporating into the member's CMP identified needs and strategies to address those needs
- Ensuring the CMP is reviewed, maintained, and updated under appropriate clinical oversight

(CalAIM ECM Policy Guide (V)(2)(c)(d)(e)(g))

Plan policy, *GG1353 CalAIM Enhanced Care Management Service Delivery* (revised June 1, 2025), stated that the Plan will conduct a Comprehensive Assessment and CMP for members receiving ECM services. ECM staff will identify necessary clinical and non-clinical resources that may be needed to appropriately assess member health status and gaps in care and may be needed to inform the development of an individualized CMP. There is an established ECM interdisciplinary team which will ensure that the CMP is reviewed, maintained, and updated under appropriate clinical oversight.

Finding: The Plan did not consistently document CMP clinical oversight, which resulted in not following ECM provisions that require identified gaps in care to be incorporated

into the CMP, using member input to assess risks and develop recommendations for service needs.

Test work found 2 of 15 medical records had identified medical care needs, but these needs were not incorporated into the CMP. In both cases, there was no documentation of CMP clinical oversight. The Lead Care Manager was non-clinical and did not direct or coordinate the members' reported concerns to clinical staff.

- The first case was a member diagnosed with a neurological condition who reported possible stroke symptoms and a fall from the stairs
- The second case involved a pediatric member whose mother reported urinary and eye injury symptoms to the Lead Care Manager

Furthermore, the test work noted an additional five samples that lacked documentation demonstrating clinical oversight of the CMP. Although members' CMPs contained ECM staff signatures, staff qualifications/roles were not documented. Therefore, it could not be ascertained if there was any clinical oversight in the development, implementation, and maintenance of the CMPs.

Plan documents indicated that the Plan conducts annual audits of ECM core components. However, the ECM Audit Tool does not specifically test all provision requirements, such as checking for CMP clinical oversight or if the CMP included the member's input. In interviews, the Plan confirmed it does not review whether CMPs are signed by clinical staff, and the ECM Audit Tool does not check for clinical oversight of the CMP.

The deficiencies occurred due to gaps in both the design and execution of the Plan's ECM oversight controls. The ECM oversight Audit Tool currently in use did not include all Comprehensive Assessment and CMP requirements to verify provision compliance. As a result, the Plan's monitoring processes did not check for CMP clinical oversight or if the CMP included the member's input.

Although Plan policy GG1353 outlines procedures for clinical oversight and care plan updates, staff did not consistently follow these procedures, indicating a breakdown in workflow execution. This includes CMPs completed without documented review by qualified clinical staff. Additionally, CMP signatures did not include staff credentials or roles, preventing verification of clinical oversight. The Plan confirmed during interviews that it does not review CMP signatures for clinical qualifications, further demonstrating insufficient governance and supervisory controls. The Plan's insufficient monitoring

tools, lack of documentation standards, and inconsistent adherence to established procedures contributed to the observed noncompliance.

When the Plan does not document clinical oversight or incorporate member-reported gaps in care into the CMP, member risks and service needs may go unaddressed, which may result in functional decline if changing health conditions are overlooked.

Recommendation: Implement and follow policies and procedures to ensure compliance with ECM provisions.

2.26 – Community Supports

2.26.1 – Community Supports Policy and Procedure

The Plan must develop and maintain policies and procedures to ensure members do not experience undue delays pending the authorization process for Community Supports. (*Contract, Exhibit A, Attachment III, 4.5.7(D))*

Finding: The Plan did not have a documented policy and procedure addressing the prevention of undue authorization delays for Community Supports.

Review of Community Supports medical records and grievances identified that the Plan did not maintain a policy and procedure to ensure members do not experience undue delays pending the authorization process for Community Supports.

Review of the Plan's Community Supports policy and procedure, *GG1355 CalAIM Community Supports* (revised September 1, 2024), found that it did not contain the contract required elements for implementing and administering Community Supports services. Specifically, the policy lacked required components reflecting the contractual requirement to develop and maintain policies and procedures to ensure members do not experience undue delays pending the authorization process of Community Supports. During the interview, the Plan confirmed that it did not have a policy or procedure fully developed to meet these contractual requirements.

There were gaps in the Plan's policies. This issue occurred because the Plan's policy review process did not include checks to ensure all contract-required Community Supports elements were incorporated.

Without a formalized policy and procedure, members may experience delays in accessing Community Supports services, which could negatively impact health outcomes.

Recommendation: Develop, implement, and maintain a policy and procedure that outlines processes and timelines to prevent undue delays in the authorization of Community Supports.

COMPLIANCE AUDIT FINDINGS

Category 6 – Plan Administration and Organization

6.15 - Obligations Regarding Suspended, Excluded, and Ineligible Providers

6.15.1 Payments Issued to Ineligible Providers

The Plan is prohibited from employing, paying, contracting, or maintaining a Medi-Cal contract with providers that are excluded, suspended, or ineligible to participate, either directly or indirectly, in the Medicare or Medi-Cal programs as cited in Code of Federal Regulations, title 42, sections 438.610(a) through (c) and *All Plan Letter (APL) 21-003, Medi-Cal Network Provider and Subcontractor Terminations*. *(Contract, Exhibit A, Attachment III, 1.3.4(B))*

The Plan must ensure that the network provider/subcontractor does not receive reimbursement for services provided to members until the payment suspension has been lifted. *(APL 21-003, Medi-Cal Network Provider and Subcontractor Terminations)*

Plan policy, *FF2001 Claims Processing* (revised February 1, 2025), stated that claims marked as "Do Not Pay" in the Provider Data Systems database will be denied.

Finding: The Plan paid claims to providers who were ineligible for Medi-Cal payment during the audit period.

The audit found that the Plan paid claims to 3 of 11 providers who were ineligible for payment under Medi-Cal requirements during the review period. Two of these providers were listed in the DHCS' Restricted Provider Database (RPD) with active payment suspensions and one provider was temporarily suspended from Medi-Cal. The amount paid totaled $10,509.21. These payments were processed contrary to DHCS Contract requirements and applicable APLs, which require managed care plans to cease payments to excluded, suspended, or ineligible providers.

These payments to ineligible providers resulted from a breakdown in the Plan's internal communication and monitoring controls. During the audit period, notifications regarding provider status changes were sent to a shared vanity email inbox that was not effectively monitored. As a result, emails were missed, preventing activation of the required "No-Payment" edit within the Plan's claims system. The Plan did not have a secondary control to ensure timely escalation of provider status changes.

In a written statement, the Plan stated that due to the volume of messages and the absence of tracking and reporting capabilities, emails were not addressed. The Plan explained the inbox is monitored daily by assigned staff, with backup coverage when staff are out of office. Despite this process, emails were overlooked and resulted in claims paid to providers who were ineligible under Medi-Cal rules. Following a review of the process gap, the audit confirmed that the Plan also performed a retrospective claims audit for the same period, which similarly did not uncover any further payments.

Improper payments to ineligible providers increase compliance risk and undermine program integrity.

Recommendation: Revise and implement policy and procedures to prevent payments to ineligible providers.

6.15.2 Failure to Notify Department of Health Care Services of Overpayments due to Potential Fraud, Waste, or Abuse

The Plan is required to notify DHCS of any identified or recovered overpayments made to a provider due to potential FWA. The Plan must notify the Managed Care Operations Division Contract Manager and the DHCS' Audits and Investigations Intake Unit within 10 calendar days of the date that the Plan identifies overpayment due to FWA regardless of the amount. *(Contract, Exhibit A, Attachment III, 1.3.6(A)(1)*).

In the event a Plan identifies or recovers an overpayment to a provider due to potential FWA, the managed care plan must notify the Managed Care Operations Division Contract Manager and the DHCS' Audits and Investigations Intake Unit at piu.cases@dhcs.ca.gov within 10 days of identifying the overpayment, regardless of the amount. *(APL 23-011, Treatment of Recoveries Made by the Managed Care Health Plan of Overpayments to Providers)*

Plan policy, *HH5000 Provider Overpayment Investigation and Determination* (effective December 1, 2016, revised May 1, 2025), established a system for detecting and preventing FWA within the Plan's programs, ensuring compliance with federal and state regulations and identifying overpayments for recoupment.

Finding: The Plan did not notify DHCS within the required 10 calendar days of identifying overpayments to providers who were ineligible for Medi-Cal reimbursement due to potential FWA.

The audit found that the Plan paid claims to three providers who were ineligible for payment under Medi-Cal requirements during the review period. On January 21, 2026, in response to an audit deliverable request, the Plan identified paid claims associated with three ineligible providers:

- Two providers were listed on the DHCS' RPD. Providers on the RPD are subject to payment suspension based on credible allegations of fraud; therefore, any payments made during this period constitute overpayments related to potential FWA, as required under APL 23-011 and federal and state program-integrity standards
- Another provider was temporarily suspended from Medi-Cal. During a temporary suspension, providers may submit claims, but payments must be withheld in a suspense account until the suspension is lifted. Payments issued during the suspension constituted overpayments associated with FWA. Claims can be submitted during the suspension, but no payment occurs until resolution. Once the provider's suspension ends or the investigation is resolved, funds are released and eligible claims are reimbursed accordingly.

The Plan issued overpayment letters on January 22, 2026. However, it did not notify DHCS within the required 10-day timeframe. In a written statement, the Plan stated that it presumed the providers listed on the RPD were not reportable to DHCS, since the RPD list was distributed by DHCS. Following an internal review on March 3, 2026, the Plan reported to DHCS the overpayments for the RPD providers on March 6, 2026. These notifications occurred more than a month after the required deadline.

The Plan did not meet the 10-day reporting requirement due to an inconsistent understanding of contractual requirements, inconsistent referral of ineligible provider findings to the FWA Department, and the absence of monitoring controls to ensure timely DHCS notification. Although Plan policy HH5000 requires the Plan's Special Investigations Unit to notify DHCS within 10 business days when an overpayment involving inappropriate billing and potential FWA is identified, these procedures were not followed. The Plan also lacked a centralized system to track overpayment identification dates and monitor compliance with the 10-day reporting window. These process deficiencies collectively resulted in delayed reporting to DHCS.

Failure to report overpayments associated with potential FWA within required timeframes impedes DHCS' ability to take timely oversight or enforcement action, compromises program integrity, and places the Plan at risk of non-compliance with state and federal contractual requirements.

Recommendation: Implement policy and procedures to ensure notification to DHCS within 10 calendar days of identifying overpayments to ineligible providers.

DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SAN DIEGO SECTION

REPORT ON THE MEDICAL AUDIT OF ORANGE COUNTY HEALTH AUTHORITY DBA CALOPTIMA HEALTH
CALENDAR YEAR 2025

Contract Number: 23-30267

Contract Type: State Supported Services

Audit Period: January 1, 2025 — December 31, 2025

Dates of Audit: February 9, 2026 — February 23, 2026

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I. INTRODUCTION

This report presents the results of the audit of Orange County Health Authority 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 January 1, 2025, through December 31, 2025. The audit was conducted from February 9, 2026, through February 23, 2026, which consisted of a document review and verification study with the Plan administration and staff.

An Exit Conference with the Plan was held on June 19, 2026. 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 services were 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 10 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.