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, 2019
Through
January 31, 2020

Report Issued: August 11, 2020

TABLE OF CONTENTS

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 to provide medical care for Medi-Cal beneficiaries residing in the County of Orange.

In addition, the Plan is currently governed by a Board of Directors made up of ten 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.

Mandatory enrollment of Seniors and Persons with Disabilities (SPD) into Managed Care began in June 2011. The California Department of Health Care Services (DHCS) received authorization (1115 Waiver) from the federal government to conduct mandatory enrollment of SPD into Managed Care to achieve care coordination, better manage chronic conditions, and improve health outcomes. In June 2011, DHCS awarded the Plan with the contract to provide Medicaid Managed Care benefits to beneficiaries under the State's SPD procurement.

The Plan currently has several programs to provide medical care to its members residing in Orange County. As of October 31, 2019, the total Plan members were as follows:

- Medi-Cal: 727,437 Medi-Cal recipients, for low-income individuals, families with children, seniors, and people with disabilities.
- OneCare (Health Maintenance Organization Special Needs Plan): 1,567 Medicare Advantage Special Needs recipients.
- OneCare Connect: 14,093 CalMediConnect recipients.
- Program of All-Inclusive Care for the Elderly: 368 Medicare/Medicaid and Medi-Cal recipients aged 55 and older who live in service area and are eligible for nursing facility services.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of February 1, 2019 through January 31, 2020. The onsite review was conducted from January 27, 2020 through February 7, 2020. The audit consisted of document reviews, verification studies, and interviews with Plan personnel.

An Exit Conference with the Plan was held on July 7, 2020. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the audit report findings. No additional information was submitted after the Exit Conference.

The full scope audit evaluated six categories of performance; Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity. In addition, the Plan's SPD population were included in this review.

The prior DHCS medical audit, for the audit period of February 1, 2018 through January 31, 2019, was issued on June 21, 2019. This audit examined documentation for compliance and to determine to what extent the Plan has operationalized their Corrective Action Plan (CAP).

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 prior year audit found that the Plan did not ensure that Behavioral Health Treatment (BHT) services were provided based upon the member's approved treatment plan that included direct service hours and did not take remedial action on non-compliant providers. Plan *Policy No. GG.1548 (revision dated 1/1/2018): Authorization for Applied Behavioral Analysis (ABA) for Autism Spectrum Disorder* did not have a procedure to monitor and ensure ABA providers were BHT services based upon an approved treatment plan that includes providing the authorized number of direct service hours.

In this year's audit, the Plan has put in place practices to resolve the prior year findings. The review of 15 verification study files and BHT documents revealed that the direct BHT use hours were documented appropriately with clear explanation of unused hours. The Plan developed monitoring tools in its systems to track the rate of utilization of authorized hours for specific providers and for specific members. The Plan looked at each member's case. Any provider that renders less than a benchmark level of authorized hours are automatically flagged and referred to the Plan's Quality Improvement (QI) Department as a Potential Quality Issues (PQI), and undergo further

quality review through that established process.

Category 3 – Access and Availability of Care

The prior year audit found that 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. As a result, the Plan was not able to analyze the performance of providers' compliance with regards to appointment wait time requirements.

In this year's audit, although the Plan conducted the 2019 Timely Access Survey to determine the appointment wait times compliance for its overall network, it was not able to analyze the performance of each provider's compliance with the various access wait times requirements and did not implement corrective actions for its providers.

Category 4 – Member's Rights

The Plan classified member's dissatisfaction as inquiries rather than grievances. The Plan does not have a policy and procedure to distinguish grievances from inquiries. Misclassification of grievances may lead to inadequate investigations and missed opportunities for healthcare QI.

The Plan did not correctly identify and process Quality of Care grievances. The Plan classified clinical grievances as care delivery and investigated as Quality of Service grievances. Improper classification and processing of grievances may lead to inadequate grievance resolution and missed opportunities for healthcare QI.

The Plan did not immediately submit all the Quality of Care grievances to its Medical Director for action. If Quality of Care grievances are not immediately submitted for Plan's Medical Director for any corrective actions, it could lead to an inadequate resolution of the problems and missed QI opportunities.

The Plan sent resolution letters without completing the investigation process to resolve both Quality of Service and Quality of Care grievances. Resolution letters sent to members without actually resolving the issue(s) could lead to inadequate grievance investigation and resolution. This could also lead to delay of proper care for the members.

Category 5 – Quality Management

The prior year audit found that the Plan did not take effective action to ensure improvements in Quality of Care for members' BHT services when their grievances indicated quality problems.

In this year's audit, the Plan took action to address prior year CAP measures. Plan

updated the BHT grievance process. If a member is not receiving BHT therapy as approved, that grievance must be referred to QI.

Category 6 – Administrative and Organizational Capacity

There are no findings in this category.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The onsite review was conducted from January 27, 2020 through February 7, 2020. The audit included a review of the Plan's Contracts with DHCS, its policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with the Plan's administrators, staff, and the delegated entity.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 15 medical prior authorizations, consisting of six Medi-Cal, nine SPD, and 21 pharmacy prior authorizations consisting of 11 Medi-Cal and ten SPD requests were reviewed for consistent application of criteria, timeliness, appropriate review, and communication of results to members and providers.

Prior Authorization Appeals: 16 medical prior authorization appeals, consisting of nine Medi-Cal, seven SPD prior authorization appeals, and 12 pharmacy authorization appeals, consisting of eight Medi-Cal and four SPD prior authorization appeals, were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

BHT: 15 Medical Records, including five grievances related to BHT files, were reviewed for evidence of care coordination and collaboration between the provider of care and individual 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

No verification studies were conducted.

Category 4 – Member's Rights

Quality of Care Grievances: 11 Quality of Care grievances with PQI, including seven

Medi-Cal and four SPD files, were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Quality of Service Grievances: 29 Quality of Service grievances, including nine Medi-Cal, five SPD, ten exempt Medi-Cal, and five exempt SPD grievance cases, were reviewed for timeliness and appropriate resolution.

Call Inquiry: eight call inquiries, including five Medi-Cal and three SPD cases were reviewed to verify the classification and investigation process.

Category 5 – Quality Management

No verification studies were conducted.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: Ten cases were reviewed for timely processing and reporting requirements.

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, 2019 through January 31, 2020 **DATE OF AUDIT: January 27, 2020 through February 7, 2020**

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1	APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES

3.1.1 Communication and enforcement of providers' compliance with appointment wait times requirement

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

The Plan shall develop, implement, and maintain a procedure to monitor waiting times to obtain various types of appointments. (*Contract, Exhibit A, Attachment 9. 3. C*)

The Plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments. (*CCR, Title 28, section 1300.67.2.1*)

Finding: The Plan did not communicate and enforce providers' compliance with the timeliness standards for members to obtain various types of appointments. The 2019 Timely Access Survey conducted the monitoring and found non-compliance of access timeliness standards by providers for the Plan's entire network. The Plan did not communicate and enforce providers' compliance because the survey report outcome did not identify and analyze the performance of non-compliant individual providers.

Plan's *Policy GG1600 (dated 9/6/2018)* indicates that if a CAP was issued, a health network shall take all necessary and appropriate action to identify the causes underlying the identified timely access deficiencies.

The Plan was not able to communicate and implement corrective actions for non-complying providers in its networks to ensure compliance with accessibility standards as required by the Contract. Although the Plan completed its appointment wait time's access survey, the results of this survey indicated the overall compliance rate for its various provider types in its entire network but it did indicate which providers did not comply with the access timely standards. For example, the 2019 Timely Access Survey reported that for providers surveyed, 70% of PCPs (431 of 616), 71% of OB/GYN providers (48 of 68), and 57% of specialty providers (349 of 608) complied with the non-urgent, pre-natal or routine appointment standards. As a result, the Plan was not able to identify any non-compliant providers and follow up with CAPs.

Without implementing effective communication and enforcement of corrective measures for providers, the Plan will continue to have non-compliant providers that could delay needed medical services to its members.

Recommendation: Ensure that Plan communicate and enforce corrective actions for non-compliant providers.

3.1.2 Telephone wait times

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 access standards. The Plan shall develop, implement, and maintain a procedure to monitor waiting times for telephone calls. (*Contract, Exhibit A, Attachment 9. 3. C*)

Finding: The Plan did not effectively monitor wait times for member's calls to provider's offices (answer and return).

Plan's *Policy GG1600 (dated 9/6/2018)* indicated the timeframe requirement for telephone wait times during member's call to provider offices was 30 seconds to pick up the call.

During the onsite interview, the Plan stated that the telephone wait times is determined through the *Provider Experience and FSR Addendum Form* that asked providers how long it took office staff to return an urgent and not urgent message, on average. This is not a sufficient monitoring procedure since the telephone wait times at provider offices were self-reported by the providers' staff.

Although the Plan has access standards for telephone wait time, the Plan's monitoring methodology was not sufficient. Without objective measurements, the Plan cannot identify non-compliant providers and this may result in members not having timely access and information for treatment.

Recommendation: Develop, implement, and maintain a procedure to effectively monitor telephone wait time for member calls to the provider's offices, including answering and returning calls.

3.1.3 Communication and enforcement of provider's compliance with office wait time requirement

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 access standards. The Plan shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices. (*Contract, Exhibit A. 9. C*)

The Plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments. (CCR, Title 28, section 1300.67.2.1)

Finding: The Plan did not communicate, enforce, and effectively monitor providers' compliance with office wait times. The *Consumer Assessment of Healthcare Providers and Systems (CAHPS)* survey found office wait times non-compliance for its overall network and its delegates, but the survey results from member responses were not able to determine which individual providers did not comply with office wait time requirements. Thus, as a result, the Plan did not communicate, enforce, and effectively monitor providers' compliance with office wait times as required by the Contract.

Plan's *Policy GG1600 (dated 9/6/2018)* indicated the timeframe requirement for office wait times was 45 minutes or less. The Plan stated that office wait times were monitored through the *CAHPS Member Survey*. However, the survey results can only identify compliance of the office wait time requirements by Plan's overall network and delegated entities, but it could not determine compliance by each provider because the survey was conducted on members and not on providers. For example, the survey report showed that 14.5% (416 of 2,860) of members surveyed indicated that providers did not comply with its office wait time requirement of 45 minutes. The *CAHPS Member Survey* cannot identify any non-compliant providers.

The Plan's Member Survey determined non-compliance of office wait times in its overall network but the Plan was not able to identify individual non-compliant providers. In order to ensure member access to timely medical care at provider offices, corrective actions need to be communicated and enforced for providers who do not comply with the office wait time requirement.

Recommendation: Ensure that the Plan communicate and enforce corrective actions for providers who do not comply with office wait time requirement.

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Grievance classification of call inquiries

The Plan shall implement and maintain procedures to monitor the Member's Grievance System and the expedited review of grievances required under CCR, Title 28, sections 1300.68 and 1300.68.01 and CCR, Title 22, section 53858.
(*Contract, Exhibit A.14.2.)*

"Grievance" means a written or oral expression of dissatisfaction regarding the Plan and/or provider, including Quality of Care concerns, and shall include a complaint, dispute, and request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered as a grievance.
(CCR, Title 28, section 1300.68. a. b)

An inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other Managed Care Plan processes. A beneficiary need not use the term "grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a grievance. If a beneficiary expressly declines to file a grievance, the complaint shall still be categorized as a grievance and not an inquiry.
(All Plan Letter (*APL)17-006*)

Finding: The Plan classified members' written or verbal complaints as inquiries rather than grievances. The Plan does not have a policy and procedure to distinguish a grievance from an inquiry.

During the interview, the Plan stated that it does not have policy and procedures to distinguish grievances from inquiries and that the Customer Service Representatives make the decision whether it's a grievance or an inquiry. The Plan indicated that the misclassification occurred due to the lack of training and experience of the Customer Service staff.

In the verification study of eight member call inquiries, the Plan misclassified two that should have been classified as grievances.

For example:

- The member called on February 1, 2019 to follow-up on a Prior Authorization for liver specialty care request that was supposedly submitted by the PCP on January 24, 2019. The Plan stated that they did not receive any prior authorization for a specialty care from the member's PCP. Though this case was a potential dissatisfaction regarding treatment delay, the Plan did not classify it as a grievance or investigate the prior authorization and treatment delay. Despite of all these issues, the Plan just closed the case and educated the member that it can change a PCP over 30 days.

- The member's mother called on February 1, 2019 and stated that the member receives prescribed medication for seizures every month but was told by the pharmacy that it is not covered. Member really needs this medication and is completely out. Although this case is a potential dissatisfaction of delay in receiving medication for the member, the Plan classified this case as an inquiry and resolved it in the next three days (February 4, 2019) as the prior authorization for the medication was approved after the pharmacy processed the prescription.

The Plan classified and investigated both of these cases as inquiries instead of grievances.

Misclassification of grievances may lead to inadequate investigations and missed opportunities for healthcare QI.

Recommendation: Develop and implement policy and procedures to distinguish a grievance from an inquiry and ensure that Customer Service staff receive training to properly classify grievances.

4.1.2 Grievance identification and processing

The Plan shall have procedures to ensure the participation of individuals with authority to require corrective action. Grievances related to medical Quality of Care issues shall be referred to the Plan's Medical Director.
(*Contract, Exhibit A.14.2.D*)

The Plan shall implement and maintain procedures to monitor the Member's Grievance System and the expedited review of grievances required under CCR, Title 28, sections 1300.68 and 1300.68.01 and CCR, Title 22, section 53858.
(*Contract, Exhibit A.14.2*)

The member grievance procedures shall at a minimum, provide for the immediate submittal of all medical Quality of Care grievances to the Medical Director for action. *(CCR, Title 28, section 53858. e. 2)*

Finding: The Plan did not correctly identify and process Quality of Care grievances. The Plan classified clinical grievances as care delivery and investigated them as Quality of Service grievances.

Plan *Policy# HH1102 (dated 3/7/2019), Member Grievance*, required to refer all grievances related to medical Quality of Care issues to the QI Department for review by Plan's Chief Medical Officer (CMO) or their designee and any action deemed necessary under the quality review process.

Plan *Policy# HH1109 (dated 8/1/2016), Complaints Decision Matrix*, required the Plan Grievance and Appeals Resolution Services (GARS) staff shall prepare the complaint case for review by the appropriate level of decision-maker, including the referral of all clinical cases for review by the CMO, or their designee.

During the interview, the Plan stated that it was not aware that GARS staff did not properly identify and classify clinical grievances. The Plan indicated that this happened due to the lack of training and experience of GARS staff.

In the verification study of 14 Quality of Service (care delivery) grievances, the Plan misclassified 11 Quality of Service (care delivery) cases that should have been classified and processed as Quality of Care grievances.

For example:

- A member stated that his legs are very swollen and he suspected it could be liquid retention due to kidney failure. The member also stated that he cannot see very well and for this problem, he had not been referred to any specialists. Member also stated that he suffered from diabetes but felt his provider had not been providing enough attention to his conditions.
- Another member felt the hospital did not care about his medical needs or physical limitations. The member was upset because he was advised he would be discharged from the hospital and sent to a shelter. The member asked to be sent to a nursing home instead but was told that if he did not meet the medical criteria therefore he would go to a shelter. Lastly the member stated that he was overweight in a wheelchair and felt that the shelter could not assist with his medical needs or physical limitations.

The Plan classified and processed both of these cases as Quality of Service instead of Quality of Care grievances.

Improper classification and processing of grievances may lead to inadequate grievance resolution and missed opportunities for healthcare QI.

Recommendation: Revise and implement policies and procedures to ensure that the GARS staff receives training to properly identify and process Quality of Care grievances.

4.1.3 Immediate submission of Quality of Care Grievances for Medical Director's review and action

The Plan shall implement and maintain procedures to monitor the Member's Grievance System and the expedited review of grievances required under CCR, Title 28, sections 1300.68 and 1300.68.01 and CCR, Title 22, section 53858.
(*Contract, Exhibit A.14.2*)

The member grievance procedures shall at a minimum, provide for the immediate submittal of all medical Quality of Care grievances to the Medical Director for action.
(CCR, Title 22, section 53858. e. 2)

The Managed Care Plan (MCP) shall ensure the participation of individuals with authority to require corrective action. All grievances and appeals related to medical Quality of Care issues shall be immediately submitted to the MCP's Medical Director for action.
(*APL 17-006*)

Finding: The Plan did not immediately submit all the Quality of Care grievances to its Medical Director for action.

Plan *Policy# HH1102 (dated 3/7/2019), Member Grievance*, required the Plan to refer all grievances related to medical Quality of Care issues to the QI Department for review by Plan's CMO or their designee and any action deemed necessary under the quality review process. However, this policy does not include the language of "immediate submittal of all medical Quality of Care grievances to the Medical Director for action".

The Plan did not immediately submit the Quality of Care grievance cases for Medical Director's review when they were initially being processed. The nurse at the Grievance Department determines whether a grievance is clinical. If it is a clinical grievance, the GARS forwards it to the QI Department to open a potential QI case for that clinical grievance.

In the verification study of 11 Quality of Care grievances, the Medical Director did not review medical records during the grievance process. The Medical Director did not

review all the 11 grievances until they were processed as PQI cases, which on average took about 130 days after the Plan received the grievances.

For example:

- A member filed the grievance on February 26, 2019 and a PQI case was opened on March 4, 2019. The Plan received the medical records from the provider on June 4, 2019, which was 90 days after the resolution letter was sent to member. The Medical Director reviewed the clinical grievance on June 10, 2019, which was 196 days after initial receipt of the grievance.
- Another member filed the grievance on February 14, 2019 and a PQI case was opened on February 19, 2019. The Plan received the medical records from the provider on July 25, 2019, which was 149 days after the resolution letter was sent to the member. The Medical Director reviewed the clinical grievance on July 26, 2019, which was 162 days after initial receipt of the grievance.

In both of these cases, the Plan did not immediately submit the medical Quality of Care grievances to the Medical Director for action.

If Quality of Care grievances are not immediately submitted for Plan's Medical Director for any corrective actions, it could lead to an inadequate resolution of the problems and missed QI opportunities.

Recommendation: Revise and implement policies and procedures to ensure that all Quality of Care Grievances are immediately submitted to the Plan's Medical Director for action.

4.1.4. Grievance resolution

The Plan shall implement and maintain procedures to monitor the Member's Grievance System and the expedited review of grievances required under CCR, Title 28, sections 1300.68 and 1300.68.01 and CCR, Title 22, section 53858.
(*Contract, Exhibit A.14.2*)

"Resolved" means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the Plan's grievance system, including entities with delegated authority.
(*CCR, Title 28, section 1300.68. a. 4*)

The Plan shall continue to comply with the State's established time frame of 30 calendar days for grievance resolution. "Resolved" means that the grievance has reached a final conclusion with respect to the member's submitted grievance as delineated in existing State regulations.
(*APL 17-006*)

Finding: The Plan sent resolution letters to members without completing the investigation process to resolve both Quality of Service and Quality of Care grievances.

Plan *Policy# HH1102*, (*dated 3/7/2019) Member Grievance*, requires escalation of the grievance for review of the factual findings, proposed resolution, and any other relevant information, in accordance with Plan *Policy HH.110 Complaint Decision Matrix*, and shall issue a decision with respect to the grievance. The grievance resolution letter shall describe the grievance and provide a clear and concise explanation of the reasons for the decision.

The Plan did not review the medical records for both Quality of Service and Quality of Care grievances before sending the resolution letter. The Plan stated that there is no medical records review in the Quality of Care grievances investigation process. Once the resolution letter was sent out to the member, the grievance was deemed resolved but the medical records were not reviewed to determine the nature of the complaint.

In a verification study, the Plan misclassified 11 of 14 Quality of Care grievances as Quality of Service grievances. The Plan sent the resolution letters without reviewing the clinical portion of the grievance and medical records. In addition, for all 11 Quality of Care grievances reviewed, the Plan sent the resolution letters without reviewing the medical records to determine the member's condition(s) related to the complaint.

For example:

- On March 19, 2019, a member's sister complained that the hospital was not doing anything about member's swollen genitals and that his lungs are filling up with water. The member has not begun his exercises for his prosthetic after having his leg amputated. The member has three big bedsores and has not gotten out of his bed for three months. The Plan just made a phone call to a care center and sent the resolution letter on April 15, 2019 without reviewing any of the medical records from the provider. The Plan received the medical records on June 20, 2019, which was about 65 days after the Plan sent the resolution letter.
- On February 26, 2019, a member arrived at a labor and delivery location and was told to walk herself to the ER location of the hospital. The member had asked for a wheelchair or at least an escort to walk with her because of the amount of pain she was in, but was told to wait outside. The member waited outside for about one hour and then asked again if they were able to see her. The member was told that she came in at the wrong time, as they did not have space to see her. The member ended up leaving and going to another ER and was seen right away. The member was told that she was having contractions and was given a shot to stop the contractions and pain. The Plan did not receive any documents regarding this grievance prior to sending the resolution letter on March 7, 2019 stating that that member's grievance case has been referred to

the QI Department. The Plan received all the documents including medical records on June 4, 2019, which was about a month after the Plan sent the resolution letter.

In both of the above cases, the Plan sent resolution letters without reviewing the medical records. The Plan did not address the complaint(s) in the resolution letter. Therefore, the Plan did not resolve the grievance before sending the resolution letter.

Resolution letters sent to members without actually resolving the issue(s) could lead to inadequate grievance investigation and resolution. This could also lead to delay of proper care for members.

Recommendation: Develop and implement a system to ensure resolution letters are sent to members after the grievances are completely resolved and investigated.

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, 2019 Through January 31, 2020
Report Issued:	August 11, 2020

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 (Plan) and its implementation of the State Supported Services (SSS) contract No. 08-85221 with the State of California. The SSS contract covers abortion services for the Plan.

The onsite audit of the Plan was conducted from January 27, 2020 through February 7, 2020. The audit covered the review period of February 1, 2019 through January 31, 2020. 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 7, 2020.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Orange County Organized Health System dba CalOptima

AUDIT PERIOD: February 1, 2019 through January 31, 2020
DATE OF AUDIT: January 27, 2020 through February 7, 2020

STATE SUPPORTED SERVICES

FINDING(S):

During the audit, interviews with Plan personnel were conducted and the Plan's policies and procedures, Provider Manual, and Member Handbook were reviewed. The audit determined that the Plan had procedures for the provision of SSS and the timely processing of claims for these services.

In the verification studies of SSS claims, it was noted that these services were covered for members, and no prior authorizations were required. No material deficiencies were noted during the audit period.

RECOMMENDATION(S): None