

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**

**2021**

Contract Number: 08-85214

Audit Period: February 1, 2020  
Through  
December 31, 2021

Report Issued: November 8, 2022

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## I. INTRODUCTION

CalOptima Health Plan (Plan) was founded in 1993 via a partnership of the 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 in the Orange County.

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 its members residing in Orange County. As of November 30, 2021, the composition of Plan membership was as follows:

- Medi-Cal: 849,616 Medi-Cal recipients for low-income individuals, families with children, seniors, and people with disabilities.
- OneCare (Health Maintenance Organization Special Needs Plan): 2,274 Medicare Advantage Special Needs recipients.
- OneCare Connect: 14,877 CalMediConnect recipients.
- Program of All-Inclusive Care for the Elderly: 415 Medicare/Medicaid and Medi-Cal recipients aged 55 and older who live in the service area and are eligible for nursing facility services.

## II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of February 1, 2020 through December 31, 2021. The review was conducted from January 24, 2022 through February 4, 2022. The audit consisted of document reviews, verification studies, and interviews with Plan personnel.

An Exit Conference with the Plan was held on September 27, 2022. 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 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, 2019 through January 31, 2020, was issued on August 11, 2020. This audit examined documentation for compliance and to determine to what extent the Plan has operationalized its Corrective Action Plan.

The summary of the findings by category is as follows:

### **Category 1 – Utilization Management**

The Plan is required to ensure accountability and quality improvement for delegated activities to ensure that the delegates fulfill their responsibilities. The Plan's delegation oversight of Post-Stabilization Authorizations (PSA) that were processed by its delegated entity, Prospect Medical Group, did not ensure that the PSA requests from outside of the Plan's network were approved or denied within the required time frame of 30 minutes or deemed them automatically approved if the decision was not rendered within this required time frame.

### **Category 2 – Case Management and Coordination of Care**

The Plan is required to ensure that their network providers provide oral or written anticipatory guidance to the parents or guardians of a child at each Periodic Health Assessment (PHA), starting at six months of age and continuing until 72 months of age. The Plan did not ensure the provision of oral or written anticipatory guidance on blood lead levels by its network providers to the parents or guardians of child members starting at six months of age and continuing until 72 months of age.

The Plan is required to ensure their network providers order or perform blood lead screening tests on all child members at 12 months and 24 months of age. The Plan did not ensure the provision of the required blood lead screening tests to members at 12 months and 24 months of age.

### **Category 3 – Access and Availability of Care**

The Plan and its transportation brokers are required to use a DHCS-approved Physician Certification Statement (PCS) form to determine the appropriate level of service for Medi-Cal members. The form must have the start and end dates for the Non-Emergency Medical

Transportation (NEMT) services. The Plan did not ensure that the PCS included the start and end dates for NEMT services.

#### **Category 4 – Member's Rights**

The Plan and Plan's delegate are required to send the grievance acknowledgment letter within five calendar days and the grievance resolution letter within 30 calendar days after receiving the grievance. The Plan and Plan's delegate did not send the resolution letter for quality of service grievances within 30 calendar days after the grievance was received. Also, the Plan's delegate did not send the quality of service grievance acknowledgment letters within five calendar days after receiving the grievance.

The Plan is required to ensure that grievances related to medical Quality Of Care (QOC) issues are referred to the Plan's Medical Director. The Plan did not ensure that all medical QOC grievances were referred to the Medical Director for review. The Plan categorized grievances that members requested not to formally file as declined grievances. The declined QOC grievances were resolved and closed by customer service representatives.

#### **Category 5 – Quality Management**

The Plan must ensure that the UM's activities are integrated into the Quality Improvement System (QIC) to continuously review, evaluate, and improve access to and availability of services. The Plan's QIC did not review UM activities to ensure that members' timely access to care was not delayed for any reason. Delays in UM prior authorizations were not escalated to the QIC.

#### **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 whether the medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and other authorities, and state Contracts.

#### **PROCEDURE**

The review was conducted from January 24, 2022, through February 4, 2022. The audit included a review of the Plan's Contracts with DHCS and other authorities, 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 delegated entities.

The following verification studies were conducted:

#### **Category 1 – Utilization Management**

Prior Authorization Requests: 37 medical prior authorizations, ten pharmacy prior authorizations, and 16 delegated prior authorizations were reviewed for consistent application of criteria, timeliness, appropriate review, and communication of results to members and providers.

Prior Authorization Appeals: Ten medical prior authorization appeals, ten pharmacy prior authorization appeals, and six delegated prior authorization appeals were reviewed for appropriate and timely adjudication.

Post-Stabilization Authorization: 46 non-contracted samples were reviewed for timely decisions.

Delegated Post-Stabilization Authorization: 34 non-contracted samples were reviewed for timely decisions.

#### **Category 2 – Case Management and Coordination of Care**

Blood Lead Screening: 20 blood lead screening samples 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 blood lead screening was ordered and performed at ages 12 months and 24 months.

Whole Child Model: Six Whole Child Model files were reviewed for appropriate care coordination.

#### **Category 3 – Access and Availability of Care**

Non-Emergency Medical Transportation PCS Forms: 23 PCS form samples were reviewed for completion.

#### **Category 4 – Member's Rights**

Call-Inquiry: Ten CalOptima in-house and nine delegated call-inquiry cases were reviewed to verify the grievance classification and investigation process.

Exempt Grievances: 15 CalOptima in-house and 15 delegated exempt grievance cases were reviewed to verify the classification, reporting timeframes, and investigation process.

Quality of Service Grievances: 15 CalOptima in-house and ten delegated quality of service grievance cases were reviewed for timeliness, investigation process, and appropriate resolution.

Quality of Care (QOC) Grievances: 24 QOC standard grievances and four QOC expedited grievances were reviewed for processing, clear and timely response, and appropriate level of review.

#### **Category 5 – Quality Management**

Potential Quality Improvement (PQI): 12 PQI files were reviewed for response to the complainant and submission to the appropriate level for review.

#### **Category 6 – Administrative and Organizational Capacity**

Overpayment Reporting: 17 overpayment recovery cases were reviewed for timely reporting to DHCS and annual reporting of total overpayment recoveries to DHCS.

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

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**CATEGORY 1 – UTILIZATION MANAGEMENT**

<b>1.4</b>	<b>POST-STABILIZATION AUTHORIZATION (PSA)</b>
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**1.4.1 Delegation Oversight of Post-Stabilization Authorization Request - Prospect Medical Group**

The Plan shall render a decision within 30 minutes upon receipt of a Post-stabilization Authorization request from an emergency services provider, or the request is deemed approved, pursuant to California Code of Regulation (CCR), Title 28, Section 1300.71.4 (*Contract, Exhibit A, Attachment 5.3B*)

In accordance with California Code of Regulation (CCR), Title 28, Section 1300.71.4, the Plan shall approve or disapprove a request for post-stabilization inpatient services made by a non-contracting provider on behalf of a member within 30 minutes of the request. If the Plan fails to approve or disapprove authorization within the required timeframe, the authorization will be deemed approved. (*Contract, Exhibit A, Attachment 8.12.G*)

The Plan shall maintain a system to ensure accountability for delegated quality improvement activities, such as: evaluating the subcontractor's ability to perform the delegated activities, including an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities, ensures subcontractor meets standards set forth by the Plan and DHCS and Includes the continuous monitoring. (*Contract, Exhibit A, Attachment 4.6*)

*Plan Policy GG1619 (revised date 12/3/20)* states that the Plan shall oversee the functions, responsibilities, processes, and performance of a delegated entity and its services. The Plan's oversight activities included a review of compliance with regulatory requirements, contractual requirements, and Plan policies and procedures.

Prospect's *Policy MM2025 (revised 1/30/2020)* states that within 30 minutes, a PSA request would be approved or denied with further coordination of the care. Prospect must cover the service if it does not respond within 30 minutes.

**Finding:** The Plan's delegation oversight of PSA that was processed by its delegated entity, Prospect Medical Group, did not ensure that the PSA requests from outside of the Plan's network were approved or denied within the required time frame of 30 minutes, or deemed them automatically approved if the decision was not rendered within this required time frame.

During the interview, the Plan indicated that its PSA oversight audit for Prospect was completed on January 5, 2022. The oversight audit found that prospect failed to submit a complete and



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accurate list of PSA requests. The oversight audit did not indicate whether the delegate complied with approving or denying the PSA within the required time frame of 30 minutes, deemed them automatically approved if the decision was not rendered within this required time frame.

A verification study was conducted on 13 PSA samples of the delegated entity, prospect. Among the 13 samples, four of 13 were denied, and nine of 13 were partially denied. All the samples did not meet the required time frame to make a decision within 30 minutes upon receipt of a PSA request and were not deemed automatically approved as required by the Contract.

For example:

- A PSA request was received on 4/5/21 at 1:10 pm for a member admitted on 4/5/21 at 10:40 pm from a non-contracted facility. The member was discharged on 4/8/20. A denial decision was made on 4/13/20 at 9:11 am, which does not comply with the required time frame of 30 minutes.
- A PSA request was received on 2/10/20 at 1:53 pm for a member admitted on 2/10/20 at 4:34 pm from a non-contracted facility. The member was discharged on 2/11/20. A denial decision was made on 2/10/20 at 4:40 pm, which does not comply with the required time frame of 30 minutes.

The Plan must maintain a system to ensure accountability and quality improvement for delegated activities. Without an effective monitoring system, the Plan might lose its ability to evaluate its delegated entities' performance in providing quality care to their members.

**Recommendation:** Ensure the Plan's delegates adhere to the contractual requirement of approving or denying the PSA request from a non-contracted provider within the required time frame of 30 minutes, or deem the PSA requests automatically approved after this required timeframe.

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**CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE**

<b>2.1</b>	<b>BLOOD LEAD SCREENING (IHA)</b>
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**2.1.1 Anticipatory Guidance for Lead Exposure**

The Plan is required to comply with all Policy Letters and All Plan Letters (APL) issued by DHCS. (*Contract, Exhibit E, Attachment 2.1.D*)

The Plan must ensure that their network providers provide oral or written anticipatory guidance to the parents or guardians of a child member that, at a minimum, includes information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age. This anticipatory guidance must be provided to the parent or guardian at each PHA, starting at six months of age and continuing until 72 months of age. (*All Plan Letter (APL) 20-016*)

Every healthcare provider who performs a periodic health assessment of a child shall provide written or oral anticipatory guidance to a parent or guardian of the child regarding harmful exposure to lead. The anticipatory guidance must be provided at each periodic health assessment, starting at six months of age and continuing until 72 months of age. (*California Code of Regulations (CCR), Title 17, section 37100 (a)(1)*)

*Plan Policy GG 1717: Blood Lead Screening of Young Children (revised date 11/1/2021)* states that the Plan must, through its primary care providers, give oral or written lead exposure anticipatory guidance for children ages six months to 72 months. Additionally, the Plan must monitor the provision of blood lead anticipatory guidance in accordance with DHCS Medical Record Review (MRR) tool and Plan policy. (*GG 1608: Full Scope Site Reviews.*)

*Plan Policy GG 1608: Full Scope Site Reviews* outlines the Plan's site review process and includes Facility Site Review (FSR), MRR, and the process by which the Plan must conduct, track, and report site reviews.

**Finding:** The Plan did not ensure the provision of oral or written anticipatory guidance by its network providers to the parents or guardians of child members ages six months and continuing until 72 months.

In a verification study of members ages six months through 72 months, 16 of 20 member records did not document the provision of blood lead anticipatory guidance.

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*Policy GG 1717: Blood Lead Screening of Young Children* states that the Plan must monitor the provision of blood lead anticipatory guidance using the MRR tool during FSR. However, the Plan's MRR tool did not have any pediatric preventive review criteria to determine if blood lead anticipatory guidance was provided for child members aged six months to 72 months.

During the interviews, the Plan acknowledged it did not monitor the provision of blood lead anticipatory guidance to parents and guardians of the member ages six months and continuing until 72 months because it did not have such a process.

If age-appropriate blood lead anticipatory guidance is not given to parents or guardians, at-risk children may not be identified, and environmental investigations will not be conducted, resulting in further lead exposure and possible blood lead poisoning.

**Recommendation:** Develop and implement procedures to ensure the provision of oral or written blood lead anticipatory guidance.

### 2.1.2 Blood Lead Screening Tests

The Plan is required to comply with all Policy Letters and APLs issued by DHCS. (*Contract, Exhibit E, Attachment 2.1.D*)

The Plan must ensure their network providers order or perform blood lead screening tests on all child members at 12 months and 24 months of age and when the provider becomes aware that the child, who is 12 months to 72 months, has no documented evidence of a blood lead screening test. (*All Plan Letter 20-016*)

Every health care provider performing a periodic health assessment of a child shall perform the screening and evaluation for blood lead level when the child is twelve months of age and twenty-four months of age, or at any time up to age 72 months if not done at the specified ages. (*California Code of Regulations (CCR), Title 17, section 37100 (b)(2)(A)-(D)*)

*Plan Policy GG 1116: Pediatric Preventive Services (revised date 4/1/2021)* states that the Plan and its network providers must ensure the provision of blood lead screening to child members at age twelve months, twenty-four months, or a catch-up screening for a child up to 72 months if there were no documented blood lead screenings.

*Plan's Policy GG 1717: Blood Lead Screening of Young Children* outlines the process by which the Plan ensures the blood lead screening to members at six months of age and continues until 72 months of age. This policy states that the Plan must monitor the provision of blood lead screening in accordance with the DHCS MRR tool and Plan Policy. (*GG 1608: Facility Site Reviews.*)

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*Plan Policy GG 1608: Facility Site Reviews* outlines the Plan's site review process and includes FSR, MRR, and the process by which the Plan conducts, tracks, and reports site reviews.

**Finding:** The Plan did not ensure the provision of blood lead screening tests to child members at 12 months and 24 months of age and up to 72 months when there were no documented blood lead screenings.

In a verification study of members ages 12 months through 72 months, 14 of 20 member records did not document the provision of blood lead screening tests.

*Plan Policy GG 1717: Blood Lead Screening of Young Children* states that the Plan must monitor the provision of blood lead screening tests using the MRR tool during FSR. However, five of the nine FSRs did not review any member eligible for blood lead screening tests. The other four of nine FSRs only had one to four eligible member records for blood lead screening test review. In addition, two of nine FSRs determined that a blood lead screening test was not provided for one and two eligible members, but no remedial action was recommended for the providers.

During the interview, the Plan stated that in addition to the FSR process, it devised a monthly customized report that reviewed encounter data and, together with the supplemental file from DHCS, identified and listed eligible child members who had not received a blood lead screening test. This monthly list was sent to the health network delegates, and the Plan expected this list to be shared with subcontracted PCPs to schedule and perform the blood lead tests. However, the Plan did not have a procedure to ensure that subcontracted PCPs received and utilized this list to reach out and schedule missed blood lead screening tests.

If age-appropriate blood lead screening tests are not given in a timely manner, at-risk children may not be identified, and this may result in lead poisoning that causes damage to the brain and nervous system, learning and behavior problems, and hearing and speech problems, and slow growth and development.

**Recommendation:** Implement a process to ensure the timely provision of the required blood lead screening tests to child members at the appropriate intervals.

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**CATEGORY 3 – ACCESS AND AVAILIBLTY OF CARE**

**3.8**

**NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)**

**3.8.1 Physician Certification Statement Form Requirements**

The Plan and transportation brokers must use a DHCS-approved PCS form to determine the appropriate level of service for Medi-Cal members. In order to ensure consistency amongst all MCPs, all NEMT PCS forms must include the dates of service needed. The form must have the start and end dates for the NEMT services. Authorizations are allowed a maximum of 12 months. *(All Plan Letter 17-010)*

**Finding:** The Plan did not ensure that PCSs included the start and end dates for NEMT services.

The Plan did not have any procedures in place during the audit period to ensure the PCS forms had the required components.

A verification study was conducted on the Plan's PCS forms. A review of the files revealed that three of the 23 PCS forms did not include both start and end dates.

For example:

- A PCS document approved one year of NEMT services and indicated "various appointments." But the form did not have a start date, approximate duration, or service. There was no documentation that the Plan contacted the provider to correctly fill out the incomplete PCS form.
- Another PCS example included the service start date but did not indicate an end date. The approximate service duration was documented as "ongoing."

The Plan did not ensure that the PCS forms contained the required components in both examples.

The Plan is not in compliance with APL 17-010 requirements when PCS forms do not include service start and end dates. Incomplete PCS forms may result in delayed authorizations or unreimbursed NEMT services.

**Recommendation:** Implement a process to ensure PCS forms have start and end dates for authorized NEMT services.

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### CATEGORY 4 – MEMBER'S RIGHTS

#### 4.1 GRIEVANCE SYSTEM

##### 4.1.1 Plan Grievance Resolution Letters

Both federal and state law delineates timeframes for resolving grievances and sending a written resolution to the member. The state's established timeframe is 30 calendar days. The Plan must comply with the state's established timeframe of 30 calendar days for grievance resolution. (*All Plan Letter 21-011*)

*Plan Policy HH 1102: Member Grievance (revised date 4/1/2021)* states the Plan must send to the member, a member's authorized representative, or provider acting on behalf of the member and with the member's written consent a grievance resolution letter, not to exceed 30 calendar days from the date the Plan receives an oral or written grievance.

**Finding:** The Plan did not send resolution letters for quality of service grievances within the required 30 calendar days.

During the interview, the Plan stated that they had to use some non-clinical staff to provide administrative support for the clinical staff to resolve QOC grievances due to the shortage of clinical staff.

In a verification study of quality of service grievance cases, the resolution letters for ten of 15 cases were not sent within the 30 calendar day timeframe.

For example:

- A member filed a grievance on 12/22/2020, and the Plan sent the grievance resolution letter on 3/1/2021. The Plan took 69 calendar days to send the resolution letter.
- A member filed a grievance on 4/22/2021, and the Plan sent the grievance resolution letter on 6/11/2021. The Plan took 50 calendar days to send the resolution letter.

Delays in resolving grievances could potentially impact member treatments and the Plan's quality of service.

**Recommendation:** Implement Plan procedures to ensure that the grievance resolution letters are sent within the required time frame of 30 calendar days.

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### 4.1.2 Delegated Grievance Resolution Letters

The Plan maintains the responsibility of ensuring that delegates are, and continue to be, in compliance with all applicable Medi-Cal, state and federal laws, and contractual requirements. (*All Plan Letter 17-004*)

Both federal and state law delineates timeframes for resolving grievances and sending a written resolution to the member. The state's established timeframe is 30 calendar days. The Plan must comply with the state's established timeframe of 30 calendar days for grievance resolution. (*All Plan Letter 21-011*)

The delegate shall implement and comply with CalOptima Policies relating to member grievances. (Article 3, section 3.7.1, Administrative Obligations of the Delegation Contract)

*Plan Policy HH 1102: Member Grievance (revised date 3/7/2019)* states that the Plan shall send the member, a member's authorized representative, or a provider acting on behalf of the member with written consent, a grievance resolution letter, not to exceed 30 calendar days from the day the Plan receives the oral or written grievance.

*Plan Policy HH 1103: Health Network Member Grievance and Appeal Process (revised date 4/1/2021)* states that the delegate shall send the member a grievance resolution letter no later than 30 calendar days after receipt of an oral or written grievance or appeal.

**Finding:** The Plan did not ensure its delegate met the standards set forth by the Plan and DHCS. The delegate did not send the quality of service grievance resolution letters within the required 30 calendar days.

During the interview, the Plan stated that they conducted an annual delegation oversight audit and chose ten quality-of-service grievance samples for a verification study. The Plan also identified that the delegate did not send grievance resolution letters within the 30-day required time frame. The delegate responded to the Plan it did not meet the time frame requirement due to a system time zone error which resulted in an 8-hour delay. However, the DHCS verification samples showed that the delegate took approximately 50 calendar days to send resolution letters.

A verification study was conducted on the delegate's grievance process. Ten quality-of-service grievance cases were reviewed for timeliness, investigation process, and appropriate resolution. Eight out of ten cases did not meet the 30 calendar day resolution letter timeframe.

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For example:

- A member filed a grievance on 6/24/2021, and the Plan's delegated entity sent the resolution letter on 8/17/2021. The Plan's delegated entity took 54 calendar days to send the resolution letter.
- A member filed a grievance on 7/4/2021, and the Plan's delegated entity sent the grievance resolution letter on 8/23/2021. The Plan's delegated entity took 50 calendar days to send the resolution letter.

Delays in resolving grievances could potentially impact member treatments and the Plan's quality of service.

**Recommendation:** Develop and implement Plan procedures to ensure the Plan delegate sends quality of service grievance resolution letters within the required time frame of 30 calendar days.

### 4.1.3 Delegated Grievance Acknowledgement Letters

The Plan maintains the responsibility of ensuring that delegates are, and continue to be, in compliance with all applicable Medi-Cal, state and federal laws, and contractual requirements. (*All Plan Letter 17-004*)

In accordance with state law, MCPs must provide written acknowledgment to the member that is dated and postmarked within five calendar days of receipt of the grievance. (*All Plan Letter 21-011*)

A grievance system shall provide a written acknowledgment within five calendar days of receipt, except for grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day. (CCR, Title 28, section 1300.68 (d)(1).)

The delegate shall implement and comply with CalOptima Policies relating to member grievances. (Article 3, section 3.7.1, Administrative Obligations of the Delegation Contract)

*Plan Policy HH 1102: Member Grievance (revised date 3/7/2019)* states that the Plan shall send the member an acknowledgment letter within five calendar days after receipt of a grievance.

*Plan Policy HH 1103: Health Network Member Grievance and Appeal Process (revised date 4/1/2021)* states that the delegate shall send the acknowledgment letter within five calendar days after receiving a grievance or appeal indicating receipt of the grievance or appeal.



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**Finding:** The Plan did not ensure its delegate met the standards set forth by the Plan and DHCS. The delegate did not send the quality of service grievance acknowledgment letters to members within five calendar days.

During the interview, the Plan stated that they conducted an annual delegation oversight audit and picked ten quality-of-service grievance samples for verification study. The Plan likewise identified that the delegate did not send grievance acknowledgment letters within the five-day required time frame. The delegate responded to the Plan it did not meet the time frame required due to a system time zone error which resulted in 8 hours delay. However, the audit samples selected by the DHCS audit showed that the delegate took about 30 calendar days to send the acknowledgment letters.

A verification study was conducted on the delegate's grievance process. Ten quality-of-service grievance cases were reviewed for timeliness, investigation process, and appropriate resolution. Six out of ten cases did not meet the five calendar-day acknowledgment letter timeframe.

For example:

- A member filed a grievance on 11/16/2020, and the Plan's delegated entity sent the acknowledgment letter on 12/17/2020. The Plan's delegated entity took 31 calendar days to send the acknowledgment letter.
- A member filed a grievance on 2/4/2021, and the Plan's delegated entity sent the grievance resolution letter on 3/12/2021. The Plan's delegated entity took 36 calendar days to send the acknowledgment letter.

Delays in member grievance acknowledgment can lead to delays in resolving the grievance and create additional dissatisfaction.

**Recommendation:** Implement Plan procedures to ensure the Plan delegate sends the grievance acknowledgment letters within the required time frame of five calendar days.

### 4.1.6 Quality of Care Grievance Medical Director Review

The Plan is required to have procedures to ensure that every grievance submitted is reported to an appropriate level and ensure the participation of individuals with authority to require corrective action. Grievances related to medical QOC issues shall be referred to the Plan's Medical Director. (*Contract, Exhibit A, Attachment 14.2.C-D*)

The Plan shall implement and maintain a member grievance system in accordance with California Code of Regulation (CCR), Title 28, Section 1300.68 (except Subdivision

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1300.68(c)(g) and (h)), 1300.68.0 (except Subdivision 1300.68.01(b) and(c)), California Code of Regulation (CCR), Title 28, Section 53858. (*Contract, Exhibit A, Attachment 14.1*)

The Plan cannot discourage the filing of grievances. If a member expressly declines to file a grievance, the complaint must still be categorized as a grievance and not an inquiry. (*All Plan Letter 21-011*)

The Plan is required to ensure the immediate submittal of all medical QOC grievances to the Medical Director for action. (*California Code of Regulations (CCR), Title 22, section 53858 (e)(2).*)

All declined grievances must be categorized and closed by Customer Service staff in accordance with *Plan Policy DD 2013 (revised date 12/22/2021)*, including assigning the closure of a grievance case with a "Declined Grievance/Resolved" disposition code if a member or its authorized representative expressly declines to file a grievance. Likewise, *Plan Policy HH 1102* states that all grievances related to medical QOC issues must be referred to the Quality Improvement Department for review by the Chief Medical Officer or their designees.

**Finding:** The Plan did not ensure that all medical QOC grievances were referred to the Medical Director for review. The declined QOC grievances were closed by customer service representatives without a Medical Director review.

During the audit period, the Plan logged 3,570 declined grievances closed by a customer service representative. There were 284 grievances where members' complaints were categorized as provider, specialist, provider issues, poor provider attitude, and the provider refused to refer, which included potential QOC grievances.

A review of seven of 284 declined grievances noted the following concerns:

- A member complained about PCP-forced services.
- A member's mother complained about PCP because they gave the member an injection for dry skin, which caused the member to have an allergic reaction.
- A member complained about their provider neglecting their health.
- A member complained that their provider would no longer see the member due to the member filing a grievance.

Plan personnel confirmed that all the declined grievances, including the seven samples reviewed, were closed by customer service representatives without referring to a Medical Director for review.

When the QOC grievances are not reviewed and resolved by a Medical Director, substandard medical care by providers may not be identified, which can lead to potential member harm.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

**PLAN:** Orange County Organized Health System dba CalOptima

**AUDIT PERIOD:** February 1, 2020 through December 31, 2022

**DATE OF AUDIT:** January 24, 2022 through February 4, 2022

**Recommendation:** Revise and Implement policies and procedures to ensure that all medical QOC grievances are referred to the Medical Director for review.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

**PLAN: Orange County Organized Health System dba CalOptima**

**AUDIT PERIOD: February 1, 2020 through December 31, 2022**

**DATE OF AUDIT: January 24, 2022 through February 4, 2022**

### CATEGORY 5 – QUALITY MANAGEMENT

#### 5.1 QUALITY IMPROVEMENT SYSTEM

##### 5.1.1 Quality Improvement Committee Oversight of UM Activity

The Plan is responsible for ensuring that the UM program includes integration of UM activities into the QIC, including a process to integrate reports on a review of the number and types of Appeals, denials, deferrals, and modifications to the appropriate QIS staff. (*Contract, Exhibit A, Attachment 5.1.G*)

The Plan is required to implement and maintain a written description of its QIS that includes a description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services. (*Contract, Exhibit A, Attachment 4.7.G*)

The Plan is required to implement an effective QIC in accordance with the standards in California Code of Regulation (CCR), Title 28, Section 1300.70. (*Contract, Exhibit A, Attachment A.4.1*)

The Plan's governing body and its quality assurance committee shall meet quarterly or more frequently if problems have been identified to oversee their respective quality assurance program responsibilities. (*California Code of Regulations (CCR), Title 28, section 1300.70 (b)(2)(C)*)

The Plan's quality assurance program shall be designated to ensure that appropriate care is consistent with professionally recognized standards of practice, is not withheld or delayed for any reason. (*California Code of Regulations (CCR), Title 28, section 1300.70 (b)(1)(D)*)

*The Plan's 2020 Quality Improvement Program Description and Policy GG 1620 (effective 5/7/20)* states that the Plan must perform a continuous improvement process to evaluate whether QI activities are consistent with the Plan's strategic goals and priorities. The QIC must ensure the quality of member care by monitoring and evaluating the quality, timeliness, and appropriateness of clinical care services provided to members and must pursue opportunities for improvement.

The Plan's organizational structure showed that the UM committee reported to the QIC. The QIC reports to the Board of Directors Quality Assurance Committee. The Contract requires the Plan and Quality Assurance Program to meet and oversee problems identified to ensure appropriate care and timely services are provided to members. (*Contract, Exhibit A, Attachment 4.4.*)

**Finding:** The Plan's Quality Improvement Committee (QIC) did not ensure that members received appropriate and quality care by monitoring and evaluating the timeliness of clinical care and services provided to members. Problems identified in UM were not discussed in the UM Committee and escalated to QIC. The Plan's QIC did not review UM activities to ensure

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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members' timely access to care was not delayed for any reason. Delays in UM prior authorizations were not escalated to the QIC.

During the interview, the Plan indicated that a delay in processing prior authorizations started in July 2021. Information obtained from the Plan during the interviews and review of Compliance Committee meeting notes and the Chief Executive Officer memorandum to the Board of Directors indicated that the Plan was unable to complete the processing of the backlog of prior authorizations until the end of January 2022.

Although the backlog was noted by the Compliance Committee in their *Audits and Oversight Committee presentation*, there was no discussion in UM Committee or QIC meeting minutes to ensure QIC acknowledgment and monitoring of this problem.

Without the involvement of the QIC, the Plan cannot ensure the quality, timeliness, and appropriateness of clinical care provided to members. Delayed prior authorizations can delay medically necessary procedures and increase morbidity and mortality.

**Recommendation:** Develop and implement procedures to ensure that QIC evaluates and monitors UM activities to ensure timely access to medical services.

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, 2020  
Through  
December 31, 2021

Report Issued: Novemeber 8, 2022

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## **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 contract No. 08-85221 with the State of California. The State Supported Services contract covers abortion services for CalOptima.

The review was conducted from January 24, 2022 through February 4, 2022. The audit covered the review period from February 1, 2020 through December 31, 2021. 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 September 27, 2022.



**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

**PLAN:** Orange County Organized Health System dba CalOptima

**AUDIT PERIOD:** February 1, 2020 through December 31, 2021

**DATE OF AUDIT:** January 24, 2022 through February 4, 2022

**STATE SUPPORTED SERVICES**

**SUMMARY OF FINDING(S):**

The Plan's provider manual and member handbook indicate that members may access sensitive services, such as abortion and abortion related services from any qualified provider, contracted or non-contracted without prior authorization. The Plan has policies and procedures in place to ensure timely and accurate processing of claims.

In the verification studies, it was noted that abortion service was covered and members did not require prior authorization for these services. There were no material findings during the audit period.

**RECOMMENDATION(S):**

None