

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

Orange County Organized Health System dba CalOptima

| | |
|------------------|---|
| Contract Number: | 08-85214 |
| Audit Period: | February 1, 2017 Through January 31, 2018 |
| Report Issued: | October 8, 2018 |

TABLE OF CONTENTS

| | | |
|------|---|---|
| I. | INTRODUCTION | 1 |
| II. | EXECUTIVE SUMMARY | 2 |
| III. | SCOPE/AUDIT PROCEDURES | 4 |
| IV. | COMPLIANCE AUDIT FINDINGS | |
| | Category 2 – Case Management and Coordination of Care | 6 |

I. INTRODUCTION

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

The Plan is governed by a Board of Directors made up of eleven (11) members appointed by the Orange County Board of Supervisors which govern the Plan. The Plan provides medical care to members by contracting with 13 privately run health networks that provide access to nearly 2,000 primary care providers and 6,000 specialists. In addition to contracted health networks, the Plan created its own directly contracted provider network called the CalOptima Community Network (CCN) in March 2015 which currently has 2,000 providers that serve 70,000 members.

The Plan currently has several programs to provide medical care to its members residing in Orange County (Plan insures 1 in 4 residents). As of February 2018, enrollments in its area of operations for these programs were as follows:

- **Medi-Cal:** 774,646 Medi-Cal recipients, for low-income individuals, families with children, seniors, and people with disabilities.
- **OneCare:** 1,372 Medicare/Medicaid recipients, for Medi-Cal members who also have Medicare.
- **OneCare Connect:** 15,223 Medicare/Medicaid & Medi-Cal recipients who live in Orange County for both Medicare Parts A and B and Medi-Cal who are 21 years and older.
- **Program of All-Inclusive Care for the Elderly (PACE):** 235 Medicare/Medicaid and Medi-Cal recipients aged 55 and older who live in service area and eligible for nursing facility services.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical review audit for the review period of February 1, 2017 through January 31, 2018. The onsite review was conducted from Monday, February 26, 2018 through Wednesday, March 7, 2018. The audit consisted of document review, verification studies, and interviews with the Plan's personnel.

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

The summary of the findings by category is as follows:

Category 1 – Utilization Management

In the prior year's audit, the language in the Notice of Action (NOA) letters to members was not clear and understandable. The Plan's corrective actions to address this finding included developing clear, understandable and standard language in the NOA letters, random and routine monthly audits to review NOA letters, and other audit techniques to review prior authorizations processed by the Plan and its delegated health networks. These corrective actions were approved on January 19, 2018 by DHCS about one week prior to the current audit and were still in process.

No findings were noted in the current audit period.

Category 2 – Case Management and Coordination of Care

The Plan did not ensure that Behavioral Health Treatment (BHT) services were provided and supervised under a Plan-approved behavioral treatment plan that included a transition plan, crisis plan, and parent/caregiver training. In ten (10) member medical records reviewed, five (5) behavioral treatment plans were missing a crisis plan, two (2) member medical records did not have a transition plan, and one did not include parent/caregiver training plan.

Category 3 – Access and Availability of Care

No findings.

Category 4 – Member's Rights

In the prior year's audit, the Plan did not report notifications of breach incidents and investigations of breaches in a timely manner. The Plan's corrective actions to address

this finding included hiring a new privacy officer and privacy manager as well as additional staff, creating a Health Information Privacy and Accountability Act (HIPAA) incident database log, and conducting monthly monitoring of privacy investigation referrals. The corrective actions for the prior audit were approved on January 19, 2018 by DHCS just prior to the onsite audit and were still in process.

No findings were noted in the current audit.

Category 5 – Quality Management

No findings.

Category 6 – Administrative and Organizational Capacity

No findings.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The Department of Health Care Services, (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 Contract.

PROCEDURE

The onsite review was conducted from February 26, 2018 through March 7, 2018. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Interviews were conducted with the Plan's administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization: Forty (40) medical and twenty (20) pharmacy prior authorization requests were reviewed for compliance with contractual requirements, including medical necessity, consistent application of criteria and timeliness.

Appeal Procedures: Ten (10) medical prior authorization appeals, and twenty five (25) pharmacy prior authorization appeals were reviewed to ensure that required timeframes were met and appeals are appropriately routed and adjudicated by appropriately qualified personnel.

Category 2 – Case Management and Coordination of Care

California Children's Services (CCS): Six (6) medical records were reviewed for evidence of coordination of care between the Plan and CCS providers.

Initial Health Assessment: Twenty (20) medical records were reviewed for completeness and timely completion.

Complex Case Management (CCM): Six (6) medical records listed as CCM were reviewed for coordination of care.

Behavioral Health Treatment (BHT): Ten (10) medical records were reviewed for evidence of coordination of care and collaboration between the provider and member.

Category 3 – Access and Availability of Care

Emergency Service Claims: Eleven (11) emergency service claims were reviewed for appropriate and timely adjudication.

Family Planning Claims: Seven (7) emergency records, and family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member’s Rights

Grievance Procedures: Forty six (46) grievances, of which thirteen (17) quality of care, eight (8) access, and twenty one (21) quality of service, were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Health Insurance Portability and Accountability Act (HIPAA): Fifteen (15) cases were reviewed for appropriate and timely resolution.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: Nineteen (19) suspected cases were reviewed for appropriate reporting and processing.

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

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: CALOPTIMA

AUDIT PERIOD:
February 1, 2017 through January 31, 2018

DATE OF ONSITE AUDIT:
February 26, 2018 - March 7, 2018

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.6

BEHAVIOR HEALTH TREATMENT (BHT)

Services for Members under Twenty-One (21) Years of Age

Contractor shall cover and ensure the provision of screening, preventive and Medically Necessary diagnostic and treatment services for members under 21 years of age, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Services. Contractor shall inform members that EPSDT services are available for members under 21 years of age, as well as how to access services.

Contractor shall ensure that appropriate EPSDT services are initiated as soon as possible but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up.

COHS Contract, Amendment 15, A.10.5

Provision of Behavioral Health Treatment (BHT) services

The Managed Care Plan (MCP) is responsible for the provision of EPSDT services to include medically necessary Behavioral Health Treatment (BHT) services such as Applied Behavior Analysis (ABA) and other evidence-based behavioral interventions that develop or restore, to the maximum extent practicable, the functioning of a member with Autism Spectrum Disorder (ASD). The MCP must ensure all children, including children with ASD, receive EPSDT screenings designed to identify health and developmental issues, including ASD, as early as possible. When a screening exam indicates the need for further evaluation of a child's health, the child must be referred for medically necessary diagnosis and treatment without delay. The MCP is required to:

1. Inform members that EPSDT services are available for members under 21 years of age
2. Provide access to comprehensive screening and prevention services in accordance with the most current Bright Futures periodicity schedule
3. Provide access to comprehensive diagnostic evaluation based upon recommendation of a licensed physician and surgeon or a licensed psychologist for treatment of ASD including all medically necessary services, including but not limited to, BHT services
4. Ensure appropriate EPSDT services are initiated in accordance with timely access standards as set forth in the contract
5. Ensure coverage criteria for BHT are met.

All Plan Letter 15-025, Responsibilities for Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: CALOPTIMA

AUDIT PERIOD:

February 1, 2017 through January 31, 2018

DATE OF ONSITE AUDIT:

February 26, 2018 - March 7, 2018

Appropriate Referral to Regional Center and Special Education Local Plan Area (SELPA)

For individuals diagnosed with ASD who are under the age of three with a rule out or provisional ASD diagnosis, or those diagnosed with an intellectual disability, the MCP must ensure appropriate referrals are made to the Regional Center and Special Education Local Plan Area (SELPA) for Regional Center services and supports and/or special education services, respectively.

Continuity of Care

MCPs must ensure continuity of care in accordance with existing contract requirements, All Plan Letter 15-025, and Health & Safety Code Section 1373.96 for the provision of BHT services.

Delegation Oversight

The MCP must ensure that delegates comply with all applicable state and federal laws and regulations, contract requirements, and DHCS guidance, including APLs for the provision of BHT services.

All Plan Letter 15-025, Responsibilities for Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder

SUMMARY OF FINDINGS:

2.6.1 Behavioral Health Treatment (BHT) Plan Requirements

The Plan is responsible for the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to include medically necessary Behavioral Health Treatment (BHT) services such as Applied Behavioral Analysis (ABA) and other evidence-based behavioral interventions services that develop or restore, to the maximum extent practicable, the functioning of a member with Autism Spectrum Disorder (ASD).

The BHT service must be provided and supervised under a Plan-approved behavioral treatment plan developed by a contracted and Plan-credentialed qualified autism service provider. The behavioral treatment plan must clearly identify the individual providers delivering services, the service type, and number of hours of direct services. It should also contain observations and directions, support and participation needed to achieve the goals and objectives, and parent/guardian training. The BHT treatment plan must include both a transition and a crisis plan and the frequency of the beneficiary's progress has to be measured and reported. (*All Plan Letter (APL) 15-025*)

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: CALOPTIMA

AUDIT PERIOD:

February 1, 2017 through January 31, 2018

DATE OF ONSITE AUDIT:

February 26, 2018 - March 7, 2018

The Plan did not ensure that BHT services are provided and supervised under a Plan-approved behavioral treatment plan that includes a transition plan, crisis plan, and parent/caregiver training.

During the audit period, the Plan's Behavioral Health Services was delegated to Magellan Healthcare effective January 1, 2017. *APL 15-025* requires that the Plan must ensure that delegates comply with all applicable state and federal laws and regulations, contract requirements, and DHCS guidance, including APLs for the provision of BHT services. The contract between the Plan and Magellan includes all the necessary requirements for Magellan to follow Medi-Cal Managed Care Division Policy Letters.

The Plan's *Policy No. GG.1900: Behavioral Health Services* describes access to behavioral health services for Medi-Cal members through its behavioral health vendor. The section on Assessment and Treatment Planning in the Plan's Provider Orientation for Autism by Magellan HealthCare details necessary elements of the ABA treatment plan, but does not include crisis planning. In addition, the Magellan ABA Treatment Plan template used by providers requires a discharge criteria and a transition plan, but does not include a crisis plan. During the interviews, the Plan Staff stated they required Magellan to comply with the APL requirements. However, Magellan developed a crisis plan on a case-to-case basis only.

In ten (10) member medical records reviewed, five (5) behavioral treatment plans were missing a crisis plan, two (2) member medical records did not have a transition plan, and one did not include parent/caregiver training plan.

During interview, the Plan stated that it conducts an overall monthly oversight audits of Magellan that includes monitoring of BHT and ABA services. Likewise, it held weekly ABA oversight meetings with Magellan to discuss key topics including treatment plan documentation. Both the oversight dashboard report and the weekly oversight meeting agenda did not indicate that the Plan reviewed the required elements of the treatment plan.

Effective January 1, 2018, the Plan is directly managing the provision of BHT/ABA services. The Plan has also updated the Audit and Oversight Department monthly internal auditing tool to incorporate the required elements of the behavioral treatment plan. However, the Plan has not updated and implemented policies and procedures to include a crisis plan in a member's behavioral treatment plan, as specified in *APL 15-025*.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: CALOPTIMA

AUDIT PERIOD:

February 1, 2017 through January 31, 2018

DATE OF ONSITE AUDIT:

February 26, 2018 - March 7, 2018

The behavioral treatment plan guides the team's approach to provide BHT services. The required elements of the behavioral treatment plan are based on research evidence of effectiveness for care of individuals diagnosed with ASD. When the individualized treatment plans do not include all the required elements, members being treated for ASD may not receive effective care and as a consequence, the quality of care may be compromised.

RECOMMENDATION:

2.6.1 Update and implement policies and procedure to ensure that the provision of BHT services comply with All Plan Letter 15-025 requirements for a complete behavioral treatment plan.

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

**Orange County Organized Health System
dba CalOptima**

Contract Number: 08-85221
State Supported Services

Audit Period: February 1, 2017
Through
January 31, 2018

Report Issued: October 8, 2018

TABLE OF CONTENTS

I. INTRODUCTION1

II. COMPLIANCE AUDIT FINDINGS2

INTRODUCTION

The audit report presents the audit findings of the contract compliance audit of Orange County Organized Health System dba CalOptima (the Plan) and its implementation of the State Supported Services contract No. 08-85221 with the State of California. The State Supported Services contract covers abortion services for CalOptima

The onsite audit of the Plan was conducted from Monday, February 26 2018 through Friday, March 9, 2018. The audit covered the review period from February 1, 2017 through January 31, 2018 and consisted of a document review of materials provided by the Plan.

An Exit Conference was held on August 30, 2018 with the Plan.

| ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖ | |
|---|---|
| PLAN: Orange County Organized Health System dba CalOptima | |
| AUDIT PERIOD: February 1, 2018 – January 31, 2018 | DATE OF AUDIT: February 26 through March 9, 2018 |

| STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS |
|--|
| <p>Abortion <i>Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:</i> <i>Current Procedural Coding System Codes*: 59840 through 59857</i> <i>HCFA Common Procedure Coding System Codes*: X1516, X1518, X7724, X7726, Z0336</i></p> <p><i>*These codes are subject to change upon the Department of Health Services' (DHS) implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.</i> <i>State Supported Services Contract Exhibit E.1</i></p> |

SUMMARY OF FINDINGS:

Review of the Plan's policy, member handbook, provider manual, and verification study analysis did not identify any material non-compliance with the requirements of the State Supported Services contract. The verification was conducted to determine appropriate and timely adjudication of State Supported Services (SSS) claims.

RECOMMENDATIONS:

None.