DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

REPORT ON THE FOCUSED AUDIT OF ORANGE COUNTY ORGANIZED HEALTH SYSTEM DBA CALOPTIMA 2023

Contract Number: 08-85214

Audit Period: February 1, 2022 Through January 31, 2023

Dates of Audit: February 27, 2023 Through March 10, 2023

Report Issued: August 30, 2024

DHCS

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I. INTRODUCTION

Background

In accordance with California Welfare and Institutions Code section 14456, the Department of Health Care Services (DHCS) may conduct additional reviews outside of the annual medical audit when DHCS determines there is good cause.

DHCS directed the Contract and Enrollment Review Division to conduct focused audits of all contracting Medi-Cal Managed Care Plans (Plans) to evaluate the current Plans' performance in the areas of Behavioral Health and Transportation services.

These focused audits differ from DHCS' regular annual medical audits in scope and depth. The annual medical audits evaluate the Plan's organizational structures, policies and procedures, and systems for compliance with contractual requirements. The focused audits examined the operational issues that may hinder appropriate and timely member access to medically necessary care. The focused audit engagement formally commenced in January 2023 through December 2023.

For the Behavioral Health section, the focused audit evaluated the Plan's monitoring activities of specific areas such as Specialty Mental Health Services (SMHS), Non-Specialty Mental Health Services (NSMHS), and Substance Use Disorder Services (SUDS). The focused audit also reviewed potential issues that may contribute to the lack of member access and oversight for SMHS, NSMHS, and SUDS.

The focused audit conducted a more in-depth look at current Plan operations/practices for executing the delivery of transportation services. The audit examined potential causes for the systemic issues surrounding the Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services, specifically when transportation is delegated to a transportation broker.

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 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 December 31, 2022, the composition of the Plan membership was as follows:

- Medi-Cal: 927,086 Medi-Cal recipients which includes low-income individuals, families with children, seniors, and people with disabilities.
- OneCare (Health Maintenance Organization Special Needs Plan): 17,381 Medi-Cal and Medicare members.
- Program of All-Inclusive Care for the Elderly: 437 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 DHCS' focused audit for the period of February 1, 2022, through January 31, 2023. The audit was conducted from February 27, 2023, through March 10, 2023. The audit consisted of document review, surveys, verification studies, interviews and file reviews with the Plan representatives.

The Plan declined an Exit Conference to be held on June 24, 2024. The Plan was allowed 15 calendar days from the date of the originally scheduled Exit Conference to provide supplemental information addressing the draft audit report findings. The Plan submitted a response after the originally scheduled Exit Conference. The results of DHCS' evaluation of the Plan's response are reflected in this report.

The focused audit evaluated the areas of performance for Behavioral Health and Transportation services.

The summary of findings by performance area follows:

Performance Area: Behavioral Health

Category 2 – Case Management and Coordination of Care:

- Specialty Mental Health Services
- Non-Specialty Mental Health Services
- Substance Use Disorder Services Category 3 – Access and Availability of Care

The Plan is required to arrange for member referrals to the county department responsible for substance use treatment, or other community resources when services are not available through counties, for members identified as requiring alcohol or Substance Use Disorder (SUD) treatment services. The Plan is required to make good faith efforts to confirm whether members receive referred treatments and document when, and where these treatments were received, and any next steps following treatment. If a member does not receive referred treatments, the Plan must follow up with the member to understand barriers and make adjustments to the referrals if warranted. The Plan did not make good faith efforts to confirm whether members received referred treatments for SUDS and did not follow-up with members who did not receive referred treatments to understand barriers and make subsequent adjustments to referrals.

Performance Area: Transportation

Category 3 – Access and Availability of Care

- Non-Emergency Medical Transportation
- Non-Medical Transportation

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

III. SCOPE/AUDIT PROCEDURES

SCOPE

This focused audit was conducted by the DHCS, Contract and Enrollment Review Division to ascertain the medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State Contract.

PROCEDURE

On November 3, 2022, DHCS informed Plans that it would be conducting focused audits to assess performance in certain identified high-risk areas. The focused audit was concurrently scheduled with the annual medical audit. The audit scope encompassed the following sections:

- Behavioral Health - SMHS, NSMHS, and SUDS
- Transportation – NEMT and NMT services

The audit was conducted from February 27, 2023, through March 10, 2023. 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. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 2 – Case Management and Coordination of Care

SMHS: Five samples were reviewed to confirm care coordination with the county Mental Health Plan (MHP) and compliance with All Plan Letter (APL) requirements.

NSMHS: Five samples were reviewed to confirm compliance with APL requirements.

SUDS: Five samples were reviewed to confirm compliance with APL requirements.

Category 3 – Access and Availability of Care

NEMT: Twelve samples were reviewed to confirm compliance with APL requirements.

NMT: Ten samples were reviewed to confirm compliance with APL requirements.

A description of the findings is contained in the following report.

COMPLIANCE AUDIT FINDINGS

Performance Area: Behavioral Health – SMHS, NSMHS, and SUDS

Category 2 – Case Management and Coordination of Care

2.1 Follow up for Referred SUD Treatment

The Plan is required to arrange for member referrals to the county department responsible for substance use treatment, or other community resources when services are not available through counties, for members identified as requiring alcohol or SUD treatment services. The Plan is required to make good faith efforts to confirm whether members receive referred treatments and document when, and where these treatments were received, and any next steps following treatment. (APL 21-014 Alcohol and Drug Screening, Assessment, Brief Intervention, Referral and Treatment)

Plan policy, GG-1100 Alcohol and Substance Use Disorder Treatment Services (revised January 1, 2022), states that the Plan shall make good faith efforts to confirm whether members receive referred treatments, and document when, where, and any next steps following treatment.

Finding: The Plan did not make good faith efforts to confirm whether members received referred treatments for SUDS.

While the Plan's policy GG-1100 states the Plan shall make good faith efforts to confirm whether the members received treatments, the Plan did not submit evidence to show it adheres to its own policy.

A verification study of five SUDS samples revealed the Plan's records did not contain any documentation that the Plan made good faith efforts to confirm whether members received referred treatments. The records also did not contain any indication that the Plan documented when, where, and any next steps following treatment.

During the interview and in a written statement, the Plan stated it has a process to obtain ad-hoc information from the MHP to confirm members received referred services through verbal or electronically. However, the Plan's policies and procedures does not contain this ad-hoc process. Also, the verification study records found no evidence to show the Plan requested this information to determine whether the member received the referred SUDS and documented the next steps following treatment.

Without good faith efforts from the Plan to ensure referred treatment was received by the member, the member may not be receiving medically necessary services.

Recommendation: Revise and implement policies and procedures to ensure that the Plan makes good faith efforts to confirm whether members receive referred treatments and document when, where, and any next steps following treatment.

2.2 SUDS – Follow-up to Understand Barriers and Adjust Referrals

The Plan must make good faith efforts to confirm whether members receive referred treatments and document when, where, and any next steps following treatment. If a member does not receive referred treatments, the Plan must follow up with the member to understand barriers and make adjustments to the referrals, if warranted. Plans should also attempt to connect with the provider to whom the member was referred to facilitate a warm hand off to necessary treatment. (APL 21-014 Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment)

Plan policy, GG-1100 Alcohol and Substance Use Disorder Treatment Services (revised January 1, 2022), states if a member does not receive referred treatments, the Plan shall follow-up with the member to understand barriers and adjust the referrals, if warranted. The Plan shall also attempt to connect with the provider to whom the member was referred to facilitate a warm hand off to necessary treatment.

Finding: The Plan did not have a process in place to follow-up with members to understand barriers and make subsequent adjustments to referrals.

A verification study of five SUDS samples found that the Plan's records did not contain any documentation that the Plan made good faith efforts to confirm whether members received referred treatments, nor any documentation of efforts to follow up with members to understand barriers and make adjustments to the referrals, if warranted.

Even though the Plan’s policy GG-1100 states the follow-up will be conducted to understand barriers, the Plan did not submit evidence to show the Plan adheres to the APL requirement and its own policy to confirm members received the referred treatment.

During the interview and in a written statement, the Plan stated it has a process to obtain ad-hoc information from the MHP to confirm members received referred services through verbal or electronically. However, the Plan’s policies and procedures do not contain this ad-hoc process. The Plan did not submit evidence to show it has a

documented process to understand the barriers and make any referral adjustments for the medically necessary services.

If there is no follow up with the member to understand barriers and make adjustments as warranted, the member may not receive medically necessary care.

Recommendation: Revise and implement policies and procedures to ensure that if a member does not receive referred treatment, the Plan must follow up with the member to understand barriers and make adjustments to the referrals, if warranted as well as follow up with members who do not receive referred treatments.