State of California—Health and Human Services Agency
Department of Health Care Services

MICHELLE BAASS
DIRECTOR

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February 11, 2022

Mary Lourdes Leone, Chief Compliance Officer
CalViva Health
7625 N. Palm Avenue, Suite 109
Fresno, CA 93711

RE: Department of Health Care Services Medical Audit

Dear Ms. Leone:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of CalViva Health, a Managed Care Plan (MCP), from February 3, 2020 through February 14, 2020. The audit covered the period of February 1, 2019 through January 31, 2020.

On February 4, 2022, the MCP provided DHCS with additional information regarding its Corrective Action Plan (CAP) in response to the report originally issued on June 30, 2020.

All items have been evaluated and DHCS accepts the MCP's submitted CAP. The CAP is hereby closed. Overall effectiveness of the CAP will continue to be assessed, as well as, to what extent the MCP has operationalized proposed corrective actions on the subsequent audit. The enclosed report will serve as DHCS' final response to the MCP's CAP.

Please be advised that in accordance with Health & Safety Code Section 1380(h) and the Public Records Act, the final report will become a public document and will be made available on the DHCS website and to the public upon request.

If you have any questions, feel free to contact me at (916) 345-7825 or Anthony Martinez at (916) 345-7828.

Sincerely,

[Signature on File]

Lyubov Poonka, Interim Unit Chief
Compliance Unit

Enclosures: Attachment A, CAP Response Form

cc: Francisco J. Mata, Contract Manager
Department of Health Care Services
Medi-Cal Managed Care Division
P.O. Box 997413, MS 4408
Sacramento, CA 95899-7413

ATTACHMENT A
Corrective Action Plan Response Form

Plan: CalViva Health **Review Period: 02/01/2019 – 01/31/2020**

Audit Type: Medical Audit and State Supported Services **Onsite Review: 02/03/2020 – 02/14/2020**

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MCPs are required to provide a CAP and respond to all documented deficiencies within 30 calendar days, unless an alternative timeframe is indicated in the letter. MCPs are required to submit the CAP in word format that will reduce turnaround time for DHCS to complete its review.

The CAP submission must include a written statement identifying the deficiency and describing the plan of action taken to correct the deficiency, and the operational results of that action. For deficiencies that require short-term corrective action, implementation should be completed within 30 calendar days. For deficiencies that require long-term corrective action or a period longer than 30 calendar days for implementation, the MCP must demonstrate it has taken remedial action and is making progress toward achieving an acceptable level of compliance. The MCP will be required to include the date when full compliance is expected to be achieved. **Policies and procedures submitted during the CAP process must still be sent to the MCP's Contract Manager for review and approval in accordance with existing requirements.**

DHCS will maintain close communication with the MCP throughout the CAP process and provide technical assistance to ensure the MCP provides sufficient documentation to correct deficiencies. Depending on the volume and complexity of deficiencies identified, DHCS may require the MCP to provide weekly updates, as applicable.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
2. Case Management and Coordination of Care				

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
2.1.1 Finding: The Plan did not take effective action to ensure new members completed the IHEBA as part of the IHA. *The Quarter 1, 2, & 3 2019 IHA Quarterly Reports showed that the Plan conducted the same interventions and took no additional actions following the identification of the same barriers and continuous non-compliance with adult IHEBA completion.*	1. Conduct quality improvement activities to identify barriers experienced by providers in completing the IHA/IHEBA with CalViva members. 1a. Identify two providers (one high performing and one low performing) to partner with to complete focus group interviews (including at a minimum quality staff, office manager, and a practitioner) to identify significant barriers and strategies for success in completing the Staying Healthy Assessment /IHEBA. • Compiled and reviewed a list of high and low performing providers to identify two partner clinics to participate in an IHA/IHEBA barrier identification activity. Clinics were selected based on FSR and MRR performance from Q1 2019 - Q1 2020. Clinic volume was also considered in the site selection.		1. October 2020 - February 2021 1a. 9/18/20 selected clinic identification completed	The MCP has implemented a number of improvement actions to identify barriers and strategies to increase completion rates for IHEBA. The Plan's policies reflect contractual requirements. Policies describe processes for member to receive IHA and IHEBA within 120 days of enrollment and also outline documentation requirements for member medical records. The Plan has taken interventions to improve IHEBA compliance rates and developed trainings and webinars for providers to ensure the best practices are used for completion of an IHA/IHEBA. Supporting documentation supports the MCP's efforts to correct this finding: • CalViva Health IHA/ IHEBA Clinic Presentation to meet with low performing selected clinic site to discuss IHA/IHEBA performance, and

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	• Met with low performing selected clinic site to discuss IHA/IHEBA performance, and conduct a barrier identification activity (driver diagram review). Clinical processes were discussed, as well as potential interventions for improvement. A regular meeting cadence was agreed upon and established. Two barriers to IHA/IHEBA completion for the low performing clinic: ○ consistent access to the new member list for outreach ○ correct coding for IHA/IHEBA • The Plan Provider Engagement Representative will train the clinic manager and identified staff leads on how to access the member list and do a refresher training on coding for IHA/IHEBA. To be scheduled:	1a. CalViva Health IHA/ IHEBA Clinic Presentation CalViva Health IHA/IHEBA Key Driver Diagram	1.a 10/14/20 met with low performing clinic	conduct a barrier identification activity. • July 2021 Meeting Minutes & IHA Tracking Grid- Low Performing Clinic for monthly meetings to address the barriers and implement actions to improve performance. • CalViva Health IHA/IHEBA Final Key Driver Diagram to reflect barriers and interventions to use for training on best practices with other providers. • 1.12.21 CalViva IHA.IHEBA Provider Profile Template to track members who have completed the IHA/SHA. • IHA Data Summary- Low Performing Clinic July 2021 and Low Performing Clinic Data Summary Run Chart July 2021 which detailed outreach to the members • 7/19/21 QI Manager Meeting Minutes which addressed the establishment of a monthly IHA/IHEBA workgroup to address persistent barriers, improve IHA/IHEBA

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	• Meet with clinic site to: review action plan for intervention deployment; deploy improvement intervention; and establish process to monitor for improvement (see 1b below). • Meet with a high performing clinic to identify best practices for IHA/IHEBA completions, and determine any opportunities to share and scale best practices within the network. 1b. Prioritize 1-2 key barriers, and develop an action plan in collaboration with the low performing provider. The provider selected will commit to participating in the improvement plan and a multidisciplinary team will be established (IHA Provider Improvement Team). Monthly meetings will be calendared.		schedule meetings for later Q4 2020 1b. November 2020 1c. February 2021	monitoring, and develop improved communication tools and processes for providers and members. • 2021 CalViva IHA-IHEBA Provider Training, and Tips for Completing the New Member IHA Draft to educate providers how to pull New Member Lists from the Provider Portal, and best practices for completion of an IHA/IHEBA. • IHA-IHEBA Patient Flow Chart used to describe IHA/IHEBA member outreach. • IHA-IHEBA Provider Performance Tracking Report provides oversight of compliance of IHA/IHEBA rates by provider. • IHA Quarterly Audit Report (Q4 2020) in which the report timing was adjusted of the IHA/IHEBA Monthly and Quarterly Claims and Encounters Data Reports to improve accuracy, and to ensure completeness by accounting for claims and

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	1c. Monitor completion of the provider action plan, evaluate the improvements and review performance after 3 months of implementation. 1d. Identify opportunities to adopt (scale up), adapt or abandon the activities in the action plan to address provider barriers and improve IHA/IHEBA.		1d. February 2021	encounters data submission /processes timeline. • Revised Lunch & Learn - Improving the Provider Experience Quarterly Webinar IHA Slide, and revised 20-298 Complete the IHA within 120 Days to Help Manage Your Patient's Health Care Need, for Provider training, education and communication content, and methodology.
2.1.1 Finding (continued) *2.1.1 For the verification study, the Plan submitted 19 of the 20 medical records requested. Non-compliance with IHEBA completion was noted in 16 of 19 medical records since there is no documented member refusal or any other rationale why the IHEBA was missing.*	2. Complete improvements to IHA/IHEBA claims and encounters reporting to increase accuracy, and include provider detail for monitoring, and re-education. 2a. Adjust report timing of the IHA/IHEBA Monthly and Quarterly Claims and Encounters Data Reports to improve accuracy, and to ensure completeness by accounting for claims and encounters data submission /processes timelines.	IHA Completion Claims and Encounters Report	2. October 2019 – February 2021 2a. & 2b. October 2019 to Q2 2020 with production of new reports completed	**Plan Response (01/28/22):** The MCP's IHA/IHEBA Project included trainings recommending the use of the MCP's tools to document the progress of IHEBA completions or the development of their own tool for this purpose. The MCP contacted a provider and requested a recent tool used for tracking IHA/IHEBA completion. A summary of the reasons documented in that log is provided below: • No show to appointment

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2.1.1 The Plan did not implement an effective quality improvement process for IHEBA completion by not taking effective action to address needed improvements following identification of continuous non-compliance with adult IHEBA requirements. **Recommendation:** Develop and implement effective follow-up actions or quality improvement procedure to ensure compliance with the IHEBA completion in the provision of the IHA.	2b. Implement IT enhancements to leverage claims and encounters data to identify PPGs and providers with a pattern of continuous non-compliance with IHEBA completion. 2c. Identify target PPGs and providers with a pattern of continuous non-compliance with IHEBA completion through IT enhancement, and conduct tailored communications and education. Due to the public health emergency, IHA/IHEBA requirements are on hold, and therefore IHA/IHEBA data is incomplete. Activities to target providers based on claims and encounters data will resume when the emergency is lifted, and requirements are re-instated.		2c. November 2020 - February 2021	• Phone number disconnected/not in service/VM not set-up • Patient seeing an OB at time of call • Patient has a different primary care provider, declined to change • Wrong number/No phone number • Distance to provider was too far • Patient out of country/state • Declined to schedule at this time, will call back

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2.1.1 Finding (continued)	3. Establish IHA/IHEBA workgroup and conduct monthly meetings to address persistent barriers, improve IHA/IHEBA monitoring, and develop improved communication tools and processes for providers and members. 3a. Centralize and consolidate the Facility Site Review (FSR)/Medical Record Review (MRR) report by transitioning the MRR/FSR data responsibilities to the Quality Improvement Research Analyst Team in IHA/IHEBA workgroup to further improve reporting efficiency and data monitoring. Note: Due to the public health emergency, the FSR/MRR requirements are on hold. CalViva Health paused FSR/MRR on March 13, 2020.	QI Manager Meeting Minutes 11-10-20 (IHA-IHEBA CAP notes)	3. December 2019; Workgroup started 8/18/20 to address the IHA/IHEBA CAP activity and meets Monthly on an ongoing basis until CAP completed 3a. March 2020 completed	**Plan Response (01/28/22):** Utilizing the findings from the pilot project and going forward, the MCP will ascertain the reasons members do not complete the IHEBA and through the Provider Engagement team disseminate the findings to PCPs in Fresno, Kings and Madera counties through the Work Guide, other educational materials and updates.

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2.1.1 Finding (continued)	4. Review and revise IHA/IHEBA Provider training, education and communication content and methodology (i.e. lunch and learns, virtual trainings, provider portal, print material, etc.) based upon interventions identified in the quality improvement activities (#1 and #2c). Lunch and Learn webinar reviewing best practices for IHA/IHEBA. 60 attendees from Fresno County A webinar training will address IHA/IHEBA requirements, and based upon identified barriers will include information on how to access new member lists to contact patients due for IHA/IHEBA.	20-298 Complete the IHA within 120 Days to Help Manage Your Patient's Health Care Need 20-530, Tips for Completing the New Member IHA Lunch & Learn - Improving the Provider Experience Quarterly Webinar IHA Slide	4. October 2020 - March 2021 Provider Update 20-298 March 20, 2020 Provider Update 20-2530 Sept. 2020 Completed September 16, 2020 Scheduled December 4, 2020	**Plan Response (02/04/22):** To ensure IHA/IHEBA Best Practices are incorporated systematically by MCP providers, the MCP plans to enhance quarterly IHA/IHEBA reporting to identify providers with low IHA/IHEBA completion rates. Providers with low performance will be offered training and additional interventions to resolve barriers to IHA/IHEBA completion. In August 2021, the MCP identified 7 high-volume provider sites with low IHA/IHEBA completion rates and offered expedited IHA/IHEBA training. As of October 27th, 100 percent of the 7 provider sites completed IHA/IHEBA training. The MCP will continue to monitor IHA/IHEBA completion rates for these 7 low-performing provider sites in future quarterly reporting cycles.

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				Plan Response (02/04/22): The IHA/IHEBA Best Practices Training is a new program communicated to all providers with the assistance of the Provider Engagement team in the MCP's 3 counties, including a new data capture process (using code 96156) with ongoing monitoring and reporting through multiple methods (MCP's Strategy for Monitoring IHA/IHEBA Compliance). • The goal of this new program is to facilitate IHA/IHEBA completion with a provider managed tool to capture the attempts to contact new members and results of those attempts including refusal to schedule an appointment for an initial health assessment. If the patient attends an appointment and refuses to complete the IHEBA, this refusal should be documented on the SHA form and maintained in the Medical

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				Record. The MCP assesses compliance with this documentation through the Facility Site Review and Medical Records Review monitoring and quarterly IHA/IHEBA reporting to identify providers with low IHA/IHEBA completion rates as described above. Corrective action plans are required for providers who do not meet documentation standards. **MCP's Strategy for Monitoring IHA/IHEBA Compliance** The MCP monitors plan performance on IHA/IHEBA visits in the following ways: ***1. Facility Site Review and Medical Records Review (Goal: 100% compliance)*** Initial Health Assessment monitoring occurs through quarterly onsite audits completed

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				during the Facility Site Review (FSR) and Medical Record Review (MRR) process, which review a sample of records for the provider's IHA/IHEBA visit completion and outreach attempts made by the provider to demonstrate compliance with DHCS requirements. Using the data collected during the FSR/MRR events, the MCP identifies noncompliant sites for corrective action. Each site within the MCP provider network is audited at least every 3 years. ***2. Plan's Outreach Attempts to New Members Reporting (Goal: 100% compliance)*** The MCP monitors outreach to new members in the 3-Step Outreach Attempts Report. A combination of three outreach attempts, consisting of at least 1 mailing and at least 1 phone call, must be completed for each newly enrolled Medi-Cal member

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				within 120 days of enrollment for compliance with DHCS performance. IHA outreach attempts consist of: 1. Notification of the IHA in the New Member Packet (Mailing) 2. A new member welcome call (Phone) 3. An IHA postcard mailed to new members (Mailing) ***3. IHA Visit Reporting (Goal: 100% compliance)*** The MCP uses claims and encounters data to report IHA/IHEBA completion rates for new members. Data is compiled semi-annually in the Claims and Encounters Report, with a scope of all new members assigned during the reporting period. Claims/encounters codes indicating that an IHA/IHEBA

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				were completed, with a Date of Service within 120 days of member assignment, indicates IHA/IHEBA visit compliance for a member. **This finding is closed.**
3. Access and Availability of Care				
3.1.1 Finding: The Plan does not have policies and procedures to impose prompt corrective actions to bring non-compliant delegated entities from the appointment availability and access standards into compliance. Recommendation: Develop and implement policies and procedures to ensure that prompt investigation and	The Plan updated PV-100 (See Section IV, Provision U and Section IV, Provision W). The updated policy and procedure ensure prompt investigation, and effective corrective actions to ensure timely access throughout the Plan's Provider Network in the following ways: 1. Identifies responsible parties for managing the corrective action process and areas where escalation shall occur. If escalation is required, the policy and procedures describe how escalation shall occur within the Plan.	PV-100 Accessibility of Providers and Practitioners (Pages 14-18 of redline policy)	Completed 7/31/2020	**07/31/20** - The following documentation supports the MCP's efforts to correct this finding: - Updated P&P, "Accessibility of Providers and Practitioners" (07/31/20) as evidence that the MCP has updated the corrective action process to add timelines and escalation processes: The Plan will conduct additional timely access oversight through the DHCS EQRO Timely Access Surveys and will subsequently identify the non-compliant providers and metrics and take the appropriate corrective action (page 8).

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effective corrective actions to ensure timely access throughout the Plan's provider network.	2. Sets timelines for noticing non-compliant providers (i.e. 30 calendar days), obtaining confirmation receipt from non-compliant providers (i.e. 10 business days), receiving a completed Timely Access Improvement Plan back (i.e. 30 calendar days) and validating a provider's submitted Timely Access Improvement Plan (i.e. 10 business days). 3. Describes the prompt corrective action the Plan takes to bring providers back into compliance (i.e. trainings, in-person/phone follow-up, sending of CAP/Educational Packets, etc.). The timeliness and progress of the corrective action plan (CAP) activity with the delegate and/or provider is tracked utilizing a log. The log includes the dates CAPs	CalViva Health CAP Tracking Template	Completed August 2020	Notices to affected contracted providers requiring corrective action are sent no later than 30 calendar days after the Plan validates the analyzed Methodology/Source data (page 15). Affected providers will receive a CAP packet from the MCP with the following materials 30 calendar days after the Plan validates the analyzed Methodology/Source data: 1) Cover Letter, 2) Report Card, 3) Non-Compliant Provider List, 4) Timely Access Improvement Plan, 5) Timely Access Report Card Flyer, 6) Improve Your Patient's Experience with Timely Access Flyer, 7) Improve Health Outcomes: A Guide for Providers Toolkit, 8) Timely Access Provider Training Registration Flyer. A written confirmation of receipt will be required within 10 business days after the MCP

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	are distributed to each PPG/Provider, the date CAP responses and improvement plans are received and the dates the improvement plans are validated. All communications with the PPGs/Providers are also logged in the tracking log. The Plan and its administrator met to review and approve the CAP escalation process. Staff performing CAP activities were trained on the new CAP escalation process. At the time of the DHCS review, the Plan's Policy PV-100 policy primarily referenced the *Provider Appointment Availability Survey* and *Provider After-Hour Access Study* which are conducted	CalViva Health CAP Escalation Process Agenda & Attendance Staff Training Attendance – CAP Escalation Process CalViva Health CAP Escalation Process PV-100 Accessibility of Providers and Practitioners (Pages 8 and 9, Attachment A and	Completed 7/14/20 Completed 7/30/20 Completed July 2020 Completed 7/31/2020	sends the CAP Packet. Failure of the affected provider to respond to the MCP within 10 business days shall be escalated by the MCP (page 15). Affected providers shall be required to complete and return back the Timely Access Improvement Plan within 30 calendar days unless an extension has been requested and approved. Any Improvement Plan not received by the 31st calendar day shall be escalated by the MCP (page 15). Affected providers identified as non-compliant 2 years or more in a row shall be escalated by the MCP (page 16). MCP staff will audit the corrective action process to ensure notices are sent to affected providers and validated Timely Access Improvement Plans are received. The audit will also include a review to ensure timelines and

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	annually to monitor rate of compliance for timely access for a measurement year (i.e. January to December). The Plan's policy and procedure was updated to also include the analysis and review of the DHCS External Quality Review Organization (EQRO) Quarterly Timely Access Survey Results (*See Section IV, B and Attachments A and B)*. DHCS monitors timely access to care for urgent and non-urgent appointment types within Primary Care, Specialty Care, Prenatal Care, Non-Physician Mental Health Care, and Ancillary Providers quarterly. As results are made available by the DHCS and shared with the Plan, the Plan will also take appropriate corrective action on a more frequent basis than annually. Non-compliant providers identified through the DHCS	B in redline policy)		escalation processes are being followed (page 17). The Plan's Access Workgroup or QI/UM Workgroup can further escalate provider accessibility issues, if applicable, to the Plan's Management Oversight Meeting. The Plan's Management Oversight Meeting will discuss the accessibility issue (i.e. non-compliant provider, etc.) and determine the appropriate course of action (i.e. escalation to Health Net Executive Leadership teams for action, a referral to CalViva QI/UM Committee for review and recommendations (page 18). **08/24/20** - The following additional documentation supports the MCP's efforts to correct this finding: - Excel Spreadsheet, "CAP Tracking Template" as evidence that the MCP is tracking and monitoring the timeliness of sending out any corrective action

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	EQRO survey will also receive corrective action as described in the Plan's policy PV-100.			plans to the PPGs/providers. The tracking log includes the dates CAPs are distributed to each PPG/Provider, the date CAP responses and improvement plans are received and the dates the improvement plans are validated. All communications with the PPGs/Providers are also logged in the tracking log. - PowerPoint training, "CalViva Health Provider Timely Access Corrective Action Plan & Escalation Process" (07/30/20) and Meeting Agenda as evidence that the MCP staff performing CAP activities were trained on the new CAP escalation process. If CAP receipt confirmation is not received within 10 calendar days, the MCP will escalate to the assigned PNA and RND for verification of correct PPG contact information and additional follow-up if required. PPGs who do not submit a CAP within 30 calendar days will be escalated to the assigned PNA

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				and RND for further follow-up and assessment of next steps (slide 5). **This finding is closed.**

Submitted by: **Original Signed by Greg Hund** **Date: July 31, 2020**
Title: **Chief Executive Officer**