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

REPORT ON THE MEDICAL AUDIT OF

FRESNO-KING-MADERA REGIONAL HEALTH AUTHORITY DBA CALVIVA HEALTH

Contract Number: 10-87050

Audit Period: February 1, 2019 Through January 31, 2020

Report Issued: June 30, 2020

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I. INTRODUCTION

Fresno-Kings-Madera Regional Health Authority (RHA) was established in 2009 as the Local Initiative Health Plan for a three-county region of Fresno, Kings and Madera. The RHA operates as CalViva Health (Plan). The Plan is governed by a 17-member commission, comprised of local physicians, county supervisors, Federally Qualified Health Centers (FQHC), local hospitals, and stakeholders from all three counties. The Plan started enrolling Medi-Cal beneficiaries from all three counties on March 1, 2011.

The Plan has a contractual relationship with a delegated entity, which includes an Administrative Services Agreement (ASA) and a Capitated Provider Services Agreement (CPSA). The delegated entity is contracted to provide services on the Plan's behalf.

In accordance with the ASA, the delegated entity maintains the systems for health plan operations and performs administrative activities on behalf of the Plan. The responsibilities delegated to the entity include utilization management, case management, credentialing and re-credentialing, clinical and non-clinical member grievances and appeals, quality improvement, and quality management functions.

Through the CPSA, the Plan provides member health care services primarily through a subcontracted network of Primary Care Providers (PCP), specialists, behavioral health providers, hospitals, ancillary providers, pharmacies and directly contracted FQHC.

As of December 2019, the Plan served 351,063 Medi-Cal members: 284,285 in Fresno County, 29,514 in Kings County, and 37,264 in Madera County. The Plan's Medi-Cal make-up is 66 percent Temporary Assistance for Needy Families, 24 percent Medi-Cal expansion, six percent of Seniors and Persons with Disabilities, three percent dual eligible, and one percent all other.

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, 2019 through January 31, 2020. The onsite review was conducted from February 3, through February 14, 2020. The audit consisted of document reviews, verification studies, and interviews with the Plan personnel and the delegated entity.

An Exit Conference with the Plan was held on May 28, 2020. The Plan was allowed 15 calendar days from the day of the Exit Conference to provide supplemental information addressing the draft audit report findings. The findings in the report reflect the evaluation of all relevant information received prior and subsequent to the Exit Conference.

The reduced scope audit evaluated five categories of performance: Utilization Management (UM), Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, and Quality Management.

Implementation of Prior Year Audit Recommendations:

The prior DHCS medical audit (for the medical audit period of April 1, 2018 through January 31, 2019) identified deficiencies. The Plan addressed the deficiencies in a Corrective Action Plan (CAP). The CAP closeout letter (December 3, 2019) noted that all previous findings were closed. This audit examined documentation for compliance and to determine to what extent the Plan has operationalized their CAP.

The summary of the findings by category is as follows:

Category 1 – Utilization Management

In the prior year audit, the Plan did not evaluate the effectiveness of the delegate's UM program. In response to the finding, the Plan implemented procedures to oversee subcontracted UM functions. The Plan revised its prior authorization file review to include additional elements, such as clear and concise explanations regarding medical necessity and clarity on their prior authorization letters to include a description of specific UM criteria or benefit provisions used in their determination.

In the prior year audit, the Plan also failed to have in place a system that would track and monitor its sub-delegated entities' responsibilities with regards to specialty referrals requiring prior authorization requests. In response to the finding, the Plan developed and implemented a specialty referral tracking policy and procedures for monitoring and reporting by delegated and sub-delegated entities about their activities. The Plan also routinely reached out to sub-delegated entities to request a list of standardized specialties in order to obtain additional data, such as referral types and the identification of specialty types requiring prior authorization.

There are no findings in this category for the current audit period.

Category 2 – Case Management and Coordination of Care

The Plan did not ensure that new members complete the Individual Health Education Behavioral Assessment (IHEBA) as part of the Initial Health Assessment (IHA) within 120 days of enrollment. The discussions in the IHA Quarterly Reports identified the same barriers for three quarters in 2019. The Plan addressed identified problems with the same interventions that were previously ineffective. The Plan has not taken any additional actions to address continued non-compliance in the completion of IHEBA for new members.

Category 3 – Access and Availability of Care

The Plan did not have policies and procedures to impose prompt effective corrective actions to bring non-compliant delegated entities into compliance.

Category 4 – Member's Rights

In the prior year audit, the Plan did not ensure its providers would not discriminate against members filing complaints. The Plan's policy and procedure did not outline a process to address cases when providers discriminate against members filing grievances. As part of the CAP, the Plan updated its grievance and appeal policies regarding providers discriminating against members by adding protected class language and procedures.

There are no findings in this category for the current audit period.

Category 5 – Quality Management

There are no findings in this category.

Category 6 – Administrative and organizational Capacity

There are no findings in this category.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The audit was conducted by the DHCS Medical Review Branch to ascertain whether the medical services provided to Plan's members comply with federal and state laws, Medi-Cal regulations and guidelines, and State's two-plan Contract.

PROCEDURE

The onsite review was conducted from February 3, 2020 through February 14, 2020. The audit included a review of the Plan's Contract with DHCS, its policies for providing services, procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with the Plan's administrators, staff, and the delegated entity.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization: 55 medical and 23 pharmacy prior authorization requests were reviewed for compliance with contractual requirements, including medical necessity, consistent application of criteria, timeliness, appropriate review, and communication of results to members and providers.

Appeal Procedures: 19 medical prior authorization appeals were reviewed to ensure that required timeframes were met and appeals were appropriately routed and adjudicated by qualified personnel.

Category 2 – Case Management and Coordination of Care

IHA: 20 medical records were reviewed for completeness and timely completion.

Category 4 – Member's Rights

Quality of Care Grievances: 15 standard, quality of care grievances were selected and evaluated for timely resolution, response to complainant, and submission to the appropriate level for review.

Quality of Service Grievances: 59 grievances were reviewed to verify the reporting timeframes, investigation process, response to complainant, and submission to the appropriate level for review. Of the sampled grievances, 11 were categorized as exempted grievances, 43 standard, and five as expedited grievances.

Category 5 – Quality Management

New Provider Training: 15 cases were reviewed for timely Medi-Cal Managed Care program training.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Fresno-King-Madera Regional Health Authority dba CalViva Health
AUDIT PERIOD: February 1, 2019 through January 31, 2020 **DATE OF AUDIT: February 3, 2020 through February 14, 2020**

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	BASIC CASE MANAGEMENT - INITIAL HEALTH ASSESSMENT

2.1.1 Initial Health Assessment

The Contract requires the Plan to ensure all new members complete the IHEBA within 120 calendar days of enrollment, as part of the IHA; and that all existing members complete the IHEBA at their next non-acute care visit. The Plan shall ensure PCP use age appropriate DHCS standardized Staying Healthy Assessment (SHA) tool or alternative approved tools that comply with DHCS criteria for the IHEBA *(Contract Exhibit A, Attachment 10 (8) (A) (10)).*

The Plan shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting *(Contract Exhibit A, Attachment 4 (1)).*

Finding: The Plan did not take effective action to ensure new members completed the IHEBA as part of the IHA.

The Plan has established procedures reflecting Contract requirements. The new Plan policy *QI-018* describes the process for Medi-Cal members to receive an IHA and IHEBA within 120 days of enrollment. If a member declines to complete the SHA, the PCP should document declination on the age appropriate questionnaire and keep documentation within the member's medical record.

The Plan submitted Medical Record Reviews (MRR) data results for the period of February to October 2019 that showed a compliance rate of 48 percent (151 of 317 medical records) for adult IHEBA completion.

The Plan generates IHA Quarterly Reports based on MRRs conducted as part of the Facility Sited Reviews. The Quarter two 2019 IHA Quarterly Report showed a compliance rate of 27 percent for adult IHEBA completion. The Quarter one, two, & three 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.

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.

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.

An IHEBA/SHA enables the PCP to comprehensively assess the member's current acute, chronic, and preventive health needs. It provides tailored health education counseling, interventions, referral, and follow-up. If the IHEBA is not completed for each new member within 120 days of enrollment, the provider will not be able to identify and track high-risk behaviors and will not be able to prioritize the member's need for health education.

Recommendation: Develop and implement effective follow-up actions or quality improvement procedure to ensure compliance with IHEBA completion in the provision of the IHA.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1	APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES

3.1.1 Policies and Procedures for Monitoring Waiting Times

The Plan is required to develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls, and time to obtain various types of appointments *(Contract, Exhibit A, Attachment 9, (3) (C)).*

The Plan is ultimately responsible for ensuring their subcontractors and delegated entities comply with all applicable state and federal laws and regulations, Contract requirements, reporting requirements, and other DHCS guidance. The Plan must also have in place policies and procedures for imposing corrective action and financial sanctions on subcontractors upon discovery of noncompliance *(Managed Care All Plan Letter 17-004, Subcontractual Relationships and Delegation).*

The Plan is required to implement prompt investigation and corrective action when compliance monitoring discloses the Plan's provider network is not sufficient to ensure timely access, which includes, but is not limited to taking all necessary and appropriate action to identify the causes underlying identified timely access deficiencies and to bring its network into compliance *(California Code of Regulations, Title 28, section 1300.67.2.2 (d) (3)).*

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.

Plan policy *PV-100, Accessibility of Providers and Practitioners* Policy revision date, December 6, 2018 states the Plan would request a CAP when providers in the contracted network do not meet established goals for one or more of the appointment access metrics or after-hours metrics, patterns, or trends of non-compliance are identified.

During the onsite interview, the Plan confirmed there is no policy or procedures outlining how the CAP process brings non-compliant network providers into compliance.

The Plan conducted a *Provider Appointment Availability Survey* and *Provider After-Hour Access Study* with the review period of August through December for 2017 and 2018. Based on the 2017 and 2018 survey results, the Plan sent out CAPs to providers who

were identified as non-compliant with timely appointments standards. A sample of CAPs were reviewed for both years.

For the 2017 survey results, the Plan's due dates for the providers' response to the CAP notifications were on September 2018 and October 2018. For the 2018 survey results, the Plan's due dates for the providers' response to the CAP notifications were on September 2019 and December 2019. For each year, the Plan waited over eight months after the review period to send out any corrective actions to the delegate. Without a policy and procedure in place, there is no timeframe to impose a prompt corrective action.

The Plan is required to ensure that delegates comply with the appointment availability and access standards. Without an effective CAP process, the Plan cannot ensure their delegated entities comply with all applicable state and federal laws, regulations and Contract requirements. The risk of prolonged non-compliance can lead to delays in obtaining necessary care.

Recommendation: Develop and implement policies and procedures to ensure that prompt investigation and effective corrective actions to ensure timely access throughout the Plan's provider network.

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REPORT ON THE MEDICAL AUDIT OF

FRESNO-KING-MADERA REGIONAL HEALTH AUTHORITY DBA CALVIVA HEALTH

Contract Number:	10-87054 State Supported Services
Audit Period:	February 1, 2019 Through January 31, 2020
Report Issued:	June 30, 2020

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I. INTRODUCTION

The audit report presents the findings of Fresno-Kings-Madera Regional Health Authority (RHA) dba CalViva Health (Plan) State Supported Services contract No. 10-87054. The State Supported Services Contract covers contracted abortion services for the Plan.

The onsite audit was conducted from Monday, February 3, 2020 through Friday, February 14, 2020. The audit covered the review period from February 1, 2019 through January 31, 2020. The audit consisted of a document review of materials provided by the Plan.

An Exit Conference with the Plan was held on May 28, 2020.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Fresno-King-Madera Regional Health Authority dba CalViva Health

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State Supported Services

The Plan outlines their processes and procedures for the consistent and accurate processing of sensitive service claims through the policies and procedures, Provider Manual, Member Handbook and their Medi-Cal Operations Guide. Abortion services are covered for Plan members and do not require prior authorization. However, if there is a hospital overnight stay required for the service performed, it is considered separate and the member will need to have prior authorization.

No errors were noted in the verification study conducted to determine appropriate and timely adjudication of State Supported Services claims. The Plan is in compliance with the current Contract.

Recommendation: None.