MEDICAL REVIEW - NORTHERN SECTION II
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Contract Number: 10-87050

Audit Period: April 1, 2016
Through
March 31, 2017

Report Issued: February 13, 2018

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I. INTRODUCTION

In 2009, the Counties of Fresno, Kings, and Madera created the Fresno-Kings-Madera Regional Health Authority (RHA) under the authority granted by the Welfare and Institutions Code section 14087.38. The RHA was established as a public entity to operate programs involving health care services including the authority to contract with the State of California to serve as a health plan for Medi-Cal Members. CalViva Health is the Local Initiative Plan for Fresno, Kings, and Madera Counties.

CalViva Health (The Plan) has an Administrative Services Agreement with a delegated enity (Delegate) to provide specified administrative services on The Plan's behalf. The Plan also has a Capitated Providers Services Agreement with the Delegate for the provision of health care services to The Plan’s Members through the Delegate’s network of contracted providers. Credentialing and Re-credentialing, Utilization Management, Quality Improvement including Quality Management and Grievance Resolution functions are provided by the Delegate on The Plan's behalf through contractual arrangements. Health care is provided for the majority of Members through the Delegate's network. The Plan has three Federally Qualified Health Centers that are contracted directly with the Plan.

As of April 1, 2017, CalViva Health had 360,687 Members

- Fresno 297,669
- Kings 26,979
- Madera 36,039

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of April 1, 2016 through March 31, 2017. The on-site review was conducted from April 17, 2017 through April 27, 2017. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference was held on January 26, 2018 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings.

The audit evaluated six categories of performance: 1 - Utilization Management (UM), 2 - Continuity of Care, 3 - Access and Availability to Care, 4 - Member Rights, 5 - Quality Management (QI) and 6 - Administrative and Organizational Capacity. There were no findings for categories 1, 2, 4, 5, and 6. Findings are as follows:

Category 3 – Access and Availability of Care

According to the 2-Plan Contract A.6.6, the Plan shall maintain adequate number and types of specialists within their network to accommodate the need for specialist care. Providing specialist care and maintaining the specialist care network is done by the Delegate, however the Plan is responsible for the oversight and monitoring. There was insufficient number of specialists in Kings County to provide services to its Members. In the prior year, the Plan did not provide evidence that actions were taken to improve the specialist shortage. The prior year's recommendation was to implement, monitor, and document actions to improve the specialist network shortage. DHCS's Corrective Action Plan (CAP) was issued to the Plan on January 12, 2017.

The Plan is aware of the specialist deficiencies in Kings County. Since specialist services are performed by the Delegate, the Plan approved a delegate corrective action plan (DCAP) submitted by the Delegate to address the specialist shortages. The DCAP focused on the review of additional reports, but did not include a solution to the Plan's specialist shortage issue in Kings County.

Category 3 – Emergency Services and Family Planning Claims

In the prior year audit the Plan did not ensure timely payment of out of network emergency claims. Claims were previously being denied as California Children's Service (CCS) risk when they had a pending Service Authorization Request (SAR). This caused the claim to be denied without a completed SAR. The Plan implemented new instructions to the Medical Review Unit (MRU) clinical team. However, the Claim's Processing Unit improperly denied claims due to a misunderstanding of the new processing instructions, which caused claims not related to CCS to be denied.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The Department of Health Care Services DHCS Medical Review Branch (MRB) conducted an audit to ascertain that the medical services provided to the Plan Members comply with federal and state laws, Medi-Cal regulations and guidelines, and the Medi-Cal Contract.

PROCEDURE

The on-site review was conducted from April 17, 2017 through April 27, 2017. 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 1 – Utilization Management

Prior Authorization Requests: 25 medical requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal Procedures: 23 prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Coordination of Care: Four records were included in the review of coordination of care between the Plan, Primary Care Provider (PCP), Member, Specialty Providers, and other services.

Initial Health Assessment: 30 medical records were reviewed for completeness and timely completion.

Category 3 – Access and Availability of Care

Emergency Service Claims: 25 emergency service claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance Procedures: 29 grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Category 5 – Quality Management

No verification study was performed in this category.

Category 6 – Administrative and Organizational Capacity

Fraud, Waste, and Abuse: Two fraud cases were reviewed for processing and reporting requirements.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
PLAN: Fresno-Kings-Madera Regional Health Authority dba CalViva Health	
AUDIT PERIOD: April 1, 2016 through March 31, 2017	DATE OF AUDIT: April 17, 2017 through April 27, 2017

3.4	SPECIALISTS AND SPECIALTY SERVICES

Specialists and Specialty Services:
Contractor shall maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care in accordance with Title 22 CCR Section 53853(a) and W & I Code Section 14182(c)(2)
2-Plan Contract A.6.6

Contractor shall arrange for the provision of seldom used or unusual specialty services from specialists outside the network if unavailable within Contractor's network, when determined Medically Necessary.
2-Plan Contract A.9.3.F

References Cited:
Title 22 CCR Section 53853(a) - Accessibility of Services
W & I Code Section 14182(c)(2) – Provider Network

SUMMARY OF FINDINGS:

3.4.1 Specialist and Specialty Services

Contractor shall maintain adequate number and types of specialists within their network to accommodate the need for specialty care in accordance with Title 22 CCR Section 53853(a) and W & I Code Section 14182(c)(2).
2-Plan Contract A.6.6

Specialist and Specialty Services referrals is a delegated function. The Plan is required to provide oversight to ensure that the Delegate is maintaining an adequate number of specialists in the provider network.

The Plan has an agreement with the Delegate to provide specialist services to its Members. It is the Plan's responsibility to maintain an adequate number and type of specialists within their network. The Plan recognizes the specialist shortage in Kings County. According to the most current Network adequacy Report (Q4 2016), submitted by the Plan to DHCS, there were network deficiencies in Kings County for hematology/oncology, rheumatology, infection diseases, neonatology, and radiology. The Plan covers geographical regions that are rural in nature. The Delegate was unable to maintain adequate number and types of specialists in Kings County. The Plan has addressed the shortages with the Delegate and issued a corrective action plan to the Delegate (DCAP) on April 13, 2017.

The Plan's specialist shortages may result in members in Kings County not receiving medical

services timely.

RECOMMENDATION:

3.4.1 Conduct rigorous oversight of the Delegate to ensure necessary actions are taken to maintain an adequate number of specialists in Kings County.

3.5	EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS

Emergency Service Providers (Claims):
Contractor is responsible for coverage and payment of Emergency Services and post stabilization care services and must cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a contract with the plan.
2-Plan Contract A.8.13.A

Contractor shall pay for emergency services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the emergency medical condition including Medically
Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Contractor or the Member is stabilized
sufficiently to permit discharge….
2-Plan Contract A.8.13.C

At a minimum, Contractor must reimburse the non-contracting emergency department and, if applicable, its affiliated providers for Physician services at the lowest level of emergency department evaluation and management Physician's Current Procedural Terminology (CPT) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.
2-Plan Contract A.8.13.D

For all other non-contracting providers, reimbursement by Contractor, or by a subcontractor who is at risk for out-of-plan emergency services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting provider pursuant to this provision shall be made in accordance with Provision 5, Claims Processing, and 42 USC Section 1396u-2(b)(2)(D). 3
2-Plan Contract A.8.13.E

Contractor shall cover emergency medical services without prior authorization pursuant to Title 28 CCR, Section 1300.67(g) and Title 22 CCR Section 53216.
2-Plan Contract A.9.7.A

Family Planning (Claims):
Contractor shall reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal FFS rate….(as required by Contract)
2-Plan Contract A.8.9

Claims Processing—Contractor shall pay all claims submitted by contracting providers in accordance with this section…Contractor shall comply with Section 1932(f), Title XIX, Social Security Act (42 U.S.C. Section 1396u-2(f), and Health and Safety Code Sections 1371 through 1371.36.
2-Plan Contract A.8.5

Time for Reimbursement. A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h).
CCR, Title 28, Section 1300.71(g)

SUMMARY OF FINDINGS:

3.5.1 Emergency Services Claims Processing

Time for Reimbursement. A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, unless the

complete claim or portion thereof is contested or denied, as provided in subdivision (h). CCR, Title 28, Section 1300.71(g)

In December 2016, the Plan implemented new instructions to process California Children's Service (CCS) claims. The Medical Review Unit (MRU) began using the new instructions February 1, 2017.

During the onsite, the Plan submitted a report of CCS related emergency room claims for the period February 2017 through March 2017. The claims processing procedures for three denied claims were analyzed for accuracy and timeliness. The Plan did not document or explain why the three claims were denied.

The Plan's MRU misinterpreted the new CCS claims processing instructions and incorrectly instructed the Claims Department to deny all potential CCS claims and requested the providers to resubmit the claim with a Service Authorization Request (SAR) and complete medical records.

The Plan improperly denied claims with potential CCS eligibility and the service providers who should have been paid did not receive payment.

Post-onsite, two of the three improperly denied claims in our sample were correctly processed and paid with interest, and the third was forwarded to the proper responsible party. In addition, the Plan reviewed previously denied CCS related claims since the implementation of the new CCS claims processing instruction and determined 223 claims were improperly denied. The Plan has corrected this process and the all the improperly denied CCS claims were paid with interest.

RECOMMENDATION:

3.5.1 Monitor procedures to ensure proper processing of emergency room claims with potential CCS eligibility.

MEDICAL REVIEW - NORTHERN SECTION II
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Contract Number: 10-87054
State Supported Services

Audit Period: April 1, 2016
Through
March 31, 2017

Report Issued: February 13, 2018

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INTRODUCTION

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

The on-site audit was conducted from April 17, 2017 through April 27, 2017. The audit period is April 1, 2016 through March 31, 2017 and consisted of document review of materials supplied by the Plan and interviews conducted onsite.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
PLAN: Fresno-Kings-Madera Regional Health Authority dba CalViva Health	
AUDIT PERIOD: April 1, 2016 through March 31, 2017	DATE OF AUDIT: April 17, 2016 through April 27, 2017

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS
Abortion *Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:* *Current Procedural Coding System Codes*: 59840 through 59857* *HCFA Common Procedure Coding System Codes*: X1516, X1518, X7724, X7726, Z0336* **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.* *State Supported Services Contract Exhibit A.1*

SUMMARY OF FINDINGS:

SSS.1 – Consent

A minor may consent to an abortion without parental consent and without court permission. (American Academy of Pediatrics v. Lungren 16 Cal.4th 307 (1997))

The Plan's policies are not compliant with the American Academy of Pediatrics v. Lungren decision that allow members of any age to receive abortion services without parental consent. Policies regarding sensitive services and materials distributed by the Plan contained language that requires parental consent.

PH-105 Pregnancy Termination:
C. Member Education on Abortion Services:

> The right of members over the age of twelve to access confidential and sensitive services without parental consent.

PH-015 Sensitive Services:
B. This policy applies to any member, 12 years of age and older, requiring family planning services, pregnancy testing, pregnancy termination, sexually transmitted infection diagnosis/treatment, or HIV testing and/or counseling.

2. Members 12 years of age and older may request a confidential referral from their PCP for family planning services, sexual assault services, pregnancy services, sexually transmitted infection diagnosis and treatment, HIV counseling and testing. Adolescents 12 years of age and older may request these services without parental consent. Members 12 years of age and older may also self-refer to any qualified provider who accepts Medi-Cal.

2016 Medi-Cal Ops Guide:
Pregnancy Termination:

An abortion is classified as a sensitive service.

Sensitive Services:

Sensitive services include those services related to treatment for injuries resulting from sexual assault,
drug or alcohol abuse treatment, pregnancy, family planning, HIV counseling and testing, pregnancy
termination, mental health treatment, and diagnosis and treatment of STIs for children ages 12 or older.

Based on the Plan's statements and a review of a summary of abortion claims revealed that the Plan did not have an age limitation for consent.

RECOMMENDATION:

SSS.1 - Revise all policies and distributed material to reflect language that complies with American Academy of Pediatrics v. Lungren 16 Cal.4th 307 (1997).