

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

**Fresno-Kings-Madera Regional Health
Authority dba CalViva Health**

Contract Number: 10-87050 A01

Audit Period: November 1, 2013
Through
October 31, 2014

Report Issued: July 3, 2015

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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.

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

As of February 1, 2015, CalViva Health had 304,615 Members

- Fresno 249,616
- Kings 23,422
- Madera 31,577

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of November 1, 2013 through October 31, 2014. The on-site review was conducted from February 3, 2015 through February 13, 2015. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An exit conference was held on June 9, 2015 with the Plan. The Plan was allowed fifteen (15) calendar days from the date of the exit conference to provide supplemental information addressing the draft audit report findings. The Plan submitted supplemental information after the exit conference which is reflected in this report.

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

Category 1 – Utilization Management

The Plan was compliant with the requirements in this Category.

Category 2 – Case Management and Coordination of Care

The requirements for Basic Case Management include the provision of an Initial Health Assessment (IHA) for each new Member within the required timeframes and coordination of carved-out and linked services. The requirement for ensuring the provision of an IHA within required timelines for each new Member was not met. Based on the verification study, IHAs were completed outside of required timeframes.

Category 3 – Access and Availability of Care

Standards for after-hours accessibility to care were not met. The Provider network failed to constantly have clear instructions for emergency situations and comprehensive instructions on how to contact the on-call physician for after hours. **This is an ongoing finding.**

The Plan maintains procedures to arrange seldom used or unusual specialty services from specialists outside the Plan and takes appropriate action to address Member needs when the number or type of specialists is inadequate. However, the Plan continues to have insufficient availability of specialty care Providers; allergist and pediatricians, in Kings County. **This is an ongoing finding.**

The Plan failed to assure timely processing for out-of-plan emergency service and family planning claims as required by the Contract. The Plan's Policy failed to include language to ensure interest will be paid as applicable for any family planning claims not paid within required timeframes. The Plan's reimbursement system incorrectly denied claims, causing a delay in payments.

Category 4 – Member’s Rights

The Plan has an established grievance system to receive, review and resolve grievances within required timeframes. However, in one instance, the Plan did not meet the contractual timeframe for sending an *acknowledgement letter* to a Member within 5 calendar days of receipt of the grievance. In another instance, the Plan did not send a *resolution letter* to a Member within 30 calendar days of receipt of the grievance.

Category 5 – Quality Management

The Plan was compliant with the requirements in this Category.

Category 6 – Administrative and Organizational Capacity

The Plan was compliant with the requirements in this Category.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the Department of Health Care Services (DHCS) Medical Review Branch 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 on-site review was conducted from February 3, 2015 through February 13, 2015. 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: 21 medical and 33 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review and communication of results to Members and Providers.

Appeal Procedures: 21 prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

California Children's Services (CCS): 5 medical records were reviewed for evidence of coordination of care between the Plan and CCS Providers.

Initial Health Assessment: 17 medical records were reviewed for completeness and timely completion.

Category 3 – Access and Availability of Care

Emergency Service Claims: 20 emergency service claims were reviewed for appropriate and timely adjudication.

Family Planning Claims: 20 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member’s Rights

Grievance Procedures: 50 grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Category 5 – Quality Management

Medical Records: 26 medical records were reviewed for completeness.

New Provider Training: 12 new Provider training records were reviewed for timely Medical Managed Care program training.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.4

INITIAL HEALTH ASSESSMENT

Provision of Initial Health Assessment:

Contractor shall cover and ensure the provision of an IHA (complete history and physical examination) in conformance with Title 22, CCR, Sections 53851(b)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below.

2-Plan Contract A.10.3.A

Provision of IHA for Members under Age 21

1. For Members under the age of 18 months, Contractor is responsible to cover and ensure the provision of an IHA within 60 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger whichever is less.

2. For Members 18 months of age and older upon enrollment, Contractor is responsible to ensure an IHA is performed within 120 calendar days of enrollment.

2-Plan Contract A.10.5.A.1-2

IHAs for Adults, Age 21 and older

- 1) Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.
- 2) Contractor shall ensure that the performance of the initial complete history and physical exam for adults includes, but is not limited to:
 - a) blood pressure,
 - b) height and weight,
 - c) total serum cholesterol measurement for men ages 35 and over and women ages 45 and over,
 - d) clinical breast examination for women over 40,
 - e) mammogram for women age 50 and over,
 - f) Pap smear (or arrangements made for performance) on all women determined to be sexually active,
 - g) chlamydia screen for all sexually active females aged 21 and older who are determined to be at high-risk for chlamydia infection using the most current CDC guidelines. These guidelines include the screening of all sexually active females aged 21 through 25 years of age,
 - h) screening for TB risk factors including a Mantoux skin test on all persons determined to be at high risk, and,
 - i) health education behavioral risk assessment.

2-Plan Contract A.10.6.A.2.a-i

Contractor shall make reasonable attempts to contact a Member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA shall be considered evidence in meeting this requirement.

2-Plan Contract A.10.3.D

SUMMARY OF FINDINGS:

The Contract requires the provision of an Initial Health Assessment (IHA) for each new Member within stipulated timelines and reasonable attempts to contact a Member to schedule an IHA be made and that all attempts be documented.

Pursuant to the Plan's Policies, *Initial Health Assessment* (PH-061) and *Individual Health Education Behavioral Assessment/Staying Healthy Assessment* (HE-001), the Plan will cover and ensure the provision of an IHA for all new Members age 18 months and older within 120 days of enrollment and all Members under the age of 18 months within 60 days of enrollment.

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According to the Plan, welcome letters explaining IHA requirements are sent to new Members to encourage initial appointments but the scheduling of IHAs is done by the primary care provider (PCP). The Plan tracks Member contacts through Member Services, medical records, and new Member Enrollment Rosters. PCPs access the newly enrolled Member Roster for purposes of contacting Members to schedule the IHA.

A Facility Site Review/Medical Record Review (FSR/MRR) is conducted every three years by the Plan to monitor and ensure comprehensive medical assessment and follow-up care are rendered. The Plan stated it does not have any other monitoring system for the completion of IHAs aside from the FSR/MRR process.

In a verification study, seventeen (17) medical records were reviewed. Two (2) of 17 medical records exceeded the timeframe to perform the IHA. [2-Plan Contract: Exhibits A.10.3.A, A.10.5.A, and A.10.6.A]

Although the Plan has systems in place to support compliance with the IHA requirements, the requirement for ensuring the provision of an IHA within required timelines for each new Member was not met.

RECOMMENDATION:

Enhance quality controls to ensure Providers complete the Initial Health Assessment for all new Members within the timelines stipulated in the Contract.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.3

TELEPHONE PROCEDURES / AFTER HOURS CALLS

Telephone Procedures:

Contractor shall require Providers to maintain a procedure for triaging Members' telephone calls, providing telephone medical advice (if it is made available) and accessing telephone interpreters.

2-Plan Contract A.9.3.D

Member Services Staff:

Contractor shall maintain the level of knowledgeable and trained staff sufficient to provide Covered Services to Members and all other services covered under this Contract.

2-Plan A.13.2.A

After Hours Calls:

At a minimum, Contractor shall ensure that a physician or an appropriate licensed professional under his/her supervision will be available for after-hours calls.

2-Plan Contract A.9.3.E

SUMMARY OF FINDINGS:

The Plan's Policy, *Accessibility of Providers and Practitioners (QI-007)* establishes parameters for appointment and telephonic access to health care services and delineates the monitoring activities to ensure compliance.

The Plan conducts the Provider Appointment Availability and After-Hour Access Survey to assess Provider compliance with required after-hours emergency information and after-hours Primary Care Physician availability for urgent needs. Providers must ensure office answering services or automated messages include instructions for accessing emergency services. For urgent care, Providers are required to inform Members about receiving a return call by a qualified health care professional within a maximum of 30 minutes.

As a result of the last Department of Health Care Services audit, the Plan implemented an Access and Availability Improvement Plan for noncompliant Providers to assist in meeting after-hours access standards. Results from the Provider Appointment Availability and After-Hour Access survey, indicate a significant need for improvement in the ability to contact a physician after-hours, and a need for improvement in appropriate instructions given for accessing emergency care. All three counties had low compliance rates. **This is an ongoing finding.**

RECOMMENDATION:

Continue to improve on the availability to contact physician after-hours and provide appropriate instructions for accessing emergency care.

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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

SUMMARY OF FINDINGS:

The Plan's Policy, *Availability of Practitioners and Providers* (QI-008) establishes standardized geographic, ratio, open practice standards, and monitoring activities to ensure the Plan has a network that is sufficient and adequate to provide its Members appropriate access to, and availability of, Providers and health care services.

The Primary Care Physician (PCP) is responsible for coordinating all referrals for specialty care if the necessary services fall outside the scope of the PCP's practice. The Plan shall arrange for the provision of *seldom used or unusual specialty services* from specialists outside the network if unavailable within the Plan's network, when determined medically necessary.

The Plan monitors services to ensure adequate availability of specialists within the network through the annual *GeoAccess* survey. Based on the 2013 CalViva Health Availability Report, *GeoAccess* results indicated that access to specialty care Providers was below standards in Kings County. To address these barriers, the Plan's strategies are to contract with additional specialty care Providers as evidenced through the Access WorkGroup Meeting minutes. The Plan was compliant with specialists and specialty services requirements in Fresno and Madera Counties. **This is an ongoing finding.**

RECOMMENDATION:

Continue to monitor and ensure Members receive services in areas where there is insufficient availability of such specialists.

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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)

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. Contractor shall be subject to any remedies, including interest payments provided for in these sections, if it fails to meet the standards specified in these sections.

2-Plan Contract A.8.5.A

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:

The Plan's Policy, *Emergency Care and Services/Post Stabilization Care and Services* (UM-001), indicates the Plan provides payment for emergency services necessary to screen, treat, and stabilize Members with emergency conditions to a qualified Provider, regardless of whether the Provider is within the Plan's network. Prior authorization is not required for medically necessary services for emergency conditions provided in the physician's office, immediate care center, urgent care center, or hospital emergency department. Properly documented, uncontested claims are paid within 45 working days after receipt; all misdirected claims involving emergency service and care will

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be sent to the appropriate capitated entity within ten (10) working days of receipt of the claims.

Twenty (20) out-of-plan emergency service claims were reviewed for appropriate and timely payment. For eleven (11) of 20 claims, the Plan failed to process the claim within 45-working days of receipt. In addition, errors in the Plan's claims adjudication process were noted, in which some claims were incorrectly denied for pending disenrollment. This caused a delay in payment, which in some cases went beyond the required 45-working day processing period. There were no denials of service due to medical necessity.

The Plan's Policy, *Family Planning Services* (PH-104), states how the Plan provides Members timely access to the full array of family planning services from any qualified family planning Provider, including their primary care physician and other contracting and non-contracting (out-of-plan) Providers without prior authorization.

However, the Policy lacks the following language: "*Interest* will be paid as applicable for any claims not paid within required timeframes." [2-Plan Contract: Exhibit A.8.5.A]

The Plan's Policy, PH-104, erroneously identified it processed and paid claims within 30 calendar working days instead of 30 working days after receipt of the claim as required. According to Plan personnel, the Policy will be revised to reflect appropriate reimbursement timeframes. Guidelines for claims processing stated in the Policy should read "...90% of claims within 30-*working* days after CalViva Health's receipt of the claim." as required by California Code of Regulations, Title 28, Section 1300.71.

Twenty (20) out-of-plan family planning claims were reviewed for appropriate and timely payment. For three (3) of 20 claims, the Plan failed to process the claim within 45-working days of receipt. There were no denials of service due to medical necessity.

RECOMMENDATIONS:

- Enhance internal quality controls to ensure the timeliness, accuracy, and appropriateness of the claims adjudication process within 45-working days.
- Enhance the claims department staff training to ensure consistent application of the Plan's claims Policies and procedures; ensure system edits for claim denials are appropriately applied.
- Update the language in Policy PH-104 to clarify claims processing deadlines and to ensure interest will be paid as applicable for any claims not paid within required timeframes.

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CATEGORY 4 – MEMBER’S RIGHTS

4.1

GRIEVANCE SYSTEM

Member Grievance System and Oversight:

Contractor shall implement and maintain a Member Grievance System in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.13), and 42 CFR 438.420(a)-(c).

2-Plan Contract A.14.1

Contractor shall implement and maintain procedures...to monitor the Member's grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858....(as required by Contract)

2-Plan Contract A.14.2

Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any subcontracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in Title 22 CCR Section 53858(e).

2-Plan Contract A.14.3.A

SUMMARY OF FINDINGS:

The Plan established policies and procedures for the operation of the grievance process and the delegated activities coordinated with Health Net. The Plan delegates to Health Net for intake, investigation, review and communication with Members. The Plan monitors Health Net with weekly case notification, monthly case logs, quarterly analysis and annual summaries. The Plan's Chief Medical Officer (CMO) is responsible for the process and is involved in the final review of all clinical Quality of Care grievances.

Fifty (50) grievance cases were selected for review: twenty-eight (28) Quality of Care (QOC) cases and twenty-two (22) Quality of Service (QOS) cases. All QOC grievance cases reviewed were adjudicated appropriately by the Health Net Medical Director and the Plan CMO. Grievances were reviewed for timeliness of acknowledgement and resolution notifications and for proper classification and disposition of the grievance:

- For one (1) QOS grievance case, the acknowledgement letter was not sent to the Member complainant within five (5) calendar days of receipt,
- For one (1) QOC grievance case, the resolution letter was not sent to the Member complainant within thirty (30) calendar days of receipt.

One QOC grievance case exemplified access concerns related to care of a specialist in a timely manner. The Member involved waited almost a year for an appointment with an orthopedic specialist for a consultation involving knee pain. Subsequently the appointment was cancelled because the specialist involved was no longer accepting Medi-Cal patients. Attempts to reschedule with another Provider showed the first available appointment was not until the following year. The case was closed on time as a QOS complaint and referred for resolution to contracts and case management. This case demonstrates the lack of Contract fulfillment which states that Members should be seen within 15 days for specialty care appointments.

RECOMMENDATIONS:

- Ensure all acknowledgement and resolution notification letters are sent to the Members within the required timeframes.
- Ensure the timely provision of specialty care.