DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SACRAMENTO SECTION

REPORT ON THE MEDICAL AUDIT OF FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY DBA CALVIVA HEALTH FISCAL YEAR 2024-25

Contract Number: 23-30220

Audit Period: April 1, 2024 — March 31, 2025

Dates of Audit: June 2, 2025 — June 13, 2025

Report Issued: October 30, 2025

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I. INTRODUCTION

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

The Plan has an Administrative Services Agreement with Health Net Community Solutions (Health Net) to provide administrative services on the Plan's behalf. In accordance with the Administrative Services Agreement, responsibilities delegated to Health Net include utilization management, case management, credentialing and re-credentialing, clinical and non-clinical member grievances and appeals, quality improvement and quality management functions, and administrative and organizational capacity.

The Plan also has a Capitated Provider Services Agreement with Health Net for the provision of health care services to Plan members through Health Net's subcontracted network of primary care providers, specialists, behavioral health providers, hospitals, ancillary providers, pharmacies, and directly contracted Federally Qualified Health Centers.

The Plan's delegate, Health Net, is responsible for administering all provisions of the Contract. The Plan retains overall responsibility in ensuring Health Net carries out contractual obligations in the provision of health care services to Plan members.

As of April 2025, the Plan has a total Medi-Cal membership of 432,619, with 344,009 in Fresno County, 50,015 in Madera County, and 38,595 in Kings County. The Plan's Medi-Cal composition is 60 percent Temporary Assistance for Needy Families, 28 percent Medi-Cal Expansion, 7 percent Dual eligible, 5 percent Seniors and Persons with Disabilities, and less than 1 percent for all others.

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, 2024, through March 31, 2025. The audit was conducted from June 2, 2025, through June 13, 2025. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on October 13, 2025. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On October 28, 2025, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Utilization Management, Case Management and Coordination of Care, Case Management and Coordination of Car Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity.

The prior DHCS medical audit for the period of April 1, 2023, through March 31, 2024, was issued on October 1, 2024. This audit examined the Plan's compliance with the DHCS Contract and assessed the implementation of the prior year Corrective Action Plan.

The summary of the findings by category is as follows:

Category 1 – Utilization Management

The Plan is required to apply the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) standard of medical necessity for members under 21 years of age. The Plan is also required to oversee and remain responsible for any services provided by a subcontractor to ensure compliance with all applicable requirements. The Plan did not ensure the delegate, Health Net, applied EPSDT criteria in medical necessity denial decisions for members under 21 years of age.

Category 2 – Case Management and Coordination of Care

The Plan is required to ensure eligible members in all applicable Enhanced Care Management (ECM) Populations of Focus receive all seven ECM core service components. The core ECM services include Outreach and Engagement, Comprehensive

Assessment and Care Management Plan, Enhanced Coordination of Care, Health Promotion, Comprehensive Transitional Care, Member and Family Supports, and Coordination of and Referral to Community and Social Support Services. The Plan is also required to oversee and remain responsible for any services provided by a subcontractor to ensure compliance with all applicable requirements. The Plan did not ensure the delegate, Health Net, provided members with all ECM core service components.

The Plan is required to notify members of the discontinuation of ECM benefits and ensure members are informed of their right to appeal through the Notice of Action (NOA) process. The Plan is also required to oversee and remain responsible for any services provided by a subcontractor to ensure compliance with all applicable requirements. The Plan did not ensure the delegate, Health Net, notified members of the discontinuation of ECM benefits through the NOA process.

The Plan must develop member-facing written material about ECM for use across its network of ECM providers. This material must explain how members may request ECM services; that participation is voluntary and can be discontinued at any time, that ECM-related data sharing must be authorized, the process members may choose a different ECM Lead Care Manager or provider and must meet standards for cultural and linguistically appropriate communication. The Plan is also required to oversee and remain responsible for any services provided by a subcontractor to ensure compliance with all applicable requirements. The Plan did not ensure the delegate, Health Net, included all required information in ECM member-facing written materials.

Category 3 – Network and Access to Care

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

Category 4 – Member's Rights

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

Category 5 – Quality Management

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

Category 6 –Administrative and Organizational Capacity

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

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The DHCS conducted an audit of the Plan from June 2, 2025, through June 13, 2025, for the audit period of April 1, 2024, through March 31, 2025. The audit included a review of the Plan's Contract with the DHCS, policies and procedures 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 and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Service Requests: Thirty medical service requests, including seven for Seniors and Persons with Disabilities members, were reviewed for timeliness, consistent application of criteria, and appropriate review.

Category 2 – Case Management and Coordination of Care

Complex Case Management: Fifteen medical records were reviewed to confirm coordination of care.

ECM: Twenty medical records were reviewed to confirm coordination of care and fulfillment of ECM requirements.

Category 5 – Quality Management

Potential Quality Issues: Twenty Potential Quality Issues cases were reviewed for appropriate evaluation and effective action taken to address needed improvements.

New Provider Training: Twenty-five records were reviewed for timely Medi-Cal Managed Care program training.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: Nineteen fraud and abuse cases were reviewed for appropriate reporting and processing.

Encounter Data: Twenty-five encounter data records were reviewed for the accuracy of the information.

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management

1.2 Prior Authorization Review and Requirements

1.2.1 Early and Periodic Screening, Diagnostic, and Treatment Criteria Application

The Plan is required to apply the EPSDT standard of medical necessity for members under 21 years of age. *(2024 Contract, Exhibit A, Attachment III, Section 5.3.2)*

The Plan is required to provide and cover all medically necessary EPSDT services, unless otherwise carved out of the Contract, when the services are determined to be medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions. *(All Plan Letter (APL) 23-005 Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment services for Medi-Cal members under the age of 21)*

The Plan is required to ensure that subcontractors and downstream subcontractors fully comply with all applicable terms and conditions of the Contract and all duties delegated to subcontractors and downstream subcontractors. The Plan is also required to oversee and remain responsible for any services provided by a subcontractor or downstream subcontractor and must meet all applicable requirements set forth in state and federal law, regulation, any APLs or DHCS guidance, and this Contract. *(2024 Contract, Exhibit A, Attachment III, Section 3.1.4)*

The Plan policy, *UM 113, Clinical Criteria for Utilization/Care Management Decisions* (revised 11/21/24), stipulated that unless otherwise specified, the policy requirements are applicable to the Plan delegate, Health Net, in which the responsibility for activities affected by the policy have been delegated. The policy included the definition of EPSDT criteria which specified that members under the age of 21 have additional benefits available for services that correct, ameliorate, maintain, or improve the member's current health condition. The policy also stated the Plan will audit the delegate, Health Net, annually to ensure approved criteria are used for medical necessity decision making.

Finding: The Plan did not ensure the delegate, Health Net, applied EPSDT criteria in medical necessity denial decisions for members under 21 years of age.

Four of five verification samples of Prior Authorization (PA) requests for members under 21 years of age did not indicate the application of EPSDT criteria in the denial process. The sample PA requests noted below may have been approved with consideration of EPSDT criteria:

- PA request for a disabled 20-year-old member for a specialized bed which was denied for lack of medical necessity. There was no indication within the file or the NOA letter that EPSDT criteria were considered in the denial.
- PA request for a one-year-old member for a cranial remodeling (head helmet). The request was denied for lack of medical necessity. There was no indication within the file or the NOA letter that EPSDT criteria were considered in the denial.
- PA request denied for a four-month-old member for a procedure to correct a tongue-tied condition. There was no indication within the file or the NOA letter that EPSDT criteria were considered in the denial.
- PA request denied for a two-year-old member for removal of extra foreskin. There was no indication within the file or the NOA letter that EPSDT criteria were considered in the denial.

The Plan's delegate, Health Net, applied medical guidelines found in the Medi-Cal Manual and InterQual, and an outside specialist review in denial decisions where EPSDT criteria were not utilized.

The Plan did not ensure the delegate, Health Net, applied EPSDT criteria in medical necessity denial decisions for members under 21 years of age. Review of the Plan's audit of its delegate revealed that the audit tool did not capture evidence to ensure application of EPSDT criteria in PA denials. During an interview, the Plan confirmed there was a gap in its oversight audit process of the delegate, indicating there was an absence of a specific audit tool regarding EPSDT criteria application. It was also acknowledged that EPSDT criteria were not documented as part of the medical necessity denial process.

When EPSDT criteria are not considered in medical necessity denial decisions, members under 21 years of age may not receive the additional benefits available for medically necessary services.

Recommendation: Implement policies and revise oversight procedures to ensure the Plan's delegate, Health Net, properly applies EPSDT criteria in medical necessity denial decisions for members under 21 years of age.

COMPLIANCE AUDIT FINDINGS

Category 2 – Case Management and Coordination of Care

2.6 Enhanced Care Management

2.6.1 Enhanced Care Management Core Service Components

The Plan is required to ensure members receive all seven ECM core service components: Outreach and Engagement, Comprehensive Assessment and Care Management Plan, Enhanced Coordination of Care, Health Promotion, Comprehensive Transitional Care, Member and Family Supports, and Coordination of and Referral to Community and Social Support Services. *(2024 Contract, Exhibit A, Attachment III, 4.4.11)*

The Plan is required to perform oversight of ECM providers, holding them accountable to all ECM requirements contained in the Contract, the DHCS' policies and guidance, APLs, and the Plan's Model of Care. *(2024 Contract, Exhibit A, Attachment III, 4.4.13)*

The Plan is required to ensure members receive all seven ECM core service components to eligible members in applicable ECM Populations of Focus. The ECM core service components must include, but are not limited to, the following:

Comprehensive Assessment and Care Management Plan

- Developing a comprehensive, individualized, person-centered Care Management Plan with input from the members, their family, legal guardians, authorized representatives, caregivers, and other authorized support persons, as appropriate, to assess strengths, risks, needs, goals and preferences, and to make recommendations for service needs.
- Ensuring the Care Management Plan is reviewed, maintained, and updated under appropriate clinical oversight.

Enhanced Coordination of Care

- Organizing patient care activities, as laid out in the Care Management Plan; sharing information with those involved as part of the members' multi-disciplinary care team; and implementing activities identified in the members' Care Management Plan.
- Maintaining regular contact with all providers that are identified as being a part of the members' multi-disciplinary care team since their input is necessary for successful implementation of the members' goals and needs.

- Providing support to engage the members in their treatment, including coordination for medication review and reconciliation.

Member and Family Supports

- Activities to ensure the member and their family members, legal guardians, authorized representatives, caregivers, and authorized support persons, as applicable, are knowledgeable about the member's conditions, with the overall goal of improving the member's care planning and follow-up, adherence to treatment, and medication management.
- Ensuring that members and their family members, legal guardians, authorized representatives, caregivers, and authorized support persons, as applicable, have a copy of the member's Care Management Plan and information about how to request updates.

(APL 23-032, Enhanced Care Management Requirements)

The Plan is required to ensure that subcontractors and downstream subcontractors fully comply with all applicable terms and conditions of the Contract and all duties delegated to subcontractors and downstream subcontractors. The Plan is also required to oversee and remain responsible for any services provided by a subcontractor or downstream subcontractor and must meet all applicable requirements set forth in state and federal law, regulation, any APLs or DHCS guidance, and this Contract. *(2024 Contract, Exhibit A, Attachment III, Section 3.1.4)*

The Plan policy, *CMP-500 ECM, Enhanced Care Management Program Overview and Requirements* (revised 11/17/24), stipulated that unless otherwise specified, the policy requirements are applicable to Plan delegate, Health Net, in which the responsibility for activities affected by the policy have been delegated. The policy stated the Plan will ensure that ECM contains all of the following core service components for each member receiving ECM: Outreach and Engagement, Comprehensive Assessment and Care Management Plan, Enhanced Coordination of Care, Health Promotion, Comprehensive Transitional Care, Member and Family Supports, and Coordination of and Referral to Community and Social Support Services.

Finding: The Plan did not ensure the delegate, Health Net, provided members with all ECM core service components.

A verification study of 20 medical records revealed that six members did not receive all ECM core service components:

- In three of six samples, the Comprehensive Assessment and Care Management Plan was not completed. In one of the three cases, there was no documentation of a comprehensive assessment. In two of the three cases, there was no documentation that the Care Management Plan was reviewed, maintained, and updated under appropriate clinical oversight.
- In three of six samples, Member and Family Supports was not completed. There was no documentation that indicated the member's family support system was engaged or educated by the ECM provider regarding the member's current health issues to assist the member in the management and improvement of their health conditions. In two of the three cases, a copy of the member's Care Management Plan was not provided to the member and their family members. In one of the three samples, the care plan was given to the members, but not the family members.
- In four of six samples, Enhanced Coordination of Care was not completed. In all four cases, there was no documentation that information was shared with those involved as part of the multi-disciplinary care team. As a result, medication review and reconciliation were not completed in two of the four cases.

Although Plan policy, *CMP-500,* states the Plan will ensure that core service components will be provided for each member receiving ECM, the Plan did not ensure the delegate, Health Net, fully complied with applicable ECM requirements.

During an interview, the Plan confirmed that although it conducted oversight audits of the delegate, Health Net, in which providers were required to submit documentation to ensure compliance, the Plan acknowledged that there was a gap in its oversight audit process. Review of the Plan's oversight audit revealed that the audit did not capture evidence to ensure members received all ECM core service components.

ECM members are individuals with the most complex medical and social needs. When all ECM core service components are not provided, members may not receive proper coordination of services and comprehensive care management, resulting in adverse health outcomes.

Recommendation: Implement policies and revise oversight procedures to ensure the Plan's delegate, Health Net, provides members with all ECM core service components.

2.6.2 Member Notification of Enhanced Care Management Benefit Discontinuation

The Plan is required to notify members of the discontinuation of ECM benefits and ensure members are informed of their right to appeal through the NOA process. *(2024 Contract, Exhibit A, Attachment III, 4.4.10 (F))*

The Plan is required to ensure that subcontractors and downstream subcontractors fully comply with all applicable terms and conditions of the Contract and all duties delegated to subcontractors and downstream subcontractors. The Plan is also required to oversee and remain responsible for any services provided by a subcontractor or downstream subcontractor and must meet all applicable requirements set forth in state and federal law, regulation, any APLs or DHCS guidance, and this Contract. *(2024 Contract, Exhibit A, Attachment III, Section 3.1.4)*

The Plan policy, *CMP-500*, *Enhanced Case Management Program Overview and Requirements* (revised 11/17/24), stipulated that unless otherwise specified, the policy requirements are applicable to the Plan's delegate, Health Net, in which the responsibility for activities affected by the policy have been delegated. The policy stated that when ECM is discontinued, or will be discontinued for the member, the Plan shall notify the member of the discontinuation of ECM by mail and ensure the member is informed of their right to appeal and the appeals process through the NOA process. The ECM provider shall be copied on the NOA and be notified through the established data sharing process.

Finding: The Plan did not ensure the delegate, Health Net, notified members of the discontinuation of ECM benefits through the NOA process.

A verification study of 20 medical records revealed that the Plan's delegate, Health Net, discontinued ECM benefits for four members. In all four samples, the Plan's delegate did not notify the members of the discontinuation through the NOA process.

Although Plan policy, *CMP 500*, required that members be notified of the discontinuation of ECM benefits through the NOA process, the Plan did not ensure the delegate, Health Net, fully complied with applicable ECM discontinuation requirements. The Plan confirmed in a written statement that the delegate, Health Net, did not notify members when ECM benefits were discontinued.

During an interview, the Plan acknowledged that although it conducted audits of the delegate, Health Net, there was a gap in its oversight audit process. Review of the Plan's oversight audit revealed that the audit did not capture evidence to ensure members were notified of the discontinuation of ECM benefits.

When members are not notified of ECM benefit discontinuation through the NOA process, members may not be informed of their right to appeal and the appeals process.

Recommendation: Implement policies and revise oversight procedures to ensure the Plan's delegate, Health Net, notifies members of the discontinuation of ECM benefits through the NOA process.

2.6.3 Enhanced Care Management Member-Facing Written Materials

The Plan must develop member-facing written material about ECM for use across its network of ECM providers. This material must include the following:

1. Explain how members may request ECM services.
2. Explain that ECM participation is voluntary and can be discontinued at any time.
3. Explain that members must authorize ECM-related data sharing.
4. Describe the process by which members may choose a different ECM Lead Care Manager or ECM provider.
5. Meet standards for cultural and linguistically appropriate communication.

(2024 Contract, Exhibit A, Attachment III, 4.1.1(K))

The Plan is required to ensure that subcontractors and downstream subcontractors fully comply with all applicable terms and conditions of the Contract and all duties delegated to subcontractors and downstream subcontractors. The Plan is also required to oversee and remain responsible for any services provided by a subcontractor or downstream subcontractor and must meet all applicable requirements set forth in state and federal law, regulation, any APLs or DHCS guidance, and this Contract. *(2024 Contract, Exhibit A, Attachment III, Section 3.1.4)*

The Plan policy, *CMP-500, Enhanced Case Management Program Overview and Requirements* (revised 11/17/24), stipulated that unless otherwise specified, the policy requirements are applicable to the Plan delegate, Health Net, in which the responsibility for activities affected by the policy have been delegated. The policy stated that the ECM provider will obtain verbal or written consent from the member or member's guardian to receive ECM and consent for related data sharing. Members may request to change their assigned Lead Care Manager at any time by contacting the ECM provider or by contacting the Plan's member services on the back of the member's identification card.

Finding: The Plan did not ensure the delegate, Health Net, included all required information in ECM member-facing written materials.

A review of ECM member-facing written materials revealed that two of the five required elements were not included. These member-facing written materials lacked information explaining that the member must authorize ECM-related data sharing and did not describe the process by which the member may choose a different ECM Lead Care Manager or ECM provider.

Although Plan policy, *CMP 500*, addressed the required ECM material, the policy did not specify that all required information must be included in all member-facing written material. Additionally, the Plan did not ensure the delegate, Health Net, fully complied with ECM written material requirements. During an interview, the Plan stated that members were notified of ECM benefits through flyers, email, newsletters, and the provider directory. However, the Plan could not identify all required information within the member-facing written materials.

During an interview, the Plan confirmed that although it conducted audits of its delegate, Health Net, there was a gap in its oversight process. Review of the Plan's oversight audit revealed that the audit did not capture evidence to ensure member-facing written materials included all required information.

When member-facing written materials do not contain all required information, members may not be informed of or understand all services offered through the ECM program.

Recommendation: Revise policies and implement oversight procedures to ensure all required information is included in ECM member-facing written materials.

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REPORT ON THE MEDICAL AUDIT OF FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY DBA CALVIVA HEALTH FISCAL YEAR 2024-25

Contract Number: 23-30252

Contract Type: State Supported Services

Audit Period: April 1, 2024 — March 31, 2025

Dates of Audit: June 2, 2025 — June 13, 2025

Report Issued: October 30, 2025

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I. INTRODUCTION

This report presents the results of the audit of the Fresno-Kings-Madera Health Authority dba CalViva Health's (Plan) compliance and implementation of the State Supported Services Contract number 23-30252 with the State of California. The State Supported Services Contract covers abortion services with the Plan.

The audit covered the period of April 1, 2024, through March 31, 2025. The audit was conducted from June 2, 2025, through June 13, 2025, which consisted of a document review and verification study with the Plan's administration and staff.

An Exit Conference with the Plan was held on October 13, 2025. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On October 28, 2025, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

COMPLIANCE AUDIT FINDINGS

State Supported Services

The Plan is required to provide, or arrange to provide, to eligible members the following State Supported Services: Current Procedural Terminology Codes: 59840 through 59857. These Codes are subject to change upon the Department of Health Care Services' implementation of the Health Insurance Portability and Accountability Act of 1996 electronic transaction and code sets provisions. *(State Supported Services Contract, Exhibit A, Sections 1.2.1 and 1.2.2)*

Abortion services are covered by the Medi-Cal program, as outlined in the Medi-Cal Provider Manual. The Plan must cover abortion services, as well as the medical services and supplies incidental or preliminary to an abortion, consistent with the requirements outlined in the Medi-Cal Provider Manual. Plans and their network providers and subcontractors are prohibited from requiring medical justification or imposing any utilization management or utilization review requirements, including prior authorization and annual or lifetime limits, on the coverage of outpatient abortion services. *(All Plan Letter 24-003 Abortion Services)*

Plan policy, *PH-105 Pregnancy Termination* (reviewed: 10/17/24), states that abortion services and supplies are covered under Medi-Cal and are required to be provided in accordance with state and federal law and are considered by the California Department of Health Care Services to be a "sensitive service". The policy states the Plan provides members with timely access to abortion services from any qualified provider without prior authorization and members may access abortion services from any qualified contracted or non-contracted provider.

A verification study of 30 State Supported Services claims was conducted to determine the appropriate process and timely adjudication of claims. No deficiencies were noted during the audit period.

Recommendation: None.