CONTRACT AND ENROLLMENT REVIEW – SACRAMENTO
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

FRESNO-KING-MADERA REGIONAL HEALTH AUTHORITY
DBA CALVIVA HEALTH

2023

Contract Number:	10-87050
Audit Period:	April 1, 2022 Through March 31, 2023
Dates of Audit:	April 17, 2023 Through April 28, 2023
Report Issued:	September 18, 2023

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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 the Plan's 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, specialists, behavioral health providers, hospitals, ancillary providers, pharmacies, and directly contracted FQHC.

As of December 2022, the Plan served 418,048 Medi-Cal members: 336,359 in Fresno County, 45,484 in Madera County, and 36,205 in Kings County. The Plan's Medi-Cal composition is 63 percent Temporary Assistance for Needy Families, 27 percent Medi-Cal Expansion, 6 percent Seniors and Persons with Disabilities, 4 percent Dual eligible, and less than one 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, 2022 through March 31, 2023. The audit was conducted from April 17, 2023 through April 28, 2023. The audit consisted of document review, verification studies, and interviews with Plan and delegated entity representatives.

An Exit Conference was held with the Plan on August 24, 2023. 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 findings in the report reflect the evaluation of all relevant information received prior and subsequent to the Exit Conference.

The reduced scope audit evaluated four categories of performance: Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, and Quality Management.

The prior DHCS medical audit for the period April 1, 2020 through March 31, 2022, was issued on November 17, 2022. This audit examined documentation for compliance and determined to what extent the Plan has implemented their Corrective Action Plan.

The summary of the findings by category follows:

Category 2 – Case Management and Coordination of Care

There were no findings in this category.

Category 3 – Access and Availability of Care

There were no findings in this category.

Category 4 – Member's Rights

The Plan is required to establish, implement, maintain, and oversee a grievance system to ensure the receipt, review, and resolution of grievances. The Plan did not classify, process, review, or resolve all expressions of dissatisfaction as grievances.

Category 5 – Quality Management

There were no findings in this category.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The audit was conducted from April 17, 2023 through April 28, 2023. The audit included the review of the Plan's policies for providing services, the procedures used to implement the policies, and the verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with the Plan administrators, staff, and delegated entity.

The following verification studies were conducted:

Category 2 – Case Management and Coordination of Care

Health Risk Assessment (HRA): 17 member files were reviewed to confirm coordination of care and fulfillment of HRA requirements.

Initial Health Assessment: 20 member files were reviewed to confirm the performance of the assessment.

Behavioral Health Treatment: Ten member files were reviewed to confirm services were provided and covered, or arranged, as appropriate, in a timely manner.

Category 3 – Access and Availability of Care

Claims: 25 emergency services and 25 family planning claims were reviewed for appropriate and timely adjudication.

Transportation Access Standards: 15 Non-Emergency Medical Transportation (NEMT) and 15 Non-Medical Transportation (NMT) files were reviewed to confirm compliance with the NEMT and NMT requirements.

Category 4 – Member's Rights

Grievances: 60 standard grievances, 15 exempt grievances, five expedited grievances, and 20 call inquiries were reviewed for timely resolution, appropriate classification, response to complainant, and submission to the appropriate level of review. The 60 standard grievance cases included 38 quality of care grievances and 22 quality of service grievances.

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

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Classification of Grievances

The Plan is required to establish, implement, maintain, and oversee a grievance and appeal system to ensure the receipt, review, and resolution of grievances and appeals. The grievance and appeal system must operate in accordance with all applicable federal and state laws. A grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination. An inquiry is a request for information that does not include an expression of dissatisfaction. A complaint is the same as a grievance. If the Plan is unable to distinguish between a grievance and an inquiry, it must be considered a grievance. *(All Plan Letter 21-011, VII)*

The Plan is required to implement and maintain procedures to monitor the member's grievance system and ensure that the grievance submitted is reported to an appropriate level. (*Contract 10-87050 A01, Exhibit A, Attachment 14 (2)(C))*

Plan policy, *#AG-001 Member Grievance Process*, indicated if the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. A member does not need to use the term "grievance" for a complaint to be captured as an expression of dissatisfaction and processed as a grievance by the Plan.

Finding: The Plan did not classify, process, review, or resolve all expressions of dissatisfaction as grievances.

A verification study revealed that the Plan's delegate did not classify four of 22 inquiry calls as a grievance. All four calls contained an expression of dissatisfaction. A written narrative was provided in an additional document request to explain the Plan's response:

- In three of four inquiry calls, the Plan concurred that the calls should have been classified as a grievance after internal review of the inquiry calls.
- In one of four inquiry calls, the member expressed concern about a balance billing issue and the Plan indicated this was not an expression of dissatisfaction. However, the request for information involved an expression of dissatisfaction with an unwarranted bill.

The Plan provided a written response stating that it did not classify the three inquiries as grievances due to an error in judgement by the member services representatives and would provide additional training and coaching to those representatives.

When the Plan does not ensure that all expressions of dissatisfaction are classified as grievances, member grievances cannot be addressed or resolved in a timely manner.

Recommendation: Revise policies and procedures to monitor inquiry calls and ensure all member expressions of dissatisfaction are classified, processed, reviewed, and resolved as grievances.

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REPORT ON THE MEDICAL AUDIT OF

FRESNO-KING-MADERA REGIONAL HEALTH AUTHORITY
DBA CALVIVA HEALTH

2023

Contract Number:	22-20470 State Supported Services
Audit Period:	April 1, 2022 Through March 31, 2023
Dates of Audit:	April 17, 2023 Through April 28, 2023
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I. INTRODUCTION

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

The audit was conducted from April 17, 2023 through April 28, 2023. The audit period was April 1, 2022 through March 31, 2023. The audit consisted of document review of materials supplied by the Plan, a verification study, and interviews.

Twenty-five State Supported Services claims were reviewed for appropriate and timely adjudication.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: April 1, 2022 through March 31, 2023
DATES OF AUDIT: April 17, 2023 through April 28, 2023

STATE SUPPORTED SERVICES

SUMMARY OF FINDING(S): The Plan outlines their processes and procedures for the consistent and accurate processing of sensitive service claims through the policies and procedures, Provider Communications, and Member Handbook. 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 findings were noted in the verification study conducted to determine appropriate and timely adjudication of State Supported Services claims.

RECOMMENDATION(S): None.