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: April 1, 2018
Through
January 31, 2019

Report Issued: October 29, 2019

TABLE OF CONTENTS

I. INTRODUCTION 1

II. EXECUTIVE SUMMARY 2

III. SCOPE/AUDIT PROCEDURES 4

IV. COMPLIANCE AUDIT FINDINGS
Category 1 – Utilization Management 6
Category 4 – Member's Rights 11

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 (Plan) is the local initiative plan for Fresno, Kings, and Madera counties.

The Plan has a contractual relationship with a delegated entity, which includes an administrative services agreement and capitated provider services agreement. The delegated entity is contracted to provide services on the Plan's behalf for clinical services and non-medical administrative services. The Plan's role is to provide oversight of delegated and administrative functions.

The functions handled by the delegated entity include, but are not limited to, utilization and case management, credentialing, and re-credentialing. Quality Improvement (QI), including Quality Management and grievance resolution functions are also provided by the delegated entity. Health care services are provided for the majority of members through the delegate's network. The Plan has three Federally Qualified Health Centers that are contracted directly with them.

Mandatory enrollment of Seniors and Persons with Disabilities (SPD) into managed care began in June 2011. The California Department of Health Care Services (DHCS) received authorization (1115 Waiver) from the federal government to conduct mandatory enrollment of SPD into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes. In June 2011, DHCS awarded the Plan with the contract to provide Medicaid Managed Care benefits to beneficiaries under the State's SPD Procurement.

As of January 2019, the Plan served approximately 357,409 Medi-Cal members: 291,690 in Fresno County, 28,970 in Kings County, and 36,749 in Madera County. The Plan served approximately 32,815 SPD members: 27,780 in Fresno County, 2,566 in Kings County, and 2,469 in Madera County.

II. EXECUTIVE SUMMARY

This report presents the audit findings of DHCS medical review audit for the review period of April 1, 2018 through January 31, 2019. The onsite review was conducted from February 25, 2019 through March 1, 2019. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference with the Plan was held on September 27, 2019. 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 audit evaluated six categories of performance: Utilization Management (UM), Case Management and Coordination of Care, Access and Availability of Care, Members' Rights, Quality Management, and Administrative and Organizational Capacity. In addition, the Plan's SPD population were included in this review period.

Implementation of Prior Year Audit Recommendations
The prior DHCS medical audit (for the review period of April 1, 2017 through March 31, 2018 with onsite review conducted from April 16, 2018 through April 27, 2018) identified deficiencies. The Plan addressed the deficiencies in a Corrective Action Plan (CAP). The CAP closeout letter 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 follows:

Category 1 – Utilization Management

The Plan did not demonstrate adequate oversight of its delegated and sub-delegated entities' prior authorization process. The Plan did not evaluate the effectiveness of the delegate's (UM) program.

The Plan did not have an established specialty referral tracking system of its sub-delegated entities. The Plan did not ensure that its sub-delegated entities are tracking and monitoring specialty referrals requiring prior authorization requests.

Category 2 – Case Management and Coordination of Care

There are no findings in this category.

Category 3 – Access and Availability of Care

There are no findings in this category.

Category 4 – Member's Rights

The Plan did not ensure its providers would not discriminate against members filing complaints. The Plan's grievance policy provided instructions to prohibit discrimination against members for filing grievances. However, the policy did not outline a process to address cases when providers discriminate against members filing grievances.

Category 5 – Quality Management

In the prior year audit, the Plan failed to demonstrate that new providers received training within the requirement of 10 working days. In response to the CAP, the Plan updated monitoring policies and procedures to implement the use of attestation forms. The forms are to be completed, signed, and returned to the Plan by the new providers within the period requirement. Attestation forms are now included in the provider's welcome packet and a required component of the credentialing process.

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

Category 6 – Administrative and Organizational Capacity

There are no findings in this category.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The onsite review was conducted from February 25, 2019 through March 1, 2019. The audit included a review of the Plan's contract with DHCS, its 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 the Plan's administrators, staff, and the delegated entity.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization: 32 medical prior authorization and 20 pharmacy prior authorization requests were reviewed for consistent application of criteria, timeliness, and appropriate review and communication of results to members and providers.26 prior authorization requests were for the Medi-cal only population and 26 prior authorization requests were for the SPD population.

Appeal Procedures: 20 medical prior authorization appeals and seven pharmacy prior authorization appeals were reviewed for appropriate and timely adjudication. 19 prior authorization appeals were for the Medi-cal only population and eight prior authorization appeals were for the SPD population.

Category 2 – Case Management and Coordination of Care

Initial Health Assessment: 16 medical records were reviewed for completeness and timeliness.

Health Risk Assessment: Three SPD member's medical records were reviewed for evidence of coordination of care between the Plan providers. Referrals and reports were reviewed for appropriate case management and the use of the Health Information Form (HIF) tool.

Category 3 – Access and Availability of Care

Appointment wait times: 30 providers from the Plan's directory were surveyed. The survey

consisted of five new patient specialty, five established patient routine specialty, five first prenatal, five established patient routine prenatal, five routine primary care provider, and five urgent care primary care providers. The “third-next available” appointments were used to measure access to care.

Category 4 – Member’s Rights

Quality of Care Grievances: A total of 44 Medi-Cal quality of care grievances were selected. 37 standard, 4 expedited, and 3 exempt grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review. This verification study also included 35 SPD grievance cases.

Quality of Service Grievances: 11 Medi-Cal quality of service grievances which included 7 standard, and 4 exempt grievance cases were reviewed to verify the reporting timeframes and investigation process. This verification study also included five SPD grievance cases.

Category 5 – Quality Management

New Provider Training: Five new provider training files were reviewed for timely Medi-Cal managed care program training.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: Four 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-King-Madera Regional Health Authority dba CalViva Health

AUDIT PERIOD: April 1, 2018 through January 31, 2019
DATE OF AUDIT: February 25, 2019 through March 1, 2019

CATEGORY 1 - UTILIZATION MANAGEMENT

1.1	UTILIZATION MANAGEMENT PROGRAM/ REFERRAL TRACKING SYSTEM / DELEGATION OF UM / MEDICAL DIRECTOR & MEDICAL DECISIONS

Utilization Management (UM) Program Requirements:
Contractor shall develop, implement, and continuously update and improve, a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. …(as required by Contract)
2-Plan Contract A.5.1

There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.
2-Plan Contract A.5.2.C

Review of Utilization Data:
Contractor shall include within the UM Program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Member Utilization Patterns shall be reported to DHCS upon request.
2-Plan Contract A.5.4

Referral Tracking System:
Contractor is responsible to ensure that the UM program includes: … An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals.
2-Plan Contract A.5.1.F

Delegated Utilization Management (UM) Activities:
Contractor may delegate UM activities. If Contractor delegates these activities, Contractor shall comply with Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities.
2-Plan Contract A.5.5

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Fresno-King-Madera Regional Health Authority dba CalViva Health
AUDIT PERIOD: April 1, 2018 through January 31, 2019 **DATE OF AUDIT: February 25, 2019 through March 1, 2019**

1.1	UTILIZATION MANAGEMENT PROGRAM/ REFERRAL TRACKING SYSTEM / DELEGATION OF UM / MEDICAL DIRECTOR & MEDICAL DECISIONS

Medical Director:
Contractor shall maintain a full time physician as medical director pursuant to Title 22 CCR Section 53857 whose responsibilities shall include, but not be limited to, the following:

A. Ensuring that medical decisions are:
   1) Rendered by qualified medical personnel.
   2) Are not influenced by fiscal or administrative management considerations.
B. Ensuring that the medical care provided meets the standards for acceptable medical care.
C. Ensuring that medical protocols and rules of conduct for plan medical personnel are followed.
D. Developing and implementing medical policy.
E. Resolving grievances related to medical quality of care.
F. Direct involvement in the implementation of Quality Improvement activities.
G. Actively participating in the functioning of the plan grievance procedures.

2-Plan Contract A.1.6

Medical Decisions:
Contractor shall ensure that medical decisions, including those by sub-contractors and rendering providers, are not unduly influenced by fiscal and administrative management.
2-Plan Contract A.1.5

SUMMARY OF FINDINGS:

1.1.1 Oversight of delegate and sub-delegate compliance with the prior authorization process.

The Plan shall ensure that its delegation procedures meet the following requirement: If the Plan delegates UM activities, the Plan shall comply with *Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities. (Contract, Exhibit A, Attachment 5 (5))*

The Plan is accountable for all QI functions and responsibilities (e.g. UM). The Plan shall maintain a system to ensure accountability for delegated QI activities that at a minimum ensures subcontractor meets standards set forth by the Plan and DHCS. *(Contract, Exhibit A, Attachment 4 (6))*

Delegation oversight policy #*UM-004,* states that the Plan will conduct annual reviews of its delegated entity. The Plan's medical management staff will monitor its delegated and sub-delegated entities in accordance with required timeframe standards, Plan approved criteria, and other contractual, state, and federal requirements. The policy states that the Plan's QI/UM committee will evaluate the effectiveness of the delegate's UM program.

The Plan did not provide oversight to ensure that the sub-delegated entities were compliant with prior authorization requirements. Plan policy #*UM-004,* did not address how it would evaluate its delegate's oversight of sub-delegated entities.

The Plan audited its delegated entity in 2018. The August 2018 report included 84 prior authorization cases and concluded with a 94 percent compliance rate. The Plan submitted an audit tool, which evaluated organizational capacities according to records and documents (e.g. policies and procedures). The Plan's audit tool did not identify how the prior authorization files were compliant. The audit did not monitor for qualified health professionals making decisions on denials, notice of adverse benefit determination, clear explanations of denial decisions, rights to appeal, and other areas of compliance.

DHCS reviewed 32 prior authorization medical requests and the files revealed several deficiencies. A retrospective authorization request was denied on the basis that it was not an emergency. The case involved a physician providing obstetrical services to a high-risk pregnant member. In another retrospective authorization request, the Plan provided no response for 192 days.

Additionally, the Plan's sub-delegates did not process urgent requests in two files within the required time. In another file, the sub-delegate did not provide a clear reason for denial of the requested service in the notice of adverse benefit determination.

The Plan's policy and audit tool did not specify how to ensure that these entities were compliant with the requirements.

Without closely monitoring for prior authorization request compliance of its delegated and sub-delegated entities, the Plan risks denying its members medically necessary services. Denial of necessary services can lead to preventable complications, including an increase in member morbidity and mortality.

1.1.2 Oversight of delegate and sub-delegate specialist referrals.

The Plan shall ensure that its delegation procedures meet the following requirement: If the Plan delegates UM activities, the Plan shall comply with *Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities. (Contract, Exhibit A, Attachment 5 (5))*

The Plan is accountable for all QI functions and responsibilities (e.g. UM). The Plan shall maintain a system to ensure accountability for delegated QI activities that at a minimum ensures subcontractor meets standards set forth by the Plan and DHCS. *(Contract, Exhibit A, Attachment 4 (6))*

The Plan is responsible to ensure that the UM program includes an established specialty referral system to track and monitor referrals requiring prior authorization. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. *(Contract, Exhibit A, Attachment 5 (1) (F))*

The Plan's policy on specialty referral tracking, *#UM-005* states, that its sub-delegates may require authorization for referrals to specialists. The policy states that the Plan will monitor its delegated and sub-delegated entities on the timeliness of its specialty referrals. The Plan did not have a policy that identifies how it selects the specialties to monitor or which specialty referrals require prior authorization.

The Plan did not have an established prior authorization-required specialty referral tracking system of its sub-delegated entities. The Plan did not ensure that its sub-delegated entities are tracking and monitoring specialty referrals requiring prior authorization requests.

The Plan's Management Oversight committee reviews a report of the sub-delegated entities, which includes the sub-delegates' top 10 specialties. The report did not identify which specialty services require a prior authorization by the sub-delegates. The QI/UM committee reviews a specialty report that includes data on delegated specialist denials due to administrative reasons (e.g. the specialist being out-of-network). This report only covers the Plan's prioritized specialties, such as dermatology, oncology, orthopedics, neurosurgery, and neurology. The report did not cover the specialties that require prior authorization by the sub-delegated entities.

During the interview, the Plan and the delegated entity could not identify what specialties require prior authorization by the sub-delegate. Both the Plan and its delegate only stated that some of the sub-delegates required prior authorization for some specialties.

The Plan must track specialties requiring prior authorization in order to ensure that members are getting medically necessary services in a timely manner. The Plan did not track important specialties (e.g. pulmonology, nephrology, and gynecology) in their delegate and oversight reports. One or more of the Plan's sub-delegates may require prior authorizations for these and other specialties. The prior authorization process can take as long as 28 days. Therefore, the Plan could be delaying members' access to needed specialties by 28 or more days due to this process. Without monitoring, the Plan also risks worsening its members' health, as well as increasing expensive, preventable services, such as Emergency Department and hospital services due to the members not getting access to specialists sooner.

RECOMMENDATIONS:

1.1.1 Revise and implement delegation oversight policy and procedures that meet prior authorization requirements and evaluate the effectiveness of the delegate's UM program.

1.1.2 Revise and implement delegation oversight policy and procedures to ensure that its sub-delegated entities are tracking and monitoring specialty referrals requiring prior authorizations.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Fresno-King-Madera Regional Health Authority dba CalViva Health
AUDIT PERIOD: April 1, 2018 through January 31, 2019 **DATE OF AUDIT: February 25, 2019 through March 1, 2019**

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:

4.1.1 Member nondiscrimination after filing grievances.

The Plan shall ensure that its delegation procedures meet the following requirement: The Plan shall implement and maintain a Member Grievance System in accordance with *California Code of Regulations (CCR), Title 28, section 1300.68. (Contract, Exhibit A, Attachment 14 (1))*

An officer of the plan shall be designated as having primary responsibility for the Plan's grievance system whether administered directly by the Plan or delegated to another entity. *(CCR, Title 28, section 1300.68 (b) (1))*

The Plan's grievance policy *#AG-001,* provides instructions prohibiting discrimination against members for filing grievances. However, the policy did not outline a process to address cases when providers discriminate against members filing grievances.

The Plan did not ensure that its providers would not discriminate against members for filing complaints.

One file revealed a physician expressing in writing that he will not see any member who files grievances against him. The delegate's nurse reviewer quoted the treating physician's comments, but did not make any recommendations to communicate with the physician or to report the physician to the delegate's Provider Network Management . Similarly, the delegate's Medical Director concluded, "The provider response is unrevealing". While the Plan's Chief Medical Officer approved the delegate's conclusion, he did not make any recommendations to address the treating physician's discrimination. The Plan could not demonstrate that the issue was addressed.

By not having policy and procedures implemented to ensure that providers do not discriminate against members who file grievances, the Plan risks members not filing grievances. If members believe that a provider will retaliate against them if they file a grievance, the member might not inform the Plan when a provider is practicing substandard medicine. This can lead to members receiving delays in care or the wrong care for the conditions that they seek treatment. As a result, members' medical conditions can worsen, leading to otherwise preventable progression of diseases.

RECOMMENDATION:

4.1.1 Revise and implement policies and procedures to meet requirements that neither the Plan nor providers discriminate against members who file grievances.

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:	10-87054 State Supported Services
Audit Period:	April 1, 2018 Through January 31, 2019
Report Issued:	October 29, 2019

TABLE OF CONTENTS

I. INTRODUCTION 1

II. COMPLIANCE AUDIT FINDINGS 2

I. INTRODUCTION

This report presents the audit findings of Fresno-Kings-Madera Regional Health Authority (RHA) dba CalViva Health (the Plan) 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 February 25, 2019 through March 1, 2019. The audit covered the review period from April 1, 2018 through January 31, 2019 and consisted of document review of materials supplied by the Plan.

An Exit Conference with the Plan was held on September 27, 2019.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: FRESNO-KING-MADERA REGIONAL HEALTH AUTHORITY DBA CALVIVA HEALTH

AUDIT PERIOD: April 1, 2018 through January 31, 2019
DATE OF AUDIT: February 25, 2019 through March 1, 2019

CATEGORY 1 - UTILIZATION MANAGEMENT

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 FINDING(S):

The Plan's *Policy #PH-105: Pregnancy Termination,* stated that the Plan provided Medi-Cal members timely access to abortion services from any qualified provider without prior authorization. Prior authorization of coverage may be required only for inpatient hospitalization for an abortion procedure. Members may access abortion services from any qualified contracting or non-contracting provider, including their primary care physician , contracted OB/GYN physicians, midwives, nurse practitioners, physician assistants, family planning clinics and Federally Qualified Health Centers.

Policy #PH-019: Minor Consent Services, described the process for Plan members to receive minor consent services. The Plan met Federal and State requirements for ensuring the provision of minor consent services for members under the age of 18 years. Minor consent services were available within the Plan's provider network. Plan members under the age of 18 years of age did not need parental consent to access these services. Members under the age of 18 received access to services from any qualified in or out of plan providers.

The Plan's *State Supported Services Billing Code Sheet,* stated their abortion services included Current Procedural Terminology Codes 59840 through 59857 as billable pregnancy termination services.
The *Member Handbook,* informed members that minors do not need an adult's consent

or referral to access pregnancy termination services. The *Medi-Cal Operations Guide,* informed providers of the rights of members to receive timely access to care for abortion services.

RECOMMENDATION(S):

None