Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Contract Number: 10-87050

Audit Period: April 1, 2015
Through March 31, 2016

Report Issued: January 12, 2017
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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 Re-credentialing, 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 April 1, 2016, CalViva Health had 349,084 Members
• Fresno 288,696
• Kings 25,873
• Madera 34,515
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, 2015 through March 31, 2016. The on-site review was conducted from April 18, 2016 through April 29, 2016. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference was held on September 6, 2016 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report finding. 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), Continuity of Care, Access and Availability to Care, Member Rights, Quality Management (QI), and Administrative and Organizational Capacity. There were no findings for categories 1, 4, 5 and 6. Findings are as follows:

Category 2 – Case Management and Coordination of Care

The Plan utilizes the Facility Site Review/Medical Record Review to monitor Initial Health Assessment (IHA) compliance, which was not designed to continuously monitor IHA.

Category 3 – Access and Availability of Care

The Plan did not provide evidence that it took actions to improve specialist shortages. It also did not ensure out of network emergency claims were paid timely.
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 April 18, 2016 through April 29, 2016. 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: 47 medical and 23 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal Procedures: 27 prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Coordination of Care: 6 records were included in a review of coordination of care between the Plan, PCP, Member, Specialty Providers, and other services.

California Children’s Services: 3 medical records were reviewed for evidence of coordination of care between the Plan and CCS Providers.

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

Category 3 – Access and Availability of Care

Emergency Service Claims: 33 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: 59 grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Category 5 – Quality Management

New Provider Training: 20 new provider training records were reviewed for timely Medi-Cal Managed Care program training.

A description of the findings for each category is contained in the following report.
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
For Members under the age of 18 months, Contractor is responsible to cover and ensure the provision of an IHA within 120 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.

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

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

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:

2.4 The Plan uses a methodology that is not intended to monitor IHA compliance.

The Plan is accountable to cover and ensure the provision of an IHA in conformance with Title 22 CCR section 53851 (b)(1) and 53910.5 (a)(1) to each new member within 120 calendar days of enrollment. Contract, Exhibit A, Attachment 10(3)(A)

The Plan must have procedures for monitoring IHA completion within the required timeframes. MMCD Policy Letter No.08-003 Initial Comprehensive Health Assessment
The Plan utilizes the Facility Site Review/Medical Record Review (FSR/MRR) to monitor IHA compliance. According to “MMCD Policy Letter No.14-004 Site Reviews: Facility Site Review and Medical Record Review” the purpose of the FSR/MRR is to evaluate the site’s capacity to deliver quality services. The FSR/MRR was not designed to continuously monitor IHA completion. Using FSR/MRR process, the Plan cannot determine if the provider is meeting IHA contractual requirements between periodic site visits which are conducted every 3 years.

The IHA Quarterly Report (FSR/MRR IHA review Q4 2015) shows a high compliance rate. However, the DHCS verification study demonstrates otherwise. Out of 30 medical records selected using a sampling method similar to the Plan’s FSR/MRR process, only 2 had a completed IHA.

During an interview, the Plan acknowledged the weakness in their monitoring system and stated that they are working with their information Technology Department on enhancements such as looking at certain CPT codes to cast a wider net to pick up on IHA completion. The Plan indicated that this will be completed by August 2016.

**RECOMMENDATIONS:**

2.4 Develop, validate, and implement a methodology that monitors compliance with IHA contractual requirements.
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:
3.4 Plan did not provide evidence that it took actions to improve specialist shortages.

Contractor shall ensure adequate staff within the Service Area, including physicians, administrative and
other support staff directly and/or through Subcontracts, sufficient to assure that health services will be
provided in accordance with Title 22 CCR Section 53853(a) and consistent with all specified requirements.
Contract, Exhibit A, Attachment 9(1)

Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the
quality of care delivered by all providers rendering services on its behalf, in any setting.
Contract, Exhibit A, Attachment 4(1)

The previous audit finding states that the Plan continues to have insufficient availability of allergists and
pediatricians in Kings County. DHCS reviews the Plan’s access committee minutes and found no
documentation of discussion or action items related to the improvement of specialist shortages. The quality
improvement director /medical director confirmed there is no documentation in the audit period to show
steps to alleviate last year’s finding had been discussed, implemented, or monitored.

RECOMMENDATIONS:
3.4 Implement, monitor, and document actions to improve specialist network shortages.
Emergency Service Providers (Claims):
Contractor is responsible for coverage and payment of Emergency Services and post stabilization care services and must cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a contract with the plan.
2-Plan Contract A.8.13.A

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

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

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

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

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

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

3.5 The Plan did not ensure out of network emergency claims were paid timely.

For all 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. Amendment A04, Exhibit A, Attachment 13(A, E)

The Plan explained during an interview that Health Net adjudicates out-of-network emergency service claims on behalf of the Plan. The Plan stated it performs an annual audit to oversee the Health Net claims payment process.

DHCS reviewed 137 claim lines with California Children Services (CCS) denial codes from the claims detail submitted by the Plan. Twenty-seven of the 137 claim lines were not paid timely. The claim detail shows that these claims were not paid because the members may have been CCS eligible. However, a review of the CCS database CMSNet shows the members were not open to CCS at the time of the claim.

RECOMMENDATIONS:

3.5 Develop, implement, and monitor procedures to ensure timely payment of out of network emergency claims.
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INTRODUCTION

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

The on-site audit was conducted from April 18, 2016 through April 29, 2016. The audit period is April 1, 2015 through March 31, 2016 and consisted of document review of materials supplied by the Plan and interviews conducted onsite.
PLAN: Fresno-Kings-Madera Regional Health Authority dba CalViva Health

AUDIT PERIOD: April 1, 2015 through March 31, 2016

DATE OF AUDIT: April 18, 2016 through April 29, 2016

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

**Abortion**
Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:
- Current Procedural Coding System Codes*: 59840 through 59857
- HCFA Common Procedure Coding System Codes*: X1516, X1518, X7724, X7726, Z0336

*These codes are subject to change upon the Department of Health Services’ (DHS’) implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.

State Supported Services Contract Exhibit A.1

**SUMMARY OF FINDINGS:**

No deficiencies were noted during this review.

**RECOMMENDATIONS:**

None
Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Contract Number: 10-87054
State Supported Services

Audit Period: April 1, 2015
Through
March 31, 2016

Report Issued: January 12, 2017
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### COMPLIANCE AUDIT FINDINGS (CAF)

**PLAN:** Fresno-Kings-Madera Regional Health Authority dba CalViva Health  
**AUDIT PERIOD:** April 1, 2015 through March 31, 2016  
**DATE OF AUDIT:** April 18, 2016 through April 29, 2016

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State Supported Services Contract Exhibit A.1

### SUMMARY OF FINDINGS:

No deficiencies were noted during this review.

### RECOMMENDATIONS:

None