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

FRESNO-KING-MADERA REGIONAL HEALTH AUTHORITY DBA CALVIVA HEALTH

Contract Number: 10-87050

Audit Period: April 1, 2017
Through
March 31, 2018

Report Issued: December 17, 2018

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I. INTRODUCTION

In 2009, the counties of Fresno, King, 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.

CalViva Health 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 CalViva Health's behalf for clinical services and non-medical administrative services. CalViva Health'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, 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 CalViva Health.

This report presents the findings of the medical audit of CalViva Health and its compliance and implementation of the local initiative contract to provide services in the three counties listed below.

Fresno County
Kings County
Madera County

As of March 2018, CalViva Health served approximately 360,950 Medi-Cal members, with Fresno County 296,327, Kings County 28,045 and Madera County 36,578.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical review audit for the review period of April 1, 2017 through March 31, 2018. The onsite review was conducted from April 16, 2018 through April 27, 2018. The audit consisted of document review, verification studies, and interviews with CalViva Health (Plan) personnel.

An exit conference was held on November 16, 2018 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 findings. On November 16, 2018, the Plan submitted supplemental documentation that is reflected in this report.

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

Implementation of Prior Year Audit Recommendations
The prior DHCS medical audit (for the review period of April 1, 2016 through March 31, 2017 with onsite review conducted from April 17, 2017 through April 27, 2017) identified deficiencies. The Plan addressed the deficiencies in a Corrective Action Plan (CAP). The CAP closeout letter, dated May 8, 2018, 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

There are no findings in this category.

Category 2 – Case Management and Coordination of Care

There are no findings in this category.

Category 3 – Access and Availability of Care

The prior year audit found that the Plan did not conduct oversight of the delegates to ensure necessary actions were taken to maintain an adequate number of specialists in Kings County. To address the prior year audit finding, the Plan implemented processes to improve network specialty access. The Plan started contracting and credentialing specialists in Kings County. In addition, the Plan developed a report "Specialist Access Improvement Correction Action Plan" which describes the actions taken to improve specialist network shortages. The report also describes the outreach and contracting

efforts to close network gaps and increase access to network.

The prior year audit found that the Plan did not monitor procedures to ensure proper processing of emergency room claims with potential California Children's Service (CCS) eligibility. To address the prior year audit finding, the Plan implemented new CCS claims processing instructions. In addition, the Plan conducted a focused audit of its delegated entity's claims processing functions involving out of network CCS denied claims.

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

Category 4 – Member's Rights

There are no findings in this category.

Category 5 – Quality Management

The Plan is contractually required to conduct training to all newly contracted provider on active status within 10-working days. The Plan's policies and procedures do not outline the monitoring of the required timeframe. The Plan does not have documentation showing that the new providers received the training package within the 10-working days.

Category 6 – Administrative and Organizational Capacity

There are no findings in this category.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The Department of Health Care Services (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 April 16, 2018 through April 27, 2018. 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 and staff. In the audit review process, the verification study samples were requested from the Plan and the delegated entity.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization: 14 medical and 6 pharmacy prior authorization requests were reviewed for consistent application of criteria, timeliness, and appropriate review and communication of results to members and providers.

Appeal Procedures: 14 prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

California Children's Services (CCS): 10 medical records were reviewed for evidence of coordination of care between the Plan and CCS providers.

Initial Health Assessment: 15 medical records were reviewed for completeness and timeliness.

Behavioral Health Treatment: 10 medical records were reviewed for evidence of coordination of care between the Plan providers.

Category 3 – Access and Availability of Care

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

Family Planning Claims: 9 family planning claims were reviewed for appropriate and timely

adjudication.

Category 4 – Member's Rights

Grievance Procedures: 13 quality of care and 10 quality of service grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Confidentiality Rights Procedures: 10 Health Insurance Portability and Accountability Act (HIPAA) case samples were review for timeliness and confidentiality.

Category 5 – Quality Management

New Provider Training: 10 new provider-training records were reviewed for timely Medi-Cal Managed care program training.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: 2 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, 2017 through March 31, 2018	DATE OF AUDIT: April 16, 2018 through April 27, 2018

CATEGORY 5 – QUALITY MANAGEMENT

5.2	PROVIDER QUALIFICATIONS

Credentialing and Re-credentialing:
Contractor shall develop and maintain written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of Physicians including Primary Care Physicians and specialists in accordance with the MMCD Policy Letter 02-03, Credentialing and Re-credentialing.
Contractor shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.
2-Plan Contract A.4.12

Standards:
All providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered….Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's provider network.
2-Plan Contract A.4.12.A

Medi-Cal Managed Care Provider Training:
Contractor shall ensure that all providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable Federal and State statutes and regulations. Contractor shall ensure that provider training relates to Medi- Cal Managed Care services, policies, procedures and any modifications to existing services, policies, or procedures. Training shall include methods for sharing information between Contractor, provider, Member and/or other healthcare professionals. Contractor shall conduct training for all providers within ten (10) working days after the Contractor places a newly contracted provider on active status….
2-Plan Contract A.7.*5*

Delegated Credentialing:
Contractor may delegate credentialing and recredentialing activities. If Contractor delegates these activities, Contractor shall comply with Provision 6, Delegation of Quality Improvement Activities…
2-Plan Contract A.4.12.B

Disciplinary Actions:
Contractor shall implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities….
2-Plan Contract A.4.12.D

SUMMARY OF FINDINGS:

5.2.1 New Provider Training

The Plan shall ensure that all providers receive training regarding the Medi-Cal Managed Care program. The Plan shall conduct training for all providers within ten (10) working days after the Plan places a newly contracted provider on active status (*Contract, Exhibit A, Attachment 7.5.A*).

The Plan failed to demonstrate that new providers received training within the ten (10) working day training requirement.

The Plan has policies and procedures in place for provider training, including available resources. *Plan Policy #PV-201: Provider Orientation Program* states new providers receive the welcome orientation packet within ten (10) days of being placed on active status. However, the provision of this policy does not specify the monitoring of the ten (10) working day training requirement.

The Plan's provider relations department maintains logs and conducts oversight and monitoring to ensure that welcome packets are received. However, there is no documentation to support that the welcome packet was received by the new providers, within the ten (10) working day requirement.

Ten (10) new provider training records were reviewed for timely Medi-Cal managed care program training. The Plan was not able to demonstrate compliance with the ten (10) working day new provider training contractual compliance for 10 samples.

The Plan's noncompliance with the time requirement may cause missed opportunities for newly contracted providers to offer the services and benefits to Medi-Cal members on a timely basis. This training is a requirement as soon as the Plan-provider work relationship is established to protect the rights and privileges of the Medi-Cal population.

RECOMMENDATION:

5.2.1 Develop a system to demonstrate that new providers received training within the ten (10) working day training requirement.

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AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

FRESNO-KING-MADERA REGIONAL HEALTH AUTHORITY DBA CALVIVA HEALTH

Contract Number: 10-87054
State Supported Services

Audit Period: April 1, 2017
Through
March 31, 2018

Report Issued: December 17, 2018

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II. COMPLIANCE AUDIT FINDINGS 2

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 16, 2018 through April 27, 2018. The audit covered the review period from April 1, 2017 through March 31, 2018 and consisted of document review of materials supplied by the Plan and interviews conducted onsite.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
PLAN: Fresno-King-Madera Regional health Authority dba CalViva Health	
AUDIT PERIOD: April 1, 2017 through March 31, 2018	DATE OF AUDIT: April 16, 2018 through April 27, 2018

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:

The prior Department of Health Care Services' (DHCS) medical audit for the review period of April 1, 2016 through March 31, 2017, with onsite review conducted from April 17, 2017 through April 27, 2017 (report issued date of February 13, 2018) identified deficiencies.

The Plan addressed the deficiencies in a Corrective Action Plan (CAP) with DHCS. The Plan revised policies and Medi-Cal operations guidelines to include language that complies with *American Academy of Pediatrics versus Lungren decision (1997)*, and California minor consent requirements categorized by age.

The CAP closeout letter, dated May 8, 2018, noted that all previous findings were closed.

No findings were noted in the current audit.

RECOMMENDATIONS:

None