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 2024

Contract Number: 23-30220

Audit Period: April 1, 2023 – March 31, 2024

Dates of Audit: May 20, 2024 – May 31, 2024

Report Issued: October 1, 2024

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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 members from all three counties on March 1, 2011.

The Plan has a contractual relationship with Health Net, which includes an Administrative Services Agreement (ASA) and a Capitated Provider Services Agreement (CPSA). Health Net is contracted to provide services on the Plan's behalf.

In accordance with the ASA, Health Net maintains the systems for the Plan's operations and performs administrative activities on behalf of the Plan. The 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.

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 March 2024, the Plan served 435,626 Medi-Cal members: 348,065 in Fresno County, 48,684 in Madera County, and 38,877 in Kings County. The Plan's Medi-Cal composition is 60 percent Temporary Assistance for Needy Families, 27 percent Medi-Cal Expansion, 7 percent Seniors and Persons with Disabilities, 6 percent Dual eligible, 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, 2023, through March 31, 2024. The audit was conducted from May 20, 2024, through May 31, 2024. The audit consisted of document review, verification studies, and interviews with the Plan and Health Net (delegated entity) representatives.

An Exit Conference was held with the Plan on September 16, 2024. 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 September 16, 2024, the Plan submitted a response to address the audit findings. The results of the DHCS evaluation of the Plan's response are reflected in this report.

The audit evaluated four categories of performance: Utilization Management (UM), Case Management and Coordination of Care, Member's Rights, and Administrative and Organizational Capacity.

The prior DHCS medical audit for the period April 1, 2022, through March 31, 2023, was issued on September 18, 2023. This audit examined documentation for compliance and to determine to what extent the Plan had operationalized the Corrective Action Plan.

The summary of findings by category follows:

Category 1 – Utilization Management

The Plan is required to provide written extension notifications for Prior Authorization (PA) delays that specify the missing medical information needed to approve or deny services. The Plan did not ensure that the UM delegate's PA written extension notices specified the missing medical information needed to approve or deny the services.

Category 2 – Case Management and Coordination of Care

No findings were noted for the audit period.

Category 4 – Member's Rights

No findings were noted for the audit period.

Category 6 – Administrative and Organizational Capacity

The Plan is required to ensure prompt referral of any potential Fraud, Waste, and Abuse (FWA) to the DHCS, Audits and Investigations Intake Unit within ten working days. The

Plan did not ensure that all preliminary reports of suspected FWA were reported to DHCS within ten working days.

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 May 20, 2024, through May 31, 2024, for the audit period of April 1, 2023, through March 31, 2024. The audit included the 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 the Plan administrators, staff, and the delegated entity.

The following verification studies were conducted:

Category 1 – Utilization Management

PA Requests: 22 PA requests were reviewed for consistent application of criteria, timeliness, appropriate review, and communication of results to members and providers.

Category 2 – Case Management and Coordination of Care

California Children's Services (CCS): ten member files were reviewed to confirm care coordination for members with CCS conditions and developmental disabilities.

Continuity of Care (COC): ten member files were reviewed to confirm COC and fulfillment of requirements.

Category 4 – Member's Rights

Grievance Procedures: 48 grievances were reviewed, including 27 standard, 13 exempt grievances, and 8 expedited grievances. The grievances were reviewed for timely resolution, response to the complaint, and submission to the appropriate level of review.

Confidentiality Rights: 15 Health Insurance Portability and Accountability Act breach and security incidents were reviewed for processing and timeliness requirements.

Category 6 – Administrative and Organizational Capacity

FWA: ten cases were reviewed for appropriate reporting and processing within the required timeframes.

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management

1.2 PRIOR AUTHORIZATION REVIEW REQUIREMENTS

1.2.1 Prior Authorization Written Extension Notifications

The Plan is required to approve, modify, or deny a provider's prospective or concurrent request for health care services for a member within the shortest applicable timeframe that is appropriate for the member's condition. If an extension is required, the Plan has two alternatives: to either deny the authorization request or immediately notify the provider to request the information needed to make an authorization decision. The Plan's written notice requesting additional medical information must specify the information the Plan requested but did not receive. *(All Plan Letter (APL) 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

Regardless of the relationship the Plan has with a delegate, whether direct or indirect through additional layers of contracting or delegation, the Plan has the ultimate responsibility for adhering to, and fully complying with, all terms and conditions of the Contract with the DHCS. (*APL 23-006, Delegation and Subcontractor Network Certification)*

Plan policy, *UM-002 Precertification and Prior Authorization (PA) Requests* (revised 11/16/2023), stated that the Plan will notify requesting providers of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider may be orally or in writing. However, the policy did not require the Plan's notice to specify the information that was requested but did not receive.

Finding: The Plan did not ensure the delegate, Health Net, met the contractual requirement that written PA extension notices specify the information Health Net requested but did not receive.

A verification study review revealed that 11 of 22 PA files required written extension notices to the provider. Four of 11 written extension notices did not meet the requirement to specify the information the Health Net requested but did not receive.

During an interview, the Plan stated that it delegated most UM functions to Health Net. Health Net stated that if a PA is not decided in 14 days, the policy was to communicate

to the provider and member in writing, indicating the delay and the nature of the delay. The Plan did not measure or identify this metric in the annual audit of Health Net and did not issue Corrective Action Plans for the specification of missing information in PA written extension notifications. As a result, the Plan's written notices for PA delays did not contain all required information.

When the Plan does not ensure all required information is included in the written extension notices to providers for PAs, it may cause delays in member care.

Recommendation: Implement policies and revise procedures to ensure that written extension notifications for PA delays specify the missing medical information needed to approve or deny services.

COMPLIANCE AUDIT FINDINGS

Category 6 – Administrative and Organizational Capacity

6.2 FRAUD, WASTE, AND ABUSE

6.2.1 Fraud, Waste, and Abuse Reporting

The Plan is required to file a preliminary report with DHCS' Program Integrity Unit detailing any suspected FWA identified by, or reported to a contractor, subcontractor, downstream subcontractor, and/or network provider within ten working days of the discovery or notice of FWA. The Plan must submit a preliminary report in accordance with requirements set forth in APLs or other similar instructions. After the filing of the preliminary report, the Plan must promptly conduct a complete investigation of all reported or suspected FWA activities. *(Contract, Exhibit A, Attachment III (1.3.2) (D.1))*

Regardless of the relationship the Plan has with a delegate, whether direct or indirect through additional layers of contracting or delegation, the Plan has the ultimate responsibility for adhering to, and fully complying with, all terms and conditions of the Contract with the DHCS. (*APL 23-006, Delegation and Subcontractor Network Certification)*

Plan policy, *CO-005 Fraud and Abuse Prevention Detection Investigation* (revised 04/05/2024), stated that the Plan shall promptly report any suspected FWA that the Plan identifies to the DHCS, Audits and Investigations Intake Unit within ten working days of the date the Plan first becomes aware of, or is on notice of, such activity by means of a substantiated preliminary report. The Policy also stated the Plan conducts quarterly and annual audits of the delegated FWA functions as part of the oversight process. When appropriate, Corrective Action Plans are implemented to resolve deficiencies in compliance.

Finding: The Plan did not ensure that all preliminary reports of suspected FWA were reported to DHCS within ten working days.

A verification study of eight cases found that the Plan did not report suspected FWA to DHCS within the required ten working days. In all eight cases, the Plan reported the suspected FWA to DHCS between 72 and 350 days after the date of initial discovery.

Health Net policy, *CC.Comp.16 Fraud, Waste, and Abuse Plan* (revised 02/23/2024), stated that the Health Net Special Investigation Unit (SIU) will conduct a preliminary

review of potential FWA and share the results and recommendation of the preliminary review to the Plan within 40 days. If the results of the SIU's preliminary investigation substantiates a finding of potential FWA, then the substantiated case will be reported to the DHCS within ten working days.

The Plan's FWA reporting process consisted of a preliminary and full investigation of potential FWA. However, the Plan allowed Health Net's SIU up to 40 days to substantiate a suspected FWA allegation through a preliminary review. The Plan did not adhere to Plan policy CO-005 as all potential FWA cases were not reported within ten working days as required.

During an interview, the Plan stated that it conducted an annual review of Health Net's policies to ensure contract compliance and confirmed that suspected fraud was only reported to DHCS when enough credible evidence had been obtained from Health Net's SIU preliminary investigation. In a written response, the Plan confirmed awareness that FWA allegations undergo a preliminary investigation which may take up to 40 days. The Plan's ten day reporting requirement went into effect only after receiving the SIU substantiated preliminary report from Health Net. Therefore, the Plan did not ensure timely reporting of all suspected FWA.

When the Plan does not ensure delegate's policies are contract compliant, it can lead to non-timely reporting. Failure to report all identified cases of potential FWA to DHCS timely may limit the ability to track, analyze, and respond to incidents and mitigate the impact to members, providers, the Plan, and the Medi-Cal program.

Recommendation: Revise policies and implement procedures to ensure prompt reporting of all potential FWA to DHCS within ten working days of when the Plan first becomes aware of, or is on notice of, the activity.

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SACRAMENTO SECTION

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

Contract Number: 23-30252 (State Supported Services)

Audit Period: April 1, 2023 – March 31, 2024

Dates of Audit: May 20, 2024 – May 31, 2024

Report Issued: October 1, 2024

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I. INTRODUCTION

The report presents the audit findings of Fresno-Kings-Madera Regional Health Authority dba CalViva Health (Plan), and the implementation of the State Supported Services contract number 23-30252 with the State of California. The State Supported Services Contract covers abortion services for the Plan.

The audit was conducted from May 20, 2024, through May 31, 2024, and covered the review period from April 1, 2023, through March 31, 2024. The audit consisted of a document review of materials provided by the Plan and interviews with Plan staff. Twenty-five State Supported Services claims were reviewed for appropriate and timely adjudication.

An Exit Conference with the Plan was held on September 16, 2024. 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.

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 and Health Care Financing Administration Common Procedure Coding System Codes: X1516, X1518, X7724, X7726, and Z0336. 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, (1.2))*

Plan policy, *FN-100 Family Planning Compensation* (reviewed 02/05/2024), stated that members are allowed freedom of choice of family planning providers and may receive such services from any family planning provider, including non-participating providers without prior authorization, referral, or physician approval. The contracted provider shall be paid in accordance with the applicable contract while non-contract providers are paid for covered services at not less than 100 percent of the Medi-Cal Fee-For-Service rates.

The Plan's Medi-Cal Member Handbook 2024, informed members that for sensitive care, including abortions, the doctor or clinic does not have to be in the Plan's network. The member can choose to go to any Medi-Cal provider for these services without a referral or pre-approval (prior authorization) from the Plan.

The verification study revealed the Plan appropriately processed abortion claims for payment and did not demonstrate any deficiencies related to State Supported Services. Based on the review of the Plan's documents, there were no deficiencies noted for the audit period.

RECOMMENDATION:

None.