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

2022

Contract Number:	10-87050
Audit Period:	April 1, 2020 Through March 31, 2022
Dates of Audit:	April 18, 2022 Through April 29, 2022
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I. INTRODUCTION

Fresno-Kings-Madera Regional Health Authority (RHA) was established in 2009 as the Local Initiative Health Plan for the 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, including an Administrative Service Agreement (ASA) and a Capitated Provider Services Agreement (CPSA). The delegated entity is contracted to provide services on the Plan's behalf.

In agreement with the ASA, the delegated entity maintains the systems for health plan operations and performs administrative activities on the Plan's behalf. 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 services primarily through a subcontracted network of Primary Care Providers (PCPs), specialists, behavioral health providers, hospitals, ancillary providers, pharmacies, and directly contracted FQHC.

As of December 2021, the Plan served 393,125 Medi-Cal members: 317,500 in Fresno County, 33,378 in Kings County, and 42,247 in Madera County. The Plan's Medi-Cal make-up is 65 percent Temporary Assistance for Needy Families, 25 percent Medi-Cal expansion, six percent for Seniors and Persons with Disabilities (SPD), three percent dual eligible, and 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, 2020, through March 31, 2022. The review was conducted from April 18, 2022, through April 29, 2022. The audit consisted of document reviews, verification studies, and interviews with the Plan personnel and the delegated entity.

An Exit Conference with the Plan was held on October 4, 2022. 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 Plan did provide additional information after the Exit Conference in which DHCS reviewed.

The audit evaluated six categories of performance: Utilization Management, 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 was included in this review period.

The prior DHCS medical audit, for the audit period of February 1, 2019, through January 31, 2020, was issued on June 30, 2020. This audit examined documentation for compliance and to determine to what extent the Plan has operationalized its Corrective Action Plan.

The summary of the findings by category is as follows:

Category 1 – Utilization Management

There were no findings in this category.

Category 2 – Case Management and Coordination of Care

The Plan did not ensure the provision of a blood lead screening test to members at 12 months and 24 months of age and members 12 months to 72 months of age who have no documented evidence of a blood lead screening test taken. In addition, the Plan did not make reasonable attempts to ensure the blood lead screening was provided and did not document attempts to provide the test or the members' refusal of the test.

The Plan did not ensure that their network providers gave verbal or written anticipatory guidance to the parents or guidance of a child member at each Periodic Health Assessment (PHA) starting at six months of age and continuing until 72 months.

Category 3 – Access and Availability of Care

The Plan did not ensure Physician Certification Statement (PCS) forms for authorization of Non-Emergency Medical Transportation (NEMT) services were completed by treating physicians as required by the Contract.

Category 4 – Member's Rights

There were no findings in this category.

Category 5 – Quality Management

There were no findings in this category.

Category 6 – Administrative and Organizational Capacity

There were no findings in this category.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The review was conducted from April 18, 2022, through April 29, 2022. The audit included a review of the Plan's contracts with DHCS, its policies for providing services, the procedures used to implement the policies, and verifications studies of the implementation and effectiveness of the policies. Documents were reviewed, and interviews were conducted with the Plan's administrators, a delegated entity, and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization: 12 medical and 12 pharmacy prior authorization denials requests were reviewed for medical necessity, consistent application of criteria, timeliness, appropriate review, and communication of results to members and providers.

Appeal Procedures: 13 prior authorization medical and pharmacy appeals were reviewed to ensure that required timeframes were met and appeals were appropriately routed and adjudicated.

Category 2 – Case Management and Coordination of Care

Initial Health Assessment: 27 new member medical records and 29 blood lead screenings of young children were reviewed for completeness and compliance with the requirements.

Category 3 – Access and Availability of Care

Transportation Access Standards: 12 NEMT and 12 Non-Medical Transportation (NMT) records were reviewed to confirm compliance with the NEMT and NMT requirements.

Category 4 – Member's Rights

Grievance Procedures:

Quality of Care Grievances: 10 quality of care grievances were reviewed for timely resolution, response to the complainant, and submission to the appropriate level for

review.

Quality of Service Grievances: 55 quality of service grievances were reviewed to verify the reporting timeframes, investigation process, response to the complainant, and submission to the appropriate level for review.

Category 5 – Quality Management

Potential Quality Improvement Issues: eight cases were reviewed for an appropriate level of review and decision-making process.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: 13 cases were reviewed for timely 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, 2020 through March 31, 2022 **DATE OF AUDIT: April 18, 2022 through April 29, 2022**

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	INITIAL HEALTH ASSESSMENT

2.1.1 Provision of Blood Lead Screening of Young Children

The Plan shall document and appropriately follow up on blood lead screening test results. The Plan is also required to make reasonable attempts to ensure the blood lead screening is provided and attempts to provide the tests are documented. If the member refuses the blood lead screen test, proof of voluntary refusal of the test shall be documented in the member's medical record. *(Contract, Exhibit A, Attachment 10 (5)(D))*

The Plan is required to comply with all existing final Policy Letters and All Plan Letters (APL) issued by DHCS. *(Contract, Exhibit E, Attachment 2)*

The Plan is required to provide blood lead screening tests to all child members at 12 months and 24 months of age, and when the network provider performing a PHA becomes aware that a child member who is 12 to 72 months of age has no documented evidence of a blood lead screening test taken. (*APL 20-016, Blood Lead Screening of Young Children*)

The Plan Policy (# PH-005), *Childhood Blood Lead Screening* (Revised March 3, 2021), stated that the Plan's PCPs must order and perform blood lead screening tests on all child members at ages specified in APL 20-016.

Finding: The Plan did not ensure the provision of a blood lead screening tests to members at 12 months to 72 months of age.

The Plan's Provider Manual, *Medi-Cal Operation Guide,* described the requirement of blood lead screening tests for children at 12 months and 24 months of age and 24 months to 72 months of age who have not been tested. The operation guide also required providers to document the parents or guardians' refusal of blood lead screening in the child member's medical record. However, in a verification study, six of 26 member records showed no documentation that the Plan ordered or performed blood lead screening tests for child members ages one to two years of age. Additionally, there was no documentation that a blood lead level test was refused so that a follow-up attempt could be made to ensure the provision of the blood lead screening.

The Plan submitted a, *2022 Year-To-Date Gap Closure Needed Report,* which indicated that blood lead screening in children was below the 50th percentile in all counties. Discussion of this report was not evident in the *2020 and 2021 quarterly Quality Improvement Committee Meeting Minutes* nor was there documentation of the Plan monitoring and taking effective action to ensure their network providers performed blood lead screening tests on child members.

During the interview, the Plan acknowledged that it does not have an established process to report the blood level screening performance to the *Quality Improvement/ Utilization Management Committee.*

The blood lead screening test assists in identifying and tracking young children's high-risk lead exposure. If the Plan does not ensure the provision of a blood lead screening tests to members at 12 months to 72 months of age, this can lead to poor health outcomes such as damage to the brain and nervous system, slowed growth and development, learning and behavior problems, hearing and speech problems.

RECOMMENDATION: Revise and implement policies and procedures to ensure the provision of a blood lead screening tests to members at 12 months to 72 months of age.

2.1.2 Provision of Anticipatory Guidance for Lead Exposure and Lead Poisoning

The Plan is required to comply with all existing final Policy Letters and APL issued by DHCS. *(Contract, Exhibit E, Attachment 2)*

The Plan is required to ensure their network providers give verbal or written anticipatory guidance to the parent or guardian of a child member that, at a minimum, includes information that children can be harmed by exposure to lead and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age. The parent or guardian must be provided this anticipatory guidance at each PHA, starting at six months of age and continuing until 72 months. *(APL 20-016, Blood Lead Screening of Young Children)*

The Plan Policy (# PH-005), *Childhood Blood Lead Screening* (Revised March 3, 2021), stated that the Plan's PCPs must provide verbal or written blood lead anticipatory guidance to the parent or guardian of a child member at each PHA starting at six months to 72 months of age.

Finding: The Plan did not ensure the giving of verbal or written blood lead anticipatory guidance to the parent or guardian of a child member at each PHA starting at six months of age and continuing until 72 months.

In a verification study, 19 of 26 member records showed no documentation of verbal or written anticipatory guidance provided to the parent or guardian of a child member at each PHA starting at six months of age and continuing until 72 months.

During the interview, the Plan acknowledged that it does not have an established process to monitor and report the provision of verbal or written blood lead anticipatory guidance to the *Quality Improvement/ Utilization Management Committee.*

Regular anticipatory guidance helps to educate members' parents/guardians in understanding and preventing their child from lead poisoning and exposure. If the anticipatory guidance is not provided to parents/guardians at each PHA, the child member's health can be seriously harmed, resulting in damage to the brain and nervous system, slowing growth and development, learning and behavior problems, and hearing and speech problems.

RECOMMENDATION: Revise and implement policies and procedures to ensure the provision of anticipatory guidance concerning childhood lead poisoning and lead exposure to members' parents/guardians at each PHA starting at six months to 72 months of age.

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.8	NON-EMERGENCY MEDICAL TRANSPORTATION NON-MEDICALTRANSPORTATION

3.8.1 Physician Certification Statement

The Plan is required to comply with all existing final Policy Letters and APLs issued by DHCS. *(Contract, Exhibit E, Attachment 2 (1)(D))*

The Plan must use a DHCS-approved PCS form to determine the appropriate level of service for Medi-Cal members. Once the member's treating physician prescribes the form of transportation, the Plan cannot modify the authorization. Each Plan must have a mechanism to capture and submit data from the PCS form to DHCS. (*APL 17-010, Non-Emergency Medical and Non-Medical Transportation Services)*

The Plan Policy, *PH-062 Non-Emergency, Non-Medical Transportation Assistance, and Coordination (Revised August 17, 2020),* stated the Plan and transportation brokers must use DHCS approved PCS form to determine the appropriate level of service for Medi-Cal members. Once the member's treating physician prescribed the form of transportation, the Plan cannot modify the authorization. The PCS forms must have included a certification statement: Prescribing physician's statement certifying that medical necessity was used to determine the type of transportation requested.

Finding: The Plan did not require PCS forms for NEMT services.

A verification study of 12 NEMT files identified nine files where the PCS form was not completed at the time of the trip. Seven PCS forms were never submitted, and two PCS forms were signed months after the service date.

During the interview, the Plan stated it was standard practice for its transportation broker to make three follow-up attempts with providers for the PCS form. If the Plan could not reach the provider, the transportation services would still be provided without a PCS form and physician certification.

Without the PCS form or a fully completed PCS form from the treating physician, Medi-Cal members' medical transportation needs may be compromised, subject to inadequate assistance and transportation methods, and unsafe transportation conditions.

Recommendation: Revise and implement policies and procedures to ensure that a completed PCS form is received from providers before NEMT services are provided.

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REPORT ON THE MEDICAL AUDIT OF

FRESNO-KING-MADERA REGIONAL HEALTH AUTHORITY DBA CALVIVA HEALTH

2022

Contract Number:	10-87054 State Supported Services
Audit Period:	April 1, 2020 Through March 31, 2022
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I. INTRODUCTION

The audit report presents the 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 contracted abortion services for the Plan.

The onsite audit was conducted from Monday, April 18, 2022 through Friday, April 29, 2022. The audit covered the review period from April 1, 2020 through March 31, 2022. The audit consisted of a document review of materials provided by the Plan.

An Exit Conference with the Plan was held on October 4, 2022.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: April 1, 2020 through March 31, 2022
DATE OF AUDIT: April 18, 2022 through April 29, 2022

STATE SUPPORTED SERVICES

SUMMARY OF FINDING:

The Plan outlines their processes and procedures for the consistent and accurate processing of sensitive service claims through the policies and procedures, Provider Manual, Member Handbook and their Medi-Cal Operations Guide. 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 errors were noted in the verification study conducted to determine appropriate and timely adjudication of State Supported Services claims. The Plan is in compliance with the current Contract.

RECOMMENDATION: None.