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

SENIOR CARE ACTION NETWORK HEALTH PLAN

Contract Number:	07-65712
Audit Period:	March 1, 2018 Through February 28, 2019
Report Issued:	June 28, 2019

TABLE OF CONTENTS

I. INTRODUCTION

Senior Care Action Network Health Plan (SCAN) commenced operations in Long Beach, California in 1977 as a non-profit Multipurpose Senior Services Program. SCAN received its full service Knox Keene license in 1984. SCAN contracted with California Department of Health Care Services to provide health care services as a Dual Eligible Special Needs Plan in 1985.

Senior Care Action Network Health Plan has the only Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) contract in California and provides this product line to seniors in Riverside, San Bernardino, and Los Angeles counties. SCAN administers its FIDE-SNP contract to dual eligible seniors who are entitled to both Medicare (Title XVIII) and medical assistance from a State Plan under Title XIX (Medi-Cal in California) where both Medicare and Medi-Cal services are administered through one plan. Dual eligible seniors voluntarily enroll both their Medicare and Medi-Cal coverage with SCAN. The Plan administers covered services for members by coordinating between Medicare and Medi-Cal.

Senior Care Action Network Health Plan contracts with 27 medical groups, 51 hospitals, 3,205 primary care physicians, and 4,057 specialists to provide a full range of Medicare Advantage product lines.

As of March 2019, Senior Care Action Network Health Plan has a total enrollment of 202,975 Medicare Advantage members, of which 14,214 are enrolled as dual eligible members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period March 1, 2018 through February 28, 2019. The on-site review was conducted from March 18, 2019 through March 22, 2019. The audit consisted of document review, verification studies, and interviews with Plan personnel and delegated entity.

An Exit Conference was held on June 11, 2019 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information to address the preliminary audit findings. The findings in the report reflect the evaluation of relevant information received prior and subsequent to the Exit Conference.

The audit evaluated six categories of performance: Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity.

The prior DHCS medical audit (for the audit period March 1, 2017 through February 28, 2018) was issued on June 29, 2018. The Corrective Action Plan (CAP) closeout letter was sent to the Plan on September 18, 2018. This year's audit examined documentation to determine implementation and effectiveness of the Plan's CAP.

The summary of the findings by category are as follows:

Category 1 – Utilization Management

Review of prior authorization and appeal requests for appropriate and timely adjudication yielded no findings during this audit period.

Delegation oversight review yielded no findings during this audit period.

Category 2 – Case Management and Coordination of Care

During the prior year audit, the Plan did not have written policies and procedures entailing the oversight and training of its network providers to ensure its members received comprehensive Initial Health Assessments (IHA). Also, the Plan did not have procedures requiring their providers to document the required components of a comprehensive IHA. The review of the Plan's IHA program yielded no findings during this audit period.

Review of the Plan's complex management program yielded no findings during this audit period.

Category 3 – Access and Availability of Care

The Plan did not enforce its delegated medical group's compliance with accessibility requirements and did not ensure the delegate conducted the required annual access to care survey.

Category 4 – Member's Rights

The Plan did not send written acknowledgement to members upon receipt of a grievance. In addition, the Plan did not send resolution letters within the required 30-day timeframe.

The Plan did not classify and process all member expressions of dissatisfaction as grievances.

The Plan did not use the updated standardized "Your Rights" template to notify members about new requirements and filing timeframes for a State Hearing.

Category 5 – Quality Management

The Plan did not ensure provider training was conducted for newly contracted providers within the 10-working-days requirement.

Category 6 – Administrative and Organizational Capacity

Review of the Plan's organizational capacity to guard against fraud and abuse yielded no findings during the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the Department of Health Care Services (DHCS), Medical Review Branch to ascertain medical services provided to Plan members comply with Federal and State laws, Medi-Cal regulations and guidelines, and the State's Contract.

The audit evaluated six categories of performance: Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity.

PROCEDURE

The on-site review was conducted from March 18, 2019 through March 22, 2019. 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 those 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: 9 medical and 14 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Appeals Process: 19 prior authorization appeal requests were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Complex Case Management: 10 medical records were reviewed for evidence of continuous tracking, monitoring, and coordination of resources to members who received complex case management services.

Initial Health Assessment: 16 medical records were reviewed for completeness, comprehensiveness, and timely completion.

Category 3 – Access and Availability of Care

Appointment Availability: 10 contracted providers from the Provider's Directory were reviewed to determine if appointments were accurate, complete, and available. The third next available appointment was used to measure access to care.

Category 4 – Member's Rights

Grievance Procedures: 15 quality of care and 13 quality of service grievances were reviewed for timely resolution, response to complaint, and submission to the appropriate level for review.

Category 5 – Quality Management

New Provider Training: 20 newly contracted providers were reviewed to determine if they received Medi-Cal Managed Care program training in a timely manner.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse Reporting: 10 cases were reviewed for proper reporting of all suspected fraud and/or abuse to DHCS within the required time frame.

A description of the findings for each category is contained in the following report.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
PLAN: Senior Care Action Network	
AUDIT PERIOD: March 1, 2018 through February 28, 2019	DATE OF AUDIT: March 18, 2019 through March 22, 2019

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1	Access and Availability of Care

Access Requirements:
Contractor shall establish acceptable accessibility requirements in accordance with Title 28, CCR, section 1300.67.2.1 and as specified below. DHCS will review and approve standards for reasonableness. Contractor shall communicate, enforce, and monitor providers' compliance with these standards.
Contract, A.9.3

Appointments:
Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, Urgent Care, routine specialty referral appointments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.
Contract A.9.3.A

Members must be offered appointments within the following timeframes:

3) Non-urgent primary care appointments – within ten (10) business days of request;
4) Appointment with a specialist – within 15 business days of request;
5) Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within 15 business days of request.

Contract A.9.4.B

Waiting Times:
Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments indicated in subparagraph A. Appointments, above.
Contract A.9.3.C; See Appointments above, Contract A.9.3.A

SUMMARY OF FINDINGS:

3.1.1 Access Requirements

The Plan is required to establish acceptable accessibility requirements in accordance with Title 28, CCR, Section 1300.67.2.1. DHCS will review and approve standards for reasonableness. The Plan shall communicate, enforce, and monitor providers' compliance with these standards. (Contract, Exhibit A, Attachment 9 (3))

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
PLAN: Senior Care Action Network	
AUDIT PERIOD: March 1, 2018 through February 28, 2019	DATE OF AUDIT: March 18, 2019 through March 22, 2019

Plan Policy *CRP-0078 - Corrective Action and Escalation Process for Non-Compliant First Tier, Downstream, or Related Entities Deficiencies* states the Plan's Network Performance Committee (NPC) is responsible for ensuring that compliance issues are escalated as set forth in the corrective action leveling and escalation grid.

Plan Policy *DOU-007 UM Oversight Audit Process* states the Plan's Network Compliance Auditor Clinical (NCAC) conduct annual audits of its delegates for compliance with Plan's criteria. The delegate will be provided a Corrective Action Plan for deficiencies identified during the audit. The contracted delegate is required to respond to areas of deficiency within 30 calendar days of when the audit CAP is issued by the Plan. If delegate does not respond, the NCAC will escalate the situation to the Network Management Specialist for resolution and report all activity to Plan's Network Performance Committee.

The Plan did not enforce its delegated medical group's compliance with accessibility requirements and did not ensure the delegate conducted the required annual access to care survey. Although the Plan has a policy and procedure in place for corrective action and escalation process for non-compliant delegates, the Plan did not effectively implement the procedures to this delegate.

The Plan's delegation oversight audit department reviewed its delegates for compliance with access to care study requirements. The Plan issued CAPs to seven delegates that did not perform the access to care survey. All delegates except one responded to Plan's issued CAPs. During the audit period the Plan issued two additional CAPs to the non-complaint delegate, however the delegate did not respond to the corrective action plans and did not meet the compliance to access to care standards. Although the Plan has a policy and procedure in place for ensuring that non-compliance performance and corrective actions are escalated to the Network Performance Committee for resolution, the Plan has not initiated the escalation process to address the delegates' repeated deficiencies.

The Plan's failure to ensure compliance with accessibility requirements may delay members' treatment.

RECOMMENDATION:

3.1.1 Develop and implement effective procedures and corrective actions to ensure the Plan's delegates meet the access to care standard requirements set forth by the Plan and DHCS.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
PLAN: Senior Care Action Network	
AUDIT PERIOD: March 1, 2018 through February 28, 2019	DATE OF AUDIT: March 18, 2019 through March 22, 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, 1300.68.01; Title 22 CCR Section 53260; Exhibit A, Attachment 13, Provision 4, paragraph D.12, and 42 CFR 438.420(a)(B) and (c)..
Contract A.14.1

Contractor shall implement and maintain procedures as described below 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 53260.
Contract A.14.2

Contractor shall maintain and have available for DHCS review grievance logs, including copies of grievance logs of any sub-contracting 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).
Contract A.14.3

SUMMARY OF FINDINGS:

4.1.1 **Acknowledgment and Resolution Letters**

The Plan shall implement and maintain a Member Grievance system in accordance with Title 28, CCR, Sections 1300.68, 1300.68.01 and Title 22, CCR section 53260….The Plan shall also implement and maintain procedures to ensure timely resolution and feedback to members. *(Contract, Exhibit A, Attachment 14 (1)(2)(A))*

The Plan shall provide a written acknowledgment to the member grievance within five (5) calendar days of receipt. The Plan shall also provide a resolution, written response to the member grievance within thirty (30) calendar days of receipt. *(Title 28, Section 1300.68 (d)(1)(3))*

All Plan Letter 17-006 *Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments* states the Plan shall provide written acknowledgment to members that is dated and postmarked within five calendar days of receipt of the grievance. The Plan shall also comply with the State's established timeframe of 30-calendar-days for grievance resolution.

The Plan did not send written acknowledgement to members upon receipt of a grievance. In addition, the Plan did not send resolution letters within the 30-calendar-day timeframe. Although

the Plan has a policy and procedure in place for Medi-Cal timely grievance notification and resolution to members, the verification study for quality of service grievances demonstrated the following:

- The Plan did not send acknowledgment letters to members in 13 occasions.
- The Plan did not send resolution letters to members within the required 30 days in eight occasions. The resolution letters were late by a median of 22 days.

During the onsite interview, the Plan stated the grievance department experienced a backlog. The backlog was due to lack of staff and implementation of a new grievance system.

Untimely notification and resolution of members' grievances could delay members' ability to make informed health decisions that may lead to an adverse effect on members' health and safety.

4.1.2 **Capturing Grievances**

Grievance means an oral or written expression of dissatisfaction, including any complaint, dispute, and request for reconsideration or appeal made by a member. DHCS considers complaints and appeals the same as a grievance. (Contract, Exhibit A, Attachment 14 (4))

When the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered as a grievance. (Title 28, California Code of Regulation, section, 1300.68 (a)(1))

The Plan did not classify and process all member expressions of dissatisfaction as grievances. Although the Plan has a grievance desktop procedure, it is not effectively implemented to capture and code grievances for expressions of dissatisfaction. Ten inquiries were reviewed to confirm the Plan opened grievance cases on members' expressions of dissatisfaction. The Plan Grievance and Appeal Department (GAD) returned two inquiries to Member Service Department (MSD) for insufficient information and GAD dismissed six inquires for lack of information, such as valid Power of Attorney or Appointment of Representative (AOR). Therefore, expressions of dissatisfaction were not properly processed as grievances. A function of the Plan's Member Service Department is to assist members during inquiry calls to resolve the issue, and any oral expression of dissatisfaction shall be coded as a grievance.

The Plan acknowledged that during the initial intake of members' inquiries, they did not gather sufficient information before assigning the case to the Grievance and Appeal Coordinator to proceed with the investigation and resolution. Furthermore, there was no communication between the Member Service Department, and the Grievance and Appeal Department to ensure inquiries were monitored and processed as grievances.

Not capturing and properly classifying members' expressions of dissatisfaction as grievances could result in the failure to detect quality of care issues.

4.1.3 **State Hearing Notice of Action (NOA) "Your Rights" Attachments**

The Plan shall have well-publicized appeals procedure for both providers and members. (Contract, Exhibit A, Attachment 5 (2)(D))

The Plan is required to provide information on the Member's right to the Medi-Cal hearing process and information….regardless of whether or not a grievance has been submitted or if the grievance has been resolved, pursuant to Title 22, CCR, Section 53452, when a health care service requested by the Member or provider has been denied, deferred or modified. The Plan shall also include information on the timelines which govern a Member's right to a State Hearing, pursuant to Welfare & Institutions Code Section 10951. (Contract, Exhibit A, Attachment 13 (15))

All Plan Letter 17-006, *Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments* states, the Plan shall utilize the revised Notice of Action (NOA) templates and corresponding "Your Rights" attachments to comply with the new federal requirements. In addition, "New federal regulations warrant substantial revision to the "Your Rights" attachment, which informs beneficiaries of critical Appeal rights...New federal regulations require beneficiaries to exhaust the Plan's internal appeal process and receive notice that the Adverse Benefit Determination has been upheld prior to proceeding to a State Hearing. If the Plan does not adhere to the required timeframe when resolving the appeal, the member is deemed to have exhausted the Plan's internal Appeal process and may request a State Hearing."

The Plan did not use the updated standardized "Your Rights" template to notify members about new requirements and filing timeframes for a State Hearing. Although the Plan has a policy and procedure in place, it is not effectively implemented to notify members of their rights in the event the Plan does not adhere to the notice and timely requirements. The Plan's existing template did not meet the new requirements and did not contain critical information requiring members to exhaust the Plan's internal appeal process before requesting a State Hearing. The verification study demonstrated the following:

- The Plan did not include the updated standardized NOA "Your Rights" attachment in nine grievance cases.
- The Plan did not include NOA "Your Rights" attachment in four grievance cases.

During the interview, the Plan acknowledged they did not utilize the updated NOA "Your Rights" attachments. The Plan confirmed it was an oversight and remediation is underway. The Plan also stated this was caused by technical glitches from recent integration of their new medical management systems.

Without properly informing members of their appeal and State Hearing rights may lead to delay in medical services and ultimately result in negative health outcomes.

RECOMMENDATIONS:

4.1.1 Implement policies and procedures to monitor and ensure timely grievance acknowledgement and resolution letters to members.

4.1.2 Implement policies and procedures to ensure expressions of dissatisfaction are properly classified as grievances.

4.1.3 Implement policies and procedures to ensure the standardized NOA “Your Rights” template is utilized to comply with new federal regulations.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
PLAN: Senior Care Action Network	
AUDIT PERIOD: March 1, 2018 through February 28, 2019	DATE OF AUDIT: March 18, 2019 through March 22, 2019

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, re-credentialing, 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.
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.
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….
Contract A.7.*5*

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
PLAN: Senior Care Action Network	
AUDIT PERIOD: March 1, 2018 through February 28, 2019	DATE OF AUDIT: March 18, 2019 through March 22, 2019

5.2	PROVIDER QUALIFICATIONS

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. Contractor shall implement and maintain policies and procedures for disciplinary actions including reducing, suspending, or terminating a practitioner's privileges. Contractor shall implement and maintain a provider appeal process.
Contract A.4.12.D

SUMMARY OF FINDINGS:

5.2.1 **Newly Contracted Provider Training**

The Plan is required to 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. The Plan is required to conduct training or provide information 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))

Contracted provider means a physician, nurse, technician, teacher, researcher, hospital, home health agency, nursing home, or any other individual or institution that contracts with contractor to provide medical services to members. (Contract, Exhibit E, Attachment 1(19))

The Plan did not ensure provider training was conducted within 10-working-days. The verification study demonstrated twenty newly contracted providers did not receive training within the 10-working-day requirement. The training was given between 13 to 60 days of providers being placed on active status.

During the onsite interview, the Plan acknowledged their provider training tracking system is not able to fully capture all newly contracted providers. In addition, the verification study demonstrated that dates in 19 provider orientation packets and attestation forms sent to providers did not match the start date in tracking system; five providers' confirmation training date also did not match the dates in the tracking system.

Without provider training to newly contracted providers, the Plan cannot ensure providers have the necessary information to provide adequate access to covered services to meet members' needs.

RECOMMENDATION:

5.2.1 Develop and implement effective processes and corrective actions to ensure newly contracted providers receive training within the 10-working-day requirement.