MEDICAL REVIEW – RANCHO CUCAMONGA
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

Senior Care Action Network Health Plan

Contract Number: 07-65712

Audit Period: March 1, 2020
Through
February 28, 2021

Report Issued: June 07, 2021

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I. INTRODUCTION

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

The 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. The Plan administers its FIDE-SNP Contract to dual eligible seniors, entitled to both Medicare (Title XVIII) and Medi-Cal (Title XIX), for the provision of both Medicare and Medi-Cal services integrated and coordinated through one Plan.

The Plan contracts with 39 medical groups, 56 hospitals, 3,551 primary care physicians, and 6,879 specialists to provide a full range of Medicare Advantage product lines.

As of March 1, 2021, the Plan had a total enrollment of 220,981 Medicare Advantage members, of which 14,928 were enrolled as dual eligible members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit of the Plan for the period of March 1, 2020 through February 28, 2021. The review was conducted from March 1, 2021 through March 10, 2021. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference with the Plan was held on May 11, 2021. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information to address preliminary audit findings. The Plan submitted supplemental information after the Exit Conference. The results of our evaluation of the Plan's response are reflected in this report.

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 report (for audit period March 1, 2019 through February 29, 2020) was issued on June 10, 2020. The Corrective Action Plan (CAP) closeout letter was sent to the Plan on July 28, 2020. This year's audit also examined documentation to determine implementation and effectiveness of the Plan's CAP.

The summary of findings by category follows:

Category 1 – Utilization Management

Review of prior authorization and appeal requests for appropriate and timely adjudication yielded no findings.

Category 2 – Case Management and Coordination of Care

Review of case management and coordination of care yielded no findings.

Category 3 – Access and Availability of Care

Review of the Plan's claims payment system yielded no findings.

Category 4 – Member's Rights

During the prior year audit, the Plan did not have policies and procedures to address the required reading level and ensure members' understanding of grievance acknowledgement and resolution letters. The Plan corrected the deficiency by implementing a readability verification process to ensure the required reading level was met for both the acknowledgement and resolution letters. This year's audit verified the implementation of the Plan's revised procedures and corrective actions regarding the prior year's finding.

The Plan is required to provide written member information regarding grievance processing requirements and filing timeframes. Member informing materials are required to be current, readily accessible, and prominent on the Plan's website. Both the Plan's website and written member information contained contradictory information regarding grievance filing timeframes. The Plan did not have an effective monitoring system to ensure accurate grievance timeframe information was provided to members.

The Plan is required to provide a Provider Manual with updates to serve as a source of information to health care providers regarding Medi-Cal services, policies, and procedures. The Plan's Provider Operation Manual (POM) contained contradictory information regarding grievance filing timeframes. The Plan did not have an effective monitoring system to ensure its providers gave accurate grievance timeframe information to members.

The Plan is required to monitor its subcontractors and take effective action when necessary. The Plan did not effectively monitor its subcontracted vendors. The Plan did not have a system in place to ensure its subcontractors complied with grievance reporting procedures.

Category 5 – Quality Management

Review of the Plan's quality improvement and monitoring system yielded no findings.

Category 6 – Administrative and Organizational Capacity

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

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The review was conducted from March 1, 2021 through March 10, 2021. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies to determine that policies were implemented and effective. 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: 20 medical and ten pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Appeal Procedures: 15 medical and 15 pharmacy prior authorization appeal requests were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Initial Health Assessment (IHA) requirements: 25 adult medical records were reviewed to confirm timely completion of coordination of care and fulfillment of IHA requirements.

Category 3 – Access and Availability of Care

Emergency Service Claims: 15 emergency service claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance Procedures: 14 quality of service grievances, ten quality of care grievances, and 30 inquiries were reviewed for timely resolution, appropriate response to complainant, and submission to the appropriate level for review.

Category 5 – Quality Management

New Provider Training: 15 new provider training records were reviewed for timely Medi-Cal managed care program training.

Potential Quality Issues: Seven cases were reviewed for timely evaluation and effective action taken to address needed improvements.

Category 6 – Administrative and Organizational Capacity

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

A description of the applicable findings are contained in the following report:

❖ COMPLIANCE AUDIT FINDINGS ❖
PLAN: Senior Care Action Network Health Plan
AUDIT PERIOD: March 1, 2020 through February 28, 2021 **DATE OF AUDIT: March 1, 2021 through March 10, 2021**

CATEGORY 4 - MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Written Member Information (Grievance Filing Timeframes)

The Contract requires in part, the Plan provide written member information regarding the grievance process which shall include requirements and timelines for the contractor to acknowledge receipt of grievances, to resolve grievances, and to notify members of the resolution. (Contract, Exhibit A, Attachment 13 (4) (D) (12))

According to APL 17-006, "Timeframe for filing Grievances are delineated in both federal and state regulations. While existing state regulations establish a timeframe of at least 180 calendar days from the date of the incident subject to the beneficiary's dissatisfaction, new federal regulations allow Grievances to be filed at any time. Managed Care Plans (MCPs) shall adopt the standard which is least restrictive to beneficiaries and allow Grievances to be filed at any time in accordance with new federal regulations."

Finding: The Plan provided members with contradictory written information regarding grievance filing timeframes. The Plan did not have an effective monitoring system in place to ensure accurate grievance timeframe information was provided to members.

Federal regulation requires that Plan's adopt grievance standards that are less restrictive to members by allowing grievances to be filed at any time. During the audit period, the Plan's written materials provided members with contradictory grievance filing timeframes. The Plan's website informed members that grievances could be filed at any time after an incident. However, other written member materials also states grievances are to be filed within 60 calendar days after the incident occurred. The 60 calendar day filing timeframe is a more restrictive standard which can limit members' rights. Our audit revealed the Plan conducts an annual review of the website and written member materials to ensure all edits are applied to the content. However, the Plan did not have written procedures that delineates this review process.

During an interview, the Plan acknowledged the contradictory grievance timeframe information was the result of neglecting to submit the required language and content changes during the annual review process. In addition, review of the Plan's website and previous member materials revealed that grievance filing timeframes had not been updated since 2018. Therefore, the Plan did not maintain an effective monitoring system that could identify contradictory timeframe information and ensure necessary updates were completed.

Conflicting grievance filing timeframes may cause member confusion and can potentially affect the member's ability to make appropriate health care decisions.

Recommendation: Develop and implement effective monitoring procedures to ensure accurate grievance timeframe information is provided to members.

4.1.2 Provider Operation Manual (Grievance Filing Timeframes)

The Plan shall issue a Provider Manual and updates to the providers of Medi-Cal services. The manual and updates shall serve as a source of information to health care providers regarding Medi-Cal services, policies, and procedures, statutes, and regulations, telephone access and special requirements. (Contract, Exhibit A, Attachment 7 (4))

According to APL 17-006, "Timeframe for filing Grievances are delineated in both federal and state regulations. While existing state regulations establish a timeframe of at least 180 calendar days from the date of the incident subject to the beneficiary's dissatisfaction, new federal regulations allow Grievances to be filed at any time. MCPs shall adopt the standard which is least restrictive to beneficiaries and allow Grievances to be filed at any time in accordance with new federal regulations."

Finding: The Plan's POM contained contradictory information regarding grievance filing timeframes. The Plan did not have an effective monitoring system to ensure accurate grievance timeframe information was provided to members.

The POM serves as one of the primary resources utilized to inform network providers of grievance procedures and filing timeframes. Federal regulations require that MCPs allow members to file grievances at any time. During the audit period, the Plan's POM provided network providers with contradictory grievance filing timeframes. The POM indicated that members could file a grievance at any time after an incident; as well as, required members to file grievances within 60 calendar days after the incident occurred. According to the Plan's desktop procedure #37, updating the POM, each department's "Section Owner" maintains the responsibility to submit content changes to the POM during the annual review process, in which a non-submission is considered as "no change".

During the interview, the Plan acknowledged the contradictory timeframe information was the result of neglecting to submit the necessary content changes during the POM review period. Review of prior year manuals revealed that grievance filing timeframes had not been updated since 2018. Therefore, the Plan's process to update the POM was not effectively implemented since its current monitoring system did not identify the contradictory grievance filing timeframes.

Contradictory grievance filing timeframes contained within the Provider Manual may cause confusion when assisting members in filing grievances and could adversely affect the members' ability to make appropriate health care decisions.

Recommendation: Update the Plan's POM to reflect current grievance filing timeframes according to APL 17-006, and implement an effective monitoring system to ensure future POM updates are completed.

4.1.3 Oversight of Contracted Vendors

The Plan is required to maintain a system to ensure accountability and delegated quality improvement by ensuring subcontractors meet standards as set forth by the contractor and DHCS that includes continuous monitoring, evaluation and approval of delegated functions. (Contract, Exhibit A, Attachment 4 (6) (B))

The Plan is required to 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. The Plan is also held accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between the Plan and the provider. (Contract, Exhibit A, Attachment 4 (1))

Regardless of the relationship that the MCP has with a subcontractor, whether direct or indirect through additional layers of contracting or delegation, the MCP has the ultimate responsibility for adhering to, and fully complying with, all terms and conditions of its contract with the DHCS. (APL 17-004)

Finding: The Plan did not effectively monitor its subcontracted vendors. The Plan did not have a system in place to ensure its subcontractors complied with grievance reporting procedures.

The Plan utilizes subcontracted vendors to provide in-home services to its members through business contracts with Health Delivery Organizations (HDO). According to the Plan's POM, subcontractors (HDO vendors) are required to instruct members to contact the Plan to file all grievances. In the event that a grievance is filed directly with the vendor, the grievance is to be forwarded to the Plan on the date of receipt. The POM also states that timely filing of member grievances are sensitive procedures that require collaboration between the Plan and their vendors.

During the audit period, the Plan did not have a system in place to ensure its subcontractors complied with grievance reporting procedures. Subcontracted vendors did not forward member grievances to the Plan timely as required by the Plan's POM. The verification study revealed nine instances in which the Plan did not effectively monitor nor take corrective action against non-compliant subcontracted vendors. The following are

two examples:

- Example A - Member filed a grievance with the Plan's vendor regarding a theft allegation. The grievance was not reported by the subcontracted vendor to the Plan on the date of receipt as required by the POM. Furthermore, the Plan did not investigate the grievance and corrective action was not taken to address the non-compliant subcontractor.

- Example B - Member grievance was delayed for four months due to the subcontracted vendor not reporting the grievance to the Plan on the date of receipt. Furthermore, the grievance was not resolved timely and corrective action was not taken to address the non-compliant subcontractor.

The Plan did not effectively monitor and ensure its subcontracted vendors complied with grievance reporting procedures as outlined within the POM. During an interview, the Plan confirmed there was no mechanism in place to monitor its subcontracted vendors. As a result, the Plan did not impose corrective actions on non-compliant subcontracted vendors that did not comply with the POM.

Without effective monitoring, the Plan cannot ensure its subcontracted vendors comply with grievance reporting procedures, and possibly result in member grievances not being processed timely, investigated fully, or resolved appropriately.

Recommendation: Develop and implement an effective monitoring process to ensure subcontractor compliance with grievance reporting procedures.