

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

REPORT ON THE MEDICAL AUDIT OF

**SENIOR CARE ACTION NETWORK
HEALTH PLAN**

2022

Contract Number: 07-65712
Audit Period: March 1, 2021
Through
February 28, 2022
Dates of Audit: March 7, 2022
Through
March 17, 2022
Report Issued: August 23, 2022

TABLE OF CONTENTS

I.	INTRODUCTION.....	1
II.	EXECUTIVE SUMMARY	2
III.	SCOPE/AUDIT PROCEDURES.....	5
IV.	COMPLIANCE AUDIT FINDINGS	
	Category 1 – Utilization Management	7
	Category 3 – Access and Availability of Care.....	15

I. INTRODUCTION

Senior Care Action Network (SCAN) 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 dually 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 32 medical groups, 50 hospitals, 3,277 primary care physicians, and 4,479 specialists to provide a full range of Medicare Advantage product lines.

As of March 2022, the Plan had a total enrollment of 268,491 Medicare Advantage members, of which 14,607 were enrolled as dual eligible members.

II. EXECUTIVE SUMMARY

This report presents the findings of the DHCS medical audit of the Plan for the period of March 1, 2021 through February 28, 2022. The audit was conducted from March 7, 2022 through March 17, 2022. The audit consisted of document review, verification studies, and interviews with Plan personnel and one delegated entity.

An Exit Conference was held on July 20, 2022. 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 Plan submitted additional information; however, the information provided did not sufficiently address the area of deficiency. The results of the evaluation are reflected in this report.

The audit evaluated five categories of performance: Utilization Management (UM), Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity.

The prior DHCS medical audit report issued on June 07, 2021 (audit period March 1, 2020 through February 28, 2021) identified deficiencies incorporated in the Corrective Action Plan (CAP) dated August 27, 2021. This year's audit included review of documents to determine implementation and effectiveness of the Plan's CAP.

The summary of findings by category is as follows:

Category 1 – Utilization Management

Written Notice of Adverse (NOA) Benefit Determination submitted to providers are required to contain the name and direct telephone number or extension of the decision maker. The Plan did not ensure written NOAs submitted to providers contained the required information.

Written NOAs submitted to members are required to include the time limit in which to request a State Fair Hearing (SFH). The Plan did not ensure written NOA attachments included the SFH timeframe extension granted during the Covid-19 public health emergency.

Written Notice of Appeal Resolution (NAR) submitted to members is required to include information on how to request a SFH, as well as the criteria, clinical guidelines, or medical policies used in reaching the determination. The Plan did not ensure dual eligible members received NAR and “Your Rights” attachments that contained the required SFH rights and criteria used to reach the determination for Medi-Cal benefit appeals.

The Plan is responsible for all delegated UM functions and is required to maintain a system to ensure accountability that includes continuous monitoring of its subcontractors. The Plan did not perform continuous monitoring of delegated prior authorizations to ensure the provision of Medi-Cal covered services for dual eligible members.

Category 2 – Case Management and Coordination of Care

The Plan’s case management and coordination of care was not evaluated as part of this year’s audit.

Category 3 – Access and Availability of Care

The Plan and transportation broker must use a DHCS approved Physician Certification Statement (PCS) form to determine the appropriate level of service for Medi-Cal members. The Plan did not ensure PCS forms were obtained prior to the provision of transportation services.

The Plan is required to ensure transportation providers are enrolled in the Medi-Cal program. Subcontracted transportation providers were not enrolled in the Medi-Cal program. The Plan did not have policies and procedures to ensure subcontracted transportation providers were enrolled in the Medi-Cal program.

Category 4 – Member’s Rights

Audit of the Plan’s grievance system yielded no findings.

During the prior audit, the Plan provided members with contradictory written information regarding grievance filing timeframes. In response to the CAP, the Plan revised the written grievance documentation to reflect the correct regulatory information and developed procedures to monitor any applicable changes needed. Review of the Plan’s CAP response yielded no findings.

During the prior audit, the Plan's Provider Operations Manual (POM) contained contradictory information regarding grievance filing timeframes. In response to the CAP, the Plan revised the POM documentation to reflect the correct timeframe information and developed procedures to monitor any applicable changes needed. Review of the Plan's CAP response yielded no findings.

During the prior audit, the Plan did not effectively monitor its subcontracted vendors to ensure compliance with grievance reporting procedures. In response to the CAP, the Plan developed monitoring procedures of its subcontracted vendors to ensure timely notification. Review of the Plan's CAP response yielded no findings.

Category 5 – Quality Management

Audit of category five yielded no findings.

Category 6 – Administrative and Organizational Capacity

Audit of the Plan's identified overpayments and recoveries due to fraud, waste and abuse yielded no findings.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Medical Review Branch conducted this audit of the Plan 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 audit was conducted from March 7, 2022 through March 17, 2022 for the audit period March 1, 2021 through February 28, 2022. 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 the effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan administrators, key personnel, and one delegated entity.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 21 medical prior authorization denials reviewed for timeliness, consistent application of criteria, appropriate review, and communication of results to members and providers.

Appeals Process: 17 medical appeals and 20 pharmacy appeals were reviewed for appropriate and timely adjudication.

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

Category 3 – Access and Availability of Care

Non-Emergency Medical Transportation and Non-Medical Transportation (NEMT/NMT): five NEMT and ten NMT records were reviewed to confirm compliance with transportation requirements.

Category 4 – Member's Rights

Grievance Procedures: 51 grievances (including 24 quality of care, ten quality of service, seven exempt, and ten expedited) and five inquiries were reviewed for timely resolution, classification, appropriate response to complainant, and submission to appropriate level for review.

Category 5 – Quality Management

Quality Improvement System: 20 potential quality incident files were reviewed for proper decision-making and effective actions taken to address needed quality improvements.

Category 6 – Administrative and Organizational Capacity

Identified Overpayments: Five cases were reviewed to confirm reporting of Plan identified overpayments and recoveries due to fraud, waste, and abuse to DHCS.

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

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Senior Care Action Network (SCAN) Health Plan

AUDIT PERIOD: March 1, 2021 through February 28, 2022

DATES OF AUDIT: March 7, 2022 through March 17, 2022

CATEGORY 1 - UTILIZATION MANAGEMENT

1.2

PRIOR AUTHORIZATION REVIEW REQUIREMENTS

1.2.1 NOA Benefit Determination Contact Information

The Plan shall notify members of a decision to deny, defer, or modify request for Prior Authorization, in accordance with Title 22, California Code of Regulations (CCR), section 53894 by providing written notification to members and/or their authorized representative, regarding any denial, deferral or modification of a request for approval to provide a health care service. This notification must be provided as specified in Health and Safety Code, section 1367.01. *(Contract, Exhibit A, Attachment 13)*

NOA notifications submitted to the provider shall contain the name and direct telephone number or extension of the decision maker. Decisions shall be communicated to the provider initially by telephone or facsimile, and then in writing. If the Plan can substantiate through documentation that effective processes are in place to allow the provider to easily contact the decision-maker through means other than a direct phone number (e.g., telephone number to the specific unit of the UM Department that handles provider appeals directly), a direct telephone number or extension shall not be required. However, the Plan must conduct ongoing oversight to monitor the effectiveness of this process. *(All Plan Letter (APL) 17-006)*

Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider the ability to easily contact the professional responsible for the denial, delay, or modification. *(Health and Safety Code, section 13607.01(h)(4))*

Finding: The Plan did not ensure NOA notification submitted to providers contained the name and direct telephone number of the Plan decision maker.

A verification study found 21 out of 21 prior authorization denials in which the corresponding NOA notification did not contain the name and direct telephone number of the decision maker.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Senior Care Action Network (SCAN) Health Plan

AUDIT PERIOD: March 1, 2021 through February 28, 2022

DATES OF AUDIT: March 7, 2022 through March 17, 2022

The Plan did not include the decision maker and a direct number within the NOA written notification submitted to providers. During the interview, the Plan stated their NOA template lists the Plan's member service number in lieu of the decision maker's name and direct number. However, the member service number provided is not the specific unit that handles provider appeals directly. In addition, the Plan did not have monitoring procedures to ensure providers were able to easily contact the decision maker. Therefore, the Plan's process was not in compliance with contractual requirements. NOA Benefit Determinations submitted without the name and the direct number of the Plan decision maker can limit the provider's ability to easily contact the decision maker and potentially delay the submission of appeal for medically necessary services.

Recommendation: Develop and implement policies and procedures to ensure Notice of Adverse Benefit Determinations contain the name and direct telephone number of the Plan decision maker.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Senior Care Action Network (SCAN) Health Plan

AUDIT PERIOD: March 1, 2021 through February 28, 2022

DATES OF AUDIT: March 7, 2022 through March 17, 2022

1.2.2 State Fair Hearing (SFH) Timeframe Extension

The Plan is required to notify members of a decision to deny, defer, or modify requests for prior authorization, in accordance with Title 22, CCR, section 53894 by providing written notification to members and/or their authorized representative, regarding any denial, deferral or modification of a request for approval to provide a health care service. (*Contract, Exhibit A, Attachment 13, section 8 (A)*)

The written notice of action is required to specify the member's right to a fair hearing which should include the method by which a hearing may be obtained, and the time limit for requesting a fair hearing. (*CCR, Title 22, section 53894 (d)(4)*)

DHCS standardized templates are comprised of two components: 1) the NOA Benefit Determination and 2) "Your Rights" attachments. The written NOA is required to include a member's right to request a SFH. While the "Your Rights" attachment sent out to beneficiaries who receive a NOA will contain general information on SFH rights, the notice will primarily inform the beneficiary on how to request an appeal with the Plan. (*APL 17-006*)

Centers for Medicare and Medicaid Services (CMS) allowed a modification of the timeframe for Managed Care Plan (MCP) members to make SFH requests under (CFR), Title 42, section 438.408(f)(2). During the COVID-19 public health emergency, members are allowed up to an additional 120 days to request a SFH. MCPs must notify members receiving a NAR that upholds an adverse benefit determination that they have an additional 120 days over and above the initial 120 days allowed to request a SFH. (*Supplemental to APL 17-006*)

Finding: The Plan did not ensure written NOA attachments included information to notify members of the extended timeframe to request a SFH.

The verification study revealed 21 out of 21 prior authorization case records in which the Plan did not provide documentation to notify members of the SFH timeframe extension granted during the Covid-19 public health emergency.

The Plan is required to inform members of their right to a SFH by providing written NOA attachments which should include in part, the time limit by which a hearing may be obtained. Traditionally, members were allowed 120 days to request a SFH and due to the Covid-19 public health emergency, this timeframe was extended. According to the CMS approval letter, members are allowed up to an additional 120 days. The Plan however, did not include the extended SFH timeframe within its written NOA attachments.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Senior Care Action Network (SCAN) Health Plan

AUDIT PERIOD: March 1, 2021 through February 28, 2022

DATES OF AUDIT: March 7, 2022 through March 17, 2022

During the interview, the Plan stated that the SFH extended timeframe was understood to be a temporary process and therefore, did not update the information within the written NOA attachment. As a result, members were not notified of their timeframe extension rights.

Without ensuring written NOA attachments include the correct timeframe by which a SFH hearing may be obtained, members will not be fully aware of their rights which can potentially delay their ability to obtain approval for medically necessary services.

Recommendation: Revise and implement procedures to ensure written NOA attachments include information to notify members of the correct timeframe in which to request a SFH in accordance with the most current APL requirements.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Senior Care Action Network (SCAN) Health Plan

AUDIT PERIOD: March 1, 2021 through February 28, 2022

DATES OF AUDIT: March 7, 2022 through March 17, 2022

1.3

PRIOR AUTHORIZATION APPEAL AUDIT REQUIREMENTS

1.3.1 Notice of Appeal Resolution (NAR) Written Notification

All existing Policy Letters issued by the Medi-Cal Managed Care Division and the Office of Long Term Care are hereby incorporated into this Contract and shall be complied with by the Plan. (*Contract, Exhibit E, Attachment 2, section 1, (D)*)

A NAR is a formal letter informing a beneficiary that an Adverse Benefit Determination has been overturned or upheld. “Your Rights” attachment sent out to beneficiaries who receive a NAR that upholds the original Adverse Benefit Determination will primarily inform the beneficiary on how to request a State Hearing. The Plan shall also include in its written response the reasons for its determination and clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination. (*APL 17-006*)

The Plan’s policy *GA-0034 Member Appeal Process for Medi-Cal only benefits (publication date 9/13/2017)* applies to all dually eligible member requests for appeals for Medi-Cal only benefits or services. The policy states in part that notification to the member will include results and date of the appeal. For decisions not wholly in the member’s favor, the Plan will include the member’s right to request a SFH, and how to request a hearing.

Finding: The Plan did not ensure dual eligible members received NAR and “Your Rights” attachments that contained the required SFH rights and criteria used to reach the determination for Medi-Cal benefit appeals.

A verification study revealed three appeals in which dual eligible members did not receive NAR and “Your Rights” attachments that contained SFH rights and the Medi-Cal criteria used in reaching the appeal determination.

Although the Plan’s policy states that when processing appeals for Medi-Cal benefits, members are to receive notification that will include the member’s right to request a SFH, the Plan did not adhere to its policy to ensure dual eligible members received the required NAR and “Your Rights” attachments. Additionally, the Plan’s policy did not address the requirement to include the criteria utilized in reaching the appeal determination within the written notification.

During the interview, the Plan acknowledged that dual eligible members were not provided with the appropriate attachments that contained the required SFH rights nor the criteria utilized in the determination for Medi-Cal benefit appeals.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Senior Care Action Network (SCAN) Health Plan

AUDIT PERIOD: March 1, 2021 through February 28, 2022

DATES OF AUDIT: March 7, 2022 through March 17, 2022

Without ensuring NAR and “Your Rights” attachments are provided and contain the required appeal decision information, member’s right to obtain additional hearings for medically necessary services can potentially be delayed.

Recommendation: Revise and implement policies to ensure dual eligible members receive NAR and “Your Rights” attachments that contain the required SFH rights and criteria used in reaching the determination for appeals involving Medi-Cal covered benefits.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Senior Care Action Network (SCAN) Health Plan

AUDIT PERIOD: March 1, 2021 through February 28, 2022
DATES OF AUDIT: March 7, 2022 through March 17, 2022

1.5

DELEGATION OF UTILIZATION MANAGEMENT

1.5.1 Oversight of Utilization Management (UM) Delegate

The Plan is required to provide or arrange for the provision of medically necessary covered services for members. (*Contract, Exhibit A, Attachment 10(1)*)

UM activities may be delegated. If Plan delegates these activities, the Plan shall comply with Contract requirements for Delegation of Quality Improvement Activities. Attachment 4, provision 6. Delegation of Quality Improvement Activities. (*Contract, Exhibit A, Attachment 5(5)*)

The Plan shall maintain a system to ensure accountability for delegated quality improvement activities that at a minimum, includes the continuous monitoring, evaluation and approval of the delegated functions. (*Contract, Exhibit A, Attachment 4(6)(B)(3)*)

Plan Policy *UM-0013 (publication date 12/02/2020)* states in part that Medi-Cal only services for dually enrolled members are administered by the Plan according to Medi-Cal coverage criteria.

Plan Desktop Procedure *SCAN D-Special Needs Plan (SNP) Medi-Medi Carve out Process* delineates the delegated prior authorization process for dually enrolled members and states in part, that when medically necessary services are not a covered benefit under Medicare, the delegate is required to forward the denial to the Plan to make the final determination based on Medi-Cal eligible benefits.

Finding: The Plan did not perform continuous monitoring of delegated prior authorizations to ensure the provision of Medi-Cal covered services for dual eligible members.

A verification study was conducted based on delegated prior authorizations for dual-eligible members. No final determination was made for three Medi-Cal covered services subsequent to the initial determination that these services were not covered under Medicare. There was no documentation showing that these service requests were forwarded to the Plan for determination based on Medi-Cal coverage criteria. Consequently, dual eligible members were denied Medi-Cal covered services.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Senior Care Action Network (SCAN) Health Plan

AUDIT PERIOD: March 1, 2021 through February 28, 2022

DATES OF AUDIT: March 7, 2022 through March 17, 2022

During the interview, the Plan acknowledged the need to improve oversight of the delegated prior authorization and carve-out process for more visibility.

Without continuous monitoring of its delegated UM prior authorization process for dual eligible members, the Plan cannot ensure service requests for covered services are appropriately determined and may result in member's overall health being negatively impacted by not receiving necessary covered services.

Recommendation: Implement policies and procedures to ensure the provision of covered services for dual eligible members.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Senior Care Action Network (SCAN) Health Plan

AUDIT PERIOD: March 1, 2021 through February 28, 2022
DATES OF AUDIT: March 7, 2022 through March 17, 2022

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.8	NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) AND NON-MEDICAL TRANSPORTATION (NMT)
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3.8.1 Physician Certification Statement (PCS) Form

All existing Policy Letters issued by the Medi-Cal Managed Care Division and the Office of Long Term Care are hereby incorporated into this Contract and shall be complied with by the Contractor. (*Contract, Exhibit E, Attachment 2, section 1, (D)*)

NEMT services are a covered Medi-Cal benefit when members need to obtain medically necessary covered services and when prescribed in writing by a physician, dentist, podiatrist, mental health or substance use disorder provider. Plans and transportation brokers must use a DHCS approved PCS form to determine the appropriate level of service for Medi-Cal members. In order to ensure consistency amongst all Plans, all NEMT PCS forms must include, at a minimum, the following: function limitations justification, dates of service needed, modes of transportation needed, and certification statement. (*APL 17-010*)

The Plan's policy *Non-Emergency Medical (NEMT) and Non-Medical (NMT) Transportation (Medi-Cal) (effective date: 11/01/2021)* states that NEMT services are a covered Medi-Cal benefit when prescribed in writing by an approved treating provider. The policy also states that treating providers must complete and submit the PCS form to the Plan prior to the provision of transportation services.

Finding: The Plan did not obtain required PCS forms prior to the provision of transportation services. The Plan did not ensure compliance with APL 17-010.

The verification study revealed five NEMT transportation trips provided did not contain the required PCS form.

In an interview, the Plan confirmed that transportation services were authorized without obtaining PCS forms. The Plan did not implement its policy and stated that upon reviewing its process, it has determined the need to revise procedures to ensure compliance with APL 17-010.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Senior Care Action Network (SCAN) Health Plan

AUDIT PERIOD: March 1, 2021 through February 28, 2022

DATES OF AUDIT: March 7, 2022 through March 17, 2022

Without obtaining DHCS approved PCS forms, the Plan cannot ensure Medi-Cal members receive the necessary and appropriate level of transportation services which could place members at an increased risk for patient harm.

Recommendation: Revise and implement policies and procedures to ensure DHCS approved PCS forms are obtained prior to providing transportation services.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Senior Care Action Network (SCAN) Health Plan

AUDIT PERIOD: March 1, 2021 through February 28, 2022

DATES OF AUDIT: March 7, 2022 through March 17, 2022

3.8.2 Transportation Provider Medi-Cal Enrollment

The Plan shall ensure subcontractors comply with all applicable requirements of the DHCS, Medi-Cal Managed Care program. (*Contract, Exhibit A, Attachment 6, section 16, (B)(20)*)

The Plan is required to ensure all network providers are enrolled in the Medi-Cal program. (*APL 19-004*)

Finding: The Plan did not ensure subcontracted transportation providers were enrolled in the Medi-Cal program.

The verification study revealed five subcontracted transportation providers were not enrolled in the Medi-Cal program while providing transportation services to Medi-Cal beneficiaries. In addition, two of the five subcontracted providers were denied Medi-Cal enrollment but were still utilized to provide transportation services. The Plan did not require subcontracted transportation providers to enroll in the Medi-Cal program and did not have policies and procedures to ensure compliance with APL 19-004.

Without requiring subcontracted provider enrollment in the Medi-Cal program, the Plan cannot ensure compliance with the necessary criteria required to service Medi-Cal beneficiaries. Non-compliance with enrollment criteria can potentially result in members receiving unsafe transportation services.

Recommendation: Develop and implement policies and procedures to ensure subcontracted transportation providers are enrolled in the Medi-Cal program before providing services to Medi-Cal beneficiaries.