CONTRACT AND ENROLLMENT REVIEW DIVISION – SAN DIEGO
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

SENIOR CARE ACTION NETWORK HEALTH PLAN

2023

Contract Number:	07-65712
Audit Period:	March 1, 2022 Through February 28, 2023
Dates of Audit:	June 5, 2023 Through June 16, 2023
Report Issued:	September 27, 2023

TABLE OF CONTENTS

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. In January 2023, DHCS granted the Plan a FIDE-SNP Contract to provide health care services to dually eligible beneficiaries in San Diego County. 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.

As of March 2023, the Plan had a total enrollment of 263,897 Medicare Advantage members, of which 21,668 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, 2022 through February 28, 2023. The audit was conducted from June 5, 2023 through June 16, 2023. The audit consisted of document review, verification studies, and interviews with Plan personnel.

The audit evaluated six categories of performance: Utilization Management (UM), 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 issued on August 23, 2022, for the audit period of March 1, 2021 through February 28, 2022, identified deficiencies, which were addressed in the Corrective Action Plan (CAP) dated May 4, 2023. 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

Category 1 covers requirements and procedures for the UM program, including prior authorization review, Medical Director and medical decisions, the delegation of UM, and the appeal process.

The Plan is required to review Medi-Cal coverage when Medicare coverage has been exhausted or denied. The Plan did not include review of Medi-Cal authorization criteria for covered services.

Category 4 – Member's Rights

Category 4 includes requirements and procedures to establish and maintain a grievance system, and to protect members' rights by properly reporting suspected or actual breaches or security incidents.

The Plan is required to send acknowledgment of grievance receipt to members within the required timeframe. The Plan did not send notice of acknowledgement to members within the required five-calendar-day timeframe.

The Plan is required to include 18 non-English languages identified by the United States Department of Health and Human Services and DHCS in its Language Assistance Tagline attachment. The Plan did not include two non-English languages, Mien and Ukrainian, in the Language Assistance Tagline attachment found in the Member Handbook and member notices.

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 comply with federal and state laws, Medi-Cal regulations and guidelines, and the State Contract.

PROCEDURE

The audit was conducted from June 5, 2023 through June 16, 2023, for the audit period March 1, 2022 through February 28, 2023. 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 and key personnel.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 20 medical prior authorization approvals and denials were reviewed for timeliness, consistent application of criteria, appropriate review, and communication of results to members and providers.

Appeals Process: 18 medical 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 (NEMT) and Non-Medical Transportation (NMT): five NEMT and ten NMT records were reviewed to confirm compliance with transportation requirements.

Category 4 – Member’s Rights

Grievance Procedures: 56 standard grievances (29 quality of care and 27 quality of service), 14 exempt grievances, and 25 call 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: 14 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

Fraud and Abuse: 11 fraud and abuse cases were reviewed for processing and reporting requirements.

Encounter Data: Five encounter data records were reviewed for complete, accurate, reasonable, and timely encounter data submissions.

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, 2022 through February 28, 2023 **DATES OF AUDIT: June 5, 2023 through June 16, 2023**

CATEGORY 1 – UTILIZATION MANAGEMENT

1.3	PRIOR AUTHORIZATION APPEAL PROCESS

1.3.1 Appeal Reviews of Medi-Cal Benefits

The Plan shall have a grievance and appeal system that meet the standards described in Code of Federal Regulations (CFR), Title 42, section 422.629. *(Contract Amendment A25, Exhibit A, Attachment 14, Provision 2)*

The Plan shall develop, implement, and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of medical care services through establishment of criteria for approving, modifying, deferring, or denying requested services. *(Contract Amendment A16, Exhibit A, Attachment 5 (1)(D))*

A beneficiary with other health coverage is not entitled to receive health care benefits and services under the Medi-Cal schedule of benefits until the other health care coverage has been exhausted or denied. *(California Code of Regulations (CCR), Title 22, section 50761)*

If the Plan expects to issue a partially or fully adverse medical necessity decision based on the initial review of the request, the Plan's determination must be reviewed by a physician or other appropriate health care professional with expertise in the field of medicine or health care that is appropriate for the services at issue, including knowledge of Medicare and Medicaid coverage criteria, before the Plan issues the determination decision. *(CFR, Title 42, section 422.629(k)(3))*

Finding: The Plan did not ensure its appeal process for dual eligible members included a review of criteria for covered services under the Medi-Cal program.

The Plan's policy, *Member Appeal Process for Medi-Cal Only Benefits (published March 2023)*, states that the member or member's representative will be informed of the Medical Director's decision by mailed correspondence. However, this policy does not describe the Plan's process to cite Medi-Cal criteria in decision letters when there is non-coverage by Medicare.

A sample of 18 appeal cases were selected for a verification study. For three of 18 verification study cases, dual eligible members appealed prior authorization denials for compression stockings, a pneumatic compressor, and a power operated vehicle. The Plan's delegate initially denied these authorization requests based solely on Medicare

criteria without a subsequent Medi-Cal criteria review. Furthermore, during the appeal process for these three samples, the Plan upheld the delegate's denials based on Medicare criteria alone without conducting a Medi-Cal criteria review. The Plan's notices of resolution informed members of its decision to uphold prior authorization denials that only utilized Medicare criteria as a basis.

In a written response, the Plan stated that the three verification study appeal samples did not require a Medi-Cal criteria review. However, Medi-Cal authorization criteria exists for these services denied by the Plan. Whether the Plan upholds or overturns a denial, criteria should be cited in decision letters to assist members in navigating their Medi-Cal coverage benefits.

When the Plan does not review for Medi-Cal criteria during the appeals process for dual eligible members, this can lead to denials, delays in obtaining covered and medically necessary services, and may result in member harm.

Recommendation: Revise and implement policies and procedures to ensure the Plan's appeal process for dual eligible members includes a review of criteria for covered services under the Medi-Cal program.

❖ COMPLIANCE AUDIT FINDINGS ❖
PLAN: Senior Care Action Network (SCAN) Health Plan
AUDIT PERIOD: March 1, 2022 through February 28, 2023 **DATES OF AUDIT: June 5, 2023 through June 16, 2023**

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Timely Grievance Acknowledgment

The Plan shall provide written acknowledgement within five-calendar-days of receipt of the grievance. The acknowledgement letter shall advise the member that the grievance has been received, the date of the receipt, and provide the name, telephone number, and address of the representative who may be contacted about the grievance. *(Contract Amendment A25, Exhibit A, Attachment 14, Provision 3)*

The Plan must provide written acknowledgement to the member that is dated and postmarked within five-calendar-days of receipt of the grievance. *(All Plan Letter 21-011)*

The Plan's policy GA-0033, *Medi-Cal Grievance Resolution Process (published November 2022)*, states that written acknowledgment of the grievance request will be provided to the member or the member's authorized representative within five-calendar-days.

Finding: The Plan did not send acknowledgement of grievance receipt notices to members within five-calendar-days.

The Plan's policy, GA-0033, states that the Grievance and Appeal Department (GAD) Coordinator will validate the information or documentation received, the member's eligibility, and request additional information as needed. The GAD Coordinator will also create and mail the acknowledgment letter to the member or member's authorized representative within five-calendar-days from receipt of the request. Additionally, GAD will perform monitoring and oversight of the process to ensure the receipt, review, and resolutions of grievances. Priority metric reports, such as the GAD Monthly Operation Report, regarding timeliness of all grievances will be submitted to the Compliance Department.

A verification study of grievances found that the Plan did not have timely acknowledgement letters. Five of 29 quality of care and three of 27 quality of service grievance samples had acknowledgement letters sent between six to 25-calendar-days.

In an interview, the Plan stated that an unanticipated increase in grievances led to acknowledgement letters sent beyond five-calendar-days. An analysis of the Plan's grievance log found that grievance volume increased nearly 34 percent during the audit

period. The untimely acknowledgement letters were attributed to an increase in grievances and a shortage of staff. A review of the organizational chart submitted by the Plan, shows four vacancies in their GAD.

Additionally, the Plan's database system does not notify Plan staff if acknowledgment letters are sent to members. Review of the GAD Monthly Operation Report showed that the Plan tracks grievance rates, however it does not include tracking of timely acknowledgements.

When the Plan does not send grievance acknowledgment letters to its members within the five-calendar-day time limit, members may not know if their grievances are processed in a timely manner, and it may delay their ability to address potential quality of care issues.

Recommendation: Implement policies and procedures to ensure the Plan acknowledges dually eligible members' Medi-Cal grievances within five-calendar days of the grievance receipt.

4.2	CULTURAL AND LINGUISTIC SERVICES

4.2.1 Language Assistance Taglines

The Plan shall have a Cultural and Linguistic Services Program that incorporates the requirements of CCR, Title 22, section 53876. The Plan shall monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. *(Contract Amendment A16, Exhibit A, Attachment 9, Provision 12 & 13)*

The top 15 non-English languages spoken by Limited English Proficiency (LEP) individuals in California, as identified by the US Department of Health and Human Services Office for Civil Rights in 2016, are Arabic, Armenian, Cambodian, Chinese, Farsi, Hindi, Hmong, Japanese, Korean, Punjabi, Russian, Spanish, Tagalog, Thai, and Vietnamese. Although state law only requires that Plans use taglines for the top 15 non-English languages in California, DHCS also requires the addition of taglines in Laotian, Ukrainian and Mien. *(APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services)*

Finding: The Plan's Language Assistance Taglines excluded two non-English languages, Mien and Ukrainian.

A review of the Member Handbook and all grievance and appeal letters found an accompanying Language Assistance Tagline attachment excluding two non-English languages, Mien and Ukrainian.

The Plan utilizes Centers for Medicare and Medicaid (CMS) guidelines instead of DHCS APL 21-004 standards in determining the languages to include in the Language Assistance Tagline attachment. The Plan acknowledged it received approval from DHCS regarding its Language Assistance Tagline attachment. However, review of the Submission Review Form completed by the DHCS Managed Care Operations Division, Contract Oversight Branch only demonstrates an approval of the Plan's policies impacted by APL 21-004, titled *Access and Availability to Linguistic Services* and *Discrimination Grievance Process*. The Submission Review Form excluded any approval for the use of a Language Assistance Tagline attachment per CMS guidelines.

When the Plan does not provide informing materials in all required 18 non-English Language Assistance Taglines, LEP members who require language assistance services may not know how to access them and resolve issues when they arise.

Recommendation: Revise the Language Assistance Tagline template to include all 18 non-English languages per APL 21-004.