MEDICAL REVIEW BRANCH – SOUTHERN SECTION IV
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, 2019
Through
February 29, 2020

Report Issued: June 10, 2020

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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 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, 51 hospitals, 3,428 primary care physicians, and 4,661 specialists to provide a full range of Medicare Advantage product lines.

As of March 2020, the Plan had a total enrollment of 216,961 Medicare Advantage members, of which 14,626 were enrolled as dual eligible members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of DHCS medical audit of the Plan for the period of March 1, 2019 through February 29, 2020. The onsite review was conducted from March 2, 2020 through March 11, 2020. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference was held on May 22, 2020. 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 did not submit any additional information.

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, 2018 through February 28, 2019) was issued June 28, 2019. The Corrective Action Plan (CAP) closeout letter was sent to the Plan on November 19, 2019. This year's audit examined documentation to determine implementation and effectiveness of the Plan's CAP.

The summary of 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.

Review of delegated utilization management oversight 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

During the prior year audit, the Plan did not enforce its delegated medical group's compliance with accessibility requirements. The Plan corrected the deficiency by implementing a new escalation process for delegates. This year's audit verified the implementation of the Plan's revised process.

Review of the Plan's access and availability of care yielded no findings.

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

Category 4 – Member's Rights

During the prior year audit, the following findings were noted:

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 corrected the deficiency by training staff and implementing revised policies and procedures.

The Plan did not use the updated standardized "Your Rights" template to notify members about new requirements and filing timeframes for a State Hearing. The Plan corrected the deficiency by including the appropriate template to ensure compliance.

The Plan did not classify and process all members' complaints as grievances. The Plan corrected the deficiency by training staff and implementing revised policies and procedures.

This year's audit verified implementation of the Plan's corrective actions and revised procedures regarding prior year audit findings.

The Plan is required to provide information that is written at a sixth grade reading level to ensure members' understanding and ability to make informed health decisions. Grievance acknowledgement and resolution letters sent to members were written above the sixth grade reading level. The Plan did not have a monitoring system in place to ensure written information provided to members contained the required reading level.

Category 5 – Quality Management

During the prior year audit, the Plan did not ensure training was conducted for newly contracted providers within the required ten-working-day timeframe. The Plan corrected the deficiency by implementing revised procedures to ensure compliance. This year's audit verified implementation of the Plan's revised procedure.

Review of the Plan's program to train newly contracted providers 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 onsite review was conducted from March 2, 2020 through March 11, 2020. 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: 19 medical and 20 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: 21 medical and 20 pharmacy prior authorization appeal requests were reviewed for appropriate and timely adjudication.

Delegated Prior Authorization Requests: 21 requests were reviewed for appropriate adjudication.

Category 2 – Case Management and Coordination of Care

Complex Case Management: Ten medical records were reviewed for evidence of continuous tracking, monitoring, and coordination of services provided to members.

Non-Emergency Medical Transportation (NEMT)/Non-Medical Transportation (NMT): 16 NEMT and 15 NMT records were reviewed for compliance with transportation requirements.

Initial Health Assessment: 15 adult medical records were reviewed to confirm timely completion.

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: 20 quality of service grievances and 26 quality of care grievances were reviewed for timely resolution, appropriate response to complaint, and submission to the appropriate level for review.

Confidentiality rights: The single Health Insurance Portability and Accountability Act case reported in the audit period was reviewed for appropriate reporting and processing.

Category 5 – Quality Management

New Provider Training: Ten newly contracted providers were reviewed to determine if they received Medi-Cal Managed Care program training within the required time frame.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse Reporting: The five cases reported in the audit period were reviewed for proper reporting of suspected fraud, waste, or abuse to DHCS within the required time frame.

A description of the applicable finding is contained in the following report.

❖ COMPLIANCE AUDIT FINDINGS ❖
PLAN: Senior Care Action Network Health Plan
AUDIT PERIOD: March 1, 2019 through February 29, 2020 **DATE OF AUDIT: March 2, 2020 through March 11, 2020**

CATEGORY 4 - MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Reading Level of Grievance Notification Letters

The Plan is required to ensure all written information provided to members is at a sixth grade reading level or as determined appropriate through Contractor's group needs assessment and approved by DHCS. The written member information shall ensure members' understanding of the health plan processes and ensure the member's ability to make informed health decisions. *(Contract, Exhibit A, Attachment 13(4)(D))*

Finding: Grievance acknowledgement and resolution letters sent to members were not written at a sixth grade reading level. The Plan did not have a monitoring system in place to ensure written information provided to members contained the required reading level.

The Plan did not have policies and procedures in place that addressed the required reading level to ensure members' understanding of grievance acknowledgement and resolution letters. Grievance notification letters sent to members contained lengthy and confusing language, such as, "We confirmed you were advised about the duties of a Caregiver, you were advised a Caregiver may not touch your medications". In addition, the verification study utilized results from *Flesch-Kincaid*, a computer application that calculates the readability level of written information, and identified four cases in which grievance acknowledgement and resolution letters contained reading levels that ranged from grade nine to college level.

During the onsite interview, the Plan confirmed that grievance acknowledgement and resolution letters sent to members were written at high grade levels and not at the required sixth grade reading level. The Plan further explained it did not have a monitoring system in place to ensure written grievance notification provided to members contained the required reading level.

Grievance acknowledgement and resolution letters not written at the required sixth reading grade level may lead to confusion and misunderstanding of the health plan processes, and ultimately cause members to make poor health care decisions.

Recommendation: Develop and implement procedures to monitor and ensure grievance notification letters are provided at the required reading level.