DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

May 4, 2023

Sharrah White
Regulatory Affairs & Compliance Administrator
Senior Care Action Network Health Plan
3800 Kilroy Airport Way, Suite 100
Long Beach, CA 90806

RE: Department of Health Care Services Medical Audit

Dear Ms. White:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of Senior Care Action Network Health Plan, a Managed Care Plan (MCP), from March 7, 2022 through March 17, 2022. The audit covered the period of March 1, 2021 through February 28, 2022.

All items have been evaluated and DHCS accepts the MCP's submitted Corrective Action Plan (CAP). The CAP is hereby closed. The enclosed documents will serve as DHCS' final response to the MCP's CAP. Closure of this CAP does not halt any other processes in place between DHCS and the MCP regarding the deficiencies in the audit report or elsewhere, nor does it preclude the DHCS from taking additional actions it deems necessary regarding these deficiencies.

Please be advised that in accordance with Health & Safety Code Section 1380(h) and the Public Records Act, the final audit report and final CAP remediation document (final Attachment A) will be made available on the DHCS website and to the public upon request.

If you have any questions, please reach out to CAP Compliance personnel.

Sincerely,

[Signature on file]

Oksana Meyer, MPA
Chief, CAP Compliance & FSR Oversight Section
Managed Care Quality & Monitoring Division
Department of Health Care Services

Enclosures: Attachment A (CAP Response Form)

cc: Lyubov Poonka, Chief
CAP Compliance Unit
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Department of Health Care Services

Diana O'Neal, Lead Analyst
CAP Compliance Unit
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ATTACHMENT A
Corrective Action Plan Response Form

Plan: SCAN

Review Period: 03/01/2021 – 02/28/2022

Audit Type: Medical Audit

Onsite Review: 03/07/2022 – 03/17/2022

MCPs are required to provide a CAP and respond to all documented deficiencies included in the medical audit report within 30 calendar days, unless an alternative timeframe is indicated in the CAP Request letter. MCPs are required to submit the CAP in Word format that will reduce turnaround time for DHCS to complete its review. According to ADA requirement, the document should be at least 12 pt.

The CAP submission must include a written statement identifying the deficiency and describing the plan of action taken to correct the deficiency, and the operational results of that action. The MCP shall directly address each deficiency component by completing the following columns provided for MCP response: 1. Deficiency Number and Finding, 2. Action Taken, 3. Implementation Documentation, and 4. Completion/Expected Completion Date. The MCP will be required to include project timeline with milestones in a separate document for each finding. Supporting documentation should accompany each Action Taken. If supporting documentation is missing, the MCP submission will not be accepted. For policies and other documentation that have been revised, please highlight the new relevant text, and include additional detail such as title of the document, page number, revision date, etc. in the column "Supporting Documentation" to assist DHCS in identifying any updates that were made by the plan. For deficiencies that require short-term corrective action, implementation should be completed within 30 calendar days. For deficiencies that may be reasonably determined to require long-term corrective action for a period longer than 30 days to completely remedy or operationalize, the MCP is to indicate that it has initiated remedial action and is on the way towards achieving an acceptable level of compliance. In those instances, the MCP will be required in addition to the above steps, to include the date when full compliance will be achieved. Policies and procedures submitted during the CAP process must still be sent to the MCP's Contract Manager for review and approval, as applicable in accordance with existing requirements.

Please note, DHCS expects the plan to take swift action to implement improvement interventions as proposed in the CAP, therefore DHCS encourages all remediation efforts to be in place no later than month 6 of the CAP, unless prior approval for an extended implementation effort is granted by DHCS.

DHCS will maintain close communication with the MCP throughout the CAP process and provide technical assistance to ensure the MCP provides sufficient documentation to correct deficiencies. Depending on the volume and complexity of deficiencies identified, DHCS may require the MCP to provide weekly updates, as applicable.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
1. Utilization Management				
1.2.1 NOA Benefit Determination Contact Information The Plan did not ensure NOA notification submitted to providers contained the name and direct telephone number of the Plan decision maker.	SCAN utilizes the CMS required Integrated Denial Notice (IDN)/Coverage Decision Letter for the notice of unfavorable decisions. SCAN developed and implemented processes to include decision maker name and direct number when notifying a provider of benefit determinations. The provider is notified by faxing the decision notification including the IDN/Coverage Decision Letter and Fax Cover Sheet which includes the name and contact information of the decision maker. In the event the provider notification fax fails, the notification will be mailed via US Postal mail. The SCAN's Medical Management Department has implemented the following corrective actions: • Development of a fax coversheet to include decision maker name and contact for provider	• 70614 FAX Cover Sheet – Auth and Denial UM - CA • Member and Provider Correspondence DTP Eff 033122	Full implementation Date: March 20, 2022	The following documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** • DTP: Member and Provider Correspondence publication date 9/2/22, instructs staff to include the FAX coversheet that includes Decision Maker Name and direct contact information. In the event the provider notification fax fails three (3) attempts, the notification will be mailed via US Postal mail and documented in the Notes section. **MONITORING & OVERSIGHT** • SCAN Medical Management leadership team monitors for inclusion of the decision maker's contact information on the FAX coversheet during final review and approval of the provider notification. **TRAINING** • FAX coversheet was developed to include decision maker name and contact for provider written notification of adverse decision. **The Corrective Action Plan for Finding 1.2.1 is accepted.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	written notification of adverse decision • Implementation of new FAX cover sheet with the IDN/Coverage Decision Letter • Update and implement adverse decision provider notification process, including notification, monitoring and auditing processes.			
1.2.2 State Fair Hearing (SFH) Timeframe Extension The Plan did not ensure written NOA attachments included information to notify members of the extended timeframe to request a SFH.	The plan's Medical Management Team is developing and implementing an updated denial notice to include language to inform the member of the correct timeframe in which to request a State Fair Hearing in accordance with the most current APL requirement and the Covid-19 public health emergency guidelines. The SCAN's Medical Management Department is implementing the following	• 70395 Coverage Decision – Eng – MediCal Only Benefit DRAFT	• Develop new denial notice template – Sept 2022 • Obtain approval new notice template – Oct 2022 • Request and obtain template language translations – Oct 2022 • Deactivate	The following documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** • Letter Template, "Coverage Decision Letter" (excluding the additional language) was implemented in February 2023, including Your Rights Denial Version, Antidiscrimination/MLI, and Member Addendum. The Member Addendum advises, "Members have 120 days from the date of the Notice of Appeal Resolution letter to request a State Fair hearing. Due to the current public health emergency, members have an additional 120 days (240 days total) to make a request." The letters are currently being provided using a manual process (not system generated). (Coverage Decision - Medi-Cal ONLY Benefit MANUAL USE). • Desktop Procedure, "Monitoring and Oversight of Organizational

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	corrective actions: • Develop new denial notice template to include required language and State Fair Hearing timeframe • Obtain approval of new denial notice template (Compliance and/or DHCS) • Request and obtain template language translations • Deactivate current denial notice in system (English) • Implement new denial notice process (English) – manual (dependent on approval) • Deactivate current denial notice in system (translated languages) – (dependent on receipt of translations) • Implement new denial notice process (translated languages) - manual		current notice in system (English) – Oct 2022 • Implement new manual process (English) – Oct 2022 • Deactivate current notice in system (translated) – Nov 2022 • Implement new manual process (translated languages) – Dec 2022 • Integrate new notice into system (all languages) – Feb 2023 • Full implementation: February	Determinations" (04/06/23) which demonstrates that the Medical Management Clinical Supervisor/Manager will review all denial letters and language contained prior to issuance and document review in the system. (DTP Monitoring and Oversight of Organization Determinations). • System Screenshot, "Follow Ups" (03/23/23) which demonstrates the documentation of supervisor review and approval of denial letters in the system. (Example of Manager Supervisor Documentation in System). **MONITORING & OVERSIGHT** • Monitoring Tool, "Denial Notification (Coverage Decision Letter) Review Tool" is used to ensure that the information to notify members of the extended timeframe to request a SFH is included in the member notice. (Denial Notification (Coverage Decision Letter) Review Tool 2023). **The Corrective Action Plan for finding 1.2.2 is accepted.**

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	• Integrate new denial notice into system (all languages)		2023	
1.3.1 Notice of Appeal Resolution (NAR) Written Notification 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 presently using the correct NAR templates with the appropriate "Your Rights" attachments, the three cases out of the 15 samples that were reviewed in the verification study contained human error in which incorrect letter templates were selected. After review of the three cases, the Dual eligible members who did not receive the NAR and "Your Rights" attachments were determined to be a staff training issue. Because this was an isolated issue, the Plan will continue monitoring dual cases for accuracy. Additionally, the Grievance and Appeals Department (GAD) Auditor will provide quarterly staff trainings related to these kinds of dual specific requirements. In an effort to ensure the letters		Full implementation Date: October 3, 2022	The following documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** • Updated P&P, "GA-0034, Member Appeal Process for Medi-Cal Only Benefits (Standard/Expedited)" (02/10/23) which has been updated to include the requirement to include the criteria used in the member's closure letter. • Revised Desk Top Procedure, "How To" Appendix Compendium (02/10/23) which outlines the steps for the Grievance & Appeals team members on how to complete tasks and processes related to the different workflows managed by the Department. For example, when generating the NAR template, it will have the system automatically generate the multi-language disclaimer as well as the applicable "Your Rights" attachment. **MONITORING & OVERSIGHT** • Monitoring Process, "DSNP Appeals Monitoring Process Description" (01/20/23) as evidence the Plan is validating 2-3 times a month to ensure an increased accuracy in the following area:

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	were easily understood by members and to stay within the 6th grade reading level, the Plan did not include the detailed criteria used in making appeal determinations. Moving forward, GAD Coordinator's will provide the criteria utilized in reaching the appeal determination within the written notification. Once the determination has been drafted by the Medical Director (MD), the GAD Coordinator will use the language level tools to meet the 6th grade reading requirement. All criteria language that is modified to meet reading level will be reviewed by the RN for accuracy prior to sending out the NAR letter to the member. SCAN's Grievance and Appeals Department has implemented the following corrective actions: • On-going quarterly training of dual requirements			• Correct letter templates are being generated for DSNP appeal cases • Monitoring Report, "Appeals January Monitoring Report" (01/23) which is conducted monthly. The Plan can validate that the appropriate DSNP letter template is being utilized for DSNP appeal cases (Column U). In addition, the Plan is also validating that the criteria is being used for Medi-Cal benefit appeal cases (Column G). In this report, the 10 cases reviewed had a 100% pass rate. • Email Notice, "DSNP Email Reminder" (02/08/23) as evidence the Plan will submit an email and notify the appeals team member when an DSNP appeal case was found to have the incorrect letter. The appeals team member will then issue the correct template. **Training** • Weekly Meeting, "Appeals Team Weekly Meeting" (12/22/22) this was a reminder/discussion of DSNP specific requirements. • PowerPoint Presentation, "Appeals Team Refresher" (01/2023) as evidence the Plan has reminded staff the importance of members receiving SFH rights on any letter that is providing unfavorable appeal information. **The Corrective Action Plan for finding 1.3.1 has been accepted.**

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	• Including criteria used in reaching appeal determinations			
1.5.1 Oversight of Utilization Management (UM) Delegate The Plan did not perform continuous monitoring of delegated prior authorizations to ensure the provision of Medi-Cal covered services for dual eligible members.	The current supplemental report is being enhanced to identify prior authorization denials for code sets typically covered by Medi-Cal. This report will be reviewed monthly by SCAN's Medical Management Department. Any identified Medi-Cal eligible services will be evaluated for authorization by SCAN. Additional staffing will be needed to conduct this review. The Medical Management department to add 2 full- time employees. The annual Utilization Management (UM) audit will use the revised supplemental report to conduct a focused file review for the UM audit, enhancing the oversight for dual members.	A desktop procedure for the monthly UM review (still in development)	• Supplemental Report Enhancements – December 2022 • Monthly Review of UM Denials – January 2023 • Full implementation Date: January 2023	The following documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** • Plan has confirmed Delegate (PrimeCare, part of Optum) has an established process to forward prior authorization requests to Plan for final determination when carved out from Medicare: • Optum Carve Out Policy and Workflow 12-01-04-073 Carve out determinations are made depending on the member's health plan requirements. Plan will determine if services are carved out. Carve out letters will be provided to member and requesting physicians when it is determined that the member's health plan is responsible for services being requested. Copy of referral is sent to the health plan. • SCAN Policy UM-0013 (9/28/21) Organization Determination Process Plan policy outlines the process for the receipt, decision, and notification of decision to the member and requesting provider of requests for organization determinations. Requests are reviewed for: Member eligibility, Benefit Coverage and Medical

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	The plan's Delegation Oversight Unit (DOU) and Medical Management Department are implementing the following corrective actions: • Supplemental Report Enhancements • Monthly Review of UM Denials • Focused file review in annual UM audits			Necessity. Medi-Cal ONLY services for dually enrolled members are administered by SCAN according to eligibility, benefit structure, and Medi-Cal coverage criteria. **MONITORING & OVERSIGHT** • Provider Communication to be distributed in February 2023 Provider Today Publication informs providers of their responsibilities relating to Medi-Cal dual eligible members. • Updated supplemental report is used to identify prior authorization denials codes normally covered by Medi-Cal. The report, initiated in January will be reviewed monthly for any identified Medi-Cal eligible covered services for authorization by SCAN. Plan will regularly monitor the supplemental report to ensure service requests are forwarded to the Plan when the initial determination indicates no coverage under Medicare. • Supplemental Report 202301 was as evidence the Plan is utilizing the report to identify certain denials of potential non-compliance. SCAN reviews each denial to ensure affected members receive appropriate benefits/services. Denials with the highest potential of member impact will be prioritized, however all denials are reviewed. • Plan UM audit tool has been updated to target select samples from the supplemental report for potential denial of Medi-Cal benefits, as well as P&P review to validate delegates are forwarding to SCAN. 1.5.1_2023

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				UM Audit Tool Excerpt 2023 UM audits started in March 2023. If a provider partner is found to be non-compliant, SCAN will request root cause analysis, and implement Corrective Action Plans to ensure provider partners rectify their processes. **The Corrective Action Plan for Finding 1.5.1 is accepted.**
3. Access and Availability of Care				
3.8.1 Physician Certification Statement (PCS) Form 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.	SCAN has revised the Policy and Procedure to ensure the receipt and completion of the PCS form, including an escalation process should the transportation broker be unable to secure the physician signature prior to providing the transport. This will ensure the necessary review and signature is obtained and recorded in a timely and efficient manner. See SCAN Policy and Procedure Policy Title: Non-Emergency Medical (NEMT) and Non-Medical (NMT) Transportation (Medi-Cal), SCAN Desk-Top Process (DTP) Desktop Title: DTP: Non-Medical Transportation (NMT) and Non-Emergency Medical	• DTP: Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) Eff 08152022 • Policy Procedure: Non-Emergency Medical (NEMT) and Non-Medical (NMT) Transportation (Medi-Cal)	• Transportation Vendor to implement updated PCS SOP - 11/29/2021 • Monthly NEMT Trip Monitoring/JOC Review - 2/1/2022 • Delegation of new transportation vendor for NEMT trips - 1/1/2023 • Full implementation Date:	The following documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** The Plan updated P&Ps to address the gap that contributed to the deficiency: • Procedure "CA Medi-Cal PCS SOP #2021-003" demonstrates the Plan has a process to ensure Physician Certification Statement (PCS) Forms are collected for members requiring NEMT services, prior to services being rendered, that are more than 75 miles one way. [4.0 Procedures, Page 1] • SCAN is a Fully Integrated Dual Eligible Special Needs Plan ("FIDE-SNP") through a Medicare Advantage contract with CMS & a limited scope Medi-Cal services contract with DHCS. Under this arrangement, Medicare services are primary & Medi-Cal services are secondary for dual eligible members enrolled under SCAN's contract with DHCS. Plan policies describe the process in which the NEMT & NMT transportation

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	Transportation (NEMT), and Modivcare "California Medi-Cal Physician's Certification Statement" Standard Operating Procedure #2021-003. SCAN transportation broker will be delegated to request prior authorization for NEMT trips exceeding 75-miles. Transportation broker will make two attempts at obtaining physician signature from requesting party. If a signature was not able to be obtained, transportation broker will contact SCAN Medical Management to review request and obtain proper physician signature. SCAN continues to work with current contracted vendor to ensure requirements are met and implemented. Current vendor contract will be terminating December 31, 2022. SCAN is collaborating with new	Eff 081522 • PCS Form Process - 20211129 California PCS Form SOP 2021-003	January 1, 2023	benefit is administered under the Medi-Cal segment of coverage once the transportation benefit is exhausted under Medicare (trips greater than 75 miles or outside of the benefit). [See Plan Response, MCP Response 01-08-23] **OVERSIGHT & MONITORING** The Plan identified, developed and deployed an internal auditing process to continuously self-monitor to detect and prevent future non-compliance: • Plan Document "DHCS Follow-Up Request" cites contract agreement "Fully-Managed Transportation Vendor Agreement" which demonstrates the transportation broker has a process in place to monitor & oversee the compliance of contracted transportation providers – no-show frequency (quarterly), provider punctuality (quarterly), grievance rates (quarterly), & door-to-door services (monthly). • Plan Response "MCP Response 12-07-22" demonstrates the Plan conducts biweekly broker meetings & receives monthly trip logs from the transportation broker which are reviewed & audited for identification of trips requiring PCS forms. Should the broker not fulfil contract requirement of obtaining PCS form signature, a corrective action plan is required as well as monetary sanctions. **The Corrective Action Plan for Finding 3.8.1 is accepted.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	vendor to establish a contract and scope of work that includes all requirements including monthly review of NEMT trips more than 75-miles and ensure proper documentation and signatures are obtained. NEMT trips requiring physician signature will be reviewed during tri-annual JOC meetings with the new transportation broker starting in January 2023. The plan's Medical Management and Product Development Departments are implementing the following corrective actions: • SCAN Transportation broker to implement updated PCS Standard Operating Procedure #2021-003 • SCAN to monitor NEMT trips monthly to ensure appropriate documentation is obtained. Review findings during monthly			

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	Joint Operating Committee (JOC) meeting with 2022 transportation vendor. • New SCAN transportation provider will be delegated in contract to obtain physician signature for NEMT trips in 2023.			
3.8.2 Transportation Provider Medi-Cal Enrollment The Plan did not ensure subcontracted transportation providers were enrolled in the Medi-Cal program.	SCAN's transportation broker has implemented processes to perform monthly transportation provider verification and ensure all transportation providers are deemed eligible to transport SCAN Connection and Connections at Home members under APL 19-004 guidelines. SCAN's transportation broker will implement a monthly review process to monitor and record the status of all transportation providers used to transport SCAN Connections and SCAN Connections at Home members to ensure appropriate eligibility. Transportation providers	• 20220816 MODV CA Provider Enrollment SOP	• SCAN Transportation Vendor to implement monthly process - 3/1/2022 • Contract with New SCAN Transportation vendor - 1/1/2023 • Delegation of New SCAN transportation for monthly provider verification -	The following documentation supports the MCP's efforts to correct this finding: **POLICIES & PROCEDURES** The Plan updated P&Ps to address the gap that contributed to the deficiency: • Plan procedure "DHCS Transportation Provider Process" demonstrates the broker will remove any provider who does not have proof of Medi-Cal enrollment or current application pending. The provider's status will be changed to "inactive", unless such removal will create an access barrier for Medi-Cal members, at which point will require health plan approval to continue use of providers not enrolled, until additional enrolled providers can be contracted. **OVERSIGHT & MONITORING**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	deemed “approved” will be utilized to provide transportation services for SCAN Connections and SCAN Connections at Home members. See Modivcare “California Medi-Cal Provider Enrollment Verification” Standard Operating Procedure #2021-001 SCAN continues to work with current contracted vendor to ensure requirements are met and implemented. Current vendor contract will be terminating December 31, 2022. SCAN is collaborating with new vendor to establish a contract and scope of work that includes all requirements including The plan has implemented the following corrective actions: • SCAN Transportation broker to implement monthly process to screen and monitor transportation providers		1/1/2023 Full implementation Date: January 1, 2023	The Plan identified, developed, and deployed an internal auditing process to continuously self-monitor to detect and prevent future non-compliance: • Plan policy “SOW_Agreement SCAN_SafeRide” demonstrates the following: o The transportation broker will monitor & oversee the compliance of enrollment status of transportation providers. (Monthly) [Page 23, 2.18.4] o The broker will monitor & oversee DHCS approved drivers on a monthly basis through the DHCS portal. [Page 23, 2.18.5] o NMT/NEMT providers are able to transport members up to 120 days, pending the outcome of DHCS enrollment process. [Page 23, 2.18.6] • Vendor Workflow “DHCS Transportation Workflow” demonstrates the onboarding process for transportation providers. The network team cross checks the transportation roster monthly to verify enrollment for all providers. If provider is not listed, broker does not use these providers for 75+ miles & removes them from roster. • 2023 SafeRide DHCS Network_Transpor Roster o The roster demonstrates that since implementation of new transportation broker, all transportation providers have been confirmed as enrolled with Medi-Cal. **The Corrective Action Plan for Finding 3.8.2 is accepted.**

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	within the DHCS Approved NMT Provider System. • New SCAN Transportation vendor is being contracted to provide supplemental transportation services for SCAN Connections and SCAN Connections at home members beginning January 2023. • New SCAN transportation provider will be delegated in contract to perform monthly provider verification under DHCS APL 19-004 requirements.			

Submitted by: [redacted] **Date: 9/23/22**
Title: CVP Compliance Officer, Chief Risk Executive