State of California—Health and Human Services Agency
Department of Health Care Services

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November 19, 2019

Ginette Hawkins, MSW
Director of Regulatory Affairs and Compliance
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. Hawkins:

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 18, 2019 through March 22, 2019. The survey covered the period of March 1, 2018 through February 28, 2019.

On November 15, 2019, the MCP provided DHCS with additional information regarding its Corrective Action Plan (CAP) in response to the report originally issued on June 28, 2019.

All items have been reviewed and DHCS accepts the MCP's submitted CAP. The CAP is hereby closed. Full implementation of the CAP will be monitored on the subsequent audit. The enclosed report will serve as DHCS' final response to the MCP's CAP.

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

If you have any questions, feel free to contact me at (916) 345-7831 or Joshua Hunter at (916) 345-7830.

Sincerely,

Original Signed by

Michael Pank, Chief
Compliance Unit

Enclosures: Attachment A CAP Response Form

cc: Manual Munoz, Contract Manager
Department of Health Care Services
Medi-Cal Managed Care Division
P.O. Box 997413, MS 4408
Sacramento, CA 95899-7413

ATTACHMENT A
Corrective Action Plan Response Form

Plan: SCAN **Review Period: 3/1/18 – 2/28/19**

Audit Type: DHCS Medical Audit **Onsite Review: 3/18/19 – 3/22/19**

MCPs are required to provide a CAP and respond to all documented deficiencies within 30 calendar days, unless an alternative timeframe is indicated in the letter. MCPs are required to submit the CAP in word format that will reduce turnaround time for DHCS to complete its review.

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. For deficiencies that require short-term corrective action, implementation should be completed within 30 calendar days. For deficiencies that require long-term corrective action or a period longer than 30 calendar days for implementation, the MCP must demonstrate it has taken remedial action and is making progress toward achieving an acceptable level of compliance. The MCP will be required to include the date when full compliance is expected to be achieved. **Policies and procedures submitted during the CAP process must still be sent to the MCP's Contract Manager for review and approval in accordance with existing requirements.**

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
3. Access and Availability of Care				
3.1.1 Access Requirements				
The Plan did not enforce its delegated medical group's compliance with accessibility requirements and did not ensure the delegate conducted the required annual access to care	Delegation Oversight Unit (DOU) implemented an escalation process to escalate consecutive repeat deficiencies as a result of an audit and/or Corrective Action Plan (CAP) to	1.DO-052 - Performance Oversight Workgroup Escalation	October 1, 2019	**08/21/19** – The following documentation supports the MCP's efforts to correct this finding: - Desktop procedure,

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survey. Although the Plan has a policy and procedure in place for corrective action and escalation process for non-compliant delegates, the Plan did not effectively implement the procedures to this delegate.	the Network Performance Committee (NPC) and/or Performance Oversight Workgroup for discussion, recommendations, and next steps to ensure timely remediation. This includes an improved documented escalation process that involves collaboration with Network Management leadership to engage in more frequent communications with the delegates to address areas of non-compliance in a timelier manner; i.e., having Medical Director to Medical Director conversations with the delegate to resolve issues. Escalation Workgroup formed to meet monthly prior to committee/workgroup meetings to discuss delegates that have unresolved non-compliance issues.	2. Escalation Process Improvement Workflow		"DO-052: Performance Oversight Workgroup Escalation Process" (08/05/19) as evidence that manager and staff receive guidance on the process to escalate issues that meets criteria to the Performance Oversight (PO) and Escalation workgroup. MCP desktop procedure standardizes escalation process for repeat deficiencies in consecutive audits. - Escalation Process Workflow (09/01/19) demonstrates the improved escalation process. **09/20/19** – The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding:

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				- Network Performance (NPC) workgroup meeting minutes (04/02/19 and 05/13/19) which provide evidence of documented review and discussion of the delegate's noncompliance of conducting an annual access to care survey. Meeting as evidence that this deficiency was escalated to NPC for further actions to correct this deficiency (page 20 and 23). - Provider Oversight (PO) Escalation Meeting minutes (09/12/19) which provide documented review and discussion of delegate's noncompliance of conducting the annual access to care survey. Meeting minutes as evidence that

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				collaboration amongst MCP PO Escalation workgroup and delegates to resolve deficiency in a timely manner. In this meeting, staff determined actions that need to be taken and next steps if MSO is unable to provide an access study by October. MCP's VP Medical Director contacted the delegate's CEO to reiterate the importance of their compliance in this area. If non-compliance is not resolved, Escalation Workgroup plans to freeze panels to new member enrollments (page 2). **10/28/19** – The following additional documentation submitted supports the MCP's subsequent efforts to correct this finding:

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				- Tracking log, "2019 Annual Evidence of Access to Care – AMG" as evidence of delegate's access to care survey. Delegate conducted the annual access to care survey and providers who were noncompliant were placed in a corrective action by the delegate. - PO Workgroup meeting minutes (10/03/19) which provide evidence of documented review and discussion that the access study was received by the new MSO and the issue was closed. **This finding is closed.**

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4. Member Rights				
4.1.1 Member Grievance System and Oversight				
The Plan did not send written acknowledgement letters to members upon receipt of a grievance. In addition, the Plan did not send resolution letters within the 30 calendar day timeframe. Although the Plan has a policy and procedure in place for Medi-Cal timely grievance notification and resolution to members, the verification study for quality of service grievances demonstrated the following: • The Plan did not send acknowledgment letters to members in 13 occasions. • The Plan did not send resolution letters to members within the required 30 days in eight occasions. The resolution letters were late by a median of 22 days.	Effective April 30, 2019 the Grievance and Appeals Department (GAD) Auditor will run weekly reports of all dual members with grievance cases, to determine whether cases are categorized correctly. As a part of the review, the GAD Auditor documents the case with any corrections and tracks all true Medi-Cal cases to ensure the acknowledgement letter is mailed timely. All performance issues and feedback is provided to the Grievance Supervisor for coaching to staff.	Revised P&P DHCS Grievance Resolution Process	April 30, 2019	**09/24/19** - The following documentation supports the MCP's efforts to correct this finding: - Updated P&P, "GA-0033: Medi-Cal Grievance Resolution Process" (08/05/19) which has been amended to validate whether grievances are categorized correctly and acknowledgement letters are mailed timely (page 3). **10/17/19** – The following additional documentation submitted supports the MCP's efforts to correct this deficiency: - Written response describing MCP monitoring process. All Medi-Cal cases are

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				reviewed weekly by GAD auditor who validates that appropriate acknowledgement letters are generated timely. Prior to closure, all cases must be approved by management, who validates that appropriate resolution letters are generated timely. - Desktop Procedure, "Open Cases – Spot Check" has been revised to ensure correct acknowledgement and resolution letters are being generated timely on all Medi-Cal cases. Spot Check reports are run 2-3 times per week by GAD auditor who validates acknowledgement letter

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				is generated timely. Prior to closing, all cases are reviewed by GAD auditor who validates resolution letters are generated timely. **This finding is closed.**
4.1.2 Capturing Grievances				
4.1.2 The Plan did not classify and process all member expressions of dissatisfaction as grievances. Although the Plan has a grievance desktop procedure, it is not effectively implemented to capture and code grievances for expressions of dissatisfaction. Ten inquiries were reviewed to 'confirm the Plan opened grievance cases on members' expressions of dissatisfaction. The Plan Grievance and Appeal Department (GAD) returned two inquiries to Member Service Department (MSD) for	Lack of communication between Grievances and Appeals and Member Services on inquiries with insufficient information resulted in cases that were improperly processed. There was no follow up from either department on cases that lacked adequate information required to begin the grievance process. In order to prevent the improper processing of cases the Grievance and Appeals Triage Specialists have been trained to set up and assign all grievance cases where a member	N/A	August 1, 2019	**09/24/19** - The following documentation supports the MCP's efforts to correct this finding: - An email (07/24/2019) which includes a layout and notes from the MCP's recent Grievance Meeting has been sent out for review to team members to confirm their understanding of the process to have employees confirm with an attached voting tool,

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insufficient information and GAD dismissed six inquires for lack of information, such as valid Power of Attorney or Appointment of Representative (AOR). Therefore, expressions of dissatisfaction were not properly processed as grievances. A function of the Plan's Member Service Department is to assist members during inquiry calls to resolve the issue, and any oral expression of dissatisfaction shall be coded as a grievance. The Plan acknowledged that during the initial intake of members' inquiries, they did not gather sufficient information before assigning the case to the Grievance and Appeal Coordinator to proceed with the investigation and resolution. Furthermore, there was no communication between the Member Service Department, and the Grievance and Appeal Department to ensure inquiries were monitored and processed	expresses dissatisfaction. The Triage Specialists assign the cases to a Grievance Coordinator who will make 3 attempts to obtain any information required to investigate the member's expression of dissatisfaction.			and attaching questions for any follow up. - Updated Desktop Procedure, "Grievance DTP" (rev. 2/27/18) as evidence that the member service staff received guidance on how to distinguish inquiries from grievances. The DTP included direct links to reference material to assist them in processing grievances as they came in. This includes a link to the Grievance Decision Tree - Medi-Cal Grievance Resolution Process, "Policy Number: GA-0033" (02/01/2017) has been revised to indicate GAD will validate member grievances are categorized correctly.

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as grievances.				Feedback is provided to staff and supervisors to enable corrections to be made within the mandated timeframes. - Flow chart describing "How to Classify an Incoming Call" - Grievance vs. inquiry, to assist in the grievance process to ensure beneficiaries are receiving the proper channels of support and being routed for assistance. **This finding is closed.**
4.1.3 State Hearing Notice of Action (NOA) "Your Rights" Attachments				
The Plan did not use the updated standardized "Your Rights" template to notify members about new requirements and filing timeframes for a State Hearing. Although the Plan	The plan will remove "NOA" and "Your Rights" attachments from the grievance closure template. The NOA and Your Rights attachments will be included in appeals templates as required in APL 17-006.	**N/A**	**August 9, 2019**	**09/25/19** -The following documentation supports the MCP's efforts to correct this finding: - MCP submitted a non-Knox Keene Your

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has a policy and procedure in place, it is not effectively implemented to notify members of their rights ·in the event the Plan does not adhere to the notice and timely requirements. The Plan's existing template did not meet the new requirements and did not contain critical information requiring members to exhaust the Plan's internal appeal process before requesting a State Hearing. The verification study demonstrated the following: • The Plan did not include the updated standardized NOA "Your Rights" attachment in nine grievance cases. • The Plan did not include NOA "Your Rights" attachment in four grievance cases.				Rights attachment. MCQMD confirmed with MCOD that MCP is Knox-Keene licensed. While MCP is primarily a Medicare plan, MCOD confirmed that MCP's current contract does not exempt MCP from offering IMRs to Medi-Cal members. **10/17/19** – The following additional documentation submitted supports the MCP's efforts to correct this deficiency: - Current DHCS approved sample template letters and Knox-Keene licensed Your Rights attachment. Note: For the Medi-Cal only benefit, MCP does not utilize the "Modify" template letter in an effort to communicate decisions

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				clearly to the members. - Desktop Procedure, "Open Cases – Spot Check has been revised to ensure correct acknowledgement and resolution letters are being generated timely on all Medi-Cal cases. Spot Check reports are run 2-3 times per week by GAD auditor who validates acknowledgement letter is generated timely. Prior to closing, all cases are reviewed by GAD auditor who validates resolution letters, along with appropriate Your Rights attachments are generated timely. **This finding is closed.**

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5. Quality Management				
5.2.1 Newly Contracted Provider Training				
The Plan is required to ensure that all providers receive training regarding the Medi-Cal managed care program in order to operate in full compliance with the contract and all applicable Federal and State statutes and regulations. The Plan is required to conduct training or provide information for all providers within ten (10) working days after the Plan places a newly contracted provider on active status. (Contract, Exhibit A, Attachment 7(5)) Contracted provider means a physician, nurse, technician, teacher, researcher, hospital, home health agency, nursing home, or any other individual or institution that contracts with contractor to provide medical services to members.	Network Management has instituted a business rule that all providers are to be added prospectively the first of the following month. Monthly reports are provided to the Network Management Administration team on the first of the month. In addition, we implemented regenerating the monthly report on day two and day three to capture any providers that could potentially have been missed in the first report due to system glitches when loading new providers to our SCAN operating system. Report includes all newly added providers for that current month. The Network Management Administration team is responsible for ensuring that the report is received timely and that all training packets are mailed promptly. Also, the team	N/A	April 17, 2019	**10/09/19** -The following documentation supports the MCP's efforts to correct this deficiency: - Desktop Procedure-Provider Orientation Packet (POP) for LA/RV/SB County Providers went into effect 4/17/19. The POP serves as evidence the MCP will conduct new provider orientation training within 10 working days of being placed on active status. Reports are generated on the first business day of the month that identify all new contracted providers. Additional reports are generated on the second and third

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(Contract, Exhibit E, Attachment 1 (19)) The Plan did not ensure provider training was conducted within 10-working-days. The verification study demonstrated twenty newly contracted providers did not receive training within the 10working-day requirement. The training was given between 13 to 60 days of providers being placed on active status. During the onsite interview, the Plan acknowledged their provider training tracking system is not able to fully capture all newly contracted providers. In addition, the verification study demonstrated that dates in 19 provider orientation packets and attestation forms sent to providers did not match the start date in tracking system; five providers' confirmation training date also did not match the	ensures that attestations / confirmation of receipt is collected and logged to meet the 10-day training requirement.			business days of the month to ensure providers missed or not captured in the first report are identified. All outreach efforts to obtain attestation are documented in the tracking log. - Updated P&P, "Provider Orientation Training - Connections Providers-pka: 0004" (07/12/2018) as evidence that the MCP has a policy in place to conduct new provider training within ten business days of being placed on active status. Network Management Administration Specialists (NMAS) are responsible for delivering Provider Orientation Training packets. Monthly reports are generated to

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dates in the tracking system. Without provider training to newly contracted providers, the Plan cannot ensure providers have the necessary information to provide adequate access to covered services to meet members' needs.				identify all new contracted providers. NMAS will reach out to provider offices if attestation is not received within designated timelines. All outreach efforts are tracked and logged. - Connections-New Physicians Tracking Log (07/19 – 09/19) as evidence that new provider training is being tracked. Additional fields have been added to the tracking log in an effort to track non-compliant providers. MCP working with appropriate departments addressing filtering errors and/or system glitches. System set to go into production in 10/19. **10/15/19** – The following

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				additional documentation submitted supports the MCP's efforts to correct this deficiency: - Written response (10/15/19) from MCP addressing tracking log – non-compliant notes involving system a glitch or manual process. System glitch: Process established (10/01/19) that addresses providers not captured after the second and third day reports generated. Process established to add providers who error out due to system processing delay. Manual process: Second review of final report added to desktop procedure that ensures any duplicates are

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				removed and all providers not listed in the first report are incorporated in the second report. -Email (11/07/19) provided MCP technical assistance pertaining to efforts to meet contractual timeframe requirements for new provider training. **This finding is closed.**

Signature: 

Submitted by: Chris Wing
Title: Chief Executive Officer, SCAN Health Plan

Date: August 13, 2019