REPORT ON THE MEDICAL AUDIT OF SENIOR CARE ACTION NETWORK HEALTH PLAN CALENDAR YEAR 2025

DHCS Audits and Investigations
Contract and Enrollment Review Division
San Francisco Section

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Audit Period: March 1, 2025 — December 31, 2025
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DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

TABLE OF CONTENTS

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 a full-service Knox-Keene license in 1984. The Plan contracted with the 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, Los Angeles, and San Diego counties. The Plan administers the FIDE-SNP Contract to dually eligible seniors and integrates care by providing a full range of Medicare and Medi-Cal services under a single managed care organization.

As of April 2026, the Plan has a total of 27,169 members enrolled. The Plan served 15,386 members in Los Angeles County, 5,150 members in Riverside County, 3,879 members in San Bernardino County, and 2,754 members in San Diego County through the FIDE-SNP line of business.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of March 1, 2025, through December 31, 2025. The audit was conducted from April 6, 2026, through April 17, 2026. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on July 29, 2026. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On August 13, 2026, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

The audit evaluated five categories of performance: Utilization Management Program, Population Health Management and Coordination of Care, Network and Access to Care, Grievances, Appeals, and Member Rights, and Plan Administration and Organization.

The prior DHCS medical audit for the period of March 1, 2024, through February 28, 2025, was issued on September 19, 2025. This audit examined the Plan's compliance with the DHCS Contract and assessed the implementation and effectiveness of the Plan's prior year 2025 Corrective Action Plan.

The summary of the findings by category follows:

Category 1 – Utilization Management Program

The Plan is required to notify the requesting provider of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The decisions to approve, modify, or deny prior authorization requests must be communicated by the Plan to the provider within 24 hours of the decision. Finding 1.2.1: The Plan did not communicate the decision to approve, modify, or deny prior authorizations to the requesting provider within 24 hours of the decision.

Category 2 – Population Health Management and Coordination of Care

There were no findings noted for this category during the audit period.

Category 3 – Network and Access to Care

There were no findings noted for this category during the audit period.

Category 4 – Grievances, Appeals, and Member Rights

There were no findings noted for this category during the audit period.

Category 6 – Plan Administration and Organization

The Plan is required to report investigation results within 10 working days of the conclusion of any fraud and/or abuse investigation. Finding 6.13.1: The Plan did not submit completed investigation reports to DHCS within the required timeframe.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted the audit to ascertain that medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State Contract.

PROCEDURE

DHCS conducted an audit of the Plan from April 6, 2026, through April 17, 2026, for the audit period of March 1, 2025, through December 31, 2025. The audit included a review of the Plan's Contract with DHCS, policies and procedures for providing services, procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management Program

Prior Authorization and Review Procedures: Twenty-five medical Integrated Organization Determination records were reviewed for compliance with contract requirements.

Category 2 – Population Health Management and Coordination of Care

Initial Health Appointment: Twenty medical records were reviewed to confirm the performance of Initial Health Appointment requirements and evidence of coordination of care.

Category 3 – Network and Access to Care

Timely Payments: Twenty-six claims were reviewed for appropriate and timely adjudication.

Category 4 – Grievances, Appeals, and Member Rights

Appeal Procedures: Twenty appeal records were reviewed for appropriate and timely adjudication.

Quality of Care Grievances: Twenty-six quality of care grievance cases were reviewed for processing, clear and timely response, and appropriate level of review.

Quality of Service Grievances: Twenty quality of service grievance cases were reviewed for timeliness, investigation process, and appropriate resolution.

Cultural and Linguistic Programs: Twelve cases were reviewed for appropriate access to cultural and linguistic services.

Member Rights and Responsibilities: Four Health Insurance Portability and Accountability Act/Protected Health Information breach and security incidents were reviewed for timeliness and appropriate processing.

Category 6 – Plan Administration and Organization

Fraud Prevention Program: Eight fraud and abuse cases were reviewed for appropriate reporting and processing.

Obligations Regarding Suspended, Excluded, and Ineligible Providers: Ten cases were reviewed for timely reporting to DHCS and appropriate removal from the Plan's network.

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management Program

1.2 Prior Authorization Review

1.2.1 Integrated Organization Determination Timeframes

The Plan is required to notify the requesting provider of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. *(Contract Amendment A16, Exhibit A, Attachment 5, 2 (H))*

The decisions to approve, modify, or deny prior authorization requests must be communicated by the Plan to the provider within 24 hours of the decision. *(All Plan Letter 21-011, Grievance and Appeal Requirements, Notice And "Your Rights" Templates)*

The Plan's desktop procedure, *Organization Determinations* (revised 08/11/2025), states that for routine pre-service requests, the provider will be notified within 24 hours of the decision by facsimile or verbally.

Finding: The Plan did not communicate the decision to approve, modify, or deny prior authorizations to the requesting provider within 24 hours of decision.

A verification study of 19 service authorization requests revealed 4 samples where the Plan did not notify the requesting provider within 24 hours of its decision to approve or deny a service. In three samples, the provider notifications were faxed between 5 and 24 days after the decisions. In one sample, no provider notification was sent.

While the Plan's desk top procedure, *Organization Determinations,* mandates provider notification within 24 hours of a determination, and Plan policy, UM-0013 *Organization Determination Process* states that the Utilization Management (UM) Department will monitor this process by reviewing and reporting UM metrics, the compliance tools currently utilized by the Plan to evaluate this metric have incorrect and conflicting timeframes. For example, the Plan's UM Compliance Report, which is run weekly and reported monthly, assesses for provider notification sent within two working days of the Plan's decision. Whereas the Plan's UM Chart Audit Tool assesses for written provider notification within seven days of receipt of a service request. Therefore, the Plan is using tools that are not designed to assess compliance with the 24-hour timeframe for provider notification.

During the interview, the Plan acknowledged that provider faxes were not sent upon initial processing of the four samples as required. The Plan's internal monitoring detected three of the unsent provider notifications and ultimately sent them late. The Plan further acknowledged its procedures did not include instructions for staff to verify that provider letters were created and sent. Staff errors accounted for faxes not being sent upon initial processing for three samples. The Plan's monitoring was not sufficient to ensure provider letters were successfully generated and faxed by staff as required.

When the Plan does not notify providers of its decisions on service requests in a timely manner, it may lead to delays in shared decision-making with members regarding alternative treatments or appeals.

Recommendation: Revise and implement policies and procedures to ensure the Plan communicates the decision to approve, modify, or deny prior authorization to the requesting provider within 24 hours of the decision.

COMPLIANCE AUDIT FINDINGS

Category 6 – Plan Administration and Organization

6.13 Fraud Prevention Program

6.13.1 Submission of Completed Investigation Reports to the Department of Health Care Services within the Required Timeframe

The Plan is required to establish policies and procedures for identifying, investigating and taking appropriate corrective action against fraud and/or abuse in the provision of healthcare services under the Medi-Cal program. The Plan is required to report investigation results within 10 working days of the conclusion of any fraud and/or abuse investigation. *(Contract Exhibit E, Attachment II (26) (A))*

The Plan's Special Investigations Unit (SIU) desktop procedure, *Fraud, Waste, and Abuse Case Investigative Steps* stated when suspected FWA is identified, the SIU will refer allegations and investigative findings to the appropriate regulatory and law enforcement agencies.

Finding: The Plan did not report the completion of all FWA cases to DHCS within the required timeframe of 10 working days of conclusion of any fraud and/or abuse investigation.

In a verification study of eight FWA samples, five completed investigation reports were not reported until 12 to 234 working days after completion.

- In one sample, the Plan completed the investigation report on 06/03/2025; however, the report was not reported to DHCS until 13 days after the completion of the investigation.
- In another sample, the Plan completed the investigation report on 04/25/2025; however, it was not reported to DHCS until 234 days after the completion of the investigation.

During the interview, the Plan stated it discovered that completed investigation reports were not submitted to DHCS timely due to knowledge gaps, which contributed to inconsistencies in reporting complete investigation reports to DHCS. Specifically, the Plan's SIU updated the status of investigation as closed prior to sending the completed investigation reports to DHCS. The Plan further acknowledged that its FWA desktop procedure did not include a reference to the required process for submitting investigation reports to DHCS.

The Plan's SIU desktop procedure instructs the SIU to refer allegations and investigative findings to the appropriate regulatory and law enforcement agencies; however, it did not include specific submission deadlines for completed investigation reports or assign responsibility to any individual for submitting these reports to DHCS.

When the Plan does not submit completed FWA investigation reports as required, DHCS may not be aware of all issues, which could impact member access to care or safety.

Recommendation: Revise and implement policies and procedures to ensure complete FWA investigation reports are reported to DHCS within the required time frame.