

DHCS AUDITS AND INVESTIGATIONS  
CONTRACT AND ENROLLMENT REVIEW DIVISION  
SACRAMENTO SECTION

**REPORT ON THE MEDICAL AUDIT OF  
HEALTH PLAN OF SAN JOAQUIN  
2025**

Contract Number: 23-30224

Audit Period: August 1, 2024 — December 31, 2025

Dates of Audit: January 12, 2026 — January 23, 2026

Report Issued: May 12, 2026

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## I. INTRODUCTION

The Health Plan of San Joaquin (Plan) is a non-profit corporation headquartered in French Camp, California, and established in 1995. In 1996, the Plan received a Knox-Keene license and contracted with the State of California to provide health care services to Medi-Cal members in San Joaquin County.

On January 12, 1995, the State of California contracted with the San Joaquin County Board of Supervisors to serve as the Local Initiative under the Two-Plan Model, pursuant to the California Welfare and Institutions Code section 14087.31. On January 1, 2013, the Plan began to serve as the Stanislaus Local Initiative. The San Joaquin County Health Commission governs the Plan through a 13-member commission consisting of local government members, clinical, and non-clinical community representatives. In 2024, the Plan expanded to Alpine and El Dorado Counties as Mountain Valley Health Plan. In 2018, 2021, and 2024, the Plan was awarded the National Committee for Quality Assurance accreditation renewal.

Health care services are provided through contracts with independent medical groups and individual physicians (1,200 plus network providers and specialists). Health care services not provided directly by primary care physicians are arranged through contracts with other medical groups/physicians, allied health service suppliers, and hospitals. As of December 2025, the Plan had 400,164 Medi-Cal members. The Plan's Medi-Cal market share is about 80.7 percent in San Joaquin County, 69.6 percent in Stanislaus County, 21.8 percent in El Dorado County, and 13.6 percent in Alpine County.

## II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of August 1, 2024, through December 31, 2025. The audit was conducted from January 12, 2026, through January 23, 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 April 17, 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 May 4, 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 four categories of performance: 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 August 1, 2023, through July 31, 2024, was issued on April 9, 2025. This audit examined the Plan's compliance with the DHCS Contract and assessed the implementation and effectiveness of the Plan's prior year 2024, Corrective Action Plan.

Findings denoted as repeat findings are uncorrected deficiencies substantially similar to those identified in the previous audit.

The summary of the findings by category follows:

### **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**

The Plan is required to provide members with written acknowledgement within five calendar days of receiving each grievance. However, the Plan did not issue written acknowledgement letters to members within the required timeframe.

## **Category 6 – Plan Administration and Organization**

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

## 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 January 12, 2026, through January 23, 2026, for the audit period of August 1, 2024, 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 the Plan's administrators and staff.

The following verification studies were conducted:

#### **Category 2 – Population Health Management and Coordination of Care**

Enhanced Care Management (ECM): Twenty medical records were reviewed to confirm coordination of care and fulfillment of ECM requirements.

Initial Health Appointment (IHA): Twenty cases were reviewed to confirm the performance and completeness of the IHA.

#### **Category 3 – Network and Access to Care**

Claims: Thirty-seven emergency services and 27 family planning claims were reviewed for appropriate and timely adjudication.

#### **Category 4 – Grievances, Appeals, and Member Rights**

Grievances: Thirty-four quality of service grievances were reviewed for timely resolution, response to the complainant, and submission to the appropriate level for review.

#### **Category 6 – Plan Administration and Organization**

There were no verification studies conducted for the audit review.

# COMPLIANCE AUDIT FINDINGS

## Category 4 – Grievances, Appeals, and Member Rights

### 4.2 Grievance Process

#### 4.2.1 Written Acknowledgment

The Plan is required to ensure timely written acknowledgement of each grievance and provide a notice of resolution to the member as quickly as the member's health condition requires. *(Contract, Exhibit A, Attachment III, Section 4.6.1 (B))*

The Plan is required to provide members with written acknowledgment that is dated and postmarked within five calendar days of receipt of the grievance. *(All Plan Letter 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

The Plan is required to maintain policies and procedures to ensure written acknowledgement is provided to the member within five calendar days of receipt of the grievance. *(Contract, Exhibit A, Attachment, Section 4.6.2 (E))*

The Plan policy, *GRV02 Grievance Procedure* (revised 01/2024), states that all standard grievances are acknowledged in writing and postmarked within five calendar days of receiving the grievance.

**Finding:** The Plan did not issue written acknowledgment letters to members within the required five calendar day timeframe.

A verification study found that 27 of 34 grievance acknowledgment letters were issued to members beyond the required timeframe. The delays ranged from 7 to 53 days past the established five calendar day requirement.

According to Plan policy GRV02, members must receive written acknowledgment of grievances within five calendar days. However, system configuration problems and insufficient staff training caused delays in sending letters to the printing vendor, resulting in late notifications to members.

During the interview, the Plan explained that several factors contributed to the untimely issuance of acknowledgment letters. The Plan stated that a system issue discovered in April 2025 indicated that acknowledgment letters were initiated but not sent to the printing vendor to be mailed to the member. The Plan identified that the way the system calculated days was flawed: Day 5 was counted as day 6, and day 4 as day 5, which

contributed to the problem. The Plan also confirmed instances in which the grievance coordinator did not open or forward cases in a timely manner which also contributed to delays and highlighted a need for additional staff training and coaching. Although monthly audits helped uncover these issues, the Plan's monitoring activities did not detect delays promptly to ensure acknowledgement letters were sent timely.

Although the Plan reconfigured its system with its vendor and provided staff training, deficiencies were noted within the third and fourth quarter grievance logs. These deficiencies indicate that despite the Plan's corrective measures, continued training and oversight are still needed to ensure compliance.

When the Plan does not issue written acknowledgment of grievances within the required timeframe, members are not provided with the necessary information to make informed decisions. Delays in acknowledgment can also impede the Plan's ability to ensure grievances are resolved within the required regulatory timeframe, and any needed improvements are addressed timely.

**Recommendation:** Implement policies and procedures to ensure that written acknowledgment letters are provided to members within the required five calendar day timeframe.

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**REPORT ON THE MEDICAL AUDIT OF  
HEALTH PLAN OF SAN JOAQUIN  
2025**

Contract Number: 23-30256

Contract Type: State Supported Services

Audit Period: August 1, 2024 — December 31, 2025

Dates of Audit: January 12, 2026 — January 23, 2026

Report Issued: 05/12/2026

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## I. INTRODUCTION

This report presents the results of the audit of Health Plan of San Joaquin (Plan) compliance and implementation of the State Supported Services contract number 23-30256 with the State of California. The State Supported Services Contract covers abortion services with the Plan.

The audit covered the period of August 1, 2024, through December 31, 2025. The audit was conducted from January 12, 2026, through January 23, 2026, which consisted of a document review and verification study with the Plan administration and staff.

An Exit Conference with the Plan was held on April 17, 2026. No deficiencies were noted during the review of the State Supported Services Contract.

# COMPLIANCE AUDIT FINDINGS

## State Supported Services

The Plan is required to provide, or arrange to provide, to eligible members enrolled under either this Contract or the Primary Contract, the following private services:

- Current Procedural Terminology codes: 59840 through 59857
- Centers for Medicare & Medicaid Services (CMS) Common Procedure Coding System codes: X1516, X1518, X7724, X7726, Z0336

The Plan agrees to provide, or arrange to provide, to Unsatisfactory Immigration Status (UIS) members enrolled under this Contract all covered services specified in the Primary Contract, except as set forth in Exhibit A, Section 1.3 of this Contract.

The provision of pregnancy-related services for UIS members as described in Exhibit A, Attachment 3, Subsection 5.3.6 (Pregnant and Postpartum Members), of the Primary Contract. 1.3.2 The provision of emergency services for UIS members as described in Exhibit A, Attachment 3, Subsection 3.3.16 (Emergency Services and Post-Stabilization Care Services), and defined in Exhibit A, Attachment 1, Section 1.0 (Definitions), of the Primary Contract.

The Plan's policy, *CLMS 13 Reimbursement of Services* (revised January 2024), stated the Plan shall reimburse claims from both in-network and out-of-network providers for abortion services, no less than the Medi-Cal Fee-for-Service rates in accordance with claim requirements and timeframes outlined in the DHCS contract and *All Plan Letter, 24-003 Abortion Services*.

A verification study of 27 State Supported Services claims was conducted to determine the appropriate process and timely adjudication of claims.

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

**Recommendation:** None.