REPORT ON THE MEDICAL AUDIT OF SANTA CLARA FAMILY HEALTH PLAN CALENDAR YEAR 2025

DHCS Audits and Investigations
Contract and Enrollment Review Division
Los Angeles Section

Contract Number: 23-30240
Audit Period: February 1, 2025 — December 31, 2025
Dates of Audit: May 11, 2025 — May 21, 2025
Report Issued: September 1, 2026

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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I. INTRODUCTION

Santa Clara Family Health Plan (Plan) is a community-based, not-for-profit, health plan established by Santa Clara County Board of Supervisors. The Plan has contracted with the State of California Department of Health Care Services (DHCS) as the local initiative for Santa Clara County under the Two-Plan Medi-Cal Managed Care model. The Plan is licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act of 1996.

The Plan is accredited by the National Committee for Quality Assurance for its Medi-Cal and Medicare line of business. The Plan's network is comprised of over 9,000 providers, 5 delegates, direct contracts, medical group contracts, and hospitals.

As of April 2026, the Plan had 288,893 members, of which 277,102 were Medi-Cal members and 11,791 were DualConnect members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of February 1, 2025, through December 31, 2025. The audit was conducted from May 11, 2026, through May 21, 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 August 13, 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 27, 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 February 1, 2024, through January 31, 2025, was issued on June 24, 2026. The Plan's Corrective Action Plan was still open at the start of the audit.

The summary of the findings by category follows:

Category 2 – Population Health Management and Coordination of Care

The Plan must comply with *All Plan Letter (APL) 22-025, Responsibilities for Annual Cognitive Health Assessment for Eligible Members 65 Years of Age or Older,* and ensure the provision of an annual cognitive health assessment for members who are 65 years of age or older who do not qualify to receive a similar assessment as part of a Medicare annual wellness visit. Finding 2.29.1: The Plan did not ensure the provision of an annual cognitive health assessment for Medi-Cal members who are 65 years of age or older and who do not have Medicare coverage.

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

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 May 11, 2026, through May 21, 2026, for the audit period of February 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 the Plan's administrators and staff.

The following verification studies were conducted:

Category 2 – Population Health Management and Coordination of Care

Initial Health Appointment: Sixteen records were reviewed for completion and care coordination of services.

Category 3 – Network and Access to Care

Emergency Services and Family Planning Claims: A total of 40 (20 emergency services and 20 family planning) claims were reviewed for appropriate and timely adjudication.

Category 4 – Grievances, Appeals, and Member Rights

Grievance Procedures: Twenty standard grievances, 15 inquiries, and 15 exempted grievances, were reviewed for timely resolutions, response to complainant, and submission to the appropriate level for review. All standard grievance cases were quality of service.

Confidentiality Rights: Six Protected Health Information breach and security incidents were reviewed for processing and timeliness requirements.

Category 6 – Plan Administration and Organization

Fraud and Abuse: Ten fraud and abuse cases were reviewed for appropriate reporting and processing.

Suspended and Ineligible Providers: Seven files were reviewed for integrity and quality of services rendered, and for the protection of the health and safety of the members.

COMPLIANCE AUDIT FINDINGS

Category 2 – Population Health Management and Coordination of Care

2.29 Initial Health Appointment

2.29.1 Cognitive Assessments for Medi-Cal Members

The Plan must comply with *APL 22-025, Responsibilities for Annual Cognitive Health Assessment for Eligible Members 65 Years of Age or Older,* and ensure the provision of an annual cognitive health assessment for members who are 65 years of age or older and are otherwise ineligible to receive a similar assessment as part of a Medicare annual wellness visit. (*Contract, Exhibit A, Attachment III, section 5.3.5.B.3)*

The Plan must cover an annual cognitive health assessment for members who are 65 years of age or older and who do not have Medicare coverage. Providers must administer the annual cognitive health assessment as a component of an evaluation and management visit including, but not limited to an office visit, consultation, or preventive medicine service.

The Plan must document all of the following in members' medical records and have available upon request:

- The screening tools used, that include at least one approved cognitive assessment tool to help identify whether a full dementia evaluation is necessary
- Verification that screening results were reviewed by the provider
- The results of the screening
- The interpretation of results
- Details discussed with the member or their authorized representative and any appropriate actions taken in regard to screening results

The Plan must ensure providers are providing the appropriate, and necessary, follow-up services based on assessment scores and may include, but are not limited to, additional assessment or specialist referrals. (*APL 22-025, Responsibilities for Annual Cognitive Health Assessment for Eligible Members 65 Years of Age or Older*)

Plan policy and procedure, *UM0127 v4 Access to Ser*vices (approved 03/21/2025), includes the annual cognitive health assessment requirement and incorporates APL 22-025 elements, including eligible population, cognitive screening tools, provider

training/billing requirements, documentation expectations, and follow-up based on assessment results.

Finding: The Plan did not ensure the provision of an annual cognitive health assessment for Medi-Cal members who are 65 years of age or older and who do not have Medicare coverage.

The Plan did not follow its policy and procedures to ensure consistent completion of an annual cognitive health assessment for eligible Medi-Cal members. In a verification study, nine clinical records of Medi-Cal members, age 65 years or older and without Medicare coverage, were reviewed for evidence of an annual cognitive health assessment. All nine records did not demonstrate evidence of a completed annual cognitive health assessment or cognitive screening. The records lacked required documentation, such as the use of recognized cognitive screening tools, evaluations, screening results or scoring, provider interpretation, and follow-up actions.

The Plan's Medical Record Review (MRR) and Facility Site Review (FSR) tools reviewed did not demonstrate a specific item assessing or monitoring annual cognitive health assessments. Cognitive assessments were not scored or a required component of the MRR or FSR tools.

In an interview, the Plan acknowledged that the annual cognitive health assessment requirement for eligible Medi-Cal members was not monitored for completion during the audit period. The Plan stated that the MRRs and FSRs assessed broader risk assessments rather than a distinct annual cognitive health assessment. Therefore, providers were not cited for missing cognitive assessment documentation.

When an annual cognitive health assessment is not conducted, eligible members may not receive timely identification of cognitive impairment and access to necessary follow-up, referrals, care coordination treatment, or support.

Recommendation: Implement policies and procedures to ensure the provision of an annual cognitive health assessment for eligible Medi-Cal members.

REPORT ON THE MEDICAL AUDIT OF SANTA CLARA FAMILY HEALTH PLAN CALENDAR YEAR 2025

DHCS Audits and Investigations
Contract and Enrollment Review Division
Los Angeles Section

Contract Number: 23-30272
Contract Type: State Supported Services
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I. INTRODUCTION

This report presents the results of the audit of Santa Clara Family Health Plan's (Plan) compliance and implementation of the State Supported Services contract number 23-30272 with the State of California. The State Supported Services Contract covers abortion services with the Plan.

The audit covered the period of February 1, 2025, through December 31, 2025. The audit was conducted from May 11, 2026, through May 21, 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 August 13, 2026. No deficiencies were noted during the review of the State Supported Services Contract.

COMPLIANCE AUDIT FINDINGS

State Supported Services

The Plan must provide, or arrange to provide, to eligible members enrolled under either Contract or the Primary Contract, the following private services: Current Procedural Terminology codes: 59840 through 59857 and Centers for Medicare and Medicaid Services Common Procedure Coding System codes: X1516, X1518, X7724, X7726, and Z0336. (*Contract, Exhibit A, sections 1.2.1 and 1.2.2*)

Abortion services are covered by the Medi-Cal program. The Plan must cover abortion services, as well as the medical services and supplies incidental or preliminary to an abortion, consistent with the requirements outlined in the Medi-Cal Provider Manual. Minors who wish to receive abortion services may do so without parental consent under the Medi-Cal Minor Consent Program. The Plan and their network providers and subcontractors are prohibited from requiring medical justification or imposing any utilization management or utilization review requirements, including prior authorization and annual or lifetime limits, on the coverage of outpatient abortion services. (*All Plan Letter 24-003, Abortions and Directly Related Medical Services and Supplies*)

Plan policy, *CL22 v7 Processing of Abortion Claims* (approved 06/05/2025), states that the Plan covers abortions regardless of the gestational age of the fetus. The Medi-Cal Minor Consent Program allows minors to access abortion services without parental consent. Members may go to any provider of their choice for abortion services regardless of network affiliation. If the Plan does not have contracted providers who perform abortions, the Plan will arrange and pay for the service from a non-contracted provider.

Plan procedure, *CL2201 v3 Processing of Abortion Claims Procedure* (approved 03/16/2026), outlines procedures for accurately processing claims regarding abortion services in accordance with state and federal regulatory requirements. The Plan covers abortion services and related medical services and supplies. The abortion procedure codes are listed as follows: 59840, 59841, 59850, 59851, 59855, 59856, and 59857. The Plan prohibits the requirement of medical justification, or imposing any utilization management or utilization review requirements, including prior authorization, on the coverage of outpatient abortion services.

The Plan communicates information regarding abortion services to both members and providers through the Member Handbook and the Provider Manual.

The verification study determined that the Plan accurately processed abortion claims for payment and did not identify any deficiencies concerning State Supported Services.

Finding: No deficiencies were identified in this audit.

Recommendation: None.