

DHCS AUDITS AND INVESTIGATIONS  
CONTRACT AND ENROLLMENT REVIEW DIVISION  
LOS ANGELES SECTION

**REPORT ON THE MEDICAL AUDIT OF AIDS  
HEALTHCARE FOUNDATION DBA POSITIVE  
HEALTHCARE CALIFORNIA  
YEAR 2025-26**

Contract Number: 23-30211

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

Dates of Audit: February 10, 2026 — February 24, 2026

Report Issued: June 2, 2026

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## I. INTRODUCTION

AIDS Healthcare Foundation dba Positive Healthcare California (Plan) was founded in 1987 and is a not-for-profit organization providing Human Immunodeficiency Virus (HIV) treatment. The Plan provides specialty health care for Medi-Cal members in Los Angeles County.

The Plan was established in California in 1995, under a Federal Waiver from the Department of Health and Human Services. The Department of Health Care Services (DHCS) entered into an agreement with the Plan in 2012. The Plan is the first Managed Care Program in the county for Medicaid members diagnosed with Acquired Immunodeficiency Syndrome (AIDS). Effective July 1, 2019, the Plan transitioned into a full-risk Medi-Cal managed care plan in Los Angeles County. The Plan is a licensed Knox-Keene Health Care Service Plan.

The Plan provides care for eligible members residing within its designated service areas and members who are at least 21 years old.

The Plan provides health care services designed around the needs of people living with stage three HIV infection. The Plan has a comprehensive network of providers and offers the following contracted services: primary medical care (HIV specialists), specialty consultation, outpatient, radiology, laboratory, hospice, hospital inpatient, and mental health. The Plan delivers services to members through a delegated group and vendors or subcontractors.

As of January 1, 2026, the Plan is not fully accredited by the National Committee for Quality Assurance (NCQA) for the Medi-Cal line of business. The Plan has accreditation from the Association for Ambulatory Health Care, Inc.

As of November 30, 2025, the Plan had 908 members, which included 585 Medi-Cal and 323 with Dual Benefits.

## II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of October 1, 2024, through December 31, 2025. The audit was conducted from February 10, 2026, through February 24, 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 May 21, 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 22, 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 October 1, 2023, through September 30, 2024, was issued on March 18, 2025. This audit examined the Plan's compliance with the with the DHCS Contract.

The summary of the findings by category follows:

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

The Plan was required to have NCQA Health Plan Accreditation and Health Equity Accreditation by January 1, 2026. Finding 2.1.1: The Plan did not obtain the full NCQA Health Plan Accreditation and NCQA Health Equity Accreditation by the required date of January 1, 2026.

The Plan must cover vaccinations, except for vaccinations expressly excluded by DHCS in guidance to Medi-Cal managed care health plans, at the time of any health care visit, and ensure the timely provision of vaccines in accordance with the most recent adult immunization schedule and recommendations published by the Advisory Committee on Immunization Practices (ACIP). Documented attempts that demonstrate the Plan's unsuccessful efforts to provide the vaccination will be considered sufficient in meeting the requirement. Finding 2.29.1: The Plan did not ensure its medical providers

completed vaccination records per ACIP guidelines or documented unsuccessful vaccination attempts.

### **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 February 10, 2026, through February 24, 2026, for the audit period of October 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**

Initial Health Appointment: Ten files were reviewed for completion and care coordination of services.

Enhanced Care Management: Thirteen files were reviewed for care coordination and completeness to evaluate service performance.

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

Family Planning and Emergency Services Claims: The Plan did not have any family planning requests, and five emergency service claims were reviewed for appropriateness and timeliness.

Non-Emergency Medical Transportation: Eight records were reviewed to confirm compliance with transportation requirements and timeliness.

Non-Medical Transportation: Eight records were reviewed to confirm compliance with transportation requirements and timeliness.

Non-Emergency Medical Transportation and Non-Medical Transportation Grievances: Sixteen standard and eight exempt grievance records were reviewed for responses to the complainant and submission to the appropriate level of review.

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

Grievance Procedures: Ten standard and five exempt grievances were reviewed for timely resolutions, response to complainant, and submission to the appropriate level for review. The 15 grievance cases reviewed included issues related to quality of service.

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

Fraud, Waste, and Abuse Reporting: Thirteen cases were reviewed for proper reporting of any potential fraud, waste, and abuse to DHCS within the required time frames.

Suspended and Ineligible Providers: Four 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

### 2.1 Population Health Management Program Requirements

#### 2.1.1 National Committee for Quality Assurance Accreditation

The Plan must ensure its Population Health Management Program meets, at a minimum, all National Committee for Quality Assurance (NCQA) standards as well as applicable federal and state requirements as set forth in *All Plan Letter 22-024, Population Health Management Policy Guide*. (Contract, Exhibit A, Attachment III, section 4.3.1.B)

The Plan must have full NCQA Health Plan Accreditation and NCQA Health Equity Accreditation by no later than January 1, 2026. The Plan must maintain full NCQA Health Plan Accreditation and Health Equity Accreditation throughout the term of the Contract and submit every three years NCQA Health Plan Accreditation and Health Equity Accreditation results. (Contract, Exhibit A, Attachment III, section 2.2.8)

Plan policy and procedure, *CM 13.4 PHC-CA Population Health Management* (revised 12/03/2025), states the Plan has aligned the Population Health Management Program with NCQA standards and data elements required to attain Health Plan Accreditation. The Plan program will be NCQA Health Plan and NCQA Health Equity accredited by January 1, 2026.

Plan policy and procedure, *QM 24.1 PHC-CA National Committee for Quality Assurance Accreditation* (revised 12/10/2025), states the Plan will achieve full National Committee for Quality Assurance (NCQA) Accreditation Health Plan Accreditation and NCQA Health Equity Accreditation no later than January 1, 2026.

**Finding:** The Plan did not obtain the full NCQA Health Plan Accreditation and NCQA Health Equity Accreditation by the required date of January 1, 2026.

Review of the Plan documentation and responses indicated that the NCQA survey was conducted from July 2025 through August 2025. The Plan must have full NCQA Health Plan Accreditation and NCQA Health Equity Accreditation by no later than January 1, 2026. However, the Plan only received a provisional NCQA Health Plan Accreditation and did not obtain full or provisional NCQA Health Equity Accreditation.

Additionally, the Plan confirmed it did not receive full accreditation by NCQA as of the audit dates and is scheduled for the follow up NCQA survey in July 2026 for the areas that were deficient in the first review.

When the Plan does not have timely full NCQA Health Plan Accreditation and NCQA Health Equity Accreditation, the Plan cannot ensure meeting the Contract requirements to evaluate and improve the quality of care provided to members.

**Recommendation:** Implement policies and procedures to ensure the Plan is fully NCQA accredited in accordance with the Contract requirements.

## 2.29 Initial Health Appointment

### 2.29.1 Services for Adults - Immunizations

The Plan must cover vaccinations, except for vaccinations expressly excluded by DHCS in guidance to Medi-Cal managed care health plans, at the time of any health care visit and ensure the timely provision of vaccines in accordance with the most recent adult immunization schedule and recommendations published by the ACIP. Documented attempts that demonstrate the Plan's unsuccessful efforts to provide the vaccination will be considered sufficient in meeting this requirement. (*Contract, Exhibit A, Attachment III, section 5.3.5.C.1, Services for Adults*)

The Plan must require its network providers to document each member's need for the ACIP-required documentation during regular health visits. ACIP-recommended immunizations are viewed as preventive services. (*All Plan Letter 24-008, Immunization Requirements (06/21/2024)*)

Plan policy and procedure, *QM 2.5 PHC-CA Member Health Record* (revised 12/10/2025), states the Plan requires that complete, legible medical records are maintained in accordance with California Code of Regulations, title 22, section 53861, which reflects all aspects of patient care including documentation of blood lead screening, immunizations, and other preventive services provided in accordance with ACIP recommendations. Member refusal to receive blood lead screening, immunizations, or other preventive services must also be documented in the member's medical record.

**Finding:** The Plan did not ensure its medical providers completed vaccination records per ACIP guidelines or documented unsuccessful vaccination attempts.

In a verification study, four out of ten medical records revealed missing documentation of adult-focused vaccination or documentation of unsuccessful attempts for the Tdap, Meningococcal, and the Zoster vaccines.

The Plan's policy and procedure *QM 2.5 PHC-CA Member Health Record* outlined the Contract requirements. However, the Plan did not ensure that its medical providers consistently followed the procedures. This highlights the need for improved oversight and clearer guidance to providers regarding immunization record-keeping and documenting of unsuccessful vaccination attempts.

During the interview the Plan stated that all information for vaccination were in the member records. Furthermore, in a written statement the Plan stated that documentation of vaccine administration attempts, including any unsuccessful efforts, resides solely with the contracted medical providers who are responsible for delivering direct patient care. While the contracted medical providers are directly responsible for documenting all vaccine administration attempts, including any unsuccessful efforts, the Plan retains an overarching responsibility. Specifically, the Plan must actively monitor and confirm that its providers are adhering to all contractual obligations related to vaccination documentation and patient care.

When the Plan does not ensure its medical providers' completion of vaccination records and fails to document unsuccessful vaccination attempts, this may result in missed opportunities for members to receive recommended vaccines, potentially increasing their risk of preventable diseases and compromising member health outcomes.

**Recommendation:** Implement policies and procedures and ensure medical providers are documenting both the completion of vaccinations and unsuccessful vaccination attempts in the member's medical records.

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**REPORT ON THE MEDICAL AUDIT OF AIDS  
HEALTHCARE FOUNDATION DBA POSITIVE  
HEALTHCARE CALIFORNIA  
FISCAL YEAR 2025-26**

Contract Number: 23-30243

Contract Type: State Supported Services

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

Dates of Audit: February 10, 2026 — February 24, 2026

Report Issued: June 2, 2026

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## I. INTRODUCTION

This report presents the results of the audit of AIDS Healthcare Foundation dba Positive Healthcare California (Plan) compliance and implementation of the State Supported Services contract number 23-30243 with the State of California. The State Supported Services Contract covers abortion services with the Plan.

The audit covered the period of October 1, 2024, through December 31, 2025. The audit was conducted from February 10, 2026, through February 24, 2026, which consisted of a document review with the Plan administration and staff.

An Exit Conference with the Plan was held on May 21, 2026. No deficiencies were noted during the review of the State Supported Services Contract.

# COMPLIANCE AUDIT FINDINGS

## State Supported Services

The Plan agrees 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 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*)

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. The Plan, 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. However, non-emergency inpatient hospitalization for the performance of an abortion may require prior authorization under the same criteria as other medical procedures. (*All Plan Letter 24-003, Abortion and Directly Related Medical Services and Supplies*)

Plan policy and procedure, *CL 13.5 PHC-CA State Supported Services, Family Planning and Proposition 56 Claims Processing* (revised 12/12/2025), states the Plan reimburses State Supported Services pursuant to contractual requirements and the published Department of Health Care Services' All Plan Letter 24-003. The Plan maintains appropriate procedure codes per Medi-Cal guidelines to allow for claims processing. Procedure codes are updated monthly to ensure appropriate reimbursement and processing of claims received. Procedure codes are subject to change based on Medi-Cal updates, Current Procedural Terminology codes 59840 through 59857 and HealthCare Financing Administration Common Procedure Coding System codes X1516, X1518, X7724, X7726, and Z0336.

Plan policy and procedure, *UM 36.3 PHC-CA Abortion Services* (revised 12/15/2025), states the Plan covers abortion services, as well as medical services and supplies incidental or preliminary to an abortion, consistent with the requirements detailed in the Medi-Cal Provider Manual. The Plan treats abortion services as a "sensitive service," ensuring members' confidentiality in accessing such services. The Plan ensures that members have timely access to abortion services.

Should the member choose to use an out-of-network provider for abortion services, the Plan will reimburse the out-of-network provider.

The Plan informs members and providers about abortion services through the Evidence of Coverage (Member Handbook) and Medi-Cal Provider Manual. The Member Handbook states that if a member is 18 years of age or older, they can choose any doctor or clinic for outpatient abortion services. Furthermore, members do not need a referral to access adult-sensitive services.

A review of the documentation indicated that the Plan has policies and procedures to provide and process claims for State Supported Services if needed. During the audit period, no services were requested by members.

**Finding:** No deficiencies were identified in the audit.

**Recommendation:** None.