DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

LOS ANGELES SECTION

REPORT ON THE MEDICAL AUDIT OF SANTA CLARA COUNTY HEALTH AUTHORITY DBA SANTA CLARA FAMILY HEALTH PLAN FISCAL YEAR 2024-25

Contract Number: 23-30240

Audit Period: February 1, 2024 — January 31, 2025

Dates of Audit: February 3, 2025 — February 14, 2025

Report Issued: June 24, 2025

TABLE OF CONTENTS

I. INTRODUCTION

In 1995, the Santa Clara County Board of Supervisors established the Santa Clara County Health Authority (SCCHA) under the authority granted by California Welfare and Institutions Code section 14087.36. The SCCHA, distinct from the County, was given the mission to develop a community-based health plan, Santa Clara County Authority dba Santa Clara Family Health Plan (Plan), to provide coverage to Medi-Cal Managed Care members.

The Plan is licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act of 1996. Since 1997, 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 delivers services to members through delegated groups and vendors. The Plan partners with over 6,000 providers that includes a network of 6 delegates, direct contracts, medical group contracts, and hospitals.

The Plan is accredited by the National Committee for Quality Assurance for the Medi-Cal and Medicare line of business.

As of January 2025, the Plan had 294,441 members, of which 283,578 were Medi-Cal members and 10,863 were DualConnect members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of February 1, 2024, through January 31, 2025. The audit was conducted from February 3, 2025, through February 14, 2025. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on June 4, 2025. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On June 18, 2025, 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 six categories of performance: Utilization Management, Population Health Management and Coordination of Care, Network and Access to Care, Member Rights, Quality Improvement and Health Equity Transformation, and Administrative and Organizational Capacity.

The prior DHCS medical audit for the period of March 1, 2023, through January 31, 2024, was issued on June 26, 2024. This audit examined the Plan's compliance with the DHCS Contract and assessed the implementation of the prior year 2024, Corrective Action Plan.

The summary of the findings by category follows:

Category 1 – Utilization Management

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

Category 2 – Population Health Management and Coordination of Care

The Plan is required to ensure the provision of Initial Health Appointment (IHA) within 120 calendar days of enrollment with the Plan, including making and documenting reasonable attempts to contact members for IHA scheduling. The Plan did not ensure the provision of IHA within 120 calendar days of enrollment with the Plan, including making and documenting reasonable attempts to contact members for IHA scheduling.

The Plan must provide oral or written anticipatory guidance that includes information that children can be harmed by exposure to lead. The Plan did not provide oral or

written blood lead anticipatory guidance to the parent or guardian of members starting at six months to six years of age.

The Plan must send Continuity of Care (COC) approval notices containing all notification requirements in accordance with *All Plan Letter (APL) 23-022*, *Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or After January 1, 2023*, including (1) the process that will occur to transition the member's care at the end of the COC period and (2) the member's right to choose a different network provider. The Plan did not ensure member notification letters for approved COC requests included all required information as specified in the APL 23-022.

The Plan is required to ensure all members, who meet the eligibility criteria for the Enhanced Care Management (ECM) Populations of Focus, receive all seven ECM core service components. The ECM core service components include the following: comprehensive assessment and Care Management Plan (CMP); enhanced coordination of care; health promotion, comprehensive transitional care; member and family support; and coordination of and referral to community and social support services. The Plan did not ensure that all members received all seven ECM core service components.

Category 3 – Network and Access to Care

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

Category 4 – Member Rights

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

Category 5 – Quality Improvement and Health Equity Transformation

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

Category 6 – Administrative and Organizational Capacity

The Plan must submit a quarterly report to DHCS' Program Integrity Unit (PIU) on all Fraud, Waste, and Abuse (FWA) investigative activities ten working days after the close of every calendar quarter. The quarterly report must contain the status of all preliminary, active, and completed investigations. The Plan did not ensure the quarterly FWA status report was submitted to DHCS' PIU ten working days after the close of every calendar quarter.

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 3, 2025, through February 14, 2025, for the audit period of February 1, 2024, through January 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 1 – Utilization Management

Service Requests: A total of 20 medical services requests (4 approved and 16 denied) were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal Procedures: Thirty appeals related to medical services were reviewed for appropriateness and timeliness of decision-making.

Delegated Prior Authorization (PA) Requests: Thirty medical PA requests were reviewed for appropriate and timely adjudication.

Category 2 – Population Health Management and Coordination of Care

IHA: Fifteen medical records were reviewed for appropriate documentation, timely completion, and fulfillment of all required IHA components.

Behavioral Health Treatment (BHT): Ten medical records were reviewed for coordination, completeness, and compliance with BHT provision requirements.

COC: Thirteen medical records were reviewed to evaluate the process used for COC approval and notification of services.

ECM: Twelve files were reviewed to confirm coordination of care and compliance with ECM requirements.

Category 3 – Network and Access to Care

Emergency Service and Family Planning Claims: Twenty emergency services and 20 family planning claims were reviewed for appropriate and timely adjudication.

Non-Emergency Medical Transportation (NEMT): Twenty records were reviewed to confirm compliance with NEMT requirements.

Non-Medical Transportation (NMT): Twenty records were reviewed to confirm compliance with NMT requirements.

Category 4 – Member Rights

Grievance Procedures: Twenty-six standard grievances and 11 expedited grievances were reviewed for timely resolutions, response to complainant, and submission to the appropriate level for review. The 37 grievance cases included 17 quality of care and 20 quality of service grievances.

Category 5 – Quality Improvement and Health Equity Transformation

Potential Quality Issues (PQI): Ten PQI cases were reviewed for appropriate evaluation, investigation, and effective action taken to address improvements and remediation.

New Provider Training: Twenty-eight newly contracted providers were reviewed for timely provision of Medi-Cal Managed Care Program training.

Category 6 – Administrative and Organizational Capacity

FWA Reporting: Nine cases were reviewed for proper reporting of any potential FWA to DHCS within the required time frames.

Encounter Data Review: Fifteen records were reviewed to verify the completeness and accuracy of the data reported.

COMPLIANCE AUDIT FINDINGS

Category 2 – Population Health Management and Coordination of Care

2.1 Initial Health Appointment

2.1.1 The Provision of Initial Health Appointments

The Plan must ensure the provision of an IHA in accordance with California Code of Regulations (CCR), Title 22, sections 53851(b)(1), and 53910.5(a)(1), and *APL 22-030, Initial Health Appointment*. An IHA at a minimum must include a history of the member's physical and mental health, an identification of risks, an assessment of need for preventive screens or services and health education, a physical examination, and the diagnosis and plan for treatment of any diseases, unless the member's Primary Care Provider (PCP) determines that the member's medical record contains complete information, updated within the previous 12 months, consistent with the assessment requirements. The Plan must ensure that a member's completed IHA is documented in their medical record and that appropriate assessments from the IHA are available during subsequent health visits. (*Contract, Exhibit A, Attachment III, 5.3.3*)

The Plan must cover and ensure that IHAs are performed within 120 calendar days of enrollment with the Plan. (*Contract, Exhibit A, Attachment III, 5.3.4 (A) and 5.3.5 (A)(1)*)

The Plan must make reasonable attempts to contact a member to schedule an IHA. The Plan must document all attempts to contact a member. Documented attempts that demonstrate the Plan's efforts to unsuccessfully contact a member and schedule an IHA will be considered evidence in meeting this requirement. (*Contract, Exhibit A, Attachment III, 5.3.3 (C)*)

Plan policy, *QI.10 v5 Initial Health Appointment Policy* (approved 01/06/2023), mandated that all Medi-Cal members complete an IHA within 120 days of enrollment. The Plan is responsible for overseeing the completion of IHAs, ensuring that providers conduct comprehensive assessments that address members' acute, chronic, and preventive health needs. The Quality Improvement Department is tasked with monitoring compliance and collaborating with Health Educators and Provider Services to train and educate providers on IHA expectations. Furthermore, this policy stated that the providers must make at least two documented outreach attempts: one phone call and one written notification (mail or other approved method). If a member fails to respond

or misses a scheduled appointment, providers are expected to continue outreach efforts and attempt to complete the IHA at the member's next medical visit, if and when they seek care. Providers are also required to document all outreach efforts in the member's medical record in preparation for monthly and quarterly audits.

Finding: The Plan did not ensure the provision of IHAs within 120 calendar days of enrollment with the Plan, including making and documenting reasonable attempts to contact members for IHA scheduling.

In a verification study, 8 of 15 medical records revealed that the Plan did not ensure the provision and timely performance of an IHA. For all eight samples, there was no documentation of outreach efforts from the Plan to schedule an IHA.

- Seven of eight samples lacked records of an IHA visit.
- One of eight samples showed that an IHA was completed. However, IHA completion was delayed 93 days past the 120 day IHA timeframe.

In an interview, the Plan stated that providers are responsible for conducting and documenting outreach. The Plan relied on provider self-reporting and retrospective audits but did not have a process to ensure outreach documentation is consistently maintained and readily available for review.

When the Plan does not conduct and document member outreach to ensure the provision of timely IHA completion, it can lead to delays in assessment and management of the acute, chronic, and preventative health needs of the member.

Recommendation: Implement policies and procedures to ensure that IHAs are performed within 120 calendar days of enrollment with the Plan, and document all attempts to contact a member to schedule an IHA.

2.1.2 Blood Lead Level Anticipatory Guidance

The Plan must comply with all DHCS guidance, including but not limited to APLs, Policy Letters (PLs), the California Medicaid State Plan, and the Medi-Cal Provider Manual. (*Contract, Exhibit E, 1.1.2*)

The Plan is required to provide oral or written anticipatory guidance to the parent or guardian of a child that at a minimum, includes information that children can be harmed by exposure to lead. This anticipatory guidance must be provided to the parent or guardian at each PHA, starting at six months of age and continuing until six years of age. (*APL 20-016, Blood Lead Screening of Young Children*)

Plan policy, *QI.02.06 v5 Blood Lead Screening in Children Policy* (approved 01/06/2025), outlined the provider responsibilities for lead exposure prevention. It requires providers to give oral or written anticipatory guidance to parents or guardians, emphasizing risks from lead-based paint and dust. Guidance must be provided at each PHA from six months to six years to protect children during their most vulnerable years.

Finding: The Plan did not provide oral or written blood lead anticipatory guidance to the parent or guardian of members starting at six months to six years of age.

A verification study revealed that the Plan did not document the provision of blood lead anticipatory guidance for four of four members, aged one to six years old.

In an interview, the Plan stated that a key barrier for missing documentation of BLL anticipatory guidance was the lack of built-in prompts within provider Electronic Medical Records (EMR) systems, as well as the absence of standardized documentation processes among providers who still use paper-based records. Furthermore, a review of the Plan's MRR tool revealed that BLL anticipatory guidance is not included as an item to check, which limits the Plan's ability to systematically track compliance with this requirement. Without EMR prompts, standardized paper-based documentation, or a dedicated audit measure in the MRR tool, providers may inadvertently overlook this requirement, resulting in gaps in patient education on lead exposure prevention.

Failing to provide anticipatory guidance to patients may result in the Plan missing opportunities to inform parents or guardians about the risks of lead exposure. This communication gap could lead to reduced awareness of preventive measures, potentially increasing the risk of lead poisoning in children.

Recommendation: Implement policies and procedures to effectively monitor and document that the oral or written blood lead anticipatory guidance is provided to the parent or guardian of members starting at six months to six years of age.

2.4 Continuity of Care

2.4.1 Member Notification Letter of Continuity of Care Approval

The Plan must comply with all DHCS guidance, including but not limited to APLs, PLs, the California Medicaid State Plan, and the Medi-Cal Provider Manual. *(Contract, Exhibit E, 1.1.2)*

The Plan must include in the approval notice for COC requests the following information: (1) a statement of the decision; (2) the duration of the COC arrangement;

(3) the process that will occur to transition the member's care at the end of the COC period; and (4) the member's right to choose a different network provider. (*APL 23-022, Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or After January 1, 2023*)

Plan policy, *UM.01.05 v7 Continuity of Care* (updated 09/23/2024), stated for COC requests that are approved, the Plan must include the following information: a statement of the Plan's decision; the duration of the COC arrangement; the process that will occur to transition the member's care at the end of the COC period; and the member's right to choose a different network provider.

Finding: The Plan did not ensure member notification letters for approved COC requests included all required information as specified in the APL 23-022.

In a verification study of five approved COC requests, in all five COC approval letters, the Plan did not provide all required information in accordance with APL 23-022. The letters were missing two required elements: (1) the process that will occur to transition the member's care at the end of the COC period and (2) the member's right to choose a different network provider.

During the interview, the Plan stated that the approval notices primarily serve as authorization letters rather than comprehensive COC notifications. In a written response, the Plan confirmed the use of a PA letter for COC approval notification letters to the member. Since the Plan does not have a dedicated COC approval letter template, key information such as the process for transitioning care at the end of the COC period and the member's right to choose a different network provider is missing from member notifications.

Without the required information in the approval notice, members may not fully understand how their care will transition at the end of the COC period or that they have the option to choose a different network provider, which could lead to confusion and disruptions in care.

Recommendation: Implement policies and procedures to ensure all required information for COC approvals are in the notification letter to members as specified in APL 23-022.

2.6 Enhanced Care Management

2.6.1 Enhanced Care Management Core Service Components

The Plan must ensure all members receive the following seven ECM core service components, as further defined in APLs: outreach and engagement; comprehensive assessment and CMP; enhanced coordination of care; health promotion, comprehensive transitional care; member and family support; and coordination of and referral to community and social support services. (*Contract, Exhibit A, Attachment III, 4.1.11*)

The Plan is required to perform oversight of ECM providers, holding them accountable to all ECM requirements contained in the Contract, the DHCS' policies and guidance, APLs, and the Plan's Model of Care. (*Contract, Exhibit A, Attachment III, 4.4.13*)

The Plan must administer ECM that includes:

- A Comprehensive Assessment and CMP, which must include, but is not limited to: Identifying necessary clinical resources that may be needed to appropriately assess member health status and gaps in care and may be needed to inform the development of an individualized CMP.
- ECM requires Enhanced Coordination of Care, which must include, but is not limited to: Ensuring care is continuous and integrated among all service providers and refers to and follows up with primary care, physical and developmental health, mental health, substance use disorder treatment and communicating the member's needs and preferences timely to the member's multi-disciplinary care team in a manner that ensures safe, appropriate, and effective person-centered care.
- ECM requires Member and Family Supports which includes ensuring that the member and their family members, legal guardians, authorized representatives, caregivers, and authorized support persons, as applicable, have a copy of the member's CMP and information about how to request updates.

(*APL 23-032, Enhanced Care Management Requirements*)

Plan policy, *CB.01v13 Enhanced Care Management* (approved 06/28/2024), stated that the Plan's ECM Provider Network provides core ECM services through its network of ECM providers. The Plan provides the following seven core ECM services to eligible members: outreach and engagement, comprehensive assessment and CMP, enhanced coordination of care, health promotion, comprehensive transitional care, member and family supports; and coordination of and referral to community and social support services.

Finding: The Plan did not ensure that all members received the seven ECM core service components.

For six of ten members enrolled in the ECM program, a verification study revealed that the Plan did not ensure all ECM core service components were completed. A review of medical records showed:

- Core Service 1 – Comprehensive Assessment and CMP: In two of six samples, there was no completion of a comprehensive assessment. The Plan did not identify necessary clinical resources that may be needed to appropriately assess member health status and gaps in care and may be needed to inform the development of an individualized CMP. The comprehensive assessment form showed completion of the non-clinical needs assessment, but not the clinical needs assessment portion of the form. In one example, one member was referred to the ECM program for: health/medical support, mental health wellness and substance abuse. This member's medical records showed that these concerns were not identified in the comprehensive assessment form nor was it addressed in the CMP. The Plan cannot identify clinical needs requiring care coordination if it does not complete the clinical portion of the comprehensive assessment form. Comprehensive assessment is required to develop an individualized CMP that addresses clinical and non-clinical care coordination needs.
- Core Service 2 – Enhanced Coordination of Care: In four of six samples, medical records lacked evidence of coordination of care. For example, a member requested a referral to mental health and/or substance use treatment. However, medical records indicated this referral was not made and that the Lead Case Manager did not indicate the PCP was informed of this request. This member has a history of recurrent syncope, Human Immunodeficiency Virus (HIV) infection, difficulty walking, alcohol withdrawal symptoms syndrome and sciatic nerve pain.
- Core Service 3 – Member and Family Supports Services: In two of six samples, a disabled member and a member with cancer and their support persons did not receive a copy of the member's CMP and information about how to request updates.

In an interview, the Plan stated that there were challenges with ECM program staffing, which include recruitment and retraining, that caused the issues related to incomplete records.

When the Plan does not provide all ECM core service components, members may not receive proper coordination of services and comprehensive care management, resulting in adverse health outcomes.

Recommendation: Implement policies and procedures to ensure all ECM core service components, including the comprehensive assessment and CMP, enhanced coordination of care, and member and family supports services, are completed.

COMPLIANCE AUDIT FINDINGS

Category 6 – Administrative and Organizational Capacity

6.2 Fraud and Abuse

6.2.1 Quarterly Reports

In accordance with Code of Federal Regulations, Title 42, section 438.608(a)(7), the Plan must refer, investigate, and report all FWA activities that the Plan identifies to DHCS' PIU, in a manner prescribed by PIU. The Plan must submit a quarterly report to DHCS' PIU on all FWA investigative activities ten working days after the close of every calendar quarter. The quarterly report must contain the status of all preliminary, active, and completed investigations and must include both Plan initiated and DHCS initiated referrals. In addition to quarterly reports, the Plan must provide updates and available documentation as DHCS may request from time to time. (*Contract, Exhibit A, Attachment III, 1.3.2(D)(3))*

Plan policy, *CP.02.02 v2 Fraud, Waste, and Abuse Management Procedure* (approved 05/03/2023), stated that the Compliance Department provides a quarterly, and an annual report, to DHCS, on the status of any validated or suspected potential FWA and the outcome of any prosecuted cases.

Finding: The Plan did not ensure the quarterly FWA status reports were submitted to DHCS' PIU within ten working days after the close of every calendar quarter.

Review of the Plan's documentation revealed that, during the audit period, the quarterly FWA reports were submitted 3 to 74 working days past the 10 working days following the close of the quarter requirement.

The Plan's policies and procedures did not specify that the FWA quarterly status reports must be submitted to DHCS' PIU ten working days after the close of each calendar quarter.

The Plan acknowledged that the quarterly reports were not submitted timely. In a written response, the Plan stated that they are aware of the requirement. However, it did not successfully implement the reporting process efficiently. During the review period, there were instances where the report was held up in different individuals draft email boxes and various handoff were not followed up to ensure timely submission of the

report. In summary, the Plan did not have an effective reporting process to ensure timely submission.

Untimely submission of the quarterly status reports may hinder DHCS' ability to oversee and follow up with the Plan on all reported FWA investigative activities.

Recommendation: Revise and implement policies and procedures to ensure timely submission of the FWA quarterly status reports to DHCS' PIU within ten working days after the close of every calendar quarter.

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REPORT ON THE MEDICAL AUDIT OF SANTA CLARA COUNTY HEALTH AUTHORITY DBA SANTA CLARA FAMILY HEALTH PLAN FISCAL YEAR 2024-25

Contract Number: 23-30272

Contract Type: State Supported Services

Audit Period: February 1, 2024 — January 31, 2025

Dates of Audit: February 3, 2025 — February 14, 2025

Report Issued: June 24, 2025

TABLE OF CONTENTS

I. INTRODUCTION

This report presents the results of the audit of Santa Clara County Health Authority dba 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, 2024, through January 31, 2025. The audit was conducted from February 3, 2025, through February 14, 2025, which consisted of a document review and verification study with the Plan's administration and staff.

An Exit Conference with the Plan was held on June 4, 2025. 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 the following State Supported Services: Current Procedural Terminology Codes: 59840 through 59857. These codes are subject to change upon the Department of Health Care Services' implementation of the Health Insurance Portability and Accountability Act of 1996 electronic transaction and code sets provisions. (*State Supported Services Contract, Exhibit A, Sections 1.2.1 and 1.2.2)*

Abortion services are covered by the Medi-Cal program, as outlined in the Medi-Cal Provider Manual. 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. Plans 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 Abortion Services*)

Plan policy, *CL.22.v7 Processing of Abortion Claims* (approved 08/02/2024), stated that the Plan covers abortions regardless of the gestational age of the fetus. Members may go to any provider of their choice for abortion services regardless of network affiliation. Contracted providers shall be paid in accordance with their contract while non-contract providers are paid for covered services at no less than 100 percent of the Medi-Cal Fee-For-Service rates. The Claims Department is responsible for ensuring accurate and timely processing of abortion claims.

Plan policy, *CL.22.01v3 Processing of Abortion Claims Procedure* (approved 08/02/2024), outlined procedures for accurately processing claims regarding abortion services in accordance with state and federal regulatory requirements. The Plan covers abortion services and the medical services and supplies incidental or preliminary to an abortion. The abortion procedure codes listed as follows: 59840, 59841, 59850, 59851, 59855, 59856, and 59857.

The verification study revealed the Plan appropriately processed abortion claims for payment and did not demonstrate any deficiencies related to State Supported Services.

Finding: No deficiencies were identified in this audit.

Recommendation: None.