



Policy and Procedure No: CO 7.7		Revision No: 7
Division: Care Management		
Department: Compliance		
Title: PHC-CA Auditing and Monitoring		
Effective Date: 1/1/2006		
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Reviewed/Revised by: Sandra Holzner		Review/Revision Date: 12/13/2025
Approving Committee: Compliance Committee		Date: 12/15/2025
Executive Oversight Committee Date: 12/16/2025		

Purpose:

The purpose of this document is to establish an effective internal compliance program for PHC California (the Health Plan) that includes the implementation and operation of a robust system for routine monitoring and auditing. This system is designed to identify compliance risks and instances of Fraud, Waste, and Abuse (“FWA”) promptly, enabling timely responses as necessary to protect the integrity of the Medi-Cal program and ensure the delivery of high-quality managed health care services. The program also addresses non-compliance by enforcing adherence to all applicable Department of Health Care Services (DHCS) contract standards, ensuring corrective actions are taken swiftly to maintain compliance and uphold program integrity.

The Health Plan must develop maintain effective systems for routine monitoring and auditing, and identification of compliance risks including but not limited to:

1. Dedicated staff for routine internal monitoring and auditing of compliance risks.
2. Methods and tools for assessing whether Health Plan activities required under DHCS Managed Care contract comply with State and federal law and this Contract. This includes having methods and tools to evaluate and trend an activity over time to assess noncompliance.
3. Routine and periodic reporting of internal monitoring and auditing activities and results to compliance and oversight committee of the board; and
4. Unannounced audits of Subcontractors and Downstream Subcontractors to assess the compliance with requirements set forth in DHCS Managed Care Contract as relevant to delegated functions.

Policy:

The Health Plan will fully comply with all applicable federal and state laws and regulations governing the establishment and operation of its Medi-Cal Compliance Program and Work Plan(s). To proactively identify potential or actual compliance risks, including Fraud, Waste, and Abuse (FWA), the Health Plan has developed and maintains a comprehensive process for auditing and monitoring its Medi-Cal functions. This process encompasses ongoing monitoring and auditing to ensure adherence to Medi-Cal regulatory and sub-regulatory guidance, contractual obligations, relevant federal and state laws, and the Health Plan’s own policies and procedures. The Health Plan is committed to promptly addressing any identified risks to safeguard the integrity of the Medi-Cal program and the quality of managed health care services delivered.

Procedure:

A. Annual Work Plan

1. The Care Management Compliance Officer, with the assistance of the Care Management Compliance Committee, will develop an annual work plan that will:
 - a. Identify the areas of highest risk for the organization that will be audited that year, both within the Health Plan and with respect to contracted entities.
 - 1) Priorities may be developed based on any internal or external corrective action plans from the previous year, Office of Inspector General annual work plan, audit results of the Health Plan, law enforcement actions, compliance literature, published enforcement actions, etc.
 - 2) Priorities will include any state-required self-audits.
 - b. Provide an audit schedule.
 - c. Describe the kind of audits that will be performed.
 - d. Identify the ongoing monitoring projects for the year.
2. The Compliance Officer will present the Work Plan to the Care Management Compliance Committee for approval annually.
3. The Compliance Officer will direct and oversee the monitoring and auditing to be performed under the work plan. The Compliance Officer will rely on subject matter experts within or without the Health Plan (subject to budget approval by the Chief of Care Management) to review findings where the Compliance Officer does not have expertise in the area being audited. The Compliance Officer will present the results to the Care Management Compliance Committee at each meeting.
4. Areas of monitoring (for both participating and nonparticipating providers) may include:
 - a. Ensuring that the Health Plan's staff are monitoring the [OIG LEIE](#) exclusion list for Medicare, the GSA SAM Exclusion List, Medicaid and other required State or federal exclusions list monthly.
 - b. Ongoing monitoring of marketing representative activities, including review of marketing materials and random monitoring of recipient interactions for Medi-Cal.
 - c. Ongoing monitoring of recipient disenrollment reasons.
 - d. Ensuring that employees and representatives are:
 - 1) Maintaining documents and records in an appropriate manner which is in accordance with regulatory and legal requirements;
 - 2) Adhering to the Health Plan's confidentiality standards;
 - 3) Adhering to the Health Plan's standards related to use of electronic media;

- 4) Executing transactions in accordance with management's authorization and recording and reporting them in accordance with the Health Plan's contractual and regulatory requirements;
- 5) Immediately notifying the Compliance Officer of any issues that result from monitoring/auditing functions.

5. Areas for auditing may include but are not limited to:

- a. Appeals
- b. Call Logs
- c. Care Management
- d. Compliance with Policies and Procedures
- e. Claims
- f. Delegation Oversight
- g. Enrollment/Disenrollment
- h. Grievances
- i. Marketing
- j. Timely Access
- k. Transportation
- l. Utilization Management

B. Auditing and Monitoring Process

1. The auditing process is a structured and methodical approach designed to provide assurance on the effectiveness of internal controls, compliance with policies, and accuracy of data.
 - a. It begins with the planning phase, where auditors define the audit objectives, scope, and methodology based on risk assessments and organizational priorities. During this stage, auditors also identify key stakeholders, gather preliminary information, and develop timelines.
 - b. The next phase is fieldwork, which involves collecting and analyzing data through document reviews, interviews, and control testing to evaluate processes and identify gaps or non-compliance.
 - c. Findings are then assessed against established criteria and documented with supporting evidence to ensure accuracy and objectivity.
 - d. Once analysis is complete, auditors prepare a report that communicates results clearly, prioritizes issues based on risk, and provides actionable recommendations for improvement.

- e. The process and follow-up to monitor corrective actions.
- f. Throughout all stages, auditors maintain independence, confidentiality, and adherence to professional standards to ensure reliability and integrity of the audit outcomes.

2. Documentation of Internal Audit Reports

- a. When drafting internal audit reports, it is essential to follow a standardized structure that includes sections such as the executive summary, scope and objectives, methodology, findings, recommendations, and required follow up.
- b. Reports should be clear and concise, using plain language to ensure stakeholders can easily understand the content.
- c. Accuracy and completeness are critical—every finding must be supported by documented evidence and linked to the criteria used for evaluation.
- d. Issues should be prioritized based on risk level, with significant matters highlighted in the executive summary.
- e. Objectivity is key; findings must be presented factually without bias, and recommendations should be specific, practical, and aligned with identified risks.
- f. Reports must comply with regulatory requirements and internal audit standards, referencing relevant frameworks where applicable.
- g. Before finalization, conduct a thorough review for quality, grammar, and adherence to templates, and include management responses with agreed-upon corrective actions and timelines.
- h. Finally, ensure confidentiality by applying appropriate classification labels and handling sensitive information according to organizational policies.
- i. See Attachment A for Internal Audit Report Template.

3. The Health Plan’s auditing and monitoring techniques may include but are not limited to:

- a. Sampling protocols, on-site visits, questionnaires or interviews (for providers, members and employees), and trend analyses to identify and review variations from an established baseline.
- b. Track statistical data on claims, transportation invoices, medical management (underutilization or overutilization of services, referrals), quality improvement (activities and feedback, outcomes), and customer satisfaction (disenrollment’s).
- c. Conducting random reviews, including letters sent to members who were seen by identified providers in order to identify improper coding (upcoding and unbundling), billing for services never rendered or inflating the bills for services and/or goods provided, i.e., through validation of encounter data with comparison to the medical record, unannounced site visits.

4. In addition to audits identified in the Work Plan, the Health Plan’s Department may request or the Compliance Officer may initiate ad hoc audits (announced or unannounced), which will be overseen by the Compliance Officer.

5. The Compliance Officer collaborates with the Quality Improvement and Claims Processing



department personnel to develop and review reports related to utilization and payment with the goal of identifying instances of possible fraud, waste, and abuse.

6. The Compliance Officer, and the Special Investigations Unit (“SIU”) will on a regular basis verify, by sampling or other method to verify, confirming that services that have been represented to have been delivered by Network Providers were received by Members. Proof of compliance will be provided when requested by DHCS and in form and manner specified by DHCS.
7. The Compliance Officer will also recommend and oversee monitoring and auditing of subcontracted or downstream entities.
8. Development of Reports:
 - a. The Compliance Officer collaborates with the Quality Improvement and IT departments to develop standard reports to be used for identifying trends related to suspected fraud and abuse by providers, members, and/or employees.
 - b. The Compliance Officer will on his/her own initiative or at the request from the Chief of Care Management, or other members of the Care Management Executive Oversight Committee (EOC) of the Board of Directors, develop ad hoc reports on an as-needed basis.
 - c. The Compliance Officer will report to EOC the results of audits.
 - d. Compliance Officer will maintain the reports on a secure network.
 - e. The Compliance Officer and the SIU collaborates with IT to generate reports to assist in the prevention and detection of potential or suspected fraud and abuse including but not limited to:
 - i) Claims edits;
 - ii) Post-processing review of claims;
 - iii) Provider profiling, including a review process for claims and encounters that shall include providers and non-participating providers:
 1. Who demonstrate a pattern of submitting falsified encounter data or service reports;
 2. Who demonstrate a pattern of overstated reports or up-coded levels of service;
 3. Who alter, falsify or destroy clinical record documentation; and,
 4. Who make false statements relating to credentialing.
 5. Providers who fail to render medically necessary covered services that they are obligated to provide according to their subcontracts; and,
 6. Providers who charge members for covered services.

9. The Compliance Officer, with the assistance of the SIU and the Care Management Compliance Committee, will analyze data developed through the auditing and monitoring process for use in fraud, waste, and abuse prevention and detection for the Health Plan's contractors and subcontractors. Such data will be used in developing indicators for identifying norms, abnormalities, and individual variables that describe statistically significant time-series trends.

C. Employee Responsibilities in Detecting/Reporting Fraud

1. Human Resources and Credentialing Departments shall use the List of Excluded Individuals and Entities (LEIE) or its equivalent, and the federal System for Award Management (SAM), monthly, to identify excluded parties during the process of hiring staff and enrolling providers to ensure that they are not in a non-payment or excluded status. AHF shall not employ or contract with excluded providers and shall terminate them if they become excluded. Provider Relations and Credentialing shall do ongoing monitoring of existing providers to ensure they do not become excluded providers and will immediately initiate contract termination in the event of exclusion.
2. Claims Department will report to the Compliance Officer all instances of questionable billing or other potential fraudulent practices and also prepare reports to identify patterns of suspicious billing practice at the request of Compliance Officer.
3. Member Services will report to the Compliance Officer all instances where a member has raised a potential fraudulent provider practice). Member Services will ensure that Enrollee Handbooks inform members on how to report fraud to the Compliance hotline (1-800-AIDSHIV).
4. Provider Relations will inform all providers of the Compliance hotline number (1-800-AIDSHIV) and will report to the Compliance Officer all instances where a provider has reported a potentially fraudulent practice. Provider Relations will also ensure that provider contracts and handbooks contain all required provisions regarding detecting and reporting fraud and regarding the provider's responsibility to educate/train their staff and subcontractors regarding fraud, waste and abuse. Provider Relations will ensure that providers complete all fraud and abuse training required by law (i.e., the federal Deficit Reduction Act, section 6032) or the Health Plan. Provider Relations will ensure that all provider contracts provide that federal or state regulators shall have access to all medical records as required by law and that providers shall cooperate fully with the regulators' investigations and prescribed corrective actions.
5. Quality will report to the Compliance Officer or the SIU all instances where it has detected a potentially fraudulent member or provider activity and assist with any investigation. Quality will also assist in ensuring that any corrective action plan is carried out as prescribed.
6. Utilization Management will report to Compliance Officer or the SIU any suspicious utilization activity.).
7. Human Resources will ensure that Employee Handbooks contain specific information about the False Claims Act and employee protections, as set forth in section 6032 of the federal Deficit Reduction Act, as well as how to report compliance concerns (i.e., Compliance hotline).
8. Compliance Officer shall oversee all compliance efforts described in the Health Plan's Compliance policies and procedures. The Officer shall maintain a schedule of all the Health Plan's reporting requirements and monitor it to ensure timely reporting of all contractual requirements. The Compliance Officer (with the Chief of Managed Care) will also meet with federal or state regulators at their request to discuss fraud, abuse, neglect and overpayment issues.

9. The Health Plan's Medical Director will review enrollee utilization and/or claims for suspicious activity and report any suspected instances of FWA to the Compliance Officer and/or the SIU.

D. Referral and Tracking

1. The Compliance Officer and/or the Special Investigations Unit (SIU)/Compliance Manager receives referrals of noncompliance and FWA. Referrals may come from internal departments or outside the Health Plan via voicemail, fax, oral communication, confidential interoffice mail, mail, AHF email, or the Compliance hotline.
2. The SIU/Compliance Manager maintains a record of all reports of FWA in a secure folder and maintains any papers in a secured cabinet.

Definitions:

1. Abuse: means practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program
2. AHF: refers to AIDS Healthcare Foundation and its affiliates/subsidiaries who offer managed care health plans.
3. Audit: refers to a formal review of compliance with a particular set of internal (e.g., policies and procedures) or external (e.g., laws and regulations) standards used as base measures.
4. Department of Health Care Services (DHCS) or Department: means the single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health-related programs, as provided by statute and/or regulation.
5. Downstream Subcontractor: means an individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.
6. Downstream Fully Delegated Subcontractor: means a Downstream Subcontractor that contractually assumes all duties and obligations of Contractor under the Contract, through the Subcontractor, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A managed care plan can operate as a Downstream Fully Delegated Subcontractor.
7. Downstream Partially Delegated Subcontractor: means a Downstream Subcontractor that contractually assumes some, but not all, duties and obligations of a Subcontractor under the Contract, including, for example, obligations regarding specific Member populations or obligations regarding a specific set of services. Individual physician associations and medical groups often operate as Downstream Partially Delegated Subcontractors.
8. Downstream Administrative Subcontractor: means a Downstream Subcontractor that contractually assumes administrative obligations of a Subcontractor under the Contract. Administrative obligations include functions such as credentialing verification or claims processing. However,

functions related to coordinating or directly delivering health care services for Members, such as Utilization Management (UM) or Care Coordination, are not administrative functions.

9. Downstream Subcontractor Agreement: means a written agreement between a Subcontractor and a Downstream Subcontractor or between any Downstream Subcontractors. The Downstream Subcontractor Agreement must include a delegation of Contractor's and Subcontractor's duties and obligations under the Contract.
10. Excluded Entities or Excluded Providers: means entities, Providers, and individuals that are excluded from participation in federally funded health care programs for a variety of reasons, including a conviction for Medicare or Medicaid Fraud.
11. Fraud: means an intentional deception or misrepresentation made by persons with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person and includes any act that constitutes Fraud under applicable federal or State law, including 42 CFR section 455.2 and W&I section 14043.1(i).
12. Marketing: means any activity conducted by or on behalf of Contractor where information regarding the services offered by Contractor is disseminated in order to persuade or influence Potential Members to enroll. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of Contractor.
13. Medically Necessary or Medical Necessity: means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.
14. Monitoring: activities refer to reviews that are repeated regularly during the normal course of operations.
15. Subcontractor: means an individual or entity that has a Subcontractor Agreement with Contractor that relates directly or indirectly to the performance of Contractor's obligations under this Contract. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.
16. Subcontractor Agreement: means a written agreement between Contractor and a Subcontractor. The Subcontractor Agreement must include a delegation of Contractor's duties and obligations under the Contract.
17. Subcontractor Network: means a Network of a Subcontractor or Downstream Subcontractor, wherein the Subcontractor or Downstream Subcontractor is delegated risk and is responsible for arranging for the provision of and paying for Covered Services as stated in their Subcontractor or Downstream Subcontractor Agreement.
18. Suspended and Ineligible Provider List: means the list containing the names of former Medi-Cal Providers suspended from or ineligible for participation in the Medi-Cal program. The Suspended and Ineligible Provider List is available online at <https://files.medi-cal.ca.gov/pubsdoco/SandILanding.aspx>.

19. Utilization Management (UM) or Utilization Review means the evaluation of the Medical Necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.

20. Waste: means the overutilization or inappropriate utilization of services and misuse of resources.

Monitoring:

This policy is updated, as necessary, reviewed and approved annually by the Care Management Compliance Committee.

Reference(s):

1. 42 C.F.R. § 438.608(b)(6) [Medicaid]
2. DHCS Managed Care Contract Exhibit A, Attachment III, 1.3.1 subsection K



Attachment A

Internal Audit Report

Date: [MM/DD/YYYY]

Prepared by: [Auditor Name / Audit Team]

Line(s) of Business:

Operational Area:

1 SUMMARY

Objective: Briefly state the purpose of the audit.

Scope: Define the areas, processes, and time period covered.

Key Findings: Summarize major issues or observations.

Overall Conclusion: Provide a high-level assessment.

2 METHODOLOGY

Insert here

3 DETAILED FINDINGS

For each finding:

- Finding Number: [e.g., F-01]
- Description: Explain the issue clearly.
- Risk/Impact: Describe potential consequences.
- Root Cause: Identify underlying reasons.
- Recommendation: Suggest corrective actions.
- Management Response: Include comments from responsible parties.

4 CONCLUSION

Insert here

5 ACTION PLAN

Finding	Action	Responsible Person	Deadline

6 APPENDICES
