REPORT ON THE MEDICAL AUDIT OF COMMUNITY HEALTH GROUP FOUNDATION DBA COMMUNITY HEALTH GROUP PARTNERSHIP PLAN CALENDAR YEAR 2025

DHCS Audits and Investigations
Contract and Enrollment Review Division
San Diego Section

Contract Number: 23-30217
Audit Period: April 1, 2025 — December 31, 2025
Dates of Audit: April 20, 2026 — May 1, 2026
Report Issued: September 3, 2026

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I. INTRODUCTION

Community Health Group Foundation dba Community Health Group Partnership Plan (Plan) was incorporated in 1986 and contracted with the Department of Health Care Services (DHCS) to provide services to Medi-Cal members. In 2005, the Plan obtained a Knox-Keene license from the California Department of Managed Health Care to serve Medi-Cal members.

The Plan currently contracts with DHCS to provide services to Medi-Cal members under the Geographic Managed Care program in San Diego County. The Plan provides health care services through contracts with its provider network, including private physicians, group practices, Federal Licensed Community Health Centers, Indian Health Services, all hospitals in its service area, an array of ancillary providers, and pharmacy services through Medi-Cal Rx.

The Plan is accredited by the National Committee for Quality Assurance as a Medicaid Health Maintenance Organization from September 25, 2023, through September 25, 2026, and for Health Equity from August 17, 2023, through August 17, 2026.

As of December 31, 2025, the Plan served a total of 360,263 members through the following programs: Medi-Cal, 350,464; Dual Special Needs Plan, 9,351; and Chronic Condition Special Needs Plan, 448.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of April 1, 2025, through December 31, 2025. The audit was conducted from April 20, 2026, through May 1, 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 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 September 2, 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 six categories of performance: Utilization Management (UM) Program, Population Health Management and Coordination of Care, Network and Access to Care, Grievances, Appeals, and Member Rights, Quality Improvement and Health Equity Transformation Program, and Plan Administration and Organization.

The prior DHCS medical audit for the period of June 1, 2024, through March 31, 2025, was issued on November 14, 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.

The summary of the findings by category follows:

Category 1 – Utilization Management Program

The Plan must process non-standard benefit requests on a case-by-case basis. When non-standard benefit requests demonstrate medical necessity, the request is a covered service. Finding 1.2.1: The Plan did not correctly process Prior Authorization (PA) requests for non-standard benefits, including sending Notice of Action (NOA) letters with all NOA-required elements.

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 must provide written translations of member information, including NOAs, in all threshold and concentration languages. In San Diego County, as of March 2024, threshold languages include Chinese, which encompasses Cantonese, Mandarin, and other Chinese languages, as defined in *All Plan Letter (APL) 25-005, Standards for Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services, and Alternative Format*. Finding 4.4.1: The Plan did not provide written translations of NOAs in the threshold language of Chinese for members whose preferred language was Cantonese.

Category 5 – Quality Improvement and Health Equity Transformation Program

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

Category 6 – Plan Administration and Organization

The Plan must maintain a full-time Chief Health Equity Officer who has the necessary qualifications or training at the time of hire or within one year of hire to meet the requirements of the position. Additionally, the Plan's Compliance Officer must be a full-time employee and must be independent, which means they must not serve in both a compliance and operational role. Finding 6.7.1: The Plan's policies and procedures did not include safeguards to prevent dual-role conflicts of key leadership positions, specifically the Chief Health Equity Officer and Compliance Officer roles.

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 April 20, 2026, through May 1, 2026, for the audit period of April 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 1 – Utilization Management Program

PA Requests: Twenty-five PA requests were reviewed for timeliness, consistent application of criteria, appropriate review, and communication of results to members and providers.

Delegated PA Requests: Fifteen delegated PA requests were reviewed for appropriate and timely adjudication.

Category 2 – Population Health Management and Coordination of Care

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

Enhanced Care Management: Ten medical records were reviewed for care coordination and completeness to evaluate service performance.

Category 3 – Network and Access to Care

Timely Payments: Nine emergency service and five family planning claims were reviewed for appropriateness and timeliness.

Category 4 – Grievances, Appeals, and Member Rights

Grievance Procedures: Forty-one standard grievances (20 quality of care and 21 quality of service), 3 expedited grievances, 3 exempt grievances, and 10 call inquiries were reviewed for timely resolution, response to the complainant, submission to the appropriate level for review, and translation in the member's preferred language (if applicable).

Appeal Procedures: Fifteen appeals (12 routine and 3 expedited) were reviewed for appropriateness and timeliness of decision-making.

Confidentiality Rights: Two Health Insurance Portability and Accountability Act/Protected Health Information breach and security incidents were reviewed for processing and timeliness requirements.

Category 5 – Quality Improvement and Health Equity Transformation Program

Quality Management: Eight potential quality issue cases were reviewed for timely evaluation and effective action taken to address improvements.

Category 6 – Plan Administration and Organization

Fraud, Waste, and Abuse : Three fraud, waste, and abuse cases were reviewed for processing and reporting requirements.

Suspended, Excluded, and Ineligible Providers: Six providers were reviewed for completion of required monthly screenings against federal and state exclusion databases and for compliance with prohibitions on employing, paying, or contracting with excluded, suspended, or otherwise ineligible providers

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management Program

1.2 Prior Authorizations and Review Procedures

1.2.1 Non-Standard Benefits Review Procedures

The Plan must ensure that covered services and other services required in the Contract are provided to a member in an amount no less than what is offered to Medi-Cal beneficiaries in Medi-Cal Fee-For-Service, as defined in the most current Medi-Cal Provider Manual and consistent with current, evidence-based medical standards. *(Contract, Exhibit A, Attachment III, 5.3.1 (A))*

Non-standard benefits are services that are not a standard Medi-Cal benefit for the general Medi-Cal population. However, non-standard benefits may be provided with an approved Treatment Authorization Request (TAR) demonstrating medical necessity. With non-standard benefit procedure codes, Medi-Cal may cover and provide reimbursement for services associated with the procedure code on a case-by-case basis for individual Medi-Cal members based on a TAR demonstrating medical necessity. *(Medi-Cal Provider Manual (2025), TAR and Non-Standard Benefits: Introduction to List)*

The Plan must provide a clear and concise written explanation of the reasons for denying, deferring, or modifying a service; a description of the criteria or guidelines used; and the clinical reasons for the decision based on medical necessity. *(Contract, Exhibit A, Attachment III, 2.3.1 (E))*

For PA decisions based in whole or in part on medical necessity, the written NOA must contain a description of the criteria guidelines used. This includes a reference to the specific regulation or authorization procedure(s) that supports the decision, as well as an explanation of the criteria or guideline. The NOA must also contain the clinical reasons for the decision. The Plan must explicitly state how the member's condition does not meet the criteria or guidelines. *(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

Plan *UM policy 7254 Notification of Utilization Management Decisions* (revision effective Date August 31, 2025), states that written NOAs are sent to members for denial, delay, or modification of requested services. The letter contains the reason for the denial, modification, or delay, including an easily understandable summary of the UM criteria or

criteria of specific regulations, and the clinical reasons for the decisions regarding medical necessity.

Plan *UM policy 7251.8 Review of Requests for Health Care Services* (revisions effective August 31, 2025), states that requests are reviewed to determine whether adequate supportive medical documentation has been received. Any UM decisions determined not to meet medical necessity must be reviewed by a physician. Administrative denials on requests that are not a covered benefit and lack appropriate clinical documentation may be processed by a registered nurse.

Plan *UM policy 7224 Denial Review Process* (revision effective August 31, 2025), outlines the process to review cases when a denial is recommended. The policy outlines that a nurse reviewer will determine whether a request does not meet medical necessity criteria or the request is a non-covered benefit before it is presented to the Chief Medical Officer (CMO) or Medical Director for denial determination. The nurse reviewer develops denial language based on the CMO or Medical Director recommendations, which is reviewed by the CMO or Medical Director before the final denial letter is processed.

Finding: The Plan did not correctly process PA requests for non-standard benefits, including sending NOAs with all NOA-required elements.

A verification study of 25 PA requests revealed that 5 non-standard benefit requests were denied. Although Plan documentation demonstrated that a medical necessity evaluation was completed for all five non-standard benefit requests, the Plan issued NOAs without the following NOA-required elements:

- A description of the medical necessity criteria or guidelines used,
- An explanation of how the member did not meet the criteria, and
- The clinical reasons to support the decision.

All five requests were for non-standard benefits as noted in the Medi-Cal Provider Manual's *TAR and Non-Standard Benefits List (Introduction to List)*. Coverage of non-standard benefits is determined on a case-by-case basis upon confirmation of medical necessity. Although there is evidence that a medical necessity evaluation was completed for the five PAs, the NOAs sent to members omitted the criteria or clinical rationale for the denial decisions.

In an interview and written response, the Plan explained that:

- It completed a medical necessity review and considered the five PA requests to be non-covered benefits. Following the PA decision, the Plan's subsequent actions were not based on its medical necessity review, which requires sending out an NOA with all NOA-required elements.
- Because the Plan considered these five PA requests as non-covered benefits, they were adjudicated as administrative denials.
- Ultimately, the Plan's actions following its PA decision were based on its administrative denial of non-covered benefits, which does not require including medical necessity criteria or clinical reasons for benefit denials.

The Plan misinterpreted DHCS requirements for non-standard benefits and incorrectly processed the identified cases as administrative denials of non-covered services, despite completing medical necessity reviews. Because PA decisions involving medical necessity require NOAs with all required elements, this misclassification resulted in NOAs lacking mandatory information. Additionally, the Plan's policies and procedures do not distinguish non-standard benefits from non-covered benefits and do not include a process for handling non-standard benefit requests.

The misclassification of non-standard benefit requests resulted in members receiving NOAs that incorrectly advised that the services were excluded from Medi-Cal coverage. When the Plan does not process PA requests for non-standard benefits and sends NOAs without all required elements, members are left unable to make informed decisions and exercise their appeal rights.

Recommendation: Develop and implement policies and procedures to process PA requests for non-standard benefits based on a case-by-case medical necessity review, including sending NOAs with all NOA-required elements.

COMPLIANCE AUDIT FINDINGS

Category 4 – Grievances, Appeals, and Member Rights

4.4 – Notices of Action

4.4.1 Translation of Notices of Action

The Plan must ensure all NOAs informing a member of an Adverse Benefit Determination are in writing in a format and language that meets the standards set forth in *APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services*. *(Contract, Exhibit A, Attachment III, 4.6.4 (E))*

The Plan must provide written translations of member information, including NOAs, in the threshold and concentration languages. In San Diego County, the Plan's service area, Chinese is one of the threshold languages. Chinese is the combination of Cantonese, Mandarin, and other Chinese language. *(APL 25-005, Standards for Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services, and Alternative Formats)*

Plan policy, *7400a Language Assistance Program (Linguistic Services)* (revised August 1, 2025), states that the Plan provides translated written information, using a qualified translator, in the required threshold and concentration languages outlined in the Notice of Availability (English, Spanish, Vietnamese, Arabic, Tagalog, Farsi, Chinese, and Russian). The policy further states the Plan has an established process for translations in Chinese to provide members with Chinese as their preferred language with documents translated in simplified Chinese characters. If a member has requested to receive translated written information in either traditional or simplified Chinese characters, the Plan must provide written information in the member's preferred characters.

Finding: The Plan did not provide required written translations of NOAs in the threshold language of Chinese for members whose preferred language was Cantonese.

A verification study revealed that in 1 of 25 PAs, the NOA was issued only in English, without a Chinese-language translation. Chinese is a designated threshold language for San Diego County under APL 25-005. Documentation reviewed confirmed the member's preferred language as Cantonese. The Plan's policy 7400a, did not identify Cantonese as a dialect of Chinese that must be supported through written translation in either

simplified or traditional Chinese characters. In a written statement, the Plan acknowledged Cantonese was not identified as being one of the threshold languages in its policy.

This occurred because the Plan misinterpreted APL 25-005 by relying solely on the threshold language table's page 2 grid and failing to review the related footnote clarifying that Chinese includes Cantonese, Mandarin, and other Chinese languages. The Plan's language assistance policy does not explicitly state that Cantonese falls under the Chinese threshold language category, and staff were not trained to interpret dialects in alignment with DHCS standards. Additionally, the Plan's workflow lacks a control mechanism to ensure that all Chinese dialects trigger the required written translation process. As a result, staff incorrectly concluded that Cantonese was not a threshold language and did not initiate the translation of the NOA.

When the Plan does not provide written translation of NOAs, members may not be informed of actions taken by the Plan and of their member rights, which prevents them from making informed decisions about their health care. In addition, health inequities for members with limited English proficiency may be exacerbated.

Recommendation: Revise and implement Plan policy and procedure to ensure that the Plan provides written translations of NOAs in Chinese for members whose preferred language is Mandarin, Cantonese, or other Chinese language.

COMPLIANCE AUDIT FINDINGS

Category 6 – Plan Administration and Organization

6.7 – Chief Health Equity Officer

6.7.1 Key Leadership Roles

The Plan must maintain a full-time Chief Health Equity Officer who has the necessary qualifications or training at the time of hire or within one year of hire to meet the requirements of the position. *(Contract, Exhibit A, Attachment III, 1.1.7)*

The Contract's Article 1.0 outlines DHCS' requirements for plan administration and organization including key leadership roles, including the designation of a Chief Health Equity Officer, has the authority to design and implement policies that ensure health equity is prioritized and addressed. *(Contract, Exhibit A, Attachment III, 1.0)*

The Plan's compliance program includes the designation of a Compliance Officer who is responsible for developing, implementing, and ensuring compliance with the requirements and standards under the Contract and who reports directly to the Chief Executive Officer and the Board of Directors. The Plan's Compliance Officer must be a full-time employee and must be independent, which means they must not serve in both a compliance and operational role. For example, when the Compliance Officer is the Chief Operating Officer, Finance Officer or General Counsel. *(Contract, Exhibit A, Attachment III, 1.3.1 (E))*

Finding: The Plan's policies and procedures did not include safeguards to prevent dual-role conflicts of key leadership positions, specifically the Chief Health Equity Officer and Compliance Officer roles.

The Plan has assigned a single individual to simultaneously perform the full-time duties of both the Compliance Officer and the Chief Health Equity Officer, resulting in dual occupancy of two distinct full-time leadership roles.

The audit found that the Plan appointed its full-time Compliance Officer to concurrently serve as its full-time Chief Health Equity Officer. Documentation reviewed, including the Plan's organization chart and job descriptions for both positions, and interview statements, confirmed that one individual occupies both full-time leadership roles. The Plan does not maintain a policy or procedure requiring the Chief Health Equity Officer role to be separate from other key leadership roles, nor a policy reinforcing the

Compliance Officer's independence by prohibiting concurrent operational responsibilities. As a result, the Plan's structure does not comply with Contract requirements, which requires dedicated full-time leadership for both roles and independence of the compliance function.

The dual role situation occurred because the Plan misinterpreted the DHCS Contract, concluding that a single individual could meet the full-time designation requirements for both the Compliance Officer and Chief Health Equity Officer positions simultaneously. The Plan bases its interpretation on the absence of explicit language requiring two natural persons or full-time equivalent allocations. In its written statement, the Plan explained that it interpreted the Contract to allow one individual to fulfill both positions concurrently so long as the individual remained full-time with the Plan, performed the full scope of duties associated with each role, and maintained sufficient capacity and authority. The Plan also lacked internal policy guidance on Compliance Officer independence and segregation of duties. Consequently, leadership did not identify that assigning the Chief Health Equity Officer responsibilities to the Compliance Officer created an operational role inconsistent with Contract requirements for compliance independence.

Assigning both key leadership roles to the same individual impairs the independence of the Compliance Officer. If the Compliance Officer does not maintain their independence, the effectiveness of compliance oversight is reduced and limits the Plan's ability to provide dedicated executive leadership for health equity strategy, monitoring, and interventions.

Recommendation: Develop and implement policies and procedures to maintain separate, full-time Chief Health Equity Officer and Compliance Officer positions, that ensure independence and segregation of duties in accordance with Contract requirements.

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DHCS Audits and Investigations
Contract and Enrollment Review Division
San Diego Section

Contract Number: 23-30249
Contract Type: State Supported Services
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I. INTRODUCTION

This report presents the results of the audit of Community Health Group Foundation dba Community Health Group Partnership Plan (Plan) compliance and implementation of the State Supported Services contract number 23-30249 with the State of California. The State Supported Services Contract covers abortion services with the Plan.

The audit covered the period of April 1, 2025, through December 31, 2025. The audit was conducted from April 20, 2026, through May 1, 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 17, 2026. No deficiencies were noted during the review of the State Supported Services Contract.

COMPLIANCE AUDIT FINDINGS

State Supported Services

The Plan's policies and procedures, Provider Manual, and Member Handbook indicated that abortion services were covered, and prior authorization was not required for this service. Members may go to any Medi-Cal provider of their choice for abortion services, at any time for any reason, regardless of network affiliation.

A verification study of 10 State Supported Service claims was conducted to determine appropriate and timely adjudication of claims. There were no compliance issues identified during the audit period.

Recommendation: None.