# REPORT ON THE MEDICAL AUDIT OF SAN MATEO HEALTH COMMISSION DBA HEALTH PLAN OF SAN MATEO 2025

**DHCS Audits and Investigations**
**Contract and Enrollment Review Division**
**San Francisco Section**

**Contract Number: 23-30238**
**Audit Period: September 1, 2024 — December 31, 2025**
**Dates of Audit: February 3, 2026 — February 12, 2026**
**Report Issued: August 7, 2026**

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

# TABLE OF CONTENTS

# I. INTRODUCTION

The California Legislature authorized the Board of Supervisors of San Mateo County to establish a county commission for negotiating an exclusive contract for the provision of Medi-Cal services in San Mateo County in 1983. San Mateo County Board of Supervisors created the San Mateo Health Commission (SMHC) in June 1986, as a local, independent public entity.

In 1987, the SMHC founded the San Mateo Health Commission dba Health Plan of San Mateo (Plan) to provide county residents with access to a network of providers and a benefits program that promotes preventive care.

The SMHC is the governing board for the Plan. Board members are appointed by the San Mateo County Board of Supervisors. The Plan received its Knox-Keene license as a full-service plan on July 31, 1998.

Senate Bill 849 (Chapter 47, Statutes of 2018) authorized the Department of Health Care Services (DHCS) to establish a dental integration program in San Mateo County to include Medi-Cal dental services as a covered benefit under the Plan. The integration of the dental benefit took effect on January 1, 2022. All Medi-Cal members enrolled in San Mateo County now receive dental care through the Plan in addition to medical services.

The Plan's provider network includes independent providers practicing as individuals, small and large group practices, community clinics, and the San Mateo Medical Center, which operates multiple clinic sites.

As of December 31, 2025, the Plan had 144,044 members of which 132,568 (92.03 percent) were Medi-Cal, 8,288 (5.75 percent) were Dual Eligible Special Needs Plan, 827 (0.57 percent) were Access and Care for Everyone (ACE) Program, 1,316 (0.91 percent) were HealthWorx, and 1,045 (0.73 percent) were Whole Child Model Program. Out of the Plan's 144,044 members, 8,044 (5.58 percent) were Seniors and Persons with Disabilities (SPD).

# II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of September 1, 2024, through December 31, 2025. The audit was conducted from February 3, 2026, through February 12, 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 June 18, 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 July 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 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 September 1, 2023, through August 31, 2024, was issued on April 17, 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 is as follows:

## Category 1 – Utilization Management Program

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

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

The Plan must provide basic Population Health Management (PHM) to all members. The Plan is responsible for ensuring Complex Case Management (CCM) Care Managers comply with all of the basic PHM requirements and all National Committee for Quality Assurance CCM standards. The Plan must also comply with federal regulations that stipulate specific care plan requirements for members with Long-Term Services and Supports (LTSS) needs. Finding 2.7.1: The Plan did not include all of the required standardized LTSS referral questions in their assessment of members enrolled in CCM.

The Plan must ensure that all members receive all seven Enhanced Care Management (ECM) core service components. The Plan must perform oversight of ECM providers, holding them accountable to all ECM requirements contained in the Contract. Finding 2.25.1: The Plan did not ensure that all members received all seven ECM core service components.

## Category 3 – Network and Access to Care

The Plan must pay at least 90 percent of all clean claims from providers within 30 calendar days of the date of receipt and 99 percent of all clean claims within 90 calendar days. If the Plan does not pay a clean claim within 45 working days of receipt, the Plan is required to pay interest at the rate of 15 percent per annum beginning on the first day after a 45 working day period. Finding 3.17.1: The Plan did not pay the correct interest amount on family planning claims that were not paid within 45 working days of receipt.

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

The Plan must ensure adequate consideration of grievances and that each issue presented by the member is addressed and resolved. The written resolution must contain a clear and concise explanation of the Plan's decision. Finding 4.1.1: The Plan sent resolution letters to members without resolving each issue presented in Quality of Care (QOC) grievances.

The Plan must provide written acknowledgement to the member within five calendar days of receiving a grievance. The Plan must comply with the timeframe of 30 calendar days from the received date for grievance resolution and sending written notice to the member. The Plan must provide full and immediate translation of grievance acknowledgement and resolution letters for Limited English Proficiency (LEP) members who speak threshold or concentration languages. Finding 4.1.2: The Plan did not provide translated grievance acknowledgement and resolution letters to members within the required timeframes.

The grievances and appeals written record must be reviewed periodically by the Plan's governing body. The review must be thoroughly documented. Finding 4.1.3: The Plan's governing body did not review the grievances and appeals written record.

The grievances and appeals written record must be submitted at least quarterly to the Plan's quality assurance committee for aggregation and analysis for quality improvement. Finding 4.1.4: The Plan did not submit the grievances and appeals written record to the Quality Assurance Committee for aggregation and analysis for quality improvement.

The Plan must have written policies and procedures to ensure members are informed of what an advance directive is and how to put a valid advance directive in place. The Plan must have policies and procedures in place to ensure all involved in the member's care comply with a valid advance directive. Finding 4.12.1: The Plan did not have written policies and procedures informing members on how to put a valid advance directive in place nor did it have written policies or procedures to ensure all involved in the member's care comply with a valid advance directive.

## 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 file a preliminary report with the DHCS Program Integrity Unit (PIU) detailing any suspected Fraud, Waste, and Abuse (FWA) identified by or reported to the Plan within 10 working days of the Plan's discovery or notice of such FWA. Finding 6.13.1: The Plan did not file a preliminary report of suspected FWA to DHCS within 10 working days after its discovery or notice of such FWA.

The Plan must promptly conduct a complete investigation of all reported or suspected FWA activities. Within 10 working days of completing its FWA investigation, the Plan must submit a completed report to DHCS PIU. This report must include the Plan's findings, actions taken, and include all documentation necessary to support any action taken by the Plan. Finding 6.13.2: The Plan did not promptly conduct a complete investigation of all reported or suspected FWA activities.

# 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, 2026, through February 12, 2026, for the audit period of September 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 1 – Utilization Management Program

Prior Authorization Requests: Thirty-three prior authorization request files, including eleven SPD members, were reviewed for timeliness, consistent application of criteria, and appropriate review.

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

CCM: Ten files were reviewed to confirm the provision of care management for eligible members.

California Children's Services (CCS): Ten files were reviewed to confirm care coordination for members with CCS conditions and developmental disabilities.

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

Behavioral Health Treatment: Ten files were reviewed to confirm the performance of services and completion of case file elements.

Initial Health Appointment: Twenty files were reviewed to confirm the performance and completeness of the assessment.

Continuity of Care: Ten files were reviewed to confirm appropriate and timely processing of members' continuity of care requests.

## Category 3 – Network and Access to Care

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

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

Grievances: Seventy-one standard grievances, 10 exempt grievances, and 10 call inquiries were reviewed for timely resolution, appropriate classification, response to complainant, and submission to the appropriate level for review. The standard grievance cases included 40 quality of service and 31 QOC grievances.

Appeals Procedures: Thirty-two appeal files were reviewed for appropriate and timely adjudication.

Confidentiality Rights: Fifteen 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

Potential Quality Issues: Twelve potential quality issue files were reviewed for appropriate evaluation and effective action taken to address needed improvements.

## Category 6 – Plan Administration and Organization

Fraud and Abuse: Fifteen fraud and abuse files were reviewed for appropriate reporting and processing.

# COMPLIANCE AUDIT FINDINGS

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

### 2.7 Care Management Programs

#### 2.7.1 Complex Case Management Assessment Tool

The Plan must provide basic PHM to all members. The Plan is responsible for ensuring CCM Care Managers comply with all of the basic PHM requirements and all National Committee for Quality Assurance CCM standards. The Plan must maintain policies and procedures that meet the following basic PHM requirements, at a minimum: Ensure members have access to needed services including care coordination, navigation and referrals to services that address members' developmental, physical, mental health, substance use disorder, dementia, LTSS, palliative care, and oral health needs. *(Contract, Exhibit A, Attachment III, 4.3.8 (A)(2))*

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

The PHM Policy Guide outlines policies and contains DHCS operational requirements and guidelines on the PHM Program. *(APL 22-024, Population Health Management Policy Guide)*

Following federal and state law, the Plan or their delegates must continue to assess members who may need LTSS, using the existing standardized LTSS referral questions. The Plan must also comply with federal regulations that stipulate specific care plan requirements for members with LTSS needs. These standardized LTSS referral questions from *APL 17-013, Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities,* will continue to be required for Plans or their delegates to use to assess members who may need LTSS. *(CalAIM Population Health Management Policy Guide, (D)(2))*

The LTSS referral questions are intended to assist Plans in identifying members who may qualify for and benefit from LTSS services. The LTSS questions must be used verbatim. However, they may be incorporated into the existing Health Risk Assessment (HRA) and can replace similar existing HRA questions. *(APL 17-013, Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities)*

Plan policy, *CC-01 Integrated Care Management* (revised 9/25/25), stated that information obtained during the HRA will be used to make referrals and coordinate LTSS services as appropriate.

**Finding:** The Plan did not include all of the required standardized LTSS referral questions in their assessment of members enrolled in CCM.

In an interview, the Plan stated that LTSS questions are included in their CCM assessment tool. However, review of the Plan's CCM assessment tool revealed that the following standardized LTSS questions from APL 17-013 were not included:

- Low Health Literacy Questions
  - Do you need help filling out health forms?
  - Do you need help answering questions during a doctor's visit?
- Fall Risk Questions
  - Have you fallen in the last month?
  - Are you afraid of falling?
- Isolation Questions
  - Over the past month (30 days), how many days have you felt lonely?
    - None – I never feel lonely
    - Less than five days
    - More than half the days (more than 15)
    - Most days – I always feel lonely

A verification study of 10 member records revealed that the Plan used their CCM assessment tool on all 10 members. However, the CCM assessment tool did not include all of the standardized LTSS referral questions in all 10 samples.

- In one sample, a member was diagnosed with chronic neuropathy in their spinal cord which impacts their lower extremities. The member was dependent on some of the activities of daily living and was wheelchair bound. The member was not asked if they had fallen in the last month and if the member is afraid of falling.

- In 10 samples, members were asked if over the last two weeks they have been bothered by little interest or pleasure in doing things and if they are feeling down, depressed or hopeless. Required standardized LTSS isolation question states that members will be asked if in the past month (30 days), how often the members have felt lonely.
- In 10 samples, the members were not asked health literacy questions to ensure members had the ability to properly complete health forms and answer questions during doctor visits.

Subsequent to the Exit Conference, the Plan acknowledged that their CCM assessment tool does not contain the LTSS questions labeled or written verbatim, but stated that it does include assessment domains intended to identify LTSS needs. Furthermore, the Plan also stated that the current question structure may not clearly identify these LTSS questions enough for audit validation or consistent interpretation. However, APL 17-013 and the CalAIM Population Health Management Policy Guide required verbatim use of the LTSS questions.

When the Plan does not include all standardized LTSS referral questions in their CCM assessment tool, the Plan may miss identifying members LTSS needs and members may not receive necessary LTSS services.

**Recommendation:** Revise and implement the CCM assessment tool to include all standardized LTSS referral questions.

## 2.25 Enhanced Care Management

### 2.25.1 Enhanced Care Management Core Service Components

The Plan must ensure that all members receive all seven ECM core service components: Outreach and Engagement, Comprehensive Assessment and Care Management Plan (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. *(Contract, Exhibit A, Attachment III, 4.4.11)*

The Plan must 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 core ECM services must include, but are not limited to, the following:

Comprehensive Assessment and Care Management Plan

- Identifying clinical and non-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; and
- Incorporating into the members' CMP identified needs and strategies to address those needs, including, but not limited to, physical and developmental health, mental health, dementia, substance use disorders, LTSS, oral health, palliative care, necessary community-based and social services, and housing.

Enhanced Coordination of Care

- Providing support to engage the members in their treatment, including coordination for medication review and reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to member engagement in treatment.

Member and Family Supports

- Ensuring that the members 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, *Partners.03 Enhanced Care Management* (revised 10/23/25), stated that the Lead Care Manager (LCM) will administer the core service components of ECM in accordance with DHCS ECM policy guide. The LCM will participate in multidisciplinary team meetings and shall take lead in coordinating with and/or referring for other services, community resources, and programs to address social determinant of health such as but not limited to LTSS, behavioral health, palliative care, community supports and oral health as appropriate per the member's consent to address gaps in care as identified in the member's individualized care plan.

Plan policy, *Partners-02 Partner Oversight for Enhanced Care Management and Community Supports* (revised 10/23/25), stated that the Plan will ensure all ECM providers are administering the ECM benefit in accordance with the DHCS ECM policy

guide to include ensuring an LCM administers the core service components of ECM. The Plan will conduct internal audits with ECM providers as a part of program oversight.

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

A verification study of 15 members medical records found that 7 of 15 did not include all ECM core service components:

- In one sample, comprehensive assessment and CMP were not completed. The Plan did not use all the LTSS referral questions in assessing the member. The member was not asked about all of the functional capacity risk factors and was not asked about fall risk.
- In two samples, enhanced coordination of care was not completed. The Plan did not complete a medication review and reconciliation.
- In five samples, member and family supports were not completed. The Plan did not provide a copy of the CMP to the members or their applicable authorized support persons.

In an interview and written statement, the Plan stated that the internal audit is the formal way they conduct oversight of ECM providers. During the audit period, the Plan completed two audits on one ECM provider out of the Plan's 11 contracted ECM providers. The Plan also stated that their internal audit process includes case file reviews for one member per provider. The Plan's audit process was insufficient to identify the deficiencies noted in the verification study.

Subsequent to the Exit Conference, the Plan acknowledges that there is opportunity to strengthen their oversight methodology to require more self-evident documentation standards to reflect the processes and operations that support comprehensive ECM service delivery.

ECM members are individuals with the most complex medical and social needs. When the Plan does not ensure that all ECM core service components are completed, members may not receive proper coordination of services and CCM, which may result in adverse health outcomes.

**Recommendation:** Revise and implement policies and procedures to ensure all ECM core service components are completed.

# COMPLIANCE AUDIT FINDINGS

## Category 3 – Network and Access to Care

### 3.17 Timely Payments

#### 3.17.1 Family Planning Claims

The Plan must pay at least 90 percent of all clean claims from providers within 30 calendar days of the date of receipt and 99 percent of all clean claims within 90 calendar days. If the Plan does not pay a clean claim within 45 working days of receipt, the Plan is required to pay interest at the rate of 15 percent per annum beginning on the first day after a 45 working day period. The first day is considered to be the first calendar day after 45 working days following the receipt of the claim. *(Contract, Exhibit A, Attachment III (3.3.5)(B))*

On July 3, 2025, the United States Congress passed *House of Representatives One Big Beautiful Bill (H.R. 1)*, which includes *Section 71113, Federal Payments to Prohibited Entities*. *H.R. 1* was enacted on July 4, 2025 (Public Law No: 119-21). Section 71113 prohibits federal Medicaid payment for one year to nonprofit health care providers that serve predominantly low-income, medically underserved individuals (i.e., essential community providers) if the provider (1) primarily furnishes family planning services, reproductive health, and related care; (2) offers abortions in cases other than that of rape, incest, or life-threatening conditions for the woman; and (3) in Fiscal Year 2023, received federal and state Medicaid payments totaling more than $800,000.

*APL 25-011, H.R. 1 – Federal Payments to Prohibited Entities* (revised 9/17/25), provided guidance to Medi-Cal Managed Care Plans (MCP) on handling of payments to Medi-Cal and Family Planning, Access, Care, and Treatment Program providers who may be impacted by H.R. 1. This APL also provides guidance pertaining to a temporary restraining order blocking immediate implementation of Section 71113 in H.R. 1, subsequent Preliminary Injunctions (PI), and recent Order to Stay the PIs.

Plan policy, *CL.01 Processing Family Planning Claims* (revised 3/20/25), stated that the Plan pays 99 percent of all clean claims within 90 calendar working days from the date of receipt. Any payable claims that are paid beyond 45 business days are paid with interest. A clean claim is a payable claim that does not require development with any

external parties for the claim to be processed and paid by the Plan. A claim becomes a payable claim when the last piece of information needed to process the claim is received by the Plan.

**Finding:** The Plan did not pay the correct interest amount on family planning claims that were not paid within 45 working days of receipt.

In a verification study of 20 family planning claims, 6 were not paid timely and these 6 claims were not paid the correct interest amount. These claims were paid between 65 to 92 days beyond 45 working days.

In an interview, the Plan stated the delay in payment was a result of confusion caused by the enactment of H.R. 1. The Plan initially denied claims. This is not a systemic issue; it affected only one national family planning organization with multiple provider numbers.

Upon publication of APL 25-011, the Plan initiated a project to reprocess all claims impacted. Review of the Plan's document titled *HR Reprocessed Claims Excel Report* revealed 6,033 family planning codes were not paid timely. The project concluded in January 2026, and the Plan later paid the claims. However, the interest paid was less than the required amount. The Plan calculated interest using the September 17, 2025 APL 25-011 instead of the actual clean claim date based on claim submission date.

Subsequent to the Exit Conference, the Plan stated that it treated the September 17, 2025 APL 25-011 issue date as the point at which claims became payable. However, the July 4, 2025 APL 25-011 required Plans to continue processing/paying claims for prohibited entities such as Planned Parenthood with preliminary injunction relief beginning July 4, 2025, and interest rules were not altered by the APL revision issued September 17, 2025.

If the Plan does not properly process family planning services claims, providers may be discouraged from participating in the Medi-Cal program which could affect QOC and availability of services.

**Recommendation:** Implement policies and procedures to ensure qualified family planning claims that are not paid within 45 working days of receipt are paid the correct interest amount.

# COMPLIANCE AUDIT FINDINGS

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

### 4.1 Grievance and Appeal Program Requirements

#### 4.1.1 Resolution of Quality of Care Grievances

The Plan must follow grievance and appeal requirements set forth in *APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights: Templates*. *(Contract, Exhibit A, Attachment III, 4.6.1)*

The Plan must comply with all DHCS guidance, including APLs. APLs existing on the effective date of this Contract will be considered part of the Contract. *(Contract, Exhibit E, 1.1.2(A)(1))*

The Plan must ensure adequate consideration of grievances and that each issue presented by the member is addressed and resolved. "Resolved" means the grievance has reached a final conclusion with respect to the member's submitted grievance. The written resolution must contain a clear and concise explanation of the Plan's decision. *(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

**Finding:** The Plan sent resolution letters to members without resolving each issue presented in QOC grievances.

The verification study revealed 3 of 31 QOC grievances were closed, and resolution letters were sent to members, without providing a clear and concise explanation of the Plan's decision for each presented issue. The deficient grievances included:

- A member filed a grievance against a sleep center alleging the technician was unprofessional during a sleep study.
- A member's parent filed a grievance against a provider expressing dissatisfaction with the care their child received.
- A member filed a grievance against a skilled nursing facility stating that the facility was too hot and alleging the presence of roaches and rodents.

The Plan requested a provider response for each of these grievances which indicated the Plan deemed provider responses relevant to the investigation and resolution of these grievances. However, the grievances were closed, and resolution letters were sent to the members without the Plan having received and evaluated the provider responses. The grievances did not reach a final conclusion, and the resolution letters for these cases were deficient because the provider responses were necessary to address and resolve each issue presented by the members.

For each of the three deficient grievances the Plan provided the same information in the resolution letters. The Plan informed the member that they did not receive a response from the provider despite multiple requests. They also informed the member that the Plan's Provider Services Department was notified to further assist in communicating with the provider. The Plan apologized to the member for not being able to offer a more detailed response to their concerns and stated that the case was forwarded to the Quality Improvement Department for further investigation.

In an interview and written statement, the Plan explained that it requests a provider response for QOC grievances, but the response is not required to close grievances. If a response cannot be obtained within the 30 calendar day resolution timeframe, the grievance is closed, a resolution letter is sent to the member, and the grievance is referred to the Potential Quality Issue Program. This process was contractually noncompliant as each of the deficient grievances reached a final conclusion and were resolved when the provider's response was obtained by the Potential Quality Issue Program after the grievances were closed and resolution letters were sent.

Plan policy, *GA.07 Member Grievance Procedure for Medi-Cal, HealthWorx, and ACE* (revised 8/20/24), stated that a grievance is closed when a resolution letter is sent to the member and a grievance may not be closed until all issues have been fully resolved. Also, a grievance cannot be closed if follow-up is required to fully resolve all issues and the file must include all relevant documentation before a grievance is closed. However, the procedure also stated that the minimum necessary documentation for QOC grievances includes the provider's response only if it was provided. Thus, the procedure did not give sufficient guidance to ensure grievances were fully investigated and each issue was resolved prior to closure and sending resolution letters to members.

When QOC grievances are not fully resolved prior to closure and sending resolution letters, members may be deprived of information necessary to make informed healthcare decisions, which could adversely affect QOC.

**Recommendation:** Revise and implement policies and procedures to ensure that each issue presented in QOC grievances is resolved before closing the grievance and sending the resolution letter to the member.

### 4.1.2 Translated Grievance Acknowledgement and Resolution Letters

The Plan must provide a resolution notice to the member within 30 calendar days from the date the member files a standard grievance. *(Contract, Exhibit A, Attachment III, 4.6.1(B))*

The Plan must provide written acknowledgement to the member within five calendar days of receiving a grievance. *(Contract, Exhibit A, Attachment III, 4.6.2(E))*

The Plan must be able to provide full and immediate translation of written materials for LEP members who speak threshold or concentration languages and fully translated member information, including grievance acknowledgement and resolution letters. *(Contract, Exhibit A, Attachment III, 5.2.10(B)(3)(b))*

The Plan must comply with all DHCS guidance, including APLs. APLs existing on the effective date of this Contract will be considered part of the Contract. *(Contract, Exhibit E, 1.1.2(A)(1))*

The Plan must provide written acknowledgement to the member within five calendar days of receiving a grievance. The Plan must comply with the timeframe of 30 calendar days from the received date for grievance resolution and sending written notice to the member. The Plan must fully translate and provide written member information in the required language, including all grievance notices. *(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

Plan policy, *GA.10 Overview of Member Complaints Process for Medi-Cal, HealthWorx, and ACE* (revised 6/21/24), stated that all written materials are translated to meet a member's linguistic needs.

Plan policy, *GA.07 Member Grievance Procedure for Medi-Cal, HealthWorx, and ACE* (revised 8/20/24), stated that the deadline for processing standard grievances is 30 calendar days from the filing date. An acknowledgement letter will be mailed to the members within five calendar days of filing.

Plan policy, *HE.103 Translation Procedures* (revised 1/24/24), documents the Plan's procedure for translating written informing materials for LEP members into the Plan's threshold languages. For all documents that require translation, the source document is given to the Plan's contracted translation vendor. After printing, the completed document is then distributed to members in their threshold languages. For documents submitted to the Plan's contracted translation vendor, the standard turn-around time is 7 to 10 working days, and for rush translations the standard is less than 3 working days. This includes any standard and non-standardized documents that are requested by the member to be translated.

**Finding:** The Plan did not provide translated grievance acknowledgement and resolution letters to members within the required timeframes.

A verification study of 71 standard grievances revealed that 13 of the 16 samples involving members whose primary language was a threshold or concentration language, the Plan sent translated acknowledgement or resolution letters to the members beyond the required timeframes.

- In 13 of 16 samples, translated acknowledgement letters were sent between 2 to 51 days after the five calendar day requirement.
- In 12 of the 16 samples, translated resolution letters were sent between 2 to 26 days after the 30 calendar day requirement.

In an interview, the Plan explained its process for translating grievance acknowledgement and resolution letters. When letters are complete, English versions are sent to the member and the translation vendor. There is not a set timeframe for sending letters to the vendor. They can be sent up to day 5 (for acknowledgement letters) and day 30 (for standard resolution letters) from the date the grievance was received. It takes five to seven days to receive the translated letter from the vendor and then it is sent to the member. This process was contractually noncompliant as it did not ensure translated grievance acknowledgement and resolution letters were sent within the required timeframes.

Plan policy GA.10 stated that to comply with regulatory timeframes, the English version of a resolution letter must be mailed within the timeframe, for example, 30 days for standard grievances. In a written statement, the Plan acknowledged that this procedure was deficient as it did not specify that translated letters must meet the required timeframes. Thus, the policy did not provide sufficient guidance to ensure translated versions of grievance acknowledgement and resolution letters were provided to members within the required timeframes.

The Plan stated that they monitor timeliness through a dashboard to ensure the letters are sent in English within the required timeframes. However, the Plan does not monitor the timeliness of translated grievance letters. They stated that within the required 30 days timeframe the member is contacted with a translator to explain the resolution to the grievance, which is also described in Plan policy GA.10. However, this procedure does not meet the requirements of APL 21-011, which requires the Plan to send out fully translated letters within 30 calendar days. The Plan's gaps in translation workflow and lack of timely coordination between the production of the English letter and sending the letter to the vendor for translation led to the delays in producing fully translated letters dated within the required timeframes.

When translated letters are not provided within the required timeframes, members may be deprived of information necessary to make timely and informed healthcare decisions, which could adversely affect QOC.

**Recommendation:** Revise and implement policies and procedures to ensure that translated grievance acknowledgment and resolution letters are provided to members within the required timeframes.

### 4.1.3 Grievances and Appeals Written Record (Governing Body)

The Plan must follow grievance and appeal requirements set forth in APL 21-011. *(Contract, Exhibit A, Attachment III, 4.6.1)*

The Plan must comply with all DHCS guidance, including APLs. APLs existing on the effective date of this Contract will be considered part of the Contract. *(Contract, Exhibit E, 1.1.2(A)(1))*

The Plan must regularly analyze grievance and appeal data to identify, investigate, report, and act upon systemic patterns of improper service denials and other trends impacting health care access and delivery to members. *(Contract, Exhibit A, Attachment III, 4.6.1 (J))*

The Plan must maintain a written record for each grievance and appeal received by the Plan. The record of each grievance and appeal must be maintained in a log and include the following information:

1. The date and time of receipt of the grievance or appeal.
2. The name of the member filing the grievance or appeal.
3. The representative recording the grievance or appeal.
4. A description of the complaint or problem.
5. A description of the action taken by the MCP or provider to investigate and resolve the grievance or appeal.
6. The proposed resolution by the MCP or its medical professional

   responsible for making utilization management decisions.
7. The name of the MCP provider or staff responsible for resolving the grievance or appeal.
8. The date of notification to the member of resolution.

The grievances and appeals written record must be reviewed periodically by the Plan's governing body. The review must be thoroughly documented. *(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

**Finding:** The Plan's governing body did not review the grievances and appeals written record.

A review of the SMHC, the Plan's governing body, meeting minutes for the audit period did not show that the grievances and appeals written record was reviewed. In an interview, the Plan confirmed the SMHC did not review the written record. Thus, the Plan was noncompliant with this contractual requirement.

In a written statement, the Plan explained that the Consumer Advisory Committee (CAC) reviews grievances and appeals data and reports to SMHC. The CAC meeting minutes, which included review of grievances and appeals reports, were included in the materials for 5 of 13 SMHC meetings for the audit period. However, the SMHC's meeting minutes did not include review of the CAC's meeting minutes or grievances and appeals reports. In an interview, the Plan clarified that SMHC members are expected to review meeting materials which include CAC meeting minutes and the CAC's review of grievances and appeals reports. However, this process did not meet the requirement that the governing body periodically review the grievances and appeals written record.

Plan policy, *GA.10 Overview of Member Complaints Process for Medi-Cal, HealthWorx, and ACE* (revised 6/21/24), stated that the Member Experience and Engagement Committee (MEC) and the CAC review grievances and appeals written reports quarterly. Also, aggregate grievances and appeals information is presented to the CAC, MEC, Provider Grievance Subcommittee, and Quality Improvement Committee quarterly. However, the policy did not include periodic review of the grievances and appeals written record by the SMHC. In an interview, the Plan was unable to clarify why this requirement was not included. Thus, the policy did not provide sufficient guidance to ensure the written record was reviewed by the governing body as contractually required.

Lack of periodic review of the written record by the governing body could lead to missed opportunities to improve the grievances and appeals system and adversely affect QOC.

**Recommendation:** Revise and implement policies and procedures to ensure the grievances and appeals written record is reviewed periodically by the Plan's governing body.

### 4.1.4 Grievances and Appeals Written Record (Quality Assurance Committee)

The Plan must follow grievance and appeal requirements set forth in APL 21-011. *(Contract, Exhibit A, Attachment III, 4.6.1)*

The Plan must maintain records of grievances and appeals and must have policies and procedures in place governing the review of the information as part of its ongoing Quality Improvement System. *(Contract, Exhibit A, Attachment III, 4.6.9 (D))*

The Plan must comply with all DHCS guidance, including APLs. APLs existing on the effective date of this Contract will be considered part of the Contract. *(Contract, Exhibit E, 1.1.2(A)(1))*

The Plan must maintain a written record for each grievance and appeal received by the Plan. The record of each grievance and appeal must be maintained in a log and include the following information:

1. The date and time of receipt of the grievance or appeal.
2. The name of the member filing the grievance or appeal.
3. The representative recording the grievance or appeal.
4. A description of the complaint or problem.
5. A description of the action taken by the MCP or provider to investigate and resolve the grievance or appeal.
6. The proposed resolution by the MCP or its medical professional responsible for making utilization management decisions.
7. The name of the MCP provider or staff responsible for resolving the grievance or appeal.
8. The date of notification to the member of resolution.

The grievances and appeals written record must be submitted at least quarterly to the Plan's Quality Assurance Committee for aggregation and analysis for quality improvement. *(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

**Finding:** The Plan did not submit the grievances and appeals written record to the Quality Assurance Committee for aggregation and analysis for quality improvement.

In a written statement, the Plan explained that the Quality Improvement and Health Equity Committee (QIHEC) is the primary quality committee. A review of the QIHEC meeting minutes and materials for the audit period did not show that the grievances and appeals written record was received, aggregated, or analyzed by the QIHEC. Thus, the Plan was noncompliant with this contractual requirement.

During the audit period, the QIHEC reviewed *the 2024 Quality Improvement and Health Equity Program (QIHEP) Annual Evaluation*. This document included the *Member Experience Committee (MEC) Grievance and Appeals National Committee for Quality Assurance Report* (reporting period 2023), *8/1/24*. The report included grievances and appeals statistics and analysis for the 2023 calendar year but did not include the grievances and appeals written record. Thus, review of the QIHEP Annual Evaluation by the QIHEC did not meet the contractual requirement that the grievances and appeals written record must be submitted at least quarterly to the Quality Assurance Committee for aggregation and analysis for quality improvement.

Plan policy, *GA.10 Overview of Member Complaints Process for Medi-Cal, HealthWorx, and ACE* (revised 6/21/24), stated that the MEC and CAC review grievances and appeals written reports quarterly. Also, aggregate grievances and appeals information is presented to the MEC, CAC, Provider Grievance Subcommittee, and Quality Improvement Committee quarterly. However, review of the QIHEC meeting minutes for the audit period did not show that grievances and appeals information was presented. The Plan is required to submit the grievances and appeals written record, not aggregate information, to the Quality Assurance Committee at least quarterly for aggregation and analysis for quality improvement. Thus, the policy did not provide sufficient guidance to ensure compliance with this contractual requirement. In an interview, the Plan confirmed that the written record was not submitted to the QIHEC for aggregation and analysis and was unable to clarify why this requirement was not included in Plan policy GA.10.

Not submitting the written record to the Quality Assurance Committee for systematic aggregation and analysis could lead to missed opportunities to make needed improvements to the QOC and service.

**Recommendation:** Revise and implement policies and procedures to ensure the grievances and appeals written record is submitted at least quarterly to the Quality Assurance Committee for aggregation and analysis for quality improvement.

## 4.12 Member Rights and Responsibilities

### 4.12.1 Advance Directive

The Plan must have written policies and procedures to ensure members are informed of what an advance directive is and how to put a valid advance directive in place. The Plan must have policies and procedures in place to ensure all involved in the member's care comply with the terms of a member's valid advance directive in accordance with the requirements of Code of Federal Regulations (CFR), title 42, sections 422.128 and 438.3(j). *(Contract, Exhibit A, Attachment III, 5.1.1 (c))*

Advance directive means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. *(CFR, tit. 42, section 489.100)*

The Plan must maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the Plan. The Plan must provide written materials to individuals about their rights and the Plan's policies on implementation of those rights. If the Plan cannot implement an advance directive as a matter of conscience objection, those terms must be clarified in the policy. The information must be provided to members at time of enrollment, be documented in the members' chart, and provide education to staff concerning policies and procedures on advance directive. *(CFR, tit. 42, section 422.128)*

Plan policy, *MS 04-04 Member Rights and Responsibilities and Non-Discrimination* (revised 6/14/18), covers the Plan member's rights and responsibilities, including how this information is communicated with members and providers. The policy states members should contact Member Services for other elements of their rights but does not include how members may put an advance directive in place nor how all involved in the members care should comply with the terms of a member's advance directive. The policy then states for members to contact member services for other elements of their rights, but not how to put an advance directive in place.

Plan policy, *CC-13 Palliative Care Policy – Adult 2026* (revised 11/9/23), stated that the Plan's Palliative Care Program is designed to help manage symptoms and maximize quality of life for members with advanced-stage conditions. The members must meet various eligibility requirements and have one of the conditions: congestive heart failure, chronic obstructive pulmonary disease, advanced cancer, or liver disease. The policy stated that the palliative care services include the following services, when necessary and reasonable, given the member's condition: advanced care planning, palliative care assessment and consultation, plan of care and advanced care plan discussion, care coordination, and other care referrals.

**Finding:** The Plan did not have written policies and procedures informing members on how to put a valid advance directive in place nor did it have written policies or procedures to ensure all involved in the member's care comply with a valid advance directive.

In an interview, the Plan stated that advance directives are a component of their end-of-life planning for those involved in Complex Case Management Program (CCMP) which is covered in Plan policy CC-13. This process is only applicable to members enrolled in CCMP and members with specific conditions. It does not address how members could create a valid advance directive if they did not have one of the conditions or were not enrolled in the CCMP.

During provider facility site review, which includes medical record review, the Plan assesses if the medical record has any documentation of whether the member has ever been offered information on, or executed, an advance directive, and if the member has a Physician Orders for Life Sustaining Treatment (POLST) form within the medical record. The Plan did not have policy or procedure on Plan expectations on how providers would comply with valid advance directives in medical records.

While the Plan informs members of the right to have an advance directive in the Member Handbook, it informs providers that advance directives are part of CCMP, and ensures advance directives are documented prominently in the members medical record, the Plan did not have written policies and procedures on how to put a valid advance directive in place and how to ensure all involved in the member's care comply with the terms of a member's advance directive.

If the Plan does not have a written policy or procedure for advance directives, members may not be fully informed on how to put a valid advance directive in place or current State law on advance directives. The Plan's providers, and all involved in a member's care, may not know the Plan's policies and legal obligations on complying with, or objecting to, a member's advance directive.

**Recommendation:** Develop and implement policies and procedures on informing members of how to create valid advance directives and ensure all involved in care comply with a member's valid advance directive.

# COMPLIANCE AUDIT FINDINGS

## Category 6 – Plan Administration and Organization

### 6.13 Fraud Prevention Program

#### 6.13.1 Preliminary Fraud, Waste, and Abuse Report

The Plan must file a preliminary report with DHCS PIU detailing any suspected FWA identified by or reported to the Plan within 10 working days of the Plan's discovery or notice of such FWA. (*Contract, Exhibit A, Attachment III, 1.3.2 (D)(1))*

Plan policy, *CP-DP.002 FWA Incident Investigation and Reporting* (revised 9/6/19), provides Compliance Department staff with necessary instructions to receive, investigate, report and resolve FWA incidents. The Plan's compliance staff files all suspected FWA cases with DHCS, and reports are made no later than 10 working days after the Plan first becomes aware of or is notified of FWA activity.

Plan policy, *CP.003 Reporting Compliance Concerns* (revised 8/4/25), stated that every employee has a responsibility to report compliance concerns to their immediate supervisor, manager, division director or the Chief Government Affairs and Compliance Officer.

Plan policy, *CP.016 Investigating and Reporting Fraud, Waste, Abuse and Neglect* (revised 9/17/24), stated that every Plan employee is trained at onboarding and annually thereafter the requirement to report compliance issues in accordance with Plan policy CP.003.

The Plan's FWA course training transcript stated that while the Plan's employees should know the differences between FWA, the Plan staff are not required to determine if a specific situation is one or the other. That responsibility rests with the Plan's Compliance Department. If the Plan staff encounter a situation where FWA is suspected, Plan staff should report it to the Plan's Compliance Department. When FWA is found through a standard process, or through day-to-day work, it needs to be reported immediately to the Plan's Compliance Department. The Plan staff do not need to wait to gather additional information; reports should be submitted based on the information known at the time.

**Finding:** The Plan did not file a preliminary report of suspected FWA to DHCS within 10 working days after its discovery or notice of such FWA.

The verification study revealed 7 of 15 sample cases were reported late to DHCS, with delays exceeding 10 working days ranging from 13 to 140 days.

- In four sample cases, the Plan acknowledged that the preliminary reports for these were not filed timely due to the Compliance Manager not performing up to standard which impacted case oversight, timeliness, and documentation completeness.
- In three sample cases, the Plan's internal departments did not inform the Compliance Department of the suspected FWA immediately. For example, a Member Services staff informed the Plan's transportation liaison regarding a member's abuse of the transportation benefits by obtaining transportation to non-healthcare related locations. The incident was not reported to the Compliance Department immediately which resulted in the incident not being reported to DHCS until 26 working days after the Plan became aware of the incident.

In an interview, the Plan emphasized that the Compliance Department is only able to act once they have been notified. The Plan explained that the Member Services team frequently works with the transportation liaison on routine transportation matters, so ongoing back-and-forth communication is common. However, the Plan did not ensure that all Plan employees report incidents to the Compliance Department immediately when suspected FWA incidents are identified so that it can be investigated and reported to DHCS timely.

During the audit period, the Plan experienced challenges within its Compliance Department. A key compliance staff member could not fulfill their required responsibilities, such as monitoring case timeliness and conducting meetings with their team to discuss case investigation progress and expectations, which resulted in cases not being reported to DHCS timely. In response to the issue, the Plan conducted a detailed review of historical cases and initiated a project to correct any FWA reporting deficiencies.

In a written statement, the Plan explained that they maintain a FWA tracking log, to support oversight and monitoring activities. However, the log does not flag or highlight cases that are aging or need further investigation, nor did the Plan provide evidence that the log was reviewed regularly by the Compliance Department's management. Plan

policy CP.DP-002, did not address procedures for the oversight of FWA incident investigation and reporting.

Subsequent to the Exit Conference, the Plan stated that the sampled cases involving the transportation liaison were reported within the required 10 working days. The Plan further asserted that the 10 day reporting period begins when the Compliance Department is notified by the transportation liaison rather than when the transportation liaison first becomes aware of the suspected FWA incident. However, the reporting period begins when the Plan becomes aware of the suspected FWA incident, not the Compliance Department. The Plan's practice creates a delay in the reporting and investigating of potential FWA. This delay increases the risk that FWA activities continue uninvestigated for longer periods.

When the Plan does not file preliminary report to DHCS detailing suspected FWA incidents within 10 working days, fraudulent activity may not be addressed, and abusive practices may persist resulting in misuse of public funds.

**Recommendation:** Revise and implement policies and procedures to ensure suspected FWA is reported to DHCS within 10 working days after its discovery or notice of such FWA.

### 6.13.2 Investigation of Reported or Suspected Fraud, Waste, and Abuse Activities

The Plan must promptly conduct a complete investigation of all reported or suspected FWA activities. *(Contract, Exhibit A, Attachment III, 1.3.2 (D)(1))*

Within ten working days of completing its FWA investigation, the Plan must submit a completed report to the DHCS PIU. This report must include the Plan's findings, actions taken, and include all documentation necessary to support any action taken by the Plan, and any additional documentation as requested by DHCS or other state and federal agencies. *(Contract, Exhibit A, Attachment III, 1.3.2 (D)(2))*

Plan policy, *CP.016 Investigating and Reporting Fraud, Waste, Abuse, and Neglect* (revised 9/17/24), stated that all potential cases of fraud or abuse reported to the Compliance Department are investigated. Investigations for all cases begin as quickly as possible, but no later than 10 business days after the date the potential noncompliance or FWA is identified or reported.

Plan policy, *CP-CP.002 FWA Incident Investigation and Reporting* (revised 9/6/19), stated that investigations are initiated no later than three business days after receipt of the FWA referral. The Chief Compliance Officer is responsible for overseeing the Plan's Compliance Program, including the FWA Program. The Compliance Manager is responsible for day-to-day operational oversight of the FWA Program. The Chief Compliance Officer is responsible for overseeing Plan's Compliance Program, including the FWA Program.

Plan policy, *CP.DP.003 Compliance Issue Investigation & Reporting* (revised 9/6/19), stated that compliance staff, upon receipt of a compliance referral, immediately begin an investigation of the issue(s) contained in the report. Compliance staff are responsible for coordinating the investigation into the referral, including communicating with providers, business associates, members, and/or the Plan's staff. Compliance referrals are investigated and corrective actions are initiated without unreasonable delay and in no case later than 60 calendar days after the issue is discovered.

**Finding:** The Plan did not promptly conduct a complete investigation of all reported or suspected FWA activities.

The verification study revealed 5 of 15 samples did not undergo a timely and complete investigation of the reported or suspected FWA activities. Examples include:

- In one case involving fraudulent billing to a member by a network provider, the Plan did not request the necessary medical records for investigation within a reasonable time. It took the Plan five months after the FWA incident was discovered to make the request.
- In another case, the Plan closed the case after the member declined ride monitoring, even though it had already been confirmed that three separate individuals were using the member's transportation benefit and credible evidence of misuse existed. The Plan acknowledged this was an oversight and confirmed that the case should not have been closed.
- In a third case, the Plan took five months to determine that the member had other insurance coverage; information that could have been immediately verified at the beginning of the investigation. Subsequent to the Exit Conference, the Plan explained that this case was submitted to DHCS in error. However, despite identifying the submission error, the Plan still required a significant amount of time

to determine the member's correct insurance coverage. This delay highlights a systemic deficiency in the Plan's investigation procedures.

Although the Plan has established procedures for investigating potential FWA issues, as outlined in Plan policy CP.DP.003, the Plan did not implement these procedures consistently. In a written statement, the Plan explained that the oversight provided by managerial staff responsible for the day-to-day operation of compliance team; including reviewing open cases, ensuring adherence to timeliness expectations, and monitoring investigative progress, was insufficient and was not discovered for six months.

When the Plan does not promptly conduct a thorough investigation of reported or suspected FWA activities, there is an increased risk of ongoing financial risk, misuse of services, and fraudulent activity that may result in the improper use of public funds.

**Recommendation:** Implement policies and procedures to ensure all reported or suspected FWA activities are investigated promptly and completely.

# REPORT ON THE MEDICAL AUDIT OF SAN MATEO HEALTH COMMISSION DBA HEALTH PLAN OF SAN MATEO 2025

**DHCS Audits and Investigations**
**Contract and Enrollment Review Division**
**San Francisco Section**

**Contract Number: 23-30270**
**Contract Type: State Supported Services**
**Audit Period: September 1, 2024 — December 31, 2025**
**Dates of Audit: February 3, 2026 — February 12, 2026**
**Report Issued: August 7, 2026**

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

# TABLE OF CONTENTS

# I. INTRODUCTION

This report presents the results of the audit of San Mateo Health Commission dba Health Plan of San Mateo (Plan) compliance and implementation of the State Supported Services contract number 23-30270 with the State of California. The State Supported Services Contract covers abortion services with the Plan.

The audit covered the period of September 1, 2024, through December 31, 2025. The audit was conducted from February 3, 2026, through February 12, 2026, which consisted of document review and verification study with the Plan administration and staff.

An Exit Conference with the Plan was held on June 18, 2026. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The Plan submitted a response after the Exit Conference. The results of the Department of Health Care Services' evaluation of the Plan's response are reflected in this report.

# COMPLIANCE AUDIT FINDINGS

## State Supported Services

The Plan is bound by all applicable terms and conditions of the Primary Contract as of the effective date of the Hyde Contract. *(Hyde Contract, Exhibit E (1.1) (1.1.1))*

The Plan must pay at least 90 percent of all clean claims from providers within 30 calendar days of the date of receipt and 99 percent of all clean claims within 90 calendar days. If the Plan does not pay a clean claim within 45 working days of receipt, the Plan is required to pay interest at the rate of 15 percent per annum beginning on the first day after a 45 working day period. The first day is considered to be the first calendar day after 45 working days following the receipt of the claim. *(Contract, Exhibit A, Attachment III (3.3.5)(B))*

On July 3, 2025, the United States Congress passed *House of Representatives One Big Beautiful Bill (H.R. 1)*, which includes *Section 71113, Federal Payments to Prohibited Entities*. Section 71113 prohibits federal Medicaid payment for one year to nonprofit health care providers that serve predominantly low-income, medically underserved individuals (i.e., essential community providers) if the provider (1) primarily furnishes family planning services, reproductive health, and related care; (2) offers abortions in cases other than that of rape, incest, or life-threatening conditions for the woman; and (3) in Fiscal Year 2023, received federal and state Medicaid payments totaling more than $800,000.

*All Plan Letter (APL) 25-011, H.R. 1 – Federal Payments to Prohibited Entities* (revised 9/17/25), provided guidance to Medi-Cal managed care plans on handling of payments to Medi-Cal and Family Planning, Access, Care, and Treatment Program providers who may be impacted by H.R. 1. This APL also provides guidance pertaining to a temporary restraining order blocking immediate implementation of Section 71113 in H.R. 1, subsequent Preliminary Injunctions (PI), and recent Order to Stay the PIs.

Plan policy, *CL.29 Processing Claims for Abortion Services* (revised 6/4/24), stated that the Plan pays 100 percent of all clean claims within 45 working days from the date of receipt. A clean claim is a payable claim that does not require any development with any external parties for the claim to be processed and paid by the Plan. A claim becomes a payable claim when the last piece of information needed to

process the claim is received by the Plan. Any payable claims that are paid beyond 45 working days are paid with interest in accordance with Medi-Cal policy.

**Finding:** The Plan did not pay the correct interest amount on state supported services claims that were not paid within 45 working days of receipt.

In a verification study of 20 state supported services claims, 5 claims were not paid timely and these 5 claims were not paid the correct interest amount. These claims were paid between 35 and 90 days beyond 45 working days.

In an interview, the Plan stated the delay in payment was a result of confusion caused by the enactment of H.R. 1. The Plan initially denied claims. This is not a systemic issue; it affected only one national family planning organization with multiple provider numbers.

Upon publication of APL 25-011 (dated 9/17/25), the Plan initiated a project to reprocess all claims impacted. Review of the Plan's document titled HR Reprocessed Claims Excel Report revealed 33 state supported services codes were not paid timely. The project concluded in January 2026, and the Plan later paid the claims. However, the interest paid was less than the required amount. The Plan calculated interest using the September 17, 2025 APL 25-011 date instead of the actual clean claim date based on claim submission date.

Subsequent to the Exit Conference, the Plan stated that it treated the September 17, 2025 APL 25-011 issue date as the point at which claims became payable. However, the July 4, 2025 APL 25-011 required Plans to continue processing/paying claims for prohibited entities such as Planned Parenthood with preliminary injunction relief beginning July 4, 2025, and interest rules were not altered by APL revisions issued September 17, 2025.

If the Plan does not properly process state supported services claims, providers may be discouraged from participating in the Medi-Cal program which could affect quality of care or availability of services.

**Recommendation:** Implement policies and procedures to ensure qualified state supported services claims that are not paid within 45 working days of receipt are paid the correct interest amount.