DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SAN FRANCISCO SECTION

REPORT ON THE MEDICAL AUDIT OF CONTRA COSTA HEALTH PLAN FISCAL YEAR 2025-26

Contract Number: 23-30219

Audit Period: August 1, 2024 – July 31, 2025

Dates of Audit: August 18, 2025 – August 29, 2025

Report Issued: March 16, 2026

TABLE OF CONTENTS

I. INTRODUCTION 3

II. EXECUTIVE SUMMARY 4

III. SCOPE/AUDIT PROCEDURES 7

IV. COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management Program 9

Category 3 – Network and Access to Care 13

Category 4 – Grievances, Appeals, and Member Rights 15

Category 5 – Quality Improvement and Health Equity Transformation Program 19

Category 6 – Plan Administration and Organization 21

I. INTRODUCTION

Since 1984, Contra Costa Health Plan (Plan) has contracted with the State of California to provide health care services to Medi-Cal members in Contra Costa County. The Plan is a county sponsored Health Maintenance Organization. The Plan is licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act. The Contra Costa County Board of Supervisors exercises oversight of the Plan through a Joint Conference Committee.

In October 1996, the State of California contracted with the County of Contra Costa as the Local Initiative under the Two-Plan model to provide managed care services to Medi-Cal members under the provisions of California Welfare and Institutions Code section 14087.3. The Plan received approval from the State of California to begin operations and commenced enrollment as the Local Initiative for Contra Costa County on February 1, 1997.

Effective January 1, 2024, Contra Costa County changed the Medi-Cal Managed Care model from a Two-Plan model to a Single-Plan model.

The Plan contracts with Contra Costa Regional Medical Center, as well as other network providers, to arrange for Medi-Cal covered services.

As of July 31, 2025, the Plan had 274,153 members. Of these, 267,648 were Medi-Cal, including 17,836 Seniors and Persons with Disabilities members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of August 1, 2024, through July 31, 2025. The audit was conducted from August 18, 2025, through August 29, 2025. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on February 5, 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 February 20, 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 August 1, 2023, through July 31, 2024, was issued on February 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.

Findings denoted as repeat findings are uncorrected deficiencies substantially similar to those identified in the previous audit.

The summary of the findings by category follows:

Category 1 – Utilization Management Program

The Notice of Action (NOA) letter is required to include the clinical reasons for decisions based on medical necessity. The Plan must explicitly state how the member's condition does not meet the criteria or guidelines. Finding 1.2.1: The Plan's concurrent NOA letters did not explicitly state how the member's condition did not meet the clinical criteria or guidelines.

The Plan is prohibited from imposing Prior Authorization (PA) requirements on biomarker testing that is associated with a Food and Drug Administration (FDA) approved therapy for advanced stage 3 or 4 cancer. The Plan may only require PA for inpatient hospice care. Finding 1.2.2: The Plan incorrectly applied PA requirements to cancer biomarker testing and home hospice services.

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

The Plan shall not improperly deny or contest a claim or portion thereof. Finding 3.6.1: The Plan improperly denied emergency services claims that involved California Children's Services (CCS) eligible diagnoses.

Category 4 – Grievances, Appeals, and Member Rights

The Notice of Availability must be included in all member informational notices, including electronic and written notices to an individual, such as those pertaining to rights and benefits. Finding 4.1.1: The Plan did not send readable Ukrainian and Russian taglines in the Notice of Availability attached to grievance acknowledgement and resolution letters.

The Plan is required to fully translate and provide written member information in a member's required language, including all grievance notices. The Plan is required to comply with the State's established timeframe of 5 calendar days for grievance acknowledgment and 30 calendar days for grievance resolution. Finding 4.1.3: The Plan did not send translated acknowledgement letters within the required 5-calendar day timeframe or translated resolution letters within the 30-calendar day timeframe.

The Plan is required to notify DHCS within 24 hours of any suspected security incident which risks unauthorized access of Protected Health Information and/or confidential information. Finding 4.12.1: The Plan did not notify DHCS within 24 hours of suspected security incidents.

Category 5 – Quality Improvement and Health Equity Transformation Program

The Plan must conduct training for all network providers. The Plan must ensure delegates meet all contract requirements for the functions undertaken. To ensure compliance, the Plan must monitor and oversee all delegated functions. Finding 5.13.1: The Plan is not conducting oversight to ensure that its delegated entities conduct new provider training.

Category 6 – Plan Administration and Organization

The Plan must promptly conduct a complete investigation of all reported or suspected Fraud, Waste, or Abuse (FWA) activities. Finding 6.13.1: The Plan did not conduct an investigation of all reported or suspected FWA activities.

The Plan must file a preliminary report with the DHCS Program Integrity Unit detailing any suspected FWA identified within ten working days of the Plan's discovery or notice of such FWA. Finding 6.13.2: The Plan did not report all suspected fraud cases to the DHCS within ten working days.

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 August 18, 2025, through August 29, 2025, for the audit period of August 1, 2024, through July 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

Service Requests: A total of 33 clinical service request cases were reviewed for timeliness, consistent application of criteria, and appropriate review. Twenty-six were PA requests, four were concurrent review requests, and three were retrospective review requests.

Appeal Procedures: Twenty-one medical cases were reviewed for appropriate and timely adjudication.

Category 2 – Population Health Management and Coordination of Care

Initial Health Appointment: Sixteen files were reviewed to confirm the performance of the appointment.

Continuity of Care: Twelve files were reviewed to confirm coordination of care and fulfillment of continuity of care requirements.

Enhanced Care Management: Twenty files were reviewed to confirm coordination of care and compliance with Enhanced Care Management requirements.

Category 3 – Network and Access to Care

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

Non-Emergency Medical Transportation: Twenty claims were reviewed for timeliness and appropriate adjudication.

Non-Medical Transportation: Fifteen claims were reviewed for timeliness and appropriate adjudication.

Category 4 – Grievances, Appeals, and Member Rights

Grievances: Forty-six standard grievances, ten exempt grievances, nine expedited grievances, and seven 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 25 quality of service and 21 quality of care grievances.

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

Background Check Verification: Ten samples were reviewed for appropriate background checks of Plan staff prior to granting access to Protected Health Information.

Category 5 – Quality Improvement and Health Equity Transformation Program

Potential Quality Issues: Nine potential quality issue cases were reviewed for timely evaluation and effective action taken to address needed improvements.

Provider Training: Ten new provider training records were reviewed for the timeliness of Medi-Cal Managed Care program training.

Category 6 – Plan Administration and Organization

Fraud and Abuse: Eight fraud and abuse cases were reviewed for appropriate reporting and processing.

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management Program

1.2 Prior Authorizations and Review Procedures

1.2.1 Clinical Reason for Prior Authorization Denials

The Plan must ensure that its PA, concurrent review, and retrospective review authorization procedures meet the following minimum requirements: a 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))*

The Plan must comply with all DHCS guidance, including All Plan Letters (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 NOA letter is required to include the clinical reasons for decisions based on medical necessity. 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 policy, *UM15.003 Policy for Prior Authorization* (approved 04/2025), stated that within two business days of an authorization, denial, or modification, a written notification is sent to the member and provider. This notification includes a description of the criteria or guidelines used and the clinical reasons for the decision regarding medical necessity.

Plan desk procedure, *Denial/Modification Letter Process* (implemented 10/2024), stated that an NOA letter will be generated based on APL 21-011, at a sixth-grade reading level, and explicitly state the clinical reason for the decision why the member's condition did not meet criteria and guidelines. Concurrent review NOA letters must include the InterQual criteria and subset used to make the determination and may use the explanation box to further clarify.

Finding: The Plan's concurrent NOA letters did not explicitly state how the member's condition did not meet the clinical criteria or guidelines.

In four of four concurrent PA cases, the Plan did not explicitly state how the member's condition did not meet the clinical criteria or guidelines within the letter. The NOA letters documented the following:

- A provider requested authorization for a 20-year-old male admitted with abdominal pain. The NOA letter stated the service was denied, as the member's condition did not meet the clinical guidelines of Acute Adult General Medical. The NOA further stated that the member did not need to be admitted to the hospital and could have received care outside of the hospital. However, the NOA letter did not explicitly state how the member's condition did not meet the clinical criteria or guidelines.
- A provider requested authorization for an 80-year-old female admitted for a urinary tract infection, sepsis, acute kidney injury, and failure to thrive. The NOA stated the service was denied, as the member's condition did not meet the clinical guidelines for pyelonephritis or urinary tract infection, and did not need to be admitted to the hospital. However, the NOA did not explicitly state how the member's condition did not meet the clinical criteria of guidelines.

During the interview, the Plan stated that concurrent NOA letters are generated using a template within its electronic health record. The Plan's template includes an "Other Explanation" field for entering additional details manually. In the concurrent samples reviewed, this option was not used to clearly state why the members' conditions did not meet clinical criteria. The Plan's desk procedure requires denial letters to explicitly provide the clinical reason for the decision. However, the concurrent example in the desk procedure does not explain why the member's condition failed to meet the required criteria or guidelines.

The Plan acknowledged, during the interview and in a written response, that the letters did not explicitly state how the member's condition failed to meet clinical criteria. The Plan cited the need to maintain a sixth-grade reading level for member comprehension as the rationale for omitting detailed clinical explanations. However, the Plan is still required to explicitly state how the member's condition did not meet the clinical criteria or guidelines, at a sixth-grade reading level.

When concurrent NOA letters do not explicitly state how the member's condition did not meet the clinical criteria or guidelines, the member may not understand why services were denied, which could adversely affect their ability to make informed healthcare decisions.

Recommendation: Revise and implement policies and procedures to ensure concurrent NOA letters explicitly state how the member's condition did not meet the applicable clinical criteria or guidelines.

1.2.2 Services Exempt from Prior Authorization

The Plan is prohibited from imposing PA requirements on biomarker testing that is associated with an FDA approved therapy for advanced or metastatic stage 3 or 4 cancer. *(Contract, Exhibit A, Attachment III, 5.3.7(Q))*

The Plan may only require PA for inpatient hospice care. (*Contract, Exhibit A, Attachment III, 2.3.2(G)*.

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 is prohibited from imposing PA requirements on biomarker testing that is associated with an FDA approved therapy for advanced or metastatic stage 3 or 4 cancer. (*APL 22-010, Cancer Biomarker Testing*)

Plan policy, *UM15.072 Biomarker Testing* (approved 04/2024) applicable to commercial members, stated requests for biomarker testing will be processed and reviewed according to the Plan's existing authorization/utilization policies and procedures.

Plan policy, *UM15.003 Policy for Prior Authorization* (reviewed 04/2025), stated that no health plan PA or primary care physician/other provider referral is required for the following services if medically necessary:

- Labs (excludes genetic testing, which requires authorization)
- In-Home Hospice Services

Plan policy, *CLIN13.008 Hospice Services* (approved 07/2025), stated that the Plan will not require PA for routine home care, continuous home care, respite care, or hospice physician services.

Finding: The Plan incorrectly applied PA requirements to cancer biomarker testing and home hospice services.

A verification study found that in 26 PA cases, the Plan inappropriately applied PA requirements in two of three cancer biomarker testing and two of two home hospice service PA requests.

In two of three cases involving cancer biomarker testing for members with advanced stage 3 or 4 cancer, the Plan inappropriately applied PA requirements:

- A request for a member with advanced pancreatic cancer was approved following clinical review. However, the Plan should not have imposed PA requirements.
- A request for a member with advanced lung cancer was approved by the Plan after 11 days. PA was inappropriately applied to this request, resulting in a delay in testing.

The Plan lacks a biomarker testing policy, specifically for Medi-Cal members.

During the interview, the Plan confirmed that Plan policy, *UM15.072 Biomarker Testing* (approved 04/2024), which applies to commercial members was used to adjudicate requests for Medi-Cal members. In a written narrative response, the Plan acknowledged it did not have a biomarker testing policy specifically for Medi-Cal members during the audit period.

Regarding the home hospice services, the Plan inappropriately applied PA requirements to two of two PA requests.

In January 2025, the Plan implemented a Current Procedure Terminology Search Tool intended to assist staff in determining which services require PA. Despite this enhancement, the tool did not capture the applicable hospice code for an in-home hospice care sample reviewed after its implementation.

During the interview, the Plan stated that hospice services do not require authorization and all staff, including Health Plan Authorization Review Specialists and Registered Nurses , should know which services do not require PA. However, the Plan did not follow its own Plan policy UM15.003, which stated that no PA is required for in-home hospice services.

When PA is inappropriately required for services that should be exempt, it can lead to harmful delays or denials in care.

Recommendation: Develop and implement policies and procedures to ensure that the Plan does not apply PA requirements for cancer biomarker testing services. Implement policies and procedures to ensure that the Plan does not apply PA requirements for home hospice services.

COMPLIANCE AUDIT FINDINGS

Category 3 – Network and Access to Care

3.6 Access to Emergency Service Providers and Emergency Services

3.6.1 Denial of Emergency Services Claims

The Plan is required to pay for emergency services received by a member from non-contracting providers. *(Contract, Exhibit A, Attachment III, 3.3.16(A)(3))*

The Plan shall not improperly deny or contest a claim or portion thereof. For each claim that is denied or contested, the Plan is required to provide an accurate and clear written explanation of the specific reasons. *(California Code of Regulations (CCR), Title 28, section 1300.71 (d) (1) and (h))*

The CCS program requires authorization for health care services related to a member's CCS-eligible medical condition. *(California Children's Service (CCS) Program Service Authorization Request (SAR), Part 2 Provider Manual (updated 09/2020))*

Plan policy, *CLM 4.526e Emergency Services* (approved 04/11/2023), stated the Plan is responsible for coverage and payment of emergency services. The Plan did not deny payment for treatment obtained when a member had an emergency medical condition.

Finding: The Plan improperly denied emergency services claims that involved CCS eligible diagnoses.

A verification study found that 8 of 20 emergency services claims were automatically processed and denied by the Plan's claims system. All claims were denied by the Plan on the basis that payment responsibility lies with the CCS program.

The Plan stated its claim system was configured to flag CCS-eligible conditions and deny claims for members with a CCS indicator regardless of whether a valid SAR was on file. The CCS flag could be triggered by any prior CCS activity, including a past SAR, pending SAR, approved SAR, or a CCS NOA. However, the Plan is responsible for claims when no CCS SAR is on file.

In a written response, the Plan acknowledged that its claims system incorrectly denied the claims as there were no active CCS-approved or pending SARs on file for the billed diagnoses.

If the Plan does not properly process emergency services claims, providers may be discouraged from participating in the Medi-Cal program, which may impact members' access to care.

Recommendation: Implement policy and revise procedures to ensure claims for emergency services, including those that may be covered by CCS criteria, are properly adjudicated.

COMPLIANCE AUDIT FINDINGS

Category 4 – Grievances, Appeals, and Member Rights

4.1 Grievance and Appeal Program Requirements

4.1.1 Complete Ukrainian and Russian Taglines in Notice of Availability

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

The Plan is required to send members the grievance and appeals notifications to comply with the nondiscrimination and language assistance requirements as outlined in APL 21-004, *Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services,* (superseded by APL 25-005, *Standards for Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services, and Alternative Formats*), including any subsequent updates or revisions to APL 21-011, *Grievance and Appeal Requirements, Notice and "Your Rights" Templates*.

Federal regulations include the use of the term "Notice of Availability of Language Assistance Services and Auxiliary Aids and Services" and "Notice of Availability" for short when referring to language taglines. The Notice of Availability must include taglines in English and 18 non-English languages, including Ukrainian and Russian, to inform members of the availability of free language assistance services. The Notice of Availability must be included in all members informational notices, including electronic and written notices to an individual, such as those pertaining to rights and benefits. *(APL 25-005, Standards for Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services, and Alternative Formats)*

Plan policy, *AGD 20.002 Handling of Complaints and Grievances* (revised 06/2025), stated that the Plan will attach a notice of language rights to the acknowledgement and resolution letters sent for standard and expedited grievances.

Plan desktop procedure, *Desktop Procedure for sending Translation Requests*, stated that taglines are to be mailed with the acknowledgment and resolution letters.

Finding: The Plan did not send complete Ukrainian and Russian taglines in the Notice of Availability attached to grievance acknowledgement and resolution letters.

A verification study found that in 8 of 25 quality of service standard grievance cases and 1 of 4 quality of service expedited grievance cases, the Ukrainian and Russian taglines in the Notice of Availability were unreadable with blank spaces. The unreadable taglines were in:

- Five acknowledgement letters
- Seven resolution letters
- One expedited resolution letter

In a written response, the Plan reported a system printing error in the letter templates used to generate grievance acknowledgment and resolution letters, which resulted in unreadable or missing taglines in Russian and Ukrainian.

When the Plan does not follow the member notice requirements set forth by DHCS, non-English speaking members may not be informed of free language assistance services, potentially limiting their access to grievance support and violating federal and state nondiscrimination requirements.

Recommendation: Implement policies and procedures to ensure that the Plan sends complete taglines in the Notice of Availability included with member grievance letters.

4.1.3 Timely Translation of Acknowledgment and Resolution Letters

The Plan is required to provide full and immediate translation of written materials for limited English proficient members and members who speak threshold or concentration standard languages, fully translated member information, including but not limited to member rights information, form letters, and individual notices, including NOA letters, and all notices relating to grievances including grievance acknowledgment and resolution letters. *(Contract, Exhibit A, Attachment III, (5.2.10) (B)(b))*

Federal and state law, the DHCS Contract, and APL 21-004, *Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services,* (superseded by APL 25-005), require the Plan to fully translate and provide written member information in a member's required language, including all grievance notices. The Plan is required to comply with the State's established timeframe of 5 calendar days for grievance acknowledgment and 30 calendar days for grievance resolution. *(APL 21-011, Grievance and Appeal Requirements, Notice And "Your Rights" Templates and APL 25-005, Standards for Determining Threshold Languages,*

Nondiscrimination Requirements, Language Assistance Service, and Alternative Formats) Plan desktop procedure, *Desktop Procedure for sending Translation Requests*, stated that grievance staff are to review the grievance case screen to identify the member's preferred written language. If there is any other language other than English, a translated request is required. A note will be added to the case log that the acknowledgement letter has been sent for translation. When the translated letter is received, it will be attached to the grievance case, mailed to the member, and documented in the case log.

Finding: The Plan did not send translated acknowledgement letters within the required 5-calendar day timeframe or translated resolution letters within the 30-calendar day timeframe.

A verification study of 20 grievance cases requiring translation revealed:

- Five cases found translated acknowledgment letters were issued 7 to 48 days after grievance receipt, exceeding the required 5-calendar day timeframe.
- Six cases found translated resolution letters were issued 31 to 344 days after grievance receipt, exceeding the required 30-calendar day timeframe. Two letters were only sent 232 and 344 days after receipt, and only after DHCS requested the verification samples.

During the interview and in a written response, the Plan stated it did not have a tracking mechanism to monitor letter translation requests that had been sent out for translation, received back from translation, or uploaded to the grievance case's file.

The Plan's quarterly internal grievance audits showed the Plan is checking whether selected grievances had acknowledgement letters sent in the member's preferred language. However, the Plan acknowledged that its grievance audits did not review whether the translated letters were sent in a timely manner. Additionally, the audit tool did not review whether the resolution letters were sent in the member's preferred language and in a timely manner.

If the Plan does not send translated acknowledgment and resolution letters in the members' threshold languages in a timely manner, members may not understand all the information needed to make informed health care decisions.

Recommendation: Implement procedures to ensure the timely submission of translated acknowledgement and resolution letters.

4.12 Member Rights and Responsibilities

4.12.1 Timely Reporting of Suspected Security Incidents

The Plan is required to notify DHCS within 24 hours of any suspected security incident which risks unauthorized access of Protected Health Information and/or confidential information. *(Contract, Exhibit A, Attachment III, Section 5.1.1, Exhibit G, Section 18.1.2)*

Plan policy, *ADM1.039 Reporting of Improper Disclosures* (revised 07/05/2020), stated that notification to DHCS is required, within 24 hours by email or telephone, for any suspected security incident, intrusion, or unauthorized access, use, or disclosure of Protected Health Information.

Finding: The Plan did not notify DHCS within 24 hours of suspected security incidents.

In a verification study of 14 samples, 8 samples exceeded the required 24-hour notification timeframe. Samples found the suspected security incidents were reported 3 days to 126 days after the date of discovery. In two of four samples, the Grievance Department conducted an initial review before notifying the Compliance Department of the suspected security incident.

The Plan did not follow its own Plan policy ADM1.039, which requires notification to the DHCS within 24 hours of discovering a suspected security incident.

During the interviews, the Plan stated that the Grievance and Compliance Departments conducted initial investigations prior to reporting it to the DHCS. The Plan acknowledged that the discovery date may need to be clarified among its staff.

If the Plan does not notify DHCS within the required 24-hour timeframe, it may compromise DHCS' ability to initiate a timely response to suspected security incidents.

Recommendation: Implement policies and revise procedures to ensure timely reporting of suspected security incidents.

COMPLIANCE AUDIT FINDINGS

Category 5 – Quality Improvement and Health Equity Transformation Program

5.13 Credentialing and Recredentialing

5.13.1 Oversight of Delegated New Provider Training

The Plan must ensure delegates meet all contract requirements for the functions undertaken. The Plan remains fully responsible for all delegated duties and obligations. To ensure compliance, the Plan must monitor and oversee all delegated functions. *(Contract, Exhibit A, Attachment III, 3.1.1(B)(4))*

The Plan must ensure that delegated entities comply with all state and federal laws and regulations, contract requirements, and APLs. *(APL 23-006, Delegation and Subcontractor Network Certification)*

Regardless of the relationship with the delegated entity, the Plan is ultimately responsible for adhering to and fully complying with all Contract terms and conditions. *(Code of Federal Regulations, Title 42, section 438.230(b)(1))*

The Plan is required to ensure that all network providers receive training regarding the Medi-Cal Managed Care program to ensure they operate in full compliance with the Contract and all applicable federal and state statutes, regulations, APLs, and Policy Letters. The Plan must conduct training for all network providers. *(Contract, Exhibit A, Attachment III, 3.2.5)*

Plan policy, *PA 9.830 Sub-Contractual Relationships and Delegation* (reviewed 06/2025), stated that the Plan maintains the responsibility of ensuring that delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance including, but not limited to APLs.

Plan policy, *PA 9.816 Provider Training* (revised 06/2025), stated that the delegated entities' orientation training is performed at the time of "onboarding" and prior to being credentialed by the entity and delivering services to any member. If a provider does not complete the training, the delegated entity excludes them from the monthly rosters sent to the Plan. Providers are required to sign an attestation to acknowledge that they have completed the training, which is stored in their electronic credential file or the delegated entities' Human Resources Department.

Finding: The Plan did not conduct oversight to ensure that its delegated entities conduct new provider training.

A review of the Plan's oversight monitoring for entities delegated new provider training found that the Plan did not verify four of six entities conducted new provider training.

The Plan does not have a formal process to monitor or validate that the delegated entities are conducting and documenting new provider training. It relies on providers being listed on a roster, rather than requiring evidence of training completion. The Plan stated that it monitors the delegates' monthly rosters for discrepancies such as incorrect specialty types or service locations. However, this review does not include whether provider training was completed.

During the interview and in written responses, the Plan stated for three of the delegated entities, new provider training is completed through the entities' Human Resources Departments' internal training modules, and they cannot provide reports from their human resources system to the Plan. The Plan stated if a provider does not complete the training, the delegated entity does not include the provider in the monthly roster of newly added providers sent to the Plan. However, the monthly rosters do not contain information that provider training was completed for those providers included in the rosters. The Plan relies on the providers being listed in the roster as evidence that new provider training was conducted.

For the remaining delegate, the Plan stated that the delegate is unable to provide a signed attestation form from the provider that the new provider training has been completed. The Plan accepts acknowledgment that the training was completed through the submission of the monthly roster listing all newly added providers by the delegate. However, the monthly roster does not contain information that provider training was completed for those providers listed in the roster. The Plan relies on the providers being listed in the roster as evidence that new provider training was conducted.

When the Plan does not ensure that delegates conduct timely training of newly contracted providers, the providers may not be aware of key Medi-Cal requirements, and the Plan cannot ensure the delegates are meeting its contractual requirements with the DHCS.

Recommendation: Revise and implement policies and procedures to conduct oversight to ensure the delegated entities provide new provider training.

COMPLIANCE AUDIT FINDINGS

Category 6 – Plan Administration and Organization

6.13 Fraud Prevention Program

6.13.1 Fraud, Waste, or Abuse Investigation

Subsequent to the filing of the preliminary report, 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*)

Plan policy, *ADM1.006 CCHP Anti-Fraud Program* (revised 06/2024), stated the Plan's Anti-Fraud Unit is responsible for the overall management of the Anti-Fraud Program, including the detection, investigation, and reporting of suspected fraudulent activities. The Plan will conduct, complete, and promptly report to the DHCS the results of a preliminary investigation.

Finding: The Plan did not complete an investigation of all reported or suspected FWA activities.

The Plan received four lead package reports of suspected FWA from its contracted entity, Cotiviti, which is responsible for analyzing billing claims for potential FWA issues. In total, there were 15 cases of suspected FWA identified in the Cotiviti reports. However, none of the cases identified by Cotiviti were investigated by the Plan.

In a written response, the Plan acknowledged that no investigative steps were taken on the reports sent by their vendor Cotiviti due to staff turnover. The Plan stated that the Cotiviti reports were treated differently than other sources of suspected FWA but did not specify the reason. The cases of suspected FWA identified by Cotiviti were not included in the log for notification to DHCS.

Failure to investigate all reported or suspected FWA activities may compromise the Plan's ability to detect and prevent improper use of program resources, which could lead to continued noncompliance, financial loss, and potential harm to program integrity.

Recommendation: Revise and implement a process to review and investigate all FWA leads received from the contracted entity and conduct a complete investigation of all reported or suspected FWA activities.

6.13.2 Fraud, Waste, or Abuse Reporting

The Plan must file a preliminary report with the DHCS' Program Integrity Unit detailing any suspected FWA identified within ten working days of the Plan's discovery or notice of such FWA. The Plan must submit a preliminary report in accordance with requirements set forth in APLs or other similar instructions. Subsequent to the filing of the preliminary report, 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*)

Plan policy, *ADM1.006 CCHP Anti-Fraud Program* (revised 06/2024), stated when there is a potential or suspected fraud case reported to the Anti-Fraud Unit, or the Anti-Fraud Compliance Officer (or designee), the Plan's Anti-Fraud Compliance Officer (or designee) shall log all FWA inquiries and evaluate the reported incident for validity. Based upon the supporting documentation, the Anti-Fraud Coordinator will either close the case or refer the case for further investigation. The Plan's Anti-Fraud Compliance Officer will communicate cases referred to the DHCS' Program Integrity Unit, or other appropriate government agency to the Anti-Fraud Unit, including the Plan's Chief Medical Officer, Chief Operating Officer, and other members as required.

Finding: The Plan did not report all suspected fraud cases to the DHCS within ten working days.

The Plan received four lead package reports of suspected FWA from its contracted entity, Cotiviti, which is responsible for analyzing billing claims for potential FWA issues. In total, there were 15 cases of suspected FWA abuse identified in the Cotiviti reports. However, none of the cases identified by Cotiviti were reported to DHCS as required.

In a written response, the Plan stated that the Cotiviti reports were treated differently than other sources of suspected FWA but did not specify a reason. As a result, the Plan did not incorporate these reports into its formal tracking or reporting workflow, and the cases were not logged or reported to DHCS as required.

This is a repeat finding of the prior year 2024, 6.2.4 Fraud, Waste, or Abuse Reporting. The Plan did not report all suspected fraud cases to the DHCS within ten working days.

As a Corrective Action Plan to the prior audit deficiency, the Plan submitted an updated Compliance Plan and Policy, Committee Meeting Minutes, and provided staff training. However, the Plan did not implement its policy to report all cases of suspected FWA to DHCS.

When the Plan does not notify DHCS of suspected cases of fraud, DHCS may not be able to take appropriate and timely action with suspected FWA providers.

Recommendation: Revise and implement policies and procedures to ensure all suspected cases of fraud sent to the Plan by its contractors are reported to DHCS.

DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SAN FRANCISCO SECTION

REPORT ON THE MEDICAL AUDIT OF CONTRA COSTA HEALTH PLAN FISCAL YEAR 2025-26

Contract Number: 23-30251

Contract Type: State Supported Services

Audit Period: August 1, 2024 – July 31, 2025

Dates of Audit: August 18, 2025 – August 29, 2025

Report Issued: March 16, 2026

TABLE OF CONTENTS

I. INTRODUCTION 3
II. COMPLIANCE AUDIT FINDINGS 4

I. INTRODUCTION

This report presents the results of the audit of Contra Costa Health Plan (Plan) compliance and implementation of the State Supported Services contract number 23-30251 with the State of California. The State Supported Services Contract covers abortion services with the Plan.

The audit covered the period of August 1, 2024, through July 31, 2025. The audit was conducted from August 18, 2025, through August 29, 2025, which consisted of a document review and verification study with the Plan administration and staff.

Twenty claims were reviewed for appropriate and timely adjudication.

An Exit Conference with the Plan was held on February 5, 2026. No deficiencies were noted during the review of the State Supported Services Contract.

COMPLIANCE AUDIT FINDINGS

State Supported Services

The Plan is required to provide, or arrange to provide, to eligible members enrolled under this Contract or the Primary Contract, the following private services:

1) Current Procedure Terminology codes: 59840 through 59857
2) Centers for Medicare and Medicaid Services Common Procedure Coding System codes: X1516, X1518, X7724, X7726, and Z0336

These codes are subject to change upon the Department of Health Care Services implementation of the Health Insurance Portability and Accountability Act of 1996 electronic transaction and code set provisions. *(Contract, Exhibit A, (1.2.1 and 1.2.2))*

The Plan is required to cover abortion services, as well as the medical services and supplies incidental or preliminary to an abortion, consistent with the requirements in the Medi-Cal Provider Manual. The Plan, network providers, and subcontractors are prohibited from requiring medical justification, imposing any utilization management or utilization review requirements, including prior authorization, for the coverage of outpatient abortion services. *(All Plan Letter 24-003, Abortion Services)*

Finding: No deficiencies were identified in the audit.

Recommendation: None.