DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SAN FRANCISCO SECTION

REPORT ON THE MEDICAL AUDIT OF HEALTH NET COMMUNITY SOLUTIONS, INC. FISCAL YEAR 2024-25

Contract Numbers: 23-30221, 23-30222, and 23-30223

Audit Period: June 1, 2024 — April 30, 2025

Dates of Audit: May 12, 2025 — May 23, 2025

Report Issued: November 21, 2025

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I. INTRODUCTION

Health Net Community Solutions, Inc. (Plan), a wholly owned subsidiary of Centene Corporation, is a managed care organization that delivers managed health care services through health plans and government-sponsored Managed Care Plans.

The Plan delivers care to members under the Two-Plan contracts covering Los Angeles, San Joaquin, Stanislaus, and Tulare Counties, Geographic Managed Care Plan contract covering Sacramento County, and Regional Plan contracts covering Amador, Calaveras, Inyo, Mono, and Tuolumne Counties.

The Plan operates mainly as a delegated group network model. Services are delivered to members through the Plan's Participating Provider Groups (PPG), Independent Physician Associations, or directly contracted primary care and specialty care practitioners.

As of May 2025, the Plan's enrollment total for the Medi-Cal line of business was 1,590,410. Membership composition by county was 1,927 for Amador, 5,945 for Calaveras, 1,976 for Inyo, 1,102 for Mono, 1,189,160 for Los Angeles, 34,322 for San Joaquin, 64,590 for Stanislaus, 137,448 for Tulare, 6,431 for Tuolumne, and 147,509 for Sacramento.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of June 1, 2024, through April 30, 2025. The audit was conducted from May 12, 2025, through May 23, 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 October 24, 2025. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On November 7, 2025, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Utilization Management (UM) Program, Population Health Management and Coordination of Care, Network and Access to Care, Grievances, Appeals, and Member Rights, Quality Improvement and Health Equity Transformation, and Plan Administration and Organization.

The prior DHCS medical audit for the period of April 1, 2022, through May 31, 2024, was issued on February 14, 2025. This audit examined the Plan's compliance with the DHCS Contracts and assessed the implementation of the prior year 2024, Corrective Action Plan.

The summary of the findings by category follows:

Category 1 – Utilization Management Program

The Plan must ensure that its UM program has a specialty referral system to track and monitor referrals requiring prior authorization by the Plan. The Plan's specialty referral systems must include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. Finding 1.1.1: The Plan did not have a system to track and monitor specialty referrals requiring prior authorization.

The Plan must follow the expedited appeal process when it determines, or the requesting provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. Finding 1.3.1: The Plan did not ensure appeals

were processed in an expedited manner when there was an indication that a delay in receiving treatment could seriously jeopardize the member's health.

The Plan must ensure that its grievance and appeal system meets the requirement to ensure timely written acknowledgement of each grievance or appeal, and provides a Notice of Resolution letter to the member as quickly as the member's health condition requires, not to exceed 30 calendar days from the date the member makes an oral or written request to the Plan for a standard grievance or appeal. The Plan must notify the member, provider, or authorized representative with a written resolution of the grievance or appeal in the member's preferred language. Finding 1.3.2: The Plan did not ensure that members received fully translated resolution letters in their threshold language within 30 calendar days for a standard appeal.

The Plan must ensure that its UM program has a specialty referral system to track and monitor referrals requiring prior authorization. When prior authorization is delegated to subcontractors and downstream subcontractors, the Plan must ensure that subcontractors and downstream subcontractors have systems in place to track and monitor referrals requiring prior authorization and must furnish documentation of subcontractor's and downstream subcontractor's referrals to DHCS upon request. Finding 1.5.1: The Plan did not ensure that Regal Medical Group (a Plan subcontractor) was tracking and monitoring specialty referrals requiring prior authorization requests.

Category 2 – Population Health Management and Coordination of Care

The Plan is required to provide blood lead screening tests to all child members at 12 months and 24 months of age, and when the network provider performing a Periodic Health Assessment becomes aware that a child member who is 12 to 72 months of age has no documented evidence of a blood lead screening test taken. Finding 2.1.1: The Plan did not ensure the provision of a blood lead screening test was given to members under six years of age.

The Plan is required to ensure that their network providers provide oral or written anticipatory guidance to the parent(s) or guardian(s) of a child member that, at a minimum, includes information that children can be harmed by exposure to lead. Finding 2.1.2: The Plan did not ensure that blood lead anticipatory guidance was given to members under six years of age.

The Plan must facilitate coordination of care and case management in the provision of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits, including Behavioral Health Treatment (BHT). The Plan is responsible for developing a treatment plan that meets the following criteria, including but not limited to care coordination that involves the guardian, school, state disability programs, and other programs and institutions, as applicable. Finding 2.3.1: The Plan did not ensure care coordination for members receiving BHT services.

The Plan must attempt to notify the member of the Continuity of Care (COC) decision via the member's preferred method of communication or by telephone and must also send a notice by mail to the member within seven calendar days of the COC decision. The Plan must include the following information in the notice: a statement of the Plan's decision, a clear and concise explanation of the reason for denial, and the member's right to file a grievance or appeal. Finding 2.4.1: The Plan did not process and notify members of COC request decisions as approvals or denials in accordance with *All Plan Letter (APL) 23-022, Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, On or After January 1, 2023*, dated August 15, 2023.

A non-urgent COC request must be completed within 30 calendar days from the date the Plan received the request. Finding 2.4.2: The Plan did not ensure that members' non-urgent COC requests were completed within 30 calendar days.

The Plan must ensure efficient care coordination and COC for members who may need or are receiving services and/or programs from Out-of-Network (OON) providers. If the Plan and the member's OON provider are unable to reach an agreement, the Plan must offer the member a network provider alternative. Finding 2.4.3: The Plan did not ensure care coordination for members who had denials of their COC requests.

The Plan must follow all provisions in the Enhanced Care Management (ECM) Policy Guide. The Plan must ensure ECM provided to each member encompasses the ECM core service components. Finding 2.6.1: The Plan did not ensure all ECM core service components were provided to members.

Category 3 – Network and Access to Care

The Plan must cover and pay for Emergency Room (ER) professional services as specified in California Code of Regulations (CCR), Title 22, section 53855. This includes all professional mental and substance use treatment services, including screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services medically necessary to stabilize the member. Finding 3.6.1: The Plan improperly denied emergency services claims relating to mental health services.

Category 4 – Grievances, Appeals, and Member Rights

The Plan's grievance resolution and written response is required to contain a clear and concise explanation of the Plan's decision. Finding 4.1.1: The Plan did not send resolution letters with a clear and concise explanation of the decision for Quality of Care (QOC) grievances.

The Plan is required to maintain a written record made for each grievance received by the Plan, including the date received, the Plan representative recording the grievance, a summary or other document describing the grievance, and its disposition. The written record of grievances shall be reviewed periodically by the governing body of the Plan, the public policy body, and by an officer or designee of the Plan. Finding 4.1.2: The Plan did not ensure that transportation related exempt grievances are reviewed by its governing body, public policy body, and the Plan's officer or designee.

Category 5 – Quality Improvement and Health Equity Transformation Program

The Plan is required to start training within ten working days, and complete training within 30 working days, after the Plan places a newly contracted network provider on active status. Finding 5.3.1: The Plan did not ensure that all individual providers joining contracted medical groups received new provider training.

Category 6 – Plan Administration and Organization

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

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 Contracts.

PROCEDURE

DHCS conducted an audit of the Plan from May 12, 2025, through May 23, 2025, for the audit period of June 1, 2024, through April 30, 2025. The audit included a review of the Plan's Contracts 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: Thirty medical service request cases were reviewed for timeliness, consistent application of criteria, and appropriate review. Of the 30 cases, 16 were concurrent review authorization requests and 14 were prior authorization requests.

Appeal Requests: Twenty-five prior authorization appeals were reviewed for appropriate and timely adjudication.

Delegated Authorization Requests: Thirty medical service request cases from Regal Medical Group were reviewed for timeliness, consistent application of criteria, and appropriate adjudication. Of the 30 cases, 26 were prior authorization requests, 2 were post-service authorization requests, and 2 were concurrent review authorization requests.

Category 2 – Population Health Management and Coordination of Care

Basic Population Health Management/Population Risk Stratification and Segmentation, and Risk Tiering: Ten medical records were reviewed to confirm coordination of care and fulfillment of requirements.

California Children's Services: Seven files were reviewed for evidence of care coordination between the Plan and California Children's Services providers.

Initial Health Appointment: Ten medical records were reviewed for evidence of coordination of care and fulfillment of initial health appointment requirements.

Complex Case Management: Ten cases were reviewed to confirm the provision of complex case management for eligible members.

BHT: Fifteen medical records were reviewed for care coordination, completeness, and compliance with BHT service requirements.

COC: Fifteen medical records were reviewed to evaluate the timeliness and appropriateness of COC request determination.

ECM: Fifteen files were reviewed to confirm coordination of care and compliance with 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: Thirty 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: Sixty-five standard grievances, ten exempt, five expedited grievances, and seven member call inquiries were reviewed for timely resolution, appropriate classification, response to the complainant, and submission to the appropriate level for review. The 65 standard grievance cases included 45 quality of service and 20 QOC grievances.

Confidentiality Rights: Ten 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 issues cases were reviewed for timely evaluation and effective action taken to address needed improvements.

Provider Training: Twelve 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: Ten fraud and abuse cases were reviewed for appropriate reporting and processing.

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management Program

1.1 UTILIZATION MANAGEMENT PROGRAM

1.1.1 Specialty Referral System

The Plan must develop, implement, update as needed (but at least annually), and improve its UM program to ensure appropriate processes are used to review and approve the provision of medically necessary covered services for its members. The Plan must ensure that its UM program has a specialty referral system to track and monitor referrals requiring prior authorization by the Plan. The Plan's specialty referral systems must include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. The Plan's specialty referral systems must include information on requested OON services. *(Contract 23-30221, A02 2.3 H))*

Plan policy, *CA.UM.40 Specialty Referral System* (revised 04/02/2024), stated that the Plan has a specialty referral system to track and monitor referrals requiring prior authorization. The Plan does not require prior authorization for most in-network specialist visits and in-network diagnostic services. The Plan monitors and tracks internal authorizations via the electronic medical management system.

Plan policy, *CA.UM.56 V9 Referrals to Non-Participating Practitioners/Providers* (revised 11/22/2023), stated the Plan maintains an on-line referral tracking system to track and monitor referrals, for OON providers requiring prior authorization. The system documentation includes authorized, denied, deferred, or modified referrals, and the timeliness of the referrals.

Finding: The Plan did not have a system to track and monitor specialty referrals requiring prior authorization.

The Plan's policy CA.UM.40 states that the Plan does not require prior authorization for most in-network specialist visits and in-network diagnostic services. The Plan did not provide any reports related to specialty referrals requiring prior authorization for the in-network providers. The Plan did not aggregate and analyze the in-network specialty referrals requiring prior authorizations.

The Plan stated that they track OON prior authorization requests and provided an OON summary report covering a nine-month period. The report included all referrals to OON provider types such as clinics, adult day care, hospitals, medical supplies or laboratory, but there was no evidence provided indicating the Plan aggregated and analyzed data related to OON specialists' referrals.

Plan policy CA.UM.40 does not describe its procedures for tracking and monitoring all in-network specialty referrals that require prior authorization. Additionally, it did not include the process for the required documentation to include authorized, denied, deferred, or modified referrals.

When the Plan does not have a system in place for specialty referral tracking, its ability to identify underutilization of specialty services is limited, which may lead to delays in obtaining medically necessary services in a timely manner.

Recommendation: Revise and implement policies and procedures to track and monitor all specialty referrals requiring prior authorization.

1.3 APPEALS

1.3.1 Expedited Appeal Denials

The Plan is required to maintain a Medical Director, pursuant to CCR, Title 22, section 53913.5, whose responsibilities shall include ensuring that medical decisions are rendered by qualified medical personnel. (*Contract 23-30221, Exhibit A, Attachment III, 1.1.6)*

The Plan is required to ensure that all grievance or appeals related to medical QOC issues be immediately submitted to the Plan's Medical Director for action. The Plan must ensure that the person making the decision on the grievance or appeal has clinical expertise in treating a member's condition or disease when deciding any grievance or appeal involving clinical issues. *(Contract 23-30221, Exhibit A, Attachment III, 4.6.1 (D)(3))*

The Plan must follow the expedited appeal process when it determines or the requesting provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. *(Contract 23-30221, Exhibit A, Attachment III, 4.6.6)*

The Plan must comply with all existing state regulations pertaining to expedited appeal handling in accordance with state law. The decision-maker must be a health care professional with clinical expertise in treating a member's condition or disease on any appeal involving clinical issues. *(APL 21-011, Grievance and Appeals Requirements, Notice and "Your Rights" Templates*, dated August 31, 2022*)*

Plan policy, *UM.CA.36 Medi-Cal Member Appeal Process* (revised 02/26/2025), stated the Plan ensures that grievances are reported to an appropriate level, i.e., medical issues versus health care delivery issues. The Plan ensures that any grievance involving the appeal of a denial based on lack of medical necessity, appeal of a denial of a request for expedited resolution of a grievance, or an appeal that involves clinical issues are resolved by a health care professional with appropriate clinical expertise in treating the member's condition or disease.

If an issue involves an imminent and serious threat to the health of the member, including, but not limited to, severe pain, potential loss of life, limb or major bodily function, as determined by the Plan or as indicated by a provider acting on behalf of the member, the Case Coordinator forwards the expedited appeal review to an Appeals and Grievance Clinical Specialist II, a Registered Nurse who coordinates appeals with the appropriate Medical Director, for immediate attention and resolution. An expedited appeal review contains the steps noted within the appeal procedures; however, the timeframe for execution is condensed to meet the needs of the member's medical condition.

Finding: The Plan did not ensure appeals were processed in an expedited manner when there was an indication that a delay in receiving treatment could seriously jeopardize the member's health.

The verification study found that in 16 of 16 sample expedited appeals, the appeals were downgraded to standard appeals without documented escalation to a Medical Director.

- The clinical rationale for downgrading expedited appeals requests was not documented.
- Four appeals involved cancer patients in the middle of ongoing treatment for their disease. Their expedited requests were processed as standard appeals, leading to delays in their treatment. All four appeals were overturned resulting in delays of at least three weeks.

- Five additional appeals, involving cancer patients, were downgraded from expedited requests to standard appeals for consultations and treatment due to OON providers. Four of these decisions were upheld, but an expedited appeal decision would lead to earlier treatment for these cancer patients. For example, a member diagnosed with advanced cancer submitted an expedited appeal for a denied OON gynecologic oncology referral. Since the appeal was downgraded to a standard appeal, the member had to wait 30 calendar days for the decision as opposed to only having to wait 72 hours for the decision if the Plan processed it as expedited.
- An additional case involved an OON appeal for a procedure in an advanced-stage cancer patient. The expedited request was processed as a standard request. There was no documentation in the case file that a Medical Director was consulted regarding the decision to downgrade. The oncologist would not move forward with treatment until the procedure was completed in order to decrease the infection risk. The in-network alternative referrals were noted to be two to three months out due to scheduling. The appeal was overturned after it was concluded that, "further delay could cause harm to the member." This appeal downgrade resulted in a delay of more than three weeks.
- The last case involved a procedure request to decrease the risk of infection in a heart transplant patient. This downgraded expedited appeal request was overturned, resulting in a delay of at least three weeks.
- The remaining five appeals were also downgraded with no documented escalation to a Medical Director.

The Plan's policy did not specify the conditions under which expedited appeals are escalated to the Medical Director. The Plan's process only escalated appeals to the Medical Director on an as-needed basis. There were no controls to ensure that all appeals involving clinical issues would be escalated to a Medical Director.

When the Plan downgrades expedited appeals without a Medical Director's review, it may lead to service delays, which may jeopardize members' health.

Recommendation: Revise and implement policy and procedures to ensure appeals are processed expeditiously when members' health could be seriously jeopardized.

1.3.2 Translation of Member Appeal Notice Letters

The Plan must have in place a member grievance and appeal system that complies with federal and state regulations for covered services. The Plan must follow grievance and appeal requirements set forth in and use all notice templates included in, *APL 21-011, Grievance and Appeals Requirements, Notice and "Your Rights" Templates*, dated August 31, 2022. The Plan must ensure that its grievance and appeal system meets the requirement to ensure timely written acknowledgement of each grievance or appeal, and provides a Notice of Resolution letter to the member as quickly as the member's health condition requires, not to exceed 30 calendar days from the date the member makes an oral or written request to the Plan for a standard grievance or appeal. The Plan must notify the member, provider, or authorized representative with a written resolution of the grievance or appeal in the member's preferred language. *(Contract 23-30221, A02 Exhibit A, Attachment III, 4.6.1 (B))*

Federal and state law, the DHCS Contracts, and *APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services*, dated May 3, 2022, require the Plan to fully translate and provide written member information in a member's threshold language, as specified, including all grievance and appeals notices referenced in APL 21-011. Plans that are not currently in compliance with immediate, full translation of the entire NAR letter are expected to come into compliance with full translation within six months of the issuance date of this APL (21-011). During the six-month compliance period, if the Plan mails a partially translated NAR letter with the clinical rationale written in English, the following requirement must be met: provide a fully translated written notice, including a fully translated clinical rationale, as soon as possible but not later than 30 calendar days from the date the partially translated notice was sent. The compliance period ended February 28, 2023. *(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates*, dated August 31, 2022*)*

Plan policy, *UM.CA.36 Medi-Cal Member Appeal Process* (reviewed 02/26/2025), stated that written communications are provided in the threshold languages defined by the DHCS. Federal and state law, the DHCS Contracts, and APL 21-004 require the Plan to fully translate and provide written member information in a member's required language, including all grievance and appeals notices. The Plan shall fully translate the NAR letter, including the clinical rationale for the Plan's decision, that must be included in the NAR letter in the member's preferred threshold language. If a partially translated NAR letter is mailed to the member, the Plan will provide a fully translated written notice. The resolution letter is issued within the 30-calendar day requirement.

Finding: The Plan did not ensure that members received fully translated resolution letters in their threshold language within 30 calendar days for a standard appeal.

A verification study of 25 member appeals identified 4 appeals requiring full translation. Two of the four appeals were not translated timely. The members received partially translated NAR letters, and the fully translated NARs were sent out after the 30-day requirement. The Plan translated the part of the letter which informs members that they will receive a fully translated copy of the letter within 30 days and provides the phone number to call if the member needs assistance in understanding the letter. These letters did not have translated final resolution, clinical rationale for the decision, and members' rights. The fully translated letters were sent out 40 and 41 days after the appeal was submitted.

During the interview, the Plan stated that partially translated letters are initially sent out prior to the 30 days and that the fully translated letters are sent out after the translation service completes the translation. The Plan stated that their process did not account for additional time to fully translate the letter and relied on the grievance coordinator to request emergency translation services to fully translate letters within the 30-day requirement. The Plan's gaps in translation workflow and lack of timely coordination between appeal resolution and translation services led to delays in fully translated letters.

Plan policy UM.CA.36 did not document a process to ensure that a fully translated written notice is sent out within 30 calendar days of the appeal request. The Plan's policy states that the Plan can send partially translated NAR letters. However, APL 21-011 requires the Plan to send out fully translated letters within 30 calendar days.

If the Plan does not provide members with fully translated appeal notices, members may not be given the necessary and timely information about their appeal rights to help them make informed decisions about their health care.

Recommendation: Revise and implement policies and procedures to ensure that full translations of appeal notices are provided to members in their threshold language within 30 calendar days of a standard appeal.

1.5 DELEGATION OF UTILIZATION MANAGEMENT

1.5.1 Oversight of Delegate Specialty Referrals

The Plan may delegate UM activities. If the Plan delegates any UM activities, the Plan must comply with Exhibit A, Attachment III, Subsection 2.2.5 Subcontractor and Downstream Subcontractor Quality Improvement Activities. *(Contract 23-30221, Exhibit A, Attachment III, 2.3.4)*

The Plan must maintain an adequate oversight procedure to ensure subcontractor's and downstream subcontractor's compliance with all quality improvement or health equity delegated activities that ensures subcontractor and downstream subcontractor meet quality improvement and health equity standards set forth in these Contracts. *(Contract 23-30221, Exhibit A, Attachment III, 2.2.5 B)*

The Plan must ensure that its UM program has a specialty referral system to track and monitor referrals requiring prior authorization. When prior authorization is delegated to subcontractors and downstream subcontractors, the Plan must ensure that subcontractors and downstream subcontractors have systems in place to track and monitor referrals requiring prior authorization and must furnish documentation of subcontractors and downstream subcontractors referrals to DHCS upon request. The Plan's specialty referral systems must include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. The Plan's specialty referral systems must include information on requested OON services. The Plan must ensure that all network providers are aware of the specialty referral processes and tracking procedure. *(Contract 23-30221, Exhibit A, Attachment III, 2.3(H))*

Plan policy, *CA.UM.40 Specialty Referral System* (revised 04/02/2024), stated that the Plan has a specialty referral system to track and monitor referrals requiring prior authorization. The Compliance Department will monitor compliance for its delegates.

Finding: The Plan did not ensure that Regal Medical Group (a Plan subcontractor) tracked and monitored all specialty referrals requiring prior authorization requests.

The Plan provided the Regal Medical Group, Specialty Referral Report, which only showed ten specialties. Regal Medical Group requires prior authorization for all specialty referrals but did not track all specialties and OON specialty requests. The Specialty Referral Report also did not include deferred and modified referrals. Review of the prior authorization requests processed by Regal Medical Group during the audit period revealed Regal Medical Group processed all types of specialty referrals and not just limited to the ten specialties included in the Specialty Referral Report.

A review of Regal Medical Group policies, *UM-048 Prior Authorization Process* and *UM-004 Monitoring of Utilization Management*, found that there was no process for describing the tracking of specialty referral requests. Regal Medical Group did not provide a policy and procedure specific to tracking the specialty referrals.

In a written narrative, the Plan stated that its Compliance Department reviews Regal Medical Group's policies and procedures related to system controls and validates that required data is captured. The Plan did not provide a response describing its specialty referral system. The annual oversight audit of Regal Medical Group did not review the Specialty Referral Report. Additionally, the Plan's policy review process did not ensure the inclusion of all specialty referrals, along with the four categories: authorized, denied, deferred, or modified.

When the Plan does not monitor its subcontractors' specialty referral tracking, specialty access issues may not be identified, which may lead to delays in members obtaining appointments and care.

Recommendation: Revise and implement the Plan's policies and procedures to ensure that subcontractors and downstream subcontractors have systems in place to track and monitor specialty referrals requiring prior authorization.

COMPLIANCE AUDIT FINDINGS

Category 2 – Population Health Management and Coordination of Care

2.1 BASIC CASE MANAGEMENT

2.1.1 Provision of Blood Lead Screening Tests

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 23-30221, Exhibit E, 1.1.2)*

The Plan is required to cover and ensure the provision of blood lead screening tests to members at the ages and intervals specified in CCR, Title 17, sections 37000 through 37100, and in accordance with *APL 20-016, Blood Lead Screening of Young Children,* dated November 2, 2020. The Plan must ensure its network providers follow the Childhood Lead Poisoning Prevention Branch guidelines when interpreting Blood Lead Levels (BLLs) and determining appropriate follow-up activities, including, without limitation, appropriate referrals to the local Public Health Department. The Plan must notify the network provider responsible for the care of an identified member of the requirement to test the member and provide the written or oral anticipatory guidance as required pursuant to CCR, Title 17, section 37100. *(Contract 23-30221, Exhibit A, Attachment III, 5.3.4 (D))*

The Plan is required to provide blood lead screening tests to all child members at 12 months and 24 months of age, and when the network provider performing a Periodic Health Assessment becomes aware that a child member who is 12 to 72 months of age has no documented evidence of a blood lead screening test. The Plan must ensure that the network provider documents the reason(s) for not performing the blood lead screening test in the child member's medical record. *(APL 20-016, Blood Lead Screening of Young Children,* dated November 2, 2020*)*

Plan policy, *CA.QI.02 Childhood Blood Lead Screening* (revised 02/18/2025), stated the Plan will ensure that contracted providers perform BLL testing on all children at 12 months and at 24 months of age. Providers are also to perform BLL testing when the provider becomes aware that a child member who is 24 to 72 months of age has no documented evidence of a blood lead screening test. Providers must document the reasons for not screening in the child's medical record and if refused, obtain a signed

statement of voluntary refusal to document the reason for not performing the blood lead screening test.

Finding: The Plan did not ensure the provision of a blood lead screening test was given to members under six years of age.

In a verification study, two of four pediatric members did not have evidence of a blood lead screening test. There was no documentation about the risk of lead exposure or BLL test results. Documentation of a refusal of a lead test from the member's representative was not shown. The records did not indicate that a blood lead screening was completed or that outreach was done in an attempt to complete the blood level screening.

In an interview, the Plan also acknowledged that documentation regarding BLL test results, anticipatory guidance, and/or BLL risk assessment (risk of lead exposure) was not completed and should have been done. The Plan did not provide an explanation for it not being conducted.

According to the Plan policy CA.QI.02, the Plan identifies all children under six years of age with no record of lead screening and notifies providers responsible for the care of identified non-compliant children at least quarterly of: the age in which lead screening was missed, the requirement to test the child, and to provide required oral or written anticipatory guidance to parents/guardians, as required. However, the Plan policy did not detail the Plan's follow-up process to ensure non-compliant providers adhere to the BLL testing requirement. For the deficient sample member files, the Plan did not provide evidence that the providers followed up regarding the member's gap in care. During the interview, the Plan stated it was the provider's responsibility to complete the BLL testing. However, the Plan still maintains the responsibility to ensure BLL testing is completed, or a member's refusal is documented.

A review of the Plan's documents showed that there were care gaps with the Plan meeting the 50 percent benchmark for compliance with lead screening completion. However, the reports did not include specific measures or steps the Plan would take to follow up with providers who were non-compliant with ensuring blood lead screening for members. The Plan identified barriers such as staffing and lack of availability of blood lead testing machines at the provider's office.

Subsequent to the Exit Conference, the Plan submitted written statement and supplemental information explaining its lead screening efforts for children such as funding of blood lead screening equipment for providers. However, their rebuttal did not address the non-compliant samples in the verification study.

When the Plan does not provide blood lead screening tests in a timely manner, this may lead to undetected high BLLs and can cause irreversible developmental and neurological damage in children.

Recommendation: Revise and implement policies and procedures to ensure the provision of blood lead screening tests to all members under six years of age.

2.1.2 Blood Lead Anticipatory Guidance

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 23-30221, Exhibit E, 1.1.2)*

The Plan is required to cover and ensure the provision of blood lead screening tests to members at the ages and intervals specified in CCR, Title 17, sections 37000 through 37100, and in accordance with *APL 20-016, Blood Lead Screening of Young Children,* dated November 2, 2020. The Plan must notify the network provider responsible for the care of an identified member of the requirement to test the member and provide the written or oral anticipatory guidance as required pursuant to CCR, Title 17, section 37100. *(Contract 23-30221, Exhibit A, Attachment III, 5.3.4 (D))*

The Plan is required to ensure that their network providers provide oral or written anticipatory guidance to the parent(s) or guardian(s) of a child member that, at a minimum, includes information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age. *(APL 20-016, Blood Lead Screening of Young Children,* dated November 2, 2020*)*

Plan policy, *CA.QI.02 Childhood Blood Lead Screening* (revised 02/18/2025), stated the Plan will ensure that contracted providers perform BLL testing on all children at 12 months and at 24 months of age, and when the provider performing a Periodic Health Assessment becomes aware that a child member who is 24 to 72 months of age has no documented evidence of a blood lead screening test. Anticipatory guidance is provided at each Periodic Health Assessment to a parent or guardian of the child, starting at six months of age and continuing until 72 months of age. Anticipatory guidance must be documented in the member's record.

Finding: The Plan did not ensure that blood lead anticipatory guidance was given to members under six years of age.

In a verification study, two of four pediatric members did not have evidence that blood lead anticipatory guidance was provided to the members.

In an interview, the Plan also acknowledged that documentation regarding BLL test results, anticipatory guidance, and/or BLL risk assessment (risk of lead exposure) was not completed and should have been done. The Plan did not provide an explanation for it not being conducted.

According to the Plan policy CA.QI.02, the Plan identifies all children under six years of age with no record of lead screening and notifies providers responsible for the care of identified non-compliant children at least quarterly of: the age in which lead screening was missed, the requirement to test the child, and to provide required oral or written anticipatory guidance to parents/guardians as required. However, the Plan policy did not detail the Plan's follow-up process to ensure non-compliant providers adhere to the BLL testing requirement. For the deficient sample member files, the Plan did not provide evidence that the providers followed up regarding the member's gap in care. During the interview, the Plan stated it was the provider's responsibility to complete the BLL testing. However, the Plan still maintains the responsibility to ensure anticipatory guidance is given, and BLL testing is completed, or a member's refusal is documented.

Subsequent to the Exit Conference, the Plan stated it provided annual training to physicians on blood lead screening requirements. However, the Plan's response did not address the deficient samples during the audit period.

When the Plan does not provide blood lead anticipatory guidance, members may not be informed of the harmful effects of lead exposure in children.

Recommendation: Revise and implement policies and procedures to ensure the provision of blood lead anticipatory guidance to all members under six years of age.

2.3 BEHAVIORAL HEALTH TREATMENT

2.3.1 Care Coordination for Members Receiving Behavioral Health Treatment Services

The Plan has primary responsibility for the provision of medically necessary BHT services and must coordinate with Local Education Agencies (LEAs), regional centers, and other entities that provide BHT services to ensure that members timely receive all medically necessary BHT services, consistent with the EPSDT benefit. The Plan must provide medically necessary BHT services across settings, including home, school, and in the community, that are not duplicative of BHT services actively provided by another entity. *(Contract 23-30221, Exhibit A, Attachment III, 5.3.4 (F)(3))*

The Plan must provide case management and care coordination to the member, or the parent, legal guardian, or authorized representative, to ensure the provision of all medically necessary covered services identified in the Individualized Education Plan (IEP) developed by the LEA, with Primary Care Provider (PCP) participation. *(Contract 23-30221, Exhibit A, Attachment III, 4.3.16, (A))*

The Plan has primary responsibility for ensuring that EPSDT members receive all medically necessary BHT services covered under Medicaid. Examples of BHT services include behavioral interventions, comprehensive behavioral treatment, language training, parent/guardian training, self-management, and social skills. Plans must not rely on LEA programs to be the primary provider of medically necessary BHT services on-site at school or during remote school sessions. The approved behavioral treatment plan must also meet the following criteria, including but not limited to, care coordination that involves the guardian, school, state disability programs and other programs and institutions, as applicable. *(APL 23-010, Responsibilities for Behavioral Health Treatment Coverage for Members under the Age of 21*, dated November 22, 2023*)*

The Plan must ensure the provision of comprehensive medical case management services, including coordination of care for all medically necessary EPSDT services delivered both within and outside the Plan's provider network. The Plan is also responsible for the coordination of carved-out and linked services and referral to appropriate community resources and other agencies, regardless of whether the Plan is responsible for paying for the service. *(APL 23-005, Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members under the Age of 21*, dated March 16, 2023*)*

Plan policy, *CBH.UM.136 Responsibilities for Behavioral Health Treatment (BHT) Coverage for Members under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit* (revised 12/19/2024), stated that the Plan's Autism Center's behavioral health utilization review clinician reviews the provider's submitted Applied Behavior Analysis (ABA) treatment plan, and verifies the required criteria. The approved behavioral treatment plan must meet the criteria which includes care coordination that involves guardian, school, state disability programs, and other programs and institutions, as applicable. When needed, the Autism Center provides ongoing ABA case management and will refer to formal case management.

Plan policy, *CA.CR.07 Coordinating Services with Local Educational Agency (LEA) Providers* (revised 05/19/2025), stated that the Plan must not assume that BHT services included in a member's IEP are actively being provided by the LEA. The Plan is responsible for determining whether such services continue to be provided by the LEA and must provide any medically necessary BHT services that have been discontinued by the LEA. The Plan will coordinate services with these entities and when there are overlapping responsibilities to assess the level of medically necessary services the member requires to avoid duplicative services and ensure that the child is receiving all medically necessary EPSDT services in a timely manner.

Finding: The Plan did not ensure care coordination for members receiving BHT services.

A verification study revealed that in 6 of 15 samples, members did not receive care coordination with behavioral health services, PCPs, or schools. Examples of deficient samples include the following:

- In one sample, the member was receiving BHT services. The member was prescribed multiple medications for mental health condition and had severe impairments with communication, socialization, and disruptive behavior. The member also heard voices to harm themselves and others, had been hospitalized previously, and was under the care of the psychiatrist. The treatment plan noted that the member had an increase in aggressive behavior and stated that care would be coordinated with other providers and referrals made as needed. Despite this information, the case file did not indicate that care coordination with the PCP or behavioral health services had been conducted for the member during the audit period.

- In a second sample, the member was receiving BHT services which were put on hold for part of the audit period due to the member's high aggression. This resulted in the BHT provider having to find experienced staff to work with the member for safety reasons. Although the treatment plan stated that the BHT provider would follow coordination of care with therapy and other medical services, the sample file did not contain documentation of care coordination such as a referral to case management, or communication with the PCP regarding the member's behavior that was impacting BHT service delivery.
- In a third sample, the member received BHT services from a county Office of Education. The treatment plan noted the member's family consistently cancelled and later discontinued sessions due to a lack of transportation. The member had an IEP that included speech and language services. The Plan did not coordinate care with the member's school or address transportation issues for the member.
- In a fourth sample, the member was receiving BHT services along with speech therapy. The treatment plan noted that the member had an IEP, but the member's parent was unable to gain access to the IEP to share with the BHT team. The treatment plan's coordination of care section stated that the provider coordinates with the family and the regional center, but coordination with the school was not discussed. The sample file did not indicate that the BHT provider or the Plan attempted to coordinate with the school regarding the IEP to evaluate for the provision of medically necessary services and prevention of duplicate services.

Review of Plan policy CBH.UM.136 indicated that care coordination evaluation is part of the six-month treatment plan review process. However, the policy did not specify when case management and referrals to formal case management would be provided for members. Additionally, monitoring and oversight of care coordination processes for members receiving BHT services were not described in the policy. In an interview, the Plan stated that it would try to encourage care coordination, but it was up to the treating BHT providers to do care coordination for members needing behavioral health services. The Plan also stated that care coordination with the schools was the BHT providers' responsibility. However, the Plan retains responsibility to ensure that care coordination is provided to all members in accordance with the Plan's Contracts and APLs 23-010 and 23-005. In the deficient samples, members had behavioral health conditions or other factors, such as an active IEP, which could affect BHT service delivery. Care coordination was not conducted with PCPs, behavioral health services, or the schools by either the BHT providers or the Plan.

Subsequent to the Exit Conference, the Plan provided a statement that its ABA team coordinates care for members by assessments and referrals for any needed services and coordination of care. The Plan also stated that the treatment plans are reviewed to ensure that providers are also performing care coordination. However, the Plan did not provide supplemental documentation to demonstrate care coordination was provided for the deficient samples.

When the Plan does not ensure care coordination for members receiving BHT services, members may experience service duplications and delays, which may negatively impact physical and behavioral health conditions.

Recommendation: Revise and implement policies and procedures to ensure that care coordination is conducted for members receiving BHT services.

2.4 CONTINUITY OF CARE

2.4.1 Processing of Continuity of Care Requests

The Plan must deliver quality care that enables all its members to maintain health and improve or manage a chronic illness or disability. The Plan must ensure quality care in each of the following areas including but not limited to: access to primary and specialty health care providers and services; COC and care coordination across settings and at all levels of care with the goal of establishing consistent provider-patient relationships; and member experience with respect to clinical quality, COC, and care coordination. *(Contract 23-30221, Exhibit A, Attachment III, 2.2(A))*

The COC process begins when the Plan receives the COC requests. COC requests must be completed within 30 calendar days for non-urgent requests from the date the Plan received the request. A COC request is considered complete when the Plan notifies the member of the Plan's decision. The Plan must attempt to notify the member of the COC decision via the member's preferred method of communication or by telephone and must also send a notice by mail to the member within seven calendar days of the COC decision. The Plan must include the following information in the notice: a statement of the Plan's decision; a clear and concise explanation of the reason for denial; and the member's right to file a grievance or appeal. *(APL 23-022, Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, On or After January 1, 2023,* dated August 15, 2023)

Plan policy, *CA.UM.20 Continuity of Care* (revised 10/30/2024), stated that members who make a COC request to the Plan are given the option to continue treatment for up to 12 months with an OON Medi-Cal provider. These eligible members may require COC for services they have been receiving through Medi-Cal Fee-For-Service or through another Managed Care Plan. Decision timelines for non-urgent requests: 30 calendar days from the date the Plan received the request. Upon determination of a COC request, the Plan will notify the member using the member's known preferred method of communication, or by using one of these methods in the order below: telephone call, text message, or email, followed by notification by mail.

Finding: The Plan did not process and notify members of COC request decisions as approvals or denials in accordance with APL 23-022.

In a verification study, 3 of 15 cases showed that the Plan did not send written member notifications for denied COC requests. Additionally, it was noted that two of the three denied cases were initially cancelled before the Plan made a final decision to deny these two requests.

A review of the Plan's COC tracking logs showed multiple COC requests with a determination status of "cancelled." The Plan routinely cancelled or voided COC requests, and these cancellations were not initiated by members. The Plan provided a written response that it had voided or cancelled 242 of 268 COC requests received during the audit period.

In an interview, the Plan stated that it did not send written member notifications upon deciding to cancel COC requests. Instead, the Plan verbally notified members of these cancellations. As a result, members did not receive written notification of their appeal rights since the Plan did not implement its policies and procedures to process and notify members of COC request decisions as approvals or denials in accordance with APL 23-022.

When the Plan does not ensure COC requests are processed appropriately, members may encounter delays in receiving ongoing medical services to address health conditions and may not be informed of their rights to file an appeal.

Recommendation: Implement policies and procedures to ensure members' COC requests are processed in accordance with APL 23-022.

2.4.2 Continuity of Care Request Timelines

The Plan must deliver quality care that enables all its members to maintain health and improve or manage a chronic illness or disability. The Plan must ensure quality care in each of the following areas including but not limited to: access to primary and specialty health care providers and services; COC and care coordination across settings and at all levels of care with the goal of establishing consistent provider-patient relationships; and member experience with respect to clinical quality, COC and care coordination. *(Contract 23-30221, Exhibit A, Attachment III, 2.2)*

The COC process begins when the Plan receives the COC requests. A non-urgent COC request must be completed within 30 calendar days from the date the Plan received the request. A COC request is considered complete when the Plan notifies the member of its decision. The Plan must attempt to notify the member of the COC decision via the member's preferred method of communication or by telephone. The Plan must also send a notice by mail to the member within seven calendar days of the COC decision. *(APL 23-022, Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, On or After January 1, 2023*, dated August 15, 2023)

Plan policy, *CA.UM.20 Continuity of Care* (revised 10/30/2024), stated that members who make a COC request to the Plan are given the option to continue treatment for up to 12 months with an OON Medi-Cal provider. Decision timelines for non-urgent requests are 30 calendar days from the date the Plan received the request. The Plan's prior authorization-COC unit and the Public Programs Department run a monthly report relating to COC requests.

Finding: The Plan did not ensure that members' non-urgent COC requests were completed within 30 calendar days.

A verification study revealed that 3 of 15 samples with non-urgent COC requests-were not completed within 30 calendar days. The COC requests were completed between 48 and 55 days.

The Plan's policy contained information regarding monthly reports and data sharing but did not contain specific information on monitoring and oversight of COC processes.

In an interview and written response, the Plan acknowledged it had challenges with the timely completion of COC requests during the audit period. The Plan attributed these processing delays to changes in staffing, including leadership changes, and new staff hired.

When the Plan does not ensure that non-urgent COC requests are completed within 30 calendar days, members may encounter delays in receiving ongoing medical services, which may lead to worsening health conditions.

Recommendation: Revise and implement the policy and procedures to ensure members' non-urgent COC requests are completed within 30 calendar days.

2.4.3 Care Coordination for Members with Continuity of Care Denials

The Plan must deliver quality care that enables all its members to maintain health and improve or manage a chronic illness or disability. The Plan must ensure quality care in each of the following areas: COC and care coordination across settings and at all levels of care, including transitions in care, with the goal of establishing consistent provider-patient relationships; and member experience with respect to clinical quality, access and availability, culturally and linguistically competent health care and services, COC, and care coordination. *(Contract 23-30221, Exhibit A, Attachment III, 2.2)*

The Plan must provide Population Health Management to all members, in accordance with Code of Federal Regulations, Title 42, section 438.208. The Plan must maintain policies and procedures that meet the following Population Health Management requirements, at a minimum: ensure that each member has an ongoing source of care that is appropriate, ongoing, and timely to meet the member's needs; ensure members have access to needed services including care coordination; ensure efficient care coordination and COC for members who may need or are receiving services and/or programs from OON providers. *(Contract 23-30221, Exhibit A, Attachment III, 4.3.8, (A))*

For newly enrolled Seniors and Persons with Disabilities (SPD) who request COC, the Plan must provide continued access for up to 12 months to an OON provider with whom the SPD member has an ongoing relationship, as long as the Plan has no QOC issues with the provider and the provider will accept either the Plan's or the Medi-Cal Fee-For-Service rates, whichever is higher. The Plan must conduct person-centered planning for SPD members as follows: upon the enrollment of an SPD member, the Plan must provide, or ensure the provision of, person-centered planning and treatment approaches that are collaborative and responsive to the SPD member's continuing health care needs. The Plan must ensure that SPD members receive all necessary information regarding treatment and services to make an informed choice. *(Contract 23-30221, Exhibit A, Attachment III, 5.2.12 (A)(D((1)(4))*

Individuals who mandatorily transition from Medi-Cal Fee-For-Service to enroll as members in the Plan, have the right to request COC with providers in accordance with federal and state law and the Plan's Contracts, with some exceptions. If the Plan and the OON provider are unable to reach an agreement because they cannot agree to a rate, or the Plan has documented QOC issues with the provider, the Plan must offer the member a network provider alternative. If the member does not make a choice, the member must be referred to a network provider. *(APL 23-022, Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For Service, On or After January 1, 2023,* dated August 15, 2023)

Plan policy, *CA.UM.20 Continuity of Care* (revised 10/30/2024), stated that members who make a COC request to the Plan are given the option to continue treatment for up to 12 months with an OON Medi-Cal provider. If the Plan and the OON Fee-For-Service provider are unable to reach an agreement because of inability to agree to a rate, or the Plan has documented QOC issues with the provider, the Plan will offer the member an in-network alternative. If a request for continuation or extension of a previously approved service is requested and subsequently cannot be approved due to no longer meeting coverage criteria or benefit exhaustion, the denial notification will include identification of alternative resources, and any transition care approved for the member.

Plan policy, *CC.CM.02 Care Coordination/Care Management Services* (dated 01/15/2025), stated that care coordination is provided for all members. Care coordination typically involves non-clinical activities performed by non-clinical staff under the direction of a care management or other designee. Clinical staff may assist if minor medical or behavioral health concerns arise. The care management ensures that SPD members receive all necessary information regarding treatment and services so that they may make an informed decision.

Finding: The Plan did not ensure care coordination and COC for members with denials of their COC requests.

A verification study of 15 samples with COC requests included four members who had denied COC requests without subsequent care coordination following the denials.

- One sample had a COC request to continue seeing their provider for diabetic disease and medication management. The request was denied due to the provider refusing to work with the Plan. The case file did not contain information regarding other options, including a referral to case management or other assistance with obtaining medications and overall care for a chronic condition in a timely manner.

- One sample had a COC request to continue to see their provider for treatment of an infectious and chronic disease, which included medication management. The member's COC request was denied. A reason for the denial was not listed in the case file. Plan staff obtained a list of providers from its delegate, and the member was informed that they would have to establish care with a PCP to get a referral to an infectious disease provider in the area. However, the Plan did not ensure that the member was connected to services to prevent a gap in care or services for their disease management. Additionally, a denial letter was not sent to the member with a list of alternative resources or other options.
- One sample was an SPD member who had a request to continue seeing their PCP. The member was nonverbal and had multiple medical conditions. However, the provider was unable to continue providing care to the member. The case file did not contain information regarding alternative resources for another PCP, case management referral, or care coordination with the regional center.
- One sample was an SPD member who had a COC request to see a specialist. The member had intellectual disabilities and was living in a facility. The request was denied due to the provider refusing to work with the Plan. The case file noted that the staff would provide a list of specialists to the member's caregiver. However, there was no evidence of the list being provided to the member.
- The case files for both SPD members did not contain documentation of collaborative person-centered planning for the members' continuing health needs. The members also did not receive all necessary information regarding treatment and services to make an informed decision.

Review of Plan policy CC.CM.02 stated that management of SPD members included that the care management ensures that SPD members receive all necessary information regarding treatment and services so that they may make an informed decision. The policy further stated that person-centered care plan development and implementation processes included that upon enrollment of a member into care management, including an SPD member, the care manager ensures a person-centered planning and treatment approach. However, the Contracts stated that upon enrollment of an SPD member, the Plan must ensure the provision of person-centered planning and treatment approaches that are responsive to the member's continuing health needs within the context of COC and not specifically upon enrollment into care management services.

In a written response, the Plan stated that its staff verbally notified members and communicated the COC outcome; however, denial letters containing information on member alternatives were not sent to all members. The Plan did not provide an explanation as to why COC denials letters did not include member alternatives. The Plan further stated that its staff offered and provided supplementary resources tailored to the members' individual needs. However, the Plan did not provide documentation of the supplementary resources provided to the members.

When the Plan does not ensure that care coordination is provided to members who receive denials of their COC requests, members may experience gaps in care and delays in accessing medical services to improve their health conditions.

Recommendation: Revise and implement policies and procedures to ensure that members receive care coordination when denied COC requests.

2.6 ENHANCED CARE MANAGEMENT

2.6.1 Enhanced Care Management Core Service Components

The Plan must follow all provisions in the ECM Policy Guide. The Plan must ensure ECM provided to each member encompasses the ECM core service components. (*Contract 23-30221, Exhibit A, Attachment III, 4.4.1 (A)(H))*

The Plan must conduct necessary screening and assessments to gain timely information on the health and social needs of all members in accordance with applicable state and federal laws and regulations. (*Contract 23-30221, Exhibit A, Attachment III, 4.3.6 (B))*

The Plan must ensure that upon the initiation of ECM, each member receiving ECM has an ECM Lead Care Manager (LCM) with responsibility for interacting directly with the member and the member's family, legal guardians, authorized representatives, caregivers, and other authorized support persons. *(Contract 23-30221, Exhibit A, Attachment III, 4.4.9 (C))*

The goal of ECM is to coordinate all primary, acute, behavioral, developmental, oral, social needs, and long-term services and supports for members, including participating in the care planning process. *(CalAIM Enhanced Care Management Policy Guide, Section V,* August 2024*).*

ECM core service components: The requirements under each core service component are described below, including but not limited to:

- Outreach and Engagement:
    - The Plan is responsible for reaching out to and engaging members who are identified to be eligible for ECM.
- Comprehensive Assessment and Care Management Plan (CMP):
    - Developing a comprehensive, individualized, person-centered CMP with input from the member and their family members, legal guardians, authorized representatives, caregivers, and other authorized support persons, as appropriate, to assess strengths, risks, needs, goals and preferences and make recommendations for service needs.
    - Ensuring the member is reassessed at a frequency appropriate for the member's individual progress, changes in needs, and/or as identified in the CMP.
    - Ensuring regular contact with the member and their family members, legal guardians, authorized representatives, caregivers, and authorized support persons, as appropriate, consistent with the CMP.
- Member and Family Supports:
    - Providing appropriate education for the member and their family members, legal guardians, authorized representatives, caregivers, and/or authorized support persons, as applicable, about care instructions for the member.
    - Ensuring that the member and their family members, legal guardians, authorized representatives, caregivers, and authorized support persons, as applicable, have a copy of the member's CMP and information about how to request updates.

(APL 23-032, Enhanced Care Management Requirements, dated December 22, 2023*)*

Plan policy, *CA.SOC.02.V5 Enhanced Care Management Program Overview and Requirements* (revised 10/04/2023), stated that the Plan's ECM services include all of the following core service components for each member receiving ECM. The Plan, in partnership with the ECM provider, shall ensure the coordination of appropriate ECM core services for members enrolled in the program.

Finding: The Plan did not ensure all ECM core service components were provided to members.

A verification study revealed 6 of 15 members did not receive all core service components. Examples include:

- Outreach and Engagement:
    - A pediatric member was authorized for ECM and consented to treatment. However, no outreach was conducted by the LCM for over two and a half months. Subsequently, this member did not have a comprehensive assessment and care plan done for over five months.
    - Another member's care plan included goals for physical therapy and an electric wheelchair. The care plan stated that the member would receive biweekly contact from the LCM. However, the call log indicated less frequent contact with almost a month between contacts by the LCM during part of the audit period, which was inconsistent with the CMP.
- Comprehensive Assessment and CMPs:
    - One pediatric member did not receive a comprehensive child/youth assessment from the ECM provider. Instead, an adult comprehensive assessment was used, which had questions about health topics including substance use, pregnancy, adult vaccinations, and depression which were not applicable for a young child. Additionally, an adult assessment was not adequate to assess for developmental and other issues unique to the needs of a pediatric member.
    - One member's case file did not contain documentation of a comprehensive assessment. The member requested assistance with transportation and getting established with a PCP and a dental provider. However, these were not included in the care plan goals until two to four months after the request.
- Member and Family Supports:
    - Three members' files did not contain documentation that education and a copy of the care plan had been provided to the caregiver of the member, even though it was indicated that these members had a caregiver. A copy of the care plan was also not provided to the members.

In an interview, the Plan stated that barriers to ECM enrollment included provider capacity, staff turnover, and a lack of member contact information. In a written response, the Plan noted some challenges and trends with ECM, including incomplete training for LCMs, untimely completion of assessments and care plans, use of appropriate assessments for child/youth compared to adult assessments, inconsistent clinical oversight, not creating goals specific to the member, and lack of documentation of multidisciplinary meetings to discuss members care in the ECM program.

When the Plan does not ensure that all ECM core services are provided, members may not receive comprehensive care management to address all physical, behavioral, and social needs.

Recommendation: Revise and implement policies and procedures to ensure that members receive all ECM core service components.

COMPLIANCE AUDIT FINDINGS

Category 3 – Network and Access to Care

3.6 EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS

3.6.1 Denial of Emergency Services Claims relating to Mental Health

The Plan is required to pay for emergency services received by a member from non-contracting providers. *(Contract 23-30221, 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. *(CCR, Title 28, section 1300.71 (d) (1) and (h))*

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 23-30221, Exhibit E, 1.1.2(A)(1))*

The Plan must cover and pay for ER professional services as specified in CCR, Title 22, section 53855. This includes all professional mental and substance use treatment services, including screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services medically necessary to stabilize the member. *(APL 22-006 Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services*, dated April 8, 2022*)*

Plan policy, *CA.CLMS.75 Emergency Care and Post Stabilization* (revised 10/07/2024), stated the Plan is responsible for coverage and payment of emergency services and must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the Plan. The Plan may not deny payment for treatment obtained when a member had an emergency medical condition. The Plan may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

Finding: The Plan improperly denied emergency services claims relating to mental health diagnoses or mental health providers.

A verification study found that in 12 of 20 emergency services claims, the Plan improperly denied emergency services claims when billed either by a mental health provider or with a mental health related diagnosis, stating that the services were not a benefit of the Medi-Cal Managed Care Plan and instead were the responsibility of the county health agency. The verification study found the Plan denied claims in three categories:

- In 10 of 12 claims, when a mental health related diagnosis code was billed by non-mental health providers. The Plan is required by APL 22-006 to pay for mental health emergency services.
- In 1 of 12 claims, when no mental health related diagnosis code was billed by a provider with a psychiatry specialty. The Plan is required by APL 22-006 to pay for emergency services rendered by a mental health provider.
- In 1 of 12 claims, when a mental health related diagnosis code was billed by a provider with a psychiatry specialty. The Plan is required by APL 22-006 to pay for mental health emergency services.

The Plan is responsible for all emergency services and all mental health emergency services in accordance with APL 22-006. In a written response, the Plan acknowledged that its claim system's configuration does not support the covering of ER services as required by APL 22-006. During the audit period, the Plan's annual claims audit only reviewed its policies with no file review of emergency services claims for proper adjudication.

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: Revise and implement policy and procedures to ensure claims for emergency services, including those with mental health diagnosis codes or billed by mental health providers, are properly adjudicated.

COMPLIANCE AUDIT FINDINGS

Category 4 – Grievances, Appeals, and Member Rights

4.1 GRIEVANCE SYSTEM

4.1.1 Clear and Concise Resolution Letters for Quality of Care Grievances

The Plan must have in place a member grievance and appeal system that complies with federal and state regulations for covered services. The Plan must follow grievance and appeal requirements set forth in, and use all notice templates included in, APL 21-011, *Grievance and Appeal Requirements, Notice and "Your Rights" Templates,* dated August 31, 2022. *(Contract 23-30221, Exhibit A, Attachment III, 4.6.1)*

The Plan's grievance resolution and written response is required to contain a clear and concise explanation of the Plan's decision. The regulation does not require the Plan to disclose information to the member that is otherwise confidential or privileged by law. *(CCR, Title 28, section 1300.68(d)(3))*

The Plan's written resolution must contain a clear and concise explanation of the Plan's decision. "Resolved" means that the grievance has reached a final conclusion with respect to the member's submitted grievance as delineated in state regulations. *(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates,* dated August 31, 2022*)*

Plan policy, *CA.AG.35 Medi-Cal Member Grievance Process* (revised 02/26/2025), stated a final resolution letter is sent to the member that clearly and concisely describes any administrative or service outcome information. Additionally, the resolution letter describes the member's options if the member is not satisfied with the grievance outcome. The final letter advises the member of the Plan's determination without releasing peer-protected information.

Finding: The Plan's resolution letters did not contain clear and concise explanation of the decisions for QOC grievances.

A verification study of 20 QOC grievance files revealed that 19 files did not have a clear and concise explanation in the resolution letter. The 19 files contained similar templated responses that did not address each member's specific concerns and no explanation of the decision was provided.

- The template responses included the following language:

  "We received your medical records, and provider's response, related to your case. Health Net's Clinical Appeals and Grievances Department has completed a clinical review of your medical information and concerns. Your complaint has been investigated and resolved... Thank you for sharing your experiences with us, as it helps us meet our members' needs. Health Net is not allowed to disclose the specific results of our clinical review as it is considered confidential and protected by law."

- One case involved a complaint about a delay in receiving an authorization to the cardiologist following a diagnosis of a heart condition from an ER visit. Documentation from the ER clearly documented the radiologic findings and the urgency for a cardiology referral. Despite the documentation being brought to the PCP's office, the referral was delayed for two weeks until medical records were obtained from the hospital. The investigation concluded that there was a delay in care due to the PCP not submitting the referral timely. The resolution letter did not include a clear and concise explanation of the Plan's decision to monitor the PCP because the investigation determined that the PCP's action led to the delay in care. The resolution letter stated:

  "We received your medical records, and provider's response related to your case. Health Net's Clinical Appeals and Grievances Department has completed a clinical review of your medical information and concerns. Your complaint has been investigated and resolved. Our Medical Director has requested that the primary care physician (PCP) be monitored for future complaints. "

- Another case involved a complaint about delays in obtaining radiological scans for pain in the shoulder, knees, back, head, and chest from their PCP's office. The member also complained about delays in receiving the results. The investigation found that the member also contributed to the delay by waiting a month to have X-rays taken. The Plan concluded that there were deficits in communication by the member. The resolution letter did not include a clear and concise explanation of the Plan's decision to monitor the provider despite the investigation concluding the member's deficits in communication contributed to the delay. The resolution letter stated:

  "We received your medical records, and the provider's response, related to your case. Health Net's Clinical Appeals and Grievances Department has completed a clinical review of your medical information and concerns. Your complaint has

been investigated and resolved. Our Medical Director has requested that the provider be monitored for future complaints."

The Plan's policy CA.AG.35 stated that the Medical Director conducts a peer review assessment of the care provided for clinical QOC grievances. However, this is done only by one Medical Director and not in the peer review committee setting. The Plan incorrectly deemed the review by the Medical Director to be confidential after categorizing it as a QOC case. During an interview, the Plan acknowledged that they did not provide a clear and concise explanation for actions taken in addressing QOC complaints.

The resolution letter sent to the member highlights that an investigation was performed, but no explanation was ever given to the member to describe the final conclusion of the investigation. The Plan currently uses standardized templates for Grievance Resolution letters without sufficient customization to reflect the unique circumstances of each case. There is no formal policy or quality control process in place to ensure individualized and complete responses.

If the Plan does not provide Grievance Resolution letters with a clear and concise explanation, members may not receive all the information necessary to make decisions about their health care and provider relationship.

Recommendation: Revise and implement policies and procedures to ensure that QOC Grievance Resolution letters contain clear and concise explanations of the Plan's decisions.

4.1.2 Exempt Grievance Reporting and Review

The Plan must have in place a member grievance and appeal system that complies with federal and state regulations for covered services. The Plan must follow grievance and appeal requirements set forth in, *APL 21-011, Grievance and Appeals Requirements, Notice and "Your Rights" Templates*, dated August 31, 2022. *(Contract 23-30221, Exhibit A, Attachment III, 4.6.1)*

The Plan is required to maintain a written record made for each grievance received by the Plan including the date received, the Plan representative recording the grievance, a summary or other document describing the grievance, and its disposition. The written record of grievances shall be reviewed periodically by the governing body of the Plan, the public policy body created pursuant to section 1300.69, and by an officer or designee of the Plan. The review shall be thoroughly documented. *(CCR, Title 28, section 1300.68(b)(5))*

Grievances received over the telephone that are not coverage disputes or disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are classified as exempt grievances. The Plan is required to maintain a log of all exempt grievances and review the information contained in the log. The Plan must ensure exempt grievances are incorporated into the quarterly grievance and appeal report that is submitted to DHCS. *(APL 21-011, Grievance and Appeals Requirements, Notice and "Your Rights" Templates,* dated August 31, 2022*)*

Plan policy, *CA.AG.35 Medi-Cal Grievance Process* (revised 02/26/2025), stated that the Plan's governing body reviews a written record of grievances and appeals to assess emerging patterns of improper appeals (service denials) and grievance trends impacting health care access and delivery to members. The Plan also reviews the record to formulate potential Plan policy/process changes or procedure improvements in the Plan's administration.

Finding: The Plan did not ensure that transportation related exempt grievances are reviewed by its governing body, public policy body, and the Plan's officer or designee.

Exempt grievances are processed by the Plan or by its transportation broker, Modivcare. The Plan delegated processing of transportation related exempt grievances to Modivcare.

As part of its delegated responsibilities, Modivcare is required to maintain a log of all exempt grievances. The Modivcare Exempt Grievance Log had 157 exempt grievances for the audit period. The Plan did not include exempt grievances processed by Modivcare in its reporting and review of grievances. The Plan's Quality Improvement and Health Equity Committee (QIHEC) meeting minutes and materials did not include exempt grievance data for Modivcare to be presented to governing body, public policy body, and the Plan's officer or designee. In a written statement, the Plan acknowledged that it does not include exempt grievances resolved by Modivcare in the QIHEC reporting.

The Plan's Vendor Oversight Committee and Joint Operation Committee meetings with Modivcare also included grievance as an agenda item. However, the documentation was limited to a summary of grievance data and the vendor's audit status; it did not include a log of all exempt grievances, nor did it reflect a review of the information contained within such a log.

Plan policy CA.AG.35 revealed that the Plan's QIHEC reviews the quarterly Member Appeals and Grievance Report. The Member Appeals and Grievance Report and Modivcare's Appeals and Grievance Vendor Reports included overall information on grievances; however, the report did not include exempt grievance data. In an interview, the Plan acknowledged that exempt grievances are not included in the Member Appeals and Grievance Report. The Plan did not provide an explanation as to why they are not included.

If the Plan does not periodically review all types of grievance data, trends may not be identified, exempt grievances may not be completely resolved, and systemic issues may not be resolved, which may adversely affect members' QOC.

Recommendation: Revise and implement policies and procedures to ensure that exempt grievances are included in the written record of grievances that is reviewed by the Plan's governing body, public policy body, and the Plan's officer or designee.

COMPLIANCE AUDIT FINDINGS

Category 5 – Quality Improvement and Health Equity Transformation Program

5.3 PROVIDER TRAINING

5.3.1 Monitoring of Provider Training

The Plan is required to maintain an adequate oversight procedure to ensure subcontractors and downstream subcontractors compliance with all quality improvement or heath equity delegated, including but not limited to, the Plan's continuous monitoring, evaluation, and approval of its delegated functions to subcontractors and downstream subcontractors. *(Contract 23-30221, Exhibit A, Attachment III, 2.2.5)*

The Plan is required to ensure that all network providers receive provider training regarding the Medi-Cal Managed Care program to ensure they operate in full compliance with the Contracts and all applicable federal and state statutes, regulations, and APLs. The Plan is required to conduct training for all network providers. The Plan is required to start training within ten working days and complete training within 30 working days after the Plan places a newly contracted network provider on active status. *(Contract 23-30221, Exhibit A, Attachment III, 3.2.5)*

Plan policy, *Network Provider Training* (revised 06/08/2023), stated that for new network providers, the new provider training needs to start within ten working days and be completed within 30 days of becoming an active Medi-Cal provider within the Plan. Providers interested in contracting with the Plan's delegated PPGs will engage directly with the PPGs to start the contracting process. The interested providers will submit the completed documentation along with the signed training confirmation form to the PPG. The PPG will then submit the required documentation to the Plan's Contracting and Credentialing Department. The Plan's Contracting and Credentialing Department will confirm receipt of the signed Certificate of New Provider Training form within 30 days of the provider becoming active with the Plan's Medi-Cal network.

Finding: The Plan did not ensure that all individual providers joining contracted medical groups received new provider training.

In a verification study, 6 of the 12 samples were new individual providers joining a contracted provider group. The Plan did not provide training directly to new individual providers joining the contracted provider group. Instead, it relied on group-level attestations from provider organizations to confirm completion of required training. These attestations did not include the names of individual providers who had completed the training. In a sample of six providers, the group attestations were signed between 25 and 912 days prior to the individual provider's effective date with the Plan. Each provider group submitted a single attestation applicable to all providers, regardless of when each individual joined the Plan's network.

The Plan's policy stated the providers will submit the completed documentation along with the signed training confirmation form to the PPG. The PPG will then submit the required documentation to the Plan's Contracting and Credentialing Department. However, the Plan did not provide a copy of the signed training confirmation forms for DHCS' review.

In an interview, the Plan stated that delegated entities can use a group attestation to attest on behalf of their providers that provider training is conducted. The Plan stated it does not request or review training documentation from the contracted groups to verify that individual providers receive and complete training within the required timeframes. The Plan stated that it collects group attestations when there are major revisions to provider training. However, this process cannot determine whether provider training is completed within the required timeframes or at all by the individual providers.

Subsequent to the Exit Conference, the Plan submitted a written statement that the Plan has had an established process to ensure all providers entering the Plan's Medi-Cal network have completed the appropriate training before becoming active with the health plan. However, the group-level provider training attestations submitted do not provide information for the completion of provider training by individual providers that are joining a provider group.

Without individualized and timely documentation, the Plan cannot demonstrate compliance with provider training requirements. This creates a risk that providers may deliver services without having completed essential training, potentially impacting QOC and regulatory compliance.

Recommendation: Develop and implement procedures to ensure provider training is received and completed within the required timeframes for all network providers.

DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SAN FRANCISCO SECTION

REPORT ON THE MEDICAL AUDIT OF HEALTH NET COMMUNITY SOLUTIONS, INC. FISCAL YEAR 2024-25

Contract Numbers: 23-30253, 23-30254, and 23-30255

Contract Type: State Supported Services

Audit Period: June 1, 2024 — April 30, 2025

Dates of Audit: May 12, 2025 — May 23, 2025

Report Issued: November 21, 2025

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I. INTRODUCTION

This report presents the results of the audit of Health Net Community Solutions, Inc. (Plan) compliance and implementation of the State Supported Services contract numbers 23-30253, 23-30254, and 23-30255 with the State of California. The State Supported Services Contracts cover abortion services with the Plan.

The audit covered the period of June 1, 2024, through April 30, 2025. The audit was conducted from May 12, 2025, through May 23, 2025, which consisted of a document review, verification study, and interviews with the Plan's administration and staff.

An Exit Conference with the Plan was held on October 24, 2025. 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' (DHCS) evaluation of the Plan's response are reflected in this report.

Twenty claims were reviewed for appropriate and timely adjudication.

COMPLIANCE AUDIT FINDINGS

State Supported Services

The Plan must provide members with State Supported Services, including services defined by procedure codes 59840 through 59857. *(Contract 23-30253, Exhibit A, (1.2.1))*

The Plan is required to maintain sufficient claims processing, tracking, and payment systems capability to comply with applicable state and federal law, regulations, and contract requirements. *(Contract 23-30221, Exhibit A, Attachment III, (3.3.5)(F))*

The Plan must cost avoid for the reasonable value of services paid by the Plan and rendered to a member whenever a member's other health coverage (health insurance other than Medi-Cal) covers the same services, fully or partially. *(Contract 23-30221, Exhibit E, 1.1.25(A))*

Cost avoidance means the practice of requiring providers to bill liable third parties prior to seeking payment from the Medi-Cal program. *(Contract 23-30221, Exhibit A, Attachment I (1.0))*

The Plan must comply with all DHCS guidance, including All Plan Letters (APL). APLs existing on the effective date of this Contract will be considered part of the Contracts. *(Contract 23-30221, Exhibit E, 1.1.2(A)(1))*

The Plan must pay providers at least a minimum of $400 for Current Procedural Terminology code 59840, a surgical abortion procedure. This payment obligation applies to contracted and non-contracted providers. In instances where a member is found to have other health insurance, the Plan must cost avoid. *(APL 23-015, Proposition 56 Directed Payments for Private Services)*

Plan policy, *CA.LTSS.18 Pregnancy Termination* (revised 04/24/2024), stated the Plan complies with all applicable state and federal laws and regulations, contractual requirements, and DHCS' APLs.

Finding: The Plan did not make the minimum payments for State Supported Services claims as required by APL 23-015 when members had other health insurance.

A verification study found two of two State Supported Services claims, eligible for APL 23-015 minimum payments, included members with other health insurance. The members' other health insurance payments were less than the required payment of $400 for code 59840. For these two claims, the Plan did not make additional payments to reach the minimum payment of $400.

In a written response, the Plan stated it implements cost avoidance in accordance with APL 23-015, by not issuing additional payments when members have other health insurance. However, the Plan cannot use cost avoidance as a justification to avoid making the minimum payments required under APL 23-015. Cost avoidance means the provider must bill the member's other health insurance first and then the Plan must determine if additional payment is necessary to meet the minimum required payment.

When the Plan does not make required minimum payments, it may discourage providers from offering services to Medi-Cal members and limit members' access to care.

Recommendation: Develop and implement procedures to make minimum payments for State Supported Services claims where members have other health insurance, in accordance with APL 23-015.