DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

LOS ANGELES SECTION

REPORT ON THE MEDICAL AUDIT OF IMPERIAL COUNTY LOCAL HEALTH AUTHORITY DBA COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY FISCAL YEAR 2024-25

Contract Number: 23-30218

Audit Period: January 1, 2024 — December 31, 2024

Dates of Audit: April 29, 2025 — May 13, 2025

Report Issued: February 9, 2026

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I. INTRODUCTION

Imperial County Local Health Authority dba Community Health Plan of Imperial Valley (Plan) was incorporated in 2024 and contracted with the Department of Health Care Services (DHCS) to provide services to Medi-Cal members. The Plan is the local Medi-Cal managed care plan serving Imperial County. The Plan is the local Initiative organized by the Imperial County Local Health Authority. On December 15, 2023, the Plan obtained a Knox Keene license from the California Department of Managed Health Care to serve its Medi-Cal members.

The Plan currently contracts with DHCS to provide services to Medi-Cal members under the Single Plan Model program in Imperial County. The Plan serves the Imperial Valley County population in the following cities: Brawley, Calexico, Calipatria, El Centro, Holtville, Imperial, Westmorland, and eight unincorporated communities (Bombay Beach, Heber, Niland, Ocotillo, Palo Verde, Salton City, Seeley, and Winterhaven).

The Plan is responsible for ensuring that residents receive quality healthcare services through a network of providers. The Plan works closely with the fully delegated subcontractor (Health Net Community Solutions, Inc.) to offer a wide range of medical services and support to the community. The fully delegated subcontractor is responsible for performing all the functions for the Plan, apart from compliance oversight, on behalf of the Plan.

The Plan is not accredited by the National Committee for Quality Assurance.

As of December 2024, the Plan had a total of 97,100 members, which included 80,542 Medi-Cal members and 16,558 members with Dual Benefits.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of January 1, 2024, through December 31, 2024. The audit was conducted from April 29, 2025, through May 13, 2025. It consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on November 20, 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 December 8, 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 Program, and Plan Administration and Organization.

This is the Plan's first year of operation; consequently, no prior DHCS medical audits have been conducted.

Systemic findings in the audit revealed issues with the monitoring and oversight of the Plan's fully delegated subcontractor. While the subcontractor directly carries out operational duties on behalf of the Plan, it must adhere to the Plan's policies and regulatory requirements and ensure compliance with the State Contract requirements. The Plan maintains ultimate responsibility for fulfilling DHCS contractual obligations.

The summary of the findings by category is as follows:

Category 1 – Utilization Management Program

The Plan must maintain a full-time Chief Health Equity Officer with the necessary qualifications or training. Finding 1.1.1: The Plan did not designate a full-time Chief Health Equity Officer who could collaborate with the Plan's Medical Director in directing the Plan's Quality Improvement Health Equity Committee (QIHEC) activities.

The Plan must have and maintain a management and information system that supports, at a minimum, referrals including tracking of referred services, to follow up with members to ensure that services were rendered. Finding 1.5.1: The Plan did not ensure that its fully delegated subcontractor had a mechanism to track and monitor referrals.

The Plan must monitor and oversee all delegated functions, including those that may flow down to downstream subcontractors. Finding 1.5.2: The Plan's monitoring and oversight of its fully delegated subcontractor and downstream subcontractor's functions were deficient.

Category 2 – Population Health Management and Coordination of Care

The requirement is that once eligibility for the California Children Services (CCS) program is established for a member, the Plan must ensure the coordination of services and joint case management between the member's Primary Care Provider (PCP), CCS providers, and the local CCS program. Finding 2.1.1: The Plan did not ensure that its fully delegated subcontractor consistently conducted care coordination and joint case management between the member's PCP, CCS providers, and the local CCS program once CCS eligibility is established as required.

The Plan must cover and ensure that Initial Health Appointments (IHAs) are performed within 120 calendar days of enrollment with the Plan. Additionally, the Plan must make reasonable attempts to contact a member to schedule an IHA and document all attempts to contact a member. Finding 2.1.2: The Plan did not ensure that its fully delegated subcontractor consistently performed an IHA within 120 calendar days of enrollment, made reasonable attempts to contact members to schedule, or document all outreach attempts.

The Plan must ensure that its network providers order or perform blood lead screening tests on all children in accordance with the All-Plan Letter (APL) 20-016 requirements, *APL 20-016, Blood Lead Screening of Young Children*. Finding 2.1.3: The Plan did not ensure that its fully delegated subcontractor consistently conducted blood lead screening tests on members at one and two years of age, including up to six years of age as specified in APL 20-016.

The Plan is required to provide oral or written anticipatory guidance to the parent(s) or guardian(s) of a child that, at a minimum, includes information that children can be harmed by exposure to lead in accordance with the APL 20-016 requirements, *APL-20-016, Blood Lead Screening of Young Children*. Finding 2.1.4: The Plan did not ensure that its fully delegated subcontractor consistently provided oral or written blood lead anticipatory guidance to the parent or guardian of members as specified in APL 20-016.

A Behavioral Health Treatment (BHT) service provider must review, revise, and/or modify the member's treatment plan at least every six months. Finding 2.3.1: The Plan did not

ensure that its fully delegated subcontractor consistently fulfilled the requirement that a BHT service provider reviewed, revised, and/or modified the member's treatment plan at least every six months.

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 send a notice by mail. Finding 2.4.1: The Plan did not monitor its fully delegated subcontractor to ensure compliance with COC requirements by consistently mailing a written notice of the denial to the member.

The Plan must ensure members have access to needed services, including care coordination, navigation, and referrals to services that address members' developmental, physical, mental health, and substance use disorder. Finding 2.5.1: The Plan did not verify that its fully delegated subcontractor had oversight mechanisms, policies, and procedures to ensure the subcontractor consistently provided members with access to needed services, including care coordination, navigation, and referrals for Mental Health and Substance Use Disorder (MHSUD) needs.

The Plan is required to provide the seven Enhanced Care Management (ECM) core service components in accordance with *APL 23-032, Enhanced Care Management Requirements* (12/22/2023). Finding 2.6.1: The Plan did not ensure that the fully delegated subcontractor provided ECM core service components to members, including the Comprehensive Assessment and Care Management Plan (CMP), and Member and Family Supports.

Category 3 – Network and Access to Care

The Plan must have processes in place to ensure door-to-door assistance is provided for all members receiving Non-Emergency Medical Transportation (NEMT) services. Finding 3.8.1: The Plan did not provide sufficient documentation to demonstrate that its delegate and downstream subcontractor had a process in place to ensure NEMT door-to-door assistance for all members receiving medically necessary NEMT services.

Category 4 – Grievances, Appeals, and Member Rights

The Plan must submit information regarding discrimination grievances to the DHCS Office of Civil Rights (OCR) within ten calendar days of mailing a Discrimination Grievance Resolution letter as specified in *APL 21-004*, *Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services* (05/24/2023). Finding 4.1.1: The Plan did not ensure that its fully delegated

subcontractor reported discrimination grievances to the DHCS OCR within ten calendar days of mailing a Discrimination Grievance Resolution letter to a member.

The Plan shall resolve each grievance and provide notice to the member as quickly as the member's health condition requires, within 30 calendar days from the date the Plan receives the grievance. Finding 4.1.2: The Plan did not ensure that its fully delegated subcontractor consistently sent Transportation Grievance letters and notify members of their rights.

Category 5 – Quality Improvement and Health Equity Transformation Program

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

Category 6 – Plan Administration and Organization

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 Contract.

PROCEDURE

DHCS conducted an audit of the Plan from April 29, 2025, through May 13, 2025, for the audit period of January 1, 2024, through December 31, 2024. The audit included a review of the Plan's Contract with DHCS, policies and procedures for providing services, procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with the Plan and delegates' administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management Program

Prior Authorization Requests: A total of 46 delegated medical authorizations, including 14 retrospective, 5 concurrent, 20 routine, and 7 expedited prior authorization requests, were reviewed for timeliness, consistent application of criteria, appropriate review, and communication of results to providers and members.

Appeal Procedures: Eighteen medical appeals (11 routine, 4 expedited, and 3 downgraded from expedited to routine) were reviewed for appropriateness and timeliness of decision-making.

Category 2 – Population Health Management and Coordination of Care

IHA: Twenty files were reviewed for completion and care coordination of services.

CCS: Fifteen files were reviewed for care coordination and compliance.

Complex Case Management: Twenty-nine files were reviewed for care coordination and completeness to evaluate service performance.

BHT: Fifteen files were reviewed for care coordination and completeness to evaluate the performance of services.

COC: Eleven files were reviewed to evaluate timeliness and appropriateness of COC request determination.

MHSUD: Nine files, including three for Non-Specialty Mental Health Services (NSMHS), three for Specialty Mental Health Services (SMHS), and three for both NSMHS and SMHS, were reviewed for care coordination and completeness to evaluate service performance.

ECM: Eight files were reviewed for care coordination and completeness to evaluate service performance.

Category 3 – Network and Access to Care

Family Planning and Emergency Services Claims: Twenty family planning and 20 emergency service claims were reviewed for appropriateness and timeliness.

NEMT: Twenty-three records were reviewed to confirm compliance with transportation requirements and timeliness.

Non-Medical Transportation (NMT): Nineteen records were reviewed to confirm compliance with transportation requirements and timeliness.

NEMT and NMT Grievances: Twenty-three records were reviewed for response to the complainant and submission to the appropriate level of review.

Category 4 – Grievances, Appeals, and Member Rights

Grievance Procedures: Eighteen standard grievances, 12 expedited and 6 exempt grievances were reviewed for timely resolutions, response to complainant, and submission to the appropriate level for review. The 36 grievance cases included 26 quality of care and 10 quality of service.

Category 5 – Quality Improvement and Health Equity Transformation Program

Potential Quality of Care Issues: Fifteen files were reviewed for reporting, investigation, and remediation.

Credentialing and Re-credentialing: A total of 20 files were reviewed for licensing and certification.

New Provider Training: No verification log was provided for this section. The Plan's fully delegated subcontractor stated that no new providers were enrolled during the review period.

Category 6 – Plan Administration and Organization

Fraud, Waste, and Abuse Reporting: There were no fraud, waste, and abuse cases reported by the Plan to DHCS.

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management Program

1.1 – Utilization Management Program

1.1.1 Chief Health Equity Officer

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

The Plan must appoint a physician as Medical Director pursuant to the California Code of Regulations (CCR), Title 22, section 53857, whose responsibilities must include, but should not be limited to, ensuring that medical decisions are rendered by qualified medical personnel. *(Contract, Exhibit A, Attachment III, section 1.1.6)*

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

QIHEC means a committee facilitated by contractor's Medical Director, or the Medical Director's designee, in collaboration with the Chief Health Equity Officer that meets at least quarterly to direct all Quality Improvement and Health Equity Transformation Program (QIHETP) findings and required actions. *(Contract, Exhibit A, Attachment I, Section 1.0)*

The Plan must maintain a QIHETP which includes the following, at a minimum:

A. Oversight and participation of the Plan's Governing Board.
B. Creation and designation of a QIHEC whose activities are supervised by the Plan's Medical Director or the Medical Director's designee, in collaboration with Plan's Chief Health Equity Officer.
C. Supervision of QIHETP activities by the Plan's Medical Director and the Chief Health Equity Officer.

(Contract, Exhibit A, Attachment III, section 2.2.1)

The Plan must implement and maintain a QIHEC designated and overseen by its Governing Board. The Plan's Medical Director or the Medical Director's designee must

head the QIHEC in collaboration with the contractor's Chief Health Equity Officer. *(Contract, Exhibit A, Attachment III, section 2.2.3)*

Finding: The Plan did not designate a full-time Chief Health Equity Officer who could collaborate with the Plan's Medical Director to direct the Plan's QIHEC activities.

The Plan lacked policies and procedures designating a full-time Chief Health Equity Officer separate from the Chief Medical Officer (CMO)/Medical Director role.

Review of the Plan's organizational chart and job duty statements revealed that the Plan established a hybrid role that assigned the titles of CMO and Chief Health Equity Officer to one person. This role is held by the Plan's CMO, and the job duty for this hybrid role includes the CMO's duties but does not specify the required responsibilities of the Chief Health Equity Officer. Since this hybrid role is filled by one person, the Plan cannot meet the following requirements:

- The Plan must appoint a physician as the Medical Director and appoint a full-time Chief Health Equity Officer.
- Additionally, QIHEC activities must be supervised by the CMO in collaboration with the Chief Health Equity Officer.

During the review, it was noted that the Contract requires the Plan to maintain a full-time Chief Health Equity Officer who has the necessary qualifications or training at the time of hire or within one year of hire to meet the requirements of the position. It is important to note that the audit team is not disputing the individual's qualifications but is specifically citing the Contract's requirement for a separate and distinct individual from the Plan's current structure.

After the exit conference, the Plan stated that they submitted organizational charts to DHCS-Program during the Operation readiness review period that specifically identified a sole resource who acted in a hybrid role as both the Plan's CMO and Chief Health Equity Officer. While the Department acknowledges it did not provide comments or requested modifications to the structure, the responsibility is on the Plan to adhere to the Contract requirements, where it clearly delineates that the Chief Health Equity Officer is a "full-time" position that works in collaboration with the CMO.

When the Plan does not have both a full-time Chief Health Equity Officer and a CMO, it may impact the oversight functions and delivery of services to members.

Recommendation: Develop policies and procedures to ensure that the Plan has a designated full-time Chief Health Equity Officer who can collaborate with the Plan's Chief Medical Director to direct the QIHEC activities.

1.5 Delegation of Utilization Management Activities

1.5.1 Referrals

The Plan must have and maintain a management and information system that supports, at a minimum: A(9) referrals including tracking of referred services to follow up with members to ensure that services were rendered; and A(11) prior authorization requests and specialty referral system as specified in *Exhibit A, Attachment III, Section 2.3. (Utilization Management Program)*. (*Contract, Exhibit A, Attachment III, section 2.1.1, A(9) and (11))*

The Plan must ensure that its UM program has a specialty referral system to track and monitor referrals requiring prior authorization by the Plan. When prior authorization is delegated to delegates and downstream subdelegates, the Plan must ensure that delegates and downstream subdelegates have systems in place to track and monitor referrals requiring prior authorization. The Plan must ensure that all network providers are aware of the specialty referral processes and tracking procedures. *(Contract Exhibit A, Attachment III, section 2.3, H)*

Plans shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the member's condition, consistent with good professional practice. Plans shall establish and maintain provider networks, policies, procedures, quality assurance monitoring systems, and processes sufficient to ensure compliance with this clinical appropriateness standard. Plans shall ensure that all plan and provider processes necessary to obtain covered health care services, including but not limited to prior authorization processes, are completed in a manner that assures the provision of covered health care services to members in a timely manner appropriate for the members condition and in compliance with the requirements of this section. *(CCR, Title 28, section 1300.67.2.2)*

The Plan has the following policies and procedures:

- *CA.UM.40 V Specialty Referral System* (revised 04/02/2024), states the following:
  - The Plan does not require prior authorization for most in-network specialist visits and in-network diagnostic services.

    - For standing referrals issued by the Plan directly, the Plan tracks the standing referral to the specialist in the medical management electronic medical record.
    - The Plan monitors and tracks internal authorizations via the electronic medical management system.
- *CA.UM.HN.27* V8 *Standing Referral to Specialty Care* (revised 02/21/2024), states that the Plan or delegated provider preferred group tracks and monitors referrals requiring prior authorization, including documentation of authorized, denied, deferred, or modified referrals, and the timeliness of the referrals.

Finding: The Plan did not ensure that its fully delegated subcontractor had a mechanism to track and monitor referrals.

During the audit, the Plan was unable to provide the requested prior authorization referral tracking reports as well as reports for open and unused referrals to demonstrate its oversight process.

In the interview, the Plan and its fully delegated subcontractor acknowledged that during the audit period neither entity had a referral tracking system and monitoring process. Additionally, in a written statement, the Plan stated that its fully delegated subcontractor did not track expired or unused prior authorizations.

The Plan has policies and procedures related to tracking and monitoring referrals. However, its fully delegated subcontractor did not follow these procedures to ensure that it had a mechanism to track referrals during the audit period.

When the Plan does not maintain oversight of its fully delegated subcontractor's compliance with the contractual requirements of a referral tracking system, the Plan may not be able to monitor the quality of care provided and its referral system procedures.

Recommendation: Implement oversight mechanisms, policies, and procedures to ensure the fully delegated subcontractor maintains a system to track and monitor referrals in accordance with the contractual requirements.

1.5.2 Oversight of Delegation Functions

The Plan remains fully responsible for the performance of all duties and obligations it delegates to subcontractors and downstream subcontractors. *(Contract, Exhibit A, Attachment III, Section 3.1.1(B)/Delegation Oversight)*

The Plan must monitor and oversee all delegated functions, including those that may flow down to downstream subcontractors. (*Contract, Exhibit A, Attachment III, section 3.1.1(B)(3)/Delegation Oversight)*

The Plan's Delegation Oversight Monitoring program states that the program is an integral component of the Plan's comprehensive risk management and compliance strategy. The program is specifically tailored to oversee the Plan's delegates through focused and ongoing monitoring activities. The following areas were identified as critical and high risk based on the Plan's Audit and Monitoring program: UM, appeals, COC, claims, provider dispute resolution, member services, and grievance. *(Delegation Oversight Monitoring Protocol)*

The Plan's policy and procedure, *CMP-002 Delegation Oversight* (revised 10/01/2024), states that the Plan shall provide oversight of all delegated entities, including proposed delegated entities. Such oversight shall be conducted using, without limitation, the following actions: periodic reviews and audits, and ongoing monitoring.

Finding: The Plan's monitoring and oversight of its fully delegated subcontractor and downstream subcontractor's functions were deficient.

The Plan demonstrated some elements of delegation monitoring, and oversight of contractual requirements. However, the Plan did not fully oversee its delegated subcontractor's performance of delegated functions, resulting in multiple areas of noncompliance with contractual and regulatory requirements. Specifically in the following areas:

- Written translations of NOAs
- Clear and concise communications
- Clinical criteria for utilization/care management decisions

The Plan did not fully monitor its delegated subcontractor's compliance with delegated responsibilities. Oversight activities such as annual delegation audits, corrective action follow-up, and performance monitoring were either not conducted or inadequately documented. Additionally, it was noted that the Plan made the decision to delay its annual delegate audit to support the Department's audit. However, the Department's expectation is that once approved for operations, the Plan should be compliant with the Contract requirements from the beginning.

The Plan did not ensure that its fully delegated subcontractor consistently translated NOA letters in the member's threshold language. In some instances, a member did not receive a letter, or the letter was not translated, or it was delayed. During the interview,

the Plan stated that it did not review the translation of letters into the required threshold language in its oversight review.

The Plan did not ensure that its fully delegated subcontractor consistently used clear and concise language in member letters and communicated the decision on prior authorizations, quality-of-care grievances, and potential quality issues. During the interview, the Plan stated that its oversight focus was on quantitative data review, and it did not include review of the member letters.

The Plan had a systemic issue related to the use of inconsistent application of criteria and determination of medical necessity for prior authorizations and appeals. The Plan has policies and procedures, *GA-002 Appeal Process*, *CA.UM.03 V5 Clinical Criteria for Utilization/Care Management Decisions*, and *CMP-002 Delegation Oversight*. However, the Plan did not provide oversight to ensure consistent application of criteria and determination of medical necessity in UM decisions. During the interview, the Plan stated that it did not review medical necessity criteria for appeals and prior authorizations in its oversight review.

When the Plan does not fully monitor and oversee its delegated functions, it may result in delayed or inappropriate care for members, potentially leading to adverse health outcomes, including member harm.

Recommendation: Ensure the Plan monitors and oversees its fully delegated subcontractor and downstream subcontractors' functions, including implementing policies and procedures.

COMPLIANCE AUDIT FINDINGS

Category 2 – Population Health Management and Coordination of Care

2.1 California Children Services

2.1.1 California Children's Services Care Coordination

The requirement is that once eligibility for the CCS program is established for a member, the Plan must ensure the coordination of services and joint case management between the member's PCP, CCS providers, and the local CCS program. The Plan must continue to provide case management services to ensure all covered services authorized through the CCS program are provided timely. (*Contract Exhibit A, Attachment III, section 4.3.14 (A)(6))*

For additional Contract criteria, reference Section 1.5.2 on Delegation Oversight *(Contract, Exhibit A, Attachment III, Section 3.1.1(B) Delegation Oversight; Delegation Oversight Monitoring Protocol/Delegation Oversight;* and Plan policy and procedure, *CMP-002 Delegation Oversight).*

The following policies and procedures were submitted as evidence of internal guidance related to CCS care coordination. These documents outline referral protocols, coordination expectations, tracking mechanisms, and requirements specific to CCS-eligible members:

- *CA.CM.02.13 California Children Services (CCS)* (revised 01/26/2024) describes CCS referral and coordination process, including eligibility, provider coordination, and avoidance of service duplication.
- CC.CM.02 *Care Coordination/Care Management* Services (revised 01/15/2025), defines care coordination approach, including risk stratification, ICT involvement, and service tracking.
- Addendum to *CC.CM.02 Care Coordination/Care Management Services* (date of creation or last revision not specified in the document), addresses California-specific CCS requirements using Population Health Management tools to identify and track CCS-eligible members.
- *CA.LTSS.06 V11 California Children's Services* (revised 01/13/2025), details expectations for seamless transitions and coordination across CCS and Medi-Cal providers, including outreach and service tracking.

Finding: The Plan did not ensure that its fully delegated subcontractor consistently conducted care coordination and joint case management between the member's PCP, CCS providers, and the local CCS program once CCS eligibility is established as required.

The Plan has several policies and procedures for CCS care coordination; however, the fully delegated subcontractor staff did not follow these procedures when providing services to CCS members. In the verification study, 4 out of 15 samples revealed that the fully delegated subcontractor exhibited repeated deficiencies in CCS coordination and documentation. The following issues were identified:

- Late service authorization request submissions led to CCS denials for services that had already been rendered.
- Missing baseline diagnostic documentation, essential for determining CCS eligibility.
- Lack of case management involvement or follow-up after CCS denials.
- No internal case notes, tracking logs, or documentation indicating COC or timely access to services.

These findings point to systemic breakdowns in the fully delegated subcontractors' referral workflows, documentation practices, and internal oversight processes related to CCS cases. The absence of documented coordination may have contributed to delays in service delivery and fragmented care for affected members.

During the interview, the Plan stated that during the audit period, it did not monitor or provide oversight of CCS-related delegated functions and file reviews.

The *Delegation Oversight Monitoring Protocol* did not include a review of CCS monitoring activities, and qualitative reviews like file-level validation.

When the Plan and its fully delegated subcontractor do not ensure coordination of services and joint case management between the member's PCP, CCS providers, and the local CCS program, it may lead to delays in access to CCS-authorized services and the provision of other covered services, potentially impacting the timely delivery of care for CCS members.

Recommendation: Implement policies and procedures to ensure care coordination and case management between the member's PCP, CCS providers, and the local CCS program.

2.1 Initial Health Appointment

2.1.2 Initial Health Appointment Timeliness and Outreach

The Plan must cover and ensure that IHAs are performed within 120 calendar days of enrollment with the Plan. (*Contract, Exhibit A, Attachment III, 5.3.4 (A)(1)(2) and 5.3.5 (A)(1))*

The Plan must make reasonable attempts to contact a member to schedule an IHA. The Plan must document all attempts to contact a member. Documented attempts that demonstrate the Plan's efforts to unsuccessfully contact a member and schedule an IHA will be considered evidence in meeting this requirement. *(Contract, Exhibit A, Attachment III, 5.3.3 (C))*

For additional Contract criteria, reference Section 1.5.2 on Delegation Oversight *(Contract, Exhibit A, Attachment III, Section 3.1.1(B) Delegation Oversight; Delegation Oversight Monitoring Protocol/Delegation Oversight;* and Plan policy and procedure, *CMP-002 Delegation Oversight).*

The following documents were submitted by the Plan to outline the Plan's requirements, expectations, provider-facing guidance related to the timely completion of IHAs, member outreach for scheduling IHAs, required outreach activities, documentation standards, and use of support tools:

- *Initial Health Appointment and Dental Assessment* (no policy number (revised 01/2024)*):*
  - Requires completion of the IHA within 120 days of member enrollment.
  - Describes provider expectations, outreach timelines (e.g., follow-up call by day 75), and corrective actions for noncompliance.
  - Requires member outreach to include a welcome packet, automated/live calls, and a follow-up call by day 75 if the IHA has not been completed.
  - Missed IHA cases (beyond 120 days) are identified through provider portal reports and addressed via outreach and health education follow-up.
  - The policy explicitly states that three outreach attempts must be tracked monthly and analyzed annually to demonstrate compliance, confirming that outreach efforts are not only required but must be documented and monitored.
- *CA.CM.01.08 New Member Welcome Call* (revised 04/02/2024), includes:
  - Scripted welcome call content that reminds members to complete their IHA within 120 calendar days of enrollment or within American Academy

of Pediatrics periodicity guidelines for children under age two, whichever is sooner.
    - Outlines monthly outreach activities for new members, including two automated welcome calls using approved scripts that inform members about the IHA requirement and offer the option to speak with a call center agent.
    - For seniors and persons with disabilities, the policy requires a minimum of three outreach attempts within 60 calendar days (or 30 days for high-risk members) using the Proactive Outreach Manager. Outreach staff also offer PCP scheduling assistance and may resend welcome packets.
    - The policy clearly specifies that successful outreach attempts are documented in the member's electronic record (TruCare), and unsuccessful attempts are logged in dialer data-automated system logs that track call attempts and outcomes.
    - Despite two separate requests, the Plan did not submit any documentation from either source (TruCare or dialer data) to demonstrate compliance with these outreach requirements, preventing verification of performance against their own stated protocols.

Finding: The Plan did not ensure that its fully delegated subcontractor consistently performed an IHA within 120 calendar days of enrollment, made reasonable attempts to contact members to schedule an IHA, or document all outreach attempts.

In the verification study, a review of 20 IHA medical records indicated the following:

- Seven out of 20 medical records had IHAs completed beyond the required 120 calendar day timeframe.
- Eight out of 20 did not have any medical records available for review to verify whether an IHA was completed or whether outreach efforts were made to facilitate a timely assessment.

The Plan is required to maintain medical records to support the performance of IHA and document outreach efforts for IHA members. Outreach records were requested twice; however, no supporting documents were provided. This absence of documentation suggests that the Plan did not adequately track or perform member outreach to support the timely completion of IHAs.

During the interview, the Plan stated that it relies on its fully delegated subcontractor to perform all outreach functions related to IHAs and acknowledged that it did not monitor subcontractor IHA activities during the audit period. The Plan further confirmed that it

did not conduct direct oversight, validation, or review of the subcontractor's IHA compliance or medical record review findings related to this section.

This acknowledgment establishes a lack of delegation oversight and demonstrates ongoing noncompliance with contractual requirements for IHA timeliness and monitoring. Although the Plan maintains IHA policies and a *Delegation Oversight Monitoring Protocol*, these were not operationalized. The Plan's absence of monitoring or validating subcontractor performance resulted in no documented assurance that IHAs were completed within 120 calendar days of enrollment.

When the Plan and its fully delegated subcontractor do not ensure that IHAs are performed within 120 calendar days of enrollment and do not conduct and document outreach attempts, it can lead to delays in the identification of health risks and care needs and may impact the quality and COC for new members.

Recommendation: Implement oversight mechanisms, policies, and procedures to ensure that its fully delegated subcontractor consistently completes IHAs within 120 calendar days of member enrollment, makes reasonable attempts to contact members for scheduling, and documents all outreach attempts.

2.1.3 Blood Lead Screening Test

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

The Plan must cover and ensure the provision of blood lead screening tests to members at the ages and intervals specified in accordance with *APL 20-016, Blood Lead Screening of Young Children* (11/02/2020). (*Contract, Exhibit A, Attachment III, section 5.3.4 (D)(1))*

The Plan must ensure that its network providers order or perform blood lead screening tests on all children in accordance with the following:

- At 12 months and at 24 months of age.
- When the health care provider performing a Periodic Health Assessment (PHA) becomes aware that a child 12 to 24 months of age has no documented evidence of blood lead screening test taken at 12 months of age or thereafter.
- When the network provider performing a PHA becomes aware that a child member 24 to 72 months of age has no documented evidence of a blood lead screening test taken.

- At any time, a change in circumstances has, in the professional judgement of the network provider, put the child member at risk.
- If requested by the parent or guardian.

(*APL 20-016, Blood Lead Screening of Young Children* (11/02/2020)*)*

For additional Contract criteria, reference Section 1.5.2 on Delegation Oversight *(Contract, Exhibit A, Attachment III, Section 3.1.1(B) Delegation Oversight; Delegation Oversight Monitoring Protocol/Delegation Oversight;* and Plan policy and procedure, *CMP-002 Delegation Oversight).*

The Plan has the following documentation outlining its requirements for Blood Lead Level (BLL) testing in accordance with APL 20-016 and Contract provisions. The documentation reflects expectations for timely screening, catch-up testing, member education, including expectations for provider education as summarized below:

- Policy and procedure, *CA.QI.02 Childhood Blood Lead Screening* (revised 02/18/2025):
  - Requires screening at 12 and 24 months.
  - Catch-up testing allowed up to 72 months.
  - Quarterly compliance monitoring and provider notification.
- Provider Manual (printed 2024):
  - Requires BLL testing at 12 and 24 months.
  - Catch-up testing for children aged 12 to 72 months without prior BLL documented.
  - Refusals must be documented.

Finding: The Plan did not ensure that its fully delegated subcontractor consistently conducted blood lead screening tests on members at one and two years of age, including up to six years of age as specified in APL 20-016.

The Plan and the fully delegated subcontractor did not follow policy and procedure *CA.QI.02 Childhood Blood Lead Screening* and Provider Manual to conduct blood lead screening tests. A review of six out of nine samples lacked documentation for completed blood lead screening tests. Although most of the non-compliant samples involved members ages three to five years beyond the routine testing ages of 12 and 24 months, APL 20-016 requires documentation of prior blood lead screening tests, efforts to obtain historical test results, or a documented test refusal. However, no such documentation was found.

During the interview, the Plan acknowledged that oversight of blood lead screening activities was not conducted during the audit period. The Plan did not assess whether the delegated subcontractor monitored provider-level blood lead screening tests. Furthermore, in a written statement, the Plan confirmed that it did not conduct any care management file reviews related to blood lead screening tests during the audit period. This acknowledgment establishes noncompliance with contractual requirements for delegated oversight and prevents assurance that blood lead screening tests were consistently conducted.

When the Plan and its fully delegated subcontractor do not ensure that blood lead screening tests are conducted at required well-child visits, it may result in missed opportunities for early detection and intervention of lead exposure risks.

Recommendation: Implement oversight mechanisms, policies, and procedures to ensure that the provision of blood lead screening tests are conducted in accordance with APL requirements.

2.1.4 Blood Lead Anticipatory Guidance

The Plan must comply with all DHCS guidance, including but not limited to APLs, Policy Letters, the California Medicaid

State Plan, and the Medi-Cal Provider Manual. (*Contract, Exhibit E, section 1.1.2)*

The Plan is required to provide oral or written anticipatory guidance to the parent(s) or guardian(s) of a child that at a minimum, includes information that children can be harmed by exposure to lead. This anticipatory guidance must be provided to parents or guardians at each PHA, starting at six months of age and continuing until six years of age. (*APL 20-016, Blood Lead Screening of Young Children* (11/02/2020)*)*

For additional Contract criteria, reference Section 1.5.2 on Delegation Oversight *(Contract, Exhibit A, Attachment III, Section 3.1.1(B) Delegation Oversight; Delegation Oversight Monitoring Protocol/Delegation Oversight;* and Plan policy and procedure, *CMP-002 Delegation Oversight)*.

The Plan has the following documentation outlining its requirements for providing oral or written anticipatory guidance to the parent(s) or guardian(s) of a child in accordance with APL 20-016 requirements as summarized below:

- Policy and procedure, *CA.QI.02 Childhood Blood Lead Screening* (revised 02/18/2025) states the Plan ensures member education on lead exposure risks and testing through anticipatory guidance starting at 6 months of age.
- Provider Manual (printed 2024) requires providers to offer and document anticipatory guidance on lead exposure risks.

Finding: The Plan did not ensure that its fully delegated subcontractor consistently provided oral or written blood lead anticipatory guidance to the parent or guardian of members as specified in APL 20-016.

The Plan and the fully delegated subcontractor did not follow policy and procedure *CA.QI.02, Childhood Blood Lead Screening* and Provider Manual, related to providing anticipatory guidance. A review of eight out of nine samples demonstrated a lack of any evidence of anticipatory guidance.

During the interview, the Plan acknowledged that oversight of blood lead screening activities was not conducted during the audit period. The Plan did not monitor whether the delegated subcontractor assessed provider-level documentation of blood lead anticipatory guidance during well-child visits. Furthermore, in a written statement, the Plan confirmed that it did not conduct any care management file reviews related to blood lead anticipatory guidance during the audit period.

This acknowledgment establishes noncompliance with contractual requirements for delegated oversight and prevents assurance that oral or written blood lead anticipatory guidance was consistently provided to members.

When the Plan and its fully delegated subcontractor do not provide oral or written blood lead anticipatory guidance at required well-child visits, it may result in missed opportunities to educate families on lead exposure risks, potentially delaying prevention or early detection of lead poisoning in young children.

Recommendation: Implement oversight mechanisms, policies, and procedures to ensure that the provision of blood lead anticipatory guidance is provided in accordance with APL requirements.

2.3 Behavioral Health Treatment

2.3.1 Behavioral Health Treatment Plan

The member's treatment plan must be reviewed, revised, and/or modified at least every six months by a BHT service provider. (*Contract, Exhibit A, Attachment III, 5.3.4 (F)(2))*

For additional Contract criteria, reference Section 1.5.2 on Delegation Oversight *(Contract, Exhibit A, Attachment III, Section 3.1.1(B) Delegation Oversight; Delegation Oversight Monitoring Protocol/Delegation Oversight;* and Plan policy and procedure, *CMP-002 Delegation Oversight).*

The Plan's following policies and procedures, and documentation reflect the requirement for timely reassessment of BHT:

- *CBH.UM.136 Responsibilities for BHT Coverage for Members under the Early and Periodic Screening, Diagnostic, and Treatment Benefit* (revised 12/19/2024) explicitly requires treatment plan reviews every six months and references coordination and corrective actions, reinforcing the Plan's obligation to ensure timely reassessment.
- *CHPIV BH-001 Behavioral Health* (effective 05/13/2024) reiterates the six-month review requirement for treatment plans and emphasizes that BHT services may only be modified or discontinued if no longer medically necessary, in line with Early and Periodic Screening, Diagnostic, and Treatment standards.
- Provider Manual (printed 2024), outlines provider responsibilities and authorization processes, including treatment plan and reassessment procedures under Medi-Cal BHT requirements.

Finding: The Plan did not ensure that its fully delegated subcontractor consistently fulfilled the requirement that a BHT service provider reviewed, revised, and/or modified the member's treatment plan at least every six months.

The Plan and the fully delegated subcontractor did not follow policy and procedure *CBH.UM.136 Responsibilities for BHT Coverage for Members under the Early and Periodic Screening, Diagnostic, and Treatment Benefit, CHPIV BH-00 Behavioral Health,* and Provider Manual. In the verification study, two out of the ten BHT samples revealed that the Plan's fully delegated subcontractor did not complete the required six-month reassessment of the member's treatment plan. For example:

- Sample 1: The initial BHT assessment and treatment plan for this member was completed on January 31, 2024. The six-month reassessment should have been conducted by July 31, 2024, or at the latest by September 30, 2024. However, no documentation for a six-month reassessment was provided.
- Sample 2: The initial BHT assessment and treatment plan were completed on February 2, 2024. Accordingly, the six-month reassessment was due by August

2, 2024, or no later than September 2, 2024. However, no documentation for a six-month reassessment was found for this sample.

In interviews, the Plan stated that oversight of its fully delegated subcontractor was limited to general reporting mechanisms such as utilization reports, dashboards, and webinars. However, the Plan acknowledged that it did not conduct BHT-specific oversight, such as case file reviews or validation of six-month reassessments. The case management team, which should be responsible for monitoring reassessments and ensuring treatment plans are current, did not perform this function. As a result, the Plan could not demonstrate how compliance with reassessment requirements was being monitored.

The subcontractor also stated that it issues automated alerts to notify providers of upcoming treatment plan expirations. Despite having this mechanism in place, the subcontractor did not provide evidence to demonstrate that reassessments were completed on time.

When the Plan and its fully delegated subcontractor do not ensure timely six-month reassessments of BHT plans, members may continue services that are no longer clinically appropriate or miss needed adjustments in care. This may lead to suboptimal treatment outcomes, unnecessary utilization, or gaps in medically necessary services for children with autism spectrum disorder.

Recommendation: Implement oversight mechanisms, policies, and procedures to ensure that the fully delegated subcontractors comply with requirements that treatment plans for BHT services are reviewed, revised, and/or modified at least every six months by a qualified BHT service provider, in accordance with contractual obligations.

2.4 Continuity of Care

2.4.1 Member Notifications for Denied Services

The Plan must allow all members to request COC in accordance with Code of Federal Regulations (CFR), Title 42, section 438.62 and *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* (08/15/2023). (*Contract Exhibit A, Attachment III, section 5.2.12 B)*

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. 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* (08/15/2023)*)*

For additional Contract criteria, reference Section 1.5.2 on Delegation Oversight *(Contract, Exhibit A, Attachment III, Section 3.1.1(B) Delegation Oversight; Delegation Oversight Monitoring Protocol/Delegation Oversight;* and Plan policy and procedure, *CMP-002 Delegation Oversight)*.

Plan policy and procedure, *CA.UM.20, Continuity of Care* (revised 10/30/2024), states as follows:

- The Plan notifies members and providers of COC decisions as follows: for non-urgent requests, within seven calendar days of the decision.
- 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: telephone call, text message, e-mail, followed by notification by mail.

Finding: The Plan did not monitor its fully delegated subcontractor to ensure compliance with COC requirements by consistently mailing a written notice of the denial to the member.

The Plan and its fully delegated subcontractor staff did not follow the policy and procedure for *CA.UM.20 Continuity of Care*. In the verification study, a review of 11 verification samples found 6 cases in which the denial of COC services was not mailed to members. The case manager's notes indicated that members were contacted by phone to communicate the decision regarding the denial of services. However, no COC denial decision notices were mailed to the members.

In a written statement and during the interview, the Plan and the fully delegated subcontractor stated that the team reviews the type of services and verifies the type of provider to ensure that it is an eligible COC provider. Members will be informed of the decision via telephone and educated on the other options available to them. In addition, the Plan stated that when the COC criteria are not met, the Plan notifies the member by telephone and then cancels the COC request without mailing the decision to the member. The Plan's practice of canceling COC services without mailing the decision letter indicates the Plan's noncompliance with the COC contractual requirements.

Without COC notification of the Plan and its fully delegated subcontractor's decision, medically necessary services for the member may be delayed, causing a setback in the member's treatment.

Recommendation: Implement policy and procedure to ensure that the fully delegated subcontractor mails notices of denied decisions to the member.

2.5 Mental Health and Substance Use Disorder

2.5.1 Coordination of Concurrent Services

The Plan must ensure members have access to needed services, including care coordination, navigation, and referrals to services that address members' developmental, physical, mental health, substance use disorder, dementia, long term support service, palliative care, and oral health needs. *(Contract, Exhibit A, Attachment III, section 4.3.8(A)(2))*

The Plan must have policies and procedures to ensure medically necessary NSMHS and SMHS provided concurrently are coordinated and non-duplicative. (*Contract, Exhibit A, Attachment III, section 5.6.2(B)(1)(g))*

For additional Contract criteria, reference Section 1.5.2 on Delegation Oversight *(Contract, Exhibit A, Attachment III, Section 3.1.1(B) Delegation Oversight; Delegation Oversight Monitoring Protocol/Delegation Oversight;* and Plan policy and procedure, *CMP-002 Delegation Oversight).*

Any concurrent NSMHS and SMHS for adults, as well as children under 21 years of age, must be coordinated between the Plan and Mental Health Plans (MHPs) to ensure member choice. The Plan must coordinate with MHPs to facilitate care transitions and guide referrals for members receiving NSMHS to transition to a SMHS provider and vice versa, ensuring that the referral loop is closed, and the new provider accepts the care of the member. Such decisions should be made via a patient-centered shared decision-making process. *(APL-22-005, No Wrong Door for Mental Health Services Policy* (03/30/2022)*)*

The memorandum of understanding requires a process for coordinating care for individuals who meet access criteria for and are concurrently receiving NSMHS and SMHS to ensure the care is clinically appropriate and non-duplicative and considers the member's established therapeutic relationships. (*Memorandum of Understanding Between Plan, the Fully Delegated Subcontractor and the County of Imperial Mental Health Plan, section 9(b)(iv)(2))*

The Plan has the following policies and procedures and documents that address screening, referrals, care coordination, and oversight responsibilities related to MHSUD services:

- *CA.CM.02.08 Referrals to Specialty Mental Health, Alcohol, and Substance Abuse Treatment Services* (revised 06/04/2024), outlines the referral processes for specialty MHSUD treatment services, affirming the Plan's responsibility to ensure members are referred appropriately to county MHPs or other systems based on clinical need.
- *BH-001 Behavioral Health* (effective 05/13/2024), outlines the Plan's oversight responsibility MHSUD services and delegates operations to the fully delegated subcontractor.
- *CBH.UM.140 Medi-Cal Screening, Assessment, and Referral Processes* (revised 11/19/2024), details the required processes for screening and referrals for MHSUD services, including coordination with county MHPs.

Finding: The Plan did not verify that its fully delegated subcontractor had oversight mechanisms, policies, and procedures to ensure the subcontractor consistently provided members with access to needed services, including care coordination, navigation, and referrals for MHSUD needs.

A review of three concurrent NSMHS and SMHS samples demonstrated the following:

- Sample 1: Was a cold transfer to the county, showing a lack of close loop coordination and no documentation of an appointment outcome.
- Sample 2: The Plan referred the member to inpatient detox but did not complete a transition of care tool or initiate direct coordination with the county for post-detox services. The burden of follow-up was placed entirely on the member, with no documented referral, warm handoff, or appointment outcome.
- Sample 3: The Plan did not confirm whether the member was linked to services. A missing release of information was noted but not resolved, and there was no documented strategy to ensure care engagement.

All three cases indicated consistent problems with a lack of care coordination, especially in ensuring successful referral completion and confirming member access to services across different delivery systems.

During interviews, the Plan stated that it relied solely on its fully delegated subcontractor for MHSUD service delivery and did not conduct oversight activities.

Policies and procedures, *CA.CM.02.08 Referrals to Specialty Mental Health, Alcohol, and Substance Abuse Treatment Services*, *BH-001 Behavioral Health Policy*, and *CBH.UM.140 Medi-Cal Screening, Assessment, and Referral Process,* require the Plan to monitor referrals, assess member needs, and ensure care coordination. These provisions were not implemented. Review of submitted documents showed the Plan did not:

- Perform care management case file reviews to confirm referrals were completed.
- Validate whether the subcontractor resolved release of information barriers or facilitated timely referrals.
- Ensure documentation of care coordination between the MHP liaison and subcontractor staff.

As a result, the Plan could not demonstrate compliance with oversight of the fully delegated subcontractor, leading to gaps in member care coordination and referral tracking.

When the Plan does not oversee its fully delegated subcontractor's provision of MHSUD services, members may experience delay in care, missed referrals, and uncoordinated treatment.

Recommendation: Implement oversight mechanisms, policies, and procedures to ensure the fully delegated subcontractor consistently provides the members with access to needed services, including care coordination, navigation, and referrals for MHSUD needs.

2.6 Enhanced Care Management

2.6.1 Enhanced Care Management Core Service Components

The Plan is required to follow all provisions in the ECM Policy Guide, in addition to provisions outlined in the Contract. *(Contract Exhibit A, Attachment III, sections 4.4.1 and 4.4.11)*

The Plan is required to perform oversight of ECM providers, holding them accountable to all ECM requirements contained in the Contract, the DHCS' policies and guidance, APLs, and the Plan's Model of Care. *(Contract, Exhibit A, Attachment III, 4.4.13)*

The Plan is required to provide the following ECM core service components, which include:

- A Comprehensive Assessment and CMP, which must include, but is not limited to: Identifying necessary clinical resources that may be needed to appropriately assess member health status and gaps in care and may be needed to inform the development of an individualized CMP.
- ECM requires Member and Family Supports which includes 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* (12/22/2023)*)*

Plan policy and procedure, *CA.SOC.02 v5 Enhanced Care Management Program Overview and Requirements* (revised 10/04/2023), states as follows*:*

- The section related to ECM core service for Member and Family Supports states the ECM provider is responsible for working with the member's chosen caregiver(s) or family support person, including guardians. This collaboration includes: Ensuring that the member has a copy of his/her care plan and information about how to request updates.
- The section titled Comprehensive Assessment and CMP states the ECM provider/care manager will conduct the comprehensive assessment and care plan in accordance with federal and state regulatory requirements.

Finding: The Plan did not ensure that the fully delegated subcontractor provided ECM core service components, including the comprehensive assessment, CMP, and Member and Family Supports.

The Plan and its fully delegated subcontractor staff did not follow the policy and procedure *Enhanced Care Management Program Overview and Requirements*. In the verification study a review of the eight medical records revealed the following:

- Two out of eight records did not include a CMP.
- Two out of eight records lacked documentation confirming that a copy of the CMP had been provided to the members' authorized support persons, as well as information about how to request updates.

The provider used the eligibility form *(ILS-CA Eligibility Review v3)*, which was filled out by non-clinical staff. A review of two out of eight medical records showed that some of the clinical and non-clinical needs of a member were not addressed, and the following are examples of the review:

- In one case, the member had high blood pressure, needed knee surgery, and had depression. In addition, a member needed food assistance.
- In one case, the member had problems with the nervous system, hip, spinal cord, depression, and anxiety. In addition, a member needed assistance with housing and food.

A comprehensive assessment is necessary to develop an individualized CMP that addresses both clinical and non-clinical care coordination needs. The Plan did not address the clinical and non-clinical needs requiring care coordination.

During the interview, the Plan and its fully delegated subcontractor acknowledged that team members were forgetting to include a CMP in care plans. As a result, the Plan acknowledged an opportunity for improvement in the ECM process.

When the Plan and its fully delegated subcontractor do not provide all ECM core service components, members may not receive coordination of services and comprehensive care management, resulting in adverse health outcomes and the inability to make informed decisions.

Recommendation: Implement policies and procedures to ensure that the fully delegated subcontractor provides all ECM core service components, including a comprehensive assessment, CMP, and Member and Family Supports.

COMPLIANCE AUDIT FINDINGS

Category 3 – Network and Access to Care

3.8 Non-Emergency Medical Transportation and Non-Medical Transportation

3.8.1 Insufficient Documentation

The Plan must cover transportation services as required in the Contract and directed in *APL 22-008, Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses* (05/18/2022), to ensure members have access to all medically necessary services. (*Contract, Exhibit A, Attachment III, section 5.3.4, part I)*

The Plan is required to provide medically necessary NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for obtaining medically necessary services. The Plan is required to provide NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches. The Plan must also have processes in place to ensure door-to-door assistance is being provided for all members receiving NEMT services. (*APL 22-008, Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses* (05/18/2022))

Plan policy and procedure, *CA. LTSS.15 Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT)* (revised 10/10/2024), states that the Plan provides medically necessary NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services. The Plan provides NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches. The Plan ensures door-to-door assistance is provided for all members receiving NEMT services**.**

Finding: The Plan did not provide sufficient documentation to demonstrate that its delegate and downstream subcontractor had a process in place to ensure NEMT door-to-door assistance for all members receiving medically necessary NEMT services.

According to APL 22-008, the Plan must maintain processes to ensure door-to-door assistance is provided for all members receiving Non-Emergency Medical Transportation (NEMT) services when medically necessary.

A review of the Plan's three-phase pre-delegation audit reports indicated that the Plan did not conduct a review of NEMT and NMT services for its fully delegated subcontractor.

Review of the Vendor Oversight Committee (VOC) meeting minutes reflects ongoing discussions held from January through December 2024 between the delegate and the downstream subcontractor. These discussions, however, were limited to establishing a specific complaint category for tracking door-to-door service complaints.

During the review, the Plan did not provide sufficient documentation to demonstrate monitoring of its subdelegated activities related to NEMT door-to-door services.

Although information was requested during the audit, the Plan did not provide adequate evidence that would outline how delegated subcontractor staff verified medical necessity and ensured that NEMT door-to-door assistance was provided in accordance with the member requests.

After the exit conference, the Plan provided a spreadsheet listing its members who received door-to-door services. It was noted that all door-to-door requests were rendered under the Non-Medical Transportation (NMT). While this data reflects completed trips, the documentation did not demonstrate how the delegated subcontractor complied with NEMT door-to-door requirements.

The Plan lacked oversight to verify that subcontractors followed the required processes for providing door-to-door assistance in accordance with medical necessity.

Without adequate documentation and monitoring procedures, the audit could not confirm whether NEMT door-to-door assistance was consistently provided in accordance with the member's medical necessity. This creates a risk of gaps in service delivery for members who need specialized transportation.

Recommendation: Implement oversight mechanisms, policies, and procedures to ensure the Plan's delegate and downstream subcontractors' NEMT door-to-door requests are supported by documentation demonstrating medical necessity.

COMPLIANCE AUDIT FINDINGS

Category 4 – Grievances, Appeals, and Member Rights

4.1 Grievances and Appeals

4.1.1 Discrimination of Grievance

Within ten calendar days of mailing a Discrimination Grievance Resolution letter, the Plan must submit information regarding the discrimination grievance to the DHCS OCR, as specified in *APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services,* (05/24/2023). *(Contract, Exhibit A, Attachment III, section 4.6.3(C))*

For additional Contract criteria, reference Section 1.5.2 on Delegation Oversight *(Contract, Exhibit A, Attachment III, Section 3.1.1(B) Delegation Oversight; Delegation Oversight Monitoring Protocol/Delegation Oversight;* and Plan policy and procedure, *CMP-002 Delegation Oversight).*

The Plan must provide written translations of member information in the threshold and concentration languages identified in the APL in the DHCS Threshold and Concentration Language Requirements section. Within ten calendar days of mailing a Discrimination Grievance Resolution letter to a member. The managed care health plans must submit detailed information regarding the grievance to DHCS OCR's designated discrimination grievance email box. (*APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance* Services (05/24/2023)*)*

The Plan's Appeals and Grievance Department had the following policies and procedures:

- *GA-001 Grievance Process* (revised 11/18/2024), states that the Plan ensures grievances alleging discrimination are forwarded to the DHCS OCR. The procedure section states that the Plan shall provide oversight and continually assess the delegated functions, responsibilities, processes, and performance of the fully delegated subcontractor.
- *CA.AG.35 Medi-Cal Grievance Process* (revised 12/12/2024), states that all grievances reviewed and resolved alleging discrimination against members or eligible beneficiaries because of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health

status, or disability shall be forwarded by the fully delegated subcontractor's Compliance Department to DHCS OCR for review and appropriate action within ten calendar days of mailing the resolution letter to the member.

Finding: The Plan did not ensure that its fully delegated subcontractor reported discrimination grievances to the DHCS OCR within ten calendar days of mailing a Discrimination Grievance Resolution letter to a member.

The Plan and its fully delegated subcontractor staff did not follow the procedure to report the discrimination grievance to the DHCS OCR. In the verification study a review of four cultural and linguistic grievance files demonstrated the presence of discrimination in the following three files:

- One file had supporting documentation, which included an e-mail to DHCS OCR without a date.
- Two files did not have supporting documentation indicating that these were reported to DHCS OCR.

The Plan's fully delegated subcontractor's Appeals and Grievances Department identified discrimination in complaints filed by members. The member's discrimination grievance was resolved within the required time frame; however, the Plan's fully delegated subcontractor did not report to the DHCS OCR within ten calendar days from the resolution letter.

During the interview, the Plan and its fully delegated subcontractor stated that they did not report these discrimination grievances to the DHCS OCR. The Plan stated that it was the responsibility of the subdelegate's Compliance staff to report to the DHCS OCR in accordance with the Plan's subcontract agreement. Additionally, the Plan did not fully oversee and monitor its fully delegated subcontractor's delegated functions.

Additionally, the Plan policy and procedure, *GA-001 Grievance Process* (revised 11/18/2024), does not include a required reporting timeframe for discrimination grievances.

When the Plan and its fully delegated subcontractor do not report discrimination grievances to DHCS OCR, it may prevent DHCS OCR from addressing members' discriminatory concerns.

Recommendation: Revise and implement policies and procedures to ensure that the fully delegated subcontractor reports discrimination grievances to DHCS OCR within ten calendar days of mailing a Discrimination Grievance Resolution letter to a member.

4.1.2 Notification of Member Rights

For covered services the Plan must have in place a member grievance and appeal system that complies with CFR, Title 42, sections 438.228 and 438.400 - 424, CCR, Title 28, sections 1300.68 and 1300.68.01, and CCR, Title 22, section 53858. *(Contract, Exhibit A, Attachment III, section 4.6.1)*

The Plan shall resolve each grievance and provide notice to the member as quickly as the member's health condition requires, within 30 calendar days from the date the Plan receives the grievance. The Plan is required to notify the member of the grievance resolution in a written member notice. *(CCR, Title 28, section 1300.68 (a) and (d)(3))*

Grievances that are not resolved within 30 calendar days, or grievances referred to the Department's complaint or independent medical review system, shall be reported as "pending" grievances pursuant to subsection (f). Grievances referred to external review processes, such as reviews of Medicare Managed Care determinations pursuant to CFR, Title 42, section 422, or the Medi-Cal Fair Hearing process, shall also be reported pursuant to subsection (f) until the review and any required action by the Plan resulting from the review is completed. *(CCR, Title 28, section 1300.68 4(B))*

For additional Contract criteria, reference Section 1.5.2 on Delegation Oversight *(Contract, Exhibit A, Attachment III, Section 3.1.1(B) Delegation Oversight; Delegation Oversight Monitoring Protocol/Delegation Oversight;* and Plan policy and procedure, *CMP-002 Delegation Oversight).*

The Plan must establish, implement, maintain, and oversee a grievance and appeal system to ensure the receipt, review, and resolution of grievances and appeals. The grievance and appeal system must operate in accordance with all applicable federal and state laws. (*APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Template* (08/31/2022)*)*

Plan policy and procedure, *CA.AG.35 Appeals & Grievances Operations – Business Operations* (revised 12/12/2024), states that if you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the DHCS for assistance. You may also be eligible for an independent medical review.

The Plan's process, *AG 001 Grievance Process* (revised 11/18/2024), states that the Plan shall provide oversight and continually assess the delegated functions, responsibilities, processes, and performances of the fully delegated subcontractor. The Plan shall ensure the fully delegated subcontractor complies with regulatory and contractual

requirements through the following activities: ongoing monitoring, performance reviews, data analysis, utilization of benchmarks, and annual desktop and onsite audits.

Finding: The Plan did not ensure that its fully delegated subcontractor consistently sent Transportation Grievance letters and notified members of their rights.

The Plan and its fully delegated and downstream subcontractors did not follow the established policy and procedure *CA.AG.35 Appeals & Grievances Operations – Business Operations*. A review of the 2024 Annual Audit Result Summary dated December 23, 2024, indicated that the fully delegated subcontractor staff conducted an annual audit of the transportation downstream subcontractor. The fully delegated subcontractor audit identified five transportation grievances to be resolved by the close of the next business day (exempt) that were not resolved during the audit period, and no notification was sent to the members to inform them of their rights.

The Plan delegates the grievance process to its fully delegated subcontractor. The subcontractor has a contract with the downstream entity to resolve transportation-exempt grievances within 24 hours. If the exempt grievance is not resolved within 24 hours, the downstream subcontractor is required to forward it to the fully delegated subcontractor for resolution, either as a standard or expedited grievance.

During the interview, the Plan did not respond as to why members were not notified of the unresolved grievances. In a written response, the Plan stated that grievances were six months old and that its fully delegated subcontractor did not notify members to avoid confusion.

Based on the information presented, the Plan did not detect or remediate the issue involving its fully delegated subcontractor through the ongoing monitoring process. This represents a deficiency and constitutes non-compliance with the contractual obligations set forth in the Plan's agreement with the DHCS.

When the Plan and its fully delegated subcontractor do not resolve grievances and notify members of their rights, members may not have all the information they need to make their health care decisions and pursue their rights.

Recommendation: Implement policies and procedures to ensure that its fully delegated subcontractor consistently sends Transportation Grievance letters and notifies members of their rights.

DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

LOS ANGELES SECTION

REPORT ON THE MEDICAL AUDIT OF IMPERIAL COUNTY LOCAL HEALTH AUTHORITY DBA COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY FISCAL YEAR 2024-25

Contract Number: 23-30250

Contract Type: State Supported Services

Audit Period: January 1, 2024 — December 31, 2024

Dates of Audit: April 29, 2025 — May 13, 2025

Report Issued: February 9, 2026

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I. INTRODUCTION

This report presents the results of the audit of Imperial County Local Health Authority dba Community Health Plan of Imperial Valley (Plan) compliance and implementation of the State Supported Services contract number 23-30250 with the State of California. The State Supported Services Contract covers abortion services with the Plan.

The audit covered the period of January 1, 2024, through December 31, 2024. The audit was conducted from April 29, 2025, through May 13, 2025, which consisted of a document review and verification study with the Plan's administration and staff.

An Exit Conference with the Plan was held on November 20, 2025. No deficiencies were noted during the review of the State Supported Services Contract.

COMPLIANCE AUDIT FINDINGS

State Supported Services

The Plan must provide, or arrange to provide, to eligible members enrolled under either this Contract or the Primary Contract, the following Private Services: Current Procedural Terminology codes: 59840 through 59857; Centers for Medicare and Medicaid Services Common Procedure Coding System codes: X1516, X1518, X7724, X7726, and Z0336. *(Contract, Exhibit A, sections 1.2.1 and 1.2.2)*

The Plan must cover abortion services, as well as the medical services and supplies incidental or preliminary to an abortion, consistent with the requirements outlined in the Medi-Cal Provider Manual. Plans and its network providers and subcontractors are prohibited from requiring medical justification, or imposing any utilization management or utilization review requirements, including prior authorization and annual or lifetime limits. However, non-emergency inpatient hospitalization for the performance of an abortion may require prior authorization under the same criteria as other medical procedures. (*All Plan Letters* 22-022 and 24-003, Abortion Services (03/28/2024)*)*

Plan policy, *15-0217H Processing Abortion Claims for Med-Cal Member* (no date), states the Medi-Cal program covers abortion regardless of the gestational age of the fetus. Medical justification and authorization for abortion are not required. The Plan must cover abortion services, as well as the medical services and supplies incidental or preliminary to an abortion. Medicare covers abortion in limited situations. Therefore, a Medicare denial is required before Medi-Cal coordination of benefits for the following Current Procedural Terminology codes: 59840-59841; 59850-59852; and 59855-59857. Furthermore, the policy lists the following Healthcare Common Procedure Coding System codes: A4649, S0190-S0191, and S0199.

The Plan informs members and providers about abortion services through the Evidence of Coverage (Member Handbook) and Provider Manual. The Member Handbook states that if a member is 18 years of age or older, they can choose any doctor or clinic for the outpatient abortion services. Furthermore, if the member is under the age of 18, they can get abortion services without a parent or guardian's permission.

A review of the verification study demonstrated that the Plan paid claims in a timely manner, and no deficiencies were noted related to State-Supported Services.

Finding: No deficiencies were identified in this audit.

Recommendation: None.