

REPORT ON THE MEDICAL AUDIT OF IMPERIAL COUNTY LOCAL HEALTH AUTHORITY DBA COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY CALENDAR YEAR 2025

**DHCS Audits and Investigations
Contract and Enrollment Review Division
Los Angeles Section**

Contract Number: 23-30218

Audit Period: January 1, 2025 — December 31, 2025

Dates of Audit: July 13, 2026 — July 24, 2026

Report Issued: October 15, 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.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of January 1, 2025, through December 31, 2025. The audit was conducted from July 13, 2026, through July 24, 2026. It consisted of documentation review, verification studies, and interviews with the Plan's and delegate representatives.

An Exit Conference with the Plan was offered on October 13, 2026. The Plan declined to hold an Exit Conference, as no areas of non-compliance were found in this audit.

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

The prior DHCS medical audit for the period of January 1, 2024, through December 31, 2024, was issued on February 9, 2026. As for this review, the Plan's 2024 Corrective Action Plan was still being implemented and remained open; accordingly, its outcomes were not evaluated in this audit.

The following categories were reviewed:

Category 1 – Utilization Management Program

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

Category 2 – Population Health Management and Coordination of Care

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

Category 3 – Network and Access to Care

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

Category 4 – Grievances, Appeals, and Member Rights

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

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 July 13, 2026, through July 24, 2026, for the audit period of January 1, 2025, through December 31, 2025. The audit included a review of the Plan's Contract with DHCS, policies and procedures for providing services, procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with the Plan's administrators and staff and with the delegate's staff.

The following verification studies were conducted:

Category 1 – Utilization Management Program

Prior Authorization Requests: A total of 40 delegated medical authorizations, including 4 retrospective, 19 routine, and 17 expedited prior authorization requests, were reviewed for timeliness, consistent application of criteria, appropriate review, and communication of results to providers and members.

Appeal Procedures: Fifteen medical appeals, including 12 routine, 2 expedited, and 1 downgraded from expedited to routine, were reviewed for appropriateness and timeliness of decision making.

Category 2 – Population Health Management and Coordination of Care

Enhanced Care Management: Ten files were reviewed for care coordination and completeness to evaluate for compliance.

Category 3 – Network and Access to Care

Timely Payments: Forty-nine emergency service claims were reviewed for appropriateness and timeliness.

Category 4 – Grievances, Appeals, and Member Rights

Grievance Procedures: A total of 41 cases were reviewed, of which 8 were expedited and 33 were standard grievances, of which 12 were quality of care and 21 were quality of service grievances. These cases were reviewed for timely resolutions, responses to complainants, and submission to the appropriate level for review.

Member Rights and Responsibilities: Five Health Insurance Portability and Accountability Act cases were selected for appropriateness.

Category 5 – Quality Improvement and Health Equity Transformation Program

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

Category 6 – Plan Administration and Organization

Fraud, Waste, and Abuse Reporting: Ten fraud, waste, and abuse cases were reviewed for compliance.

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**DHCS Audits and Investigations
Contract and Enrollment Review Division
Los Angeles Section**

Contract Number: 23-30250

Contract Type: State Supported Services

Audit Period: January 1, 2025 — December 31, 2025

Dates of Audit: July 13, 2026 — July 24, 2026

Report Issued: October 15, 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, 2025, through December 31, 2025. The audit was conducted from July 13, 2026, through July 24, 2026, which consisted of a document review and verification study with the Plan administration, staff and delegate.

An Exit Conference with the Plan was offered on October 13, 2026. The Plan declined the Exit Conference, as no areas of non-compliance were found in this audit.

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: 59840-59857; and Centers for Medicare and Medicaid Services Common Procedure Coding System codes: X1516, X1518, X7724, X7726, and Z0336. *(Contract, Exhibit A, section 1.2.1)*

In addition, the codes identified in section 1.2 are subject to change upon the Department of Health Care Services' implementation of the Health Insurance Portability and Accountability Act of 1996 electronic transaction and code sets provisions. Such changes will not require an amendment to the Contract. *(Contract, Exhibit A, section 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 Letter 24-003, Abortions and Directly Related Medical Services and Supplies (03/28/2024))*

Plan policy, *15-0217H Processing Abortion Claims for Med-Cal Member* (effective 02/08/2023), 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 Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System codes: A4649 and S0190-S0191.

The Plan informs members and providers about abortion services through the Evidence of Coverage (Plan's 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 eight verification study files 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