

DHCS AUDITS AND INVESTIGATIONS
CONTRACT AND ENROLLMENT REVIEW DIVISION
SAN DIEGO SECTION

**REPORT ON THE MEDICAL AUDIT OF
COMMUNITY HEALTH GROUP FOUNDATION
DBA COMMUNITY HEALTH GROUP
PARTNERSHIP PLAN
FISCAL YEAR 2024-25**

Contract Number: 23-30217

Audit Period: June 1, 2024 — March 31, 2025

Dates of Audit: April 21, 2025 — May 2, 2025

Report Issued: November 14, 2025

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I. INTRODUCTION

Community Health Group Foundation dba Community Health Group Partnership Plan (Plan) was incorporated in 1986 and contracted with the Department of Health Care Services (DHCS) to provide services to Medi-Cal members. In 2005, the Plan obtained a Knox-Keene license from the California Department of Managed Health Care to serve Medi-Cal members.

The Plan currently contracts with DHCS to provide services to Medi-Cal members under the Geographic Managed Care program in San Diego County. The Plan provides health care services through contracts with its provider network, including private physicians, group practices, Federal Licensed Community Health Centers, Indian Health Services, all hospitals in its service area, an array of ancillary providers, and pharmacy services through Medi-Cal Rx.

The Plan is accredited by the National Committee for Quality Assurance as a Medicaid Health Maintenance Organization from September 25, 2023, through September 25, 2026, and for Health Equity from August 17, 2023, through August 17, 2026.

As of February 18, 2025, the Plan served a total of 388,433 members through the following programs: Medi-Cal, 380,256; Dual Special Needs Plan, 7,893; and Chronic Condition Special Needs Plan, 284.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of June 1, 2024, through March 31, 2025. The audit was conducted from April 21, 2025, through May 2, 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 23, 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 6, 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 five categories of performance: Utilization Management, Population Health Management and Coordination of Care, Network and Access to Care, Member Rights, and Quality Improvement and Health Equity Transformation.

The prior DHCS medical audit for the period of June 1, 2023, through May 31, 2024, was issued on November 4, 2024. This audit examined the Plan's compliance with the DHCS Contract and assessed the implementation and effectiveness of the Plan's prior year 2024, Corrective Action Plan.

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan is required to ensure that the person making the final decision on an appeal's proposed resolution has not participated in any prior decisions related to the appeal. The audit found that the Plan's Chief Medical Officer (CMO) proposed appeal resolutions for prior authorization decisions that the CMO previously adjudicated.

Managed care providers can appeal on behalf of a member who has received a denial for services. This is often the case when the provider believes the services are medically necessary for the member's treatment. Appeals filed by the provider on behalf of the member require written consent from the member. The Plan did not obtain the member's written consent when a provider filed an appeal on their behalf.

Category 2 – Population Health Management and Coordination of Care

The Plan is required to provide acknowledgement of Continuity of Care (COC) requests within seven calendar days of the decision for non-urgent requests. The Plan did not notify members of the decision for non-urgent COC requests within seven calendar days.

For COC requests that are approved, the Plan is required to include the following information in the notice: a statement of its decision, the duration of the COC arrangement, the process that will occur to transition the member's care at the end of the COC period, and the member's right to choose a different network provider. The Plan's COC request approval member notification letter did not include all required information.

Category 3 – Network and Access to Care

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

Category 4 – Member Rights

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

Category 5 – Quality Improvement and Health Equity Transformation

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 21, 2025, through May 2, 2025, for the audit period of June 1, 2024, through March 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 Plan's administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Appeal Procedures: Twenty-five appeals related to denied prior authorizations were reviewed for appropriate and timely adjudication. Eighteen of 25 appeals were upheld while 7 of 25 appeals were overturned and approved.

Category 2 – Population Health Management and Coordination of Care

Behavioral Health Treatment (BHT): Ten medical records were reviewed to evaluate the provision of BHT service components.

COC: Ten medical records were reviewed to evaluate timeliness, appropriate determination, and notification of COC requests.

Enhanced Care Management (ECM): Ten medical records were reviewed to evaluate the provision of ECM core service components.

Category 3 – Network and Access to Care

Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT): Twenty-two records (12 NEMT and 10 NMT) were reviewed to confirm

compliance with transportation requirements for timeliness and appropriate adjudication.

Category 4 – Member Rights

Grievance Procedures: Thirty-nine standard grievances (19 quality of care and 20 quality of service), 1 expedited grievance, 5 exempt grievances, and 5 call inquiries were reviewed for classification, timely resolution, response to the complainant, submission to the appropriate level for review, and translation in the member's preferred language (if applicable).

Category 5 – Quality Improvement and Health Equity Transformation

Potential Quality Issues: Seven files were reviewed for evaluation and effective action taken to address needed improvement.

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management

1.3 Prior Authorization Appeal Process

1.3.1 Final Grievance and Appeal Decision-Maker

The Plan must ensure that its grievance and appeal system meets the following requirement: Ensures that the person making the final decision for the proposed resolution of a grievance or appeal has neither participated in any prior decisions related to the grievance or appeal. (*Contract, Exhibit A, Attachment III, 4.6.1 Grievance and Appeal Program Requirements, D*)

The Plan's process for handling member grievances and appeals of adverse benefit determinations must ensure that the individuals who make decisions on grievances and appeals are individuals who were neither involved in any previous level of review or decision-making. (*Code of Federal Regulations, Title 42, section 438.406(b)(2)(i)*)

The Plan must ensure that the person making the final decision for the proposed resolution of a grievance or appeal has not participated in any prior decisions related to the grievance or appeal. (*All Plan Letter (APL) 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates*)

Plan policy, *5510A Member Grievance and Appeal Policy* (revised August 9, 2024), stated that clinical appeals and appeals relating to medical necessity are reviewed by a practitioner who was neither involved in the initial determination nor, with respect to professional practice, directly supervised by any person involved in the initial decision.

Finding: The Plan did not ensure that the person making the final decision for resolution of an appeal had not participated in any prior decisions related to the appeal.

In a verification study, 25 appeals identified the Plan's CMO as the appeal decision maker. However, in three appeals, the audit found that the CMO participated in the related prior authorization.

The Plan does not have a system in place to ensure appeals are reviewed by a person who was neither involved in the initial determination nor directly supervised by any person involved in the initial decision. According to the Plan, the CMO adjudicates all appeals. Additionally, there are occasions where the CMO also adjudicates prior authorizations. If the CMO is not available, it is possible for a Medical Director to

provide an evaluation of an appeal where another Medical Director has been involved, if the Medical Director has not had prior involvement in the case. However, this was not evident in the verification study of the three appeals.

If the Plan does not provide impartial adjudication of appeals, members are not afforded their rights as outlined in the Plan Contract.

Recommendation: Implement policies and procedures to ensure that the person making the final decision for resolution of an appeal has not participated in any prior decisions related to the appeal.

1.3.2 Written Consent

The Plan must ensure that its grievance and appeal system allows the member, or a provider or authorized representative with the member's written consent, to file a grievance, or request an appeal with the Plan either orally or in writing. (*Contract, Exhibit A, Attachment III, 4.6.1 Grievance and Appeal Program Requirements, A.*)

Appeals filed by the provider on behalf of the member require written consent from the member. The Plan must comply with this requirement in accordance with the DHCS Contract. (*APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates*)

Plan policy, *5510A Member Grievance and Appeal Policy* (revised August 9, 2024), stated that a member, a provider acting on behalf of the member, or an authorized representative may file a written or oral grievance and/or appeal. Appeals filed by the provider on behalf of the member require written consent from the member.

Finding: The Plan did not obtain the member's written consent when a provider filed an appeal on the member's behalf.

Managed care providers can appeal on behalf of a member who has received a service denial. This is often the case when the provider believes the services are medically necessary for the member's treatment. Appeals filed by the provider on behalf of the member require written consent from the member.

In a verification study, 3 of 25 appeals reviewed, dated in June, August, and September 2024, were initiated by the provider. For all three, the Plan did not obtain written consent from the members. Instead, the Plan documented oral notification in the records that the members were aware of the appeal, were in favor of filing the appeal, and had been working with their providers to obtain the previously denied services.

In a written narrative, the Plan stated that for provider-initiated appeals where member written consent was not submitted with the appeal, the Plan would reach out to the members and providers to obtain the written consent. In cases where the Plan was unsuccessful in obtaining written consent, the Plan would attempt to serve the best interests of the members by documenting that the members were aware of the appeal and were in favor of filing the appeal. Although member-centric, the Plan acknowledged that this practice was not consistent with contractual requirements and implemented a new process in December 2024.

Not obtaining written consent from a member when a provider files an appeal on their behalf may interfere with their autonomy, which is their right to make decisions about their medical care without their health care provider's influence.

Recommendation: Implement policies and procedures to ensure that the member's written consent is obtained when a provider files an appeal on their behalf.

COMPLIANCE AUDIT FINDINGS

Category 2 – Population Health Management and Coordination of Care

2.4 Continuity of Care

2.4.1 Member Notification of Continuity of Care Request Decision

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, 1.1.2*)

Plans must provide acknowledgement of COC requests within seven calendar days of the decision for non-urgent requests and within the shortest applicable timeframe that is appropriate for the member's condition, but no longer than three calendar days of the decision for urgent requests. A COC request is considered complete when a Plan notifies the member of its decision. A Plan must attempt to notify the member of the COC decision via the member's preferred method of communication or by telephone. Plans 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*)

Plan policy, 7264.2 *Continuity of Care* (revised October 3, 2024), stated that upon approval of a COC request, the Plan will notify the member using the member's known preference of communication or via phone call, text message, and then notice by mail.

Finding: The Plan did not notify members of the decision for non-urgent COC requests.

In a verification study, for three of ten records reviewed, the Plan did not notify members about the decision for non-urgent COC requests via their preferred method of communication or by telephone, nor did it send a notice by mail. When asked about the three records, the Plan stated in a narrative that it identified an issue with its system where a notification letter will not be mailed if there is missing member profile information. Missing member profile information may include an invalid address, a telephone number, or procedure code. The Plan began creating reports in September 2024 to monitor member notification letters that were not automatically generated, so the letters could be prepared manually and mailed the next day. The verification study showed:

- For one of the three records, which predated the process implementation, a letter was not generated due to a missing telephone number. However, the Plan still did not send notification letters for the remaining two records that had COC requests in September and November 2024, respectively.
- For the second record, the Plan approved the initial 30-day COC request received on September 10, 2024. The Plan sent a notice of action letter to the member on September 12, 2024. On September 13, 2024, the Plan received an extension COC request recommending the member receive care for six months. Although the Plan approved the request, there is no indication the member was notified by the member's preferred method of communication, telephone, or mail of the care extension from 30 days to 6 months.
- For the third record, the member did not receive a COC notification letter for the service requested.

Although the Plan implemented a new monitoring process, the reports only identify letters that were not generated due to missing member information. The Plan does not have an effective monitoring system to ensure notification letters are generated appropriately and sent to members.

If members are not notified of COC request decisions, there may be a delay to seek care or treatment which could lead to adverse health outcomes.

Recommendation: Revise and implement policies and procedures to ensure members are notified of COC request decisions.

2.4.2 Member Notification Letter of Continuity of Care Request Decision

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, 1.1.2*)

For COC requests that are approved, the Plan must include the following information in the notice: a statement of the Plan's decision, the duration of the COC arrangement, the process that will occur to transition the member's care at the end of the COC period, and the member's right to choose a different 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*)

Plan policy, 7264.2 *Continuity of Care* (revised October 3, 2024), stated that the approval request shall include the following: a statement of the Plan's decision, the duration of

the COC agreement, the process that will occur to transition the member's care at the end of the COC period, and the member's right to choose a different provider from the Plan's provider network.

Finding: The Plan did not include all required information in the COC approval notices sent to members.

In a verification study, for five of five records reviewed, the Plan's member notification letter did not include the process that will occur to transition the member's care at the end of the COC period and the member's right to choose a different network provider.

In a written statement, the Plan confirmed that it does not have a specific COC approval letter template. Instead, the Plan utilizes a general approval template for various cases, including COC requests. The Plan's reliance on a general approval template led to the omission of two required COC approval letter elements, as stated in Plan policy 7264.2. The Plan did not align its practices with established procedures.

If members are not fully informed about the COC transition process and the right to choose a different network provider, there may be an interruption in necessary care and services, which may put members' health and well-being at risk.

Recommendation: Implement policy and procedures to ensure the Plan's COC request approval member notification letter includes all required information.

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**REPORT ON THE MEDICAL AUDIT OF
COMMUNITY HEALTH GROUP FOUNDATION
DBA COMMUNITY HEALTH GROUP
PARTNERSHIP PLAN
FISCAL YEAR 2024-25**

Contract Number: 23-30249

Contract Type: State Supported Services

Audit Period: June 1, 2024 — March 31, 2025

Dates of Audit: April 21, 2025 — May 2, 2025

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I. INTRODUCTION

This report presents the results of the audit of Community Health Group Foundation dba Community Health Group Partnership Plan (Plan) compliance and implementation of the State Supported Services contract number 23-30249 with the State of California. The State Supported Services Contract covers abortion services with the Plan.

The audit covered the period of June 1, 2024, through March 31, 2025. The audit was conducted from April 21, 2025, through May 2, 2025, which consisted of a document review, verification study, and interview with the Plan administration and staff.

An Exit Conference with the Plan was held on October 23, 2025. No deficiencies were noted during the review of the State Supported Services Contract.

COMPLIANCE AUDIT FINDINGS

State Supported Services

The Contract requires the Plan to provide eligible members the following State Supported Services: Current Procedural Terminology (CPT) codes 59840 through 59857 and the Centers for Medicare and Medicaid Services Common Procedure Coding System codes X1516, X1518, X7724, X7726, and Z0336. These codes are subject to change upon the Department of Health Care Services implementation of the Health Insurance Portability and Accountability Act of 1996 electronic transaction and code sets provisions. (*State Supported Services Contract, Exhibit A*)

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

The Plan's policy, *7809a Claims for Abortion Services* (revised April 1, 2024), stated that the Plan covers abortions performed as a physician service. Abortion is a covered benefit regardless of the gestational age of the fetus. Medical justification and authorization for abortion are not required for outpatient care. However, inpatient hospitalization requires prior authorization under the same criteria as other medical procedures. The Plan covers CPT codes 59840, 59841, 59850 through 59852, 59855 through 59857, and Healthcare Common Procedure Coding System codes A4649, S0190, S0191, and S0199. Members may go to any provider of their choice for abortion services, at any time for any reason, regardless of network group.

The Plan informs members and providers about abortion services through the Member Handbook, the Provider Manual, and newsletters.

A review of 20 claims (10 paid and 10 denied) demonstrated that the Plan appropriately processed, paid, or denied abortion service claims within the required time frames.

Based on the review of the Plan's documents, no deficiencies were noted for the audit period.

Recommendation: None.