IMPERIAL COUNTY
Local Health Authority Commission

Regulatory Compliance Oversight Committee of the Commission

AGENDA

Date/Time: April 23, 2024, 2:00 PM
Location: Community Health Plan of Imperial Valley, 512 West Aten Road, Imperial, CA 92251

Members of the committee, staff and the public can attend the meeting in person at the address listed above. Public comments can be made live and in person at the meeting. To listen to the meeting via videoconference please join by calling +1 469-998-7368 (audio only, Phone Conference ID: 887 365 522) or clicking on the link below:

Click here to join the meeting
Meeting ID: 287 922 817 996
Passcode: Q9V2eW

All supporting documentation is available for public review at https://chpiv.org

Committee Members	Representing	Present
Dr. Allan Wu (Chair)	LHA Commissioner and Regulatory Compliance Oversight Committee Chair Innercare, Chief Medical Officer	
CHPIV Staff	**Job Title**	**Present**
Lawrence Lewis	Chief Executive Officer	
Elysse Tarabola	Chief Compliance Officer	
Dr. Gordon Arakawa	Chief Medical Officer	
Mark Southworth	Chief Financial Officer	
Michelle Ortiz-Trujillo	Senior Director of Human Resources and Community Services	
Chelsea Hardy	Senior Director of Compliance	
Jadira Alcaraz	Delegation Oversight Manager	
Rosa Sanchez	Compliance Advisor	
Fernanda Ortega	Delegation Oversight Specialist	
Amanda Delgado	Compliance Coordinator	
Donna Ponce	Executive Assistant/Commission Clerk	

1. Call to Order — Dr. Allan Wu, *Chair*

2. Roll Call — Donna Ponce, *Executive Assistant/Commission Clerk*

3. Approval of the Agenda — Dr. Allen Wu, *Chair*

   a. Items to be pulled or added from the Consent/Information/Action/Closed Session Calendar
   b. Approval of the order of the agenda

4. Public Comment — *Chair*

   This is an opportunity for members of the public to address the Commission on any subject matter within the Commission's jurisdiction. Any action taken as a result of public comment shall be limited to the direction to staff. When addressing the Commission, state your name for the record prior to providing your comments. Please address the Commission as a whole, through the Chairman. Individuals will be given 3 minutes to address the Commission;

groups or topics will be given a maximum of 15 minutes. Public comments will be limited to a maximum of 30 minutes. If additional time is required for public comments, they will be heard at the end of the meeting.

5.	Chairperson's Report	*Chair*
6.	Chief Compliance Officer Report (page. ##)	Elysse Tarabola, *Chief Compliance Officer*
	a. Compliance Training	Amanda Delgado, *Compliance Coordinator*
	b. Approve Updated and New Policies & Procedures	Chelsea Hardy, *Senior Director of Compliance* Dr. Gordon Arakawa, *Chief Medical Officer* Mark Southworth, *Chief Financial Officer*
	c. New All Plan Letters (APLs) and Status	Rosa Diaz, *Compliance Advisor*
	d. Regulatory Submissions	Chelsea Hardy, *Senior Director of Compliance*
	e. DHCS Transition Monitoring Results	*Senior Director of Compliance*
	f. Regulatory Member Issues	*Senior Director of Compliance*
	g. Go-Live Issues	Jadira Alcaraz, *Delegation Oversight Manager*
	h. Health Net Deliverables	*Delegation Oversight Manager*
	i. Pre-Delegation Audit	*Delegation Oversight Manager* Fernanda Ortega, *Delegation Oversight Specialist*
	j. Delegation Oversight Program Update	*Delegation Oversight Manager*
7.	Adjourn to Closed Session Pursuant to Welfare and Institutions Code § 14087.38 (m)	Dr. Allen Wu, *Chair*
8.	Reconvene in Open Session	*Chair*
9.	Adjournment	*Chair*

Regulatory Compliance Oversight Committee (RCOC)

April 23, 2024

Community Health Plan
OF IMPERIAL VALLEY

Agenda

- Welcome/Introductions
- Compliance Training
- Updated and New Policies and Procedures
- New All Plan Letters (APLs) Released and Status
- Regulatory Submissions
- DHCS Transition Monitoring Results
- Regulatory Member Issues
- Go-Live Issues
- Health Net Deliverables
- Pre-Delegation Audit
- Delegation Oversight Program Update

Compliance Training

Compliance Training

As of 3/18/2024, all CHPIV employees and Commissioners have completed Compliance Training

- On 1/2/2024 Compliance escalated noncompliance to the Compliance & Policy Committee
- Compliance reported noncompliance to the Finance & Executive Committee of the Commission on 1/3/2024 and the full Commission on 1/8/2024.
- Compliance coordinated with the Commission Clerk and CEO on following up with the Commissioners who have not completed training.
- On 2/2/2024, the number of noncompliant Commissioners decreased from 3 to 2.
- On 3/18/2024, the 2 remaining outstanding Commissioners completed the training.

Updated and New Policies and Procedures

Updated and New P&Ps

P&P #	P&P Name	Department	Functional Area	Summary of Changes
CMP-001	Writing and Processing P&Ps	Compliance	Compliance	Added section on dissemination to subcontractors; moved Compliance approval after legal approval
UM-003	Continuity of Care	Health Services	Utilization Management	DMHC Knox Keene updates
BH-001	Behavioral Health	Health Services	Behavioral Health	New Policy
QM-001	Quality Management and Improvement	Health Services	Quality Management	DMHC Knox Keene updates
CLM-001	Claims & PDR	Finance, Network & Informatics	Claims	DMHC Knox Keene updates
BC-001	States of Emergency	Finance, Network & Informatics	Business Continuity	DMHC Knox Keene updates & added DHCS requirements
PNM-001	Standards of Network Accessibility and Timely Access to Care	Finance, Network & Informatics	Provider Network Management	DMHC TAR filing & DHCS APL 23-006 updates
PNM-002	Provider Directory	Finance, Network & Informatics	Provider Network Management	DMHC Knox Keene updates

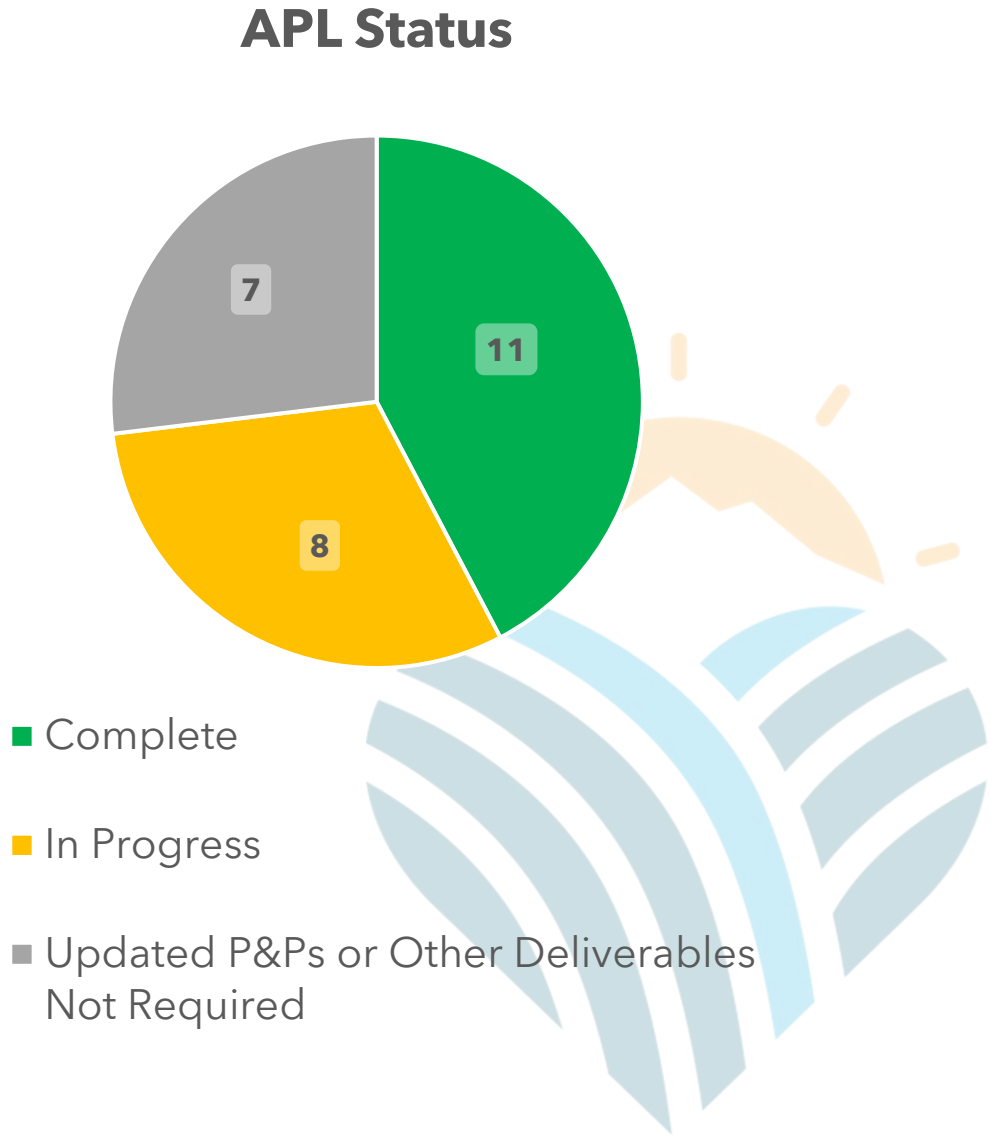
See Exhibit A – Policy Packet

New All Plan Letters (APLs) Released and Status

New APLs Released and Status

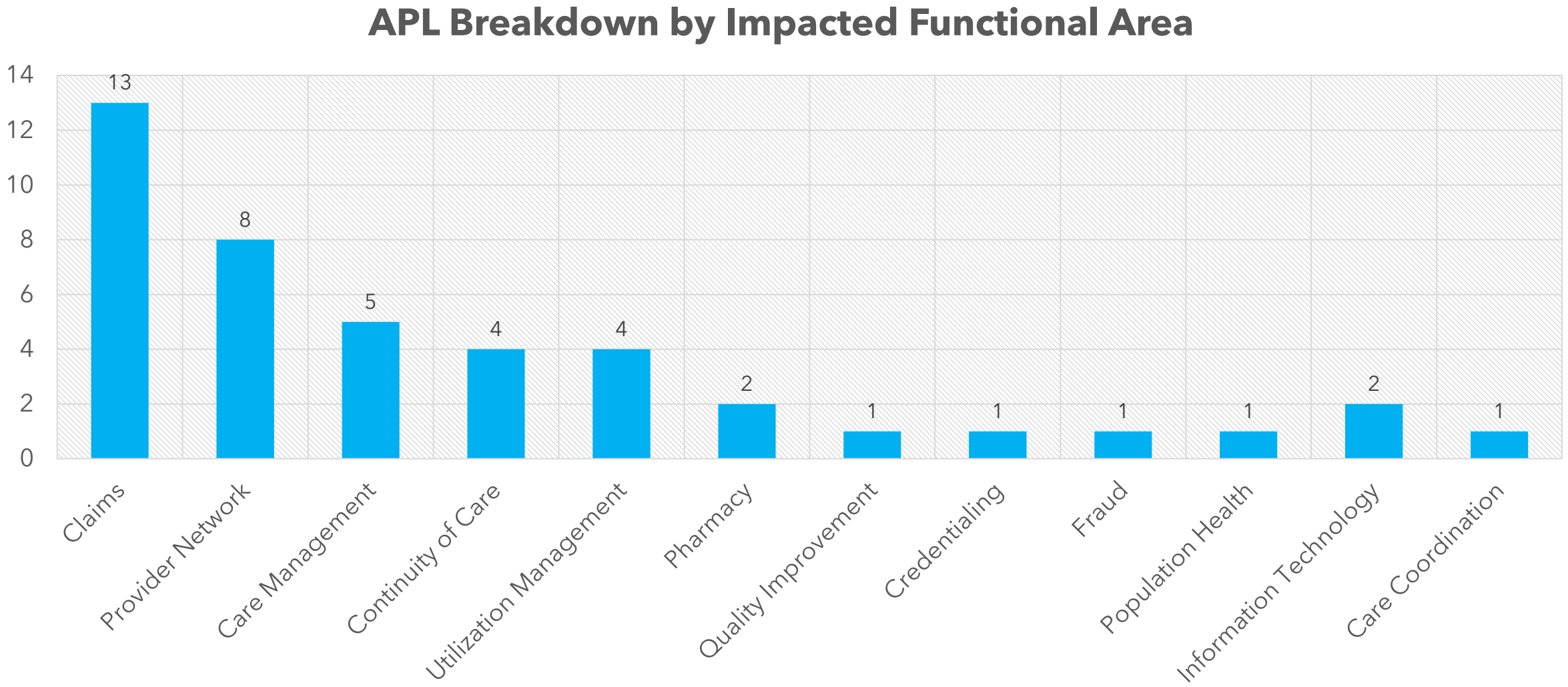
June 2023 - April 2024

- APLs are communications from DHCS & DMHC providing updates and guidance on policy changes and procedures.
- In most cases, Medi-Cal plans are expected to submit updated policies reflecting the APL updates or other deliverables outlined within the APL.
- 26 APLs released since June 2023
  - 24 DHCS
  - 2 DMHC
  - All were related to functions delegated to Health Net



New APLs released and Status

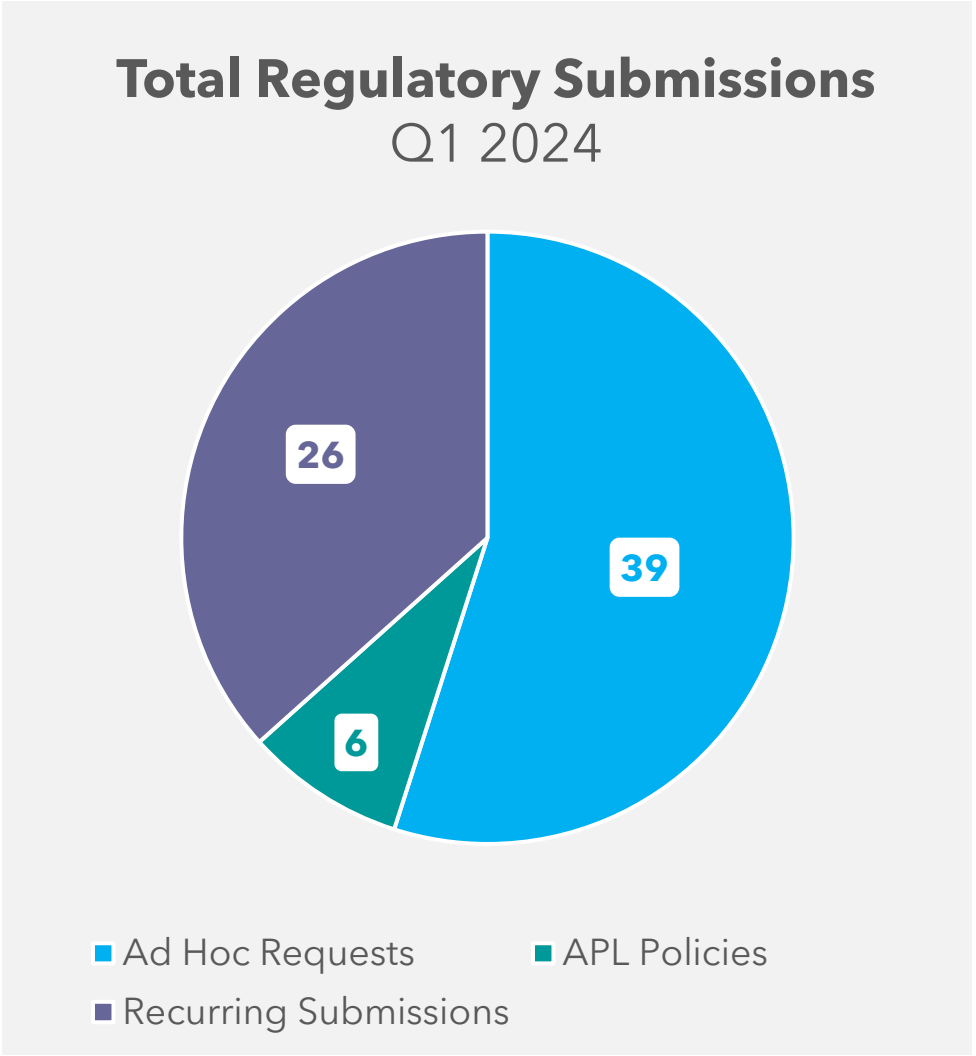
June 2023 - April 2024

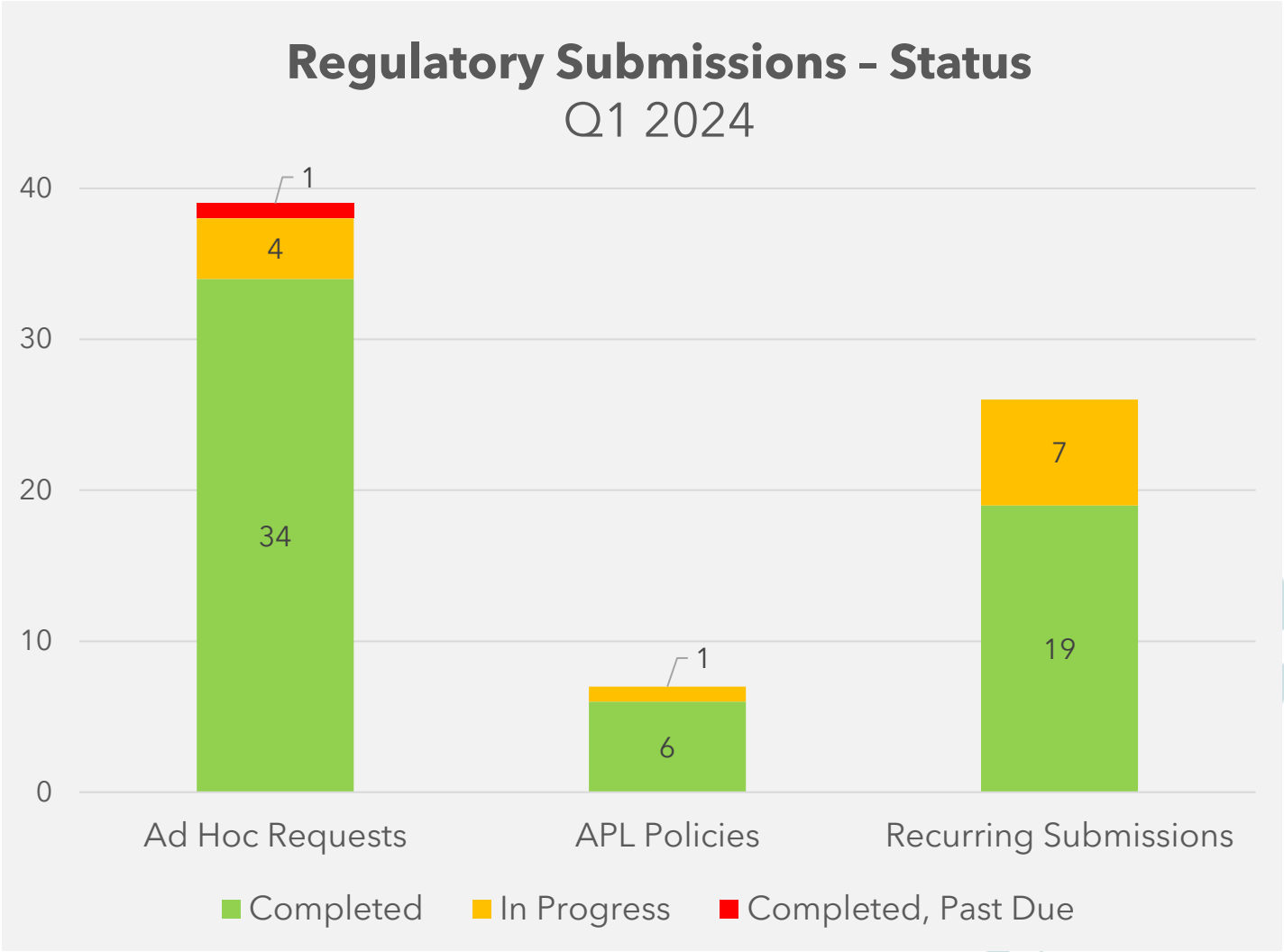


Regulatory Submissions

Regulatory Submissions – *Q1 2024*

Total Regulatory Submissions in Q1 2024: 71





DHCS Transition Monitoring Results

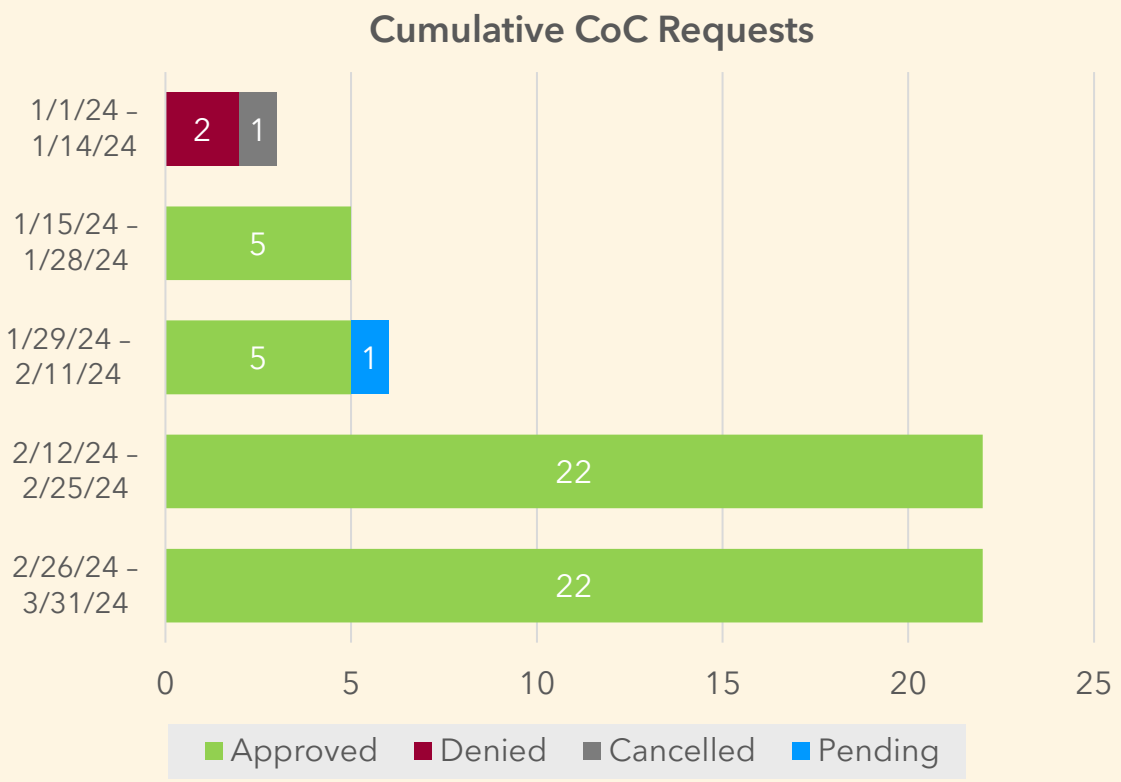
DHCS Transition Monitoring Results

- **Purpose:** Enables DHCS to monitor potential access to care or technical issues resulting from the transition.
- **Report Frequency:** every 2 weeks
- **Survey focus:**
  - Continuity of care (CoC)
    - ✓ All members & special populations (SP),
    - ✓ Enhanced Care Management (ECM) & Community Supports (CS) services & providers
  - Member issues
    - ✓ Reported via call centers
    - ✓ Reported through appeals & grievances (A&G).

DHCS Transition Monitoring Results

Continuity of Care

All Members



Special Populations

As of 3/31/2024, 10 eligible Specialty Population Providers were identified.

- 3 providers were brought into the network
- 7 providers entered CoC agreements

Community Supports

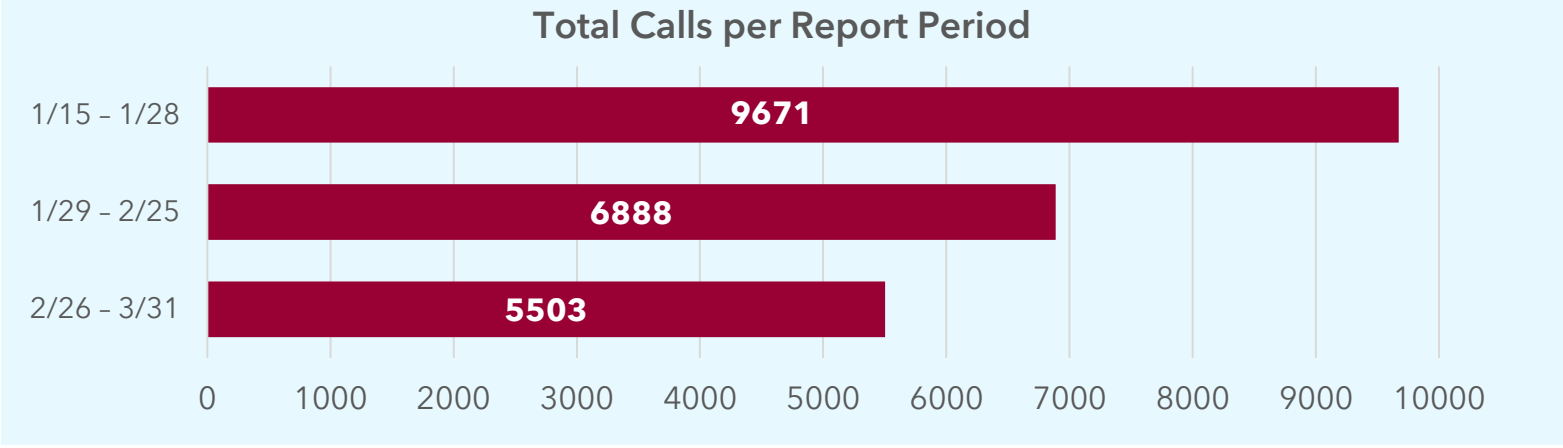
- 9 transitioning members automatically authorized to receive CS services
- No identified Community Supports providers out of network- all are in-network with CHPIV

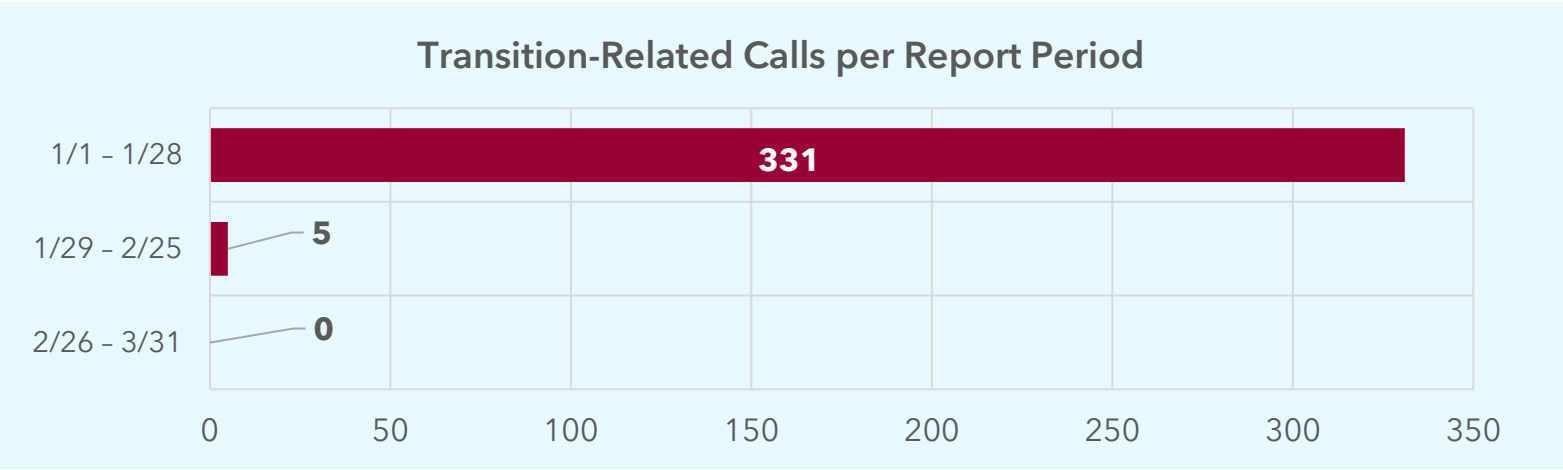
Enhanced Care Management

- 212 members automatically authorized to receive ECM services
- No identified Enhanced Care Management providers out of network- all are in-network with CHPIV

DHCS Transition Monitoring Results

Member Issues – *Call Center*



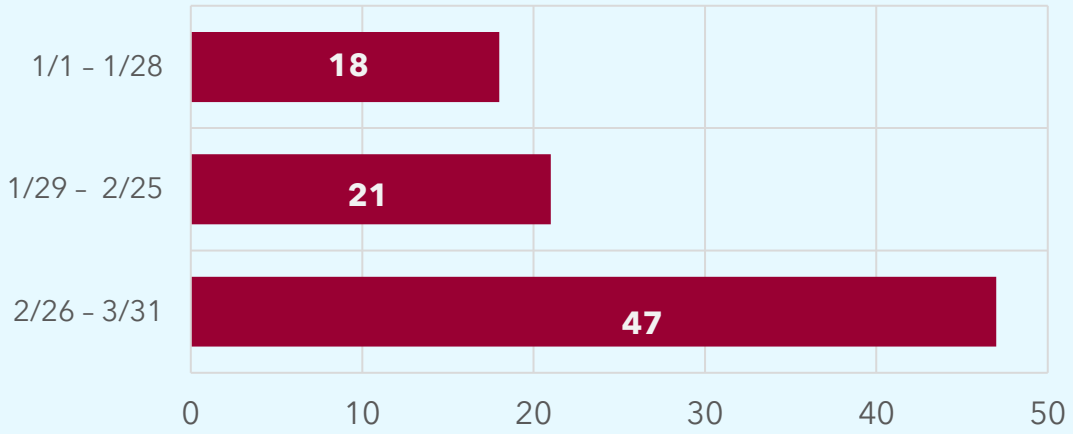


- Transition-related calls dropped significantly over the observed reporting periods with the eventual drop to zero throughout March 2024
- At the start of go-live, there was a high volume of transition-related calls specifically related to access to care (308 calls) which dropped to 7 calls at the end of January. February 2024 had zero access related calls.
- Low volume of other transition-related calls, including 11 calls on general transition and 10 calls regarding Continuity of Care for Transportation.

DHCS Transition Monitoring Results

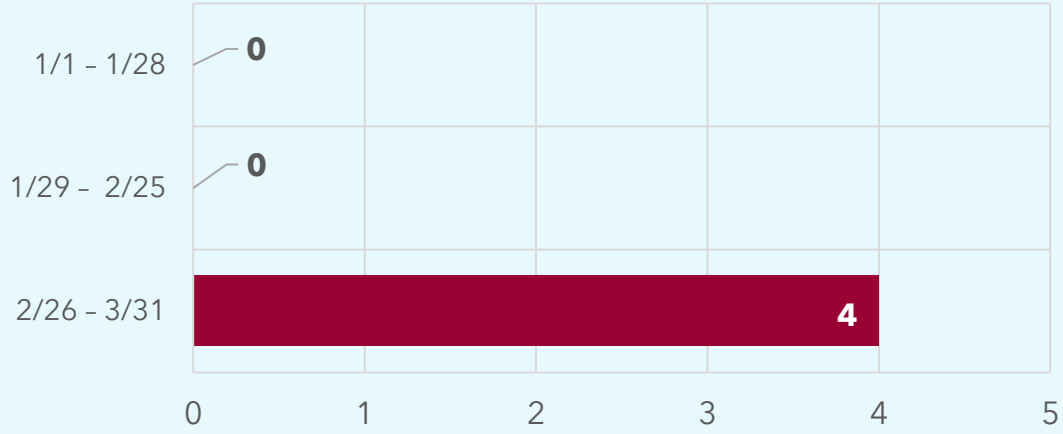
Member Issues – *Grievances & Appeals*

Transition-Related Grievances per Reporting Period



- **86** total grievances since go-live
  - Highest grievance categories are Provider Availability (15 grievances), Provider/Staff Attitude (16 grievances) & Transportation (28 grievances)
  - Other grievances related to timely response to auth/appeal requests, enrollment, Pharmacy, DME, Authorization, OP Physical Health, Plan Customer Service & CoC

Transition-Related Appeals per Reporting Period



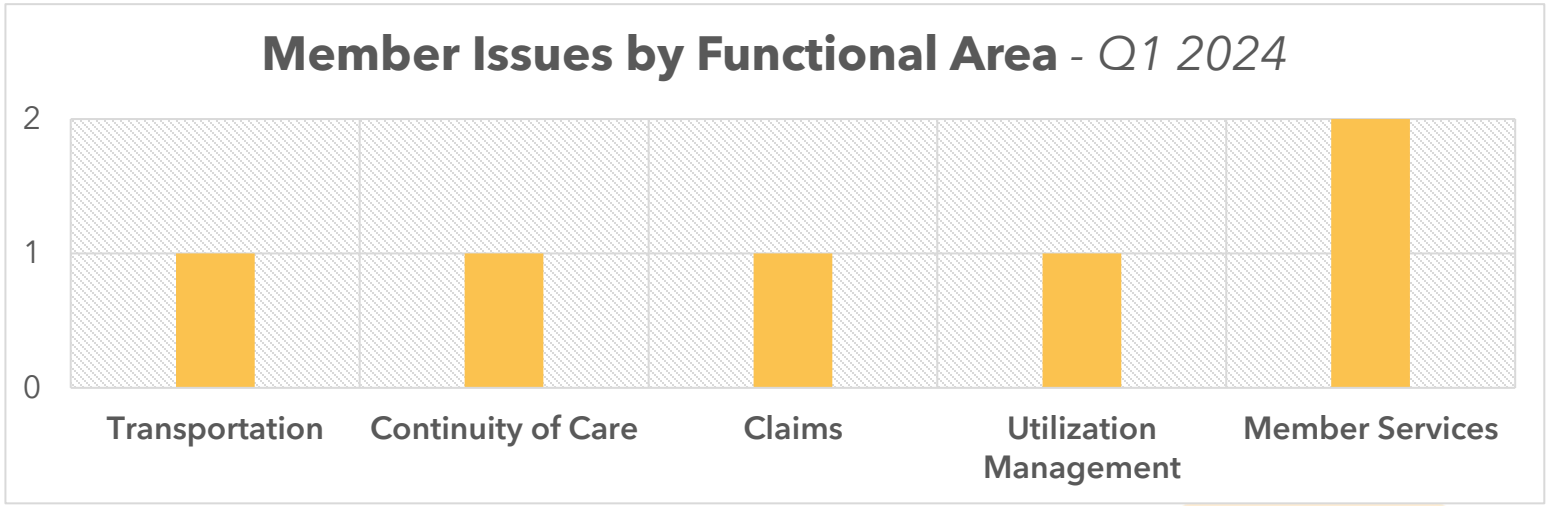
- **4** total appeals reported since go-live
  - All 4 related to denial or limited authorization of a requested service
    - 1 inpatient physical health
    - 3 outpatient physical health

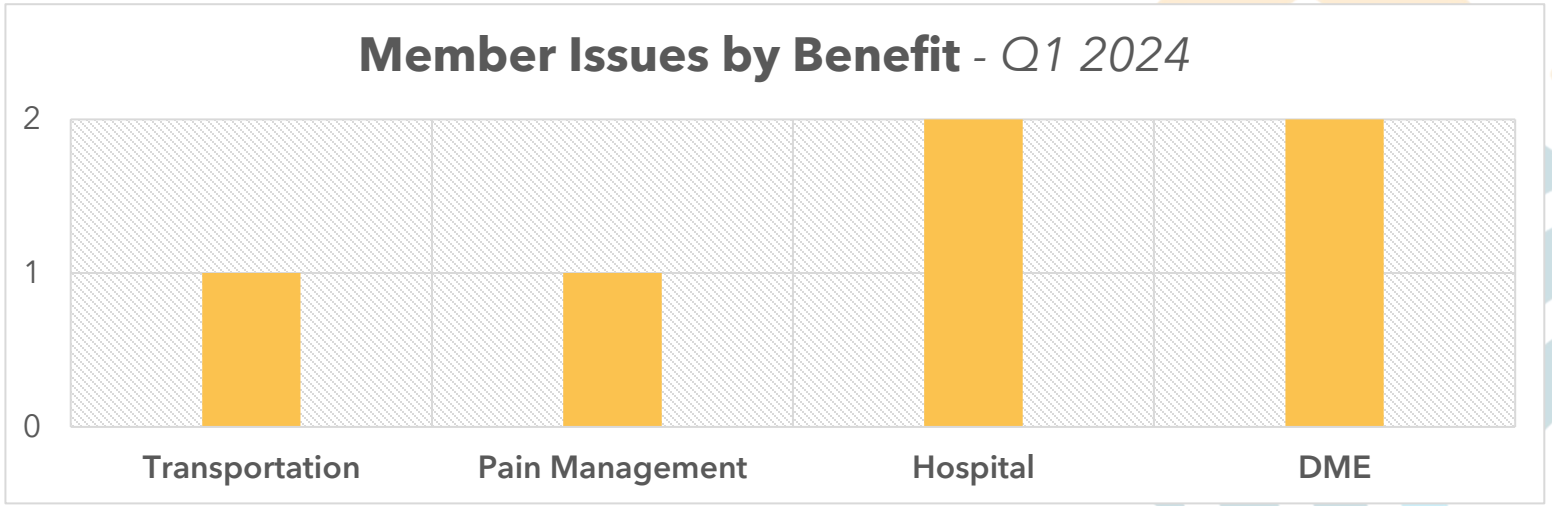
Regulatory Member Issues

Regulatory Member Issues – *Q1 2024 Trends*

Regulatory member issues occur when members directly report concerns to regulators, who then notify us and request resolution.

- 6 total regulatory member issues in Q1 2024
  - 1 DMHC Complaint
  - 1 DMHC Independent Medical Review (IMR) Request
  - 4 DHCS Ombudsman Complaints

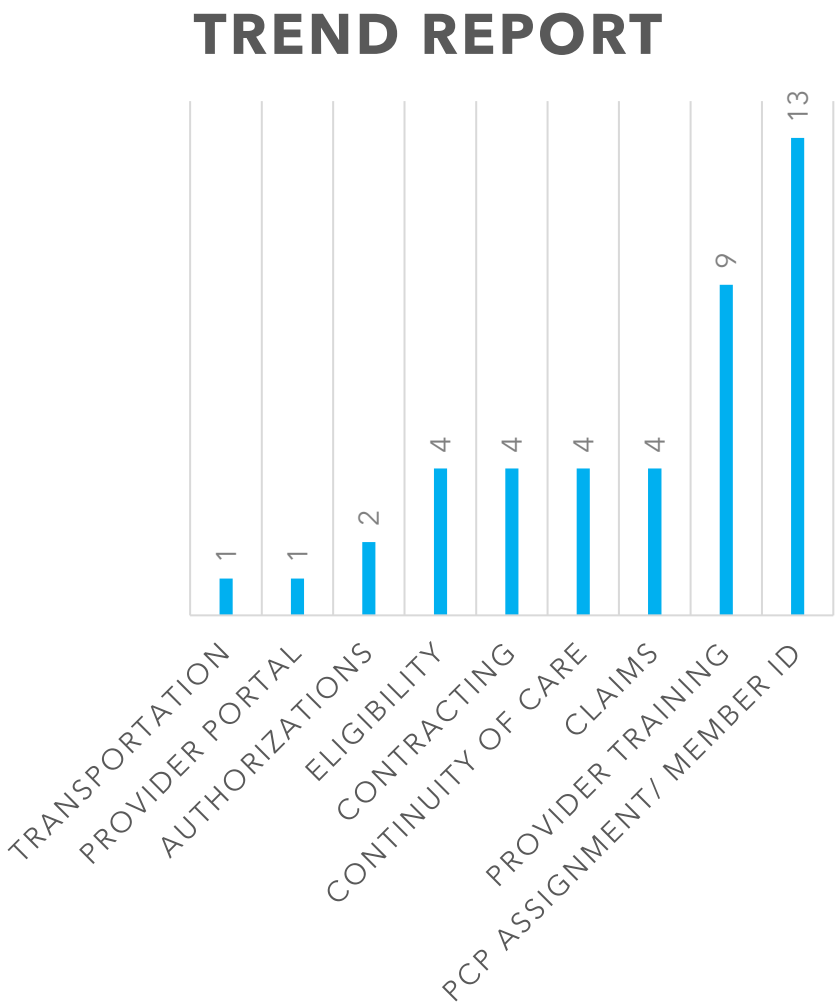




No trends identified in Q1 2024 that require corrective action.

Go-Live Issues

Go-Live Issues – Trend Report

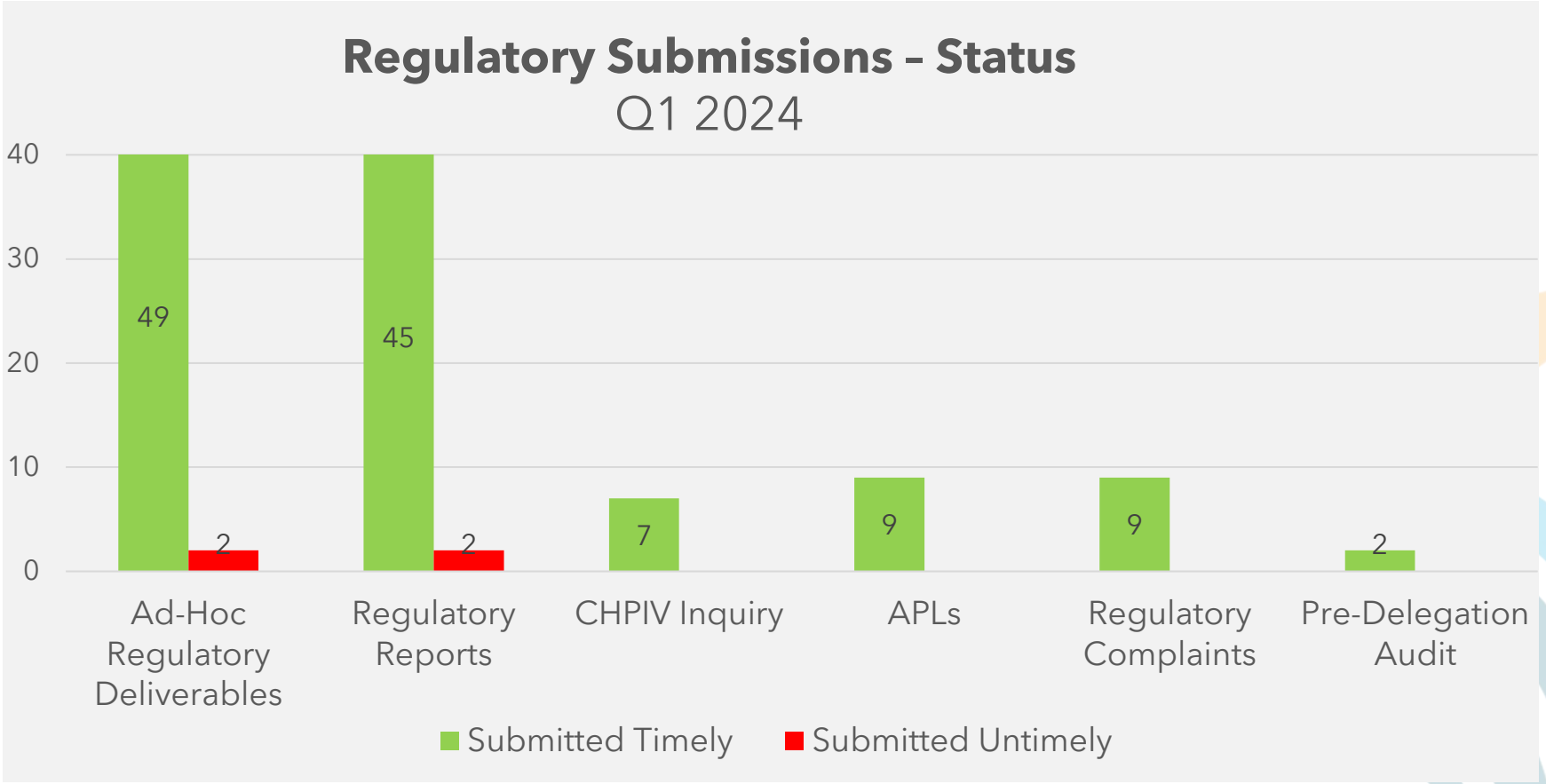


Trend	Trend Description	Summary of Resolution
PCP Assignment / Member ID	Issues related to provider contract types being displayed incorrectly in the system, affecting PCP assignments and Member IDs.	• A manual process has been put in place to manage PCP transfers. Seems to serve as an interim solution while systemic fixes are developed. • Health Net's Provider Network team tasked with identifying and rectifying gaps in provider data.
Provider Training	Providers expressed lack of clarity about procedural changes tied to the transition. Specific concerns include the absence of provider orientation, challenges in using support systems like toll-free numbers, and questions about billing and patient care protocol	• Direct outreach to providers aiming to address confusion and clarify any changes or requirements. • Targeted communication and training sessions to address individual provider concerns • Continued provider education

Health Net Deliverables

HN Deliverables Submissions

Total Deliverables Submissions in Q1 2024: 125



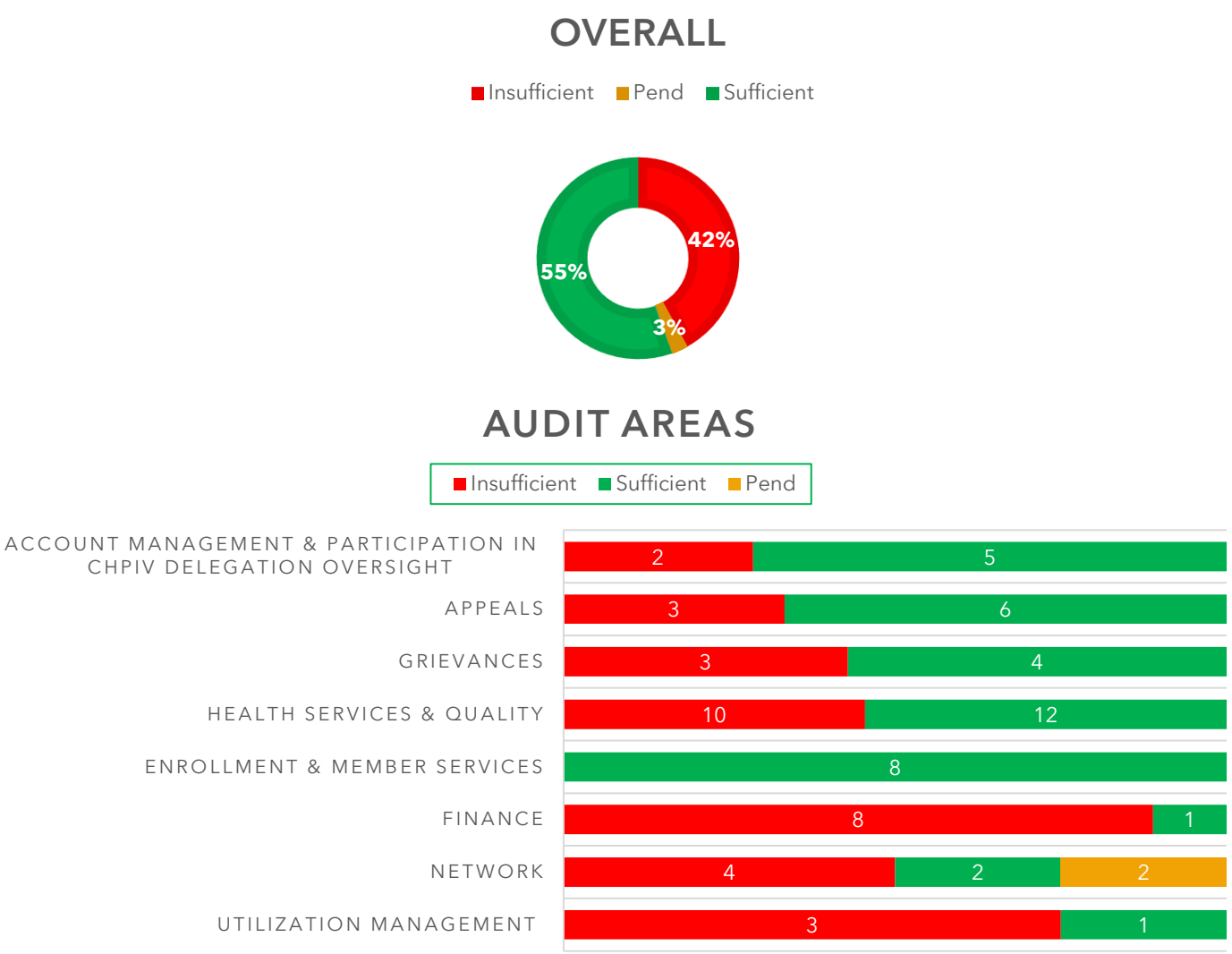
Health Net's untimely submissions in Q1 2024 resulted in CHPIV having to request an extension from our regulators.

Pre-Delegation Audit

Pre-Delegation Audit - Overview

Phase	Audit Scope	Scope Overview	Status	CAPs Issued
1	Processes and Workflows	Review Health Net's processes and workflows to ensure readiness to meet Plan-to-Plan and DHCS requirements	Closed	Yes
2	KPIs and Finance Reports	Tests Health Net's ability to submit complete and accurate data to CHPIV to measure compliance and performance	Closed	No
3	DHCS 2023 APL Implementation	Validate Health Net's timely implementation of regulatory changes issued by DHCS in 2023	Closed	No

Pre-Delegation Audit – Phase 1 Results



Audit Scope: Processes and Workflows

CHPIV Review Health Net's processes and workflows to ensure readiness to meet Plan-to-Plan and DHCS requirements

Audit Trends

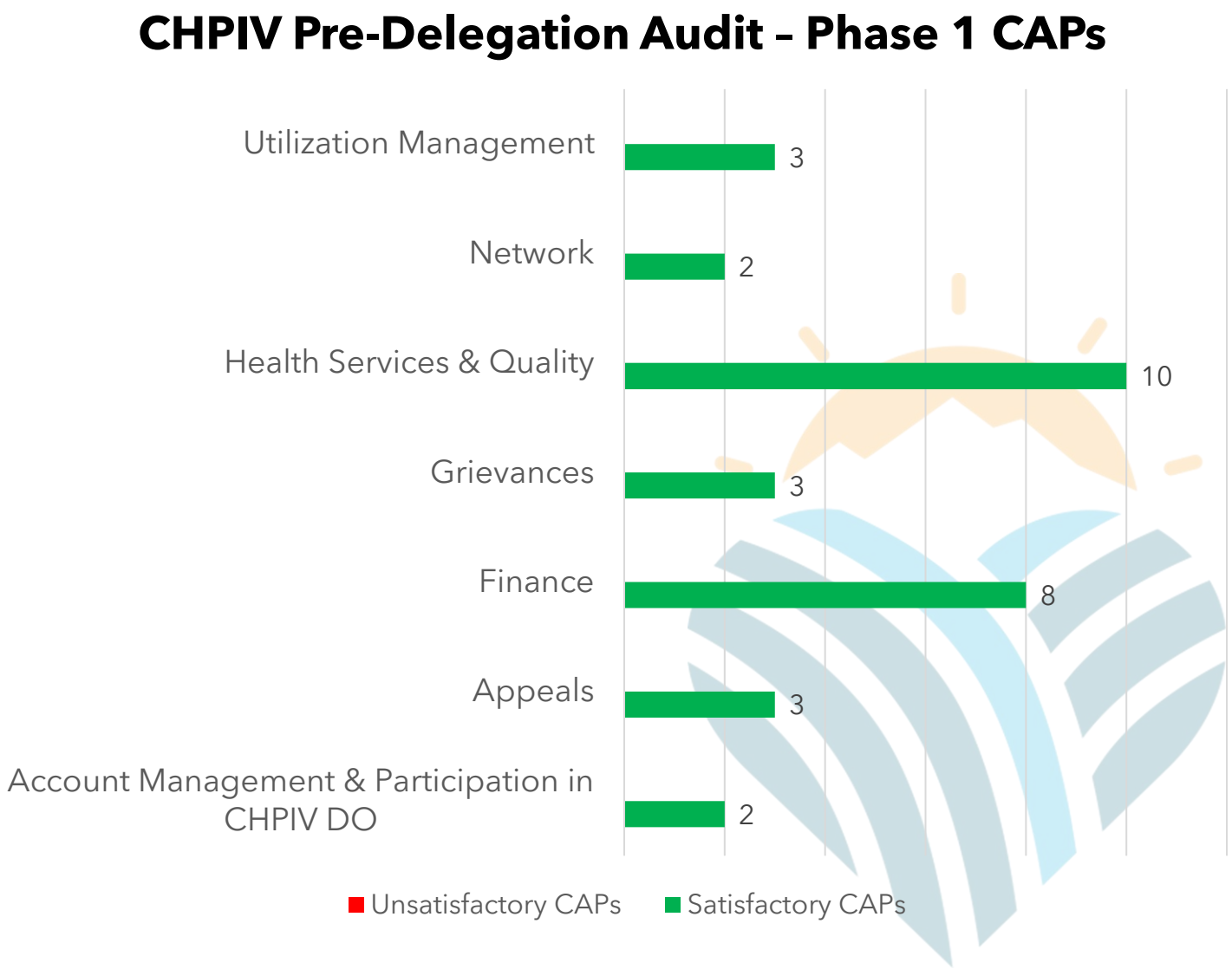
1. **Incomplete Documentation and Evidence:** HN provided narratives but lacked supporting documents to validate completion.
2. **Lack of Procedures for Noncompliance and Escalation:** No processes for reporting severe noncompliance or systemic deficiencies, and no clear steps to identify and escalate issues.
3. **Training Gaps:** No evidence of deployed training or CHPIV-specific materials, despite mentions of training.
4. **System and Process Configuration Issues:** Claims and UM systems not yet set up for CHPIV-specific data.
5. **Timelines and Workplans Missing:** No clear plans or deadlines for implementing changes and updates.
6. **Procedures or Policies:** P&Ps lacking CHPIV-specific processes or adequate details to meet requirements.

See Exhibit B – Pre-Delegation Audit Report Phase 1

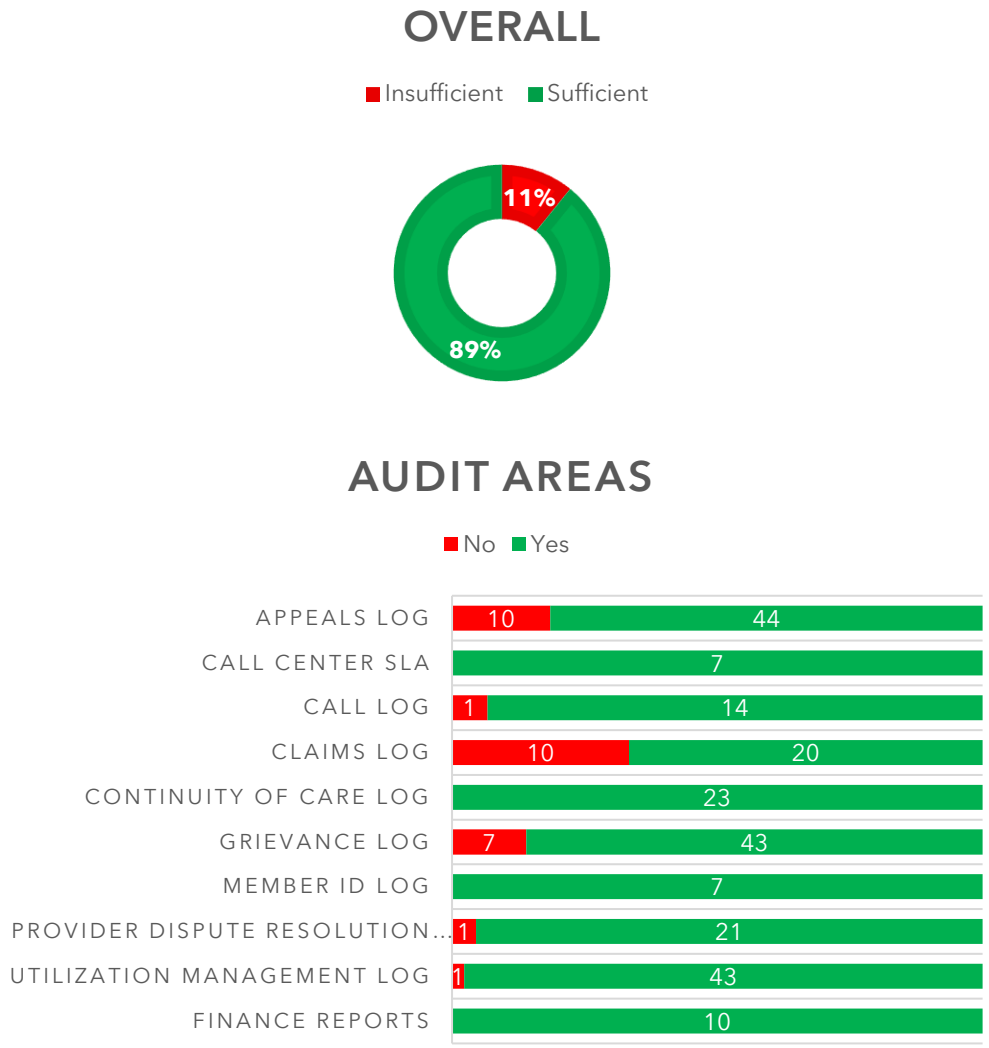
Pre-Delegation Audit – Phase 1 CAPs

Background

- CHPIV issued total of **31 Corrective Action Plans (CAPs)**
  - 12 of the 31 CAPs were deemed **unsatisfactory** and Health Net was required to submit additional documentation
- Health Net submitted CAP responses on 2/28/2024, and additional documents on 3/25/2024.
- CHPIV review was completed on 03/25/2024
- 12 of the 12 remaining open/ unsatisfactory CAPs were deemed satisfactory.
  - CAP Closure Letter was sent to Health Net on 3/26/2024.



Pre-Delegation Audit – Phase 2 Results



Audit Scope: KPIs and Finance Reports

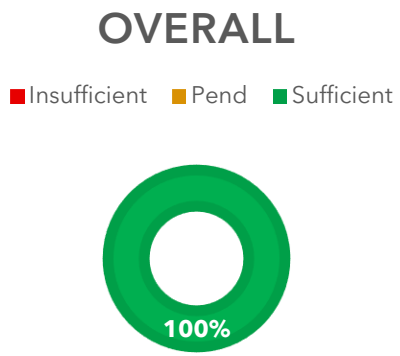
CHPIV tested Health Net's ability to submit complete and accurate data to CHPIV to measure compliance and performance

Audit Trends

1. **Validation Issues:** There is a recurring inability to validate if reports apply to expedited appeals/grievances, indicating a documentation gap or lack of clear process distinction.
2. **Data Field Compliance**: Unable to validate key fields tied to regulatory requirements and SLAs as they are not required in audit logs, hindering performance measurement.
3. **Comprehensive Reporting:** Incomplete log submissions lack category-specific templates required for validation of regulatory requirements.

See Exhibit C – Pre-Delegation Audit Report Phase 2

Pre-Delegation Audit – Phase 3 Results



Audit Areas	Results
APL 23-001	Sufficient
APL 23-003	Sufficient
APL 23-004	Sufficient
APL 23-005	Sufficient
APL 23-006	Sufficient
APL 23-007	Sufficient
APL 23-008	Sufficient
APL 23-009	Sufficient
APL 23-010	Sufficient
APL 23-011	Sufficient
APL 23-013	Sufficient
APL 23-014	Sufficient
APL 23-015	Sufficient
APL 23-016	Sufficient
APL 23-017	Sufficient
APL 23-019	Sufficient
APL 23-020	Sufficient
APL 23-021	Sufficient
APL 23-022	Sufficient
APL 23-023	Sufficient
APL 23-024	Sufficient

Audit Scope: DHCS 2023 APL Implementation

CHPIV validated Health Net's timely implementation of regulatory changes issued by DHCS in 2023

Audit Trends

No trends observed during Phase 3 of the pre-delegation audit. **CHPIV issued audit report with a final score of 100% and no Corrective Action Plans (CAPs) required**

See Exhibit D – Pre-Delegation Audit Report Phase 3

Pre-Delegation Audit - Conclusion

- Findings issued during the Pre-Delegation Audit were due to Health Net not submitting required documents during the audit period.

- After audit reports were issued, Health Net was able to submit additional documentation and demonstrate operational readiness.

- Now that CHPIV is live, we will continue to oversee Health Net's operations performance through ongoing monitoring and audits.

DO Monitoring Program

CHPIV DO Monitoring Program

- CHPIV has developed a detailed protocol outlining expectations and processes, including a comprehensive list of Key Performance Indicators (KPIs), timelines, reporting frequency, and report specifications.

- The protocol was sent to Health Net for review and approval, with additional revisions made to the DO Monitoring Protocol. Key revisions to the updated CHPIV DO Monitoring Protocol include:
  - Health Net will submit monthly KPI metrics (self-reported data)
  - Universes/Logs will be submitted quarterly instead of monthly
  - Quarterly data validations to ensure report accuracy and verify self-reported KPI metrics

- CHPIV conducted a crosswalk of Health Net's self-reported data against our quantitative KPIs.
  - Our preliminary review revealed that the self-reported monthly metrics provided by Health Net include performance scores but do not capture all CHPIV KPIs, including metrics referenced in the Plan-to-Plan.
  - Health Net was requested to provide responses and/or additional documentation to fulfill the missing KPI metrics.

See Exhibit E –Monitoring Program Draft Redline

Questions

	Writing And Processing Policies and Procedures	CMP-001
Department	Compliance	
Functional Area	Compliance	
Impacted Delegate	☐ Subcontractor ☒ NA	

DATES			
Policy Effective Date	6/12/2023	**Last Revised Date**	
Next Annual Review Due	6/12/2024	**Regulator Approval**	Not Applicable

APPROVALS			
Internal		**Regulator**	
Name	Elysse Tarabola	☐ DHCS ☒ NA ☐ DMHC	
Title	Chief Compliance Officer		

ATTACHMENTS

- Attachment A – Policy Template
- Attachment B – Policy Template Guide
- Attachment C – Definitions Repository

AUTHORITIES/REFERENCES

- Medi-Cal Managed Care Division (MMCD) All-Plan Letter 00-003, "Policy and Procedure Revisions"

HISTORY

Revision Date	Description of Revision
6/12/2023	Policy created

I. OVERVIEW

A. Community Health Plan of Imperial Valley (CHPIV) will develop policies and procedures that define the rules governing organizational actions, that assign organizational functions and responsibilities, and that demonstrate compliance with regulatory, contractual, and accreditation requirements. CHPIV's Compliance Department is the designated responsible organizational unit and repository for all CHPIV policies and procedures.

II. POLICY

A. Policies and procedures shall be developed and processed in accordance with this policy and procedure, including the documents included in the "References" and "Attachments" sections of this policy and procedure, and documented by using CHPIV's system of record.
B. All CHPIV policies and procedures, and the applicable attachments, shall be made accessible to all employees on the CHPIV One Drive.
C. The Compliance Department is authorized to revise the policy and procedure template, as well as the policy and procedure process, without immediate revisions to this policy and procedure. CHPIV departments are not required to implement a revised template until the next review date for their policies and procedures, including annual review or immediate review and revision because of changes to state and federal regulatory, contractual or accreditation requirements.
D. Policies and procedures should be reviewed and revised, immediately, if changes are necessary to comply with new or revised state and federal regulatory, contractual and accreditation requirements. CHPIV departments must not wait until the annual review date to make such changes.
E. Changes to attachments and references may require changes to be made to the policies and procedures.

III. PROCEDURE

A. Drafting Policies and Procedures
    1. The ORIGINATOR will draft new policies and procedures or revise existing policies and procedures.
        a. The Overview should reflect the scope, purpose, and background of the policy.
        b. The Policy should outline CHPIV's guidelines for how to conduct business and reflect the requirements that the implemented process will satisfy.
        c. Policies involving multiple functional areas require cross-functional collaboration that involves all functional owners and agreement on drafted policy language.
        d. All revisions to existing policies must be redlined and indicate reference to the regulatory, contractual, or accreditation requirement, as applicable.
        e. The procedures should describe the process that is being implemented to satisfy the requirements in the policy.
            i. All policies should have procedures in the same document.
            ii. All procedures should be linked to a policy, either in the same document or by reference.

A. If DESKTOP PROCEDURES are required (desk level procedures, technical procedures, job aids, etc.), then a separate document is appropriate and should be listed in the "Attachments" section.
B. DESKTOP PROCEDURES (desk level procedures, technical procedures, job aids, etc.) do not have to go through the formal approval process outlined in the Approval Processing section of this policy.

iii. Definitions should be included in the policies and procedures templates.
A. Definitions should be specific to the policies and procedures.
B. The ORIGINATOR should use the standardized definitions, provided by the Compliance Department.
C. If the ORIGINATOR has a new definition or has a suggested change for an existing definition, it must be submitted to the Compliance Department at compliance@chpiv.org for review and addition to the standardized definitions.

iv. For assistance with regulatory, contractual, and accreditation requirements, the policy ORIGINATOR should consult with the Compliance Department, prior to submitting policies and procedures into CHPIV's system of record.

2. Once the policy and procedure is ready for review and approval, the ORIGINATOR will submit the draft policy to Compliance to begin the Approval Process

B. Standard Approval Process

1. The following reviews will occur consecutively as applicable.

~~a. Compliance Review~~
~~i. The Compliance Department shall review all policies and procedures.~~
~~ii.i. Compliance will have seven (7) calendar days to review.~~

~~b.~~a. NCQA Review
i. If the policy or procedure is being used to fulfill National Committee for Quality Assurance (NCQA) requirements, designated staff within Health Services shall review.
ii. Designated staff within Health Services will have seven (7) calendar days to review.

~~c.~~b. Legal Review
i. If the policy or procedure is related to Human Resources processes, CHPIV's Legal team shall review.
ii. If the policy or procedure is required to be filed with DMHC, CHPIV's Legal team may review at the discretion of the ORIGINATOR or Compliance.
iii. Legal will have seven (7) calendar days.

c. Compliance Review
i. The Compliance Department shall review all policies and procedures.
Compliance will have seven (7) calendar days to review.

d. Committee Review
i. After Compliance, NCQA, and/or Legal review, Compliance will notify the ORIGINATOR. The ORIGINATOR will take the policies and procedures to the COMPLIANCE & POLICY COMMITTEE (CPC) for review and approval.
ii. If the CPC requests changes to be made to the policies and procedures, and the changes impact the sections reviewed by Compliance, NCQA,

and/or Legal, the policies and procedures may need to revisit one or more of the previous steps in the review process, prior to being approved.

e. COMMISSION Review:
   i. After CPC approval, Compliance will notify the ORIGINATOR. The ORIGINATOR will take the policies and procedures to the Regulatory Compliance Oversight Committee of the COMMISSION for review and approval.
   ii. The COMMISSION approval is considered the final approval.

C. Expedited Approval Process
1. The Expedited Approval Process applies when there is an urgent regulator submission that the Standard Approval Process timeframes will not meet.
2. The following reviews will occur concurrently, as applicable. The timeframe for the concurrent review will be determined by Compliance based on regulator due dates.
   ~~a. Compliance Review~~
      ~~i. The Compliance Department shall review all policies and procedures.~~
   ~~b.~~a. NCQA Review
      i. If the policy or procedure is being used to fulfill National Committee for Quality Assurance (NCQA) requirements, designated staff within Health Services shall review.
   ~~c.~~b. Legal Review
      i. If the policy or procedure is related to Human Resources processes, CHPIV's Legal team shall review.
      ii. If the policy or procedure is required to be filed with DMHC, CHPIV's Legal team may review at the discretion of the ORIGINATOR or Compliance.
   c. Compliance Review
      i. The Compliance Department shall review all policies and procedures.

3. Committee Review
   i. After Compliance, NCQA, and/or Legal review, Compliance will send the policy for unanimous electronic committee approval.
   ii. If the CPC requests changes to be made to the policies and procedures, and the changes impact the sections reviewed by Compliance, NCQA, and/or Legal, the policies and procedures may need to revisit one or more of the previous steps in the review process, prior to being approved.
4. COMMISSION Review:
   i. After CPC approval, Compliance will send the policies and procedures electronically to the chair of the Regulatory Compliance Oversight Committee of the COMMISSION for review and approval.
      A. The Chair of the Regulatory Compliance Oversight Committee of the COMMISSION is the designated reviewer for the expedited approval process.
   ii. The COMMISSION approval is considered the final approval.

D. Posting
1. After COMMISION approval, Compliance will
   a. Remove all red-lines and comments from the policies and procedures
   b. Formatting

c. Complete the review or revision details to the History section of the policies and procedures
d. Add the appropriate dates
    i. The Commission approval date is the Policy Effective Date/Last Revised Date.
e. Publish the policies and procedures to CHPIV's system of record.

2. At any time, the CHIEF COMPLIANCE OFFICER (CCO), the COMPLIANCE & POLICY COMMITTEE (CPC) and/or the COMMISSION can review policies and procedures, and request changes to be made by the ORIGINATING DEPARTMENT.

E. When approval is not required
1. Polices and Procedures are not required to go through the formal approval processes outlined above if the revisions include non-substantive changes.
    a. Examples of non-substantive changes include formatting changes, updates to definitions, changes to header information, and corrective typos.
2. Updated policies and procedures that do not require formal approval shall be submitted to Compliance to be posted to the P&P Repository.

F. Regulatory Agency Filings
1. The Compliance Department will ensure that all applicable policies and procedures are filed with the appropriate regulatory agencies, to demonstrate compliance with laws and regulations.
    a. CHPIV is required to file certain policies and procedures with DMHC within thirty (30) calendar days after its effective date or review date.
    b. Regulatory agencies may request revisions to CHPIV policies.
2. The Compliance Department can request that changes be made to policies and procedures prior to submitting them to regulatory agencies.
    a. Substantive revisions, especially revisions due to non-compliance, will be required to be routed back through the full review process.

G. Policy and Procedure Archives
1. The Compliance Department will maintain an archive of all policies and procedures, as well as policy-related written correspondence submitted to and received from SUBCONTRACTORS, for a period of ten (10) years.

H. Annual Review
1. All policies and procedures must be reviewed by the ORIGINATING DEPARTMENT, on an annual basis.
    a. The ORIGINATOR will review the policies and procedures, to ensure that they reflect the most current state and federal regulatory, contractual and accreditation requirements. If significant or material revisions are made to a policy and procedure, it may need refiling with the DMHC and/or other regulatory agency.
    b. The ORIGINATOR will ensure that the policies and procedures are on the current template, and will follow the appropriate process outlined herein, and in all supporting documents.
    c. Failure to review the policies and procedures by the due date could result in the following DISCIPLINARY ACTIONS for the management of the ORIGINATING DEPARTMENT:
        i. Reporting to ICC
        ii. Requirement for submission of a CORRECTIVE ACTION PLAN (CAP)

I. Dissemination of P&Ps to SUBCONTRACTORS

1. The ORIGINATOR and Compliance department will identify which P&Ps need to be disseminated based on delegated functions, relevance, regulatory obligations, and business needs.
2. When a new P&P or update to an existing P&P is developed, CHPIV will disseminate it to the relevant subcontractors and delegated entities.
3. P&Ps are shared via email.
4. Any time a regulatory change affects a P&P, the policy will be updated and redlined to clearly show changes.
5. Upon receipt of the P&Ps, SUBCONTRACTOR is required to acknowledge receipt and understanding.
6. The Compliance Department maintains a log of all P&Ps sent, the date of acknowledgment, and any feedback or queries raised by the recipient.
7. As needed, CHPIV will provide training sessions or support materials to subcontractors/delegated entities to aid in the understanding and implementation of the P&Ps.
8. SUBCONTRACTORS are encouraged to provide feedback or seek clarifications on any P&Ps. Feedback will be reviewed by the ORIGINATING DEPARTMENT and Compliance Department and, where necessary, changes will be made to the P&Ps or additional guidance provided.

IV. DEFINITIONS

Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the "Definitions" below.

TERM	DEFINITION
Chief Compliance Officer (CCO)	CHPIV staff member who serves as the focal point for compliance activities as well as manages the Compliance Department of CHPIV. The CCO reports directly to the Chief Executive Officer and the COMMISSION. The CCO is responsible for developing, operating, and monitoring the compliance program. This includes establishing an auditing and monitoring plan, overseeing compliance audit functions, continuously reviewing organizational risk areas to identify necessary auditing and monitoring activities, assisting in the formulation of correction action plans, and overseeing and/or verifying implementation of corrective action.
Commission	The governing body of the Local Health Authority (LHA). It is comprised of thirteen voting members that represent different sectors of the health system, the public, Medi-Cal beneficiaries, and businesses as outlined in LHA Establishing Ordinance.
Compliance & Policy Committee (CPC)	An internal committee comprised of CHPIV management staff that monitors compliance activities and makes recommendations for action to CHPIV staff, including CHPIV's executive staff, and the Commission.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CHPIV, the Centers

	for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CHPIV departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CHPIV and its regulators.
Desktop Procedure	Document used to provide additional detailed information that is not in a policy but will assist in conducting day-to-day operations (also known as technical procedures or job aids).
Disciplinary Action	A formal action taken in response to unacceptable performance or misconduct.
Originating Department	Any department within CHPIV that develops, produces, manages, coordinates, and/or submits any Member Communications material or policies and procedures to the Compliance Department for review and to obtain approval from the Regulatory Agencies.
Originator	Member of a department that is designated to submit and process policies and procedures for their department.
Subcontractor	An individual or entity that has a subcontract with the MCP that relates directly or indirectly to the performance of the MCP's obligations under the contract with DHCS. A network provider is not a subcontractor by virtue of the network provider agreement, as per 42 CFR § 438.2.

	Continuity of Care	UM-003
	Department	Health Services
	Functional Area	Utilization Management
	Impacted Delegate	☒ Subcontractor ☐ NA

DATES			
Policy Effective Date	6/12/2023	**Reviewed/Revised Date**	
Next Annual Review Due	6/12/2024	**Regulator Approval**	

APPROVALS			
Internal		**Regulator**	
Name	Gordon Arakawa, MD	☐ DHCS ☒ DMHC	☐ NA
Title	Chief Medical Officer		

ATTACHMENTS

NA

AUTHORITIES/REFERENCES

- **Internal**
  - CHPIV, Delegation Oversight Policy and Procedure, CMP-002
- **Federal**
  - Title 42 Code of Federal Regulations ("CFR") 418.3
- **State**
  - California Health and Safety Code Sections ("H&S Code") 1367(d), 1373.95, 1373.96
  - Title 22 California Code of Regulations Rules ("CCR") 51340, 51340.1, 53887, 53923.5
  - Title 28 CCR Rules 1300.67.1 (a) – (e); 1300.67.1.3 (b)
  - DMHC: Technical Assistance Guide ("TAG") "Continuity of Care" (last published 06/27/2014); All Plan Letter ("APL") 19-013
  - DHCS: DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III, Section 5.2.12 ; APLs 15-019, 16-002, 17-007, 20-017, 21-003; 22-032, 22-032
  - Knox-Keen Health Care Service Act and Regulations, Section 1373.95
- **Accreditation**
  - NCQA: Network Management (NET) 4, Element B: Continued Access to Practitioners
  - NCQA: Quality Management and Improvement (QI) 3, Element D: Transition to Other Care

HISTORY

Revision Date	Description of Revision
6/12/2023	Policy creation
7/6/2023	Policy revision to include additional 1373.95 provisions

I. OVERVIEW

A. ~~This policy addresses~~ Community Health Plan of Imperial Valley's ("CHPIV" or the "Plan") is responsible for ensuring there are CONTINUITY OF CARE ("CoC") processes in place that are in strict adherence to the guidelines and processes stated herein.~~requirements, policy, and procedures. The purpose of this policy is to establish a comprehensive CoC process for newly enrolled Members at CHPIV who request CONTINUITY OF CARE.~~ CHPIV delegates its CoC processes to CHPIV's Subcontractor, Health Net, who performs the function on behalf of CHPIV.

II. POLICY

A. CHPIV ~~provides~~ will ensure continued access for up to 12 months to an OUT-OF-NETWORK PROVIDER with whom the MEMBER has an ONGOING RELATIONSHIP, as long as CHPIV has no Quality of Care issues with the PROVIDER and the PROVIDER will accept either CHPIV's or the Medi-Cal FFS Rates, whichever is higher, pursuant to W&I Code section 14182(b)(13) – (14).

B. CHPIV will ensure the MEMBER's right to continue receiving Medi-Cal services covered under the CHPIV's Contract when transitioning to CHPIV even in circumstances in which the Member does not continue receiving services from their pre-existing Provider. CHPIV will ensure CoC for Covered Services without delay to the Member with a Network Provider, or if there is no Network Provider to provide the Covered Service, with an OON Provider.

C. CHPIV will ensure that active prior treatment authorizations for services remain in effect for 90 days and must be honored without a request by the MEMBER, authorized representative, or Provider for MEMBERS transitioning to CHPIV. CHPIV will ensure arrangement of services authorized under the active prior treatment authorization with a Network Provider, or if there is no Network Provider to provide the service, with an OON Provider.

D. CHPIV will ensure that all MEMBERS are allowed~~allows all MEMBERSs~~ to request CONTINUITY OF CARE in accordance with 42 CFR section 438.62 and APL 22-032.

E. CHPIV will ensure that additional ~~provide for additional~~ CONTINUITY OF CARE Protections are provided for MEMBERS with specific conditions as defined in H&S Code section 1373.96.

F. CHPIV will ensure proper evaluation of denied Medical Exemption Requests (MER) as automatic CONTINUITY OF CARE requests.

G. CHPIV ~~has a~~ensures there is a comprehensive process for block transfers of MEMBERs from a NETWORK PROVIDER GROUP or HOSPITAL to a new PROVIDER GROUP or HOSPITAL.

~~G.~~H. CHPIV ~~provides~~ will ensure a review for the completion of Covered Services at the request of a MEMBER in accordance with H&S Code section 1373.~~96~~95. All MEMBERSs with PRE-EXISTING RELATIONSHIP with the PROVIDER who make a CONTINUITY OF CARE

request must be given the option to continue treatment for up to 12 months with an OUT-OF-NETWORK PROVIDER, if the following criteria are met:

1. The MEMBER has seen the OUT-OF-NETWORK PROVIDER at least once within the 12 months before Enrollment with CHPIV;
2. The OUT-OF-NETWORK PROVIDER accepts CHPIV's rate offered in accordance with H&S Code section 1373.96(d)(2) or €(2); and
3. The OUT-OF-NETWORK PROVIDER meets CHPIV's applicable professional standards and has no disqualifying Quality of Care issues.

I. CHPIV ~~will~~ensures facilitate~~i~~ion of the completion of covered services in accordance with H&S Code section 1373.96 for the following conditions:
   1. An acute condition. Completion of covered services shall be provided for the duration of the acute condition.
   2. A serious chronic condition. Completion of covered services shall be provided for a period necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by CHPIV in consultation with the MEMBER and the terminated provider or nonparticipating provider and consistent with good professional practice.
   3. A pregnancy. Completion of covered services shall be provided for the duration of the pregnancy.
   4. Care of a newborn child between birth and age 36 months.
   ~~1.~~5. Surgery or other procedure that is authorized by CHPIV.

J. CHPIV ~~will~~ensures ~~send~~ an Enrollee Transfer ~~n~~ Notice is sent to MEMBERs describing its policy and informing MEMBERs of their right of completion of covered services

K. CHPIV ensures that reasonable consideration is given to the potential clinical effect on the MEMBER's treatment caused by a change of PROVIDER.

~~H.~~L. CHPIV will ensure ~~has~~ a process for accepting requests from the MEMBER, authorized representative, or PROVIDER over the telephone, according to the requester's preference, and must not require the requester to complete and submit a paper or online form if the requester prefers to make the request by telephone. To complete a telephone request, the MCP may take any necessary information from the requester over the telephone.

M. CHPIV will ensure~~has~~ a process for accepting and approving retroactive CoC requests and for reimbursing PROVIDERS for services that were already provided if the request meets all CoC requirements.

~~I.~~N. CHPIV ensures the development and implementation of procedures that further describe the following:

1. Date of CoC process initiation.
2. Validation of has a PRE-EXISTING RELATIONSHIP with the PROVIDER by requesting all relevant treatment information from the OUT-OF-NETWORK (OON) PROVIDER,
3. Timelines for making CoC determinations:
   a. 30 calendar days for non-urgent requests;
   b. 15 calendar days if the MEMBER's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or
   c. As soon as possible, but no longer than three calendar days for urgent requests (i.e., there is an identified risk of harm to the MEMBER).

4. Acknowledgment of the CoC request within the required timeframes, advising the MEMBER that the CoC request was received, the date of receipt, and the estimated timeframe for resolution.
5. Decision notification by using the MEMBER's known preference of communication or by notifying the MEMBER using one of these methods in the following order: telephone call, text message, email, and then notice by mail:
    a. For non-urgent requests, within seven calendar days of the decision.
    b. For urgent requests, within the shortest applicable timeframe that is appropriate for the MEMBER's condition, but no longer than three calendar days of the decision.
6. Content of MEMBER notification:
    a. Denial notifications:
        i. A statement of the MCP's decision.
        ii. A clear and concise explanation of the reason for denial.
        iii. The MEMBER's right to file a grievance or appeal. For additional information on grievances and appeals, refer to APL 21-011 or subsequent iterations of this APL.
    b. Approval notifications:
        i. A statement of the MCP's decision.
        ii. The duration of the CONTINUITY OF CARE arrangement.
        iii. The process that will occur to transition the MEMBER's care at the end of the CONTINUITY OF CARE period.
        iv. The MEMBER's right to choose a different Network PROVIDER.
7. Process for notifying MEMBERSs within 30 calendar days before the end of the CONTINUITY OF CARE period, using the MEMBER's preferred method of communication, about the process that will occur to transition the MEMBER's care to a IN-NETWORK PROVIDER at the end of the CONTINUITY OF CARE period. This process includes engaging with the MEMBER and PROVIDER before the end of the CONTINUITY OF CARE period to ensure continuity of services through the transition to a new PROVIDER.

III. PROCEDURE

A. CHPIV delegates the COC process to its Subcontractor, Health Net.
B. Delegation Oversight
    1. CHPIV shall provide oversight and continually assess the delegated functions, responsibilities, processes, and performance of Health Net. CHPIV ensures Health Net's compliance with regulatory and contractual requirements through the following activities which are detailed in *CHPIV Policy CMP-002: Delegation Oversight Policy and Procedure*:
        a. Ongoing monitoring
        b. Performance reviews
        c. Data analysis
        d. Utilization of benchmarks, if available
        e. Annual desktop and on-site audits

IV. DEFINITIONS

Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the "Definitions" below.

TERM	DEFINITION
Member	A beneficiary enrolled in a CHPIV program.
Active Course of Treatment	Means an ongoing treatment in which discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes. Treatment typically involves regular visits with the practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment, or modify a treatment protocol.
Acute Condition	Means a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Examples include a heart attack, pneumonia, or appendicitis.
Block Transfer	Means a transfer or redirection of two thousand (2,000) or more members by CHPIV from a Terminated Provider Group or Terminated Hospital to one or more contracting providers that takes place as a result of the termination or non-renewal of a Provider Contract.
Continuity of Care ("COC")	Means the process by which the member and the Provider are cooperatively involved in ongoing health care management toward the goal of high quality, cost-effective medical care.
Chronic	Means a condition that is long-term and ongoing and is not acute. Examples include diabetes, asthma, allergies, and hypertension.
Medically Necessary/Medical Necessity	Means all Covered Services that are reasonable and necessary to protect life, prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity per Title 22 CCR Section 51303(a) and 42 CFR 438.210(a)(5).When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and W & I Code Section 14132 (v). For individuals under 21 years of age, EPSDT service is considered medically necessary or a medical necessity when it is necessary to correct or ameliorate defects and physical and mental illnesses and conditions that are discovered by screening services. A service need not cure a condition in order to be covered under EPSDT. Services that maintain or improve the child's current health condition are also covered under EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. The common definition of

TERM	DEFINITION
	"ameliorate" is to "make more tolerable". Additional services must be provided if determined to be medically necessary for an individual child.
Non-Participating Provider or Out-of-Network Provider	Means a health care professional or facility that does not have a service contract with the Plan and/or its delegate HNCS that is responsible for providing health care services for the Member who has requested completion of services with that professional or facility at the in-network benefit level.
Ongoing Relationship or Pre-Existing Relationship	Means the member has seen the requested out-of-network provider (PCP or Specialist) at least once during the 12 months prior to the date of the member's initial enrollment in the managed care plan for a non-emergency visit. The Plan and/or its delegate HNCS determines if a relationship exists using data provided by DHCS to the Plan and/or its delegate HNCS, such as Medi-Cal FFS utilization data. The member or their provider may also provide information to the Plan and/or its delegate HNCS that demonstrates a pre-existing relationship with a provider. A member may not attest to a pre-existing relationship (instead of actual documentation being provided).
Participating Provider or In-Network Provider	Means a health care professional or facility that is contracted with the Plan and/or its delegate HNCS, who or that provides covered services to Plan members.
Prior Authorization	Means the formal process that requires a Provider to obtain advanced approval from the Plan and/or its delegate HNCS to provide specific services or procedures. Prior authorization is required for most services or care; however, prior authorization is not required for emergency or out-of-area urgent care services.
Provider	Means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Pregnancy	Means a pregnancy with a three trimester duration and immediate postpartum period.
Seniors and Persons with Disabilities (SPDs)	Means a member who falls under a specific SPD aid code as defined by DHCS.
Serious Chronic Condition	Means a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and that does either of the following: Persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.
Terminal Illness	Means a terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less.
Terminated Provider	Means a Provider whose contract to provide covered services to members is terminated or not renewed by the Plan and/or its delegate HNCS.

	Behavioral Health	BH-001
Department	Health Services	
Functional Area	Behavioral Health	
Impacted Delegate	☒ Subcontractor ☐ NA	

DATES			
Policy Effective Date		**Reviewed/Revised Date**	
Next Annual Review Due		**Regulator Approval**	

APPROVALS			
Internal		**Regulator**	
Name	Gordon Arakawa	☐ DHCS ☒ NA ☐ DMHC	
Title	Chief Medical Officer		

ATTACHMENTS

- NA

AUTHORITIES/REFERENCES

- **Internal**
  - CHPIV, Delegation Oversight Policy and Procedure, CMP-002
- **Federal**
  - 42 CFR section 438.900 et seq.;
- **State**
  - DHCS: DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III, Section 2.2.10.F-G., 4.3.14.C, 4.4.3.C., 4.4.8.F, 5.0, 5.3.4.F, 5.5.2, 5.5.4

HISTORY

Revision Date	Description of Revision
7/5/2023	Policy Creation

I. OVERVIEW

A. This policy addresses Community Health Plan of Imperial Valley's ("CHPIV" or the "Plan") requirements for the provision of behavioral health services to its members.

II. POLICY

A. CHPIV adheres to all requirements set forth in Exhibit A, Attachment 5.5 (Mental Health and Substance Use Disorder Benefits) for the provision of mental health and substance use disorder services to Members less than 21 years of age.

B. CHPIV collaborates with the Department of Health Care Services (DHCS) in its effort to implement the California Children and Youth Behavioral Health Initiative.

C. To facilitate the provision of Medically Necessary services to Children, CHPIV will execute a Memorandum of Understanding (MOU) with Local Education Agencies (LEAs) in each EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) county within its Service Area for school-based services, including but not limited to EPSDT and Behavioral Health Services for Members less than 21 years of age. CHPIV will ensure that Members' Primary Care Providers cooperate and collaborate with LEAs in the development of Individualized Education Plans (IEPs) or Individualized Family Service Plans (IFSPs) and ultimately ensure that care is coordinated regardless of financial responsibility.

D. CHPIV will ensure the implementation of interventions that increase access to preventive, early intervention, and Behavioral Health services by school-affiliated Behavioral Health Providers for children in publicly funded childcare and preschool, and TK-12 children in public schools, in accordance with the interventions, goals, and metrics set forth in W&I Code section 5961.3(b).

E. CHPIV will ensure the prioritization of county behavioral health staff or behavioral health Providers to serve in the ENHANCED CARE MANAGEMENT (ECM) Provider role, provided they agree and are able to coordinate all services needed by those Populations of Focus, not just their behavioral health services.

F. If a Member receives services from a mental health provider for Serious Emotional Disturbance (SED), Substance Use Disorder (SUD), or Serious Mental Illness (SMI) and the Member's behavioral health Provider is a contracted ECM Provider, CHPIV must ensure that the Member is assigned to that behavioral health Provider as the ECM Provider, unless the Member indicates otherwise or CHPIV identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

G. CHPIV will ensure access to evidence-based behavioral health care, with a focus on integration with physician health and earlier identification and engagement in treatment for children, youth, and adults.

H. CHPIV will ensure provision of Medically Necessary Behavioral Health Treatment (BHT) services in accordance with a recommendation from a licensed Physician, surgeon, or a licensed psychologist and must ensure continuation of BHT services under continuity of care.

I. CHPIV ensures Member's treatment plan is reviewed, revised, and/or modified no less than every six months by a BHT service provider. The Member's behavioral treatment plan may

be modified or discontinued only if it is determined that the services are no longer Medically Necessary under the EPSDT Medical Necessity standard.

J. CHPIV will ensure the provision of Medically Necessary BHT services and coordination with LEAs, Regional Centers (RCs), and other entities that provide BHT services so that Members timely receive all Medically Necessary BHT services, consistent with the EPSDT benefit.

K. CHPIV must ensure the provision of Medically Necessary BHT services across settings, including home, school, and in the community, which are not duplicative of BHT services actively provided by another entity.

L. CHPIV must ensure good faith attempts to enter into MOUs with RCs and LEAs, and CHPIV must enter into MOUs with County Mental Health Plans (MHPs) in accordance with Exhibit A, Attachment III, Section 5.6.1 (*MOUs with Third-Party Entities and County Programs*), to facilitate the coordination of services for Members with developmental disabilities, including Autism Spectrum Disorder (ASD), as permitted by federal and State law, and specified by California Department of Healthcare Services DHCS in All Plan Letter (APL) APL 18-009 and APL 21-XXX. If CHPIV is unable to ensure an MOU or a one-time case agreement with a RC, as required by APL 18-009, Contractor must inform DHCS why it could not reach an agreement with the RC and must demonstrate, by providing all evidence of contracting efforts, a good faith effort to enter into an agreement with the RC.

M. CHPIV must comply with all mental health parity requirements in 42 CFR section 438.900 *et seq*. CHPIV must ensure it is not applying any financial or treatment limitation to mental health or SUD benefits in any classification that is more restrictive than the predominant financial or treatment limitation applied to medical and surgical benefits in the same classification.

N. CHPIV ensures the coverage of Non-specialty Mental Health Services (NSMHS) including individual and group mental health evaluation and treatment, including psychotherapy, family therapy, and dyadic services; psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition; outpatient services for the purposes of monitoring drug therapy; psychiatric consultation; and outpatient laboratory, drugs, supplies, and supplements.

O. CHPIV will ensure the coverage of hypnotherapy, health behavior assessments and interventions, psychiatric collaborative care, and other NSMHS services described in the Medi-Cal Provider Manual as mental health evaluation and treatment NSMHS. CHPIV covers mental health screening services described in the Medi-Cal Provider Manual as NSMHS, including but not limited to Adverse Childhood Experiences (ACE) screening, brief emotional/behavioral assessments, depression screening, general developmental screening, autism spectrum disorder screening, and other screening services in accordance with Exhibit A, Attachment III, Subsection 5.5.2.F (*Non-specialty Mental Health Services and Substance Use Disorder Services*).

P. CHPIV will ensure the coverage of SUD services including: drug and alcohol Screening, Assessment, Brief Intervention and Referral to Treatment (SABIRT) services; tobacco cessation counseling; Medications for Addiction Treatment (MAT) (also known as medication-assisted treatment) when delivered in Primary Care offices, emergency departments, inpatient hospitals, and other contracted medical settings; and Medically Necessary behavioral health services. Covered NSMHS and SUD Services can be delivered

in person and via telehealth/telephone as specified in Exhibit A, Attachment III, Subsection 5.3.1 (*Covered Services*).

Q. If a Member is receiving NSMHS and is determined to meet the criteria for Specialty Mental Health Services (SMHS) as defined by W&I Code section 14184.402, CHPIV must ensure the use of DHCS-approved standardized transition tools in accordance with Exhibit A, Attachment III, Subsection 5.5.2.K (Non-specialty Mental Health Services and Substance Use Disorder Services) as required when Members who have established relationships with contracted mental health Providers experience a change in condition requiring SMHS.

R. If a Member is receiving SMHS and is determined to meet the criteria for NSMHS as defined by W&I Code section 14184.402, CHPIV must ensure the use of DHCS-approved standardized transition tools in accordance with Exhibit A, Attachment III, Subsection 5.5.2.K (Non-specialty Mental Health Services and Substance Use Disorder Services) as required when Members who have established relationships with SMHS providers experience a change in condition requiring NSMHS.

S. For Members 21 years of age and over who meet the criteria for NSMHS, CHPIV ensures the coverage of Medically Necessary Services in accordance with W&I Code section 14059.5 as well as Medically Necessary Covered SUD services in accordance with W&I Code section 14059.5.

T. For Members under 21 years of age, CHPIV will ensure coverage of Medically Necessary Covered NMHS in accordance with W&I Code section 14184.402(b)(2) as well as Medically Necessary Covered SUD services.

U. CHPIV ensures coverage of mental health and SUD screening, including, but not limited to, tobacco, alcohol and illicit drug screening, in accordance with American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule and United States Preventive Services Taskforce (USPSTF) grade A and B recommendations for adults, ACE screening, brief emotional/behavioral assessments, depression screening, general developmental screening, autism spectrum disorder screening, and Screening, Assessment, Brief Intervention and Referral to Treatment (SABIRT) Services.

V. CHIPIV must ensure the development and implementation of policies and procedures for mental health and substance use screenings and services provided by a Primary Care Provider (PCP) including but not limited to provision of SABIRT Services, and referrals for additional assessments and treatments as indicated by the discovery of condition or potential conditions from screening services, as required by Exhibit A, Attachment III, Subsections 4.3.13 (Mental Health Services) and 4.3.14 (Alcohol and SUD Treatment Services).

W. CHPIV will ensure the coverage of a mental health assessment without requiring Prior Authorization. CHPIV must follow the authorization criteria requirements outlined in Exhibit A, Attachment III, Section 2.3 (Utilization Management Program) of the DHCS Contract for authorizing additional mental health and SUD services.

X. CHPIV must ensure the development and implementation of policies and procedures for tracking mental and behavioral health screenings, assessments, and treatment services provided by licensed mental health care Providers.

Y. CHPIV must ensure coverage and pay for all Medically Necessary covered mental health and SUD services for the Member, including the following:

1. Emergency room professional services as described in 22 CCR section 53855;
2. Facility charges for emergency room visits that do not result in a psychiatric admission;
3. All laboratory and radiology services necessary for the diagnosis, monitoring, or treatment of a member's mental health condition;
4. Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services required by Members to access Medi-Cal covered mental health services and SUD services, in compliance with APL 17-010 and this Contract;
5. NMT services and, for Members less than 21 years of age, NEMT services, to and from Drug Medi-Cal (DMC) services, Drug Medi-Dal Organized Delivery System (DMC-ODS) services, and SMHS, in compliance with APL 17-010 and this Contract;
6. Medically Necessary Covered Services after Contractor has been notified by a DMC, DMC-ODS, MHP, or mental health Provider that a Member has been admitted to an inpatient psychiatric facility, including an Institution for Mental Diseases (IMD) as defined by 9 CCR section 1810.222.1, regardless of the age of the Member;
7. All Medically Necessary Medi-Cal-covered psychotherapeutic drugs, when administered in the outpatient setting as part of medical services for Members not otherwise excluded under the DHCS Contract.
8. CHPIV shall ensure that access to Covered Services is not materially delayed through the application of Utilization Review controls, such as Prior Authorization, or by requiring that Covered Services be provided through CHPIV's Network, consistent with CHPIV's assurance to provide timely Covered Services.

Z. CHPIV must ensure the use of DHCS-approved standardized screening tools (including standardized screening tools specific for adults and standardized screening tools specific for children and youth) to ensure Members seeking mental health services who are not currently receiving covered NSMHS or SMHS are referred to the appropriate delivery system for mental health services, either in CHPIV's network or the MHP network, in accordance with the No Wrong Door policies set forth in W&I Code section 14184.402(h) and specified in Exhibit A, Attachment III, Subsection 4.3.13 (Mental Health Services).

1. If a member becomes eligible for SMHS during the course of receiving covered NSMHS, CHPIV must ensure the provision of non-duplicative, Medically Necessary NSMHS even if the Member is simultaneously accessing SMHS.
2. CHPIV must make its best efforts to ensure a member's existing mental health Provider is notified during an Urgent Care situation, when possible. CHPIV must allow the Member's existing mental health Provider to coordinate care with the MHP or emergency room personnel for Urgent Care.
3. CHPIV must ensure the development and implementation of policies and procedures for the provision of psychiatric emergencies during non-business hours.
4. CHPIV must ensure monitoring and tracking of utilization data for NSMHS as specified in Exhibit A, Attachment III, Subsection 2.3.3 (Review of Utilization Data).
5. CHPIV must have an MOU with the MHP to refer Members in need of urgent and emergency care, including person-to-person telephone transfers, to the county crisis program during their call center hours. The MOU must be executed in accordance with the requirements specified in Exhibit A, Attachment III, Sections 4.3 (*Population Health Management and Coordination of Care*) and 5.3 (*Scope of Services*).

III. PROCEDURE

A. CHPIV delegates the COC process to its Subcontractor, Health Net, for Mild to Moderate BH, BH-related Case Management, and Medical Needs for Member while Imperial County retains responsibility for SMI services.

B. Delegation Oversight

1. CHPIV shall provide oversight and continually assess the delegated functions, responsibilities, processes, and performance of Health Net.
2. CHPIV ensures Health Net's compliance with regulatory and contractual requirements through the following activities which are detailed in CHPIV Policy CMP-002: Delegation Oversight Policy and Procedure:
    a. Ongoing monitoring
    b. Performance reviews
    c. Data analysis
    d. Utilization of benchmarks, if available
    e. Annual desktop and onsite audits

IV. DEFINITIONS

Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the "Definitions" below.

TERM	DEFINITION
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	The provision of Medically Necessary comprehensive and preventive health care services provided to Members less than 21 years of age in accordance with requirements in 42 USC section 1396a(a)(43), section 1396d(a)(4)(B) and (r), and 42 CFR section 441.50 et seq., as required by W&I Code sections 14059.5(b) and 14132(v). Such services may also be Medically Necessary to correct or ameliorate defects and physical or behavioral health conditions.
Enhanced Care Management (ECM)	ECM is community-based, interdisciplinary, high touch, person-centered, and provided primarily through in-person interactions. The plan contracts with "ECM Providers," existing community providers such as Federally Qualified Health Centers (FQHCs), counties, county BH providers, local health jurisdictions, Community Based Organizations (CBOs), and others, who assign a lead care manager to each member. The lead care manager meets members wherever they are – on the street, in a shelter, in their doctor's office, or at home. ECM eligibility is based on members meeting specific "Populations of Focus" criteria.

	Quality Management and Improvement	QM-001
Department	Health Services	
Functional Area	Quality Management	
Impacted Delegate	☒ Subcontractor ☐ NA	

DATES			
Policy Effective Date	6/12/2023	**Reviewed/Revised Date**	
Next Annual Review Due	6/12/2024	**Regulator Approval**	

APPROVALS			
Internal		**Regulator**	
Name	Gordon Arakawa	☐ DHCS ☐ NA ☒ DMHC	
Title	Chief Medical Officer		

ATTACHMENTS

NA

AUTHORITIES/REFERENCES

- **Internal**
  - CHPIV, Delegation Oversight Policy and Procedure, CMP-002
- **Federal**
  - Code of Federal Regulations (CFR): 42 CFR 438.330 and 430.340: Quality Assessment and Performance Improvement Program; 28 CCR section 1300.70
- **State**
  - California Health and Safety Code Sections ("H&S Code") 1367(a) – (c), (i), 1369, 1370,
  - California Business and Professions Code Section ("B&P Code") 805
  - Title 28 California Code of Regulations Rules ("CCR") Rules 1300.51(d)(H)(iii) & (d)(j)(1)(b), 1300.67.2€, 1300.69, 1300.70 & 1300.70 (b)(2), 1300.74.16(e)
  - DMHC: Technical Assistance Guide ("TAG") "Quality Management" (last published 06/09/2014); All Plan Letter ("APL") 22-028
  - DHCS: DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III, Section 2.2 TAG Quality Improvement; APLs 19-017
  - Knox-Keen Health Care Service Act and Regulations, Section 1300.70
- **Accreditation**
  - NCQA: Quality Management and Improvement (QI) 1, Elements A-D

HISTORY

Revision Date	Description of Revision
6/12/2023	Policy creation

I. OVERVIEW

A. ~~This policy addresses~~ Community Health Plan of Imperial Valley's ("CHPIV" or the "Plan") is responsible for maintaining a comprehensive Quality Management and Improvement ("QM/QI") program in strict adherence to the guidelines and processes stated herein. CHPIV retains aspects of the QM/QI program, such as appointment of a Chief Health Equity Officer and establishment of a Quality Improvement and Health Equity Committee. All other components of the QM/QI process are delegated to CHPIV's Subcontractor, Health Net. ~~requirements, policy, and procedures.~~

II. POLICY

A. CHPIV is responsible for the quality and HEALTH EQUITY of all COVERED SERVICES regardless of whether those services have been delegated to a SUBCONTRACTOR, DOWNSTREAM SUBCONTRACTOR, or NETWORK PROVIDER.

1. CHPIV will ensure its SUBCONTRACTOR, DOWNSTREAM SUBCONTRACTOR, or NETWORK PROVIDER are compliant with the Quality Improvement Health Equity standards as follows:
    a. Organization and Operation (28 CCR 1300.51(d)(j)(1)(b))
        i. Explanation of the review system covering the matters depicted in the governing body organization chart and the following:
            1. The key people involved.
            2. Titles and qualification.
            3. The extent and type of support staff.
            4. Areas of authority and responsibility of the key persons and the committees, if divided among persons and committees.
            5. The frequency of meetings of the committees and the portion of their time devoted to the review system by key people.
    b. Program Requirements (28 CCR 1300.70 (b)(2)):
        i. Written QA plan describing the goals and objectives of the program and governing body organization arrangements, including staffing, the methodology for on-going monitoring and evaluation of health services, the scope of the program, and required levels of activity.
        ii. Written documents shall delineate QA authority, function, and responsibility, and provide evidence that the plan has established quality assurance activities and that the governing body has approved the QA Program. To the extent that the governing body QA responsibilities are within the plan or to a contracting provider, the governing body documents shall provide evidence of an oversight mechanism for ensuring that QA functions are adequately performed.
        iii. The governing body, its QA committee, if any, and any internal or contracting providers to whom QA responsibilities have been delegated, shall each meet on a quarterly basis, or more frequently if problems have been identified, to oversee their respective QA program responsibilities.

The governing body must maintain records of its QA activities and actions, and report to the governing body on a regularly scheduled basis, at least quarterly, which reports shall include findings and actions taken as a result of the QA program. The governing body is responsible for establishing a program to monitor and evaluate the care provided by each contracting provider group to ensure that the care provided meets professionally recognized standards of practice. Reports to the governing body shall be sufficiently detailed to include findings and actions taken as a result of the QA program and to identify those internal or contracting provider components which the QA program has identified as presenting significant or chronic quality of care issues.

iv. Implementation of the QA program shall be supervised by a designated physician(s), or in the case of specialized plans, a designated dentist(s), optometrist(s), psychologist(s) or other licensed professional provider, as appropriate.

v. Physician, dentist, optometrist, psychologist, or other appropriate licensed professional participation in QA activity must be adequate to monitor the full scope of clinical services rendered, resolve problems, and ensure that corrective action is taken when indicated. An appropriate range of specialist providers shall also be involved.

vi. There must be administrative and clinical staff support with sufficient knowledge and experience to assist in carrying out their assigned QA activities for the governing body.

vii. Medical groups or other provider entities may have active quality assurance programs which the governing body may use. In all instances, however, the governing body must retain responsibility for reviewing the overall quality of care delivered to plan enrollees. If QA activities are delegated to a participating provider to ensure that each provider has the capability to perform effective quality assurance activities, the plan must do the following:

1. Inform each provider of the plan's QA program, of the scope of that provider's QA responsibilities, and how it will be monitored by the governing body.
2. Ascertain that each provider to which QA responsibilities have been delegated has an in-place mechanism to fulfill its responsibilities, including administrative capacity, technical expertise, and budgetary resources.
3. Have ongoing oversight procedures in place to ensure that providers are fulfilling all delegated QA responsibilities.
4. Require that standards for evaluating that enrollees receive health care consistent with professionally recognized standards of practice are included in the provider's QA program and be assured of the entity's continued adherence to these standards.
5. Ensure that for each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, and appropriate preventive

health services based on reasonable standards established by the governing body and/or delegated providers.

6. Ensure that health services include appropriate preventive health care measures consistent with professionally recognized standards of practice. There should be screening for conditions when professionally recognized standards of practice indicate that screening should be done.

viii. A governing body that has capitation or risk-sharing contracts must:

1. Ensure that each contracting provider has the administrative and financial capacity to meet its contractual obligations; the governing body shall have systems in place to monitor QA functions.
2. Have a mechanism to detect and correct under-service by an at-risk provider (as determined by its patient mix), including possible underutilization of specialist services and preventive health care services.

ix. Inpatient Care

1. A governing body must have a mechanism to oversee the quality of care provided in an inpatient setting to its enrollees which monitors that:
   a. providers utilize equipment and facilities appropriate to the care; and
   b. if hospital services are fully capitated that appropriate referral procedures are in place and utilized for services not customarily provided at that hospital.

~~1.~~2. The governing body may delegate inpatient QA functions to hospitals and may rely on the hospital's existing QA system to perform QA functions. If the governing body does delegate QA responsibilities to a hospital, the plan must ascertain that the hospital's quality assurance procedure will specifically review hospital services provided to the governing body 's enrollees and will review services provided by governing body physicians within the hospital in the same manner as other physician services are reviewed.

~~A.~~B. CHPIV will ensure that a QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM (QIHETP) is implemented, ~~CHPIV will implement a QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM (QIHETP) that~~ ~~includes~~including, at a minimum, the standards set forth in 42 CFR sections 438.330 and 438.340, 28 CCR section 1300.70, and be consistent with the principles outlined in the DHCS Comprehensive Quality Strategy.

C. CHPIV ~~will ensure to~~has a process to ensure the implementation of a peer review body to review the basic qualifications, staff privileges, employment, medical outcomes, or professional conduct of licentiates to address necessary improvements in the quality of care delivered by all its Providers in any setting and take appropriate action to improve upon HEALTH EQUITY.

1. As a result of an action of a peer review body, the CHPIV will ensure that a process is in place to monitor, evaluate, and take timely action to address necessary improvements in

the quality of care delivered by all its Providers in any setting, and take appropriate action to improve upon HEALTH EQUITY.

~~B.~~D. CHPIV has a process to ensure the delivery of quality care that enables its Members to maintain health, improve, or manage a chronic illness or disability in the following areas:

1. Clinical quality of physical health care;
2. Clinical quality of BEHAVIORAL HEALTH care focusing on prevention, recovery, resiliency and rehabilitation;
3. Access to primary and specialty health care Providers and services;
4. Availability and regular engagement with Primary Care Providers (PCP);
5. Continuity and Care Coordination across settings and at all levels of care, including transitions in care, with the goal of establishing consistent provider-patient relationships; and
6. Member experience with respect to clinical quality, access and availability, and culturally and linguistically competent health care and services, and continuity and coordination of care.

~~C.~~E. CHPIV will ensure ~~it applies~~ the principles of continuous quality improvement (CQI) are applied to all aspects of its service delivery system through analysis, evaluation, and systematic enhancements of the following:

1. Quantitative and qualitative data collection and data-driven decision-making;
2. Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;
3. Feedback provided by Members and NETWORK PROVIDERS in the design, planning, and implementation of its CQI activities;
4. Other issues identified by CHPIV or state regulator.

~~D.~~F. CHPIV will ensure~~s~~ the development of ~~it has developed~~ Population Health Management interventions designed to address SOCIAL DRIVERS OF HEALTH, reduce disparities in health outcomes experienced by different subpopulations of Members, and work towards achieving HEALTH EQUITY by:

1. Developing equity focused interventions intended to address disparities in the utilization and outcomes of physical and BEHAVIORAL HEALTH CARE SERVICES; and
2. Engaging in a Member and family-centric approach in the development of interventions and strategies, and in the delivery of all health care services.

~~E.~~G. CHPIV will ensure that a QIHETP is implemented, maintained, periodically updated, and includes~~CHPIV will develop and ensures that it has developed, implemented, maintained, and periodically update its QIHETP and associated policies and procedures that include~~, at a minimum, the following:

1. CHPIV's commitment to the delivery of quality and equitable health care services;
2. CHPIV's FULLY DELEGATED SUBCONTRACTOR's, and DOWNSTREAM FULLY DELEGATED SUBCONTRACTOR's organizational chart, listing the key staff and the committees responsible for QIHETP activities, including reporting relationships of the QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM (QIHEC)to executive staff;
3. Qualification and identification of staff who are responsible for QI and HEALTH EQUITY activities;

4. A process for sharing QIHETP findings with SUBCONTRACTORS, DOWNSTREAM SUBCONTRACTORS, and NETWORK PROVIDERS;
5. The role, structure, and function of the QIHEC;
6. The policies and procedures to ensure that all COVERED SERVICES are available and accessible to all Members regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, and that all COVERED SERVICES are provided in a culturally and linguistically appropriate manner;
7. The policies and procedures designed to identify, evaluate, and reduce Health Disparities, by performing the following:
    a. Analyzing data to identify differences in quality of care and utilization, as well as the underlying reasons for variations in the provision of care to its Members;
    b. Developing equity-focused interventions to address the underlying factors of identified Health Disparities, including SOCIAL DRIVERS OF HEALTH (SDOH); and
    c. Meeting disparity reduction targets for specific populations and/or measures as identified by DHCS and as directed under Exhibit A, Attachment III, Subsection 2.2.9.A (External Quality Review (EQR) Requirements, Quality Performance Measures).
8. CHPIV ensures that it includes description of the integration of Utilization Management (UM) activities into the QIHETP as specified in Exhibit A, Attachment III, Section 2.3 (Utilization Management Program), including a process to integrate reports on the number and types of service requests, denials, deferrals, modifications, Appeals, and Grievances to PLAN's medical director or the medical director's designee;
9. CHPIV ensures its Policies and procedures to adopt, disseminate, and monitor the use of clinical practice guidelines that:
    a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the relevant field;
    b. Consider the needs of Members;
    c. Stem from recognized organizations that develop or promulgate evidence-based clinical practice guidelines, or are developed with involvement of board-certified Providers from appropriate specialties;
    d. Have been reviewed by a medical director, as well as SUBCONTRACTORS, DOWNSTREAM SUBCONTRACTORS, and NETWORK PROVIDERS, as appropriate; and
    e. Are reviewed and updated at least every two years.
10. CHPIV ensures it has the inclusion of Population Health Management (PHM) activities, including the findings of the annual Population Needs Assessment (PNA), as required in Exhibit A, Attachment III, Subsection 4.3.2 (Population Needs Assessment [PNA]);
11. CHPIV ensures that it has Policies and procedures that ensure the delivery of Medically Necessary non-specialty and Specialty Mental Health Services as outlined in Exhibit A, Attachment III, Section 5.5 (Mental Health and Substance Use Disorder Benefits);
12. CHPIV ensures that its SUBCONTRACTORS, DOWNSTREAM SUBCONTRACTORS, NETWORK PROVIDERS, and other entities with which CHPIV contracts for the delivery of health care services comply with all mental health parity requirements in 42 CFR section 438.900 et seq.;

13. CHPIV ensures mechanisms to detect both over- and under-utilization of services including, but not limited to, outpatient prescription drugs;
14. CHPIV ensures it has mechanisms to continuously monitor, review, evaluate, and improve access to and availability of all COVERED SERVICES. The mechanisms shall include oversight processes that ensure Members are able to obtain Medically Necessary appointments within established standards for time or distance, timely access, and alternative access in accordance with APL 20-003, and W&I Code sections 14197 and 14197.04;
15. CHPIV ensures it has mechanisms to continuously monitor, review, evaluate, and improve quality and HEALTH EQUITY of clinical care services provided, including, but not limited to, preventive services for Children and adults, perinatal care, Primary Care, specialty, emergency, inpatient, BEHAVIORAL HEALTH and ancillary care services; and
16. CHPIV ensures that it has mechanisms to continuously monitor, review, evaluate, and improve coordination and continuity of care services to all Members, including Seniors and Persons with Disability (SPDs), Children with Special Health Care Needs (CSHCN), Members with chronic conditions, including BEHAVIORAL HEALTH, Members experiencing homelessness, Members recently released from incarceration, Members who use Long-Term Services & Supports (LTSS), and Children in child welfare.
17. Participation from a broad range of providers, including Physician, dentist, optometrist, psychologist or other appropriate licensed professional, to adequately monitor the full scope of clinical services rendered, resolve problems, and ensure that corrective action is taken when indicated. An appropriate range of specialist providers shall also be involved.

~~F.~~H. CHPIV will ensure the ~~ensures~~ development of an annual comprehensive assessment of QI and HEALTH EQUITY activities that includes an evaluation of the effectiveness of QI interventions and include, at a minimum, the following components:

1. A written analysis of required quality performance measure results, and a plan of action to address performance deficiencies, including analyses of each FULLY DELEGATED SUBCONTRACTOR's and DOWNSTREAM FULLY DELEGATED SUBCONTRACTOR's performance measure results and actions to address any deficiencies;
2. An analysis of actions taken to address any CHPIV-specific recommendations in the annual External Quality Review (EQR) technical report and evaluation reports;
3. An analysis of the delivery of services and quality of care of CHPIV and its FULLY DELEGATED SUBCONTRACTORS and DOWNSTREAM FULLY DELEGATED SUBCONTRACTORS, based on data from multiple sources, including quality performance results, Encounter Data, Grievances and Appeals, Utilization Review and the results of consumer satisfaction surveys;
4. Planned equity-focused interventions to address identified patterns of over- or under-utilization of physical and BEHAVIORAL HEALTH CARE SERVICES;
5. A description of CHPIV's commitment to member and/or family focused care through member and community engagement such as review of CAC findings, Member listening sessions, focus groups or surveys, and collaboration with local community organizations; and how CHPIV utilizes the information from this engagement to inform its policies and decision-making;
6. PHM activities and findings;
7. Outcomes/findings from Performance Improvement Projects (PIPs), consumer satisfaction surveys and collaborative initiatives.

~~G.~~I. CPHIV's annual plan includes evaluation and findings specific to the FULLY DELEGATED SUBCONTRACTOR's and DOWNSTREAM FULLY DELEGATED SUBCONTRACTOR's performance in QI and HEALTH EQUITY.

~~H.~~J. CHPIV policies and procedures describe the oversight and participation of its Governing Board and describe its QUALITY IMPROVEMENT AND HEALTH EQUITY COMMITTEE (QIHEC). Policies and procedures further include the following:

1. Specify that activities are supervised by ~~CHPIV's medical director or the medical director's designee, in collaboration~~ with CHPIV's Chief HEALTH EQUITY Officer;
2. Describe activities supervised by CHPIV's ~~medical director and the~~ Chief HEALTH EQUITY Officer; and
3. Indicate that QIHEC must include participation of a broad range of NETWORK PROVIDERS, including but not limited to hospitals, clinics, county partners, physicians, community health workers, and other non-clinical providers in the process of QIHETP development and performance review.

cdfv

III. PROCEDURE

A. CHPIV will maintain a Chief Health Equity Officer as well as its own Quality Improvement and Health Equity Committee (QIHEC).

B. CHPIV delegates the remainder of the Quality Management and Improvement process, including the Quality Improvement Health Equity Transformation Program (QIHETP), to its Subcontractor, Health Net.

~~A. CHPIV delegates the Quality Management and Improvement process to its Subcontractor, Health Net.~~

~~B.~~C. Delegation Oversight

1. CHPIV delegates Quality Management to its SUBCONTRACTOR, Health Net.
2. CHPIV shall provide oversight and continually assess the delegated functions, responsibilities, processes, and performance of Health Net. CHPIV ensures Health Net's compliance with regulatory and contractual requirements through the following activities which are detailed in *CHPIV Policy CMP-002: Delegation Oversight Policy and Procedure*:
   a. Ongoing monitoring
   b. Performance reviews
   c. Data analysis
   d. Utilization of benchmarks, if available
   e. Annual desktop and on-site audits

IV. DEFINITIONS

Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the "Definitions" below.

TERM	DEFINITION
Behavioral Health	A mental health condition and/or Substance Use Disorder (SUD) condition.
Behavioral Health Care Services	Specialty Mental Health Services, Non-specialty Mental Health Services, and SUD treatment.

TERM	DEFINITION
Covered Services	Health care services, set forth in Welfare and Institutions (W&I) Code sections 14000 *et seq.* and 14131 *et seq.,* 22 CCR section 51301 *et seq*., 17 CCR section 6800 *et seq*., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, this Contract, and APLs that are made the responsibility of Contractor pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS.
Downstream Subcontractor	Individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.
Downstream Fully Delegated Subcontractor	A Downstream Subcontractor that contractually assumes all duties and obligations of Contractor under the Contract, through the Subcontractor, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A managed care plan can operate as a Downstream Fully Delegated Subcontractor.
Downstream Partially Delegated Subcontractor	A downstream Subcontractor that contractually assumes some, but not all, duties and obligations of a Subcontractor under the Contract, including, for example, obligations regarding specific Member populations or obligations regarding a specific set of services. Individual Physician Associations and Medical Groups often operate as Downstream Partially Delegated SUBCONTRACTORS.
Downstream Administrative Subcontractor	A Downstream Subcontractor that contractually assumes administrative obligations of a Subcontractor under the Contract. Administrative obligations include functions such as credentialing verification or claims processing. However, functions related to coordinating or directly delivering health care services for Members, such as Utilization Management or Care Coordination, are not administrative functions.
Fully Delegated Subcontractor	A subcontractor that contractually assumes all duties and obligations of Contractor under the Contract, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A managed care plan can operate as a Fully Delegated Subcontractor.
Health Disparity	Differences in health, including mental health, and outcomes closely linked with social, economic, and environmental disadvantage, which are often driven by the social conditions in which individuals live, learn, work, and play. Characteristics such as race, ethnicity, age, disability, sexual orientation or gender identity, socio-economic status, geographic location, and other factors historically linked to exclusion or discrimination are known to influence the health of individuals, families, and communities.
Health Equity	The reduction or elimination of Health Disparities, Health Inequities, or other disparities in health that adversely affect vulnerable populations.
Health Inequity	Systematic difference in the health status of different population groups arising from the social conditions in which Members are born, grow,

TERM	DEFINITION
	live, work, and/or age, resulting in significant social and economic costs both to individuals and societies.
Network	PCPs, Specialists, hospitals, ancillary Providers, facilities, and other Providers with whom Contractor enters into a Network Provider Agreement.
Provider	Means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Network Provider Agreement	Means a written agreement between a Network Provider and Contractor, Subcontractor, or Downstream Subcontractor.
805 Report	Written report required under Business and Professions Code Section 805(b).
Quality Improvement (QI)	Means a systematic and continuous actions that lead to measurable improvements in the way health care is delivered and outcomes for Members.
Quality Improvement and Health Equity Committee (QIHEC)	Means a committee facilitated by CHPIV's medical director, or the medical director's designee, in collaboration with the Health Equity officer, to meet at least quarterly to direct all QIHETP findings and required actions.
Quality Improvement and Health Equity Transformation Program (QIHETP)	Means the systematic and continuous activities to monitor, evaluate, and improve upon the Health Equity and health care delivered to Members in accordance with the standards set forth in applicable laws, regulations, and this Contract.
Senior and Person with Disability (SPD)	Means a member who falls under a specific SPD aid code as defined by DHCS.
Social Drivers of Health	Means the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risk
Subcontractor	Means an individual or entity that has a Subcontractor Agreement with Contractor that relates directly or indirectly to the performance of Contractor's obligations under this Contract. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.
Subcontractor Agreement	Means a written agreement between Contractor and a Subcontractor. The Subcontractor Agreement must include a delegation of Contractor's duties and obligations under the Contract.

	Claims and Provider Dispute Resolution	CLM-001
Department	Finance, Network & Informatics	
Functional Area	Claims, Provider Dispute Resolution	
Impacted Delegate	☒ Subcontractor ☐ NA	

DATES			
Policy Effective Date	6/12/23	**Reviewed/Revised Date**	
Next Annual Review Due	6/12/24	**Regulator Approval**	

APPROVALS			
Internal		**Regulator**	
Name	Mark Southworth	☐ DHCS ☐ NA ☒ DMHC	
Title	Chief Financial Officer		

ATTACHMENTS
NA

AUTHORITIES/REFERENCES

- **Internal**
  - CHPIV, Delegation Oversight Policy and Procedure, CMP-002
- **Federal**
  - 42 Code of Federal Regulations ("CFR") 438.114(b)(c)(d)
- **State**
  - California Health and Safety Code Sections ("H&S Code") 1317, 1317.1, 1363.5, 1367 (g) – (j), 1367.01, 1367.02 (c) – (d), 1368(a), 1370, 1370.2, 1371, 1371.1, 1371.2, 1371.8, 1371.22, 1371.30, 1371.31, 1371.35, 1371.36, 1371.37, 1371.38, 1371.39, 1371.4, 1371.5, 1371.8, 1371.9, 1375.1, 1375.4, 1399.55, 1399.56
  - Title 28 California Code of Regulations Rules ("CCR") 1300.67.3, 1300.68(d), 1300.71, 1300.71.31, 1300.71.38, 1300.71.39, 1300.71.4, 1300.74.30 (a) – (c), 1300.77.4, 1300.75.4.1(b), 1300.75.4.5, 1300.77.2, 1300.77.4, 1300.85.1
  - DMHC: Technical Assistance Guide ("TAG") "Claims Management and Processing" (last published 01/31/2020); All Plan Letter ("APL") 23-008
  - DHCS: DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III, Section 3.2.2, 3.2.3, 3.3.5

HISTORY

Revision Date	Description of Revision
6/12/2023	Policy creation

I. OVERVIEW

A. This policy addresses Community Health Plan of Imperial Valley's ("CHPIV" or the "Plan") Claims and Provider Dispute Resolution ("PDR") requirements, policies, and procedures. The purpose of this policy is to establish a comprehensive Claims and Provider Dispute Resolution process.

II. POLICY

A. CHPIV ensures payment of all CLEAN CLAIMS submitted by Network Providers in accordance with the Department of Health Care Services (DHCS) Medi-Cal Contract, and federal and state laws and regulations, unless agreed in writing to an alternate payment schedule.
B. CHPIV ensures compliance with 42 USC section 1396u-2(f) and Health and Safety Code sections 1371-1371.36 and their implementing regulations, unless agreed in writing to an alternate payment schedule. CHPIV shall be subject to any penalties and sanctions, including interest payments, provided by law if CHPIV fails to meet the standards specified in the DHCS Medi-Cal Contract.
C. CHPIV ensures payment of 90% of all CLEAN CLAIMS from Providers within 30 calendar days of the DATE OF RECEIPT, and 99% of all CLEAN CLAIMS from Providers' claims, within 90 calendar days of the DATE OF RECEIPT. For purposes of determining timeliness, the DATE OF RECEIPT shall be the date CHPIV receives the claim, as indicated by CHPIV's date stamp on the claim. The date of CHPIV's payment shall be the date of CHPIV's check or other form of payment.
D. CHPIV ensures accrued interest at the rate of 15% per annum for non-paid CLEAN CLAIMS beginning with the first calendar day after 45-working-days from the DATE OF RECEIPT.
E. CHPIV maintains procedures for pre-payment and post-payment claims review, including review of any data associated with Providers, MEMBERS, and the Covered Services for which payment is claimed, to ensure the proper and efficient payment of claims.
F. CHPIV ensures sufficient claims processing, tracking, and payment systems capability to comply with applicable State and federal law, regulations, and Contract requirements, to determine the status of received claims and to estimate incurred and unreported claims (IBNR) amounts as specified by 28 CCR sections 1300.77.1 and 1300.77.2.
G. CHPIV ensures development and maintenance of protocols for payment of claims to Out-of-Network Providers, and for communicating and interacting with Out-of-Network Providers regarding services and claims payment.
H. CHPIV ensures clinical protocols and evidence-based practice guidelines governing Prior Authorization, Utilization Management and Retrospective Review are provided to all Out-of-Network Providers providing services to its MEMBERS. Contractor must arrange to provide these protocols and guidelines at the time that Contractor enters into an agreement with an Out-of-Network Provider or anytime an Out-of-Network Provider submits a claim for services provided to Contractor's MEMBERS.

I. CHPIV ensures in accordance with the Health and Safety (H&S) Code section 1367, Contractor must have a fast, fair, and cost-effective dispute resolution process in place for Providers, Network Providers, Subcontractors, and Downstream Subcontractors to submit disputes. CHPIV maintains separate dispute resolution mechanism for contracted and non-contracted provider disputes and separate dispute resolution mechanisms for claims and other types of billing and contract disputes.

J. CHPIV ensures there is a formal procedure to accept, acknowledge, and resolve Provider, Network Provider, Subcontractor, and Downstream Subcontractor disputes. The resolution process must occur in accordance with the timeframes set forth in H&S Code sections 1371 and 1371.35 for both contracted and non-contracted Providers. Any Provider of Medi-Cal services may submit a dispute to Contractor regarding:
    1. The authorization or denial of a service;
    2. The processing of a payment or non-payment of a claim by Contractor; or
    3. The timeliness of the reimbursement on an uncontested CLEAN CLAIM and any interest Contractor is required to pay on claims reimbursement.

K. Contractor's Provider Dispute Resolution process must be set forth in all Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements.

L. Any provider that submits a claim dispute to the plan's capitated provider's dispute resolution mechanism involving an issue of medical necessity or utilization review shall have an unconditional right of appeal for that claim dispute to CHPIV's dispute resolution process for a de novo review and resolution for a period of 60 working days from the capitated provider's DATE OF DETERMINATION.

M. CHPIV assumes the responsibility for the processing and timely reimbursement of provider claims if the claims processing organization or the capitated provider fails to timely and accurately reimburse its claims (including the payment of interest and penalties). CHPIV obligation to assume responsibility for the processing and timely reimbursement of a capitated provider's provider claims may be altered to the extent that the capitated provider has established an approved corrective action plan.

    ~~4.~~1. CHPIV's contract with a claims processing organization or a capitated provider shall not relieve CHPIV of its obligations to comply with sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28.

~~K.~~N. Contractor must inform all Providers, Network Providers, Subcontractors, and Downstream Subcontractors that provide services to Contractor's MEMBERS of its Provider Dispute Resolution process, regardless of contracting status.

~~L.~~O. Contractor must resolve Provider, Network Provider, Subcontractor, and Downstream Subcontractor disputes within the timeframes set forth in H&S Code section 1371.35 of receipt of the dispute, including supporting documentation. Contractor and Provider, Network Provider, Subcontractor, or Downstream Subcontractor may agree that additional time is needed. If Contractor unilaterally requests additional time, it must show good cause for the extension and provide supporting good cause documentation to DHCS upon request.

~~M.~~P. Contractor must submit a Provider Dispute Resolution Report annually to DHCS which includes information on the number of Providers who utilized the dispute resolution mechanism, delineated by Providers, Network Providers, Subcontractors, and Downstream

Subcontractors and a summary of the disposition of those disputes, in accordance with H&S Code section 1367(h)(3).

~~N.~~Q. On an annual basis Contractor must assess the Providers, Network Providers, Subcontractors, and Downstream Subcontractors that regularly utilize the Provider Dispute Resolution process to identify trends and systemic issues. Contractor must submit the results of its annual assessment to DHCS with discussion on how it is addressing trends and systemic issues identified based on the assessment.

III. PROCEDURE

A. CHPIV delegates the Claims and Provider Dispute Resolution process to its Subcontractor, Health Net.

~~A.~~B. CHPIV retains a separate dispute resolution mechanism to resolve claims payment disputes when providers exhaust the Provider Dispute Resolution process with Health Net.

~~B.~~C. Delegation Oversight

1. CHPIV shall provide oversight and continually assess the aforementioned functions, responsibilities, processes, and performance of Health Net. CHPIV ensures Health Net's compliance with regulatory and contractual requirements through the following activities which are detailed in *CHPIV Policy CMP-002: Delegation Oversight Policy and Procedure*:
   a. Ongoing monitoring
   b. Performance reviews
   c. Data analysis
   d. Utilization of benchmarks, if available
   e. Annual desktop and on-site audits

IV. DEFINITIONS

Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the "Definitions" below.

TERM	DEFINITION
Member	A beneficiary enrolled in a CHPIV program.
Authorized Representative	Means any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member.
Clean Claim	Means a claim that can be processed without obtaining additional information from the Provider or from a third party.
Contracted Provider Dispute or Appeal	A contracted provider's written notice to the Plan and/or its delegate HNCS challenging, appealing or requesting post-service reconsideration of a claim (including a bundled group of substantially similar multiple claims that are individually numbered) that has been denied (including due to being "not medically necessary"), adjusted or contested, or seeking resolution of a billing determination or other contract dispute (or

TERM	DEFINITION
	a bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered) or a request for reimbursement of an overpayment of a claim. The dispute must contain, at a minimum, the following information: the provider's name; the provider's identification number; contact information; and • If the appeal concerns a claim or a request for reimbursement of an overpayment of a claim, a clear identification of the disputed item, including the original claim ID or submission ID number, the date of service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect; • If the appeal is not about a claim, a clear explanation of the issue and the provider's position thereon (e.g. not medically necessary denial or contract dispute); and/or • If the appeal involves a member or group of members: the name and identification number(s) of the member or members, a clear explanation of the disputed item, including the date of service, original claim ID or submission ID number, and the provider's position thereon.
Contested Claim	When the Plan and/or its delegated HNCS has determined that it has not received the Complete Claim and all of the information necessary to determine payer liability for the claim, or has not been granted reasonable access to information concerning practitioner services. Information necessary to determine payer liability for the claim includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for the Plan and/or its delegate HNCS to determine the medical necessity for the health care services provided. The notice that a claim, or portion thereof, is contested by the Plan and/or its delegate HNCS will identify the portion of the claim that is contested, by revenue code, and the specific information needed from the provider to reconsider the claim.
Date of Contest/Date of Denial/Date of Notice	The date of postmark or electronic mark accurately setting forth the date when the contest, denial, or notice was electronically transmitted or deposited in the US Mail or another mail or delivery service, correctly addressed to the claimant's office or other address of record with proper postage.
Date of Determination	The date of postmark or electronic mark on the written provider dispute determination or amended provider dispute determination that is delivered, by physical or electronic means, to the claimant's office or other address of record. To the extent that a postmark or electronic mark is unavailable to confirm the Date of Determination, the Plan and/or its delegate HNCS will consider the date the check is printed for any monies determined to be due and owing to the provider and the date the check is presented for payment.

TERM	DEFINITION
Date of Receipt	The Working Day when the provider dispute or amended provider dispute, by physical or electronic means, is first delivered to the Plan and/or its delegate HNCS' designated Provider Appeals Unit or post office box.
Non-Contracted Provider Dispute or Appeal	A non-contracted provider's written notice to the Plan and/or its delegate HNCS challenging, appealing or requesting post-service reconsideration of a claim (including a bundled group of substantially similar claims that are individually numbered), which has been denied (including for not being "not medically necessary"), adjusted or contested, or disputing a request for reimbursement of an overpayment of a claim. The dispute must contain, at a minimum, the following information: the provider's name, the provider's identification number, contact information and: • If the dispute concerns a claim or a request for reimbursement of an overpayment of a claim, a clear identification of the disputed item, including the original claim ID or submission ID number, including the date of service, and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, contest, denial, request for reimbursement of an overpayment of a claim or other action is incorrect. • If the dispute is not about a claim, a clear explanation of the issue and the provider's position thereon (e.g. medical necessity); and • If the dispute involves a member or group of members, the name and identification number(s) of the member or members, a clear explanation of the disputed item, including the date of service, original claim ID or submission ID number, and the provider's position thereon.
Overpayment	Reimbursement of a claim that has been determined to have been overpaid. The Plan and/or its delegate HNCS notifies the provider in writing through a separate notice identifying the overpayment and the amount of the overpayment, the provider shall reimburse the Plan and/or its delegate HNCS within 30 working days of receipt by the provider of the notice of overpayment unless the overpayment or portion thereof is contested by the provider in which case the Plan and/or its delegate HNCS shall be notified, in writing, within 30 working days. The provider's notice contesting the validity of an overpayment shall identify the portion of the overpayment that is contested and the specific reasons for contesting the overpayment.
Reasonably Relevant Information	The minimum amount of itemized, accurate and material information generated by or in the possession of the provider related to the billed services that enables a claims adjudicator with appropriate training, experience, and competence to timely and accurately process claims to determine the nature, cost, if applicable, and extent of the Plan and/or its delegate HNCS' liability, if any, and to comply with any governmental information requirements.
Working Days	Means Monday through Friday, except for state holidays as identified at

TERM	DEFINITION
	the California Department of Human Resources State Holidays page.

	States of Emergency	BC-001
Department	Finance, Network & Informatics	
Functional Area	Business Continuity	
Impacted Delegate	☒ Subcontractor ☐ NA	

DATES			
Policy Effective Date	6/12/2023	**Reviewed/Revised Date**	
Next Annual Review Due	6/12/2024	**Regulator Approval**	

APPROVALS			
Internal		**Regulator**	
Name	Mark Southworth	☐ DHCS ☐ NA ☒ DMHC	
Title	Chief Financial Officer		

ATTACHMENTS

NA

AUTHORITIES/REFERENCES

- **Internal**
  - CHPIV, Delegation Oversight Policy and Procedure, CMP-002
- **State**
  - California Health and Safety Code Sections ("H&S Code") 1368.7
  - California Government Code Sections 8625 and 101080
  - DMHC: All Plan Letter ("APL") 23-002
  - DHCS: DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III, Section 6.~~0~~ 1.5, 6.2, & 6.3

HISTORY

Revision Date	Description of Revision
6/12/2023	Policy creation
7/6/2023	Policy revised to include references to health emergency
2/7/2024	Policy revised to include DHCS timeframe requirements

I. OVERVIEW

A. This policy addresses Community Health Plan of Imperial Valley's ("CHPIV" or the "Plan") States of EMERGENCY requirements, policy, and procedures. The purpose of this policy is to establish an EMERGENCY PREPAREDNESS and Response Plan.

II. POLICY

A. CHPIV ensures there is an EMERGENCY PREPAREDNESS and Response Plan in place which includes, at a minimum:
   1. BUSINESS CONTINUITY EMERGENCY PLAN, as described in Exhibit A, Attachment III, Section 6.2 *(BUSINESS CONTINUITY EMERGENCY PLAN);*
   2. MEMBER EMERGENCY PREPAREDNESS PLAN, as described in Exhibit A, Attachment III, Section 6.3 *(MEMBER EMERGENCY PREPAREDNESS PLAN);* and
   3. Ensuring policies and procedures comply with all the requirements set forth in Article 6.

B. CHPIV ensures that the EMERGENCY PREPAREDNESS and Response Plan will be approved by DHCS prior to the start of CHPIV operations and will comply with guidance issued by the Department related to the emergency. Any updates to deliverables identified in this section must be submitted to DHCS as requested.

~~C.~~ CHPIV ensures enrollee who has been displaced by a state of EMERGENCY, as declared by the Governor pursuant to Section 8625 of the Government Code, or a health emergency, as declared by the State Public Health Officer pursuant to Section 101080 are provided access to medically necessary health care services.

C.

~~D.~~ CHPIV will notify DHCS within 24 hours of a federal, State, or county declared state of Emergency located within CHPIV's Service Area as to whether CHPIV and its subcontractors within Imperial County has experienced or expects to experience any disruption to its operations. CHPIV will report the status of its operations once a day to DHCS, or as directed by DHCS. CHPIV's daily report to DHCS must include, at a minimum, the following information:

D.

1. The number of Members in CHPIV's Service Area affected by the Emergency, per county, including the number of medium-to-high health risk Members, as identified through the Population Needs Assessment;
2. Information, to the extent available, relating to Network Provider site closures, including:
   a. The number of Network Provider site closures by Provider type, per county;
   b. The number of Members served by each closed Network Provider, per county;
   c. The number of hospitalized Members who need to be transferred;
   d. The location(s) of where Members were transferred; and
   e. For each closed Network Provider, a list of the alternative Providers or facilities where Members can receive care.
3. The number of CHPIV offices that are closed;
4. How CHPIV is communicating with impacted Members, Network Providers, Subcontractors, and Downstream Subcontractors;

5. The actions CHPIV has taken or will take to meet the continued health care needs of its Members; and
6. The Network Provider, Subcontractor, Downstream Subcontractor, or Member issues CHPIV has received.

CHPIV will submit a filing with DMHC wWithin 48 hours of a declaration by the Governor of a state of EMERGENCY or a declaration by the State Public Health Officer of a health emergency that displaces or has the immediate potential to displace enrollees or health care providers.; CHPIV ensures a notificationthe filing describing describes whether the plan has experienced or expects to experience any disruption to the operation of CHPIV and its subcontractors within Imperial County is filed with the department., explaining how CHPIV is communicating with potentially impacted enrollees, and summarizing the actions CHPIV has taken or is in the process of taking to ensure that the health care needs of enrollees are met.

E. CHPIV will take actions, including, but not limited to, the following:
   1. Shorten time limits plans to approve prior authorization, precertification, or referrals, and extend the time that prior authorizations, precertifications, and referrals remain validRelaxed time limits for prior authorization, precertification, or referrals.
   2. Extended filing deadlines for claims.
   3. Suspend prescription refill limitations and allow an impacted enrollee to refill his or her prescriptions at an out-of-network pharmacy.
   4. Authorize an enrollee to replace medical equipment or supplies.
   5. Allow enrollees to access an appropriate out-of-network provider if an in-network provider is unavailable due to the state of EMERGENCY or if the enrollee is out of the area due to displacement.
   6. Have a toll-free telephone number that an affected enrollee may call for answers to questions, including questions about the loss of health insurance identification cards, access to prescription refills, or how to access health care.

A. CHPIV will notify DHCS as to whether CHPIV and its subcontractors within Imperial County has experienced or expects to experience any disruption to its operations. CHPIV will report the status of its operations once a day to DHCS, or as directed by DHCS.

III. PROCEDURE

A. Delegation Oversight
   1. CHPIV shall provide oversight and continually assess the delegated functions, responsibilities, processes, and performance of Health Net. CHPIV ensures Health Net's compliance with regulatory and contractual requirements through the following activities which are detailed in *CHPIV Policy CMP-002: Delegation Oversight Policy and Procedure*:
      a. Ongoing monitoring
      b. Performance reviews
      c. Data analysis
      d. Utilization of benchmarks, if available
      e. Annual desktop and on-site audits

IV. DEFINITIONS

Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the "Definitions" below.

TERM	DEFINITION
Member	A beneficiary enrolled in a CHPIV program.
Emergency	Means unforeseen circumstances that require immediate action or assistance to alleviate or prevent harm or damage caused by public health crises, natural and man-made hazards, or disasters.
Emergency Preparedness	Means a continuous cycle of planning, organizing, training, equipping, exercising, evaluating, and taking Corrective Action to ensure effective coordination during incident response
Business Continuity Emergency Plan	Means a document consisting of the critical information and processes HealthNet's needs to continue operating during an Emergency
Member Emergency Preparedness Plan	Means a required subsection of the Emergency Preparedness and Response Plan that details the required coordination between CHPIV and its Members, Network Providers, Subcontractors, and Downstream Subcontractors to ensure Member access to health care services in the event of an Emergency.

	Standards of Network Accessibility and Timely Access to Care	PNM-001
Department	Finance, Network & Informatics	
Functional Area	Provider Network Management	
Impacted Delegate	☒ Subcontractor ☐ NA	

DATES			
Policy Effective Date	6/12/2023	**Reviewed/Revised Date**	
Next Annual Review Due	6/12/2024	**Regulator Approval**	

APPROVALS			
Internal		**Regulator**	
Name	Mark Southworth	☐ DHCS ☐ NA ☒ DMHC	
Title	Chief Financial Officer		

ATTACHMENTS
NA

AUTHORITIES/REFERENCES

- **Internal**
  - CHPIV, Delegation Oversight Policy and Procedure, CMP-002
- **Federal**
  - Title 42 Code of Federal Regulations ("CFR") 438.3(f)(1), 438.68, 438.206, 438.207
  - 42 United States Code ("USC") Section 18116
- **State**
  - California Health and Safety Code Sections ("H&S Code") 1317, 1345(b), 1367.03, 1367.031,
  - Title 22 California Code of Regulations Rules ("CCR") 14087.48 (b)(2) and (b)(4);
  - Title 28 CCR Rules 1300.51(H) and (J), 1300.67, 1300.67.04, 1300.67.2, 1300.68
  - DMHC All Plan Letters ("APLs") 22-024, 22-026, 22-027, and 22-029
  - 2024 DHCS Contract Exhibit A Attachment III Sections 5.2.4, 5.2.5, 5.2.7, 5.2.8, 5.2.9, 5.2.10, 5.2.12, 5.2.13
  - DHCS All Plan Letters ("APLs") 18-022, 20-003, 21-003, 21-004, 23-001
- **Accreditation**
  - NCQA: Network Management (NET) 1, Elements B-D; NET 2, Elements A-C; NET 3, Elements A-C

HISTORY

Revision Date	Description of Revision
6/12/2023	Policy creation
10/20/2023	Policy revision
1/30/2024	Policy revision: DMHC filling and DHCS APL 23-006

	Standards of Network Accessibility and Timely Access to Care	PNM-001

HISTORY	

I. OVERVIEW

A. This policy addresses Community Health Plan of Imperial Valley's ("CHPIV" or the "Plan") standards of NETWORK adequacy and accessibility and timely access to care requirements, policy, and procedures. This policy addresses NETWORK adequacy, accessibility, and timely access to care standards contained within relevant federal and state statutes, regulations, the Medi-Cal contract with the state Department of Health Care Services (DHCS), and if applicable, accreditation standards. Access to NETWORK PROVIDERS and Covered Services

II. POLICY

A. CHPIV ensures the development and maintenance of the NETWORK Accessibility and Timely Access to Care policies and procedure(s) to provide NETWORK Accessibility and Timely Access to Care services in compliance with all Legal Authority.

B. Access to NETWORK PROVIDERS and Covered Services

1. Primary Care

- **a.** CHPIV ensures that each Member has an assigned Primary Care Provider (PCP) who is available and physically present at the Service Location for sufficient time to ensure access and appointments for the assigned Member when medically required. This requirement does not preclude an appropriately licensed Provider from being a substitute for the Member's assigned PCP in the event of vacation, illness, or other unforeseen circumstances.
- **b.** CHPIV ensures it has processes in place to assist Members in selecting PCPs who are accepting new patients.
- **c.** CHPIV ensures that Members have the option of selecting an Indian Health Service Program (IHS), Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC), as their PCP, where available.

2. Specialists

- **a.** CHPIV ensures that Members have access to Specialists for Medically Necessary Covered Services in accordance with W&I Code section 14197, 22 California Code of Regulations (CCR) section 53853, and 28 CCR section 1300.67.2.2.
- **b.** CHPIV ensures the maintenance of an adequate NETWORK that includes adult and pediatric Specialists, and at a minimum, the core Specialists required in W&I Code section 14197(h)(2), within its NETWORK to ensure Medically Necessary specialty care is available in accordance with 22 CCR section 53853(a), and W&I Code sections 14182(c)(2) and 14087.3.

3. CHPIV ensures its NETWORK PROVIDERS, SUBCONTRACTORS, and DOWNSTREAM SUBCONTRACTOR have adequate NETWORKs and staff within its Service Area, including Physicians, Nurses, administrative, and other support staff to ensure that they have sufficient capacity to provide and coordinate care for Covered Services are provided in

accordance with 22 CCR section 53853, W&I Code section 14197, 28 CCR section 1300.67.2.2 and all requirements in this contract.

4. CHPIV will monitor its SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS to ensure they can adequately deliver culturally and linguistically competent care including offering interpreter services when a Limited English Proficient (LEP) Member accesses a Provider who does not speak the Member's language.
5. CHPIV ensures that Members have access to all Non-specialty Mental Health and Substance Use Disorder Covered Services in accordance with 42 CFR section 438.900 et seq. and will coordinate care for all Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) services and provide referrals including mechanisms to track completion of follow up visits, to the county mental health plan (MHP) and Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services as outlined in Exhibit A, Attachment III, Section 5.5 (Mental Health and Substance Use Disorder Benefits)

C. NETWORK Capacity

1. CHPIV maintains a NETWORK adequate to provide the full scope of benefits to 60 percent of all Potential Members or current Member Enrollment, whichever is higher, within its Service Area. CHPIV must increase the capacity of the NETWORK as necessary to accommodate all Enrollment growth beyond 60 percent.
2. CHPIV requests to renegotiate its NETWORK capacity requirement with DHCS if utilization by CHPIV's Members does not exceed 75 percent of the required NETWORK capacity, after the first 12 months of operation. Any such change is subject to DHCS review and approval.

D. NETWORK Composition

1. CHPIV maintains an adequate NETWORK within CHPIV's Service Area, in compliance with W&I Code section 14197, and if necessary to ensure contract compliance with NETWORK adequacy. CHPIV may offer to contract with Providers in adjoining Service Areas but must make good faith efforts to contract with Providers within CHPIV's Service Area. CHPIV's NETWORK must include at a minimum adult and pediatric PCPs, obstetrics, and gynecology (OB/GYNs), adult and pediatric behavioral health Providers, adult and pediatric Non-specialty outpatient mental health service (NSMHS) Providers, adult and pediatric Specialists, hospitals, and Long-Term Care (LTC) Providers to ensure adequate access to all Medically Necessary Covered Services for all Members and to meet all NETWORK adequacy requirements.
2. CHPIV maintains an adequate NETWORK of Allied Health Personnel, supportive paramedical personnel, public hospitals and health care systems, care navigators, caseworkers, and public health nurses, and an adequate number of accessible service sites to ensure adequate access to all Medically Necessary Covered Services for all Members.
3. CHPIV includes in its NETWORK, where available, IHS, FQHC, RHCs, Freestanding Birthing Centers (FBC), Certified Nurse Midwives (CNM), and Licensed Midwives (LM) in accordance with W&I Code section 14087.325, Medicaid State Health Official Letter #16-006, and APL 18-022. 1)

4. CHPIV contracts with a sufficient number of and include at least one FQHC, one RHC, and one FBC in the NETWORK, where available in Contractor's Service Area(s), to the extent that the FQHC, RHC, and FBC Providers are licensed and recognized under State law.
5. CHPIV offers to contract with all IHS available in Imperial County in accordance with 22 CCR section 55120. If CHPIV is unable to contract with an IHS, it must allow eligible members to obtain services from out-of-network IHS as per 42 CFR section 438.14.
6. CHPIV continually ensures that the composition of its NETWORK meets the ethnic, cultural, and linguistic needs of CHPIV's Members.
7. CHPIV ensures it has an adequate number of NSMHS Providers to provide Medically Necessary, NSMHS based on current and anticipated utilization trends for its Members.
8. CHPIV includes in its NETWORK any traditional and Safety-Net Provider that is willing to contract under the same terms and conditions that CHPIV offers to any other similar Provider in accordance with 22 CCR section 53800(b)(2)(C)(1).
9. CHPIV ensures that every LTC Provider in its Service Area is licensed by the California Department of Public Health (CDPH) as a qualified LTC Provider is included in their NETWORK, to the extent that the Provider remains licensed, certified, operating, and is willing to enter into a NETWORK Provider Agreement on mutually agreeable terms and meets Credentialing and quality standards. If CHPIV determines that additional LTC Providers are necessary to meet the needs of its Members, it will offer to contract or enter into a letter of agreement with any additional CDPH licensed LTC Providers in its Service Area or in adjoining Service Areas.
10. CHPIV receives a preapproval or assessment of suitability from CDPH prior to the execution of a NETWORK Provider Agreement for LTC Providers undergoing a change of ownership. NETWORK Provider Agreements must have a clause that LTC Providers must notify CHPIV if it is undergoing a change of ownership to obtain preapproval or assessment of suitability from CDPH.
11. CHPIV contracts with a sufficient number of Community-Based Adult Service (CBAS) Providers to timely meet the needs of Members who are CBAS eligible. CHPIV must have an adequate number of CBAS Providers that are geographically located within one hour's transportation time and that are appropriate for and proficient in addressing CBAS-eligible Members' specialized health needs and acuity, communication, cultural, and language needs and preferences. CHPIV must also meet expected CBAS utilization without a waitlist. CHPIV may, but is not obligated to, contract with CBAS Providers licensed as Adult Day Health Cares (ADHC) and certified by California Department of Aging (CDA) to provide CBAS on or after April 1, 2012.
12. CHPIV's Ssubcontractor ~~shall have~~maintains a process for identifying network providers and verifying that the information and data collected for reporting is true and correct and does not contain misstatements or omissions of material fact. CHPIV's subcontractor utilizes an external vendor to validate provider data included in the Timely Access Compliance Report to ensure its accuracy. CHPIV ~~The process shall include a description of how the plan designates an individual to serve as a~~ 's Chief Ccompliance ~~o~~Officer, whose qualifications are described in CHPIV's Compliance ~~Plan~~Program, ~~who~~ is responsible for reviewing and submitting the required reports and information.

13. CHPIV shall not prevent, discourage, or discipline a network provider or employee for informing an enrollee or subscriber about the timely access standards.

E. NETWORK Ratios

1. CHPIV ensures it complies with 22 CCR section 53853(a)(1) - (2) and ensure that its NETWORK meets the following full-time equivalent (FTE) Physician to Member ratios:
    a. FTE Primary Care Providers that are Physicians: Member: 1:2,000
    b. FTE Total Physicians: Member 1:1,200
2. CHPIV ensures that FTE non-physician medical practitioner's Member caseload does not exceed 1,000 patients in accordance with 22 CCR section 53853(a)(3).
3. CHPIV ensures compliance with 22 CCR sections 51240 and 51241, and Business and Professions Code sections 3516 and 2836.1 and full-time equivalent Physician supervisor to non-physician medical practitioner ratios do not exceed the following:
    - Physician Supervisor: Nurse Practitioners 1:4
    - Physician Supervisor: Physician Assistants 1:4
    - A Physician supervisor may not supervise more than four non-physician medical practitioners in any combination.

F. NETWORK Adequacy Standards

1. Timely Access
    a. CHPIV ensures compliance with 22 CCR sections 51240 and 51241, and Business and Professions Code sections 3516 and 2836.1 and full-time equivalent Physician supervisor to non-physician medical practitioner ratios do not exceed the following:
        i. CHPIV on a quarterly basis shall perform a review of all information available to The Plan regarding The Plans ability to meet timey access requirements as required by CCR section 1300.67.2.2 and 1300.68
    b. CHPIV ensures the development, implementation, and maintenance of procedures to monitor and ensure that its NETWORK PROVIDERS, SUBCONTRACTORS, and DOWNSTREAM SUBCONTRACTORS:
        i. CHPIV shall comply with the following requirements for Members to obtain appointments for routine care, Urgent Care, routine specialty referral appointments, prenatal care, Children's preventive periodic health assessments, and adult initial health assessments in accordance with W&I Code section 14197, and 28 CCR section 1300.67.2.2:
            A. Urgent Care appointment for services that do not require Prior Authorization within 48 hours of a request;
            B. Urgent Care appointment for services that do require Prior Authorization within 96 hours of a request;
            C. Non-urgent appointments for Primary Care within ten (10) business days of request;
            D. Non-urgent appointments with Specialist Physicians within 15 business days of request;
            E. Non-urgent appointment with a non-physician mental health Provider with ten (10) business days of request;

F. Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness within fifteen (15) business days of request;

G. Availability of LTC Providers within seven (7) business days of request;

H. Non-urgent follow-up appointments with a nonphysician mental health care (NPMH) or substance use disorder provider must be offered within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition, except as provided in Section 1367.03(a)(5)(H);

I. Substance use disorder providers have been added to the standards applicable to mental health care providers set forth in Section 1367.03, including the time-elapsed non-urgent appointment standard;

J. A referral to a specialist by a primary care provider or another specialist shall be subject to the relevant time-elapsed standard, unless the requirements in Section 1367.03, sub. (a)(5)(H) or (I) are met.

c. In the event that CHPIV, or a delegated subcontractor, has a shortage of one or more types of providers, CHPIV shall ensure timely access to covered health care services as required by this section, including applicable time-elapsed standards, by referring enrollees to, or, in the case of a preferred provider organization or point-of-service network, by assisting enrollees to locate, available and accessible network providers in neighboring network service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs.

i. A plan shall arrange for the provision of covered of services from providers outside the plan's network if unavailable within the network, when medically necessary for the enrollee's condition. As with in-network services, members will not have any cost obligations, and out-of-network providers are prohibited from balance billing CHPIV members. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific network provider. If medically necessary treatment of a mental health or substance use disorder is not available in network within the geographic and timely access standards set by law or regulation, a health care service plan shall arrange coverage outside the plan’s network in accordance with subdivision (d) of Section 1374.72.

d. CHPIV shall comply with all time-elapsed standards set forth in Section 1367.03(a) and Rule 1300.67.2.2(c) and will evaluate overall compliance in a manner consistent with the definition of "patterns of non-compliance" set forth in Rule 1300.67.2.2(b)(12)(A) unless the plan has received an Order of Approval from the

Department for an alternative time-elapsed standard, an alternative to time-elapsed standards, or an alternative standard to the threshold rate of compliance.

e. CHPIV shall ensure that all plan and provider processes necessary to obtain covered health care services, including the processes required under section 1367.01 of the Knox-Keene Act, are completed in a manner that assures the provision of covered health care services to enrollees in a timely manner appropriate for the enrollee's condition and in compliance with the requirements of this Rule

2. CHPIV offers Members appointments for Covered Services within a time frame appropriate for their health condition but no longer than the appointment timeframes set forth in 28 CCR section 1300.67.2.2, unless the Member's preference is to wait for a later appointment from a specific NETWORK Provider. The applicable waiting time for a particular appointment may be extended if the following conditions are met:

a. The Member's medical record notes that waiting will not have a detrimental impact on the Member's health, as determined by the referring or treating licensed health care Provider, or by the health professional providing triage or screening services, who is acting within the scope of their practice consistent with professionally recognized standards of practice.

b. The Provider's decision to extend the applicable waiting time is noted in the Member's Medical Record and made available to DHCS upon request; and

c. CHPIV ensures that the Member receives notice of the Provider's decision to extend the applicable waiting time with an explanation of the Member's right to file a Grievance disputing the extension.

3. CHPIV provides the appointment time standards to NETWORK PROVIDERS, SUBCONTRACTORS, and DOWNSTREAM SUBCONTRACTORS, and monitors appointment waiting times in NETWORK PROVIDERS' offices pursuant to 42 CFR section 438.206, W&I Code section 14197, and 28 CCR section 1300.67.2.2.

4. CHPIV ensures that NETWORK PROVIDERS comply with requirements for follow up on missed appointments.

5. CHPIV offers hours of operation to Members that are no less than the hours of operation offered to non-Medi Cal patients, or to Medi-Cal Fee-For-Service (FFS) beneficiaries if the NETWORK Provider serves only Medi-Cal beneficiaries.

6. CHPIV maintains procedures for triaging Members' telephone calls, providing telephone medical advice, and accessing telephone interpreters 24 hours a day, seven days a week.

7. During normal business hours, the waiting time for a member to speak by telephone with a customer service representative knowledgeable and competent regarding the Member's questions and concerns must not exceed ten minutes.

8. CHPIV ensures it has a medical director or licensed Physician who is available 24 hours a day, seven days a week to assist with access issues.

9. For vision, chiropractic, and acupuncture services, CHPIV shall ensure that network providers employ an answering service or a telephone answering machine during nonbusiness hours, which provide instructions regarding how an enrollee may obtain urgent or emergency care, including, if applicable, how to contact another provider who

has agreed to be on call to triage or screen by phone, or if needed, deliver urgent or emergency care.

10. Advanced Access Verification Requirements

a. Advanced Access Verification Requirements shall include the definition set forth in Rule 1300.67.2.2(b)(1).

b. If CHPIV or its SUBCONTRACTORS, and DOWNSTREAM SUBCONTRACTORS uses Advanced Access to demonstrate compliance with the PAAS (Provider Appointment Availability Survey), then CHPIV ensures that NETWORK PROVIDERS comply with-the primary care time-elapsed standards established in 1300.67.2.2(b)(1) through implementation of standards, processes, and systems providing advanced access to primary care appointments in accordance with 1367.2.2(c)(5)(1

~~a.~~**c.** CHPIV's fully delegated SUBCONTRACTOR currently does not have an Advanced Access Program.

~~**b.** Advanced Access Verification Requirements shall include reviewing access and availability for providers offering advanced access appointments as well as enrollee grievances and appeals pursuant to Rule 1300.67.2.2(d)(2)(D).~~

~~**c.** Advanced Access Verification Requirements shall include the process for verifying at least once every three years that advanced access providers are scheduling appointments consistent with the definition of advanced access set forth in Rule 1300.67.2.2(b)(1).~~

~~**d.** Advanced Access Verification Requirements shall include requiring providers give written notice to plan no more than 30 calendar days after provider stops offering advanced access appointments.~~

G. Time or Distance

1. CHPIV ensures that its NETWORK PROVIDERS, SUBCONTRACTORS, and DOWNSTREAM SUBCONTRACTORS meet the time or distance standards for adult and pediatric PCPs, adult and pediatric core Specialists, OB/GYN primary and specialty care, adult and pediatric mental outpatient health Providers, and hospitals, as required by W&I Code section 14197(b) and (c).
2. CHPIV either exhausts all other reasonable options for contracting with Providers, including offering to contract with Providers in adjoining Service Areas, or provides evidence to DHCS demonstrating that its delivery structure is capable of delivering the appropriate level of care and access as required by W&I Code section 14197 prior to submitting an Alternate Access Standard (AAS) request to DHCS.
3. If CHPIV is unable to comply with the time or distance standards set forth in W&I Code section 14197, CHPIV must submit a AAS request to DHCS for review and approval in accordance with APL 21-006 detailing how it intends to arrange for Covered Services in accordance with W&I Code section 14197(e)(3).
4. Approved AAS requests must be published in its website in accordance with W&I Code section 14197.04.
5. If CHPIV has received an AAS approval from DHCS for a core Specialist, upon a Member's request, CHPIV must assist the Member in obtaining an appointment with the appropriate

core Specialist in accordance with W&I Code section 14197.04. CHPIV must either make its best effort to establish a Member-specific case agreement with an out-of-network Provider or arrange for an appointment with a NETWORK Provider in an adjoining Service Area within the time or distance standards in accordance with W&I Code section 14197.04. If needed, CHPIV must assist in arranging transportation for the Member. CHPIV must not be held liable for fulfilling these requirements if either there is no core Specialist within the time or distance standards of this Contract, or the core Specialist has refused to contract in the previous 12 months.

H. Quality Assurance

1. CHPIV shall develop and maintain policies, procedures and quality assurance monitoring systems that ensure its networks maintain compliance with the clinical appropriateness standard.
2. CHPIV shall document its standards and description of its process for monitoring triage standards including:
    a. Provision, 24 hours per day, 7 days per week of triage or screening services by telephone.
    b. Telephone triage or screening services are provided in a timely manner appropriate for the enrollee's condition, and the triage or screening waiting time does not exceed 30 minutes.
3. CHPIV's written quality assurance processes shall address tracking and documenting network capacity and availability with respect to the standards set forth in: Subsections (c)(1)-(4), (c)(5)(G)-(I), (c)(6), and (c)(8)-(9) of this Rule, except as provided by subsection (d)(2)(F) of this Rule.
4. CHPIV's written quality assurance processes shall address tracking and documenting network capacity and availability of network providers with respect to the standards set forth in Section 1367.03(a)(5)(A)-(G) and Rule 1300.67.2.2(c)(5)(A)-(F) by administering the Provider Appointment Availability Survey, pursuant to Rule 1300.67.2.2(f) of this Rule.
5. CHPIV's quality assurance monitoring process for identifying and addressing patterns of non-compliance shall include:
    a. The plan's definition(s) of "pattern of non-compliance", which at a minimum shall include the definitions set forth in Rule 1300.67.2.2(b)(12).
    b. The plan's mechanism and sources of information or data used to identify any patterns of non-compliance. CHPIV's subcontractor will investigate and request corrective actions when timely access to care requirements are not met. If CHPIV's subcontractor identifies providers and PPGs that are non-compliance with appointment and after-hours access requirements, a Corrective Action Plan (CAP) is issued. The CAP notification to the provider/PPG includes a description of the identified deficiencies, the rationale for the corrective action, and the contact information of the person authorized to respond to provider concerns regarding the corrective action. CHPIV oversees its subcontractor's compliance process according to CHPIV policy titled *CMP-002 Delegation Oversight*.
    c. The plan's process for implementing a corrective action plan when a pattern of non-compliance is identified, which shall describe the steps the plan intends to

take in order to address the non-compliance as outlined in CHPIV policy titled *CMP-003 Corrective Action Plan*.

6. CHPIV's quality assurance monitoring process for identifying and addressing incidents of non-compliance resulting in substantial harm to an enrollee shall include:
    a. The plan's definition of an incident of non-compliance resulting in substantial harm to an enrollee which at a minimum means substantial harm means loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, severe and chronic physical pain, or significant financial loss ~~shall include the definition set forth~~as defined in Civil Code section 3428. ~~in Civil Code section 3428.~~
    b. The plan's mechanism and sources of information used to identify and investigate incidents of non-compliance resulting in substantial harm to an enrollee. CHPIV's subcontractor will investigate and request corrective actions when timely access to care requirements are not met. If CHPIV's subcontractor identifies providers and PPGs that are non-compliance with appointment and after-hours access requirements, a Corrective Action Plan (CAP) is issued. The CAP notification to the provider/PPG includes a description of the identified deficiencies, the rationale for the corrective action, and the contact information of the person authorized to respond to provider concerns regarding the corrective action. CHPIV oversees its subcontractor's compliance process according to CHPIV policy titled *CMP-002 Delegation Oversight*.
    ~~b.~~
    c. The plan's process for implementing corrective action plan when an incident of non-compliance resulting in substantial harm to an enrollee is identified, which shall describe the steps the plan intends to take in order to address the non-compliance as outlined in CHPIV policy titled *CMP-003 Corrective Action Plan.*

I. Access to Emergency Service Providers and Emergency Services

1. CHPIV ensures it has, at a minimum, a designated Emergency Services facility, providing care 24 hours a day, seven days a week. This designated Emergency Services facility will have one or more Physicians and one nurse on duty in the facility at all times.
2. CHPIV ensures that Members with Emergency Medical Conditions are seen on an emergency basis and that Emergency Services are available and accessible within Contractor's Service Area seven days a week, 24 hours a day, in accordance with 42 United States Code (USC) sections 1395dd and 1396u-2(b)(2), and 42 Code of Federal Regulations (CFR) section 438.114.
3. CHPIV ensures it reimburses the costs of Emergency Services without Prior Authorization pursuant to 42 USC section 1395dd, 42 CFR section 438.114, 28 CCR section 1300.67(g), and 22 CCR section 53216 and 53855.
4. CHPIV ensure it has a medical director or licensed Physician acting on behalf of Contractor's medical director, who is available 24 hours a day, seven days a week to authorize Medically Necessary Post-Stabilization Care Services, to respond to hospital inquiries within 30 minutes, and to coordinate the transfer of a Member whose Emergency Medical Condition is stabilized.

5. CHPIV ensures that Members have timely access to Medically Necessary follow-up care including but not limited to appropriate referrals to Primary Care, Behavioral Health Services, and social services for Members who have been screened in the emergency room and do not require emergency care.
6. CHPIV coordinates access to Emergency Services in accordance with Contractor's DHCS-approved emergency department protocol, as required in Exhibit A, Attachment III, Section 3.2 (Provider Relations).
7. If CHPIV's Delegates downstream its Emergency Services and Post-Stabilization Care Services oversight obligations to NETWORK PROVIDERS, SUBCONTRACTORS, or DOWNSTREAM SUBCONTRACTORS, it must ensure a licensed Physician is available seven days a week, 24 hours a day, to authorize Medically Necessary Post-Stabilization Care Services and coordinate the transfer of stabilized Members in an emergency department to an appropriate NETWORK Provider, if necessary, as required under Health and Safety (H&S) Code section 1371.4.

J. Out-of-network Access

1. CHPIV must authorize and arrange for out-of-network access in the following circumstances:
   - **a.** CHPIV does not meet NETWORK adequacy requirements set forth in W&I Code section 14197;
   - **b.** CHPIV does not have an AAS approved by DHCS and fails to meet the NETWORK adequacy standards set forth in W&I Code section 14197;
   - **c.** CHPIV fails to comply with the requirements for timely access to appointments; or
   - **d.** CHPIV must arrange for access to out-of-network LTC when Medically Necessary for a Member in cases where CHPIV does not have in-NETWORK LTC capacity.
   - **e.** CHPIV ensures it authorizes and arranges for services from out-of-network Providers when the Provider type is unavailable within the NETWORK but available in an adjoining county(ies). If there is no NETWORK PROVIDER in the adjoining county(ies), it will authorize out-of-network services to the most appropriate Provider as close to time or distance requirements as possible.
   - **f.** CHPIV provides Non-Emergency Medical Transportation (NEMT) or Non-Medical Transportation (NMT) to the out-of-network Provider, at no cost to the Member and informs Members of their right to obtain NEMT or NMT services to access out-of-network services in accordance with W&I Code section 14197.04.
   - **g.** CHPIV adequately and timely covers and reimburses Providers for out-of-network services rendered to its Members for as long as it is unable to provide these services in its NETWORK. CHPIV ensures that it ensures that the Member is not charged for services furnished out-of-network, and that. CHPIV ensures that Members are not balance-billed for any service provided out-of-network.

K. Specific Requirements for Access to Programs and Covered Services

1. Family Planning Services
   - **a.** CHPIV ensures Members have access to family planning services through any available family planning Provider regardless of whether they are in or out of the

NETWORK, without requiring Prior Authorization. CHPIV shall provide family planning services in a manner that ensures Members have the freedom to choose their preferred method of family planning consistent with 42 CFR section 441.20.

b. CHPIV does not restrict a Member's Provider choice for family planning services covered pursuant to W&I Code section 14132.07, and 42 CFR section 431.51(a)(3).

c. CHPIV ensures that their Member Handbook must inform Members of their right to access any qualified family planning Provider regardless of whether the Provider is in the NETWORK and without Prior Authorization, in addition to requirements included in Exhibit A, Attachment III, Section 5.1 (Member Services).

d. CHPIV ensures that Members are advised of their options for all contraceptive methods to allow them to provide informed consent for their choice of contraceptive method, including sterilization, as required by 22 CCR sections 51305.1 and 51305.3.

e. Members of childbearing age may access the following services from an out-of-network family planning Provider to temporarily or permanently prevent or delay pregnancy:

i. Health education and counseling necessary to make informed choices and understand contraceptive methods;

ii. Limited history and physical examination;

iii. Laboratory tests if medically indicated as part of the decision-making process in choice of contraceptive methods, except pap smears if Contractor provides pap smears to meet the United States Preventive Services Taskforce (USPSTF) guidelines;

iv. Follow-up care for complications associated with contraceptive methods provided or prescribed by the family planning Provider;

v. Provision of contraceptive pills, devices, and supplies;

vi. Tubal ligation;

vii. Vasectomies; and

viii. Pregnancy testing and counseling.

2. Sexually Transmitted Diseases

a. CHPIV ensures Members have access to Sexually Transmitted Disease (STD) services from any NETWORK PROVIDER or out-of-network Provider without requiring Prior Authorization or referral. CHPIV allows Members to access out-of-network STD services through Local Health Department (LHD) clinics, family planning clinics, or through other community STD service Providers.

3. HIV Testing and Counseling

a. CHPIV ensures that Members have access to confidential Human Immunodeficiency Virus (HIV) counseling and testing services from any NETWORK PROVIDER or out-of-network Provider without requiring Prior Authorization.

4. Minor Consent Services

a. CHPIV ensures access to Minor Consent Services for Members less than 18 years of age from any NETWORK PROVIDER or out-of-network Provider without requiring Prior Authorization.

b. CHPIV ensures Members are informed of the availability of these services without Prior Authorization. Minors less than 18 years of age do not need parental or legal guardian consent to access these services, and CHPIV and its NETWORK PROVIDERS, SUBCONTRACTORS, or DOWNSTREAM SUBCONTRACTORS are prohibited from disclosing any information relating to Minor Consent Services without the express consent of the minor Member. Minor Consent Services include treatment for the following:

- **i.** Sexual assault, including rape;
- **ii.** Drug or alcohol abuse for children ages 12 and over;
- **iii.** Pregnancy;
- **iv.** Family planning;
- **v.** STDs in children ages 12 and over; and
- **vi.** NSMHS for children ages 12 and over who are mature enough to participate intelligently in their health care pursuant to Family Code section 6924.

5. Immunizations

- **a.** Members may access LHD clinics for immunizations regardless of whether the LHD is in the NETWORK or out-of-network, without Prior Authorization.
- **b.** Upon request, CHPIV will provide updated information on the status of the Member's immunizations to the LHD clinic.
- **c.** CHPIV ensures it reimburses LHD clinics that provide immunizations to its Members after receipt of claims and supporting immunization records.

6. Indian Health Service Programs

- **a.** CHPIV ensures qualified Members have timely access to IHS Providers within its NETWORK, where available, as required by 42 USC section 1396j, and Section 5006 of Title V of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. § 1396o(a)).
- **b.** IHS Providers, whether in the NETWORK or out-of-network, can provide referrals directly to NETWORK PROVIDERS without requiring a referral from a NETWORK PCP or Prior Authorization in accordance with 42 CFR section 438.14(b).
- **c.** CHPIV must also allow for access to an out-of-network IHS Provider without requiring a referral from a NETWORK PCP or prior authorization in accordance with 42 CFR section 438.14(b).

7. Nurse Midwife and Certified Nurse Practitioner Services

- **a.** CHPIV ensures that its Members have access to CNM services as required by 42 USC section 1396(d)(a)(17) and 22 CCR section 51345.
- **b.** CHPIV ensures its Members have access to Certified Nurse Practitioner (CNP) services as required in 22 CCR section 51345.1.
- **c.** CHPIV informs its Members that they have a right to obtain out-of-network CNM services if CNM services are not available in-NETWORK.

8. Services to Which NETWORK PROVIDER, Subcontractor, or DOWNSTREAM SUBCONTRACTOR Has a Moral Objection

- **a.** If a NETWORK PROVIDER, Subcontractor, or DOWNSTREAM SUBCONTRACTOR has religious or ethical objections to perform or otherwise support the provision of

Covered Services, CHPIV timely arranges for, coordinates, and ensures the Member receives the Covered Services through referrals to a Provider that has no religious or ethical objection to performing the requested service or procedure, at no additional expense to DHCS or the Member.

b. CHPIV's Member Handbook must identify services to which a NETWORK PROVIDER, Subcontractor, or DOWNSTREAM SUBCONTRACTOR may have a moral objection and explain that the Member has a right to obtain such services from another Provider.

c. CHPIV's informs the Member that it will assist the Member in locating a NETWORK PROVIDER who will perform the service or procedure.

9. Federally Qualified Health Center, Rural Health Clinic, and Freestanding Birthing Center Services

a. CHPIC meets meet federal requirements for access to FQHC, RHC, and FBC services consistent with 42 USC section 1396b(m) and Medicaid State Health Official Letter #16-006.

10. Community Based Adult Services

a. CHPIV provides Members with access to CBAS as set forth in the California Medi-Cal 2020 Demonstration, Number 11-W-00193/9 Special Terms and Conditions, amended December 29, 2020, or as set forth in any subsequent demonstration amendment or renewal, or successor demonstration, waiver, or other Medicaid authority.

i. Without limitation, CHPIV ensures it does the following:

A. Provides and coordinates the provision of unbundled CBAS services for affected CBAS recipients as needed for continuity of care if there is a 5 percent reduction in CBAS Provider capacity in a county within the Service Area relative to the capacity that existed on April 1, 2012; and

B. Arranges Medically Necessary Covered Services for Members with similar clinical conditions as CBAS recipients if there is insufficient CBAS Provider capacity in a county in which ADHC was available prior to April 1, 2012, and coordinate their access to community resources to assist them to remain in the community.

L. NETWORK and Access Changes to Covered Services

1. DHCS Notification Requirements

a. CHPIV provides notification to DHCS immediately upon discovery of a NETWORK PROVIDER initiated termination or at least 60 calendar days before any change occurs in the availability or location of services Contractor's Covered Services.

b. CHPIV provides this notice if the change impacts more than 2,000 Members or impacts the ability to meet NETWORK adequacy standards in accordance with APL 21-003. In the event of an emergency or other unforeseeable circumstance,

c. CHPIV notifies DHCS of the change in the availability or location of services as expeditiously as possible.

d. CHPIV provides notification to DHCS immediately, or within 10 calendar days of learning of a Provider's exclusionary status from any database or list included in APL 21-003 or subsequent revisions.

e. CHPIV notifies DHCS when it is unable to contract with a certified CBAS Provider or upon termination of a CBAS NETWORK PROVIDER Agreement. If the CBAS Provider cannot come to an agreement on terms, CHPIV ensures notification DHCS within five Working Days of decision to exclude the CBAS Provider from its NETWORK. DHCS may attempt to resolve the contracting issue when appropriate.

f. In accordance with APL 21-003, CHPIV ensures it notifies DHCS within 60 calendar days of termination of a LTC NETWORK PROVIDER or immediately if the termination is a result of the LTC NETWORK PROVIDER having been decertified by CDPH. DHCS will attempt to resolve the contracting issue when appropriate. If termination of a LTC NETWORK PROVIDER Agreement is for a cause related to Quality of Care or patient safety concerns, CHPIV may expedite termination of the LTC NETWORK PROVIDER Agreement and transfer Members to an appropriate, contracted LTC Provider in an expeditious manner. DHCS must be notified of the termination within 72 hours of said termination. CHPIV must not continue to assign or refer Members to a LTC NETWORK PROVIDER during the 60 calendar days between notifying DHCS and the termination effective date.

2. Member Notification Requirements

a. Pursuant to 42 CFR section 438.10(f), CHPIV ensures Members are notified in writing of any changes in the availability or location of Covered Services, of any termination of a NETWORK PROVIDER, Subcontractor, or DOWNSTREAM SUBCONTRACTOR, or any other changes in information listed in 42 CFR section 438.10(f), either 30 calendar days prior to the effective date of the contract termination or at least 15 calendar days after receipt of issuance of the termination notice, whichever is longer, unless directed by DHCS. The notification must be provided to each Member who received Primary Care from, or was seen on a regular basis by, the terminated Provider. This notification must also be submitted to DHCS in writing for approval before its release.

b. CHPIV obtains DHCS approval before sending a notice of termination to its Members no later than 60 calendar days prior to the effective date of the termination. CHPIV may use a member notice template previously approved by DHCS. Any changes from the approved template must be submitted to DHCS 60 calendar days prior to the effective date of the termination for review and approval before mailing the notice. In the event of an emergency or other unforeseeable circumstance, Contractor must provide notice of the emergency or other unforeseeable circumstance to DHCS as soon as possible.

M. Access Rights

1. Equal Access for Linguistic Services

a. CHPIV ensures equal access to the provision of high-quality interpreter and linguistic services for LEP Members and Potential Members, and for Members and Potential Members with disabilities, in compliance with federal and State law, and APL 21-004.

2. Linguistic Services
    a. CHPIV complies with W&I Code section 14029.91 and ensure that all monolingual, non-English-speaking, or LEP Members and Potential Members receive 24-hour interpreter services at all key points of contact, as defined in Paragraph B.4) of this Provision, either through interpreters, telephone language services, or other legally compliant electronic options.
    b. CHPIV shall provide interpreter services to be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment without imposing delay on the scheduling of the appointment.
    c. CHPIV ensures that any lack of interpreter services does not impede or delay a Member's timely access to care.
    d. CHPIV complies with Title VI of the Civil Rights Act of 1964 and 42 CFR section 438.10(d) and have the capacity to provide, at minimum, the following linguistic services at no cost to Members or Potential Members:
    e. Oral interpreters, sign language interpreters, or bilingual Providers and Provider staff at all key points of contact. These services must be provided in all languages spoken by Members and Potential Members and not limited to the Threshold or Concentration Standards languages;
    f. Full and immediate translation of written materials pursuant to 42 CFR sections 438.10(d)(3), 438.404, and 438.408; W&I Code 14029.91; 22 CCR sections 53876 and 53884 for LEP Members and Potential Members who speak Threshold or Concentration Standard Languages, fully translated Member Information, including: the Member Handbook, Provider Directory, welcome packets, marketing information, Member rights information, form letters and individual notices, including Notice of Action (NOA) letters, all notices related to Grievances and Appeals including Grievance and Appeal acknowledgement and resolution letters, and any other materials as required by Title VI of the Civil Rights Act of 1964 and APL 21-004;
    g. Referrals to culturally and linguistically appropriate community service programs; and
    h. Auxiliary Aids such as Telephone Typewriters (TTY)/ Telecommunication Devices for the Deaf (TDD), qualified interpreters including American Sign Language interpreters, and information in alternative formats including Braille, large print text (20 point font or larger), audio, and electronic formats.
    i. Key points of contact include:
    j. Medical care settings, such as telephone, advice and Urgent Care transactions, and outpatient Encounters with Providers; and
    k. Non-medical care settings, such as Member services, orientations, and appointment scheduling.
3. Access for Persons with Disabilities
    a. CHPIV complies with the requirements of Titles II and III of the Americans with Disabilities Act of 1990, section 1557 of the Affordable Care Act of 2010, sections 504 and 508 of the Rehabilitation Act of 1973, Government Code

sections 11135 and 7405, and all applicable implementing regulations, and must ensure access for people with disabilities including, without limitation, accessible web and electronic content, ramps, elevators, accessible restrooms, designated parking spaces, and accessible drinking water.

N. Cultural and Linguistic Programs and Committees

1. Cultural and Linguistic Program

a. CHPIV must develop and implement policies and procedures for assessing the performance of its employees, contracted staff and other individuals who provide linguistic services, addressing any identified gaps in the provision of cultural and linguistic services by staff, and for overall monitoring and evaluation of its cultural and linguistic services programs.

b. CHPIV has in place and continually monitors, improves and evaluates cultural and linguistic services that support the delivery of Covered Services to Members. CHPIV ensures it has proper policies and procedures in place to provide appropriate cultural and linguistic services for all of its Members.

c. CHPIV takes immediate action to improve the delivery of culturally and linguistically appropriate services when deficiencies are noted.

d. CHPIV ensures it is active in recruiting and retaining culturally and linguistically competent Providers that reflect the needs of the Medi-Cal population in the CHPIV's Service Area.

e. CHPIV ensures it has a cultural and linguistic services program, as required by 22 CCR section 53876, that incorporates all requirements of applicable federal and state law, including without limitation those requirements cited in Exhibit A, Attachment III, Subsection 5.2.10 (Access Rights), 22 CCR sections 51202.5 and 51309.5(a), 28 CCR sections 1300.67.04(c)(2)(A) - (B) and 1300.67.04 (c)(2)(G)(v) - (c)(4), and 42 CFR section 438.206(c)(2). CHPIV ensures immediate translation of all critical Member Information as required by 42 CFR sections 438.10 and 438.404 and W&I Code section 14029.91.

f. CHPIV must review and update its cultural and linguistic services programs to align with the Population Needs Assessment (PNA). CHPIV ensures its NETWORK PROVIDERS, SUBCONTRACTORS, DOWNSTREAM SUBCONTRACTORS cultural and Health Equity linguistic services programs also align with the PNA.

g. CHPIV ensures it implements and maintains a written description of its cultural and linguistic services program which must include, at a minimum, the following:

h. Its organizational commitment to deliver culturally and linguistically appropriate health care services;

i. Services that comply with Title VI of the Civil Rights Act of 1964, section 1557 of the Affordable Care Act of 2010, 42 CFR section 438.10, Exhibit A, Attachment III, Section 5.2.10 (Access Rights), and APL 21-004

j. Use of National standards for Culturally and Linguistically Appropriate Services (CLAS) for reference;

k. An organizational chart showing the key staff with overall responsibility for cultural and linguistic services programs;

l. A narrative explaining the organizational chart and describing the oversight and direction to the Community Advisory Committee (CAC), requirements for support staff and reporting relationships. Qualifications of staff, including appropriate education, experience, and training must also be included;

m. The role of the PNA to inform cultural and linguistic services program priorities in compliance with Exhibit A, Attachment III, Subsection 4.3.3 (Population Needs Assessment);

n. The implementation and maintenance of annual sensitivity, diversity, communication skills, Health Equity, and cultural competency training and related trainings (e.g., providing gender affirming care) for employees and contracted staff (clinical and non-clinical), as determined by Section C of this Provision, Diversity, Equity, and Inclusion Training; and

o. CHPIV administrative oversight and compliance monitoring of the cultural and linguistic services program and requirements for the delivery of culturally and linguistically appropriate health care services.

2. Linguistic Capability of Employees and Contracted Staff

a. CHPIV ensures it assesses and tracks the linguistic capability of its interpreters or bilingual staff and contracted staff (clinical and non-clinical).

b. CHPIV implements a system to provide adequate training regarding its language assistance programs to all employees and contracted staff who have routine contact with LEP Members or Potential Members and systematically address any identified gaps in addressing Members' cultural and linguistic needs. The training must include instruction on:

c. Policies and procedures for language assistance;

d. How to work effectively with LEP Members and Potential Members;

e. How to work effectively with interpreters in person and through video, telephone, and other media; and,

f. Understanding the cultural diversity of Members and Potential Members, and sensitivity to cultural differences relevant to delivery of health care interpretation services, in accordance with Exhibit A, Attachment III, Subsection 5.2.11 (Cultural and Linguistic Programs and Committees)
NETWORK Reports

O. NETWORK Reports

1. Annual NETWORK Certification Report

a. CHPIV ensures it annually submits its NETWORK certification report to DHCS. The report must demonstrate its capacity to serve the current and expected membership for its Service Area in accordance with 42 CFR section 438.207(b), W&I Code section 14197(f)(1), and APL 20-003.

b. CHPIV ensures it demonstrates how it will arrange for Covered Services to Members through the use of NEMT, NMT, and Telehealth if it does not meet time or distance standards for adult and pediatric PCPs, core Specialist and

outpatient mental health Providers in accordance with W&I Code section 14197(f)(2).

c. CHPIV submits its annual NETWORK certification report before the contract year begins as outlined in APL 20-003.

2. NETWORK Access Profile

a. CHPIV shall submit an annual Network Access Profile in accordance with Title 28 CCR 1300.67.2.2 (h)(8).

3. SUBCONTRACTOR Network Certification

a. CHPIV ensures it annually submits its SUBCONTRACTOR Network Certification (SNC) report to DHCS. The SNC report must demonstrate compliance with network adequacy and access for the Provider Networks of CHPIV's DELEGATES and/or SUBCONTRACTORS' that have assumed risk per the DELEGATES and/or SUBCONTRACTORS' Agreements in accordance with CalAIM 1915(b) Waiver STCs, and APL 23-006.

b. CHPIV will ensure the annual SNC includes all Subcontractor Networks reported via the 274 Provider Network data file, unless the Subcontractor Network is exempt per the criteria listed below and the required documentation provided substantiates the exemption.

c. Subcontractor Networks that are exempt from SNC:

- If CHPIV only contracts with one Subcontractor Network in the Service Area, and no Providers directly contract with CHPIV.
- The Subcontractor Network only provides specialty or ancillary services; or
- The Subcontractor Network only provides care through single case agreements and is not available to all CHPIV's Members upon enrollment.

d. CHPIV will submit the required SNC documentation to DHCS with the correct file naming conventions through the DHCS Secure File Transfer Protocol site no later than 45 days following the RY (calendar year) or if the date falls on a weekend, the next Working Day.

- SNC submission consists of three parts (1) the Subcontractor Network Exemptions Request template, (2) the Network Adequacy and Access Assurances Report (NAAAR), and (3) verification documents.
- Failure to submit complete and accurate SNC documentation to DHCS by the SNC annual submission date, CHPIV will be subject to the imposition of a corrective action plan (CAP) and/or other enforcement actions by DHCS.

e. CHPIV identifies SUBCONTRACTOR Network deficiencies impacting Member access to care, CHPIV will ensure that the delegated SUBCONTRACTOR must authorize Covered Services from Out-of-Subcontractor Network (OOSN) Providers for Members in the deficient Subcontractor Network regardless of associated transportation or Provider costs until deficiency is addressed.

f. f. CHPIV will ensure that the deficient SUBCONTRACTOR or DOWNSTREAM SUBCONTRACTOR informs Members that OOSN access to

services is available, and the SUBCONTRACTOR's Member services staff are trained on Members' right to request OOSN access for Covered Services and transportation to Providers where the SUBCONTRACTOR or DOWNSTREAM SUBCONTRACTOR is unable to comply with Network adequacy or access standards

g. CHPIV found non-compliant with the SNC requirements.

- CHPIV will respond to the initial CAP response, no later than 30 calendar days after the issuance of the CAP notification letter, that details a plan of action and sets forth steps CHPIV will take to correct the deficiencies identified.
- CHPIV will ensure all deficiencies are corrected within 6 months during which CHPIV will provide DHCS with monthly status updates that demonstrate action steps the MCP is undertaking to address the CAP.

P. Periodic Reporting Requirements

1. CHPIV reports to DHCS any time there is a Significant Change to its NETWORK that affects NETWORK capacity and Contractor's ability to provide health care services, such as the following:
2. Change in Covered Services or benefits;
3. Change in geographic Service Area;
4. Change in the composition of, or the payments to, its NETWORK PROVIDERS, SUBCONTRACTORS, or DOWNSTREAM SUBCONTRACTORS; or enrollment of a new population.

5. CHPIV provides supporting documentation detailing any Significant Change to DHCS. DHCS will determine what information must be provided it reports a Significant Change to its NETWORK pursuant to 42 CFR section 438.207.

~~5.~~**6.** CHPIV enters into a new risk-based Subcontractor Agreement with a Subcontractor that expands to CHPIV's existing Provider Network.

~~6.~~**7.** NETWORK Change Report

a. CHPIV submits to DHCS, in a format specified by DHCS, a report summarizing changes in the NETWORK. CHPIV shall submit the report 30 calendar days following the end of the reporting quarter.

~~a.~~**b.** If a significant change occurs within 90 calendar days prior to the SNC annual submission date, CHPIV will document the change as part of the RY (calendar year) SNC filling.

Q. Subcontractor and DOWNSTREAM SUBCONTRACTOR Certification Report

1. CHPIV ensures it develops, implements, and maintains a process to annually certify its SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS that provide Medi-Cal covered services for compliance with
2. NETWORK Ratios set forth in Subsection 5.2.4 (NETWORK Ratios),
3. NETWORK Adequacy Standards set forth in Section 5.2.5 (NETWORK Adequacy Standards), and
4. NETWORK Composition requirements set forth in Section 5.2.3.B (NETWORK Composition) of this Contract.

5. CHPIV submits complete and accurate NETWORK PROVIDER, Subcontractor, and DOWNSTREAM SUBCONTRACTOR data to confirm its Subcontractor's and DOWNSTREAM SUBCONTRACTOR's NETWORK(s) is compliant with all applicable NETWORK adequacy requirements, as set forth in Section 2.1.4 (NETWORK PROVIDER DATA Reporting)
6. CHPIV has a process in place to impose Corrective Action and sanctions and report to DHCS when SUBCONTRACTORs and DOWNSTREAM SUBCONTRACTORS that provide Medi-Cal Covered Services fail to meet NETWORK adequacy standards as set forth in APL 21-006, or any subsequent revisions as outlined in CHPIV policy titled *CMP-002 Delegation Oversight*. CHPIV shall ensure all Members assigned to a SUBCONTRACTOR or DOWNSTREAM SUBCONTRACTOR that is under a Corrective Action continue access to Medically Necessary Covered Services within timely access standards and applicable time or distance standards as set forth in Section 5.2.5 (NETWORK Adequacy Standards) by supplementing the SUBCONTRACTOR's or DOWNSTREAM SUBCONTRACTOR's NETWORK until the Corrective Action is resolved.
7. CHPIV submits the results of its certification to DHCS annually in a format specified by DHCS and post its submitted certification on its website.

R. Timely Access Compliance Report

1. CHPIV shall gather and report all Timely Access Compliance Report data and information set forth in Rule 1300.67.2.2(h)(6) including subcontracted plan data.
2. With respect to the Provider Appointment Availability Survey (PAAS) Report Forms, the process shall also include how the plan identifies potential inaccuracies and steps the plan will take to verify that key data is accurate, including:
    a. Process for collecting information to identify network providers reported to the Department in the PAAS Report Forms
    b. How the plan identifies potential inaccuracies
    c. A description of the sources the plan uses to verify provider information
    d. Steps the plan will take to verify that key data, such as provider location and provider specialty, is accurate
    e. Process for incorporating updated information from provider directory verification efforts into the PAAS Report Forms
    f. Process for using the prior year's ineligible information to improve the PAAS Contact List.
    g. CHPIV will include subcontracted plan data in its Timely Access Compliance Report, including the PAAS Report Forms.
    h. CHPIV's process for administering and reporting the results of the PAAS, which complies with the methodology set forth in the PAAS Manual, incorporated in Rule 1300.67.2.2, and reporting requirements set forth in the Timely Access and Annual Network Submission Instruction Manual, incorporated in Rule 1300.67.2.2. ~~(The plan may incorporate the PAAS Manual by reference into the plan's policies and procedures.)~~

S. Enrollee Experience Survey

1. CHPIV shall offer members an Enrollee Experience Survey on an annual basis. The survey will be developed based on the following guidelines:
    a. Enrollee Experience Survey shall be conducted in accordance with a statistically valid and reliable survey methodology.
    b. Enrollee Experience Survey shall obtain enrollee perspectives and concerns regarding experience obtaining timely appointments within the standards set forth in (c).
    c. Enrollee Experience Survey shall inform enrollees of their right to obtain an appointment within each of the time-elapsed standards in Rule 1300.67.2.2(c)(1) and (5) including notice of their right to receive interpreter services at that appointment, as required by (c)(4).
    d. Enrollee Experience Survey shall evaluate the experience of limited English proficient enrollees in obtaining interpreter services by obtaining enrollees' perspectives and concerns regarding coordination of appointments with an interpreter, availability of interpreters who speak the enrollee's preferred language and the quality of interpreter services received.
    e. Enrollee Experience Survey shall be translated into the enrollee's preferred language in those situations where the plan is aware of the enrollee's language and the enrollee's preferred language is one of the top 15 languages spoken by limited English proficient individuals in California as determined by DHCS.
    f. The plan's Enrollee Experience survey questions and the process used for evaluating and comparing the results against prior years.

T. Provider Satisfaction Survey

1. CHPIV shall conduct a Provider Satisfaction Survey in accordance with a statistically valid and reliable survey methodology.
2. The Provider Satisfaction Survey shall obtain from physicians and non-physician mental health providers perspectives and concerns regarding compliance with the standards set forth in (c).
3. The Provider Satisfaction Survey shall obtain provider perspectives and concerns with the plan's language assistance program regarding coordination of appointments with an interpreter, availability of an interpreter based on the needs of an enrollee; and the ability of the interpreter to effectively communicate with the provider on behalf of the enrollee.
4. CHPIV's submission shall include the Provider Satisfaction survey questions and set forth the process used for evaluating and comparing the results against prior years.

III. PROCEDURE

A. Delegation Oversight

1. CHPIV delegates its Network to its SUBCONTRACTOR, ~~Health Net~~.
2. CHPIV will oversee its SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS compliance with the standards consistent with the Health Care Providers' Bill of Rights, and a material change in the obligations of CHPIV's NETWORK PROVIDERS shall be

considered a material change to the provider contract as set forth in HSC 1367.03 subsection (c).

3. CHPIV shall provide oversight and continually assess the delegated functions, responsibilities, processes, and performance of ~~Health Net~~. CHPIV ensures ~~Health Net~~'s compliance with regulatory and contractual requirements through the following activities which are detailed in *CHPIV Policy CMP-002: Delegation Oversight Policy and Procedure*:
   - **i.** Ongoing monitoring
   - **ii.** Performance reviews
   - **iii.** Data analysis
   - **iv.** Utilization of benchmarks, if available
   - **v.** Annual desktop and on-site audits

IV. DEFINITIONS

Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the "Definitions" below.

TERM	DEFINITION
Appointment Waiting Time	Means the time from the initial request to the plan or a provider for covered health care services by an enrollee, an enrollee's representative or the enrollee's treating provider to the earliest date offered for the appointment for services. Appointment waiting time is inclusive of time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its network providers. A grievance, as defined in Rule 1300.68(a)(1), regarding a delay or difficulty in obtaining an appointment for a covered health care service may constitute an initial request for an appointment for covered health care services.**Means** ~~the time from the initial request for health care services by a Member or the Member's treating provider to the earliest date offered for the appointment for services inclusive of the time for obtaining authorization from the plan, and completing any other condition or requirement of the plan or its contracting providers.~~
Downstream Subcontractor	Means an individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.
Network	Means a discrete set of network providers, as defined in subsection (b)(10) of CCR 28 § 1300.67.2.2, the plan has designated to deliver all covered services for a specific network service area, as defined in subsection (b)(11) of CCR 28 § 1300.67.2.2.~~Means PCPs, Specialist, hospital, ancillary Providers, facilities, and other Providers with whom Contractor enters into a Network Provider Agreement.~~
Network Adequacy	Means the sufficiency of a plan's network to ensure the delivery of all covered services, on an ongoing basis, in a manner that meets the network accessibility, availability, and capacity requirements set forth in the Knox-Keene Act, including subsection (a)(5) of section 1371.31, subsections (d) and (e) of section 1367 and section 1375.9, and Rules 1300.51, 1300.67.2, subsection (c)(7) of CCR 28 § 1300.67.2.2, and 1300.67.2.1~~Means all~~

TERM	DEFINITION
	~~regulatory requirements for an adequate provider network within CHPIV's Service Area, in compliance with W&I Code section 14197.~~
Network Provider	Means any provider as defined in subsection (i) of section 1345 of the Knox-Keene Act, located inside or outside of the network service area of a designated network, meeting all of the following criteria: **(A)** The provider is available to provide covered services to all plan enrollees in all product lines using the designated network. **(B)** The provider is one or more of the following: **(i)** An employee of the plan; **(ii)** An individual health professional or health facility contracted directly with the plan consistent with the Knox-Keene Act and implementing regulations, including the contractual requirements for providers within sections 1348.6, 1367(h), 1367.04, 1367.27, 1367.62, 1373.65(f), 1375.7, 1379 and subsection (d) of section 1351; **(iii)** An individual health professional or health facility contracted with the plan through an association, provider group, or other entity, consistent with the Knox-Keene Act and implementing regulations, including the contractual requirements for providers within sections 1348.6, 1367(h), 1367.04, 1367.27, 1367.62, 1373.65(f), 1375.5, 1379, and subsection (d) of 1351; **(iv)** An individual health professional or health facility designated to deliver covered services to enrollees in the network through a plan-to-plan contract, as defined in subsection (b)(13) of CCR 28 § 1300.67.2.2; or **(v)** An individual health professional or health facility required to be part of the plan's network under any of the following circumstances; **a.** a corrective action plan submitted to the Department by the plan or its delegated entity; **b.** as required by the Department pursuant to section 1373.65 of the Knox-Keene Act; or **c.** as otherwise required by order of the Department. **(C)** The provider is accessible to enrollees of the designated network without limitations other than established: **(i)** In-network referral or authorization processes; or **(ii)** Processes for changing provider groups consistent with section 1373.3 of the Knox-Keene Act, in networks where enrollees are assigned to a provider group. **(D)** A network provider shall not include: **(i)** Providers made available through single-case agreements, letters of intent, or contract agreements that do not include the provider contracting requirements of the Knox-Keene Act as described in subsection (b)(10)(B)(ii) and (iii) of CCR 28 § 1300.67.2.2; **(ii)** For any line-of-business that includes an out-of-network benefit (e.g., preferred provider organization (PPO) or point-of-service (POS)), providers who are available to enrollees only at non-participating or out-of-network cost-share levels; or

TERM	DEFINITION
	(iii) Noncontracting individual health professionals, as defined in subsection (f)(5) of section 1371.9 of the Knox-Keene Act.~~Means any Provider or entity that has a Network Provider Agreement with Contractor, Contractor's Subcontractor, or Contractor's Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under this Contract. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement.~~
Network Provider Data	Means information concerning all Network Providers in a Network, regardless of location, which render Covered Services to Members in a Contractor's Service Area and the provider groups, Subcontractors, and/or Downstream Subcontractors, if any, under which a Network Provider renders those services. This includes, but is not limited to, information about the contractual relationship between Network Providers, provider groups, Subcontractors, and Downstream Subcontractors within the Network, information regarding the facilities where services are rendered, and information about a Network Provider's area(s) of specialization.
Network Service Area	Means the geographical area, and population points contained therein, where the plan is approved by the Department to arrange health care services consistent with network adequacy requirements. "Population points" shall mean a representation of where people live and work in the state of California based on United States Census Bureau population data and United States Postal Service (USPS) delivery route data, and made available annually by the Department on the web portal accessible at www.dmhc.ca.gov.
Patterns of Non-compliance	"Patterns of non-compliance," with respect to the standards set forth in subsection (c) of CCR 28 § 1300.67.2.2, means any of the following: **(A)** For purposes of the Provider Appointment Availability Survey: Fewer than 70% of the network providers, as calculated on the Provider Appointment Availability Survey Results Report Form, for a specific network had a non-urgent or urgent appointment available within the time-elapsed standards set forth in subsection (c)(5)(A)-(F) of CCR 28 § 1300.67.2.2 for the measurement year. A pattern of non-compliance shall be identified using the information reported to the Department in the "Rate of Compliance Urgent Care Appointments (All Provider Survey Types)" field and the "Rate of Compliance Non-Urgent Appointments (All Provider Survey Types)" field in the Summary of Rate of Compliance Tab of the Results Report Form. **(B)** The Department receives information establishing that the plan was unable to deliver timely, available, or accessible health care services to enrollees. The Department may consider any of the following factors in evaluating whether each instance identified is part of a pattern of non-compliance that is reasonably related: **(i)** Each instance is a violation of the same standard set forth in subsection (c) of CCR 28 § 1300.67.2.2; **(ii)** Each instance involves the same network; **(iii)** Each instance involves the same provider group, or subcontracted plan; **(iv)** Each instance involves the same provider type; **(v)** Each instance involves the same network provider;

TERM	DEFINITION
	(vi) Each instance occurs in the same region. For purposes of this subsection, a region is a county in which a network provider practices, and the counties next to or adjoining that county; **(vii)** The number of enrollees in the health plan's network and the total number of instances identified as part of a pattern; **(viii)** Whether each instance occurred within the same twelve-month period; or **(ix)** Whether each instance involves the same category of health care services.~~For purposes of the Provider Appointment Availability Survey: Fewer than 70% of the network providers, as calculated on the Provider Appointment Availability Survey Results Report Form, for a specific network had a non-urgent or urgent appointment available within the time-elapsed standards set forth in subsection (c)(5)(A)-(F) for the measurement year. A pattern of non-compliance shall be identified using the information reported to the Department in the "Rate of Compliance Urgent Care Appointments (All Provider Survey Types)" field and the "Rate of Compliance Non-Urgent Appointments (All Provider Survey Types)" field in the Summary of Rate of Compliance Tab of the Results Report Form.~~ ~~The Department receives information establishing that the plan was unable to deliver timely, available, or accessible health care services to enrollees.~~
Plan-to-plan Contract	Means an arrangement between two plans, in which the subcontracted plan makes network providers available to primary plan enrollees, and may be responsible for other primary plan functions. Plan-to-plan contracts include administrative service agreements, management service agreements or other contracts between a primary and subcontracted plan.
Preventive Care	Means health care provided for prevention and early detection of disease, illness, injury, or other health conditions and, in the case of a full-service plan includes all of the following health care services required by sections 1345(b)(5), 1367.002, 1367.3 and 1367.35 of the Knox-Keene Act, and Rule 1300.67(f).~~Means health care provided for prevention and early detection of disease, illness, injury or other health condition and, in the case of a full service plan includes but is not limited to all of the basic health care services required by subsection (b)(5) of Section 1345 of the Act, and Section 1300.67(f) of Title 28.~~
Primary Plan	Means a licensed plan that holds a contract with a group, individual subscriber, or a public agency, to arrange for the provision of health care services.
Subcontracted Plan	Means a licensed plan or specialized plan that is contracted to allow a primary plan's enrollees access to the subcontracted plan's network providers. The contract may be between the primary plan and the subcontracted plan or between two subcontracted plans.
Subcontractor	An individual or entity that has a Subcontractor Agreement with Contractor that relates directly or indirectly to the performance of Contractor's obligations under this Contract. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.

	Provider Directory	PNM-002
Department	Finance, Network & Informatics	
Functional Area	Provider Network Management	
Impacted Delegate	☒ Subcontractor ☐ NA	

DATES			
Policy Effective Date	6/12/2023	**Reviewed/Revised Date**	7/10/2023
Next Annual Review Due	7/10/2024	**Regulator Approval**	

APPROVALS		
Internal		**Regulator**
Name	Mark Southworth	☐ DHCS ☐ NA ☒ DMHC
Title	Chief Financial Officer	

ATTACHMENTS

NA

AUTHORITIES/REFERENCES

- **Internal**
  - CHPIV, Delegation Oversight Policy and Procedure, CMP-002
- **Federal**
  - 42 CFR, Section 438.10
  - 42 CFR section 431.70
- **State**
  - California Health and Safety Code Section ("H&S Code") 1367.27
  - Department of Health Care Services (DHCS) APL23-002
  - DHCS: DHCS Plan Contract (2024) Section 5.1.3
  - DHCS: All Plan Letter 22-026, "Interoperability and Patient Access Final Rule" (dated November 29, 2022)
  - DHCS: All Plan Letter 19-003, "
  - Medi-Cal Managed Care Division (MMCD) Policy Letter 00-002, Supersedes Policy Letter 97-09: Health Plan Provider Directory Policy, Guidelines, and Delivery Standards N. Medi-Cal Managed Care Division (MMCD) Policy Letter 11-009, Update to Policy Letter 00-002: Update to Health Plan Provider Directory Policy and Guidelines
- **Accreditation**
  - NCQA: Network Management (NET) 5, Elements A-J

HISTORY

Revision Date	Description of Revision
6/12/2023	Policy creation

7/10/2023	Policy revised to update the frequency on updating the electronic provider directory and add the requirements for providing the printed copy of the provider directory to members and potential members.

I. OVERVIEW

A. This policy addresses Community Health Plan of Imperial Valley's ("CHPIV" or the "Plan") PROVIDER DIRECTORY requirements, policy, and procedures. The purpose of this policy is to establish a process to meet the required PROVIDER DIRECTORY statutory, regulatory, contractual, and, if applicable, accreditation standards ("Legal Authority").

II. POLICY

A. CHPIV establishes and maintains PROVIDER DIRECTORY processes pursuant to applicable statutory, regulatory, and contractual requirements.
B. CHPIV submits the PROVIDER DIRECTORY to DHCS for review and approval prior to initial operations.
C. CHPIV makes the PROVIDER DIRECTORY available in paper and electronic formats to all MEMBERS and potential MEMBERS. Potential MEMBERS can request a printed copy of the PROVIDER DIRECTORY upon request.
D. A printed copy of the PROVIDER DIRECTORY can be requested by contacting CHPIV's toll-free number, electronically or in writing. The printed copy of the PROVIDER DIRECTORY shall be provided to the requester by mail postmarked no later than 5 business days following the date of request and may be limited to the geographic region in which the MEMBER or potential MEMBER resides or works or intends to reside or work.
E. The electronic format PROVIDER DIRECTORY is made available in a machine-readable file and accessible format, with search functionality in accordance with Title 42 of the Code of Federal Regulations, section 438.10(h)(4), and section 1367.27(c)(2) of the California Health and Safety Code.
F. PROVIDER DIRECTORY information shall be included with CHPIV's written MEMBER Information for new MEMBERS, and thereafter available upon request in printed hardcopy. SPD MEMBERS are provided with a paper hardcopy PROVIDER DIRECTORY. Non-SPD MEMBERS may be provided with a notice on how to access the PROVIDER DIRECTORY electronically.
G. The PROVIDER DIRECTORY shall include information of DELEGATED PROVIDER GROUPS, hospitals, PRIMARY CARE PROVIDERS (PCPs), OB/GYNs, specialists, behavioral health PROVIDERS, managed long-term services and support (MLTSS) PROVIDERS, urgent care centers, ECM and Community Support PROVIDERS, ancillary PROVIDERS, Facilities, pharmacies, and any other PROVIDERS who are credentialed and contracted with CHPIV for Medi-Cal services, or through a subcontracted agreement:
    1. The PROVIDER's or site's location name and any group affiliation(s), NPI number, address, telephone number, and, if applicable, web site URL for each Service Location;

2. PROVIDER's specialty type and paneling status that allows them to treat specific populations, including but not limited to, whether they are a CCS paneled PROVIDER;
3. Whether the PROVIDER is accepting new patients;
4. Information on the PROVIDER's affiliated medical group or IPA, NPI number, address, telephone number, and, if applicable, web site URL for each Physician PROVIDER of affiliated group or IPA;
5. The hours and days when each Service Location is open;
6. The services and benefits available, including accessibility symbols approved by DHCS confirming whether the office/FACILITY (exam room(s), equipment, etc.) can accommodate MEMBERS with physical disabilities as required by PL 11-009;
7. The PROVIDER's cultural and linguistic capabilities, including whether non-English languages and American Sign Language are offered either by the PROVIDER or a skilled medical interpreter at the PROVIDER's FACILITY;
8. The telephone number to call after normal business hours;
9. Identification of Network PROVIDERS or sites that are not available to all or new MEMBERS
10. The link to the Medi-Cal Rx Pharmacy Locator.
~~10.~~11. Information regarding the standards for timely access to care in a separate section titled "Timely Access to Care."

H. CHPIV ensures the paper PROVIDER DIRECTORY is updated and submitted to DHCS as follows:
   1. Paper Directory: Monthly
   2. Electronic Directory: Weekly or more frequently as needed after updated PROVIDER information is received.
   3. If CHPIV establishes a mobile-enabled, electronic PROVIDER DIRECTORY, the paper PROVIDER DIRECTORY will be updated quarterly.

I. CHPIV submits its PROVIDER DIRECTORY is submitted to DHCS every six (6) months and shall includes a copy which DHCS can use for distribution, as needed.

J. Changes to information for a PROVIDER or FACILITY in the PROVIDER DIRECTORY are reported on an ongoing basis in accordance with this Policy.

K. CHPIV ensures PROVIDER data utilized for the PROVIDER DIRECTORY are validated and verified for accuracy and completeness. This includes verifying data in partnership with contracted PROVIDERS and tracking Suspended, Excluded, and Ineligible PROVIDERS at least monthly and taking appropriate action, including removal from PROVIDER DIRECTORY, in accordance with APL 15-026 and APL 21-003.

L. CHPIV maintains a publicly accessible standards-based PROVIDER DIRECTORY API as described in 42 CFR section 431.70. Online PROVIDER DIRECTORY data is updated at least weekly after the CHPIV receives the PROVIDER information or is notified of any information that affects the content or accuracy of the PROVIDER DIRECTORY.
   1. CHPIV ensures its PROVIDER DIRECTORY API is updated in accordance with 42 CFR section 438.10(h)(3) and Health and Safety Code section 1367.27
   2. CHPIV ensures accurate and complete information of reported data, screen the data for completeness, logic, and consistency, and collect service information in

standardized formats to the extent feasible and appropriate. CHPIV makes all collected data available to DHCS and CMS, upon request.

3. CHPIV ensures there is routine testing and monitoring, and updates systems as appropriate, to ensure the APIs function properly, including conducting assessments to verify that the APIs are fully and successfully implementing required privacy and security features.

III. PROCEDURE

A. CHPIV delegates the PROVIDER DIRECTORY to its Subcontractor, Health Net.
B. Delegation Oversight
   1. CHPIV shall provide oversight and continually assess the delegated functions, responsibilities, processes, and performance of Health Net. CHPIV ensures Health Net's compliance with regulatory and contractual requirements through the following activities which are detailed in *CHPIV Policy CMP-002: Delegation Oversight Policy and Procedure*:
      a. Ongoing monitoring
      b. Performance reviews
      c. Data analysis
      d. Utilization of benchmarks, if available
      e. Annual desktop and on-site audits

IV. DEFINITIONS

Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the "Definitions" below.

TERM	DEFINITION
Provider Directory	Contractor's listing of all Network Providers and that includes the Providers' contact information, whether the Provider is accepting new Members, the hours of operation, what languages are available in the Provider's office and whether the Provider's office has accommodations, including offices, exam rooms and equipment, for people with physical disabilities.
Delegated Provider Group	A physician group contracted with CHPIV or its downstream subcontractors to provide Covered Services to Members assigned to that Delegated Provider Group.
Facility	For purposes of this policy, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities.
Member	A beneficiary enrolled in CHPIV's Medi-Cal plan.
Primary Care Provider	A physician who focuses his or her practice of medicine on general practice or who is a board verified or board eligible internist, pediatrician, obstetrician/gynecologist, or family practitioner. The PCP is responsible for supervising, coordinating, and providing initial and primary care to Members, initiating referrals, and maintaining the continuity of Member care.

TERM	DEFINITION
Provider	For purposes of this Policy, any individual, entity, Health Network, or Delegated Provider Group that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
API	Application Programming Interface. A software intermediary enables two applications to communicate with each other.

Pre-Delegation Audit Report

Phase 1

October 20, 2023

Community Health Plan
OF IMPERIAL VALLEY

PRE-DELEGATION AUDIT REPORT
Phase 1

Background

In 2021, the Department of Healthcare Services (DHCS) approved Imperial County's application to move to a single plan model. In 2022, the County initiated the process to obtain a Knox Keene License (KKL) to service Medi-Cal members under this new model. As a result, Community Health Plan of Imperial Valley (CHPIV) was formed as the county's new local initiative. Effective December 22, 2023, CHPIV and Health Net entered into a Plan-to-Plan agreement to service as CHPIV's Subcontractor or "Delegate", whereby Health Net's provider network and administrative services will be used to support Imperial County upon the go-live on January 1, 2024.

Audit Scope

The audit was designed to assess Health Net's ability to perform critical delegated functions in alignment with the Health Net – CHPIV plan-to-plan agreement, as well as the Department of Health Care Services (DHCS) requirements concerning delegation oversight. **Phase 1** focuses on reviewing key go-live processes and workflows, including systems readiness and processes where CHPIV-specific activities are required for delegated functions.

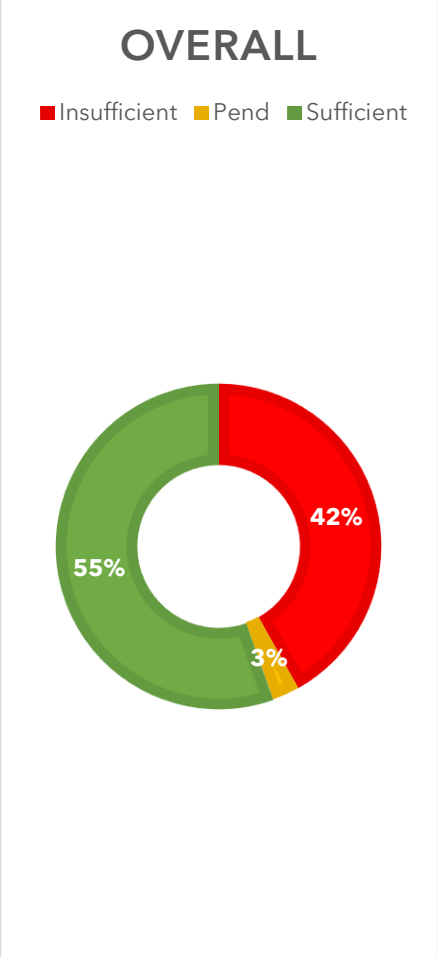
Audit Areas

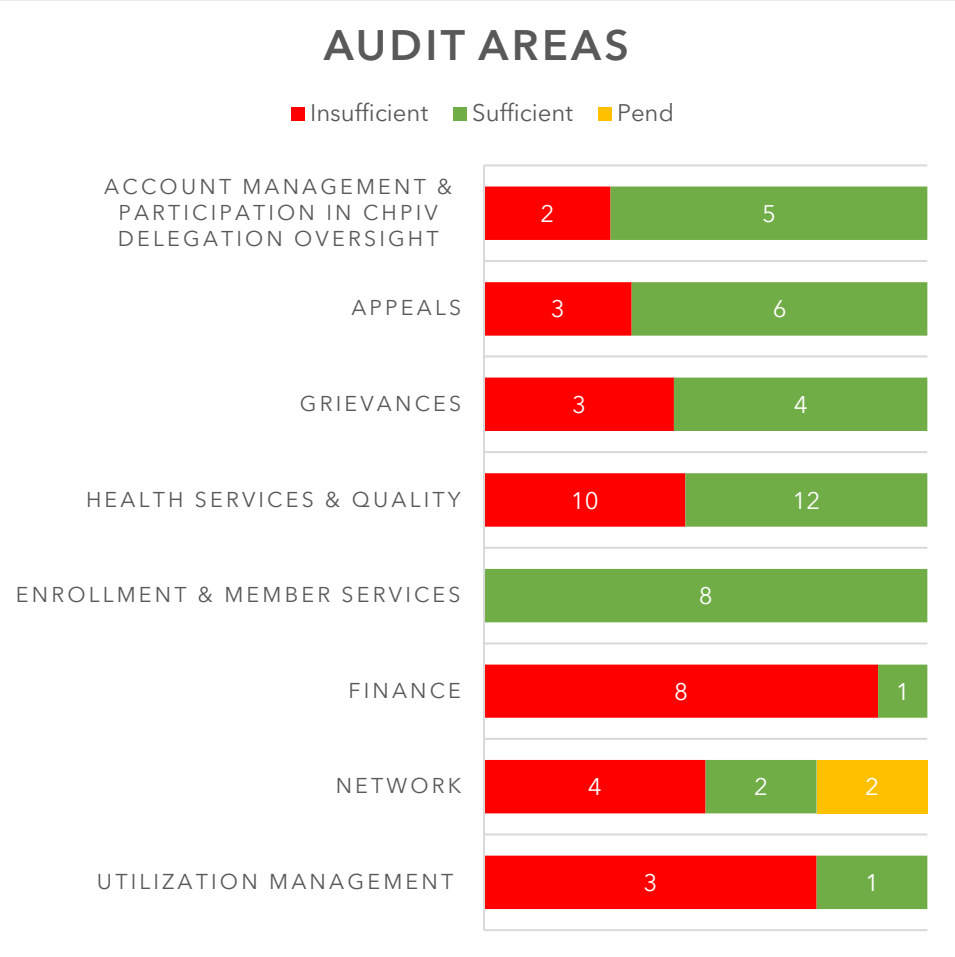
- Account Management & Participation in CHPIV Delegation Oversight (DO) Activities
- Appeals
- Grievances
- Health Services and Quality
- Enrollment & Member Services
- Finance, Claims, Provider Dispute Resolutions (PDRs) and Encounters
- Network
- Utilization Management and Continuity of Care

Methodology

With the understanding that Health Net and CHPIV are currently in process preparing for go-live by January 1, 2024, performance in each area considered implementation status for each audit measure. As such, this audit included review of draft and planning documents to assess readiness for go-live. Please see table below for assessing measure performance based on implementation status.

Summary of Findings





Audit Trends

The following section outlines the primary trends observed during Phase 1 of the pre-delegation audit. For a detailed outline regarding areas found to be insufficient or pended in each audit domain, please refer to the subsequent sections.

1. **Incomplete Documentation and Evidence:** Health Net (HN) provided narratives or indicated completion but did not provide corresponding documents, workflows, policies, or screenshots to validate completion. Missing details or evidence on CHPIV-specific steps, procedures, or considerations.
2. **Lack of Explicit Procedures for Noncompliance and Escalation:** Missing processes for *expeditiously* reporting severe noncompliance to CHPIV or systemic deficiencies that require immediate correction. Absence of outlined procedures to identify noncompliance, understand risk, and escalate severe issues.

3. **Training Gaps:** Several instances where training has been mentioned, but no clear indication that such training has been deployed. Missing evidence of training materials for CHPIV-specific steps.
4. **System and Process Configuration Issues:** Systems (Claims system, UM system) are not yet ready or configured for CHPIV-specific data.
5. **Timelines and Workplans Missing:** Missing timelines or workplans that indicate when specific changes, updates, or configurations will be made.
6. **Procedures or Policies:** Policies or procedures are missing CHPIV-specific processes, or not adequately detailed or updated to satisfy requirements.

Remediation

Corrective action plans and supporting documentation are required for areas requiring remediation within 10 business days, per CHPIV P&P CMP-003 Corrective Action Plans. CHPIV will continue to monitor the progress towards remediation and collaborate to ensure readiness by January 1, 2024.

Audit Results

ACCOUNT MANAGEMENT & PARTICIPATION IN CHPIV DO

The Account Management & Participation in CHPIV Delegation Oversight section of the pre-delegation audit assessed Health Net's processes for involvement in CHPIV activities. The audit validated Health Net's assignment of staff for CHPIV account management roles, their report completion and quality review protocols, and engagement in regulatory activities and CHPIV meetings, such as JOMs. Additionally, the audit examined Health Net's responsiveness to CHPIV-related concerns and performance challenges. Health Net's processes for designating individuals to CHPIV account management, tracking timely report submissions, managing ad-hoc CHPIV requests, and ensuring active participation in regulatory activities and regular meetings were found to be sufficient.

Account Management & Participation in CHPIV DO Findings

Request #	Measure	Documents Requested	Findings
6	Process to expeditiously escalate issues, concerns, changes, risks, barriers or any information pertinent to the performance of CHPIV and its fulfillment of its obligations to DHCS and to its members to CHPIV, including but not limited to performance against SLAs/the plan-to-plan.	Workflows/processes/documentation indicating that HN has a process to identify and inform CHPIV of any performance-related issues timely. If not yet in place, review for planning documents that indicate completion prior to go-live.	While the narrative does cover routine escalation, it does not specify a process to expeditiously report/self-disclose noncompliance to CHPIV in the event of systemic deficiencies that are so severe that they require immediate correction where the identified deficiency resulted in a lack of access to medications and/or services or posed an immediate threat to member health and safety.

Request #	Measure	Documents Requested	Findings
			Job description and additional narrative submitted outlines accountabilities and provides examples of remediation, but no P&P submitted that outlines the standard procedures used to (1) identify noncompliance, (2) understand risk/severity, and (3) immediately escalate severe noncompliance to CHPIV.
7	Process to ensure performance issues are remediated timely	Workflows/processes/documentation indicating that HN has a process to oversee its operational areas in curing performance issues timely and maintain status updates/communications with CHPIV regarding those issues. If not yet in place, review for planning documents that indicate completion prior to go-live.	Narrative references the SLA and performance standards. Additional narrative submitted outlines process at a high level but does not describe Health Net's process for correcting noncompliance (i.e., corrective action plan and escalation procedure).

APPEALS

The Appeals section of the pre-delegation audit assessed Health Net's readiness related to handling appeals for CHPIV members. The audit reviewed to ensure the appeal system was appropriately configured for CHPIV cases and that staff were trained to document CHPIV-specific appeals. It examined Health Net's internal monitoring processes for CHPIV appeals, Independent Medical Reviews, State Fair Hearings, and issues shared by DHCS and DMHC related to appeals. The audit also evaluated Health Net's procedures for informing CHPIV about arbitrations and lawsuits concerning appeals and its strategies for addressing appeal trends, implementing corrective action plans issued by CHPIV or regulators, and monitoring these plans to resolution. Health Net's processes for internal monitoring of appeals, Independent Medical Reviews, State Fair Hearings, DMHC-related appeal issues, notifications of arbitrations, and addressing appeal trends were found to be sufficient.

Appeals Findings

Request #	Measure	Documents Requested	Findings
9	Staff trained on CHPIV-specific steps/considerations for documenting CHPIV-member appeals in the system	Training materials indicating documentation processes for CHPIV member cases. If not yet in place, review for planning documents that indicate completion prior to go-live.	Health Net submitted Provider Training. However, no indication that this training was deployed to A&G staff.

Request #	Measure	Documents Requested	Findings
10	HN internal CHPIV Appeals Monitoring processes/workflows	Workflows/processes evidencing HN's process for: - overseeing CHPIV appeals operational performance, including timeliness and investigation and member letter quality - reviewing appeal trends - remediating issues identified If not yet in place, review for planning documents that indicate completion prior to go-live.	Provided audit tools are for grievances and state fair hearings. Still no workflow/document that explains how A&G expects to process ad hoc member complaints raised by DHCS.
13	Process for CHPIV-related member/provider appeal issues shared by DHCS	Workflows/processes/system screenshots indicating: - how SFH cases will be shared with CHPIV - process for tracking SFH response timeliness and attendance in order to facilitate case by case monitoring by CHPIV If not yet in place, review for planning documents that indicate completion prior to go-live.	Provided audit tools are for grievances and state fair hearings. Still no workflow/document that explains how A&G expects to process ad hoc member complaints raised by DHCS.

GRIEVANCES

The Grievance section of the pre-delegation audit evaluated Health Net's processes related to handling grievances for CHPIV members. The audit reviewed the readiness of Health Net's Grievance system, staff training, and Health Net's procedures for addressing CHPIV-related complaints from DHCS and DMHC. It also assessed protocols for informing CHPIV about grievance-related arbitrations and lawsuits and Health Net's methods for managing grievance trends and ensuring corrective action. Health Net's processes for internal monitoring of grievances, DMHC-related grievance issues, and addressing grievance trends were found to be sufficient.

Grievances Findings

Request #	Measure	Documents Requested	Findings
18	Staff trained on CHPIV-specific steps/considerations	Training materials indicating documentation processes for CHPIV member cases. If not yet in place, review for planning documents that indicate completion prior to go-live.	Health Net submitted Provider Training. However, no indication that this training was deployed to A&G staff.

Request #	Measure	Documents Requested	Findings
20	Process for CHPIV-related member/provider complaints and grievance issues shared by DHCS	Workflows/processes/system screenshots indicating: - how complaints received by CHPIV will be triaged to HN for resolution - how HN will work to respond timely to CHPIVs request for information within 3 calendar days and/or 1 business day prior to the DHCS stated due date, whichever is earlier; or in instances where DHCS requests a same day response by close of business, how HN will respond to CHPIV no later than 2pm California time. - process for escalating high risk or high priority cases to HN for expeditious resolution - how resolution will be shared with DHCS - process for tracking cases to ensure cases are handled timely If not yet in place, review for planning documents that indicate completion prior to go-live.	Provided audit tools are for grievances and state fair hearings. Still no workflow/document that explains how A&G expects to process ad hoc member complaints raised by DHCS.
22	Process for notifying CHPIV of arbitrations and lawsuits as they pertain to grievances.	Workflows/processes/system screenshots indicating: - how arbitrations and lawsuits will be escalated to CHPIV - what resource at CHPIV or HN will be responsible for responding to arbitrations/lawsuits If not yet in place, review for planning documents that indicate completion prior to go-live.	The narrative provided does not specify how HN will notify CHPIV of cases involving HN contracted providers that also serve CHPIV members. CHPIV may not be directly involved in these cases but expects to be notified if the contracted providers are treating CHPIV members.

HEALTH SERVICES & QUALITY

The Health Services and Quality section of the pre-delegation audit assessed Health Net's systems and procedures related to Quality Improvement and Health Equity focused on CHPIV members. The review included Health Net's annual development, semi-annual evaluation, and documentation of QIHETP as required by DHCS. Additionally, the audit evaluated the reporting mechanisms to CHPIV's Quality Improvement Health Equity Committee (QIHEC) and the transparency of Health Net's organizational structures, roles, and qualifications associated with Quality Improvement and Health Equity. The audit

also assessed how Health Net maintains, updates, and communicates its policies and guidelines related to clinical practices, Population Health, wellness, prevention, and care management to CHPIV. Health Net's processes for addressing performance metrics, public health reporting, and supporting CHPIV in accreditation endeavors were also reviewed. Health Net's processes for developing a QIHETP, evaluating CHPIV members semi-annually, delivering summaries of QIHEC activities (including charter, P&Ps, organization charts and updates), support CHPIV in the NCQA accreditation process, care management program development, and reporting of diseases or conditions to the public health authorities and CHPIV were found to be sufficient.

Health Services & Quality Findings

Request #	Measure	Documents Requested	Findings
29	Process to review and deliver qualifications of HN staff responsible for Quality Improvement & Health Equity relating to CHPIV membership annually.	Workflows/processes/system screenshots indicating that HN has a process to review qualifications of staff responsible for Quality Improvement & Health Equity on an ongoing basis and process to share qualifications with CHPIV annually. Process should include: - accountabilities - frequency - method of delivery to CHPIV - information quality assurance - escalation of any gaps/concerns regarding staff qualifications to CHPIV If not yet in place, review for planning documents that indicate completion prior to go-live.	Charter does not explicitly state the qualifications are reviewed. Neither the charter nor the QIHETP policy submitted discuss the interviewing/onboarding process mentioned in the DRL notes.
33	Process to update and deliver HN's policies & procedures related to Clinical Practice Guidelines to CHPIV annually.	Workflows/processes/system screenshots indicating that HN has a process to review policies & procedures related to Clinical Practice Guidelines on an ongoing basis and process to share policies & procedures with CHPIV annually. Process should include: - accountabilities - frequency - method of delivery to CHPIV - information quality assurance - escalation of any gaps/concerns to CHPIV If not yet in place, review for planning documents that indicate completion prior to go-live.	Unable to validate as documentation noted in the narrative were not submitted.

Request #	Measure	Documents Requested	Findings
34	Process for remediating any low performing metrics in MCAS, HEDIS, and CAHPs report and reporting remediation efforts to CHPIV.	Workflows/processes/system screenshots indicating: - how HN will address findings - how HN will conduct ongoing monitoring of their performance to ensure compliance with remediation efforts and requirements - how HN responds issues/CAPs issued by CHPIV and monitors CAP to closure - how HN communicates to CHPIV regarding CAPs/issues If not yet in place, review for planning documents that indicate completion prior to go-live.	Unable to validate as documentation noted in the narrative were not submitted.
35	Process for compiling PNA related to CHPIV membership on an annual basis.	Workflows/processes/system screenshots indicating that HN has a process to compile PNA for CHPIV members annually. Process should include: - accountabilities - frequency - method of delivery to CHPIV - data quality assurance - escalation of any gaps/concerns to CHPIV If not yet in place, review for planning documents that indicate completion prior to go-live.	Note indicates that documentation has not been updated yet to include the necessary information. Workplan/timeline was not submitted.
36	Process for reporting PNA related to CHPIV membership to CHPIV Community Advisory Committee annually.	Workflows/processes/system screenshots indicating that HN has a process to report out on PNA to CHPIV Community Advisory Committee. Process should include: - accountabilities - frequency - method of delivery to CHPIV - data quality assurance - escalation of any gaps/concerns to CHPIV If not yet in place, review for planning documents that indicate completion prior to go-live.	Process stating that HN bring PNA to CHPIV's CAC is not included.

Request #	Measure	Documents Requested	Findings
37	Process for remediating any areas of non-compliance in the PNA and reporting remediation efforts to CHPIV.	Workflows/processes/system screenshots indicating: - how HN will address findings - how HN will conduct ongoing monitoring of their performance to ensure compliance with remediation efforts and requirements - how HN responds issues/CAPs issued by CHPIV and monitors CAP to closure - how HN communicates to CHPIV regarding CAPs/issues If not yet in place, review for planning documents that indicate completion prior to go-live.	This measure is pulled from the DDRs and is in reference to regulatory findings about the adequacy of the PNA. The documentation submitted does not specify how Health Net will work with CHPIV to address these findings/any changes needed to the PNA.
38	Process for developing a Population Health Management Plan/Program per DHCS requirements for CHPIV members annually.	Workflows/processes/system screenshots indicating that HN has a process for producing a Population Health Management Plan/Program for CHPIV membership. Process should include: - accountabilities - TAT that aligns with DHCS submission timeframes - method of delivery to CHPIV - ensuring all elements outlined by the DHCS in the Population Health Roadmap and Guides, APLs tied to Population Health and elements section 4.3 Population Health Management and Coordination of Care and 5.3 Scope of Services of DHCS are included. - data quality assurance If not yet in place, review for planning documents that indicate completion prior to go-live.	Does not include process for how CHPIV and HN to collaborate on this PNA; if it will be brought to CHPIV CAC, etc.
41	Process to update and deliver HN's policies & procedures related to wellness and prevention programs for all CHPIV members less than 21 years of age to CHPIV annually.	Workflows/processes/system screenshots indicating that HN has a process to review policies & procedures related to quality care for children on an ongoing basis and process to share policies & procedures with CHPIV annually. Process should include: - accountabilities	Unable to validate as documentation noted in the narrative were not submitted.

Request #	Measure	Documents Requested	Findings
		- frequency - method of delivery to CHPIV - information quality assurance - escalation of any gaps/concerns to CHPIV If not yet in place, review for planning documents that indicate completion prior to go-live.	
44	Process for developing a Wellness and Prevention program description per DHCS requirements for CHPIV members annually.	Workflows/processes/system screenshots indicating that HN has a process for producing a care management program and work plan for CHPIV membership. Process should include: - accountabilities - frequency - method of delivery to CHPIV - program description regarding program structure, scope, and accountability to CHPIV If not yet in place, review for planning documents that indicate completion prior to go-live.	Health Equity Program description does not include details regarding a Wellness and Prevention Program, and how that will be developed for CHPIV members annually.
45	Process to update and deliver HN's policies & procedures related to over/under utilization training and reporting to CHPIV annually.	Workflows/processes/system screenshots indicating that HN has a process to review policies & procedures related to over/under utilization on an ongoing basis and process to share policies & procedures with CHPIV annually. Process should include: - accountabilities - frequency - method of delivery to CHPIV - information quality assurance - escalation of any gaps/concerns to CHPIV If not yet in place, review for planning documents that indicate completion prior to go-live.	UM/CM workplan notes that over/under utilization is monitored, and utilization metrics are produced, however documentation does not include: - policies and procedures which detail how staff are trained to detect and report over/under utilization

ENROLLMENT & MEMBER SERVICES

The Enrollment & Member Services section of the pre-delegation audit examined Health Net's preparedness related to CHPIV member enrollment and services. The audit reviewed to ensure that the enrollment system was configured to handle CHPIV member data, and that staff were trained for CHPIV-specific documentation within the system. It also reviewed Health Net's procedures for notifying CHPIV about potential issues with state data exchanges and the development and approval processes for the New Member Packet and Marketing and Training Plans. The audit also evaluated Health Net's Member Services system and its readiness for CHPIV data, as well as staff training for recording CHPIV member interactions. Health Net's internal monitoring practices for enrollment and member services, specifically for CHPIV cases was also reviewed. Health Net's system configurations for CHPIV member data ingestion and utilization, staff training plan on CHPIV-specific enrollment documentation, processes to notify CHPIV about enrollment data exchange issues, development and approval of the New Member Packet and Marketing and Training Plans with CHPIV, and the readiness and training of staff for handling CHPIV member cases in Member Services system were found to be sufficient.

No findings.

FINANCE, CLAIMS, PROVIDER DISPUTE RESOLUTIONS (PDRs) AND ENCOUNTERS

The Finance section of the pre-delegation audit assessed Health Net's readiness and practices related to finance, claims, provider dispute resolutions (PDRs) and encounters for CHPIV members. The audit reviewed to ensure that the Claims, Encounters, and Finance systems were properly set up for CHPIV data and validated that staff had received appropriate training on CHPIV-specific procedures for these systems. The audit also reviewed Health Net's internal monitoring methods for financial performance, claims, and encounters, specifically focused on CHPIV members. Health Net's encounters system configuration readiness for CHPIV data was found to be sufficient.

Finance Findings:

Request #	Measure	Documents Requested	Findings
55	Claims system is configured and ready for CHPIV data	System screen grabs and workflows that indicate: - all fields required to document CHPIV claims and produce necessary reporting are in system If not yet in place, review for planning documents that indicate completion prior to go-live. Plan should include steps to establish: - accountabilities	Workflows and policies submitted outline Health Net's procedures on how to process a claim. This does not evidence that the Claims system is configured and ready for CHPIV data/cases (e.g., screenshots of Claims system of record with CHPIV codes.)

Request #	Measure	Documents Requested	Findings
		- establishment of P&Ps/DLPs/other documentation - staff training launch - ensuring training completion - ongoing training opportunities/available materials - - target date for completion	
56	Staff trained on CHPIV-specific steps/considerations for utilizing Claims system for CHPIV-specific finance activities	Training materials indicating staff are made of aware of how to utilize the system for CHPIV financials. If not yet in place, review for planning documents that indicate completion prior to go-live. Plan should include steps to establish: - accountabilities - training launch - ensuring training completion - ongoing training opportunities/available materials - target date for completion	The provided presentation is focused on providers on the transition and resources. Still no evidence that Claims staff was educated or informed of CHPIV-specific steps/considerations for utilizing Claims system and processing CHPIV claims.
58	Staff trained on CHPIV-specific steps/considerations for utilizing Encounters system for CHPIV-specific finance activities	Training materials indicating staff are made of aware of how to utilize the system for CHPIV encounters. If not yet in place, review for planning documents that indicate completion prior to go-live. Plan should include steps to establish: - accountabilities - training launch - ensuring training completion - ongoing training opportunities/available materials - target date for completion	While overall processes will be the same, we anticipate some differences will necessitate training or training materials/desk-level procedures be developed (e.g., using the HP Code specific to CHPIV when submitting encounters, 'branding' on any reports to the providers for CHPIV, etc.)
59	Finance system is configured and ready for CHPIV data	System screen grabs and workflows that indicate: -all fields required to document CHPIV financials and produce necessary reporting are in system	HN indicates in the DRL that this is complete, see below. But does not provide evidence/documentation such as screenshots requested to validate system readiness.

Request #	Measure	Documents Requested	Findings
		If not yet in place, review for planning documents that indicate completion prior to go-live. Plan should include steps to establish: - accountabilities - establishment of P&Ps/DLPs/other documentation - staff training launch - ensuring training completion - ongoing training opportunities/available materials - target date for completion	*"Complete - Both CHPIV and HN receive the 834 and 820 files.* *HN is configured and ready to receive the data.* *HN has a Knox-Keene license with the state that we are contractually bound to and includes a reconciliation process of HN files quarterly statements and annual filings. Centene as a parent company backs HN.* *CHPIV would need to put a process in place where they can reconcile this information themselves.* *HN is happy to partner with CHPIV on discrepancies and resolve them.* *HN is prepared to attest that our Finance system is configured and ready for CHPIV data."* Health Net also indicates an implementation plan submitted (even though stated is complete) but there was no implementation plan submitted.

Request #	Measure	Documents Requested	Findings
60	Staff trained on CHPIV-specific steps/considerations for utilizing system for CHPIV-specific finance activities	Training materials indicating staff are made of aware of how to utilize the system for CHPIV financials. If not yet in place, review for planning documents that indicate completion prior to go-live. Plan should include steps to establish: - accountabilities - training launch - ensuring training completion - ongoing training opportunities/available materials - target date for completion	HN indicates in the DRL that this is complete, see below. But does not provide evidence or documentation such as training materials and dates to validate completion of training on CHPIV-specific steps/considerations for finance activities in system. *"HN is an experienced Health Plan with a large book of business in CA. Staff are trained and have been providing these requirements for 20+ years with excellent annual audit outcomes by the state.* *HN is prepared to attest that staff is trained on CHPIV-specific steps/considerations for CHPIV-specific finance activities."*
61	HN internal financial performance monitoring processes/workflows (for CHPIV members)	Workflows/processes/oversight and monitoring tools evidencing HN's process for: - overseeing CHPIV UM operational performance and compliance - reviewing trends - remediating issues identified If not yet in place, review for planning documents that indicate completion prior to go-live. Plan should include steps to establish: - accountabilities - reports utilized - frequency - communication to CHPIV - target date for completion	No documents were submitted for this deliverable.

Request #	Measure	Documents Requested	Findings
62	HN internal claims monitoring processes/workflows (for CHPIV members)	Workflows/processes/oversight and monitoring tools evidencing HN's process for: - overseeing CHPIV UM operational performance and compliance - reviewing trends - remediating issues identified If not yet in place, review for planning documents that indicate completion prior to go-live. Plan should include steps to establish: - accountabilities - reports utilized - frequency - communication to CHPIV - target date for completion	HN indicates in the DRL that this is complete (see below), but does not provide evidence or documentation such as training materials and dates to validate completion of training on CHPIV-specific steps/considerations for finance activities in system. *"HN is an experienced Health Plan with a large book of business in CA. Staff are trained and have been providing these requirements for 20+ years with excellent annual audit outcomes by the state.* *HN is prepared to attest that staff is trained on CHPIV-specific steps/considerations for CHPIV-specific finance activities."*
63	HN internal encounters monitoring processes/workflows (for CHPIV members)	Workflows/processes/oversight and monitoring tools evidencing HN's process for: - overseeing CHPIV UM operational performance and compliance - reviewing trends - remediating issues identified If not yet in place, review for planning documents that indicate completion prior to go-live. Plan should include steps to establish: - accountabilities - reports utilized - frequency - communication to CHPIV - target date for completion	9.01.23 Medi-Cal Encounter Data Submission (inbound): Policy describes daily and monthly monitoring of PPG encounters. Does not indicate if and when continued encounters submissions issues are escalated, formally addressed via CAP or other mechanism. CAHN.ENC.01.03: Upon re-reviewing, the policy states: "Should CHPIV receive notice of failure to meet Contractual Obligations related to encounter performance from DHCS, CHPIV will complete a CAP within 6 months of notice. Monthly status updates will be provided to DHCS via CHPIV utilizing the CAP Response Form and provide supporting documentation until the CAP is completed." CHPIV, with HN's support, may need to respond to DHCS more promptly than in 6 months. Health Net and CHPIV

Request #	Measure	Documents Requested	Findings
			will need to comply with regulatory timelines.

NETWORK

The Network section of the pre-delegation audit evaluated Health Net's procedures for managing the provider network serving CHPIV members. The review focused on how Health Net ensures ongoing network adequacy and oversees its CHPIV provider network. The audit assessed Health Net's ability to meet DHCS access requirements for both its provider network and subnetwork. It also reviewed Health Net's mechanisms for flagging and addressing network gaps, particularly for DMHC and NCQA criteria. The audit also assessed Health Net's diligence in updating its provider directory for CHPIV members to reflect accurate provider details and status changes. Health Net's processes for provider network management and maintaining network adequacy on an ongoing basis, escalation and remediation of network gaps and noncompliance, and ongoing oversight and monitoring of the provider network were found to be sufficient.

Network Findings:

Request #	Measure	Documents Requested	Findings
68	Process for ensuring HN provider subnetwork meets DHCS access requirements for CHPIV members.	Workflows/processes/system screenshots indicating: - provider time and distance standards are met for HN subnetwork providers serving CHPIV members - agreements are established for all mandatory subnetwork provider types stipulated by DHCS for Imperial County - subnetwork provider ratios for CHPIV-serving providers are compliant with DHCS requirements If not yet in place, review for planning documents that indicate completion prior to go-live.	Cannot verify if CCIPA CAPs are sufficient or whether they are closed. Narrative indicates that OON services are provided when medically necessary but cannot validate due to lack of P&Ps and/or other documentation.
71	Process for ensuring HN updates its provider directory for CHPIV members when there are changes to provider status or provider information.	Workflows/processes/system screenshots indicating: - how HN updates its CHPIV provider directory when there are changes to the network or provider information - frequency of updates - how HN will deliver updated provider directory to CHPIV in instances when updates are made If not yet in place, review for planning	Policy provided does not include any CHPIV-specific processes/notices to CHPIV for when there are changes to provider status or provider information.

Request #	Measure	Documents Requested	Findings
		documents that indicate completion prior to go-live.	

Network Pended Results:

Request #	Measure	Documents Requested	Reasons for Pend
67	Process for ensuring HN provider network meets DHCS access requirements for CHPIV members	Workflows/processes/system screenshots indicating: - provider time and distance standards are met for HN network providers serving CHPIV members - agreements are established for all mandatory provider types stipulated by DHCS for Imperial County - network provider ratios for CHPIV-serving providers are compliant with DHCS requirements If not yet in place, review for planning documents that indicate completion prior to go-live.	Pending DHCS results and approvals of Imperial network.
69	Process for ensuring HN provider network meets DMHC and NCQA standards for CHPIV members.	Workflows/processes/system screenshots indicating: - provider time and distance standards are met for HN network providers serving CHPIV members - agreements are established for all required provider types stipulated by DMHC/NCQA - network provider ratios for CHPIV-serving providers are compliant with DMHC/NCQA requirements If not yet in place, review for planning documents that indicate completion prior to go-live.	The RY2022 DMHC/DHCS Integrated Accessibility Report indicates scores that are below the targets and lists actions in progress to address barriers. No updates/information was provided to indicate whether these have been effective and if scores have improved. Pending final results. CA.NM.77 is compliant as it references Imperial County.

UTILIZATION MANAGEMENT

The Utilization Management portion of the pre-delegation audit examined Health Net's compliance with developing a UM program in line with regulations and CHPIV feedback. The audit verified the UM system's ability to document CHPIV cases and assessed staff training with the system. Additionally, the audit evaluated Health Net's internal UM oversight processes for CHPIV cases to ensure continuous quality assurance. Health Net's process for UM program development, along with the submission and integration of CHPIV inputs, meets the regulatory requirements, and was found to be sufficient. Health

Net's process to develop a UM Program and workplan and submission to CHPIV was found to be sufficient.

Utilization Management Findings:

Request #	Measure	Documents Requested	Findings
73	UM system is configured and ready to process and document CHPIV member cases	System screenshots and workflows that indicate: -all fields required to track CHPIV cases and produce necessary reporting are in system -DLPs/workflows include when/how to utilize those fields If not yet in place, review for planning documents that indicate completion prior to go-live.	Workflows and policies submitted outline Health Net's procedures on how to process an authorization. This does not evidence that the UM system is configured and ready for CHPIV data/cases (e.g., screenshots of UM system of record with CHPIV codes.) Narrative submitted confirms that a CHPIV code will be added to Health Net's UM system (TrueCare) but no timelines or work plans were submitted to evidence plan for completion.
74	Staff are trained to utilize the system for CHPIV member cases	Training materials indicating documentation processes for CHPIV member cases If not yet in place, review for planning documents that indicate completion prior to go-live.	No evidence training material was deployed (e.g., sign in sheets, meeting invite, email communication to UM staff). Narrative submitted confirms that a training will be completed at a later time, but no timelines or work plans were submitted to evidence plan for completion.
75	HN internal UM monitoring processes/workflows (for CHPIV cases)	Workflows/processes/oversight and monitoring tools evidencing HN's process for: - overseeing CHPIV UM operational performance, including timeliness, decision-making, and letter quality - reviewing trends - remediating issues identified If not yet in place, review for planning documents that indicate completion prior to go-live. Plan should include steps to establish: - accountabilities - reports utilized - frequency - communication to CHPIV - target date for completion	CA.UM.57 Precertification and Prior Authorization Request P&P and job aid includes oversight and monitoring of decision timeliness but does not include monitoring of notification timeliness. TAT definitions are included in the job aid for standard, urgent/expedited, retrospective but does not include post-stabilization. Health Net indicates that the policy will be revised to include post-stabilization by November 2023, but it has not been revised at this time.

Pre-Delegation Audit Report

Phase 2

November 17, 2023

Community Health Plan
OF IMPERIAL VALLEY

PRE-DELEGATION AUDIT REPORT
Phase 2

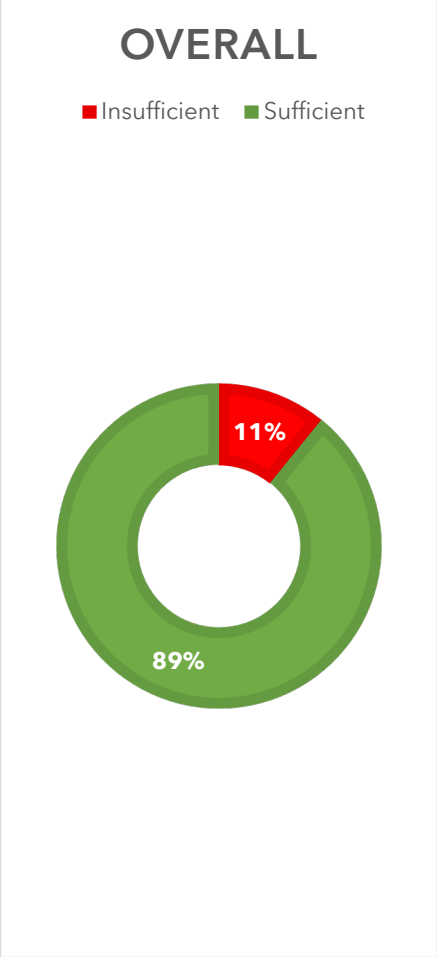
Background
In 2021, the Department of Healthcare Services (DHCS) approved Imperial County's application to move to a single plan model. In 2022, the County initiated the process to obtain a Knox Keene License (KKL) to service Medi-Cal members under this new model. As a result, Community Health Plan of Imperial Valley (CHPIV) was formed as the county's new local initiative. Effective January 1, 2024, CHPIV and Health Net enter into a Plan-to-Plan agreement and Health Net will service as CHPIV's Subcontractor or "Delegate", whereby Health Net's provider network and administrative services will be used to support Imperial County.

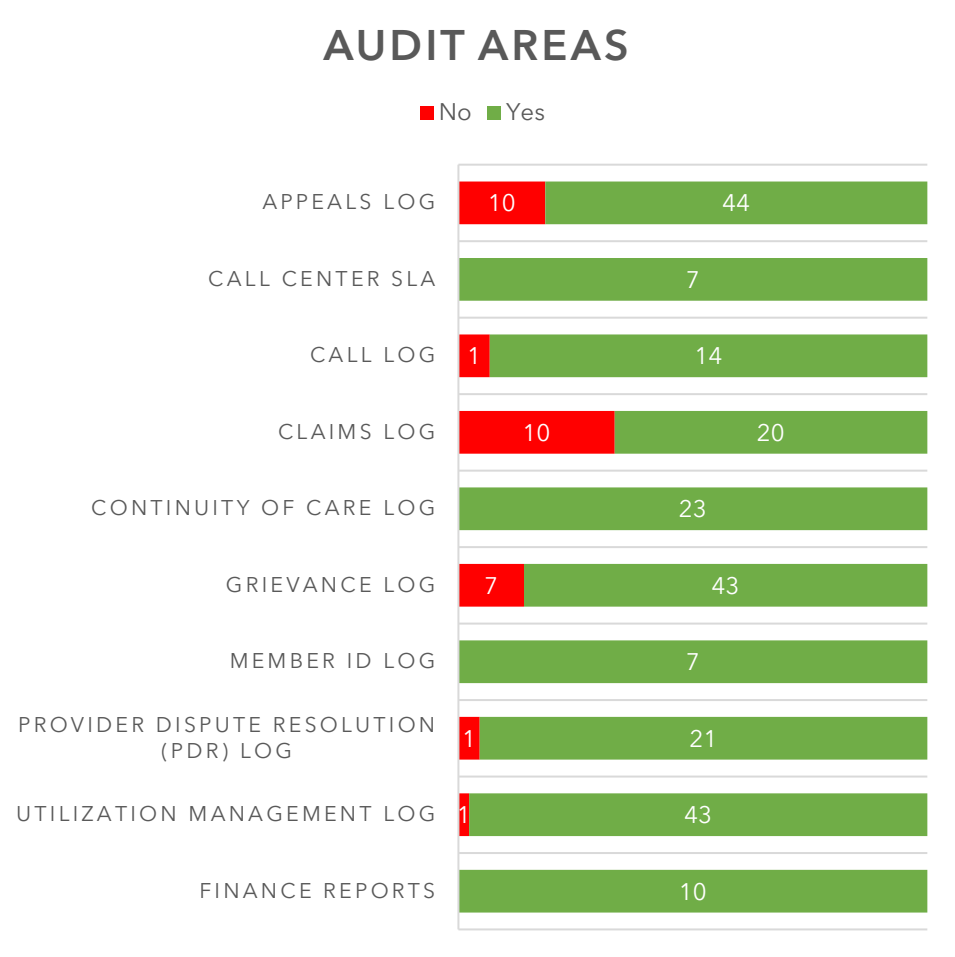
Audit Scope
The audit was designed to assess Health Net's ability to perform critical delegated functions in alignment with the Health Net – CHPIV plan-to-plan agreement, as well as the Department of Health Care Services (DHCS) requirements concerning delegation oversight. **Phase 2** of the pre-delegation audit specifically examines Health Net's proficiency in submitting necessary reports and data for CHPIV's continuous monitoring. This audit focuses on critical and high-risk areas with significant impact on members and providers as well as Health Net – CHPIV plan-to-plan service level agreements (SLAs). Specific data elements are required to assess performance and adherence to state regulations.

Audit Areas
- Key Performance Indicators (KPI) Logs
  - Appeals Log
  - Call Center SLA Log
  - Call Log
  - Claims Log
  - Continuity of Care Log
  - Member ID Log
  - Provider Dispute Resolution (PDR) Log
  - Utilization Management (UM) Authorization Log
- Finance Reports

Methodology
CHPIV provided Health Net with a list of necessary reports and data elements. Health Net was then requested to submit documentation to evidence the ability to provide the reports and data elements to CHPIV, including submission of existing Health Net reports containing these specified data elements. CHPIV conducted a thorough review of the reports and documentation provided by Health Net. The primary objective of this review was to verify whether the data elements in Health Net's reports fulfilled all the required criteria for each measure. In instances where validation of specific data elements was not possible, these were distinctly marked as "No" in our assessment.

Summary of Findings





Audit Trends

The following section outlines the primary trends observed during Phase 2 of the pre-delegation audit. For a detailed outline regarding areas found to be insufficient or pended in each audit domain, please refer to the subsequent sections.

1. **Validation Issues:** There is a recurring inability to validate if the reports submitted by Health Net for standard appeals and grievances are applicable to expedited appeals and grievances. This indicates a potential gap in the documentation process or a lack of clear delineation between standard and expedited processes.
2. **Data Field Compliance**: Unable to validate multiple data fields that are not required by regulatory audit logs but are tied to regulatory requirements and Service Level Agreement (SLA) performance standards. For example, the "Time written notification was sent to member" for expedited appeals and grievances is not required for DHCS and DMHC audit logs but is required to measure timeliness of expedited appeals and grievances. Health Net's performance in these areas cannot be measured without these data fields.

3. **Timeliness of Acknowledgment:** There are specific fields like "Date Claim Acknowledged" and "Type of PDR Submission" required for monitoring acknowledgment timeliness, which are essential for compliance with regulatory and SLA citations.
4. **Overpayment Processing:** Multiple fields related to compliance with overpayment requirements, such as "Overpayment Reason," "Overpayment Amount Recovered," and "Date Overpayment Recovery Received," are required to monitor the processing of overpayments.
5. **Comprehensive Reporting:** There are incomplete call log submissions, lacking category-specific templates for validation. For example, CHPIV could not validate that the Call Log covered the full scope of member calls as Health Net noted calls that resulted in grievances, for example, were in a different log. Additionally, CHPIV was unable to validate UM authorization types due to a lack of crosswalks and system screenshots, which is critical for monitoring authorization timeliness.

These trends suggest that Health Net may need to enhance its reporting systems, ensure the collection of all necessary data fields, and improve the comprehensiveness of its documentation to allow CHPIV to conduct required oversight of compliance with regulatory requirements and SLA performance standards.

Remediation

Corrective action plans and supporting documentation are required for areas requiring remediation within 10 business days, per CHPIV P&P CMP-003 Corrective Action Plans. CHPIV will continue to monitor the progress towards remediation and collaborate to ensure readiness by January 1, 2024.

APPEALS LOG

The Appeals Log section of the pre-delegation audit assessed Health Net's ability to submit the necessary reports and data for CHPIV's continuous monitoring of their appeals process. It compared Health Net's appeals reports against CHPIV's required data elements to identify any discrepancies, ensuring CHPIV had the necessary data for effective oversight. While many of the required data elements were found to be sufficient, key data fields necessary to evaluate timeliness, such as "Time Notice of Appeal (NAR) provided to member" and "Date/time overturned appeals effectuated in the system," were missing. CHPIV was also unable to validate if Health Net's appeals report applies to expedited appeals.

Appeals Log Findings

Data Field	Data Requirement	Findings
Appeal Number	Enter the appeal case identification number	Health Net listed and submitted a log for standard appeals. Unable to validate if this report applies to expedited appeals.
Identify source of original prior denial from the Subcontractor or Downstream Subcontractor	Identify source of original prior denial from the Subcontractor or Downstream Subcontractor	Health Net listed and submitted a log for standard appeals. Unable to validate if this report applies to expedited appeals.
Specific service requested and quantity	Enter specific service requested, as applicable	Health Net listed and submitted a log for standard appeals. Unable to validate if this report applies to expedited appeals.
Procedure request	Enter CPT Code with short description	Health Net listed and submitted a log for standard appeals. Unable to validate if this report applies to expedited appeals.
Specialty of consult/office visit request	Enter type of consult/office visit request (Neurology, DME, PT, etc.)	Health Net listed and submitted a log for standard appeals. Unable to validate if this report applies to expedited appeals.
Date Notice of Appeal (NAR) provided to member	Enter date written notification was sent to member **(CCYY/MM/DD) Enter in Text format** Enter **NA** if no written notification was provided to the member	Health Net listed and submitted a log for standard appeals. Unable to validate if this report applies to expedited appeals.

Data Field	Data Requirement	Findings
Time Notice of Appeal (NAR) provided to member	Enter time written notification was sent to member **(HH:MM:SS)** **Enter in Text format** Enter **NA** if no written notification was provided to the member	The "Time written notification was sent to member" data field is not a required regulatory audit field; however, this data field is tied to regulatory requirements and SLA performance standard for expedited appeals (72 TAT). CHPIV requires this field to measure Health Net's performance for expedited appeal member notification timeliness Regulatory and SLA Citation for expedited appeals: -DHCS Contract Exhibit A, Attachment III, 4.6.5 (C) -Appeal Process -APL 21-011 D. Expedited Appeals -42 CFR 438.408(b)(3) - Expedited Appeals -SLA A&G - Delineation of Delegation Responsibilities Health Net stated the "Time written notification was sent to member" data field is not a required regulatory audit field, however Health Net submitted the "Sample - Pre-Delegation Audit" log which includes date & time examples in the "Final Letter Date" data field. Health Net needs to confirm if the data field in the sample report captures the date and time of the Notice of Appeal (NAR) was provided.
Date Overturned Appeals Effectuated	Enter the date overturned appeals effectuated in the system **(CCYY/MM/DD)** **Enter in Text format** Enter **NA** for Upheld Appeals	The "Date overturned appeals effectuated in the system" data field is not a required regulatory audit field; however, this data field is tied to a regulatory requirements and SLA performance standards for overturned appeals (72 TAT). CHPIV requires this field to measure Health Net's performance for timely handling of overturned appeals. Regulatory and SLA Citation for overturn appeals: -APL 21-011 G. Overturned Decisions -DHCS Contract Exhibit A, Attachment III, 4.6.4 (E) -CFR 438.424(a) - Effectuation of reversed appeal resolutions -SLA A&G - Delineation of Delegation Responsibilities Without this data field, CHPIV is unable to measure performance for effectuation of overturned appeals timeliness regulatory requirements and SLA performance standards.

Data Field	Data Requirement	Findings
Time Overturned Appeals Effectuated	Enter the time overturned appeals effectuated **(HH:MM:SS)** **Enter in Text format** Enter **NA** for Upheld Appeals	The "Time overturned appeals effectuated in the system" data field is not a required regulatory audit field; however, this data field is tied to a regulatory requirements and SLA performance standards for overturned appeals (72 TAT). CHPIV requires this field to measure Health Net's performance for timely handling of overturned appeals. Regulatory and SLA Citation for overturn appeals: -APL 21-011 G. Overturned Decisions -DHCS Contract Exhibit A, Attachment III, 4.6.4 (E) -CFR 438.424(a) - Effectuation of reversed appeal resolutions -SLA A&G - Delineation of Delegation Responsibilities Without this data field, CHPIV is unable to measure performance for effectuation of overturned appeals timeliness regulatory requirements and SLA performance standards.
Members' assigned Subcontractor or Downstream Subcontractor	Enter the name of the Members' assigned Subcontractor or Downstream Subcontractor	Health Net listed and submitted a log for standard appeals. Unable to validate if this report applies to expedited appeals.

CALL CENTER LOG

The Call Center Log section of the pre-delegation audit assessed Health Net's ability to submit the necessary reports and data for CHPIV's continuous monitoring of their Call Center service level agreements. It compared Health Net's Call Center reports against CHPIV's required data elements to identify any discrepancies, ensuring CHPIV had the necessary data for effective oversight of the SLAs. Health Net was found to have sufficient capabilities to generate the reporting required for Call Center SLA oversight.

No findings.

CALL LOG

The Call Log section of the pre-delegation audit assessed Health Net's ability to submit the necessary reports and data for CHPIV's continuous monitoring of their Call Center. It compared Health Net's Call Log reports against CHPIV's required data elements to identify any discrepancies, ensuring CHPIV had the necessary data for effective oversight. While most of the required data elements were found to be sufficient, Health Net's call log reports did not provide complete log templates for all required call categories, such as Access to Care, Continuity of Care, and General Transition, impeding CHPIV's ability to validate them in accordance with the 2024 MCP Transition Policy Guide..

Call Log Findings

Data Field	Data Requirement	Findings
Call Category	Provide call categorization. Valid values: Inquiry Exempt Grievance Grievance	Per HN's response, calls are reported on separate reports based on categories. CHPIV is unable to validate this field as log templates for other categories were not submitted. Per Figure 28. Transition-Related Categorization of Member Calls to MCP Member Call Centers, call categories must include Access to Care, Continuity of Care and General Transition as required in the 2024 MCP Transition Policy Guide. Please confirm and submit additional call logs that will reflect a **complete** list of calls received.

CLAIMS LOG

The Claims Log section of the pre-delegation audit assessed Health Net's ability to submit the necessary reports and data for CHPIV's continuous monitoring of their claims processing. It compared Health Net's claims reports against CHPIV's required data elements to identify any discrepancies, ensuring CHPIV had the necessary data for effective oversight. While many of the required data elements were found to be sufficient, key data fields like "Date Claim Acknowledged," "RA/EOB Date," and "Check mail date" were missing, which are critical for monitoring acknowledgement timeliness, claims timeliness, and payment issuance timelines as per regulatory standards. Additionally, fields related to the processing of overpayments such as "Overpayment field," "Date Originally Paid," "Date Overpayment Requested," "Overpayment Reason," "Overpayment Amount Recovered," and "Method of Overpayment Recovery" were also omitted. These omissions hinder CHPIV's ability to monitor Health Net's compliance with regulations concerning claims processing and overpayment handling.

Claims Log Findings

Data Field	Data Requirement	Findings
Date Claim Acknowledged	Date claim was acknowledged to the provider. Submit in the following format: MM/DD/YYYY.	The "Date Claim Acknowledged" is required to allow CHPIV to monitor Acknowledgement Timeliness. Citation: Title 28, Section 1300.71(c) Plan and the plan's capitated provider shall identify and acknowledge the receipt of each claim, whether or not

Data Field	Data Requirement	Findings
		complete, and disclose the recorded date of receipt as defined by section 1300.71(a)(6) in the same manner as the claim was submitted or provide an electronic means, by phone, website, or another mutually agreeable accessible method of notification, by which the provider may readily confirm the plan's or the plan's capitated provider's receipt of the claim and the recorded date of receipt as defined by 1300.71(a)(6) as follows: (1) In the case of an electronic claim, identification and acknowledgement shall be provided within two (2) working days of the date of receipt of the claim by the office designated to receive the claim, or (2) In the case of a paper claim, identification and acknowledgement shall be provided within fifteen (15) working days of the date of receipt of the claim by the office designated to receive the claim.
RA/EOB Date	Provide the date the Remittance Advice or Explanation of Benefits was mailed to the provider, which is the date the RA/EOB left the organization by US Mail, fax, or electronic communication. Do not enter the date the RA/EOB was generated or printed within the organization. Submit in the following format: MM/DD/YYYY.	The "RA/EOB Date" is required to allow CHPIV to monitor claims timeliness. Citation: Title 28, Section 1300.71(g)(h) - Processes and procedures to ensure timely adjudication of claims not to exceed ninety percent (90%) of Clean Claims within thirty (30) calendar days after receipt of the claim and ninety-five percent (95%) of all other claims within forty-five (45) working days after the receipt of the claims. Plan to Plan agreement First Amendment, Exhibit A, Attachment IV, 3.3.5; Exhibit A-5
Check Mail Date	Provide the date the check was mailed to the provider, which is the date the check left the organization by US Mail, fax, or electronic communication. Do not enter the date the check was generated or printed within the organization. Submit in the following format: MM/DD/YYYY. If a	Unable to validate that checks are mailed with RA/EOB (same day/time). "Check mail date" is required to allow CHPIV to monitor for Claims Timeliness and payments are issued within the required timeframe. Citation: Title 28, Section 1300.71(g)(h) - Processes and procedures to ensure timely adjudication of claims not to exceed ninety percent (90%) of Clean Claims within thirty (30) calendar days after receipt of the claim and ninety-five percent (95%) of all other claims within forty-five (45) working days after the receipt of the claims.

Data Field	Data Requirement	Findings
	payment was not made, answer NA.	
Overpayment	Y for overpayments N for all others	Overpayment field is required to allow CHPIV to monitor processing of overpayment request. Citation: Title 28, Section 1300.71(b)(5) - A plan or a plan's capitated provider shall not request reimbursement for the overpayment of a claim, including requests made pursuant to Health and Safety Code Section 1371.1, unless the plan or the plan's capitated provider sends a written request for reimbursement to the provider within 365 days of the Date of Payment on the over paid claim. The written notice shall include the information specified in section (d)(3). The 365-day time limit shall not apply if the overpayment was caused in whole or in part by fraud or misrepresentation on the part of the provider. Title 28, Section 1300.71(a)(8)(D) - The failure to request reimbursement of an overpayment of a claim consistent with the provisions of sections (b)(5) and (d)(3), (4), (5) and (6) at least 95% of the time for the affected claims over the course of any three-month period.
Date Originally Paid	Date overpayment was originally paid. Submit in the following format: MM/DD/YYYY.	Date Originally Paid field is required to allow CHPIV to monitor overpayment request timeliness. Citation: Title 28, Section 1300.71(b)(5) - A plan or a plan's capitated provider shall not request reimbursement for the overpayment of a claim, including requests made pursuant to Health and Safety Code Section 1371.1, unless the plan or the plan's capitated provider sends a written request for reimbursement to the provider within 365 days of the Date of Payment on the over paid claim. The written notice shall include the information specified in section (d)(3). The 365-day time limit shall not apply if the overpayment was caused in whole or in part by fraud or misrepresentation on the part of the provider. Title 28, Section 1300.71(a)(8)(D) - The failure to request reimbursement of an overpayment of a claim consistent with the provisions of sections (b)(5) and (d)(3), (4), (5) and (6) at least 95% of the time for the affected claims over the course of any three-month period.
Date Overpayment Requested	Date recovery request/letter was sent to the provider. Submit in the	Date Overpayment Requested field is required to allow CHPIV to monitor overpayment request timeliness. Citation:

Data Field	Data Requirement	Findings
	following format: MM/DD/YYYY. NA for non-overpayment claims	Title 28, Section 1300.71(b)(5) - A plan or a plan's capitated provider shall not request reimbursement for the overpayment of a claim, including requests made pursuant to Health and Safety Code Section 1371.1, unless the plan or the plan's capitated provider sends a written request for reimbursement to the provider within 365 days of the Date of Payment on the over paid claim. The written notice shall include the information specified in section (d)(3). The 365-day time limit shall not apply if the overpayment was caused in whole or in part by fraud or misrepresentation on the part of the provider. Title 28, Section 1300.71(a)(8)(D) - The failure to request reimbursement of an overpayment of a claim consistent with the provisions of sections (b)(5) and (d)(3), (4), (5) and (6) at least 95% of the time for the affected claims over the course of any three-month period.
Overpayment Reason	Reason the claim was overpaid or paid in error. NA for non-overpayment claims	Overpayment Reason field is required to allow CHPIV to monitor processing of overpayment requests. Citation: Title 28, Section 1300.71(a)(8)(D) - The failure to request reimbursement of an overpayment of a claim consistent with the provisions of sections (b)(5) and (d)(3), (4), (5) and (6) at least 95% of the time for the affected claims over the course of any three-month period.
Overpayment Amount Recovered	Amount of overpayment recovered. Submit in the following format: $xxx,xxx.xx. If an overpayment recovery was not received, answer Null. NA for non-overpayment claims	Overpayment Amount Recovered field is required to allow CHPIV to monitor processing of overpayment requests. Citation: Title 28, Section 1300.71(a)(8)(D) - The failure to request reimbursement of an overpayment of a claim consistent with the provisions of sections (b)(5) and (d)(3), (4), (5) and (6) at least 95% of the time for the affected claims over the course of any three-month period.
Method of Overpayment Recovery	Provide the method in which the overpayment recovery was made or otherwise resolved. Valid values: - Refund - Refunded by provider - Retract - Retracted through the claims system - Dispute – Disputed	Method of Overpayment Recovery field is required to allow CHPIV to monitor processing of overpayment requests. Citation: Title 28, Section 1300.71(d)(4) - If the provider contests the plan's or the plan's capitated provider's notice of reimbursement of the overpayment of a claim, the provider, within 30 working days of the receipt of the notice of overpayment of a claim, shall send written notice to the plan or the plan's capitated provider stating the basis upon which the provider believes that the claim was not over paid. The plan or the plan's capitated provider shall receive and process the

Data Field	Data Requirement	Findings
	by the provider - Closed – Closed due to an administrative decision. If an overpayment recovery was not received or the case was not resolved, answer Null. NA for non-overpayment claims	contested notice of overpayment of a claim as a provider dispute pursuant to Section 1300.71.38 of title 28. Title 28, Section 1300.71(d)(5) - If the provider does not contest the plan's or the plan's capitated provider's notice of reimbursement of the overpayment of a claim, the provider shall reimburse the plan or the plan's capitated provider within 30 working days of the receipt by the provider of the notice of overpayment of a claim. Title 28, Section 1300.71(d)(6) - A plan or a plan's capitated provider may only offset an uncontested notice of reimbursement of the overpayment of a claim against a provider's current claim submission when: (i) the provider fails to reimburse the plan or the plan's capitated provider within the timeframe of section (5) above and (ii) the provider has entered into a written contract specifically authorizing the plan or the plan's capitated provider to offset an uncontested notice of overpayment of a claim from the contracted provider's current claim submissions. In the event that an overpayment of a claim or claims is offset against a provider's current claim or claims pursuant to this section, the plan or the plan's capitated provider shall provide the provider a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.
Date Overpayment Recovery Received	Provide the date the overpayment was recovered by refund or retraction only. Submit in the following format: MM/DD/YYYY. If an overpayment recovery was not received, answer Null. NA for non-overpayment claims	Date Overpayment Recovery Received field is required to allow CHPIV to monitor processing of overpayment requests. Citation: Title 28, Section 1300.71(a)(8)(D) - The failure to request reimbursement of an overpayment of a claim consistent with the provisions of sections (b)(5) and (d)(3), (4), (5) and (6) at least 95% of the time for the affected claims over the course of any three-month period.

CONTINUITY OF CARE LOG

The Continuity of Care (CoC) Log section of the pre-delegation audit assessed Health Net's ability to submit the necessary reports and data for CHPIV's continuous monitoring of their CoC process. It compared Health Net's CoC reports against CHPIV's required data elements to identify any discrepancies, ensuring CHPIV had the necessary data for effective oversight. Health Net was found to have sufficient capabilities to generate the data required for CoC oversight.

No findings.

GRIEVANCE LOG

The Grievance Log section of the pre-delegation audit assessed Health Net's ability to submit the necessary reports and data for CHPIV's continuous monitoring of their grievance process. It compared Health Net's grievance reports against CHPIV's required data elements to identify any discrepancies, ensuring CHPIV had the necessary data for effective oversight. While many of the required data elements were found to be sufficient, key data fields, essential for assessing timeliness as per regulatory and SLA standards, were absent. CHPIV was also unable to validate if Health Net's grievances report applies to expedited grievances.

Grievance Log Findings

Log Inclusions and Exclusions	Findings
Include all grievances received (from 1/1/2024 to present) that are not resolved by the end of the reporting review period.	Health Net failed to confirm the ability to pull data based on inclusion and exclusion required.
Grievances with multiple issues must be entered as a single line item.	Health Net failed to confirm the ability to pull data based on inclusion and exclusion required.

Data Field	Data Requirement	Findings
Member Date of Birth	Enter Member's DOB **(CCYY/MM/DD) Enter in Text format**	Health Net listed and submitted a log for standards grievances. Unable to validate if this report applies to expedited grievances.
Grievance Identification Number	Enter grievance identification number	Health Net listed and submitted a log for standards grievances. Unable to validate if this report applies to expedited grievances.

Data Field	Data Requirement	Findings
Date written resolution letter provided to member	Enter date written notification was sent to member **(CCYY/MM/DD) Enter in Text format** If no member written notification was sent, answer **NA**	Health Net listed and submitted a log for standards grievances. Unable to validate if this report applies to expedited grievances.
Time written resolution letter provided to member	Enter time written notification was sent to member **(HH:MM:SS) Enter in Text format** If no member written notification was sent, answer **NA**	The "Time written notification was sent to member" data field is not a required regulatory audit field. However, this data field is tied to regulatory requirements and SLA performance standards for expedited grievance (72 TAT). CHPIV requires this field to measure Health Net's performance for expedited grievance member notification timeliness Regulatory and SLA citation for expedited grievances: -APL 21-011 III Grievance E. Expedited Grievances -HSC 1368.01(b) -42 CFR 438.408(b)(3) - Expedited Appeals -SLA A&G - Delineation of Delegation Responsibilities Health Net responded that the "Time written notification was sent to member" data field is not a required regulatory audit field, yet submitted the "Sample - Pre-Delegation Audit" log which includes date & time in the "Final Letter Date" data field. Unable to confirm that this report represents a readily available report for CHPIV and if this field represents the time the notification was sent to the member.
Subcontractor or Downstream Subcontractor the grievance was filed against	Enter the name of the Subcontractor or Downstream Subcontractor the grievance was filed against	Health Net listed and submitted a log for standards grievances. Unable to validate if this report applies to expedited grievances.

MEMBER ID LOG

The Member ID Log section of the pre-delegation audit assessed Health Net's ability to submit the necessary reports and data for CHPIV's continuous monitoring of their Member ID dissemination process. It compared Health Net's Member ID report against CHPIV's required data elements to identify any discrepancies, ensuring CHPIV had the necessary data for effective oversight. Health Net was found to have sufficient capabilities to generate the data required for Member ID dissemination oversight.

No findings.

PROVIDER DISPUTE RESOLUTION (PDR) LOG

The Provider Dispute Resolution (PDR) Log section of the pre-delegation audit assessed Health Net's ability to submit the necessary reports and data for CHPIV's continuous monitoring of their PDR process. It compared Health Net's PDR reports against CHPIV's required data elements to identify any discrepancies, ensuring CHPIV had the necessary data for effective oversight. While most of the required data elements were found to be sufficient, Health Net's PDR log lacked the "Type of PDR Submission" field, necessary for CHPIV to monitor Acknowledgement Timeliness in line with Title 28, Section 1300.71.38(e), which varies depending on whether the PDR was submitted electronically or on paper.

PDR Log Findings

Data Field	Data Requirement	Findings
Type of PDR Submission	Indicate if the Provider Dispute Request was submitted in a paper or electronic format. Valid values: P for Paper Claim E for Electronic Claim	The "Type of PDR Submission" field is required to allow CHPIV to monitor Acknowledgement Timeliness. TATs are dependent on if the PDR was submitted via Paper or Electronic per Title 28, Section 1300.71.38(e). Citation: A plan or a plan's capitated provider shall enter into its dispute resolution mechanism system(s) each provider dispute submission (whether or not complete), and shall identify and acknowledge the receipt of each provider dispute: (1) In the case of an electronic provider dispute, the acknowledgement shall be provided within two (2) working days of the date of receipt of the electronic provider dispute by the office designated to receive provider disputes, or (2) In the case of a paper provider dispute, the acknowledgement shall be provided within fifteen (15) working days of the date of receipt of the paper provider dispute by the office designated to receive provider disputes.

UM AUTHORIZATION LOG

The UM Authorization Log section of the pre-delegation audit assessed Health Net's ability to submit the necessary reports and data for CHPIV's continuous monitoring of their UM Authorization process. It compared Health Net's UM report against CHPIV's required data elements to identify any discrepancies, ensuring CHPIV had the necessary data for effective oversight. While most of the required data elements were found to be sufficient, CHPIV is unable to validate Health Net's different values of authorization categorization based on various review types (CN, CU, PN, PU, PST, RS), which are crucial for monitoring differing turnaround times for each category.

UM Authorization Log Findings

Data Field	Data Requirement	Findings
Review Type	**Choose from dropdown:** **CN**= Concurrent Nonurgent **CU**= Concurrent Urgent **PN**= Preservice Nonurgent **PU**= Preservice Urgent **PST**= Post Stabilization **RS**= Retrospective	Health Net did not provide a crosswalk, screenshot, or Log UM Denials Delays Modifications. CHPIV is unable to review Health Net's different values of the categories below and validate the ability to categorize authorizations based on review types: CN= Concurrent Nonurgent CU= Concurrent Urgent PN= Preservice Nonurgent PU= Preservice Urgent PST= Post Stabilization RS= Retrospective As TATs are different for each review types, this field is critical for ongoing monitoring

FINANCE REPORTS

The Finance reports section of the pre-delegation audit aimed to confirm Health Net's capability to generate key financial reports in the future. It focused on ensuring their preparedness to produce monthly financial statements, complete with budget variance analyses and administrative cost details. The audit also confirmed Health Net's readiness to provide regular IBNR analyses, medical cost trends and variances, and updates to provider contracts. It also evaluated their ability to compile capitation payments, enrollment figures against the budget, reconciliation reports, and detailed encounter reports. This assessment included verifying Health Net's capacity to maintain accuracy, completeness, and timeliness in these reports, along with their ability to submit the monthly encounter scorecard from the state. Health Net was found to have sufficient capabilities to generate and maintain the necessary financial reports.

No findings.

Pre-Delegation Audit Report

Phase 3

March 13, 2024

Community Health Plan
OF IMPERIAL VALLEY

PRE-DELEGATION AUDIT REPORT
Phase 3

Background

In 2021, the Department of Healthcare Services (DHCS) approved Imperial County's application to move to a single plan model. In 2022, the County initiated the process to obtain a Knox Keene License (KKL) to service Medi-Cal members under this new model. As a result, Community Health Plan of Imperial Valley (CHPIV) was formed as the county's new local initiative. Effective December 22, 2023, CHPIV and Health Net entered into a Plan-to-Plan agreement to service as CHPIV's Subcontractor or "Delegate", whereby Health Net's provider network and administrative services will be used to support Imperial County upon the go-live on January 1, 2024.

Audit Scope

The audit was designed to assess Health Net's ability to perform critical delegated functions in alignment with the Health Net – CHPIV plan-to-plan agreement, as well as the Department of Health Care Services (DHCS) requirements concerning delegation oversight. **Phase 3** focuses on reviewing timely implementation of regulatory changes issued by DHCS in 2023.

Audit Areas

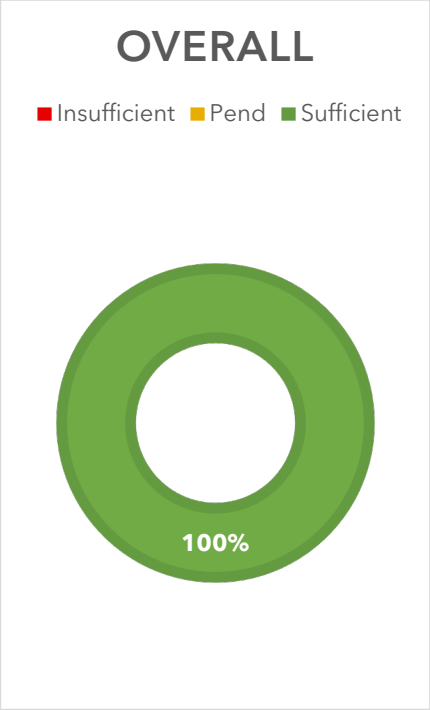
- 2023 DHCS All-Plan Letters (APLs)

Methodology

This audit included review of policies & procedures and other documents to assess implementation of regulatory changes conveyed by DHCS. Please refer to the table below for a summary of the audit results and findings, including measure performance assessments based on implementation status.

PRE-DELEGATION AUDIT REPORT
Phase 3

Summary of Findings



Audit Areas	Results
APL 23-001	Sufficient
APL 23-003	Sufficient
APL 23-004	Sufficient
APL 23-005	Sufficient
APL 23-006	Sufficient
APL 23-007	Sufficient
APL 23-008	Sufficient
APL 23-009	Sufficient
APL 23-010	Sufficient
APL 23-011	Sufficient
APL 23-013	Sufficient
APL 23-014	Sufficient
APL 23-015	Sufficient
APL 23-016	Sufficient
APL 23-017	Sufficient
APL 23-019	Sufficient
APL 23-020	Sufficient
APL 23-021	Sufficient
APL 23-022	Sufficient
APL 23-023	Sufficient
APL 23-024	Sufficient

Audit Trends

No trends observed during Phase 3 of the pre-delegation audit.

Remediation

No corrective action plans required for Phase 3 of the pre-delegation audit.

Audit Results

Request #	Measure	Documents Requested	Findings
32	APL 23-001: Network Certification Requirements	P&Ps and other documents that HN has updated appropriately as required in the APL	NA
33	APL 23-003: California Advancing and Innovating Medi-Cal Incentive Payment Program	P&Ps and other documents that HN has updated appropriately as required in the APL	NA
34	APL 23-004: Skilled Nursing Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care	P&Ps and other documents that HN has updated appropriately as required in the APL	NA

Request #	Measure	Documents Requested	Findings
35	APL 23-005: Requirements For Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21	P&Ps and other documents that HN has updated appropriately as required in the APL	NA
36	APL 23-007: Telehealth Services Policy	P&Ps and other documents that HN has updated appropriately as required in the APL	NA
37	APL 23-008: Proposition 56 Directed Payments for Family Planning Services	P&Ps and other documents that HN has updated appropriately as required in the APL	NA
38	APL 23-009: Authorizations for Post-Stabilization Care Services	P&Ps and other documents that HN has updated appropriately as required in the APL	NA
39	APL 23-010: Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21	P&Ps and other documents that HN has updated appropriately as required in the APL	NA
40	APL 23-011: Treatment of Recoveries Made by the Managed Care Health Plan of Overpayments to Providers	P&Ps and other documents that HN has updated appropriately as required in the APL	NA
41	APL 23-013: Mandatory Signatories to the California Health and Human Services Agency Data Exchange Framework	P&Ps and other documents that HN has updated appropriately as required in the APL	NA
42	APL 23-014: Proposition 56 Value-Based Payment Program Directed Payments	P&Ps and other documents that HN has updated appropriately as required in the APL	NA
43	APL 23-015: Proposition 56 Value-Based Payments for Private Services	P&Ps and other documents that HN has updated appropriately as required in the APL	NA
44	APL 23-016: Directed Payments for Developmental Screening Services	P&Ps and other documents that HN has updated appropriately as required in the APL	NA
45	APL 23-017: Directed Payments for Adverse Childhood Experiences Screening Services	P&Ps and other documents that HN has updated appropriately as required in the APL	NA
47	APL 23-019: Proposition 56 Directed Payments for Physician Services	P&Ps and other documents that HN has updated appropriately as required in the APL	NA
48	APL 23-020: Requirements for Timely Payment of Claims	P&Ps and other documents that HN has updated appropriately as required in the APL	NA
49	APL 23-021: Population Needs Assessment and Population Health Management Strategy	P&Ps and other documents that HN has updated appropriately as required in the APL	NA

Request #	Measure	Documents Requested	Findings
50	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	P&Ps and other documents that HN has updated appropriately as required in the APL	NA
51	APL 23-023: Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care	P&Ps and other documents that HN has updated appropriately as required in the APL	NA
52	APL 23-024: Doula Services (Supersedes APL 22-031)	P&Ps and other documents that HN has updated appropriately as required in the APL	NA

Delegation Oversight

Monitoring Protocol

Community Health Plan
OF IMPERIAL VALLEY

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Table of Contents

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I. Introduction

Overview of the CHPIV Delegation Oversight Monitoring Program

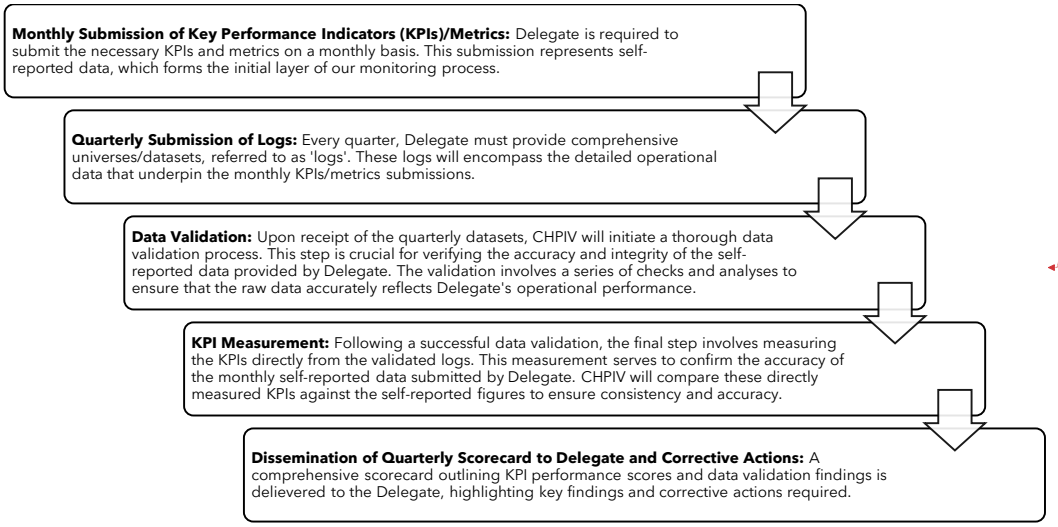
The CHPIV Delegation Oversight Monitoring Program is an integral component of CHPIV's comprehensive risk management and compliance strategy. This program is specifically tailored to oversee CHPIV's Delegates through focused and ongoing monitoring activities. Unlike the broader Audit and Monitoring Program, this protocol concentrates solely on monitoring, providing a more frequent and detailed evaluation of critical and high-risk areas.

The primary purpose of the Monitoring Program is to ensure continuous oversight of high-risk and critical delegated activities that have high member impact and regulatory focus. It emphasizes assessing compliance with federal, state, and organizational standards in real-time, using both quantitative and qualitative key performance indicators (KPIs).

Monitoring Protocol Overview

This protocol is designed for internal stakeholders responsible for overseeing Delegates, regulatory bodies monitoring CHPIV's compliance, and the Delegates. It aims to provide a clear and structured approach to continuous monitoring, ensuring all parties are aligned in their understanding of expectations and processes.

II. Monitoring Process Overview



III. Key Performance Indicators (KPIs) in Scope for Monitoring Program

In this section, we present a detailed list of Key Performance Indicators (KPIs) that are specifically designed to monitor high and critical risk areas in the CHPIV Delegation Oversight Monitoring Program. These KPIs are pivotal for ensuring stringent oversight and management of the most significant risk aspects of our delegated functions.

Note: Currently, our focus is on quantitative KPIs. We have plans to incorporate qualitative KPIs in the subsequent phases of our monitoring strategy to ensure a more comprehensive evaluation framework.

Please see Appendix A for detailed information on each KPI.

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Functional Area	KPI Type	KPI #	KPI	Thresholds			Log
				Green	Yellow	Red	
Appeals	Quantitative	APPEAL01	Timely Acknowledgement of Appeals	>96%	95-96%	<95%	Appeal Log
Appeals	Quantitative	APPEAL02	Timely Decision of Appeals	>96%	95-96%	<95%	Appeal Log
Appeals	Quantitative	APPEAL03	Timely Effectuation of Overturned Appeals	>96%	95-96%	<95%	Appeal Log
Appeals	Quantitative	APPEAL04	Member Notification Timeliness	>96%	95-96%	<95%	Appeal Log
Claims	Quantitative	CLM001	Claims Payment Timeliness - 30 Calendar Days	>91%	90-91%	<90%	Claims Log
Claims	Quantitative	CLM002	Claims Payment Timeliness - 45 Working Days	>96%	95-96%	<95%	Claims Log
Claims	Quantitative	CLM003	Claims Payment Timeliness - 90 Calendar Days	>99%	99%	<99%	Claims Log
Claims	Quantitative	CLM004	Claims Acknowledgement Timeliness	>96%	95-96%	<95%	Claims Log
Claims	Quantitative	CLM005	Misdirected Claims Timeliness	>96%	95-96%	<95%	Claims Log
Claims	Quantitative	CLM006	Timely Interest Payment on Late Claims	>96%	95-96%	<95%	Claims Log
Continuity of Care	Quantitative	COC001	CoC Processing Timeliness	>96%	95-96%	<95%	CoC Log
Continuity of Care	Quantitative	COC002	CoC Notification Timeliness	>96%	95-96%	<95%	CoC Log
Continuity of Care	Quantitative	COC003	End of CoC Notification Timeliness	>96%	95-96%	<95%	CoC Log
Grievances	Quantitative	GRV001	Timely Acknowledgement Letter	>96%	95-96%	<95%	Grievance Log
Grievances	Quantitative	GRV002	Timely Grievance Resolution	>96%	95-96%	<95%	Grievance Log Call Log

Functional Area	KPI Type	KPI #	KPI	Thresholds			Log
				Green	Yellow	Red	
Grievances	Quantitative	GRV003	Member Notification Timeliness	>96%	95-96%	<95%	Grievance Log
Member Services	Quantitative	MR001	Calls Answered within 30 seconds	>90%	80%-90%	<80%	Call Center SLA Log
Member Services	Quantitative	MR002	Call Center Abandonment Rate Level	less than 5%	5%	>5%	Call Center SLA Log
Member Services	Quantitative	MR004	Timely Loading of 834 Eligibility Files	100%	NA	<100%	NA
Member Services	Quantitative	MR005	Timely Issuance of Member ID cards	100%	NA	<100%	Member ID Cards Log
PDR	Quantitative	PDR001	PDR Submission Deadline	>96%	95-96%	<95%	PDR Log
PDR	Quantitative	PDR002	PDR Acknowledgement Timeliness	>96%	95-96%	<95%	PDR Log
PDR	Quantitative	PDR003	PDR Written Determination Timeliness	>96%	95-96%	<95%	PDR Log
PDR	Quantitative	PDR004	Timeliness of Interest Payment on Late PDRs	>96%	95-96%	<95%	PDR Log
Utilization Management	Quantitative	UM001	Decision Timeliness	>96%	95-96%	<95%	UM Authorizations Log
Utilization Management	Quantitative	UM002	Member Notification Timeliness	>96%	95-96%	<95%	UM Authorizations Log
Utilization Management	Quantitative	UM003	Provider Notification Timeliness	>96%	95-96%	<95%	UM Authorizations Log

IV. Monthly Submission of KPIs

Add detailed list of Health Net's self-reported data. Crosswalk with the KPIs in scope.

Commented [ET1]: PENDING. DO to work with Health Net

Commented [JA2R1]: DO requested detailed list from HN to conduct crosswalk within quantitative the KPIs. Pending section until HN's submission.

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V. Quarterly Submission of Logs ~~Required for Monitoring~~

~~IV.~~ Logs Required for Monitoring

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In this section, we provide a comprehensive list of all the required logs that are fundamental to the effective functioning of the CHPIV Delegation Oversight Monitoring Program. These logs are essential tools for capturing, recording, and analyzing data relevant to the monitoring of high and critical risk areas.

Log Name	File naming Convention	Submission Frequency	Due Date
Appeal Log	Appeal_QQ~~MM~~YYYY	Quarterly ~~Monthly~~	15th of the ~~every~~ month ~~(~~following the quarter being reported~~ing period)~~
Call Center SLA Log	CallCenterSLA_QQ~~MM~~YYYY	Quarterly ~~Monthly~~	15th of the month following the quarter being reported ~~15th of every month (following reporting period)~~
Call Log	CallLog_QQ~~MM~~YYYY	Quarterly ~~Monthly~~	15th of the month following the quarter being reported ~~15th of every month (following reporting period)~~
Claims Log	Claims_QQ~~MM~~YYYY	Quarterly ~~Monthly~~	15th of the month following the quarter being reported ~~15th of every month (following reporting period)~~
CoC Log	CoC_QQ~~MM~~YYYY	Quarterly ~~Monthly~~	15th of the month following the quarter being reported~~15th of every month (following reporting period)~~
Grievance Log	Grievance_QQ~~MM~~YYYY	Quarterly ~~Monthly~~	15th of the month following the quarter being reported~~15th of every month (following reporting period)~~
Member ID Log	MemberID_QQ~~MM~~YYYY	Quarterly ~~Monthly~~	15th of the month following the quarter being reported~~15th of every month (same month as reporting period)~~
PDR Log	PDR_QQ~~MM~~YYYY	Quarterly ~~Monthly~~	15th of the month following the quarter being reported~~15th of every month (following reporting period)~~
UM Authorizations Log	UMAuth_QQ~~MM~~YYYY	Quarterly ~~Monthly~~	15th of the month following the quarter being reported~~15th of every month (following reporting period)~~

~~V.~~ Log Specifications

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The specifications provided in this section are designed to be used as a comprehensive guide for those responsible for preparing and maintaining the logs. Adherence to these specifications is crucial for ensuring the integrity of the monitoring process and for facilitating effective oversight of all high and critical

risk areas. This section acts not only as a reference but also as a standard against which the quality and completeness of each log will be measured.

Appeal Log

File Naming Convention: Appeal_ QQ~~MM~~YYYY

Submission Frequency: Quarterly~~Monthly~~; 15th of ~~every~~ the month ~~(~~following ~~reporting period)~~the quarter being reported

- Include plan level appeal requests processed as expedited and standard ~~for Medi-Cal line of business~~ whether approved, modified, denied, withdrawn, or pending.
- Include all service authorization requests received (from 1/1/2024 to present) that do not have a decision by the end of the reporting review period.
- If pre-service plan level appeal includes more than one service, include all the request's line items in a single row and enter the multiple line items as a single appeal.
- Submit resolved cases based on the date the decision was rendered (the date the request was initiated may fall outside of the review period).

Column ID	Data Field	Description
A	**File ID #**	Enter the appeal case identification number
B	**Line of Business**	Medi-Cal
C	**Enrollee ID #**	CIN #
D	**Enrollee preferred language**	Enter member's preferred language
E	**Date received**	Enter the date the appeal request was received. **(CCYY/MM/DD)** **Enter in Text format**
F	**Time received**	Enter the time the appeal request was received. **(HH:MM:SS)** **Enter in Text format**
G	**Date the Plan sent its acknowledgement letter**	Enter the date the acknowledgement letter was sent to member. **(CCYY/MM/DD)** **Enter in Text format** Enter **NA** if no acknowledgement letter was sent or if Appeal was processed as expedited.
H	**Was the Appeal processed as Standard or Expedited?**	Enter how the appeal was processed: **S for Standard** **E for Expedited**
I	**For appeal involving medical necessity disputes, indicate whether**	Identify source of original prior denial from Subcontractor or Downstream Subcontractor

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Column ID	Data Field	Description
	initial utilization review determination was made by the Plan or one of its delegates	
J	**Nature of appeal/appeal category**	Enter reason for appeal/appeal category (e.g. Adverse Benefit Determination (ABD))
K	**Enrollee medical condition/diagnosis code(s)**	Enter Member medical condition/diagnosis
L	**Enrollee medical condition/diagnosis description**	Enter Member medical condition/diagnosis
M	**Requested service procedure/revenue code(s)**	Enter CPT Code with short description
N	**Requested service description**	Enter specific service requested, as applicable
O	**Indicate if the service was medical, MH/SUD or pharmacy, if applicable**	**Valid Entries:** **Medical** **MH/SUD** **Pharmacy** **NA =** Not Applicable
P	**Nature of resolution**	**Valid Entries:** **Upheld** **Overturned** **Withdrawn** **Pending**
Q	**Whether resolved In favor of the enrollee or Plan**	**Valid Entries:** **Member** **CHPIV**
R	**For appeals involving medical necessity disputes, name of criteria on which the resolution decision was based**	Enter the name of the criteria on which the resolution decision was based
S	**Date of Appeal Resolution**	Enter date of appeal resolution **(CCYY/MM/DD)** **Enter in Text format** Enter **NA** if unresolved For withdrawn requests enter the date the request was withdrawn.

Column ID	Data Field	Description
T	**Time of Appeal Resolution**	Enter date of appeal resolution **(CCYY/MM/DD)** **Enter in Text format** Enter **NA** if unresolved For withdrawn requests enter the date the request was withdrawn.
U	**Date Notice of Appeal (NAR) provided to member**	Enter date written notification was sent to member **(CCYY/MM/DD)** **Enter in Text format** Enter **NA** if no written notification was provided to the member
V	**Time Notice of Appeal (NAR) provided to member**	Enter time written notification was sent to member **(HH:MM:SS)** **Enter in Text format** Enter **NA** if no written notification was provided to the member
W	**Date Overturned Appeals Effectuated**	Enter the date overturned appeals effectuated **(CCYY/MM/DD)** **Enter in Text format** Enter **NA** for Upheld Appeals
X	**Time Overturned Appeals Effectuated**	Enter the time overturned appeals effectuated **(HH:MM:SS)** **Enter in Text format** Enter **NA** for Upheld Appeals
Y	**Referred to quality review? (yes or no)**	Enter: **Y** for Yes **N** for No Enter **NA** for pending cases

Call Center SLA Log
File Naming Convention: CallCenterSLA_QQ~~MM~~YYYY
Submission Frequency: Quarterly; 15th of the month following the quarter being reported ~~Monthly; 15th of every month (following reporting period)~~

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Column ID	Data Field	Description
A	**Year**	Defined year reporting data. Submit in the following format: **YYYY**
B	**Month**	Defined month reporting data. Submit in the following format: **MM/YYYY**.
C	**Number of Calls Received (A)**	Number of calls that enter the queue/system.
D	**Number of Calls Abandoned (B)**	Number of callers who disconnected while waiting in the call queue.
E	**Number of Calls Answered (C)**	Number of calls answered by call center reps during the reporting period.
F	**Average Wait Time**	Average wait time for calls received during the reporting period
G	**Average Talk Time**	Average length of calls for calls received during the reporting period.
H	**Abandonment Rate = B/A (Goal 5% or less)**	Percentage of callers who disconnected while waiting in the call queue.
I	**Service Level (Goal 80% in 30 seconds)**	Percentage of calls answered within 30 seconds. Submit in the following format: Round to a whole number, no decimals.
J	**Member Only Calls (Y/N)**	Indicate whether the data includes only calls from members. Valid values: **Y** for Yes **N** for No
K	**Medi-Cal Only Calls (Y/N)**	Indicate whether the data includes only calls from Medi-Cal members. Valid values: **Y** for Yes **N** for No

Call Log

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File Naming Convention: CallLog_QQ~~MM~~YYYY

Submission Frequency: Quarterly; 15th of the month following the quarter being reported ~~Monthly; 15th of every month (following reporting period)~~

- Include calls received by the Member Services call center, regardless of whether they are complaints or become formal grievances during the reporting month.
- Include all calls made by the member or on behalf of the member.
- Exclude all calls non-member initiated.
- If a call has more than one issue/categorization, report each issue/categorization in a single row.

Column ID	Data Field	Description
A	**File ID #**	The associated call ID number assigned by the organization for this request.
B	**Line of business (Individual, Small Group, Large Group or Medi-Cal)**	Medi-Cal only
C	**Enrollee ID #**	Member identifier assigned by the organization.
D	**Assigned medical group**	("N/A" if not applicable)
E	**Enrollee preferred language**	Provide member's preferred language.
F	**Date received**	Date call was received. Submit in the following format: MM/DD/YYYY.
G	**Time received**	Time call was received. Submit in the following format: HH:MM XM.
H	**Call category/issue**	Provide call categorization. Valid values: Inquiry Exempt Grievance Grievance Appeal *If the Plan's system captures more than one category, please separate each category by a delimiter (e.g., comma, semicolon, slashes, etc.) or place them in separate columns.*
I	**Indicate whether inquiry is related to medical services, MH/SUD services, or pharmacy, if applicable**	Indicate whether call is related to medical services, MH/SUD services, or pharmacy. If not applicable, enter NA.
J	**Call resolution (if the Plan's system includes fields/values to capture the resolution)**	Provide the complete call notes describing the resolution for the call.
K	**Call Notes**	Provide the complete call notes describing the reason for the call.

Claims Log

File Naming Convention: Claims_ QQ~~MM~~YYYY

Submission Frequency: Quarterly; 15th of the month following the quarter being reported ~~Monthly; 15th of every month (following reporting period)~~

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- Requests for Processed Claims, which includes Paid, Partially Paid, Denied, Contested and Pending claims during reporting period.
- Include requests for Processed Claims, which includes Paid, Partially Paid, Denied, Contested and Pending claims during reporting period.

- Include all claims for both contracted and non-contracted providers received (from 1/1/2024 to present) that have not been processed by the end of the reporting review period.
- Exclude all requests processed as adjustments to claims and overpayments.
- If a claim has more than one service line item, include all the claim's service line items in a single row and enter the multiple line items as a single claim.
- Claim statuses defined:
    - Paid Claim: Any claim paid for non-capitated services within the reporting period regardless of the date received, even though one or more line items may have been denied for that claim.
    - Denied Claim: Any claim adjudicated within the reporting period in which the total amount paid is zero, regardless of the date received. This includes duplicate claims, member eligibility and provider denials.

Column ID	Data Field	Description
A	**SOURCE**	Enter the claims source data.
B	**CLAIM_NUMBER**	Provide the associated claim number assigned by the organization for this request. If a claim number is not available, please provide your internal tracking or case number. Answer **NA** if there is no claim or other tracking number available.
C	**DATE_OF_SERVICE**	Date service was performed. Submit in the following format: **MM/DD/YYYY**.
D	**PLACE_OF_SERVICE**	Provide the place of service billed. Valid values include, but are not limited to: - 11 for Office visit - 12 for Home Health - 21 for Inpatient - 22 for Outpatient Hospital - 23 for Emergency Room
E	**PAID_DATE**	Date the claim was paid. Submit in the following format: **MM/DD/YYYY**.
F	**DENIED_DATE**	Date the claim was denied or contested. Submit in the following format: **MM/DD/YYYY**.
G	**RECEIVED_DATE**	Provide the date the claim was received by your organization. Submit in the following format: **MM/DD/YYYY**.
H	**ENTRY_DATE**	Date claim was acknowledged to the provider. Submit in the following format: **MM/DD/YYYY**.
I	**DATE_ADDL_INFO_RECD**	Provide the date the additional information was received. Submit in the following format: **MM/DD/YYYY**. If additional

Column ID	Data Field	Description
		information was not requested or the additional information was not received, answer **NA**.
J	**AMOUNT_BILLED**	Total amount billed on claim. Submit in the following format: **$xxx,xxx.xx**.
K	**AMOUNT_PAID_LESS_INTEREST**	Net amount paid on the claim (excluding interest). Submit in the following format: **$xxx,xxx.xx**. If payment was not made, answer **NA**.
L	**WITHHOLD_AMOUNT**	Amount withheld on claim. Submit in the following format: **$xxx,xxx.xx**. If no amount was withhold, answer **NA**.
M	**CHECK_NUMBER**	Provide the check number or EFT (Electronic Funds Transfer) record number.
N	**INTEREST_AMOUNT**	Amount of interest paid. Submit in the following format: **$xxx,xxx.xx**. If interest was not paid, answer **NA**.
O	**INTEREST_PAID_DATE**	Date interest was paid. Submit in the following format: **MM/DD/YYYY**. If interest was not paid, answer **NA**.
P	**INTEREST_CHECK_NUMBER**	Provide the check number or EFT (Electronic Funds Transfer) record number.
Q	**CLAIM_STATUS**	Provide the status of the claim. Valid values: - **Paid** - **Partially Paid** - **Denied** - **Contested** - **Pending** If a claim has multiple lines that are Denied and Contested, valid value: **Denied/Contested**.
R	**DENIAL_REASONS**	Reason claim was denied. If Paid or Partially Paid, answer **NA**.
S	**LINE_OF_BUSINESS**	Medi-Cal only
T	**REDIRECTION_DATE**	Provide the date the claim was redirected to appropriate entity for payment or returned to provider, which is the date the claim left the organization by US Mail, fax, or electronic communication. Do not enter the date the claim was generated or printed within the organization. Submit in the following format: **MM/DD/YYYY**. **NA** for non-redirected claims
U	**CLAIM_TYPE**	Indicate if the claim was submitted in a paper or electronic format. Valid values: **P** for Paper Claim **E** for Electronic Claim

Column ID	Data Field	Description
V	ER_CLAIM_IND	Indicate whether the services were performed on the Emergency Room (POS 23). Valid values: **Y** for Yes **N** for No
W	PROVIDER_NAME	Name of the provider rendering service.
X	PROVIDER_STATUS	Indicate whether the provider who performed the service is a contracted or non-contracted provider. Valid values: **C** for Contracted Provider **NC** for Non-Contracted Provider
Y	FACILITY_STATUS	Indicate whether the facility in which the services were performed is a contracted or non-contracted facility. Valid values: **C** for Contracted Facility **NC** for Non-Contracted Facility
Z	PRODUCT_TYPE	Medi-Cal only
AA	EOB_RA_CODES	Provide the adjustment codes of the claim that are reflected in the EOB/RA.
AB	SERVICE_TYPE	Provide the service type billed. Valid values: **Professional** **Institutional**

CoC Log

File Naming Convention: CoC_QQ~~MM~~YYYY

Submission Frequency: Quarterly; 15th of the month following the quarter being reported ~~Monthly; 15th of every month (following reporting period)~~

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- Requests for processed Coc Requests, which includes Approved, Denied, Modified and Deferred requests during reporting period.
- Types of CoC requests defined:
  - Urgent Requests: CoC requests in which there is identified risk of harm to the member.
  - Immediate Requests: CoC requests in which the member's medical condition requires more immediate attention, such as a provider appointment or other pressing services.
  - Non-Urgent Requests: CoC requests in which the member's condition does not qualify for immediate or urgent status.
  - Special Populations Requests: CoC requests for all transitioning members living with complex or chronic conditions.

Column ID	Data Field	Description
A	**Case #**	The associated CoC case number assigned by the organization for this request.
B	**Member ID #**	Member identifier assigned by the organization.
C	**Member Last Name**	Last name of member.
D	**Member First Name**	First name of member.
E	**Member's Preferred Language**	Provide member's preferred language.
F	**Enrollment Effective Date**	Date the member's enrollment was effected with CHPIV. Submit in the following format: **MM/DD/YYYY**.
G	**Date of CoC Request**	Date the organization received the request. Submit in the following format: **MM/DD/YYYY**.
H	**CPT, HCPCS, or Revenue Code (s)**	Provide the applicable CPT, HCPCS, or Revenue Procedure Code(s) as the service description associated with the request.
I	**Diagnosis Code(s)**	Provide the member's ICD-10 diagnosis/diagnoses codes related to this request.
J	**CoC Request Type**	Provide the level of the request. Valid values: - **Urgent** - **Immediate** - **Non-Urgent** - **Special Populations**
K	**CoC Request Disposition**	Provide the status of the request. Valid values: - **Approved** - **Denied** - **Modified** - **Deferred**
L	**If Denied or Modified, Reason Description**	Reason request was **Denied** or **Modified**. If Approved, answer **NA**.
M	**Date of CoC Determination**	Date of request decision. Submit in the following format: **MM/DD/YYYY**.
N	**Date of CoC Determination Notification**	Provide the date the member was notified of the CoC request determination. Submit in the following format: MM/DD/YYYY
O	**CoC Determination Notification Method**	Provide the method used by the organization to notify the member of the determination of the request. Valid values: - **Telephone Call** - **Text Message** - **Email**
P	**CoC Determination Letter Mailed Date**	Provide the date the notification letter was mailed to the member, which is the date it left the organization by US Mail.

Column ID	Data Field	Description
		Do not enter the date the determination was made within the organization. Submit in the following format: **MM/DD/YYYY**
Q	**Date CoC Closed**	Date request is expected to end. Submit in the following format: **MM/DD/YYYY**. If Denied, answer **NA**.

Grievance Log

File Naming Convention: Grievance_ QQ~~MM~~YYYY

Submission Frequency: Quarterly; 15th of the month following the quarter being reported ~~Monthly; 15th of every month (following reporting period)~~

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- Include internal expedited and standard grievances ~~Health Net/CHPIV~~ responded (resolved) to during the reporting month ~~for the Medi-Cal lines of business~~ whether approved, modified, denied, withdrawn, or pending.
- Include all service authorization requests received (from 1/1/2024 to present) that do not have a decision by the end of the reporting review period.
- Include withdrawn cases.
- Exclude external grievances (i.e., IMR and SFH complaints).
- Grievances with multiple issues must be entered as a single line item unless.

Column ID	Data Field	Description
A	**File ID #**	Enter grievance ~~identification number~~identification number
B	**Line of Business**	Medi-Cal
C	**Enrollee ID #**	CIN #
D	**Subcontractor or Downstream Subcontractor the grievance was filed against**	Enter the name of the Subcontractor or Downstream Subcontractor the grievance was filed against
E	**Enrollee preferred language**	Enter member's preferred language
F	**Date received**	Enter the date the grievance was received. **(CCYY/MM/DD)** **Enter in Text format**
G	**Time Grievance was Received**	Enter the time the grievance was received. **(HH:MM:SS)** **Enter in Text format**
H	**Was the Grievance processed as Standard or Expedited?**	Enter how the grievance was processed: **S for Standard** **E for Expedited**

Column ID	Data Field	Description
I	**Date the Plan sent its acknowledgement letter**	Enter the date the acknowledgement letter was sent to member. **(CCYY/MM/DD)** **Enter in Text format** Enter **NA** if no acknowledgement letter was sent.
J	**Grievance category**	Enter the category of the grievance as assigned by the plan. Enter based on the plan's internal labeling system (e.g., quality of care, quality of service, access to care, etc.) If system captures more than one category, separate each category by a delimiter (e.g., comma, semicolon, slashes, etc.)
K	**Nature of grievance**	Enter the nature of the grievance (e.g. appointment cancellation)
L	**Nature of resolution**	Enter a description of the grievance resolution. Enter **NA** for pending cases
M	**Whether resolved In favor of the enrollee or Plan**	**Valid Entries:** **Member** **CHPIV** Enter **NA** for pending cases
N	**Date of Grievance Resolution**	Enter date of grievance resolution **(CCYY/MM/DD)** **Enter in Text format** Enter **NA** if unresolved For withdrawn requests enter the date the request was withdrawn.
O	**Time of Grievance Resolution**	Enter time of grievance resolution **(HH:MM:SS)** **Enter in Text format** Enter **NA** if unresolved For withdrawn requests enter the date the request was withdrawn.
P	**Date the Plan sent its resolution letter**	Enter date written notification was sent to member **(CCYY/MM/DD)** **Enter in Text format**

Column ID	Data Field	Description
		If no member written notification was sent, answer **NA**
Q	**Time written resolution letter provided to member**	Enter time written notification was sent to member **(HH:MM:SS)** **Enter in Text format** If no member written notification was sent, answer **NA**
R	**Referred to quality review? (yes or no)**	Enter: **Y** for Yes **N** for No Enter **NA** for pending cases

Member ID Log
File Naming Convention: MemberID_QQ~~MM~~YYYY
Submission Frequency: Quarterly: 15th of the month following the quarter being reported ~~Monthly; 15th of every month (same month as reporting period)~~

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- Include all new enrollments during the reporting month.
- Include retro enrollments of the previous month.
- Exclude all member ID cards reissued for existing members.

Column ID	Data Field	Description
A	**MAIL_DATE**	Provide the date the ID card was mailed to the member, which is the date it left the organization by US Mail, fax, or electronic communication. Do not enter the date the member ID was generated or printed within the organization. Submit in the following format: MM/DD/YYYY
B	**FIRST_NAME**	First name of member.
C	**LAST_NAME**	Last name of member.
D	**MBR_STAT_EFF_DATE**	Date the member's enrollment was effective with CHPIV. Submit in the following format: MM/DD/YYYY.
E	**CIN_NUMBER**	Member identifier assigned by the organization.

PDR Log
File Naming Convention: PDR_QQ~~MM~~YYYY

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Submission Frequency: Quarterly; 15th of the month following the quarter being reported ~~Monthly; 15th of every month (following reporting period)~~

- Include requests for all Provider Disputes, which includes Overturned, Upheld and Pending dispute dispositions during the reporting period.
- Include all provider disputes for both contracted and non-contracted providers received (from 1/1/2024 to present) that have not been processed by the end of the reporting review period.
- Exclude all requests for processed paid, denied, contested claims, unrelated adjustments, overpayments, and misdirected claims.
- If a claim has more than one service line item, include all the claim's service line items in a single row and enter the multiple line items as a single claim.

Column ID	Data Field	Description
A	**Claim Number**	The original claim number associated with this dispute as assigned by the organization. If a claim number is not available, please provide your internal tracking or case number. Answer **NA** if there is no claim or other tracking number available.
B	**Date of receipt of original claim**	Provide the date the original claim was received by your organization. Submit in the following format: **MM/DD/YYYY**.
C	**Date of Service - From**	From date service was performed. Submit in the following format: **MM/DD/YYYY**.
D	**Date of Service - Thru**	Thru date service was performed. Submit in the following format: **MM/DD/YYYY**.
E	**PDR Tracking Number**	The associated dispute claim number assigned by the organization for this request. If a dispute claim number is not available, please provide your internal tracking or case number. Answer **NA** if there is no claim or other tracking number available.
F	**Date Dispute Received**	Provide the date the dispute was received in your organization. Submit in the following format: **MM/DD/YYYY**.
G	**Name of Provider - first**	First name of the provider rendering service.
H	**Name of Provider - last**	Last name of the provider rendering service.
I	**Place of Service**	Provide the place of service provided. Valid values include but are not limited to: - 11 for Office visit - 12 for Home Health - 22 for Outpatient Hospital - 23 for Emergency Room

Column ID	Data Field	Description
J	**Type of Provider**	Provide the billing provider type. Valid values: **Professional** **Institutional**
K	**Provider Status**	Indicate whether the provider who performed the service is a contract or non-contract provider. Valid values: **C** for Contracted Provider **NC** for Non-Contracted Provider
L	**Type of Dispute**	Indicate if the Provider Dispute Request was submitted in a paper or electronic format. Valid values: **P** for Paper Claim **E** for Electronic Claim
M	**Disputed Amount**	Total amount disputed by provider. Submit in the following format: **$xxx,xxx.xx**.
N	**Line of Business**	Medi-Cal only
O	**ER Services**	Indicate whether services were performed in the Emergency Room. Valid values: **Y** for Yes **N** for No
P	**Date Dispute Acknowledged**	Date acknowledgement letter was issued to the provider. Submit in the following format: **MM/DD/YYYY**. If a separate acknowledgment letter was not sent to the provider, enter **NA**.
Q	**Date Dispute Paid or Denied**	Date resolution letter was issued to the provider. Submit in the following format: **MM/DD/YYYY**.
R	**Date Additional Information Requested**	Indicate whether additional information was requested for this dispute. Valid values: **Y** for Yes **N** for No
S	**Date Additional Information Received**	Provide the date the additional information was received. Submit in the following format: **MM/DD/YYYY**. If additional information was not requested or the additional information was not received, answer **NA**.
T	**Date of Determination Letter**	Provide the date the PDR determination letter was mailed to the provider, which is the date the letter left the organization by US Mail, fax, or electronic communication. Do not enter the date the letter was generated or printed within the organization. Submit in the following format: **MM/DD/YYYY**. If no letter was mailed, answer **NA**.
U	**Dispute Disposition**	Indicate whether the dispute was overturned or upheld. Valid values:

Column ID	Data Field	Description
		- **Overturned** - **Upheld** - **Pending**
V	**Dispute Paid Amount (excluding interest and penalty)**	Enter net amount paid. Submit in the following format: **$xxx,xxx.xx**. If payment was not made, answer **NA**.
W	**Dispute Interest and Penalty Paid Amount**	Amount of interest and/or penalty paid. Submit in the following format: **$xxx,xxx.xx**. If interest was not paid, answer **NA**.

UM Authorizations Log

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File Naming Convention: UMAuth_ QQ~~MM~~YYYY

Submission Frequency: Quarterly; 15th of the month following the quarter being reported ~~Monthly; 15th of every month (following reporting period)~~

- Include all service authorization requests ~~for Medi-Cal line of business~~ with the date the decision was rendered or should have been rendered within the reporting month (the date the request was initiated may fall outside of the review period).
- Include all service authorization requests received (from 1/1/2024 to present) that do not have a decision by the end of the reporting review period.
- Include decisions whether approved, deferred, denied, modified, or pending.
- Exclude payment and reimbursement requests, dismissals, reopening, or withdrawn requests.
- If the service authorization request addresses more than one service, include all the request's line items in a single row and enter the multiple line items as a single service authorization request.

Column ID	Data Field	Description
A	**File ID Number**	Enter Authorization number
B	**Line of Business**	Medi-Cal
C	**Enrollee ID #**	Member Client Index Number CIN #
D	**Assigned Medical Group ("N/A" if not applicable)**	Enter the name of Subcontractor or Downstream Subcontractor delegated to process UM Authorizations. Subcontractor: Health Net Community Solutions (HNCS) Downstream Subcontractor: *Community Care, IPA, *MedPoint Medical Management

Column ID	Data Field	Description
		*American Specialty Plans (ASH) - Acupuncture/Chiro services *eviCore - UM for sleep study and radiation therapy programs. *ModivCare - NEMT & NMT *National Imaging Associates (NIA) - UM of high-tech imaging & cardiac services *Periscope Group (In-home assessment DME) *TurningPoint - Ortho UM
E	**Date of Request**	Enter date request was received **(CCYY/MM/DD)** **Enter in Text format**
F	**Time of Request**	Enter time request was received **(HH:MM:SS)** **Enter in Text format**
G	**Type of Review (prospective, concurrent, or retrospective)**	**Valid entries:** **Concurrent** **Preservice** **Stabilization (Post Stabilization)** **Retrospective**
H	**Review Urgency (expedited or standard)**	**Valid entries:** **Expedited** **Standard** **NA** = Concurrent, Retrospective & Post Stabilization
I	**Method of request**	**Valid entries:** **Fax** **Phone**
J	**Name of requesting provider**	Enter the name of the requesting provider
K	**Requested Service procedure/revenue code(s)**	Enter CPT Code(s) If there are multiple CPT codes, provide them in a list separated by a comma.
L	**Requested Service description**	Enter CPT code(s) description If there are multiple CPT codes, provide them in a list separated by a comma.

Column ID	Data Field	Description
M	**Requested Service Units/frequency/duration**	Enter CPT code(s) units/frequency/duration. If there are multiple CPT codes, provide them in a list separated by a comma.
N	**Enrollee medical condition/diagnosis code(s)**	Enter ICD-10 CM code(s) If there are multiple Diagnosis codes, provide them in a list separated by a comma. If the character count for a list of procedure codes exceeds 100 characters, only include the procedure codes up to the 100-character limit.
O	**Enrollee medical condition/diagnosis description**	Enter ICD-10 CM code(s) with short description If there are multiple Diagnosis codes, provide them in a list separated by a comma. If the character count for a list of procedure codes exceeds 100 characters, only include the procedure codes up to the 100-character limit.
P	**Plan Requested Additional Information? (Y or N)**	**Valid entries:** **Y=**Yes **N=**No
Q	**Date Plan Requested Additional Information, if applicable**	Enter date RFI requested **(CCYY/MM/DD)** **Enter in Text format** **NA** = Not Applicable (No RFI issued)
R	**Date Plan Received Requested Additional Information, if applicable**	Enter date RFI received **(CCYY/MM/DD)** **Enter in Text format** **NA** = Not Applicable (No RFI issued)
S	**Time Plan Received Requested Additional Information, if applicable**	Enter time RFI received **(HH:MM:SS)** **Enter in Text format** **NA** = Not Applicable (No RFI issued)
T	**Decision**	**Valid entries:** **Approved** **Denied** **Modified**

Column ID	Data Field	Description
		Deferred **Pending**
U	**Approved service procedure/revenue code(s) (modifications only)**	Enter approved service **Modifications only** **NA** = Not Applicable (approvals, denials, deferred, or pending cases)
V	**Approved service description (modifications only)**	Enter approved service description **Modifications only** **NA** = Not Applicable (approvals, denials, deferred, or pending cases)
W	**Approved service units/duration (modifications only)**	Enter approved service units/duration **Modifications only** **NA** = Not Applicable (approvals, denials, deferred, or pending cases)
X	**Decision Reason**	Enter reason to deny or modify (should reflect reason specified in NOA letter) **NA** = Not Applicable (approvals or pending cases)
Y	**Date of Decision**	Enter date of decision **(CCYY/MM/DD)** **Enter in Text format** **NA** = Not Applicable (pending cases)
Z	**Time of Decision**	Enter time of decision **(HH:MM:SS)** **Enter in Text format** **NA** = Not Applicable (pending cases)
AA	**Name of Health Care Professional who Made Decision**	Enter the name of health care professional who made decision to denied, deferred, or modified **NA** = Not Applicable (approvals or pending cases)
AB	**Date requesting provider notified of decision by fax or phone call**	Enter date oral or fax notification provided to the Provider **(CCYY/MM/DD)**

Column ID	Data Field	Description
	(prospective and concurrent review only)	**Enter in Text format** **NA** = Not Applicable (Post Stabilization & Retrospective) For **Concurrent** enter the date oral or fax notification the Treating Provider was notified.
AC	**Time requesting provider notified of decision by fax or phone call (prospective and concurrent review only)**	Enter time oral or fax notification provided to the Provider **(HH:MM:SS)** **Enter in Text format** **NA** = Not Applicable (Post Stabilization & Retrospective) For **Concurrent** enter the time oral or fax notification the Treating Provider was notified.
AD	**Date Written Notice Sent to Requesting Provider**	Enter date written notification provided to the Provider **(CCYY/MM/DD)** **Enter in Text format** If no provider written notification, answer "**NA**" (not applicable) For **Concurrent** enter the date the written notice was sent to the Treating Provider.
AE	**Time Written Notice Sent to Requesting Provider**	Enter time written notification provided to the Provider **(HH:MM:SS)** **Enter in Text format** If no provider written notification, answer "**NA**" (not applicable) For **Concurrent** enter the time the written notice was sent to the Treating Provider.
AF	**Date Written Notice sent to Enrollee**	Enter date written notification was sent to member **(CCYY/MM/DD)** **Enter in Text format** If no member written notification was sent, answer "**NA**" (not applicable)
AG	**Time Written Notice sent to Enrollee**	Enter time written notification was sent to member **(HH:MM:SS)** **Enter in Text format**

Column ID	Data Field	Description
		If no member written notification was sent, answer "**NA**" (not applicable)

VI. Data Validation

1. Data Validation Webinars: CHPIV schedules separate webinars per functional area within 5 business days of log receipt to evaluate and confirm the quantitative KPIs metric scores.
2. System Verification: CHPIV reviews Delegate's live system to verify data points to demonstrate data accuracy and may request screenshots for additional review.
3. Sample Case Selection: CHPIV selects 5 cases from quarterly logs and provides sample selections to Delegates approximately one hour prior to the scheduled data validation webinar.
4. Log Integrity: If data points are incomplete, mismatched, or cannot be verified, the log integrity fails. A passing score of 95% or higher is required for log integrity. CHPIV requests corrections on the identified discrepancies and a new log upload. If necessary, a data validation will be scheduled for each corrected log to ensure accuracy.
5. Allowable Attempts: Delegates have a maximum of 3 attempts to provide complete and accurate logs. If all 3 attempts fail to meet the passing score, Delegates will have exhausted all allowed attempts and further corrective action will be taken.
6. Issuing Results: Once data quality has been confirmed, CHPIV will develop and distribute scorecards detailing the compliance rates. These scorecards will provide a summary of the results, highlighting areas of success and identifying opportunities for improvement.
7. Corrective Action: If Delegates fail to provide accurate and timely log submissions twice, CHPIV documents an observation. After the third failed attempt, or when Delegates determine they are unable to provide an accurate log, CHPIV issues a Corrective Action Plan (CAP). Delegates will have 10 business days to respond to the CAP, outlining their plan to address the identified issues and prevent future occurrences.

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VII. KPI Measurement

~~VI.~~ Quantitative KPIs~~: Calculations~~

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In this final and critical step of the monitoring process, CHPIV measures the KPIs directly from the logs submitted by Health Net (HN) on a quarterly basis. This step is designed to ensure that the monthly self-reported data from HN aligns with the data reported in the logs. The process involves key activities:~~Calculating quantitative Key Performance Indicators (KPIs) using standardized logs (raw data templates) is a key part of our monitoring framework. It focuses on~~

translating raw data into measurable KPIs. This process involves collecting specific data points, applying defined formulas, and interpreting the results to assess performance.

1. **Extraction of KPIs from Validated Data:** Using predefined algorithms and analysis methodologies, CHPIV will extract the relevant KPIs from the logs. This process is carefully designed to measure regulatory compliance in accordance with State regulatory and contractual requirements.Case Evaluation Scope

1.

2. **Comparative Analysis:** The extracted KPIs are then compared with the KPIs that HN reported monthly. This comparison is critical to identify any discrepancies between the self-reported data and the data derived from the logs. In cases where discrepancies are noted, a variance analysis is conducted to understand the root causes. This may involve reviewing the data collection, reporting methodologies, or even the calculation processes used by HN.This quantitative approach allows for the evaluation of all cases submitted in the logs.

2.

Accuracy Confirmation: If the KPIs derived from the raw data logs match closely with the self-reported KPIs, it serves as a confirmation of the accuracy of HN's reporting processes. Minor acceptable variances may be predefined to accommodate data collection and reporting nuances.Timeline

Quantitative KPI metric scores will be self-reported and submitted monthly on the 15th of each month, following the respective reporting period.

All logs are submitted quarterly on the 15th of theeach month following the quarter being reported. CHPIV will conduct data validations to ensure the accuracy and completeness of all quarterly logs submitted and to confirm quantitative KPIs metric scores.

3.

Qualitative KPIs

Data Validation Process

Data Validation Webinars: CHPIV schedules separate webinars per functional area within 5 business days of log receipt to evaluate and confirm the quantitative KPIs metric scores.

System Verification: CHPIV reviews Delegate's live system to verify data points to demonstrate data accuracy and may request screenshots for additional review.

Sample Case Selection: CHPIV selects 15 cases from quarterly logs and provides sample selections to Delegates approximately one hour prior to the scheduled data validation webinar.

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~~Log Integrity: If data points are incomplete, mismatched, or cannot be verified, the log integrity fails. A passing score of 95% or higher is required for log integrity. CHPIV requests corrections on the identified discrepancies and a new log upload. If necessary, a data validation will be scheduled for each corrected log to ensure accuracy.~~

~~Allowable Attempts: Delegates have a maximum of 3 attempts to provide complete and accurate logs. If all 3 attempts fail to meet the passing score, Delegates will have exhausted all allowed attempts and further corrective action will be taken.~~

~~Issuing Results: Once data quality has been confirmed, CHPIV will develop and distribute scorecards detailing the compliance rates. These scorecards will provide a summary of the results, highlighting areas of success and identifying opportunities for improvement.~~

~~Corrective Action: If Delegates fail to provide accurate and timely log submissions twice, CHPIV documents an observation. After the third failed attempt, or when Delegates determine they are unable to provide an accurate log, CHPIV issues a Corrective Action Plan (CAP). Delegates will have 10 business days to respond to the CAP, outlining their plan to address the identified issues and prevent future occurrences.~~
~~utilizes the logs to evaluate the quantitative KPIs and scorecards detailing the compliance rates are developed and distributed monthly.~~

~~VII. Qualitative KPIs: Case File Reviews~~

Case file reviews are a critical component of our comprehensive monitoring strategy, particularly for assessing performance for qualitative KPIs. These reviews offer an in-depth, document-based evaluation, complementing the quantitative analyses provided by other monitoring tools.

~~*Case Evaluation Scope*~~

Details regarding sampling methodology for qualitative KPIs will be provided shortly.

~~Timeline~~

~~The timeline for evaluating qualitative KPIs through case file reviews will be provided at a later date.~~

~~Case File Documents Required~~

Case File	Documents Required
Member Services	*TBD*
Appeal	*TBD*
Claims	*TBD*
CoC	*TBD*
Grievance	*TBD*
PDR	*TBD*

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UM Authorizations	*TBD*

VIII. Dissemination of Quarterly Scorecard to Delegate and Corrective Actions

The final step of the monitoring process involves the creation and dissemination of a Quarterly Scorecard to the Delegate, encapsulating the KPIs derived from the logs and highlighting key findings from the data validation process. This scorecard serves as a formal communication tool, fostering transparency and continuous improvement. The dissemination process is outlined as follows:

1. **Scorecard Development:** Compile the Quarterly Scorecard, incorporating the calculated KPIs and summarizing the data validation findings. The scorecard is designed for clarity, with visual aids such as graphs and charts to convey the performance metrics and areas of concern effectively.
2. **Internal Review:** Prior to sending the scorecard to the Delegate, conduct an internal review within CHPIV to ensure the accuracy, relevance, and completeness of the information presented. This review also ensures that the scorecard aligns with the objectives of the monitoring protocol.
3. **Executive Summary:** Include an executive summary in the scorecard that highlights key points, including strengths, areas for improvement, and any critical findings:
    a. Operational deficiencies
    b. Log inaccuracy
    c. Oversight discrepancies
4. **Scorecard Delivery:** CHPIV Delegation Oversight sends the scorecard to the Delegate via email and presents the scorecard and monitoring results during the next scheduled Monthly Oversight Meeting (MOM). This interactive presentation allows for real-time discussion, clarifications, and the opportunity to address any immediate concerns or questions from the Delegate.
5. **Corrective Actions:** In the event of noncompliance, CHPIV Delegation Oversight will enforce the following CAP process and timeline:
    1. One Quarter Non-Compliant: Warning Letter will be issued, requiring the Delegates to initiate remediation activities to improve noncompliance.
    2. Two Consecutive Quarters Non-Compliant: Corrective Action Plan (CAP) will be issued. Delegates will have 10 business days to respond to the CAP, outlining their plan to address the identified issues and prevent future occurrences. CHPIV will monitor CAP implementation and completion.
    3. Three Consecutive Quarters Non-Compliant: Focused review/audit in the area of noncompliance, potentially conducted during the annual audit.

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By systematically developing and communicating the Quarterly Scorecard, CHPIV ensures that HN is well-informed of their performance metrics and validation findings, setting the stage for ongoing dialogue and cooperative efforts towards performance enhancement and compliance.

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Appendix A – Key Performance Indicator Details

The tables below provide comprehensive details of the metrics used in CHPIV's monitoring efforts, including the subcategories, requirements, and regulatory citations that make up each KPI.

Appeals

KPI Type	KPI#	KPI	KPI Subcategory	KPI Requirement	Cite Requirement
Quantitative	APPEAL01	Timely Acknowledgement of Appeals	Standard	Within 5 calendar days from receipt of appeal.	APL 21-011 C. Standard Appeals Acknowledgement HSC 1638 (a)(4)(a) CCR 1300.68 (d)(1) CFR 438.406 (b)(1)
Quantitative	APPEAL02	Timely Decision of Appeals	Standard	Within 30 calendar days from receipt of the request	APL 21-011 C. Standard Appeals 2. Resolution 42 CFR 438.408(b)(2) & (c)(1); CCR 1300.68; DHCS Contract Exhibit A, Attachment III, 4.6.5(A)
Quantitative	APPEAL02	Timely Decision of Appeals	Expedited	Within 72 hours from receipt of request	APL 21-011 D. Expedited Appeals 42 CFR 438.408(b)(3) & c(1)
Quantitative	APPEAL03	Timely Effectuation of Overturned Appeals		Within 72 hours from the date of reverse determination.	APL 21-011 G. Overturned Decisions & VI DHCS Contract Exhibit A, Attachment III, 4.6.5(D)

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KPI Type	KPI#	KPI	KPI Subcategory	KPI Requirement	Cite Requirement
					CFR 438.424(a)
Quantitative	APPEAL04	Member Notification Timeliness	Standard	Notify member within 30 calendar days from receipt of request.	APL 21-011 C. Standard Appeals 2. Resolution DHCS Contract Exhibit A, Attachment III, 4.6.5 (A) & (B) 42 CFR 438.408 (b) ©
Quantitative	APPEAL04	Member Notification Timeliness	Expedited	Notify the member within 72 hours from receipt of request. (Written)	APL 21-011 D. Expedited Appeals 42 CFR 438.408(b)(3) & (d)(2)(ii) DHCS Contract Exhibit A, Attachment III, 4.6.6 (B)

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Claims

KPI Type	KPI#	KPI	KPI Subcategory	KPI Requirement	Cite Requirement
Quantitative	CLM001	Claims Payment Timeliness - 30 Calendar Days		90% of Clean Claims within 30 calendar days	Title 28, Section 1300.71(g)(h)
Quantitative	CLM002	Claims Payment Timeliness - 45 Working Days		95% of all other claims within 45 working days	Title 28, Section 1300.71(g)(h)
Quantitative	CLM003	Claims Payment Timeliness - 90 Calendar Days		99% of all other claims within 90 calendar days	Title 28, Section 1300.71(g)(h)

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KPI Type	KPI#	KPI	KPI Subcategory	KPI Requirement	Cite Requirement
Quantitative	CLM004	Claims Acknowledgement Timeliness	Electronic	Acknowledgement within 2 working days of receipt of claim	Title 28, Section 1300.71(c)
Quantitative	CLM004	Claims Acknowledgement Timeliness	Paper	Acknowledgement within 15 working days of receipt of claim	Title 28, Section 1300.71(c)
Quantitative	CLM005	Misdirected Claims Timeliness		Within 10 working days of receipt of the claim.	Title 28, Section 1300.71(b)(2)(A)(B)
Quantitative	CLM006	Timely Interest Payment on Late Claims		Within 5 working days of the payment of the claim	Title 28, Section 1300.71(a)(1) Title 28, Section 1300.71(i)(2)

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Continuity of Care

KPI Type	KPI#	KPI	KPI Subcategory	KPI Requirement	Cite Requirement
Quantitative	COC001	CoC Processing Timeliness	Non-Urgent Requests	30 calendar days for non-urgent requests	APL 22-032 I. Continuity of Care Requirements (A)(5)
Quantitative	COC001	CoC Processing Timeliness	Immediate Attention Requests	15 calendar days if the Member's medical condition requires more immediate attention, such as	APL 22-032 I. Continuity of Care Requirements (A)(5)

KPI Type	KPI#	KPI	KPI Subcategory	KPI Requirement	Cite Requirement
				upcoming appointments or other pressing care needs	
Quantitative	COC001	CoC Processing Timeliness	Urgent Requests	No longer than three calendar	APL 22-032 I. Continuity of Care Requirements (A)(5)
Quantitative	COC001	CoC Processing Timeliness	Special Populations	30 calendar days from receipt of Special Populations data	2024 MEDI-CAL MANAGED CARE PLAN TRANSITION POLICY GUIDE (C)(2)
Quantitative	COC002	CoC Notification Timeliness	Non-Urgent/Immediate Attention CoC Requests	7 calendar days	APL 22-032 I. Continuity of Care Requirements (A)(5)
Quantitative	COC002	CoC Notification Timeliness	Urgent CoC Requests	no longer than 3 calendar days	APL 22-032 I. Continuity of Care Requirements (A)(5)
Quantitative	COC002	CoC Notification Timeliness	Special Populations CoC Requests	7 calendar days	2024 MEDI-CAL MANAGED CARE PLAN TRANSITION POLICY GUIDE (C)(2)
Quantitative	COC003	End of CoC Notification Timeliness	End of CoC Requests	30 calendar days before the end of the Continuity of Care period	APL 22-032 I. Continuity of Care Requirements (A)(6)(b)

Grievances

KPI Type	KPI#	KPI	KPI Subcategory	KPI Requirement	Cite Requirement
Quantitative	GRV001	Timely Acknowledgement Letter	Standard	Within 5 calendar days from receipt of the grievance.	APL 21-011 III. Grievances C. Standard Grievances 1. Acknowledgement CCR 1300.68 (d)(1) CFR 438.406 (b)(1) HSC 1368.01 (b) DMHC TAG - GA-003 Key Element 1
Quantitative	GRV002	Timely Grievance Resolution	Standard	Within 30 calendar days from receipt of the request	APL 21-011 III Grievance C. Standard Grievances 2. Resolution DMHC TAG - GA-003 Key Element 3 CCR 1300.68 (a)(4)(b)
Quantitative	GRV002	Timely Grievance Resolution	Expedited	Within 72 hours from receipt of request	APL 21-011 III Grievance E. Expedited Grievances 2. Resolution. CCR 1300.68.01(a)(2) 42 CFR 438.408(b)(3) - Expedited Appeals
Quantitative	GRV002	Timely Grievance Resolution	Exempt	Within close of the next business day from receipt of the request.	APL 21-011 III Grievance D. Exempt Grievances CCR 1300.68(d)(8)
Quantitative	GRV003	Member Notification Timeliness	Standard	Notify member within 30 calendar days from receipt of grievance	APL 21-011 III Grievance C. Standard Grievances 2. Resolution DMHC TAG - GA-003 Key Element 3
Quantitative	GRV003	Member Notification Timeliness	Expedited	Notify the member within 72 hours from receipt of request	APL 21-011 III Grievance E. Expedited Grievances 2. Resolution.

KPI Type	KPI#	KPI	KPI Subcategory	KPI Requirement	Cite Requirement
					HSC 1368.01(b) 42 CFR 438.408(b)(3) - Expedited Appeals

Member Services

KPI Type	KPI#	KPI	KPI Subcategory	KPI Requirement	Cite Requirement
Quantitative	MR001	Calls Answered within 30 seconds		Eighty percent (80%) of calls must be answered within thirty (30) seconds on a monthly basis.	Plan to Plan Agreement: Exhibit A-5 Medi-Cal Benefit Program Provisions
Quantitative	MR002	Call Center Abandonment Rate Level		Abandonment rates must be less than five percent (5%) on a monthly basis.	Plan to Plan Agreement: Exhibit A-5 Medi-Cal Benefit Program Provisions
Qualitative	MR003	Correct call classification and initiation of appropriate actions		Ensure proper categorization of call inquiries, exempt grievances, and standard grievances.	Plan to Plan Agreement: Exhibit A-4a Delineation of Delegation Responsibilities - Member Appeals & Grievances System
Quantitative	MR004	Timely Loading of 834 Eligibility Files		Load monthly 834 eligibility files and resolve any fall-out within two (2) working days of receipt.	Plan to Plan Agreement: Exhibit A-5 Medi-Cal Benefit Program Provisions - Performation Standards

KPI Type	KPI#	KPI	KPI Subcategory	KPI Requirement	Cite Requirement
Quantitative	MR005	Timely Issuance of Member ID cards		Issue 100% of Member ID cards within seven (7) working days of enrollment effective date.	Exhibit A-5 Medi-Cal Benefit Program Provisions

Provider Dispute Resolution

KPI Type	KPI#	KPI	KPI Subcategory	KPI Requirement	Cite Requirement
Qualitative	PDR001	PDR Submission Deadline		Less than 365 days of plan's or the plan's capitated provider's action or, in the case of inaction, that is less than 365 days after the Time for Contesting or Denying Claims has expired	Title 28, Section 1300.71.38 (d)(1)
Quantitative	PDR002	PDR Acknowledgement Timeliness	Electronic	Within two (2) working days of the date of receipt of the electronic provider dispute	Title 28, Section 1300.71.38(e)
Quantitative	PDR002	PDR Acknowledgement Timeliness	Paper	Within fifteen (15) working days of the date of receipt of the paper provider dispute	Title 28, Section 1300.71.38(e)
Quantitative	PDR003	PDR Written Determination Timeliness		Within 45 working days after the date of receipt of the provider dispute or the amended provider dispute.	Title 28, Section 1300.71.38(f)

Utilization Management

KPI Type	KPI#	KPI	KPI Subcategory	KPI Subcategory 2	KPI Requirement	Citations
Quantitative	UM001	Decision Timeliness	Standard	Preservice	Within 5 business days from receipt of information	DHCS Contract – Exhibit A, Attachment 3, 2.3.2 (E) 42 CFR 438.210, (d)(1) APL 21-011, II (A) (1) HSC 1367.01 (h)(1) & (h)(5)
Quantitative	UM001	Decision Timeliness	Expedited	Preservice	Within 72 hours from receipt of request	HSC 1367.01 (h)(2) &)h)(5) DHCS Contract – Exhibit A, Attachment 3, 2.3.2 (F) APL 21-011, II (A)(2) CFR 438.210(d)(2) & (d)(2)(ii)
Quantitative	UM001	Decision Timeliness	Expedited & Standard	Concurrent	Within 72 hours from receipt of request	HSC 1367.01 (h)(2) & (h)(5) APL 21-011 (A)(2) DHCS Contract – Exhibit A, Attachment 3, 2.3.2 (F) Health Net does not distinguish between expedited & standard concurrent cases. Health Net processes all concurrent cases within the expedited timeframe.
Quantitative	UM001	Decision Timeliness	Standard	Retrospective	Within 30 calendar days of receipt of information	HSC 1367.01 (h)(1) DHCS contract – Exhibit A, Attachment 3, 2.3.2 (D), & 4.6.4 (C) APL 21-011, II (A) (3)

KPI Type	KPI#	KPI	KPI Subcategory	KPI Subcategory 2	KPI Requirement	Citations
Quantitative	UM001	Decision Timeliness	Standard	Post Stabilization	Within 30 minutes of receipt of request	DHCS contract – Exhibit A, Attachment 3, 2.3.2 (B) 22 CCR section 53855(a)
Quantitative	UM002	Member Notification Timeliness	Expedited	Preservice	Notify the member within 72 hours from receipt of request (denials, modifications, deferrals)	HSC 1367.01 (h)(3) & (h)(5) 2. DHCS Contract – Exhibit A, Attachment 3, 4.6.4 (B) APL 21-011, II (A)(2) CFR 438.210(d)(2)(ii)
Quantitative	UM002	Member Notification Timeliness	Standard	Preservice	Notify the member within 2 business days of the decision (denials, modifications, deferrals)	HSC 1367.01 (h)(1), (h)(3) & (h)(5) APL 21-011, II (A)(1) DHCS contract – Exhibit A, Attachment 3, 2.3.2 (E) & 4.6.4 (A)(1)
Quantitative	UM002	Member Notification Timeliness	Expedited & Standard	Concurrent	Notify the member within 72 hours from receipt of request (denials, modifications, deferrals)	HSC 1367.01 (h)(3) & (h)(5) DHCS Contract – Exhibit A, Attachment 3, 4.6.4 (B) APL 21-011, II (A)(2) Health Net does not distinguish between expedited & standard concurrent cases. Health Net processes all concurrent cases within the expedited timeframe.
Quantitative	UM002	Member Notification Timeliness	Standard	Retrospective	Notify the member within 30 calendar days of receipt of information	HSC 1367.01 (h)(1) DHCS contract – Exhibit A, Attachment 3, 2.3.2(D), & 4.6.4(C) APL 21-011, II (A) (3)

KPI Type	KPI#	KPI	KPI Subcategory	KPI Subcategory 2	KPI Requirement	Citations
Quantitative	UM003	Provider Notification Timeliness	Expedited	Preservice	Notify the requesting provider within 72 hours of receiving the request.	HSC 1367.01 (h)(3) & (h)(5) APL 21-011, II (A)(2) CFR 438.210(d)(ii)
Quantitative	UM003	Provider Notification Timeliness	Standard	Preservice	Notify the requesting provider within 24 hours of the decision.	HSC 1367.01(h)(3). (h),(4), & (h)(5) DHCS contract – Exhibit A, Attachment 3, 4.6.4(A)(2) APL 21-011, II (A)(1) DHMC UM Tag (UM-002 - Key Element 2, 2.3 assessment question)
Quantitative	UM003	Provider Notification Timeliness	Expedited & Standard	Concurrent	Notify the requesting provider within 72 hours of receiving the request.	HSC 1367.01 (h)(2), (h)(3), & (h)(5 APL 21-011, II (A)(2)
Quantitative	UM003	Provider Notification Timeliness	Standard	Retrospective	Notify the requesting provider within 30 calendar days of receipt of information	HSC 1367.01 (h)(1) DHCS contract – Exhibit A, Attachment 3, 2.3.2(D) APL 21-011, II (A) (3)