COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

# AGENDA

# Executive Committee
# April 9, 2025
# 12:00 PM
# 512 W. Aten Rd., Imperial, CA 92251

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

| Committee Members | Representing | Present |
|---|---|---|
| **Lee Hindman** | LHA Chairperson – Joint Chambers of Commerce Nominee | |
| **Yvonne Bell** | LHA Vice-Chair & Finance Committee Vice-Chair – CEO, Innercare | |
| **Dr. Carlos Ramirez** | Finance Committee Chair – CEO/ Senior Consultant DCRC | |
| **Dr. Unnati Sampat** | LHA Commissioner – Imperial Valley Medical Society | |
| **Dr. Allan Wu** | LHA Commissioner – Innercare | |

**1. CALL TO ORDER** *Lee Hindman, Chair*

A. Roll Call *Donna Ponce, Commission Clerk*

B. Approval of Agenda

1. Items to be pulled or added from the Information/Action/Closed Session Calendar
2. Approval of the order of the agenda

**2. PUBLIC COMMENT** *Lee Hindman, Chair*

Public Comment is limited to items NOT listed on the agenda. This is an opportunity for members of the public to address the Commission on any matter within the Commission's jurisdiction. Any action taken as a result of public comment shall be limited to the direction of 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 Chairperson. Individuals will be given three (3) minutes to address the board.

**3. CONSENT AGENDA**

All items appearing on the consent calendar are recommended for approval and will be acted upon by one motion, without discussion. Should any Commissioner or other person express their preference to consider an item separately, that item will be addressed at a time as determined by the Chair.

A. Approval of Minutes from 3/5/2025 ……*pg. 4-6*

B. Motion to recommend to the full commission the acceptance of monthly financial reports as reviewed and accepted by the Finance Committee…….. *pg. 7-13*

1. Executive Summary
2. Enrollment Report
3. Statement of Revenues, Expenses, and Changes in Net Position
4. Statement of Net Position (Assets)
5. Statement of Net Position (Liabilities & Net Position)
6. Summarized TNE Calculation
7. Cash Transaction Report

**4. ACTION**

**5. INFORMATION**

A. Health Services Report *(Dr. Gordon Arakawa, CMO and Jeanette Crenshaw, Executive Director of Health Services) …….. pg.14*

B. Financial Services Report *(David Wilson, CFO) ……pg. 7-13*

C. Compliance Report *(Elysse Tarabola, CCO) ……pg. 15-151*

D. Operations Report *(Julia Hutchins, COO and Michelle S. Ortiz-Trujillo, Senior Manager of Marketing and Communications) …….. pg. 152-163*

E. Human Resources Report *(Shannon Long, HR Consultant) ……. pg. 164-165*

F. CEO Report (*Larry Lewis, CEO)*

G. Other new or old business (*Lee Hindman, Chair)*

**6. CLOSED SESSION**

Pursuant to Welfare and Institutions Code § 14087.38 (n) Report Involving Trade Secret new product discussion (estimated date of disclosure, 10/2025)

A. Conference Labor Negotiations *(Committee Members and CEO ONLY)*

B. Compliance

**7. RECONVENE OPEN SESSION**

A. Report on actions taken in closed session.

**8. COMMISSIONER REMARKS (***Lee Hindman, Chair)*

A. Alternate Commissioner Member Assignment

**9. ADJOURNMENT**

Next meeting: May 7, 2025

COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

# MINUTES

## Executive Committee
## March 5, 2025
## 12:00 PM
## 512 W. Aten Rd., Imperial, CA 92251

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

| Committee Members | Representing | Present |
|---|---|---|
| **Lee Hindman** | LHA Chairperson – Joint Chambers of Commerce Nominee | ✓ |
| **Yvonne Bell** | LHA Vice-Chair & Finance Committee Vice-Chair – CEO, Innercare | ✓ |
| **Dr. Carlos Ramirez** | Finance Committee Chair – CEO/ Senior Consultant DCRC | ✓ |
| **Dr. Unnati Sampat** | LHA Commissioner – Imperial Valley Medical Society | ✓ |
| **Dr. Allan Wu** | LHA Commissioner – Innercare | A |

**1. CALL TO ORDER** *Lee Hindman, Chair*

*Meeting was called to order at 12:01 p.m.*

A. Roll Call *Donna Ponce, Commission Clerk*

*Roll call taken and quorum confirmed. Attendance is as shown.*

B. Approval of Agenda

1. Items to be pulled or added from the Information/Action/Closed Session Calendar
2. Approval of the order of the agenda

*(Ramirez/Sampat) To approve the order of the agenda. Motion carried.*

**2. PUBLIC COMMENT** *Lee Hindman, Chair*

Public Comment is limited to items NOT listed on the agenda. This is an opportunity for members of the public to address the Commission on any matter within the Commission's jurisdiction. Any action taken as a result of public comment shall be limited to the direction of 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 Chairperson. Individuals will be given three (3) minutes to address the board.

*None.*

## 3. CONSENT AGENDA

All items appearing on the consent calendar are recommended for approval and will be acted upon by one motion, without discussion. Should any Commissioner or other person express their preference to consider an item separately, that item will be addressed at a time as determined by the Chair.
*(Ramirez/Bell) To approve the consent agenda. Motion carried.*

A. Approval of Minutes from 2/5/2025

B. Motion to recommend to the full commission the acceptance of monthly financial reports as reviewed and accepted by the Finance Committee.

1. Enrollment Report
2. Statement of Revenues, Expenses, and Changes in Net Position
3. Administrative Cost Variance by Department
4. Statement of Net Position (Assets)
5. Statement of Net Position (Liabilities & Net Position)
6. Summarized TNE Calculation
7. Cash Transaction Report

## 4. ACTION *(No items)*

## 5. INFORMATION

A. Health Services Report *(Dr. Gordon Arakawa, CMO and Jeanette Crenshaw, Executive Director of Health Services)*
*CMO, Dr. Gordon Arakawa provided updates on Community Health Improvement, Audit/Accreditation, and NCQA. Dr. Arakawa also provided an update on a Provider Issue. He informed the committee that CHPIV and Health Net are investigating the issue and will update as the process progresses.*

B. Financial Services Report *(David Wilson, CFO)*
*Financial Reports presented in CONSENT AGENDA, item 3B.*

C. Compliance Report *(Elysse Tarabola, CCO)*
*CCO, Elysse Tarabola provided updates on DHCS Medical Audit, mandatory compliance training completion, DMHC D-SNP filings, and the resignation of the Compliance Manager, Rosa Sanchez.*

D. Operations Report *(Julia Hutchins, COO and Michelle S. Ortiz-Trujillo, Senior Manager of Marketing & Communications)*
*COO, Julia Hutchins presented the Operations Report and Senior Manager of Marketing & Communications, Michelle Ortiz-Trujillo provided updates on community events.*

E. Human Resources Report *(Shannon Long, HR Consultant)*
*HR Consultant Shannon Long provided updates on the following:*

- *Short-term disability plan*
- *Revised policies in the employee handbook*
- *Consolidation of all training courses to Rippling*
- *Staff survey required by NCQA on DEI topics*
- *Resignation of Rosa Sanchez, former Compliance Manager*
- *Review of the recruitment process*

F. 2025 Employee Handbook *(Shannon Long, HR Consultant)*
*Employee Handbook covered in Human Resources Report.*

G. CEO Report (*Larry Lewis, CEO)*
*CEO, Larry Lewis, provided updates on the following topics:*

- *Cancer Resource Center of the Desert funding inquiries*
- *NCQA audit*
- *D-SNP Implementation*
- *DHCS Medical Audit*
- *Grand opening of All Valley Urgent Care in Calexico*
- *Health Net targeted rate increases for Providers*
- *Upcoming changes in healthcare from Washington, D.C.*

H. Other new or old business (*Lee Hindman, Chair)*
*None.*

**6. CLOSED SESSION**

Pursuant to Welfare and Institutions Code § 14087.38 (n) Report Involving Trade Secret new product discussion (estimated date of disclosure, 10/2025)

A. Compliance *(No report)*

**7. RECONVENE OPEN SESSION**

A. Report on actions taken in closed session.

**8. COMMISSIONER REMARKS (***Lee Hindman, Chair)*
*None.*

**9. ADJOURNMENT**
*The meeting was adjourned at 1:00 p.m.*
*Next meeting: April 9, 2025*

COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

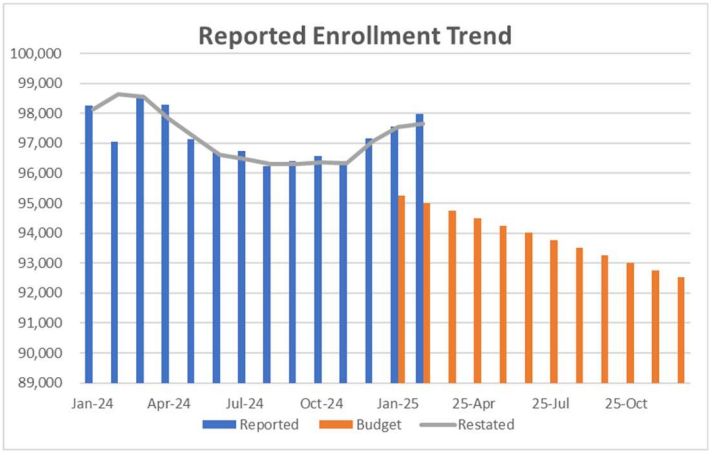
# Financial Result

*February 2025*

## Executive Summary

**Membership**

Membership continues to exceed forecasts, with February showing a favorable variance of approximately 3,000 members. Although the overall trend appears to be flattening, it remains significantly above initial estimates, which predicted a decline of approximately 250 members per month. Year-to-date, CHPIV is ahead by 5,313 member months on a reported basis.




On a member month basis, the Child Category of Aid (COA) accounted for over 50% of the increase, although SPD Dual (28% of the variance) made up 54% of the financial impact.

**Gross Margin**

Revenue exceeded forecasts by $10M for the month, primarily due to retroactive rate adjustments ($7M), with $6.3M in risk revenue (97% sharing) and $0.7M in pass-throughs. Prior period activity was evenly split between January 2025 and 2024 service months. Payments related to 2024 eligibility months were based on the updated rate structure provided by DHCS, while 2025 payments are consistent with preliminary rates published by DHCS. Notably, CHPIV received $700K in SNF WQIP directed payments (100% pass-through), which will be distributed to providers in March and April.

For the current month (February only), volume contributed an additional $0.7M in favorable revenue variance, while mix/rate drove $2.3M in incremental revenue. Given the high percentage of favorable revenue in the risk revenue category, gross margin yielded a favorable variance of $283K for the month.

**Admin**

Administrative expenses were favorable by $40K, inclusive of Depreciation/Amortization. The main drivers were Consulting (+$24K) and Travel (+$14K), both largely attributable to timing. Other favorable accounts included Consulting (driven by Operations) and Travel (driven by Compliance). As noted in the detailed financial report, Compliance anticipated high travel in February for the audit, which has now been delayed until April/May P&L. Year-to-date, administrative costs are favorable by $26K.

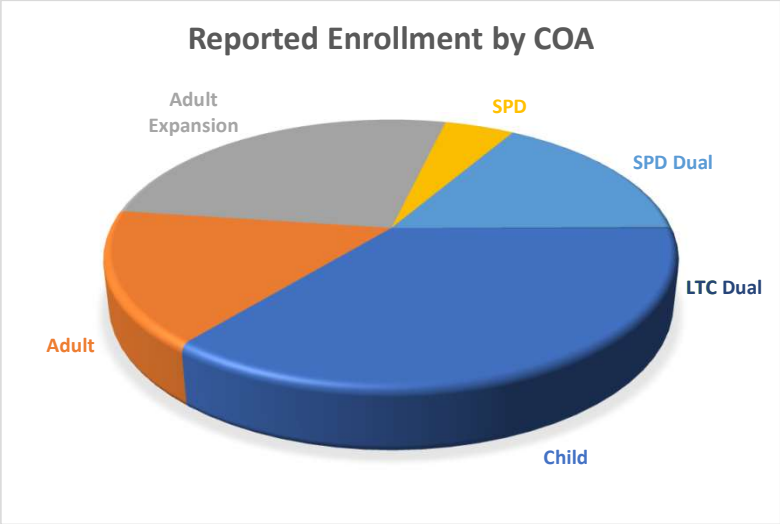
**Other**

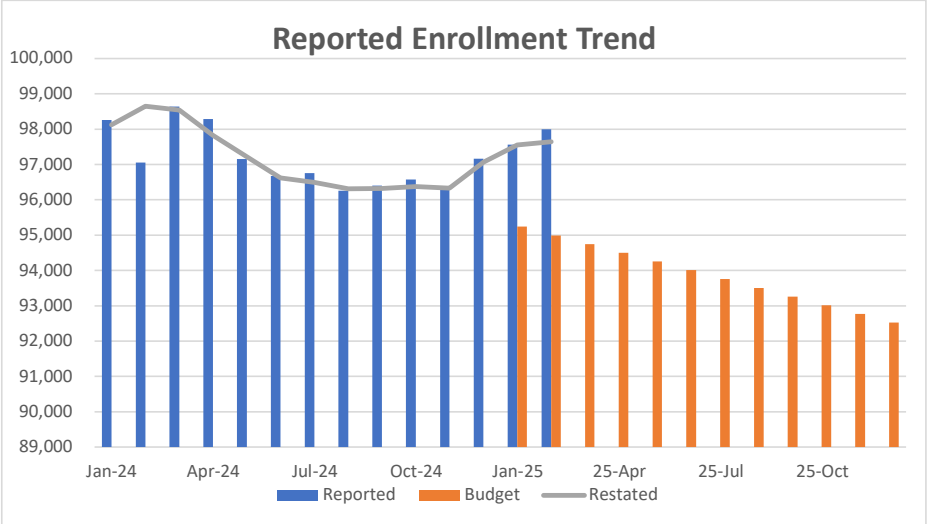
Investment income continues to be favorable based on both rates and the total dollars being invested each month. Given the high capitation in February, March investment results are also expected to be above forecast.

# Imperial County Local Health Authority
# DBA Community Health Plan of Imperial Valley
# Reported Enrollment
# For February 2025

| | 2024 | | | | 2025 | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | February | | | | February (YTD) | | | |
| | | | | | | | B/(W) | | | | B/(W) | |
| Category of Aid (COA)* | Q1-24 | Q2-24 | Q3-24 | Q4-24 | Actual | Budget | # | % | Actual | Budget | # | % |
| Child | 34,607 | 34,589 | 34,424 | 34,551 | 35,147 | 33,763 | 1,384 | 4% | 70,353 | 67,674 | 2,679 | 4% |
| Adult | 16,997 | 15,767 | 15,675 | 15,768 | 15,887 | 15,256 | 631 | 4% | 31,619 | 30,591 | 1,029 | 3% |
| Adult Expansion | 26,579 | 25,784 | 25,733 | 26,019 | 26,018 | 25,426 | 592 | 2% | 51,923 | 50,912 | 1,012 | 2% |
| SPD | 5,007 | 5,041 | 5,085 | 5,139 | 3,996 | 5,075 | (1,079) | -21% | 9,281 | 10,160 | (879) | -9% |
| SPD Dual | 14,433 | 14,760 | 15,007 | 15,288 | 16,826 | 15,348 | 1,478 | 10% | 32,130 | 30,651 | 1,479 | 5% |
| LTC | 12 | 15 | 19 | 22 | 22 | 26 | (4) | -15% | 43 | 51 | (7) | -15% |
| LTC Dual | 79 | 87 | 92 | 104 | 98 | 101 | (3) | -3% | 202 | 201 | 2 | 1% |
| Total Medicaid | 97,714 | 96,043 | 96,035 | 96,891 | 97,994 | 94,995 | 2,999 | 3% | 195,551 | 190,238 | 5,313 | 3% |
| *Monthly/Quarterly Change* | | *-1.7%* | *0.0%* | *0.9%* | *1.1%* | *-2.0%* | | | | | | |

** Source: DHCS 820 Remittance summary; includes retroactivity*



# Imperial County Local Health Authority
## DBA Community Health Plan of Imperial Valley
## Statement of Revenues, Expenses, and Changes in Net Position
## For February 2025

| | February | | | February (YTD) | | | |
|---|---|---|---|---|---|---|---|
| | Actual | Budget | Variance - B/(W) | Actual | Budget | Variance - B/(W) | Current Month Explanations |
| **REVENUE** | | | | | | | |
| Premium | $ 32,344,623 | $ 22,924,335 | **$ 9,420,288** | $ 56,148,545 | $ 45,892,734 | **$ 10,255,811** | Revenue was favorable by $10M, largely due to prior period activity (+$7.0M). Rate/Mix was favorable by $2.3M; volume favorable by $0.7M |
| Pass-Through | $ 948,435 | $ 346,404 | **$ 602,032** | $ 1,295,987 | $ 693,496 | **$ 602,491** | |
| HN Settlements | $ - | $ - | **$ -** | $ - | $ - | **$ -** | |
| **TOTAL REVENUE** | **$ 33,293,058** | **$ 23,270,738** | **$ 10,022,319** | **$ 57,444,532** | **$ 46,586,230** | **$ 10,858,302** | |
| **HEALTH CARE COSTS** | $ 32,322,719 | $ 22,583,008 | **$ (9,739,711)** | $ 55,760,076 | **$ 45,209,448** | **$ (10,550,627)** | |
| **Gross Margin** | **$ 970,339** | **$ 687,730** | **$ 282,609** | **$ 1,684,456** | **$ 1,376,782** | **$ 307,674** | |
| **ADMINISTRATIVE EXPENSE** | | | | | | | |
| Salaries & Wages | $ 317,851 | $ 321,164 | **$ 3,313** | $ 676,700 | $ 630,818 | **$ (45,882)** | |
| Benefits Expense | $ 31,083 | $ 25,147 | **$ (5,936)** | $ 55,278 | $ 48,691 | **$ (6,587)** | |
| **Total Labor Costs** | $ 348,933 | $ 346,311 | **$ (2,623)** | $ 731,978 | $ 679,509 | **$ (52,469)** | |
| Consulting, Legal, & Other Professional | $ 90,945 | $ 114,944 | **$ 24,000** | $ 208,775 | $ 255,161 | **$ 46,386** | Driven by timing within operations budget |
| Advertising & Marketing | $ 195 | $ 663 | **$ 468** | $ 1,769 | $ 2,463 | **$ 693** | |
| Information Technology | $ 11,337 | $ 4,921 | **$ (6,416)** | $ 17,052 | $ 12,243 | **$ (4,809)** | |
| Membership and Subscriptions | $ 9,706 | $ 9,180 | **$ (526)** | $ 18,868 | $ 18,360 | **$ (508)** | |
| Regulatory Fees | $ 28,465 | $ 28,418 | **$ (47)** | $ 56,883 | $ 56,836 | **$ (47)** | |
| Travel | $ 4,860 | $ 18,433 | **$ 13,574** | $ 8,161 | $ 23,367 | **$ 15,205** | Delayed travel from Compliance |
| Meals & Entertainment | $ 1,357 | $ 500 | **$ (857)** | $ 2,839 | $ 1,000 | **$ (1,839)** | |
| Insurance and Banking | $ 6,170 | $ 7,509 | **$ 1,339** | $ 11,955 | $ 15,018 | **$ 3,063** | |
| Occupancy & Facility | $ 3,562 | $ 4,717 | **$ 1,155** | $ 7,548 | $ 9,434 | **$ 1,887** | |
| Office Expense | $ 2,114 | $ 7,060 | **$ 4,946** | $ 3,976 | $ 17,520 | **$ 13,544** | |
| Other Admin | $ - | $ 4,806 | **$ 4,806** | $ 101 | $ 4,806 | **$ 4,705** | |
| **Total Administrative Expense** | **$ 507,644** | **$ 547,462** | **$ 39,819** | **$ 1,069,905** | **$ 1,095,716** | **$ 25,811** | |
| **Non-Operating Income** | | | | | | | |
| Dividend, Interest & Investment Income | $ 93,840 | $ 87,391 | **$ 6,449** | $ 192,480 | $ 174,782 | **$ 17,697** | Favorable investment income due a combination of higher portfolio balance and rate of return on investments. |
| Rental Income | $ 1,494 | $ 1,450 | **$ 44** | $ 2,987 | $ 2,900 | **$ 87** | |
| **Total Non-Operating Income** | $ 95,334 | $ 88,841 | **$ 6,493** | $ 195,467 | $ 177,682 | **$ 17,784** | |
| **Depreciation & Amortization** | $ 10,656 | $ 11,000 | **$ 344** | $ 21,311 | $ 22,000 | **$ 689** | |
| **Change in Net Position** | **$ 547,373** | **$ 218,109** | **$ 329,264** | **$ 788,707** | **$ 436,749** | **$ 351,959** | |
| **Key Metrics** | | | | | | | |
| Enrollment | 97,994 | 94,995 | **2,999** | 195,551 | 190,238 | **5,314** | |
| Revenue PMPM | $339.75 | $244.97 | **$94.78** | $293.76 | $244.88 | **$48.87** | |
| MLR | 97.09% | 97.0% | **(4) bps** | 97.1% | 97.0% | **(2) bps** | |
| Admin Ratio | 1.5% | 2.3% | **82 bps** | 1.9% | 2.3% | **49 bps** | |
| Net Income PMPM | $5.59 | $2.30 | **$3.29** | $4.03 | $2.30 | **$1.74** | |
| Net Income % | 1.6% | 0.9% | **71 bps** | 1.4% | 0.9% | **43 bps** | |

# Imperial County Local Health Authority dba
# Community Health Plan of Imperial Valley
# Statement of Net Position
# As of February 28, 2025

## ASSETS

| Current Assets | Jan 2025 | Feb 2025 | Change |
|---|---|---|---|
| Cash and Investments | | | |
| Chase - Checking | $ 200,000 | $ 200,000 | $ - |
| Chase - Money Market | 2,901,528 | 2,523,866 | (377,662) |
| JPMorgan Securities | 13,403,293 | 14,052,869 | 649,576 |
| First Foundation Bank | 137,835 | 177,057 | 39,222 |
| Receivables | | | |
| Accounts Receivable | 2,773 | - | (2,773) |
| Dividend Receivable | 11,687 | 7,992 | (3,695) |
| Interest Receivable | 86,953 | 85,847 | (1,106) |
| Premium Receivable | 23,803,923 | 32,344,622 | 8,540,700 |
| Pass-Through Receivable | 347,552 | 948,435 | 600,883 |
| Other Current Assets | | | |
| Prepaid Expenses | 177,958 | 120,681 | (57,277) |
| **Total Current Assets** | **41,073,501** | **50,461,369** | **9,387,869** |
| Noncurrent Assets | | | |
| Restricted Deposit | | | |
| First Foundation Bank - Restricted | 300,000 | 300,000 | - |
| Capital Assets | | | |
| Buildings - Net | 2,948,958 | 2,940,410 | (8,548) |
| Computers & Office Equipment - Net | 7,563 | 7,395 | (168) |
| Improvements - Net | 45,586 | 45,178 | (408) |
| Intangible Assets - Net | 67,711 | 66,461 | (1,250) |
| Operating ROU Asset (Copier) - Net | 6,193 | 5,912 | (281) |
| **Total Noncurrent Assets** | **3,376,011** | **3,365,356** | **(10,655)** |
| **Total Assets** | **$ 44,449,511** | **$ 53,826,725** | **$ 9,377,214** |

# Imperial County Local Health Authority dba
# Community Health Plan of Imperial Valley
# Statement of Net Position
# As of February 28, 2025

| | Jan 2025 | Feb 2025 | Change |
|---|---|---|---|
| **LIABILITIES** | | | |
| CURRENT LIABILITIES | | | |
| Payables | | | |
| Accounts Payable | $ 189,290 | $ 99,657 | $ (89,633) |
| Capitation Payable | 23,089,805 | 31,374,284 | 8,284,479 |
| Pass-Through Payable | 347,552 | 948,435 | 600,883 |
| Credit Card Payable | 1,588 | 14,739 | 13,151 |
| Other Current Liabilities | | | |
| Short Term Lease Liability - Copier | 3,406 | 3,421 | 15 |
| Bonus Accrual | 166,837 | 185,053 | 18,216 |
| Salaries Accrual | 161,257 | 149,427 | (11,830) |
| Vacation Accrual | 139,115 | 154,012 | 14,897 |
| **Total Current Liabilities** | **24,098,850** | **32,929,028** | **8,830,178** |
| NON-CURRENT LIABILITIES | | | |
| Long Term Lease Liability - Copier | 2,984 | 2,692 | (292) |
| **Total Noncurrent Liabilities** | **2,984** | **2,692** | **(292)** |
| **Total Liabilities** | **24,101,834** | **32,931,720** | **8,829,886** |
| **NET POSITION** | | | |
| Net investment in Capital Assets | 3,376,011 | 3,365,356 | (10,655) |
| Restricted by Legislative Authority | 300,000 | 300,000 | - |
| Unrestricted | 16,430,332 | 16,440,987 | 10,655 |
| Net Revenue | 241,334 | 788,662 | 547,328 |
| **Total Net Position** | **20,347,677** | **20,895,005** | **547,328** |
| **Total Liabilities and Net Position** | **$ 44,449,511** | **$ 53,826,725** | **$ 9,377,214** |

# Imperial County Local Health Authority dba
# Community Health Plan of Imperial Valley
# Summarized Tangible Net Equity Calculation
# As of February 28, 2025

| | | |
|---|---|---|
| | Net Equity | $ 20,895,005 |
| | Add: Subordinated Debt and Accrued Subordinated Interest | $ 0 |
| | Less: Report 1, Column B, Line 27 including:<br>Unsecured Receivables from officers, directors, and affiliates; Intangibles | $ 0 |
| | Tangible Net Equity (TNE) | $ 20,895,005 |
| | Required Tangible Net Equity * | $ 5,495,167 |
| | TNE Excess (Deficiency) | $ 15,399,837 |

| | Full Service Plan | | 1 |
|---|---|---|---|
| **A.** | Minimum TNE Requirement | $ | 1,000,000 |
| **B.** | REVENUES: | | |
| | 2% of the first $150 million of annualized premium revenues (lines 1, 2, 4, 5, 7, 9 from Income Statement) | $ | 3,000,000 |
| | Plus | | |
| | 1% of annualized premium revenues in excess of $150 million | $ | 2,495,167 |
| | Total | $ | 5,495,167 |

| * Calculated Required Tangible Net Equity | | |
|---|---|---|
| $ | 399,516,696 | - Q1 |
| $ | 399,516,696 | - Annualized |
| $ | 150,000,000 | |
| x | 2% | |
| $ | 3,000,000 | |
| $ | 249,516,696 | |
| x | 1% | |
| $ | 2,495,167 | |
| $ | 5,495,167 | - Required TNE |

**Community Health Plan of Imperial Valley**
**February 2025 Cash Transactions**

| Date | Account | Vendor | Memo/Description | Amount |
|---|---|---|---|---|
| **Chase Checking** | | | | |
| 02/07/2025 | Chase Checking | AM Copiers Inc. | Chase Bill Pay - Invoice #IN6830 | $ -7.31 |
| 02/07/2025 | Chase Checking | Brawley Rotary Club | Chase Bill Pay - January 2025 | -295.00 |
| 02/07/2025 | Chase Checking | City of Imperial | Chase Bill Pay - Invoice #1407195 | -137.07 |
| 02/07/2025 | Chase Checking | CLEANBC, LLC | Chase Bill Pay - Invoice #1407195 - Reissued Check | -750.00 |
| 02/07/2025 | Chase Checking | Health Management Associates, Inc. | Chase Bill Pay - Invoice #206100-0000021 | -20,933.75 |
| 02/07/2025 | Chase Checking | I.V. Termite & Pest Control | Chase Bill Pay - Invoice #0346567 | -120.00 |
| 02/07/2025 | Chase Checking | Junior's Cafe | Chase Bill Pay - Invoice #13-17760 | -365.96 |
| 02/07/2025 | Chase Checking | Law Office of William S. Smerdon | Chase Bill Pay - Invoice #2696 | -1,430.00 |
| 02/07/2025 | Chase Checking | Zamosky Communication | Chase Bill Pay - Invoice #0000020 - Reissued Check | -8,000.00 |
| 02/07/2025 | Chase Checking | Quench USA | Chase Bill Pay - Invoice #INV08461009 | -129.30 |
| 02/07/2025 | Chase Checking | Republic Services | Chase Bill Pay - Invoice #0497-001735843 | -152.47 |
| 02/07/2025 | Chase Checking | Shannon Long | Chase Bill Pay - Invoice #8 | -6,000.00 |
| 02/07/2025 | Chase Checking | State Compensation Insurance Fund | Chase Bill Pay - Invoice #1002772972 | -1,622.03 |
| 02/07/2025 | Chase Checking | Stericycle, Inc. | Chase Bill Pay - Invoice #8009613953 | -111.36 |
| 02/07/2025 | Chase Checking | CLEANBC, LLC | Chase Bill Pay - Invoice #014 - Canceled Check | 750.00 |
| 02/07/2025 | Chase Checking | Zamosky Communication | Chase Bill Pay - Invoice #0000020 - Canceled Check | 8,000.00 |
| 02/15/2025 | Chase Checking | 360 Business Products | Return on check for invoice: OE-QT-31148-1 paid twice. | 2,773.48 |
| 02/15/2025 | Chase Checking | Department of Health Care Services | 2/13/25 Receipt - DHCS (Jan 2025 Revenue) | 23,480,983.86 |
| 02/15/2025 | Chase Checking | Department of Health Care Services | 2/13/25 Receipt - DHCS (Jan 2025 Revenue) | 569,367.07 |
| 02/15/2025 | Chase Checking | Department of Health Care Services | 2/13/25 Receipt - DHCS (Jan 2025 Revenue) | 59,644.70 |
| 02/15/2025 | Chase Checking | Department of Health Care Services | 2/13/25 Receipt - DHCS (Jan 2025 Revenue) | 40,433.66 |
| 02/15/2025 | Chase Checking | Department of Health Care Services | 2/13/25 Receipt - DHCS (Jan 2025 Revenue) | 1,044.97 |
| 02/15/2025 | Chase Checking | American Trust Retirement Services | 02/14/25 - Return Check Payment | 1,537.66 |
| 02/15/2025 | Chase Checking | Mid Atlantic Trust Company | Payroll Date: Retirement Contribution: | -7,252.88 |
| 02/15/2025 | Chase Checking | Mid Atlantic Trust Company | Payroll Date: Retirement Contribution: | -7,923.02 |
| 02/15/2025 | Chase Checking | JPMorgan Chase | Service Charges Investment Sweep - Feb 2025 | -747.39 |
| 02/15/2025 | Chase Checking | JPMorgan Chase | Service Charges - Feb 2025 | -100.00 |
| 02/15/2025 | Chase Checking | JPMorgan Chase | Dividend Income - Jan 2025 | 11,687.01 |
| 02/21/2025 | Chase Checking | Jeffrey Scott Agency | Invoice: INV 02-12-25 | -1,170.00 |
| 02/21/2025 | Chase Checking | Health Management Associates, Inc. | Invoice: 212606-0000001, 212416-0000002 and 212806-0000006 | -81,978.75 |
| 02/21/2025 | Chase Checking | Imperial Irrigation District | Invoice: Service Period: 12/24/24 - 01/24/2025 | -1,127.46 |
| 02/21/2025 | Chase Checking | Manifest MedEx | Invoice: INV-2990 | -24,275.00 |
| 02/21/2025 | Chase Checking | Moss Adams | Invoice: 102701562 | -31,500.00 |
| 02/21/2025 | Chase Checking | Technology Depot | Invoice: 15110 & 15109 | -545.00 |
| 02/28/2025 | Chase Checking | Health Net | Rental Income - Feb 2025 | 1,493.50 |
| 02/28/2025 | Chase Checking | Mid Atlantic Trust Company | Payroll Date: 02/21//25 Retirement Contribution: | -7,166.39 |
| 02/28/2025 | Chase Checking | Mid Atlantic Trust Company | Payroll Date: 02/21//25 EE Retirement Contribution: | -1,537.66 |
| **First Foundation Bank** | | | | |
| 02/28/2025 | FFB Payroll | Rippling | Employee Reimbursement - I. Franco / S. Long / D. Campo | -3,516.89 |
| 02/28/2025 | FFB Payroll | Rippling | Employee Reimbursement - E. Tarabola | -454.51 |
| 02/28/2025 | FFB Payroll | Rippling | Employee Reimbursement - E. Tarabola | -58.00 |
| 02/28/2025 | FFB Payroll | Rippling | Employee Reimbursement - E. Tarabola / J. Hutchins / J. Perez | -1,420.75 |
| 02/28/2025 | FFB Payroll | Rippling | Employee Reimbursement - G. Arakawa | -1,066.00 |
| 02/28/2025 | FFB Payroll | Rippling | Employee Reimbursement - D. Wilson | -1,035.46 |
| 02/28/2025 | FFB Payroll | Rippling | Employee Reimbursement - D. Campo | -71.23 |
| 02/28/2025 | FFB Payroll | Rippling | Employee Reimbursement - M. Ortiz | -151.54 |
| 02/28/2025 | FFB Payroll | Rippling | Payroll Date: 02/07/25 Accrued Taxes | -59,464.02 |
| 02/28/2025 | FFB Payroll | Rippling | Payroll Date: 02/07/25 Accrued Wages | -86,617.45 |
| 02/28/2025 | FFB Payroll | Rippling | Payroll Date: 02/21/25 Accrued Taxes | -53,513.24 |
| 02/28/2025 | FFB Payroll | Rippling | Payroll Date: 02/21/25 Accrued Wages | -83,857.69 |
| 02/28/2025 | FFB Payroll | Rippling | Rippling Fee | -176.43 |
| 02/28/2025 | FFB Payroll | Rippling | Rippling Fee | -528.00 |
| 02/28/2025 | FFB Payroll | Blue Shield Insurance | Blue Shield Insurance | -18,816.58 |
| 02/28/2025 | FFB Payroll | First Foundation Bank | Wire Fee | -10.00 |
| 02/28/2025 | FFB Payroll | First Foundation Bank | Wire Fee | -10.00 |
| 02/28/2025 | FFB Payroll | First Foundation Bank | Wire Fee | -10.00 |
| **J.P. Morgan Securities** | | | | |
| 02/28/2025 | Chase Bond Portfolio | JPMorgan Chase | Bank Fee - Jan 2024 (Portfolio) | -20.00 |
| 02/28/2025 | Chase Bond Portfolio | Health Net | February Health Net Payment | -23,437,356.59 |
| 02/28/2025 | Chase Bond Portfolio | JPMorgan Chase | Accrued Investment Income - Jan 2025 | $ 86,952.52 |

# Health Services Report

1. Q1 2025 QIHEC-2024 Summary
2. Audit/Accreditation Update

## 2024 Department of Health Care Services (DHCS) Medical Audit

CHPIV is actively preparing for the onsite audit scheduled from April 29, 2025, to May 13, 2025. In collaboration with Health Net, CHPIV has submitted over 350 deliverable requests, including policies, programs, data logs, and sample case files. DHCS continues to request additional documents, and we are currently awaiting the interview schedule.

## 2025 Department of Managed Health Care (DMHC) Routine Survey

The Department of Managed Health Care (DMHC) will conduct its first onsite Routine Survey of CHPIV starting the week of September 29, 2025. The audit aims to assess CHPIV's overall performance in providing health care benefits and meeting the health care needs of our members. CHPIV is collaborating closely with Health Net to finalize audit document submissions, which include a questionnaire, data logs, programs, policies, reports, and case files.

## Updated and New Policies & Procedures (P&Ps)

The internal Compliance & Policy Committee and the Regulatory Compliance Oversight Committee (RCOC) of the Commission approved the following P&Ps in March 2025. The table below outlines the summary of changes for each policy. Attached please find copies of new and revised policies.

| Name | P&P Name | Department | Functional Area | Summary of Changes |
|---|---|---|---|---|
| CMP-002 | Delegation Oversight | Compliance | Compliance | Ad hoc Update – Updated to include Member Appeals & Grievance monitoring and Delegation Oversight quarterly meetings |
| CMP-004 | Implementation of Regulatory Notifications | Compliance | Compliance | Annual Review – No changes required |
| CMP-006 | Compliance Training | Compliance | Compliance | Annual Review – Updated to include Commissioners |
| CMP-007 | Escalation of Noncompliance Issues | Compliance | Compliance | Annual Review – No changes required |
| CMP-008 | Selecting a Chief Compliance Officer | Compliance | Compliance | Annual Review – No changes required |
| CMP-009 | Fraud Waste and Abuse Program | Compliance | Compliance | Annual Review – No changes required |

| Name | P&P Name | Department | Functional Area | Summary of Changes |
|---|---|---|---|---|
| CMP-010 | Effective Lines of Communication | Compliance | Compliance | Annual Review – No changes required |
| CMP-011 | Breach Notification | Compliance | Compliance | Annual Review – No changes required |
| CMP-014 | Compliance Program | Compliance | Compliance | New Policy |
| QM-002 | Quality Improvement Health Equity Committee (QIHEC) | Health Services | Quality Management | Annual Review – No changes required |
| CM-001 | Care Management Programs | Health Services | Care Management | Annual Review - Updated to correct CHPIV name |
| PS-001 | Pharmacy Services | Health Services | Pharmacy Services | Annual Review - Updated to include a CMS requirement |
| PNM-001 | Standards of Network Accessibility and Timely Access to Care | Health Services | Provider Network Management | Ad hoc Review – Updated to include DHCS APL 23-006 Alternative Access Standard (AAS) requirement |
| FIN-001 | Delegated Provider Financial Solvency Oversight Process | Finance & Informatics | Finance | Annual Review – No changes required |
| FIN-002 | Delegated Provider Financial Solvency Corrective Action Plan Process | Finance & Informatics | Finance | Annual Review – No changes required |
| FIN-003 | Medical Loss Requirements for Subcontractors | Finance & Informatics | Finance | New Policy required for DHCS APL 24-018 |
| IT-002 | After-Hours Computer Shutdown | Information Technology | Information Technology | New Policy |

| Name | P&P Name | Department | Functional Area | Summary of Changes |
|---|---|---|---|---|
| EXC-001 | Conflict of Interest Avoidance | Executive Services | Executive Services | Annual Review – Updated to correct grammar discrepancies and include an updated Attachment A (Expand List of Leadership) |
| EXC-002 | Delegation of Authority | Executive Services | Executive Services | Annual Review – No changes required |
| ADM-001 | Community Donations and Support | Executive Services | Administration | Annual Review – No changes required |
| HR-005 | New Positions | Human Resources | Administration | Updated policy |
| HR-009 | Remote Work | Human Resources | Administration | New Policy |
| HR-010 | Promotions | Human Resources | Administration | New Policy |

## Employee Handbook Updates

Human Resources has made the following updates to the employee handbook, which were reviewed and approved by the internal Compliance & Policy Committee and the Regulatory Compliance Oversight Committee (RCOC) of the Commission. An updated employee handbook is attached for review.

| Topic | New or revised | Content |
|---|---|---|
| **Background checks** | Revised | Adds wording to comply with California's "Ban the Box" legislation<br>Defines reasons a candidate would not be hired<br>Adds information on required Office of Inspector General (OIG) checks |
| **Job transfers** | Revised | Adds a requirement that an employee must be in their current position for 12 months before being considered for transfer<br>Adds manager notification requirements |
| **Standards of Conduct** | New | Provides examples of conduct that are prohibited |

| Topic | New or revised | Content |
|---|---|---|
| **External EEO Complaints** | New | Provides required information on how an employee would file an external EEO complaint |
| **Pay Adjustments** | Revised | Changes the timing of annual pay adjustments, if granted, to Q1 |
| **Crime Victim Leave** | Revised | Deletes the contents of the section and instead hyperlinks the section to the California Labor Commissioner's page with the details of this leave |
| **School Leave for Disciplinary Matters** | Revised | Deletes the contents of the section and instead hyperlinks the section to the California Legislative Information page with the details of this leave |
| **Bone Marrow and Organ Donation Leave** | New | Hyperlinks the section to the California Legislative Information page with the details of this leave |
| **Employer-Sponsored Social Events** | New | Requires that if an employee chooses to purchase alcohol at an organizational social event, they must arrange for alternative transportation after the event |
| **Off-Duty Use of Employer Property or Premises** | New | Disallows for the off-duty use of organizational property or premises |
| **Accommodations for Pregnant Employees** | New | Provides required information on accommodations that are available through the federal Pregnancy Worker's Fairness Act |
| **Workplace Violence and Security** | Revised | Adds that the organization maintains a Workplace Violence Prevention Program. |
| **Lactation Accommodation** | Revised | Provides information on employee rights to file a complaint with the Labor Commissioner's Bureau of Field Enforcement (BOFE) |
| **Telecommuting** | Revised | Deletes the contents of the sections and instead hyperlinks the section to the internal Remote Work Policy |
| **Confidentiality** | Revised | Adds compliance with California's Labor Code Sections 232(a) and (b) |
| **Parking** | Revised | Removes information about assigned parking places |

## Mandatory Compliance Training

CHPIV remains noncompliant with mandatory compliance training required by DHCS and CHPIV policy P&P CMP-006. Compliance training courses must be completed within ninety (90) days of onboarding and annually thereafter.

**Compliance Training Completion Report**

| | Employees | Commissioners |
|---|---|---|
| **Complete** | 20 | 8 |
| **Pending (Not Due)** | 0 | 2 |
| **Incomplete (Past Due)** | 0 | 1 |
| **Total** | **20** | **11** |

| | Care Management Programs | CM-001 |
|---|---|---|
| | **Department** | Healthcare Services |
| | **Functional Area** | Care Management |
| | **Impacted Delegate** | ☒ Subcontractor ☐ NA |

| **DATES** | | | |
|---|---|---|---|
| **Policy Effective Date** | 10/9/2023 | **Reviewed/Revised Date** | |
| **Next Annual Review Due** | 10/9/2024 | **Regulator Approval** | |

| **APPROVALS** | | | |
|---|---|---|---|
| **Internal** | | **Regulator** | |
| **Name** | Gordon Arakawa | ☐ DHCS ☒ NA<br>☐ DMHC | |
| **Title** | Chief Medical Officer | | |

## ATTACHMENTS

- NA

## AUTHORITIES/REFERENCES

- **Internal**
  - TCS policy "Transitional Care Services CM-002
- **Federal**
  - 42 CFR section 438.3(e)(2)
  - 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).
  - 42 CFR section 438.208.
  - 45 CFR parts 160 and 164 subparts A and E.
  - 42 USC sections 1396d(a), 1396d(r), and1396n(g)(2), and Welfare & Institutions (W&I) Code section 14059.5(b).
- **State**
  - Medi-Cal Managed Care Plans Imperial County Health Authority Exhibit A, Attachment III
- **Accreditation**
  - NCQA 2021 Health Plan Accreditation PHM Standards. PHM 5: Complex Case Management.

## HISTORY

| Revision Date | Description of Revision |
|---|---|
| 10/9/2023 | Policy Creation |
| 02/21/2025 | Annual Review |

## I. OVERVIEW

**A.** This policy addresses Community Health Plan of Imperial Valley's ("CHPIV" or the "Plan") Care Management Program(s) requirements, policy, and procedures.

## II. POLICY

**A.** Care Management Programs:
Utilizing a comprehensive population health managed approach CHPIV will ensure all members have equitable access to necessary, wellness and prevention services including care coordination, COMPLEX CARE MANAGEMENT (CCM), TRANSITIONAL CARE SERVICES (TCS), and ENHANCED CARE MANAGEMENT (ECM). From assessing the needs of Members on a population basis, to identifying and stratifying members' risk on an individual basis, CHPIV will ensure the systems (including data analytic capabilities), processes, and people (including ECM providers in network with direct experience working with specific populations of focus) are compliant and support appropriate POPULATION HEALTH MANAGEMENT (PHM) functions.

1. Delivery Infrastructure:
   a. CHPIV will ensure a PHM delivery infrastructure is maintained to ensure that the needs of its entire member population are met across the continuum of care. The infrastructure provides members with the appropriate level of care management through person-centered interventions based on the intensity of health and social needs and services required. The care management interventions are intended for specific segments of the population that require more intensive engagement than the BASIC PHM. Additionally, CHPIV will ensure members receiving care management have an assigned Care Manager and a CARE MANAGEMENT PLAN (CMP).
2. Screening and Assessments:
   b. Necessary screening and assessments are completed to gain timely information on the health and social needs of all members, in accordance with applicable state and federal laws and regulations, and NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) PHM standards.
   c. ~~CPIV~~ CHPIV will ensure an initial screening or assessment of each member's needs is completed within 90 days of enrollment and that the information is shared with Department of Healthcare Services (DHCS), and other managed care health plans or providers serving the member, to prevent duplication of those activities. CHPIV will ensure at least three attempts are made to contact a member to conduct the initial screening or assessment using available modalities.
   d. ~~CHIPIV~~ CHPIV ensures DHCS guidance is adhered to for member screening and assessment, including guidance for how to use the PHM service for the screening and assessment process.
   e. ~~CHIPIV~~ CHPIV ensures monitoring is completed to determine what percentage of required assessments are completed per the specifications above.

3. BASIC POPULATION HEALTH MANAGEMENT (BPHM)
   a. BPHM is an approach to care that ensures that needed programs and services are made available to each member, regardless of the member's risk tier, at the right time

and in the right setting. (BASIC PHM includes federal requirements for CARE COORDINATION listed in accordance with 42 CFR section 438.208.) CHPIV will ensure at a minimum: policies and procedures are maintained that meet the following BASIC PHM requirements, and at a minimum:

i. Ensure each member has an ongoing source of care that is appropriate, ongoing, and timely to meet the member's needs;
ii. Ensure members have access to needed services including CARE COORDINATION, navigation and referrals to services that address members' developmental, physical, mental health, substance use disorder (SUD), dementia, Long Term Support Services (LTSS) palliative care, and oral health needs;
iii. Ensures that each member is engaged with their assigned Primary Care Physician (PCP) and that the member's assigned PCP plays a key role in the CARE COORDINATION functions.
iv. Ensure each Member receives all needed preventive services in partnership with the member's assigned PCP;
v. Ensures efficient CARE COORDINATION and continuity of care for members who may need or are receiving services and/or programs from Out-of-Network (OON) providers;
vi. Review member utilization reports to identify members not using primary care; stratify such reports, at minimum, by race and ethnicity to identify health disparities that result from differences in utilization of outpatient and preventive services; and develop strategies to address differences in utilization;
vii. Facilitate access to care for members by, at a minimum, helping to make appointments, arranging transportation, ensuring member health education on the importance of primary care for members who have not had any contact with their assigned medical home/PCP or have not been seen within the last 12 months, particularly members less than 21 years of age;
viii. Ensure all services are delivered in a culturally and linguistically competent manner that promotes health equity for all members;
ix. Coordinate health and social services between settings of care, across other Medi-Cal managed care health plans, delivery systems, and programs (e.g., targeted case management, specialty mental health services), with external entities outside of contractor's provider network, and with COMMUNITY SUPPORTS and other community-based resources, even if they are not covered services, to address members' needs and to mitigate impacts of SDOH;
x. Coordinate warm hand-offs to other public benefits programs including, but not limited to, California Work Opportunity and Responsibility to Kids (CalWORKs), CalFresh, Women, Infants and Children (WIC) Supplemental Nutrition Program, Early Intervention Services, Supplemental Security Income (SSI), and all other programs requiring Memorandums of Understanding (MOUs);
xi. Assist members, members' parents, family members, legal guardians, authorized representatives, caregivers, or authorized support persons with navigating health delivery systems, including contractor's subcontractor and

downstream subcontractor networks, to access covered services as well as services not covered.

xii. Provide members with resources to address the progression of disease or disability, and improve behavioral, developmental, physical, and oral health outcomes;

xiii. Communicate to members' parents, family members, legal guardians, authorized representatives, caregivers, or authorized support persons all CARE COORDINATION provided to members, as appropriate;

xiv. Ensure that providers furnishing services to members maintain and share, as appropriate, members' medical records in accordance with professional standards and state and federal law;

xv. Facilitate exchange of necessary member information in accordance with any and all state and federal privacy laws and regulations, specifically pursuant to 45 CFR parts 160 and 164 subparts A and E, to the extent applicable; and maintain processes to ensure no duplication of services occurs.

b. In order to ensure that BASIC PHM is provided to all Members, ~~CHIPIV~~ CHPIV ~~-~~will ensure the following resources are provided to providers at a minimum:

i. A system to electronically track and monitor network provider referrals not requiring prior authorization, including referrals for care management services, and the outcomes of referrals;

ii. Access to a current and continuously updated community resource directory to the network providers; and

iii. A toll-free telephone number for network providers to obtain contractor assistance in arranging referrals.

A. Telephone referral assistance must address referrals for mental health and SUD treatment, developmental services, dementia, palliative care, dental, personal care services, and LONG-TERM SERVICES AND SUPPORT (LTSS); and

B. Communicate the availability of the telephone referral assistance by providing the toll-free number on the home page of the contractor's website and in materials supplied to network providers, including the Provider Manual.

**B.** COMPLEX CARE MANAGEMENT (CCM):

1. CCM equates to "Complex Case Management," as defined by the NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA). CCM is a service for members who need extra support to avoid adverse outcomes but who are not in the highest risk group designated for ECM. These include coordination of services for high and medium/rising risk members through the CCM approach. CCM provides both ongoing chronic CARE COORDINATION and interventions for episodic, temporary needs, with a goal of regaining optimum health or improved functional capability in the right setting and in a cost-effective manner. CCM is an opt-out program – (i.e., members may choose not to participate in CCM if it is offered to them). CHPIV may delegate CCM to providers and other entities who are themselves NCQA-certified. CHPIV will ensure CCM services are provided in line with the requirement of meeting NCQA PHM Standards. CCM is inclusive of BPHM, which CHPIV will ensure is provided to all members. Care managers conducting CCM integrate all elements of BPHM into their CCM approach. ~~CHIPIV~~ CHPIV ensures that at a minimum, the CCM program:

a. is designed and implemented to help members gain or regain optimum health or improved functional capability in the right setting;
b. includes a comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a CARE MANAGEMENT PLAN (CMP) with performance goals, monitoring and follow-up;
c. has an opt-out approach wherein members meeting criteria for CCM have the right to decline to participate;
d. includes a variety of interventions for members that meet the differing needs of high and medium/rising-risk populations, including longer-term chronic CARE COORDINATION and interventions for episodic, temporary needs;
e. and incorporates disease-specific management programs (including, but not limited to, asthma and diabetes) that include self-management support and health education.

2. Eligibility:
   a. CCM is a service intended for higher-and medium-rising-risk members and is deliberately more flexible than ECM. CHPIV will ensure the determination of eligibility criteria (within NCQA guidelines) is based on the risk stratification process outlined and local needs identified in the Population Needs Assessment (PNA).
3. Core Service Components
   a. CHPIV will ensure CCM includes:
      i. Comprehensive Assessment and Care Plan CHPIV will ensure that as in ECM, CCM includes a comprehensive assessment of each member's condition, available benefits, and resources (including COMMUNITY SUPPORTS), as well as development and implementation of a CMP with goals, monitoring, and follow-up.
      ii. CHPIV ensures this assessment is started within 30 days of identifying a member for CCM and completed within 60 days of identification.
   b. Services and Interventions:
      i. CHPIV will ensure that CCM includes a variety of interventions for members who meet the differing needs of high and medium-/rising-risk populations, including:
         A. CARE COORDINATION focused on longer-term chronic conditions.
            1. Interventions for episodic, temporary member needs
            2. Disease-specific management programs (including, but not limited to, asthma and diabetes) that include self-management support and health education.
            3. COMMUNITY SUPPORTS, if available and medically appropriate, and cost effective.
      ii. BPHM is included as part of the care management provided to members. For children and youth under age 21, CHPIV will ensure CCM includes EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) and all medically necessary services, including those that are not necessarily covered for adults, are provided if they are Medicaid-covered services.
4. Care Manager Role:
   a. Assignment of a Care Manager:

i. CHPIV will ensure that a care manager is assigned for every member receiving CCM. Following NCQA's requirements, CHPIV may delegate CCM to providers and other entities who are themselves NCQA-certified. PCPs may be assigned as care managers when they are able to fulfill all CCM requirements.
ii. If multiple providers perform separate aspects of CARE COORDINATION for a member, CHPIV will ensure that:
   A. A lead care manager has been identified.
   B. The identity of the care manager is communicated to all treating providers and the member.
   C. The member's PCP is provided with the identity of a member's assigned care manager (if the PCP is not assigned to this role) and a copy of the member's CARE MANAGEMENT PLAN (CMP).
   D. Policies and procedures are maintained to:
   E. Ensure compliance and non-duplication of medically necessary services
   F. Ensure delegation of responsibilities between the Plan and the member's providers meets all care management requirements.

5. Care Manager Responsibilities:
   a. CCM CARE MANAGERS are required to ensure all BPHM requirements and NCQA CCM standards are met. This includes conducting timely assessments of member needs to identify and close any gaps in care and completing a CMP for all members receiving CCM. CCM CARE MANAGERS must also ensure communication and information sharing on a continuous basis and facilitate access to needed services for members, including community support, and across physical and BEHAVIORAL HEALTH (BH) delivery systems. ~~CHIPIV~~ CHPIV ensures these requirements are met and ensures assistance is provided with navigation and referrals, such as to COMMUNITY HEALTH WORKER (CHW's) or community-based social services. At a minimum ~~CHIP~~ CHPIV ensures the case manager performs the following duties:
      i. Conduct member assessments as needed to identify and close any gaps in care and address the member's physical, mental health, (SUD), developmental, oral health, dementia, palliative care, chronic disease, and LTSS needs as well as needs due to Social Determinants of Health (SDOH);
      ii. Ensure continuous information sharing and communication with the member and their treating providers; and
      iii. Specify the responsibility of each provider that provides services to the Member.
      iv. Complete a CMP for all Members receiving CCM, consistent with the member's goals in consultation with the member.
         A. The CMP must:
            1. Address a member's health and social needs, including needs due to SDOH;
            2. Be reviewed and updated at least annually, upon a change in member's condition or level of care, or upon request of the member;
            3. Be in an electronic format and a part of the member's medical record, and document all of the member's services and treating providers;
            4. Be developed using a person-centered planning process that includes identifying, educating, and training the member's parents,

family members, legal guardians, authorized representatives, caregivers, or authorized support persons, as needed; and

5. Include referrals to community-based social services and other resources even if they are not covered services.

v. Ensure members receive all medically necessary services, including COMMUNITY SUPPORTS, to close any gaps in care and address the member's mental health, SUD, developmental, physical, oral health, dementia, palliative care needs as well as needs due to SDOH;

vi. Support and assist the member in accessing all needed services and resources, including across the physical and BEHAVIORAL HEALTH delivery systems;

vii. Communicate to members' parents, family members, legal guardians, authorized representatives, caregivers, or authorized support persons all CARE COORDINATION provided to members, as appropriate;

viii. Provide closed loop referrals to CHW's, peer counselors, and other community-based social services including, but not limited to, personal care services, LTSS, COMMUNITY SUPPORTS and local community organizations;

ix. Assess the member's understanding of the referral instructions and follow-up to determine whether the referral instructions were completed or whether the member needs further assistance to access the services, and if so, provide such assistance;

x. Complete a review and/or modification of the member's CMP, when applicable, to address unmet service needs;

xi. Facilitate and encourage the member's adherence to recommended interventions and treatment; and

xii. Ensure timely authorization of services to meet the member's needs in accordance with the member's CMP.

**C.** ENHANCED CARE MANAGEMENT (ECM):

1. ECM is community-based, interdisciplinary, high touch, person-centered, and provided primarily through in-person interactions. CHPIV will ensure the Plan is contracted with "ECM providers," existing community providers such as Federally Qualified Health Centers (FQHC's), counties, county BH providers, local health jurisdictions, Community Based Organizations (CBOs), and others, who will assign a lead care manager to each member. The lead care manager meets members wherever they are i.e., 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. ECM is inclusive of BPHM, which CHPIV will ensure is provided to all members. Care managers conducting ECM integrate all elements of BPHM into their ECM approach.
2. For children and youth under age 21, CHPIV will ensure that CCM includes EPSDT; all medically necessary services, including those that are not necessarily covered for adults, are provided as long as they are Medicaid-covered services.
3. Reporting requirements:
   a. DHCS monitors outcomes for the group served by ECM and evaluates whether and how the existing populations of focus definitions and policies may be improved over time to ensure that the ECM benefit continues to serve those with the highest needs. CHPIV will ensure the DHCS instituted Plan quarterly reporting requirements to monitor the implementation of ECM are completed as required.

4. ECM and CCM overlap policy and delegation:
    a. CHPIV will ensure that an individual is not enrolled in ECM and CCM at the same time; rather, CCM is on a care management continuum with ECM. CCM can be used to support members who were previously served by ECM, are ready to step down, and who would benefit from CCM; but not all members in CCM previously received ECM, and not all members who step down from ECM require CCM. CHPIV encourages providers to contract for a care management continuum of ECM and CCM programs, wherever possible, including as a way to maximize opportunities for members to step down from ECM to CCM or BPHM under the care of a single provider.

**D.** Other Population Health Requirements for Children:

1. For Members who are less than 21 years of age, CHPIV will ensure that as part of care management and BASIC PHM the following services for children are provided:
    a. EPSDT Case Management Responsibilities:
        i. Provide case management to assist Members less than 21 years of age in gaining access to all medical necessary medical, BH, dental, social, educational, and other services, as defined in 42 USC sections 1396d(a), 1396d(r), and1396n(g)(2), and Welfare & Institutions (W&I) Code section 14059.5(b). Case management services for Members less than 21 years of age also includes the data exchange necessary for the provision of services as well as the coordination of non-covered services such as social support services. Additionally, CHPIV will ensure EPSDT case management services are provided and that all medically necessary services for Members less than 21 years of age are initiated within timely access standards whether or not the services are covered services.
2. Children with Special Health Care Needs (CSHCN):
    a. CHPIV will ensure the development and implementation of policies and procedures to provide services for CSHCN. CHPIV will ensure that the policies and procedures include the following information, at a minimum, to encourage CSHCN Member participation:
        i. Methods for ensuring and monitoring timely access to pediatric specialists, sub-specialists, ancillary therapists, transportation, and DME and supplies. These may include assignment to a specialist as PCP, standing referrals, or other methods; and
        ii. Methods for monitoring and improving the quality, Health Equity, and appropriateness of care for CSHCN.
        iii. Methods for ensuring CARE COORDINATION with California Department of Developmental Services (DDS) and local CCS Programs, as appropriate.
3. Early Intervention Services:
    a. CHPIV will ensure the development and implementation of systems to identify Members who may be eligible to receive services from the Early Start program and that they are referred to the local Early Start program. These Members include those with a condition known to lead to developmental delay, those in whom a developmental delay is suspected, or whose early health history places them at risk for delay. CHPIV will ensure collaboration occurs with the local Regional Center or local Early Start program in determining the medically necessary diagnostic and preventive services and treatment plans for Members. CHPIV will ensure case

management and CARE COORDINATION to the Member are provided to ensure the provision of all medically necessary covered services identified in the Individualized Family Service Plan (IFSP) developed by the Early Start program, with PCP participation.

**E.** Wellness and Prevention Programs:

1. CHPIV will ensure comprehensive wellness and prevention programs are provided to all Members and in accordance with DHCS guidance.
2. CHPIV will ensure wellness and prevention programs are provided that meet NCQA PHM standards, including for the provision of evidence-based self-management tools;
3. CHPIV will ensure that the wellness and prevention programs align with the DHCS Comprehensive Quality Strategy;
4. CHPIV will ensure wellness and prevention programs are provided in a manner specified by DHCS, and in collaboration with Local Governmental Agencies as appropriate, that include the following, at a minimum:
   a. Identification of specific, proactive wellness initiatives and programs that address Member needs as identified in the PNA;
   b. Evidence-based disease management programs including, but not limited to, programs for diabetes, asthma, and obesity that incorporate health education interventions, target members for engagement, and seek to close care gaps for Members participating in these programs;
   c. Initiatives, programs, and evidence-based approaches to improving access to preventative health visits, developmental screenings, and services for Members less than 21 years of age;
   d. Initiatives, programs, and evidence-based approaches on improving pregnancy outcomes for women, including through 12 months post-partum;
   e. Initiatives, programs, and evidence-based approaches on ensuring adults have access to preventive care, as described and in compliance with all applicable state and federal laws;
   f. Process for monitoring the provision of wellness and preventive services by PCPs as part of Contractor's Site Review process;
   g. Health education materials, in a manner that meets Members' health education and cultural and linguistic needs, and
   h. Initiatives and programs that implement evidence-based best practices that are aimed at helping Members set and achieve wellness goals.
5. CHPIV will ensure that its wellness and prevention programs are submitted to DHCS for review and approval in a form and method prescribed by DHCS.

**F.** TRANSITIONAL CARE SERVICES (TCS)

1. Care transitions are defined as a member transferring from one setting or level of care to another, including, but not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home-or community-based settings, COMMUNITY SUPPORTS, post-acute care facilities, or long-term care (LTC) settings. CHPIV will ensure that TCS are provided to all members regardless of health risk. (See additional details regarding the TCS program in TCS policy "Transitional Care Services CM-002").

## III. PROCEDURE

**A.** Delegation:

1. CHPIV delegates the Care Management process to its Subcontractor, Health Net.
2. Delegation Oversight
   a. CHPIV shall provide oversight and continually assess the delegated functions, responsibilities, processes, and performance of Health Net. CHPIV will ensure 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 |
|---|---|
| **Basic Population Health Management (Basic PHM)** | An approach to care that ensures that needed programs and services are made available to each Member, regardless of the Member's Risk Tier, at the right time and in the right setting. Basic PHM includes federal requirements for Care Coordination. |
| **Behavioral Health** | A mental health condition and/or Substance Use Disorder (SUD) condition. |
| **Care Coordination** | Coordination of services for a member between settings of care that includes appropriate discharge planning for short term and long-term hospital and institutional stays, and appropriate follow up after an emergency room visit; coordinating services the member receives from any other managed care health plan; services the member receives in Fee-For-Service (FFS); services the member receives from OON providers; and services the member receives from community and social support providers. |
| **Care Management Plan (CMP)** | A written plan that is developed with input from the Member and/or their family member(s), parent, legal guardian, authorized representative, caregiver, and/or other authorized support person(s) as appropriate to assess strengths, risks, needs, goals, and preferences, and make recommendations for clinical and non-clinical service needs. |
| **CCM Care Manager** | An individual identified as a single point-of-contact responsible for the provision of CCM services for a member. |
| **Community Health Worker (CHW)** | A skilled and trained individual who is able to render clinically appropriate Medi-Cal covered benefits and services and is an enrolled Medi-Cal provider. |
| **Community Supports** | Substitute services or settings to those required under the California Medicaid State Plan that Contractor may select and offer to their Members pursuant to 42 CFR section 438.3(e)(2) when the substitute |

| | |
|---|---|
| | service or setting is medically appropriate and more cost-effective than the service or setting listed in the California Medicaid State Plan. |
| **Complex Care Management (CCM)** | CCM equates to "Complex Case Management," as defined by NCQA. CCM is a service for MCP members who need extra support to avoid adverse outcomes but who are not in the highest risk group designated for ECM. CCM provides both ongoing chronic care coordination and interventions for episodic, temporary needs, with a goal of regaining optimum health or improved functional capability in the right setting and in a cost-effective manner. CCM is an opt-out program – (i.e., members may choose not to participate in CCM if it is offered to them) |
| **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. |
| **Long-Term Services & Supports (LTSS)** | Services and supports designed to allow a member with functional limitations and/or chronic illnesses the ability to live or work in the setting of the Member's choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting. LTSS includes both LTC and HCBS and includes carved-in and carved-out services. |
| **National Committee for Quality Assurance** | An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs. |
| **Population Health Management (PHM)** | An approach to care that ensures that needed programs and services are made available to each Member, regardless of the Member's Risk Tier, at the right time and in the right setting |
| **Transitional Care Services** | Service provided to all Members transferring from one institutional care setting, or level of care, to another institution or lower level of care, including home settings. |

| | Delegation Oversight | CMP-002 |
|---|---|---|
| **Department** | Compliance | |
| **Functional Area** | Compliance | |
| **Impacted Delegate** | ☒ Subcontractor ☐ NA | |

| DATES | | | |
|---|---|---|---|
| **Policy Effective Date** | 6/12/2023 | **Reviewed/Revised Date** | 10/1/2024 |
| **Next Annual Review Due** | 10/2/2025 | **Regulator Approval** | 7/19/2024 |

| APPROVALS | | |
|---|---|---|
| **Internal** | | **Regulator** |
| **Name** | Elysse Tarabola | ☒ DHCS ☐ NA<br>☒ DMHC |
| **Title** | Chief Compliance Officer | |

## ATTACHMENTS

NA

## AUTHORITIES/REFERENCES

- CMP-003 Corrective Action Plans
- CHPIV Compliance Program and Plan
- CHPIV Delegation Oversight Program
- CHPIV Contract with Department of Healthcare Services (DHCS)
- Delegation Agreements
- Department of Health Care Services All-Plan Letter (APL) 17-004: Subcontractual Relationships and Delegation & All-Plan Letter (APL) 23-006: Delegation and Subcontractor Network Certification
- Title 42, Code of Federal Regulations (C.F.R.), §438.230

## HISTORY

| Revision Date | Description of Revision |
|---|---|
| 6/12/2023 | Policy creation |
| 10/1/2024 | Annual review |
| | |
| | |

## I. OVERVIEW

**A.** This policy is set to establish standardized procedures for contracted DELEGATES and/or SUBCONTRACTORS' performance of assigned responsibilities in accordance with federal or state statutes, regulations, contractual obligations, Community Health Plan of Imperial Valley (CHPIV) policies and procedures, and nationally recognized accreditation standards.

This policy defines the process for OVERSIGHT of a DELEGATED ENTITY to ensure compliance with statutory, regulatory, and contractual requirements, and Health Plan policies and procedures to ensure continuous improvement of MEMBER care, all applicable Medicaid laws and regulations, including all sub regulatory guidance and contract provisions, as well as the applicable state and federal laws, management, and administrative processes. DELEGATED ENTITIES will be assessed annually on their ability to meet CHPIV, California Department of Health Care Services, and (DHCS) Department of Managed Health Care (DMHC) requirements.

## II. POLICY

**A.** CHPIV shall provide OVERSIGHT of the functions and responsibilities, processes, and performance of a DELEGATED ENTITY and its DELEGATED SERVICES, including, PRE-DELEGATION EVALUATION as applicable, no less than annual review of DELEGATION AGREEMENT/grid, MONITORING of PERFORMANCE DATA, and OVERSIGHT AUDITING of delegated functions.

**B.** CHPIV OVERSIGHT activities include review of compliance with regulatory requirements, contractual requirements and CHPIV policies and procedures. CHPIV's Compliance department identifies whether a DELEGATED ENTITY's performance is adequate or inadequate and collaborates with the functional (Health Services, Finance, Operations, etc.) business owners to monitor a DELEGATED ENTITY's performance to ensure that improvement occurs where performance is inadequate.

**C.** CHPIV shall continually assess a DELEGATED ENTITY's ability to perform delegated functions through initial reviews, ongoing MONITORING, performance reviews, analysis of data, and utilization of benchmarks, if available. The DELEGATED ENTITY shall provide requested information in accordance with the timeframes for record keeping and as required.

**D.** At a minimum, audits of DELEGATED ENTITIES will be conducted annually by desktop review and by on-site review and/or webinar. CHPIV shall ensure audits are conducted at reasonable times at the DELEGATED ENTITY's place of business or another mutually agreeable location.

**E.** Successful completion of a READINESS ASSESSMENT and resolution of any corrective actions will be required prior to delegating any function to a DELEGATED ENTITY, except as provided in this Policy. This includes Delegation to a new DELEGATED ENTITY, Delegation of a new function to an existing DELEGATED ENTITY, or a DELEGATED ENTITY that changes its MANAGEMENT SERVICES ORGANIZATION (MSO).

**F.** If CHPIV or any authorized representative including, but not limited to, the State or Federal government, Department of Health Care Services (DHCS), Centers for Medicare & Medicaid

Services (CMS), or the Department of Health and Human Services (DHHS) Inspector General, determines there is a reasonable possibility of FRAUD or similar risk, the aforementioned agencies may inspect, evaluate, and audit the DELEGATED ENTITY at any time.

**G.** CHPIV shall revoke the delegation of activities or obligations or specify other remedies in instances where DHCS or CHPIV determine that the DELEGATED ENTITY has not performed satisfactorily.

**H.** CHPIV shall inform the DELEGATED ENTITY of prospective requirements to be met before the effective agreement date. The DELEGATED ENTITY shall comply with the new requirements within thirty (30) days of the effective date, unless otherwise instructed by CHPIV.

**I.** The DELEGATED ENTITIES shall maintain contracts, books, documents, records, encounter data and financial statements for a minimum of ten (10) years from the final date of the contract period or from completion of any audit or investigation, whichever is later and shall be available for inspection, evaluation, MONITORING, and AUDITING to:

1. CHPIV or its DESIGNEE;
2. Any authorized representative of the state or federal government, including the DHCS, CMS, the U.S. Health and Human Services Office of Inspector General, the Comptroller General, the U.S. Department of Justice, and the Department of Managed Health Care (DMHC); and
3. Any quality improvement organization, accrediting organization (e.g., NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA)), their DESIGNEES, and other representatives of regulatory or accrediting organizations.

**J.** Upon request, CHPIV or its designated representatives shall have the right to inspect, review, and make copies of such records, at the DELEGATED ENTITY's expense, to facilitate CHPIV's obligation to conduct OVERSIGHT activities.

**K.** CHPIV retains the right to publish data obtained from audits and performance reviews and may distribute such data to MEMBERS or the general public without further notice to, or consent from, a DELEGATED ENTITY.

**L.** CHPIV's Compliance Department shall maintain documentation of DELEGATED ENTITY OVERSIGHT activities described herein.

**M.** Notwithstanding the processes described in this Policy, CHPIV's Delegation of activities and responsibilities to DELEGATED ENTITY is subject to CHPIV Commission's approval of the underlying business relationship/contract.

**N.** DHCS Data Reporting: CHPIV shall monitor the quality and compliance (complete, accurate, reasonable, and timely) of SUBCONTRACTOR data submitted to DHCS and/or other entities, pursuant to reporting responsibilities under state and federal laws. This includes, but is not limited to:

1. Encounter data;
2. Monthly 274 Provider Network data files;
3. Data reported through quarterly templates;
4. Electronic visit verification reporting; and

**O.** Any other ad hoc data requests required by DHCS.CHPIV will maintain and communicate with the DELEGATED ENTITY their policies and procedures for monitoring the DELEGATED ENTITY'S compliance with all requirements related to all delegated activities, obligations, and related reporting responsibilities in accordance with DHCS APL 23-006, page 3: Monitoring Subcontractors, A. Delegation Accountability.

## III. PROCEDURES

**A.** CHPIV delegates activities to its DELEGATED ENTITIES through the Plan-to-Plan contract which incorporates DHCS and CMS contract requirements, regulations, and guidance.

**B.** CHPIV shall provide OVERSIGHT of all DELEGATED ENTITIES, including proposed DELEGATED ENTITIES. Such OVERSIGHT shall be conducted using, without limitation, the following actions:

1. Engagement Letter;
2. READINESS ASSESSMENT (desktop and on-site reviews);
3. Annual audit (desktop and on-site reviews);
4. Focused and ad hoc reviews, audits and MONITORING;
5. Periodic reviews and audits; and
6. On-going MONITORING.

**C.** The areas of OVERSIGHT focus include, without limitation, the following:

| Oversight Activities | Responsible Department |
|---|---|
| Quality Management and Quality Improvement (e.g., program, work plan, committee composition); | Health Services Compliance |
| Credentialing, recredentialing and facility site review; | Health Services Compliance |
| Staff and provider training and communication; | Finance/Operations Compliance |
| Care management, continuity of care and care transitions; | Health Services Compliance |
| Financial solvency and minimum insurance requirements; | Finance Compliance |
| Utilization Management (e.g., program structure, workplan, committee composition, criteria, consistent application of criteria, adherence to established criteria of medical necessity, MEMBER and provider notification, rates of admissions and readmissions, emergency room visits, under and over utilization, second opinions, expedited and standard review process, MEMBER Appeals & Grievances, daily census for planned and unplanned admissions, screening MEMBERS admitted for potential transition of care issues, discharge planning, retrospective review, out-of-network process, urgent care services, timeliness, clinical decisions, denial notices, emergency services, and structure); | Health Services Compliance |

| Oversight Activities | Responsible Department |
|---|---|
| Claims processing/adjudication and timely payment; | Finance/Operations<br>Compliance |
| Encounters; | Finance/Operations<br>Compliance |
| Information systems management; | Finance/Operations<br>Compliance |
| Cultural and linguistic services/language assistance; | Health Services<br>Compliance |
| Compliance Program; | Compliance |
| Care Delivery Model (e.g., Model of Care and Practice Guidelines); | Health Services<br>Compliance |
| Provider disputes and claim appeals; | Finance/Operations<br>Compliance |
| MEMBER rights; | Health Services<br>Compliance |
| MEMBER service; | Health Services<br>Compliance |
| Network management, including provider relations and provider network contracting; | Finance/Operations<br>Compliance |
| Access and availability, including Americans with Disabilities Act (ADA); | Finance/Operations<br>Compliance |
| Systems; | Finance/Operations<br>Compliance |
| Ownership and control disclosures;<br><br>1. CHPIV shall notify the DHCS contract manager within ten (10) working days upon discovery of a violation of compliance with the requirements, and/or if a disclosure reveals any potential violation(s) of the ownership and control requirements in accordance with APL 23-006.<br><br>2. To identify potential conflicts of interest, CHPIV will collect and review their DELEGATED ENTITIES ownership and control disclosures.<br><br>3. CHPIV will require and ensure DELEGATED ENTITIES accurately provide all required information in their disclosures such as:<br>a. Date of Birth<br>b. Social security number for each person with ownership or control interest<br>c. Social security number for each managing employee | Compliance |

| Oversight Activities | Responsible Department |
|---|---|
| | |
| Policies and procedures:<br><br>DELEGATED ENTITIES shall facilitate and document an annual review of all policies and procedures to ensure compliance with regulatory, statutory, and contractual requirements.<br><br>DELEGATED ENTITIES shall review and obtain approval from all applicable executive management staff and from a regulatory agency, as appropriate.<br><br>DELEGATED ENTITIES shall distribute policy and procedure updates to their employees, providers, and contractors, and ensure updated policies are posted in an accessible location for reference; | Compliance |
| Reporting and MONITORING; | Compliance |
| Sub-Delegation; | Compliance |
| Sub-Contractual, which is the area of focus that identifies the DELEGATED ENTITIES of First Tier Entity and the policies and procedures used by the First Tier Entity to perform Delegation Oversight; | Compliance |
| Marketing; | Compliance |
| Provider network contracting; | Finance/Operations<br>Compliance |
| Provider relations; | Finance/Operations<br>Compliance |
| Translation Services; | Health Services<br>Compliance |
| Insurance; | Finance/Operations<br>Compliance |
| Medi-Cal addendum, which is the area of focus for Medi-Cal related changes relating to All Plan Letters that affect the First Tier Entities; | Compliance |
| MEMBER connections, which is an NCQA area of focus; and | Health Services<br>Compliance |
| Regulatory initiatives, including but may not be limited to, Whole Child Model, California Advancing and Innovating Medi-Cal (CalAIM). | Health Services<br>Compliance |

**D.** Annual Audit Process

1. At least annually, the Compliance Department shall schedule an audit with the DELEGATED ENTITY. OVERSIGHT audits are required annually and shall be conducted as desktop and on-site Audits. The Compliance Department or the COMPLIANCE &

POLICY COMMITTEE (CPC) may determine to conduct more frequent audits and/or targeted audits.

2. Using an audit tool developed, the Audit will evaluate, at a minimum, the DELEGATED ENTITY's performance of delegated activities and responsibilities, as evidenced by the DELEGATION AGREEMENT, and compliance with applicable legal requirements, and CHPIV policies and procedures.
3. The audit will include validation based on documentation (e.g., policies & procedures, training, reports, systems) and file review(s) based on percentages for elements assessed and passed.
4. If the DELEGATED ENTITY receives a score of less than one hundred percent (100%) on any Audit element of the Delegation standards, the DELEGATED ENTITY shall be required to develop a CORRECTIVE ACTION PLAN (CAP).
    a. The auditor shall have ultimate responsibility for the CAP remediation and for MONITORING and reporting the CAP to the CPC. The auditor shall report the findings of the audit, the CAPs, if any, and the timeline for CAP remediation to the CPC.
5. Annual audit findings will be presented to the CPC, and the CPC shall determine the following based upon the Compliance Department's recommendations:
    a. Continued Delegation without interruption if one hundred percent (100%) of the annual Audit elements are met;
    b. Continued Delegation without interruption under a CAP in accordance with CHPIV P&P CMP-003 CORRECTIVE ACTION PLANS, if scores are less than one hundred percent (100%); or
    c. Any SANCTION that shall be imposed, such as suspension, revocation or termination, suspension of enrollment or other action if less than eighty percent (80%) of the annual Audit elements are met.
6. CHPIV shall provide a DELEGATED ENTITY with a written report within thirty (30) calendar days after completing a review.
7. CHPIV may impose progressive disciplinary actions on DELEGATED ENTITY with consistent performance issues or findings regarding significant complaints. The Compliance Department shall refer all incidents to the CPC for further action.
8. The CPC may recommend de-Delegation to the Regulatory Oversight Committee of the Commission (RCOC).
9. If the RCOC agrees and recommends de-Delegation, the CONTRACT OWNER will be notified by the Compliance Department.
10. If, at any time during the term of the DELEGATION AGREEMENT, a non-compliance of Delegation issue arises, it should be referred immediately to the Compliance Department, who will alert the CPC. The CPC shall determine whether ad hoc Audits, reviews, and/or other remediation are necessary to resolve any identified issues. Issues escalated will be reviewed by the Compliance Department, CPC, and RCOC, as applicable.

11. CHPIV will require DELEGATED ENTITIES to submit complete, accurate, and timely Network Provider encounter data to the CHPIV for all items and services furnished to Members either directly or through Downstream Subcontractors or other arrangements with Providers.
12. CHPIV will report any significant instances to DHCS (i.e., in terms of gravity, scope and/or frequency) of noncompliance, imposition of corrective actions, or financial sanctions pertaining to their obligations under the contract with DHCS to their MCOD Contract Managers within three (3) Working Days of the discovery or imposition.

**E.** MONITORING

1. The Compliance Department and functional business owners are responsible for conducting ongoing MONITORING of DELEGATES' performance.
2. Ongoing MONITORING shall be conducted in accordance with CHPIV's Delegation Oversight Monitoring Program and include a review of quantitative and qualitative Key Performance Indicators.
3. The Compliance Department shall collect data from DELEGATED ENTITIES on a monthly or quarterly basis to:
    a. Evaluate performance for quantitative metrics through data analysis and calculations and
    b. Select samples for qualitative case file reviews.
4. Data submitted by the DELEGATED ENTITY is subject to a data validation review to ensure data completeness and accuracy.
5. CHPIV shall monitor a DELEGATED ENTITY through reports, communication materials, and continuous improvement activities submitted by the delegates on a periodic basis.
5. The Compliance Department's Delegation Oversight team will present monitoring results on a quarterly basis via the Delegation Oversight Meeting (DOM) with delegated entities' internal stakeholders. These results will be followed up with official documentation sent via email to all internal stakeholders at the delegated entities.
6. 
6. ~~The CPC shall monitor the dashboards and may make recommendations for Corrective Action should metrics fall below the threshold.~~
7. If there is a consistent pattern of noncompliance by the DELEGATED ENTITY, the Compliance Department will conduct a focused review or request Corrective Action.
8. If the results of the focused review are unfavorable, the Compliance Department will escalate to the CPC and/or RCOC for further action.

**F.** CORRECTIVE ACTION PLANS

1. If any area of deficiency or non-compliance is identified through any internal or external sources, including but not limited to, MEMBER or provider complaints, READINESS ASSESSMENT Reviews, regulatory audits, regular reports, OVERSIGHT reviews, and ongoing MONITORING, the Compliance Department may require a DELEGATED ENTITY to respond to and submit a CAP.

2. A DELEGATED ENTITY shall comply with CAP requirements as set forth in CHPIV P&P CMP-003 CORRECTIVE ACTION PLANS.
3. The elements of the CAP must be resolved in accordance with CHPIV P&P CMP-003: CORRECTIVE ACTION PLANS.
    a. In the event the elements of the CAP are not successfully completed within ninety (90) calendar days, the Compliance department shall report to the CPC following the CAP period. CPC will review the outstanding CAP items to determine, at its discretion, whether the CAP deadline should be extended or whether the DELEGATED SERVICES should be revoked or terminated.
        i. The Compliance Department must demonstrate to the reasonable satisfaction of the CPC the reason for such an extension and provide a detailed, step action plan to ensure that the items for correction are being addressed in a timely manner.
4. CHPIV may impose progressive disciplinary actions on DELEGATED ENTITY with consistent performance issues or findings regarding significant compliance issues.

**G.** Sub-Delegation Oversight Process

1. To ensure the Compliance Department has OVERSIGHT of all sub-delegate arrangements and sub-delegate(s) are compliant with regulatory requirements, the Compliance Department shall monitor sub-Delegation through the READINESS ASSESSMENT and annual Audit of the DELEGATED ENTITIES. The sub-Delegation attestation will be reviewed and signed during the DELEGATED ENTITY READINESS ASSESSMENT and annual Audit and more frequently, if required by CHPIV.
2. Each DELEGATED ENTITY shall attest if they use sub-delegates to perform DELEGATED SERVICES.
3. DELEGATED ENTITIES that sub-delegate DELEGATED SERVICES shall provide a list of all sub-delegates and their functions.
4. DELEGATED ENTITIES that have sub-delegates must provide evidence of a Business Associates agreement holding the sub-delegate to all contractual obligations as outlined in the Business Associates agreement between the DELEGATED ENTITY and CHPIV.
5. DELEGATED ENTITIES that have sub-delegates shall have contract provisions with the sub- delegate that require that sub-delegate to make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, and DOJ, or their DESIGNEES.
6. DELEGATED ENTITIES that have sub-delegates shall retain all records and documents for a minimum of ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

**H.** Revocation of Delegation

1. Delegation may be revoked in instances where CHPIV or a regulatory agency determines that the DELEGATED ENTITY has not performed satisfactorily, including

failing to implement a CAP or quality improvement plan and or upon determination of FRAUD.

2. CHPIV may also terminate the DELEGATION AGREEMENT at any time for cause related to findings of significant deficiencies including a full investigation of FRAUD. DHCS reserves the right to suspend or terminate the DELEGATED ENTITY from participation in the Medi-Cal program, seek recovery of payments made to the DELEGATED ENTITY, impose other SANCTIONS provided under the State Plan, and direct CHPIV to terminate their DELEGATION AGREEMENT with the DELEGATED ENTITY due to FRAUD.
3. The CPC may recommend complete or partial de- Delegation of activities to a DELEGATED ENTITY to the RCOC.
4. Upon revocation or termination of Delegation, performed DELEGATED SERVICES shall be conducted by CHPIV or will be delegated to another party.
5. If the RCOC approves de-Delegation of activities from the DELEGATED ENTITY, CHPIV shall:
    a. Provide the DELEGATED ENTITY with a thirty (30) calendar day written notice of CHPIV's intent to de-delegate;
    b. Inform MEMBERS and providers of the de-Delegation, and provide instructions for continued services;
    c. Adjust the DELEGATED ENTITY's payments as appropriate to the DELEGATED ENTITY activity; and
    d. Prepare appropriate CHPIV departments to provide the de-delegated activities.
6. A DELEGATED ENTITY shall cooperate with CHPIV to ensure smooth transition and continuous care for MEMBERS during the de-Delegation transition period.
7. In the event CHPIV determines, in its sole discretion, that the circumstances warrant re-evaluation of a DELEGATED ENTITY's ability to perform delegated activities that were previously de-delegated, CHPIV shall conduct such re-evaluation no earlier than twelve (12) months after the effective date of the de-Delegation.
    a. CHPIV shall utilize the READINESS ASSESSMENT process.
    b. CHPIV shall delegate activities to the DELEGATED ENTITY based on the READINESS ASSESSMENT results.
    c. If the CPC approves Delegation of activities to the DELEGATED ENTITY, CHPIV shall re- delegate such activities, and adjust the DELEGATED ENTITY's payment accordingly.
    d. If the CPC denies re-Delegation of activities to the DELEGATED ENTITY, it may recommend additional SANCTIONS on the DELEGATED ENTITY, up to and including termination of the CHPIV Service Agreement.

## IV. DEFINITIONS

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

| TERM | DEFINITION |
|---|---|
| **Auditing** | A Systematic evaluation of performance to ensure consistency with ethical standards, federal or state statute, regulations, policies, contractual obligations and National Committee for Quality Assurance (NCQA) requirements.<br>1. External Audit – Evaluation of CHPIV as conducted by an external regulatory or accreditation body;<br>2. Internal Audit – Evaluation of CHPIV operational areas, department, or systems as conducted by Regulatory Affairs and Compliance (RAC); or<br>3. Oversight Audit – Evaluation of delegate/SUBCONTRACTOR as conducted by CHPIV, at least annually. |
| **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. |
| **Contract Owner** | The one individual within CHPIV with ultimate responsibility for the relationship between CHPIV and the Delegated Entity. Contract Owner responsibilities include, but are not limited to, initial contact, procurement, negotiation of contract terms, compliance remediation, on- going entity relations, site closings, hours of operations, etc. The Contract Owner is the individual with responsibility for ensuring that the documentation regarding the relationship between CHPIV and the Delegated Entity is complete and accurate. |
| **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. |
| **Delegated Entity (Delegate)** | A contracted entity which CHPIV authorizes to perform certain functions on its behalf. Although, CHPIV can delegate the authority to perform a function, it cannot delegate the responsibility for ensuring that the function is performed according to CHPIV and National Committee on Quality Assurance (NCQA) standards. |
| **Delegated Services** | Services delegated to a Delegated Entity through a Delegation Agreement, which may include, but are not limited to, administration and management services, marketing, utilization management, quality assurance, case management, claims processing, claims payment, credentialing, network management, provider claim appeals, Member service, enrollment, disenrollment, billing, sales and adjudicating |

| TERM | DEFINITION |
|---|---|
| | organization determinations and appeals. |
| **Delegation Agreement** | Mutually agreed upon document, signed by both parties, which includes, without limit:<br>1. CHPIV responsibilities;<br>2. Duration of the agreement;<br>3. Termination of the agreement;<br>4. Delegated Entity responsibilities and Delegated Services;<br>5. Types and frequency of reporting to the Delegated Entity;<br>6. Process by which the CHPIV evaluates the Delegated Entity's performance (Performance Measurements);<br>7. Use of confidential CHPIV information including Member Protected Health Information (PHI) by the Delegated Entity; and<br>8. Remedies available to the CHPIV if the Delegated Entity does not fulfill its obligations. |
| **Delegation Oversight Meeting** | A quarterly meeting where the Compliance Department's Delegation Oversight team reviews and discusses performance monitoring results with internal stakeholders from delegated entities. The purpose of this meeting is to ensure that all parties are informed about the performance metrics and any necessary actions or improvements. |
| **Designee** | A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role. |
| **Fraud** | As defined in Title 42 Code of Federal Regulations (section 455.2) fraud is, "An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law." Fraud also includes potential violations or activities prohibited by applicable federal or state laws including, without limitation, the Federal False Claims Act, 31 U.S.C. Sections 3729-3731 and the California False Claims Act, California Government Code, Sections 12650 – 12656. |
| **Full scope audit** | A systematic review of data, documentation, and records for all functions which the entity is delegated to perform. |
| **Limited scope audit** | A focused review of data, documentation, and records for a selected portion of functions which the entity is delegated to perform. |
| **Management Services Organization (MSO)** | For purposes of this policy, an entity that provides management and administrative support services on behalf of a Delegated Entity. |

| TERM | DEFINITION |
|---|---|
| **Member** | A beneficiary enrolled in a CHPIV program. |
| **Monitoring** | The mechanism for ongoing collection and review of performance data against benchmarks derived from statues, regulations, policy, contractual obligations, and/or NCQA standards. |
| **National Committee for Quality Assurance (NCQA)** | An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs. |
| **Oversight** | Continual performance evaluation through auditing and monitoring consistent with CHPIV policy and contractual obligations. |
| **Performance data** | Data, documentation, or information in the demonstration of compliance with agreed upon performance standards and delegated responsibility. This may include, but is not limited to:<br>1. Regular reports (utilization, timeliness, complaints/grievances, network certification, etc.);<br>2. Regulatory or accreditation deliverables;<br>3. Program descriptions and/or evaluations; or<br>4. Policies and procedures and/or template documents |
| **Pre-delegation evaluation** | The review of an external entity's policy, procedures, program descriptions, and other materials as necessary, to determine the entity's capacity to perform functions on behalf of CHPIV, prior to delegating responsibilities. |
| **Readiness Assessment** | An assessment conducted by a review team prior to the effective date of a Delegated Entity's or other contracted entity's contract with CHPIV of the Delegated Entity's or contracted entity's compliance with all or a specified number of operational functional areas as determined by CHPIV. |
| **Sanction** | An action taken by CHPIV, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CHPIV Programs. |
| **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. |

| | Compliance Training | CMP-006 |
|---|---|---|
| | **Department** | Compliance |
| | **Functional Area** | Compliance |
| | **Impacted Delegate** | ☒ Subcontractor ☐ NA |

| DATES | | | |
|---|---|---|---|
| **Policy Effective Date** | 10/9/2023 | **Reviewed/Revised Date** | |
| **Next Annual Review Due** | 10/9/2024 | **Regulator Approval** | 8/25/2023 |

| APPROVALS | | | |
|---|---|---|---|
| **Internal** | | **Regulator** | |
| **Name** | Elysse Tarabola | ☒ DHCS ☐ NA<br>☐ DMHC | |
| **Title** | Chief Compliance Officer | | |

## ATTACHMENTS

NA

## AUTHORITIES/REFERENCES

- **State**
  - 2024 DHCS Contract Exhibit A Attachment III Section 1.3.1(G)
  - 2024 DHCS Contract Exhibit A Attachment III Section 1.3.1(H)(1)
  - CMP-002 Delegation Oversight

## HISTORY

| Revision Date | Description of Revision |
|---|---|
| 10/9/2023 | Policy creation |
| | Annual Review |
| | |
| | |

## I. OVERVIEW

**A.** This policy describes the Community Health Plan of Imperial Valley's (CHPIV) Compliance Training Program requirements for its CHPIV Employees, SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS.

## II. POLICY

**A.** CHPIV will establish a system for training and educating the Compliance Officer, Senior Management, ~~and~~ Employees, and Commissioners on federal and State standards and requirements of the DHCS contract.

**B.** CHPIV compliance training will include standards of conduct, compliance plan, fraud, waste, and abuse, and compliance policies and procedures.

**C.** CHPIV will ensure compliance trainings are verified through a certification or attestation upon training completion and review of the standard of conduct, compliance program, fraud, waste, and abuse, and compliance policies and procedures.

**D.** CHPIV will ensure that training for the Compliance Officer, Senior Management, ~~and~~ Employees, and Commisioners on the compliance program is completed within ninety (90) days of employment and annually thereafter.

## III. PROCEDURE

### A. Training Content

1. When reviewing and establishing the content of the Compliance Training Program, the Compliance Officer may consider applicable statutes, regulations, regulatory contractual requirements, and regulatory guidance. The following are examples of topics the Compliance Training Program shall communicate:
    a. A description of the Compliance Program, including a review of compliance policies and procedures, the Code of Conduct, fraud, waste, and abuse, and CHPIV's commitment to business ethics;
    b. An overview of how to ask compliance questions, request compliance clarification, or report suspected, or detected, non-compliance. Training should emphasize Confidentiality, anonymity, and non-Retaliation for reporting compliance related questions, or reports of suspected, or detected, non-compliance;
    c. The requirement to report to CHPIV actual or suspected program non-compliance;
    d. Scenarios of reportable non-compliance that an Employee might observe;
    e. A review of the disciplinary guidelines for non-compliant behavior. The guidelines will communicate how such behavior can result in mandatory retraining and may result in disciplinary action, including possible termination when such behavior is serious or repeated, or when knowledge of a possible violation is not reported;
    f. Discussion of attendance and participation in the Compliance Training Program as a condition of continued employment and a criterion to be included in Employee evaluations;
    g. A review of policies related to contracting with the government, such as

the laws addressing gifts and gratuities for government Employees;

h. A review of potential conflicts of interest and CHPIV's system for disclosure of conflicts of interest;
i. An overview of HIPAA/Health Information Technology for Economic and Clinical Health Act (HITECH), the CMS Data Use Agreement (if applicable), and the importance of maintaining the Confidentiality of Protected Health Information;
j. An overview of the Monitoring and Auditing process; and
k. A review of the laws that govern Employee conduct in CHPIV programs.

**B.** Distributing Training for Existing CHPIV Employees

1. On an annual basis, the Compliance Department shall communicate to all Employees that an updated Compliance training is available and must be successfully completed within sixty (60) calendar days.
2. Upon completion, Employees can access a learner certificate confirming successful completion. The certificate will include the training title and completion date. The Compliance Department is responsible for retaining evidence of an Employee's successful completion of all Compliance training modules.

**C.** Distributing Training for New Employees

1. Upon hire, the Compliance Department shall provide each new Employee with instructions to complete the Compliance Training within ninety (90) days of employment.
2. The Compliance Department shall create a system generated report that identifies those who fail to comply within the mandated time frames. Non-compliance will result in revoking system access.

**D.** Distributing Training to Subcontractors and Downstream Subcontractors

1. The Compliance Department conducts oversight to ensure SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS complete compliance training related to federal and State standards and requirements of the DHCS contract.
2. The Compliance Department will require the Subcontractor to disseminate to the DOWNSTREAM SUBCONTRACTORS the compliance documents and complete Compliance Training. The Subcontractor and DOWNSTREAM SUBCONTRACTORS are required to attest the Compliance Training is completed by their employees within ninety (90) calendar days of hire and at least annually thereafter.
3. Annually, the Compliance Department shall distribute and monitor receipt of updated attestation to all SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS for execution.
4. When there are updates to compliance training materials and/or related policies and procedures, the Compliance Department shall communicate updates to all Subcontractors and DOWNSTREAM SUBCONTRACTORS.

**E.** Documentation of Compliance with Training

1. All CHPIV Employees and SUBCONTRACTORS/DOWNSTREAM SUBCONTRACTORS must complete the Compliance Training Program with a score of eighty percent (80%) or greater.
2. Failure to successfully complete all required Compliance training modules may lead to disciplinary action (up to and including termination). The Compliance Department will

have a systematic indicator that identifies those who fail to comply within the mandated timeframes; non-compliance will result in revoking CHPIV system access.

3. SUBCONTRACTORS/DOWNSTREAM SUBCONTRACTORS shall provide annual attestations confirming completion of all Compliance training as stated in this policy. Failure to provide timely attestation will lead to further CORRECTIVE ACTION.
4. The Compliance Department is responsible for monitoring and auditing the compliance of Employees and SUBCONTRACTORS/DOWNSTREAM SUBCONTRACTORS with the Compliance training and education requirements.
5. CHPIV shall maintain all evidence of Compliance-related training completion for at least ten (10) years. Such materials include, but are not limited to:
    a. Attendance;
    b. Topic;
    c. Certificates of Completion;
    d. Subcontractor/Downstream Subcontractor Attestations;
    e. Test scores; and
    f. Tests administered to Employees.

## IV. DEFINITIONS

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

| TERM | DEFINITION |
|---|---|
| **Corrective Action** | Means specific identifiable activities or undertakings of Contractor which address Contract deficiencies or noncompliance. |
| **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. |
| **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. |

| | Compliance Program | CMP-014 |
|---|---|---|
| **Department** | Compliance | |
| **Functional Area** | Compliance | |
| **Impacted Delegate** | ☒ Subcontractor ☒ NA | |

| DATES | | | |
|---|---|---|---|
| **Policy Effective Date** | | **Last Revised Date** | |
| **Next Annual Review Due** | | **Regulator Approval** | |

| APPROVALS | | |
|---|---|---|
| **Internal** | | **Regulator** |
| **Name** | Elysse Tarabola | ☐ DHCS ☒ NA<br>☐ DMHC |
| **Title** | Chief Compliance Officer | |

## ATTACHMENTS

N/A

## AUTHORITIES/REFERENCES

- 42 CFR § 423.504(b)(4)(vi)
- Medicare Managed Care Manual
- CHPIV Code of Conduct
- CHPIV Compliance Program

## HISTORY

| Revision Date | Description of Revision |
|---|---|
| 1/23/2025 | Policy Creation |
| | |
| | |
| | |

## I. OVERVIEW

**A.** The purpose of this policy is to establish and maintain a comprehensive Compliance Program for CHPIV, ensuring adherence to all federal and state regulatory requirements, including those outlined in **42 CFR § 423.504(b)(4)(vi)** for Medicare Part D, Medicare Part C, Medi-Cal, and other applicable programs. This policy is designed to promote a culture of compliance, ethical conduct, and accountability throughout the organization. This policy applies to all employees, contractors, governing body members, and other stakeholders involved in the operations of CHPIV, across all lines of business, including Medi-Cal and Dual Eligible Special Needs Plans (D-SNPs) operating under Medicare Part C and Part D.

## II. POLICY

**A.** CHPIV is Compliance Program incorporates the following elements to ensure program effectiveness and compliance with regulatory requirements:

1. **Written Policies, Procedures, and Code of Conduct**
   a. CHPIV maintains comprehensive compliance policies and procedures that outline expectations for regulatory compliance, fraud prevention, and ethical behavior.
   b. The Code of Conduct establishes the foundation for ethical decision-making, emphasizing integrity, accountability, and adherence to laws and regulations.
2. **Compliance Officer, Compliance Committee, and Governing Body Oversight**
   a. CHPIV has designated a Chief Compliance Officer (CCO) responsible for overseeing the Compliance Program and ensuring its implementation.
   b. The Compliance & Policy Committee (CPC) and Regulatory Compliance Oversight Committee (RCOC) of the Commission support the CCO in addressing compliance risks.
   c. The Full Commission (Governing Body) provides high-level oversight and accountability for the program's success.
3. **Effective Training and Education**
   a. All employees, contractors, and Commissioners must participate in annual compliance training.
   b. Training covers key topics such as fraud, waste, and abuse prevention, privacy regulations, and compliance expectations related to State and Federal requirements, including Medicare Part D and Part C.
4. **Effective Lines of Communication**
   a. CHPIV ensures open and accessible communication channels, including a confidential compliance hotline and direct access to the CCO.
   b. Employees are encouraged to report compliance concerns without fear of retaliation, in alignment with CMP-007 Escalation of Noncompliance Issues and CMP-010 Effective Lines of Communication.
5. **Effective Systems for Routine Monitoring and Auditing**
   a. CHPIV conducts regular monitoring and auditing activities to identify and mitigate compliance risks.
   b. Monitoring efforts focus on high-risk areas such as authorization and claims processing, provider disputes, and member grievances.

c. Findings from audits are documented, and corrective actions are implemented promptly.

**6. Procedures and Systems for Promptly Responding to Compliance Issues**

a. CHPIV has established processes for investigating, resolving, and reporting compliance issues.
b. Corrective actions include policy updates, training enhancements, and disciplinary measures where necessary.
c. Compliance issues are reported to CMS or other regulatory authorities as required.

**7. Accountability for Delegation Oversight**

a. CHPIV maintains accountability for ensuring that delegated entities comply with all applicable laws and contractual requirements.
b. Delegation oversight includes regular monitoring, audits, and corrective action plans to address deficiencies.
c. CHPIV ensures that its delegated entities meet all applicable regulatory requirements, including Medicare Part D standards.

**B. Roles and Responsibilities**

1. Chief Compliance Officer: Oversees the implementation and operation of the Compliance Program and serves as the primary point of contact for compliance issues and reports directly to the Commission (governing body).
2. Governing Body: Provides oversight and ensures the Compliance Program's effectiveness. Reviews and approves the annual compliance work plan.
3. Employees and Contractors: Adhere to the Code of Conduct and report any suspected compliance issues. Participate in mandatory compliance training.
4. Compliance Committees: Monitors compliance activities and ensures alignment with regulatory requirements.

**C. Reporting Violations**

1. All employees, contractors, and governing body members are required to report any suspected compliance violations in accordance with CMP-007 Escalation of Noncompliance Issues and CMP-010 Effective Lines of Communication.

**D. Corrective Actions**

1. When a compliance issue is identified, CHPIV investigate the issue promptly, implements corrective actions, including training, process changes, or disciplinary measures as needed, and monitors the effectiveness of corrective actions to prevent recurrence in accordance with CMP-003 Corrective Action Plans.

## III. 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. |
| **Regulatory Compliance Oversight Committee (RCOC)** | The Regulatory Compliance Oversight Committee of the Commission is a subcommittee of the Commission that is focused on ensuring the effectiveness of the Compliance Program. |
| **Compliance & Policy Committee (CPC)** | The Compliance & Policy Committee (CPC) offers valuable oversight, advice, and general guidance to CHPIV's senior management on all matters related to compliance. This committee is specifically focused on ensuring that CHPIV and its subcontractors adhere fully to both mandated and non-mandated performance standards. |
| **The Centers for Medicare & Medicaid Services (CMS)** | The federal agency within the Department of Health and Human Services that is responsible for the administration of the Medicare and Medicaid programs as well as overseeing other Federal Healthcare Programs such as the Children's Health Insurance Program (CHIP) |

| | Conflict of Interest Avoidance | EXC-001 |
|---|---|---|
| **Department** | Executive Services | |
| **Functional Area** | Executive Services | |
| **Impacted Delegate** | ☐ Subcontractor ☒ NA | |

| **DATES** | | | |
|---|---|---|---|
| **Policy Effective Date** | 9/6/2023 | **Reviewed/Revised Date** | |
| **Next Annual Review Due** | ~~9/6/2024~~2/6/2026 | **Regulator Approval** | NA |

| **APPROVALS** | | | |
|---|---|---|---|
| **Internal** | | **Regulator** | |
| **Name** | Lawrence E. Lewis | ☐ DHCS ☒ NA<br>☐ DMHC | |
| **Title** | Chief Executive Officer | | |

## ATTACHMENTS

- Attachment A – Conflict of Interest Code
- Attachment B – Conflict of Interest and Non-Discrimination Attestation (CPRC)
- Attachment C – Conflict of Interest Disclosure Form
- Attachment D – Conflict of Interest/Attestation

## AUTHORITIES/REFERENCES

- DHCS Contract Section 1.1.3 Conflict of Interest – Current and Former State Employees, Exhibit H – Conflict of Interest Avoidance Requirements
- Health and Safety Code §1367(g)
- Title 42, Code of Federal Regulations (C.F.R.), §422.205, 438.3(f)(2), 438.58
- Title 28, California Code of Regulations (CCR) §1300.67.3
- Title 22, California Code of Regulations (CCR) sections 53874 and 53600

## HISTORY

| Revision Date | Description of Revision |
|---|---|
| 9/6/2023 | Policy Creation |
| 2/6/2025 | Annual Review. three grammar changes I.A. ; "II. E."; III.A.1.c. |
| 2/6/2025 | Attachment A Expanded List of Leadership |
| | |

## I. OVERVIEW

**A.** This policy addresses the Community Health Plan of Imperial Valley (CHPIV) requirements that all individuals in an appointed, volunteer, or employed position for CHPIV including all committees and subcommittees who makes decisions regarding CHPIV operations, fully disclose any actual, perceived, or potential conflict of interest(s) that arise in the course and scope of serving in such a capacity. This policy provides guidance regarding identification, disclosure, and evaluation of conflicts of interest so that such conflicts are resolved and/or avoided in compliance with legal and ethical standards, statutes, and regulations. The policy stated herein is applicable in addition to and does not supplant the provisions of Cal. Wel. & Inst. Code § 14087.38, and the Fair Political Practices Act.

## II. POLICY

**A.** It is the policy of CHPIV to promote the best interests of its members. All decisions concerning safe care, quality of care, and services provided to CHPIV's members are to meet the needs of members without any actual, or perceived conflicts of interest. No one making decisions about the services and operations of CHPIV will place their own financial interests above that of CHPIV and its members.

**B.** CHPIV will not utilize any State officer, employee in State civil service, other appointed State official, or intermittent State employee, or contracting consultant for DHCS, unless the employment, activity, or enterprise is required as a condition of the officer's or employee's regular State employment.

**C.** All individuals will carry out their responsibilities, avoiding conflicts of interest, and must appropriately disclose when conflicts of interest arise.

**D.** All individuals have a continuous obligation to disclose the existence of any actual, perceived, or potential conflict of interest to CHPIV in accordance with this policy.

**E.** CPHIV's CHIEF EXECUTIVE OFFICER and CHIEF COMPLIANCE OFFICER shall evaluate all conflicts of interest and adjust this policy as needed.

**F.** DELEGATED ENTITY shall have policies and procedures consistent with this policy to identify, avoid, and/or manage conflicts of interest as needed.

**G.** If required by the Department of Healthcare Services (DHCS), a third-party monitor must certify CHPIV's compliance with the conflict avoidance plan.

**H.** CHPIV periodically reviews and may amend the conflict avoidance plan to address material changes impacting the conflict of interest.

## III. PROCEDURE

### A. Conflict of Interest

1. A conflict of interest depends on the situation and not on the individual. The conflict of interest may arise where an individual, including a related party directly controlled by them:
   a. Receives material compensation (gifts, grants, stipends, amenities) from any individual and/or their employer, or entity that is conducting business or services with CHPIV.
   b. Has an ownership interest in any entity that is conducting business with CHPIV.

c. Has a post ~~of~~ or present personal relationship with an entity with or individual conducting business or providing services to CHPIV.
d. Has a financial interest in any consultant that is engaged and/or contracted with CHPIV.

2. The following are examples of Conflicts of Interest:
   a. An individual who makes decisions with another entity or individual (outside of CHPIV) that is a direct competitor of CHPIV, or where there had been a past personal, employment or financial relationship.
   b. An individual has an ownership or financial interest in the consulting firm engaged by CHPIV.
   c. An individual receives monetary or non-monetary compensation from a pharmaceutical manufacturer whose drug is reviewed for listing on the CHPIV or related downstream delegate's formulary.
   d. An individual leases property to CHPIV and is a member of the COMMISSION or employed by CHPIV.

**B. Conflict of Interest Disclosure Process**

1. On an annual basis, an individual who is involved in CHPIV a governance or leadership role, shall sign a "Conflict of Interest Attestation", and complete a "Conflict of Interest Disclosure Form" identifying any activities, interests, relationships, or financial interests that create of have the potential to create a Conflict of Interest for the individual.
2. Upon appointment and prior to serving on the COMMISSION, any Committee of the COMMISSION, or senior leadership role shall sign a Conflict-of-Interest Attestation and complete a Conflict-of-Interest Disclosure Form, identifying any activities, interests, relationships, or financial holdings that create or have the potential to create a Conflict of Interest for the individual.
3. If an individual believes that he/she may have a potential, perceived, or actual Conflict of Interest prior to a committee, or subcommittee, meeting, they will provide written notice to the committee, or subcommittee, chairperson disclosing the potential, perceived, or actual Conflict of Interest.
4. Whenever a Participant believes that he/she may have a potential, perceived, or actual Conflict of Interest during a committee, or subcommittee, meeting, they will immediately alert the committee, or subcommittee, chairperson that they may have a potential, perceived, or actual Conflict of Interest. Before leaving the meeting, the Participant may be asked, and may answer, any questions concerning the Conflict of Interest.
5. In all other situations, whenever a Participant realizes that they may have a potential or actual Conflict of Interest, they will provide written notice to the CHIEF EXECUTIVE OFFICER disclosing the potential, perceived, or actual Conflict of Interest.
6. To the extent CHPIV engages an external reviewer or expert consultant, that external reviewer or expert consultant shall be required to sign a Conflict-of-Interest Statement and complete a Conflict-of-Interest Disclosure Form prior to performing any services for CHPIV.
7. In addition, all persons holding the offices listed in the Conflict-of-Interest Code which is attached hereto as Appendix One shall file a FPPC Form 700 with the Clerk of the

COMMISSION upon assuming office, annually thereafter, and upon vacating the office in question as provided in the Fair Political Practices Act.

**C. Management and Resolution of the Conflicts of Interest**

1. The CHIEF EXECUTIVE OFFICER, the COMMISSION Chairperson, or the COMMISSION committee chairperson will review and evaluate all written disclosures thoroughly for conflicts. For any decision involving a CHPIV employee, the CHIEF EXECUTIVE OFFICER shall involve Legal Counsel before taking any action.
2. The applicable committee or subcommittee chairperson shall resolve any issue over the existence of a Conflict of Interest involving an individual who is a COMMISSION or member of a committee of the COMMISSION. All other Conflict of Interest issues shall be resolved by the CHIEF EXECUTIVE OFFICER. CHPIV shall verify that no unresolved Conflicts of Interest exist prior to retaining an external reviewer or expert consultant.
3. If it is determined that there is no conflict, then the individual can continue to be involved in the matter, subject to any limitations imposed by the CHIEF EXECUTIVE OFFICER, or COMMISSION or committee of the COMMISSION, chairperson.
4. If it is determined that there is a Conflict of Interest, the individual may be excluded from participation in the matter that gave rise to the Conflict of Interest.
5. The committee chairperson and/or CHIEF EXECUTIVE OFFICER may resolve the conflict when appropriate, by imposing limitations where there is a determination that a Conflict of Interest does not prohibit the individual's continued involvement in the matter. These limitations may include, but are not limited to, requiring that the Participant abstain from voting regarding the matter, or prohibiting the individual from participating in any investigation of the matter.
6. If a Participant disagrees with a COMMISSION or committee of the COMMISSION chairperson's decision regarding a Conflict of Interest, he/she can request that the CHIEF EXECUTIVE OFFICER review the Conflict of Interest.

**D. Record Retention**

1. The CEO's office shall keep copies of all Conflict-of-Interest Disclosure Forms and any written information disclosing a Conflict of Interest in accordance with applicable regulatory record retention requirements, and no less than ten years.
2. COMMISSION and committees of the COMMISSION minutes shall reflect the disclosure of Conflicts of Interest and any abstentions and exclusions from participation from voting on actions.

**E. Non-Compliance with Conflicts of Interest.**

1. Suspected violations of this Policy should be reported to the CHIEF EXECUTIVE OFFICER or CHIEF COMPLIANCE OFFICER. Such reports may be made confidentially.
2. The failure of an individual to disclose a Conflict of Interest when it is known or reasonably should be known to the individual may result in actions against the individual, including, but not limited to disciplinary action, sanctions, removal, dismissal, and/or termination from a committee or subcommittee. The matter may also be referred to the CHPIV's CEO's office, CHIEF COMPLIANCE OFFICER's office, and/or Human Resources Department for further action, as appropriate.

## 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. |
| **Chief Executive Officer** | The Chief Executive Officer (CEO) of a Managed Care Plan is the highest-ranking executive, responsible for implementing organizational strategies, ensuring the achievement of overall objectives, and maintaining operational, legal, and financial integrity, all while being accountable to the Commission. |
| **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. |
| **Delegated Entity** | A contracted entity which CHPIV authorizes to perform certain functions on its behalf. Although, CHPIV can delegate the authority to perform a function, it cannot delegate the responsibility for ensuring that the function is performed according to CHPIV and National Committee on Quality Assurance (NCQA) standards. |

| | Medical Loss Requirements for Subcontractors | FIN-003 |
|---|---|---|
| | **Department** | Finance & Informatics |
| | **Functional Area** | Finance |
| | **Impacted Delegate** | ☒ Subcontractor ☐ NA |

| DATES | | | |
|---|---|---|---|
| **Policy Effective Date** | 03/12/2025 | **Reviewed/Revised Date** | |
| **Next Annual Review Due** | 3/12/2026 | **Regulator Approval** | |

| APPROVALS | | | |
|---|---|---|---|
| **Internal** | | **Regulator** | |
| **Name** | David Wilson | ☒ DHCS ☐ NA<br>☐ DMHC | |
| **Title** | Chief Financial Officer | | |

| ATTACHMENTS |
|---|
| NA |

| AUTHORITIES/REFERENCES |
|---|
| • **Federal**<br>  ○ 42 Code of Federal Regulations ("CFR") 438.8(j)<br>  ○ Welfare and Institutions Code (W&I) section 14197 .2<br>• **State**<br>  ○ CalAIM Section 1915(b), STC A11<br>  ○ DHCS All Plan Letter 24-018 Medical Loss Ratio Requirements for Subcontractors and Downstream Subcontractors |

| HISTORY | |
|---|---|
| **Revision Date** | **Description of Revision** |
| 02/28/2025 | Policy creation |
| | |
| | |
| | |

## I. OVERVIEW

A. In December 2021, CMS approved California's CalAIM Section 1915(b) waiver including new MLR reporting and remittance requirements which increases DHCS' oversight of MLR reporting in the context of Subcontractor arrangements. Pursuant to this requirement and as

outlined in APL 24-018, CHPIV must oversee the imposition of MLR reporting and remittance requirements on applicable downstream entities.

## II. POLICY

A. CHPIV must impose MLR reporting and remittance requirements equivalent to the requirements in 42 CFR section 438.8(k) on their applicable Subcontractors and Downstream Subcontractors.
B. CHPIV will utilize a materiality threshold established by DHCS for determining whether a Subcontractor or Downstream Subcontractor Agreement is subject to the STC A 11 reporting and remittance requirements.

## III. PROCEDURE

C. CHPIV will utilize a materiality threshold established by DHCS for determining whether a Subcontractor or Downstream Subcontractor Agreement is subject to the STC A 11 reporting and remittance requirements.
    1. For the CY 2023 MLR reporting year, and until modified by DHCS, applicable Subcontractors that receive $30,000,000 or more in Medi-Cal capitation annually from CHPIV as payment for services rendered in a single county or rating region, for which they assume risk and are not directly providing will be subject to MLR reporting requirements. Subcontractors and Downstream Subcontractors that fall below the annual threshold dollar will not be subject to reporting for the given MLR reporting year, except as required by DHCS on a case-by-case basis.
D. CHPIV, at its discretion, may use a four-part test, consistent with MLR calculations described in CFR section 438.8 and the 2012 CCIIO guidance. Under the 4-part test, payments to a clinical risk bearing entity are considered incurred claims if the following four factors are met:
    1. The entity contracts with an issuer to deliver, provide, or arrange for the delivery and provision of clinical services to the issuer's enrollees but the entity is not the issuer with respect to those services;
    2. The entity contractually bears financial and utilization risk for the delivery, provision, or arrangement of specific clinical services to enrollees;
    3. The entity delivers, provides, or arranges for the delivery and provision of clinical services through a system of integrated care delivery that, as appropriate, provides for the coordination of care and sharing of clinical information, and which includes programs such as Provider performance reviews, tracking clinical outcomes, communicating evidence-based guidelines to the entity's clinical Providers, and other, similar care delivery efforts; and
    4. Functions other than clinical services that are included in the payment (capitated or fee-for-service) must be reasonably related or incidental to the clinical services and must be performed on behalf of the entity or the entity's Providers.
E. Administrative functions performed on behalf of its Providers would be included in incurred claims. Conversely, to the extent that administrative functions are performed on behalf of the CHPIV, such as processing claims in order to issue explanations of benefits (EOBs) to enrollees and handling enrollee appeals and grievances, that portion of CHPIV's payment that is attributable to these administrative functions may not be included in incurred claims.

F. CHPIV may exempt a newly contracted Subcontractor or Downstream Subcontractor from the MLR reporting requirements in the Subcontractor's or Downstream Subcontractor's first year of operation. Exemptions only apply to the first MLR reporting year that overlaps with the newly contracted Subcontractor's or Downstream Subcontractor's first year of operation regardless of whether the overlap is less than 12 months. Beginning with the CY 2023 MLR reporting year, CHPIV will report any exempted Subcontractors and Downstream Subcontractors to DHCS by the end of the third quarter of each MLR reporting year utilizing DHCS' reporting form.
G. CHPIV will identify all Subcontractors and Downstream Subcontractors in its MLR submission whether or not the Subcontractors and Downstream Subcontractors are required to submit an MLR report.
H. CHPIV requires its Subcontractors and Downstream Subcontractors to report an MLR at the Subcontractor Agreement and Downstream Subcontractor Agreement level, respectively, by county or rating region, to their upstream entity.
I. CHPIV will ensure that Subcontractors and Downstream Subcontractors that report an MLR include within their MLR the revenues, expenses, and membership specific to the services for which they are at risk, and which are not directly provided by them. CHPIV requires Subcontractors and Downstream Subcontractors providing claims adjudication activities to provide all underlying data associated with MLR reporting within 180 days of the end of the MLR reporting year or within 30 days of being requested by CHPIV, whichever comes sooner. For each MLR reporting year, CHPIV set the paid-through dates for all levels of delegation to ensure consistency of the data received.
J. Commencing with the CY 2025 MLR reporting year, CHPIV will impose remittance requirements equivalent to 42 CFR section 438.8(j) on its Subcontractors and Downstream Subcontractors. If the MLR for a Subcontractor Agreement or Downstream Subcontractor Agreement, by county or rating region, does not meet the established minimum standard of 85 percent or higher for the respective MLR reporting year, CHPIV will require the Subcontractor or Downstream Subcontractor to pay a remittance to their upstream entity. The upstream entity must account for this remittance in their own MLR report as a reduction to expenditures.
K. Consistent with 42 CFR sections 438.8(h) and (k)(1 )(viii), and the July 31, 2017, CIB entitled Medical Loss Ratio (MLR) Credibility Adjustments, Subcontractors and Downstream Subcontractors may apply credibility adjustment factors within their MLR reporting. CHPIV requires Subcontractors and Downstream Subcontractors that are non-credible but meet the materiality threshold to submit an MLR report.
L. CHPIV will impose requirements on Subcontractors to ensure that Subcontractors and Downstream Subcontractors perform delegated activities or obligations, and related reporting responsibilities, relating to Members, in accordance with 42 CFR section 438.230(c)(1 ). Subcontractors must comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions, in accordance with 42 CFR section 438.230(c)(2).
M. CHPIV will ensure MLR reports submitted by Subcontractors and Downstream Subcontractors are consistent with the information required in 42 CFR section 438.8(k). CHPIV will review and provide oversight of their downstream entity MLR submissions and will attest to performing

this review as part of the MLR submission. Specific expectations may include, but are not limited to:

1. Review each Subcontractor's and Downstream Subcontractor's MLR and reported medical cost PMPM to identify and investigate outliers.
2. Review reported expenses to ensure medical and non-medical expenses are appropriately accounted for in the MLR calculation.
3. Review that reported expenses align with service volume reported in encounters.
4. Review that the Subcontractor's or Downstream Subcontractor's reported revenues align with the payments reported by the upstream entity.
5. For Subcontractor Agreements or Downstream Subcontractor Agreements covering multiple lines of business, review the methodologies for allocation of expenditures to ensure reasonableness.
6. Reviewing IBNR for reasonableness.

N. In accordance with 42 CFR section 438.8(k)(2), CHPIV will submit MLR reports to DHCS within 12 months of the end of the MLR reporting year, which is before the timeframe for State Directed Payments (SDP) are calculated and paid. Therefore, SDPs will not be included in the initial MLR report submitted by Subcontractors and Downstream Subcontractors. When the remittance requirement is imposed beginning with the CY 2025 MLR period, a proxy remittance amount will be calculated, which will exclude these SDPs. The remittance of payments from Subcontractors and Downstream Subcontractors to their upstream entities, and from CHPIV to DHCS, will be delayed until SDPs have been finalized and paid. After SDPs are calculated and paid, the MLR will be recalculated and resubmitted. Subcontractors and Downstream Subcontractors will only need to re-report their MLR if those SOP amounts flow to them from their upstream entity. The final remittance amounts will be calculated and collected following receipt of the restated MLRs.

O. CHPIV will review its contractually required P&Ps to determine if amendments are needed to comply with APL 2024-018. If the requirements, including any updates or revisions, necessitate a change in this P&Ps, will submit its updated P&Ps to the Managed Care Operations Division (MCOD)-MCP Submission Portal 14 within 90 days of the release of APL 24-018. If no changes are necessary, CHPIV will attach an attestation to the Portal within 90 days of the release of APL 24-018 stating that P&Ps have been reviewed and no changes were necessary. The attestation will include the title of this APL as well as the applicable APL release date in the subject line.

P. CHPIV will be responsible for ensuring that its Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters. CHPIV will ensure its Subcontractors have reviewed and updated their P&Ps. CHPIV will submit an attestation validating that Subcontractors subject to this APL have compliant P&Ps within 120 days of the release of this APL. CHPIV will review their Provider and/or Subcontractor Agreements, including Division of Financial Responsibility provisions as appropriate to ensure compliance with this APL 24-018.

## IV. Key Dates and Activities

| Date | Activity |
|---|---|
| No later than 12/31/2025 | Receipt of CY 2024 MLRs – CHPIV to submit their CY 2024 MLR report to DHCS accounting for their applicable Subcontractors' MLRs. |
| 1/1/2026 – 9/30/2026 | DHCS' MLR Review - DHCS reviews compliance with CY 2024 MLR reporting requirements, including consideration of Subcontractor reporting, and calculates, but does not collect, draft remittance in accordance with State law. |
| **No later than 3/31/2027** | Receipt of Restated CY 2024 MLRs – CHPIV will submit restated CY 2024 MLR reports including final SOP revenues and expenditures. |
| **4/1/2027 – 9/30/2027** | DHCS' MLR Review - DHCS calculates CY 2024 remittances in accordance with State law. |
| **No later than 13/31/2027** | Remittance Collection – CHPIV will remit any owed amounts for CY 2024. |

| | New Positions | HR-005 |
|---|---|---|
| **Department** | Human Resources | |
| **Functional Area** | Human Resources | |
| **Impacted Delegate** | ☐ Subcontractor ☒ NA | |

| DATES | | | |
|---|---|---|---|
| **Policy Effective Date** | 10/01/2024 | **Last Revised Date** | 02/25/2025 |
| **Next Annual Review Due** | 10/02/2025 | **Regulator Approval** | |

| APPROVALS | | |
|---|---|---|
| **Internal** | | **Regulator** |
| **Name** | Shannon Long~~Michelle Stephanie Ortiz-Trujillo~~ | ☐ DHCS ☒ NA<br>☐ DMHC |
| **Title** | ~~Senior Director of Human Resources & Community Relations~~HR Consultant | |

| ATTACHMENTS |
|---|
| NA |

| AUTHORITIES/REFERENCES |
|---|
| NA |

| HISTORY | |
|---|---|
| **Revision Date** | **Description of Revision** |
| 10/01/2024 | Policy creation |
| | |
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| | |

| | New Positions | HR-005 |
|---|---|---|

## I. OVERVIEW

**A.** This policy applies to all departments and positions at all levels, including full-time regular, part-time regular and temporary positions.

## II. POLICY

A. It is the policy of CHPIV to place a high priority on the recruitment and hiring of local staff.
B. Planning for new positions begins with the annual budget development wherever possible.
C. A needs justification is required for each new position requested.

~~**C.** Clarity of Purpose: Define the need for the new position and articulate its purpose within the organization. Clearly align the role's responsibilities with organizational goals.~~
~~**D.** Strategic Alignment: Explain how the new position aligns with the overall strategic direction of the company. Highlight how it contributes to long-term success and growth.~~
~~**E.** Resource Justification: Provide a detailed breakdown of the costs associated with the new position. Justify the allocation of resources, including budget, personnel, and time.~~
~~**F.** Risk Assessment: Identify potential risks and challenges related to the new role. Briefly outline strategies for mitigating risks and addressing challenges.~~
~~**G.** Quantifiable Benefits: Present the benefits of the new position in comparison to the incurred costs. Decision-makers are interested in understanding the return on investment.~~

## ~~VIII.~~III. PROCEDURE

**A.** General Procedure
1. Managers must complete the requisition form, including all approval signatures, whenever a department has a need to:
   a. Create and fill a new position, or
   b. Refill an existing position when there is a termination of employment, or
   c. Hire or lease a temporary employee.
2. This policy explains the necessary forms and processes for these situations.

**B.** Approval Process

~~1.~~ 1. In the case of a a new position, t~~T~~he hiring manager downloads the job description template~~requisition form~~ from the HR folder and completes all applicable sections based on the requirements of the position. In the case of an existing position, the hiring manager should make any modifications to the existing job description. ~~new position, refill position or temporary position.~~

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~~2.~~1. ~~The completed requisition form, including a copy of the current job description, must be submitted to the CEO as hard copy or electronically once all required approval signatures are obtained.~~The job description should be forwarded to HR for review and any requested modifications should be made prior to HR initiating the recruiting process.

2. ~~Once approved by the CEO, HR will review the request and ensure the job duties, requirements and pay grade are consistent with the position as described. If necessary, HR will recommend changes and work with the hiring manager to revise the request. If substantial changes made, a second round of approval signatures will be required.~~HR

market prices the position by identifying the midpoint and calculating the minimum and maximum point.

3. HR creates a requisition within the applicant tracking system. The requisition is electronically sent to the CFO followed by the CEO for approval.
4. Once approved, HR creates the job posting and posts the position.
5. As resumes are received, HR screens the resumes and sends qualified applicants to the hiring manager.
6. The hiring manager identifies candidates to formally engage in the recruiting process.
7. HR conducts a phone interview and screens for basic qualifications.
8. Any candidates that are assessed by HR to be qualified are scheduled with the hiring manager for interview.
9. The default location for all positions is the Imperial office. In exceptional cases, the CEO may approve simultaneous recruiting at the default location, as well as remotely in California. The criteria that the CEO uses to decide to make an exception is the following:
   a. The position requires such technical skills that it is unlikely that skills can be found in the Imperial area; AND
   b. The position can work remotely without any impact to productivity or collaboration
10. In the case that an exception is made, the position must remain open for 30 days to allow time for local candidates to apply. Every local candidate that is minimally qualified must be interviewed by the hiring manager.

~~3.~~11.

~~0. Upon final approval of the requisition, the hiring manager will receive a confirmation e-mail of the open requisition and posting. It is the hiring manager's responsibility to check the information for accuracy and contact HR immediately if there are any discrepancies.~~

~~0. The recruiter assigned to the open requisition will contact the hiring manager within the first week of the open job requisition to coordinate the recruitment process.~~

~~E.~~C. New position

1. The budgeting process for new positions happens each year in September for the following calendar year. All new positions should go through the normal annual budgeting process for planning and approval. In the event the business needs dictate hiring for a new position outside of this process, additional written business justifications and approvals will be needed on the job requisition form. HR may not start the candidate sourcing process for any position until all documents and signatures have been received.

~~I. Next Steps~~

~~0. Senior Leader and CEO approval of new positions with justification.~~

~~0. Senior Leader Submits a job description to CEO for review~~

~~0. Senior Leader submits new position request signed by CEO to HR along with job descriptions reviewed by CEO~~

~~0. Human Resources values the position with input from Senior Leader, Finance, Surveys, etc.~~

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~~0. Post internally for 3 days (best practice is send the announcement to everyone internally when we're this size)~~
~~0. If no internal candidate meets the criteria, then post externally.~~

## ~~XVI.~~IV. DEFINITIONS

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

| TERM | DEFINITION |
|---|---|
| None | |
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4

| | Remote Work | HR-009 |
|---|---|---|
| | **Department** | Human Resources |
| | **Functional Area** | Administration |
| | **Impacted Delegate** | ☐ Subcontractor ☒ NA |

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

| **APPROVALS** | | |
|---|---|---|
| **Internal** | | **Regulator** |
| **Name** | **Lawrence Lewis** | ☐ DHCS ☒ NA<br>☐ DMHC |
| **Title** | Chief Executive Officer | |

| **ATTACHMENTS** |
|---|
| HR-009 Attach A_Work From Home Agreement_Draft |

| **AUTHORITIES/REFERENCES** |
|---|
| N/A |

| **HISTORY** | |
|---|---|
| **Revision Date** | **Description of Revision** |
| | |
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## I. OVERVIEW

**A.** Certain positions at Community Health Plan of Imperial Valley may work in a Hybrid or Remote work arrangement. The goal of such arrangement is to ensure the continued productivity, collaboration, and security of information regardless of work location.

## II. POLICY

**A.** CHPIV provides the opportunity to work remotely, either on a full-time or a part-time basis, for certain positions/functions.

**B.** The organization may hire a position remotely because the skills needed for the position cannot be found locally. In every case, preference will be given to local candidates. However, in the case that a local candidate cannot be found, or an individual that is located remotely is determined to have more advanced skills than local candidates, the remote candidate may be hired with the approval of the Chief Executive Officer (CEO).

1. A local recruitment effort will be conducted for the first 30 days and applications shared with the hiring manager PRIOR to expanding a search. In certain circumstances, the CEO may approve recruiting both locally and remotely within California at the same time. In these instances, the CEO's decision for concurrent recruiting is based on the following factors:
    a. A belief based on both qualitative and quantitative data, when available, that the technical skill needed to be successful in the position doesn't exist locally.
    b. An assessment that Hybrid or remote work will not affect the productivity or collaboration required to be successful in the position.
2. Any remote or Hybrid work candidate that is minimally qualified must be interviewed by the hiring manager. In the event that the hiring manager wishes to proceed with hiring a non-local candidate, the rationale for recommending a non-local candidate must be approved by the CEO.

## III. PROCEDURE

**A.** Approval

1. A current office-based employee who wishes to engage in a Remote or Hybrid work arrangement must make the request to their direct manager. The request must be in writing and address the following:
    a. The reason for the request
    b. The proposed Remote or Hybrid schedule
    c. How childcare, eldercare, and other personal commitments will be met through the day while working
    d. A commitment to be available during the organization's core hours of 8:00-5:00 PT, Monday-Friday and to attend meetings in-person, as required.
    e. How sensitive information will be secured when working offsite
    f. Proof an internet bandwidth test (several free resources exist for this test). A minimum bandwidth speed of 10 Mbps is required for optimal work-at-home productivity
    g. A secure organization-issued computer will be sent to the home of any Remote employee
    h. Hybrid employees will be issued a secure, organization-issued laptop that will be utilized for any work-related processes.
    i. Home office furnishings will be at the expense of the employee

**B.** If the direct manager approves the Remote or Hybrid arrangement, the department head and CEO must also approve the arrangement. Only after all approvals have been granted, may the arrangement begin.

**C.** The arrangement is not guaranteed for any period of time, and either the employee or the organization may revoke the agreement at any time, for any reason, including convenience.

**D.** Once approved, the employee and manager must execute the Remote Work Agreement.

## 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 Executive Officer** | The Chief Executive Officer (CEO) of a Managed Care Plan is the highest-ranking executive, responsible for implementing organizational strategies, ensuring the achievement of overall objectives, and maintaining operational, legal, and financial integrity, all while being accountable to the Commission. |
| **Remote** | A working arrangement where the employee works from home 100% of the time |
| **Hybrid** | A working arrangement where the employee works from home on a set schedule, with some days per week spent in the office. |

| | Promotions | HR-010 |
|---|---|---|
| **Department** | Human Resources | |
| **Functional Area** | Administration | |
| **Impacted Delegate** | ☐ Subcontractor ☒ NA | |

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

| APPROVALS | | |
|---|---|---|
| **Internal** | | **Regulator** |
| **Name** | **Shannon Long** | ☐ DHCS ☒ NA<br>☐ DMHC |
| **Title** | HR Consultant | |

| ATTACHMENTS |
|---|
| N/A |

| AUTHORITIES/REFERENCES |
|---|
| |

| HISTORY | |
|---|---|
| **Revision Date** | **Description of Revision** |
| 3/6/2025 | Policy creation |
| | |
| | |
| | |

## I. OVERVIEW

The purpose of this promotion policy is to provide clear guidelines for employee promotions within Community Health Plan of Imperial Valley. This policy aims to ensure a fair and transparent process that recognizes and rewards employee performance, skills, and potential.

## II. POLICY

A. Promotions will be based on the following criteria:

a. Performance: Consistently high performance as reflected in performance appraisals, feedback from supervisors, and measurable outcomes.
b. Skills and Competencies: Possession of required skills, competencies, and qualifications for the new role.
c. Experience: Relevant experience and time spent in the current position.
d. Potential: Demonstrated potential for growth and ability to take on additional responsibilities.
e. Behavior and Attitude: Alignment with organizational values, teamwork, and a positive attitude

## III. PROCEDURE

**A. Identification:** Managers can initiate a promotion request based on the criteria listed above.

**B. Request for consideration:** To formally request promotion consideration, managers should send an email to their department head with a cc to the CEO and Human Resources. The email should contain the following information:
1. The nominated employee's total length of service and time in their current position
2. The employee's total year of experience, including time employed in the function outside of CHPIV
3. A narrative that addresses the employee's possession of skills, competencies, and qualifications for the new role.
4. Attachments to substantiate the narrative, including past performance evaluations or commendations.

**C. Review:** The department head will review the information and ask for any clarifying information or additional documentation.

**D. Recommendation:** The department head will make a recommendation to the CEO to either approve or deny the promotion request.

**E. Review of recommendation:** The CEO will review the initial email and the department head's recommendation and make a final decision to either approve or deny the promotion.
1. Any decision to deny the promotion at either the department head or CEO level will be specific and include areas for development or improvement for the employee before the employee will be reconsidered.

**F. Compensation benchmarking:** Once a promotion is approved, HR will conduct a salary study to determine the salary range of the new position.

**G. Compensation recommendation:** HR will make a salary recommendation to the department head and CEO.
1. In most cases, the promoted employee will receive at least a 10% salary increase
2. It is expected that salary will be below the midpoint of the new salary range, as to represent that the employee is new in the level

**H. Notification:** The employee will be formally notified of the promotion decision, new salary, and effective date

## IV. DEFINITIONS

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

| TERM | DEFINITION |
|---|---|
| **Salary range** | A range of salaries that is comprised of a minimum, midpoint, and maximum |
| **Midpoint** | The average salary that the market is paying for a position considering the size of the organization and location of the position. |

| | After-Hours Computer Shutdown Policy | IT-002 |
|---|---|---|
| | **Department** | Information Technology |
| | **Functional Area** | Information Technology |
| | **Impacted Delegate** | ☐ Subcontractor ☒ NA |

| DATES | | | |
|---|---|---|---|
| **Policy Effective Date** | 02-05-2024 | **Last Revised Date** | 12-19-2024 |
| **Next Annual Review Due** | | **Regulator Approval** | Not Applicable |

| APPROVALS | | | |
|---|---|---|---|
| **Internal** | | **Regulator** | |
| **Name** | **David Wilson** | ☐ DHCS ☒ NA<br>☐ DMHC | |
| **Title** | Chief Compliance Officer | | |

## ATTACHMENTS

- NA

## AUTHORITIES/REFERENCES

- NA

## HISTORY

| Revision Date | Description of Revision |
|---|---|
| | |
| | |
| | |
| | |

## I. OVERVIEW

**A.** This policy addresses Community Health Plan of Imperial Valley's ("CHPIV" or the "Plan") procedures for properly shutting down company-issued devices to ensure data security, system stability, and energy efficiency.

## II. POLICY

**A.** This policy outlines the procedures for properly shutting down company-issued devices, including desktops, laptops, tablets, and any other devices used for work purposes. Proper shutdown procedures are essential for:
Data Integrity: Preventing data loss and corruption.
System Stability: Minimizing system errors and malfunctions.
Energy Conservation: Reducing energy consumption and associated costs.
Security: Minimizing security vulnerabilities.

## III. PROCEDURE

**A.** Daily Shutdown
1. Save all work: Save all open files and documents.
2. Close all Applications: Close all open programs and Applications, including web browsers, email clients, and any other Software.
3. Initiate the normal shutdown process through the Operating System if closing the lid does not properly shut down the device.
4. Do not force shutdowns: Avoid abruptly powering off devices by unplugging them or pressing and holding the power button. This can lead to data loss and system instability.

**B.** End-of-Day Shutdown
1. Follow the daily shutdown procedures as outlined above.
2. The computer is scheduled to automatically shut down at 10:00 PM if it has not been manually turned off by 6:00 PM.
3. If you are still using the computer at 9:30 PM, you will receive a friendly reminder that the automatic shutdown is imminent. To continue working beyond 10:00 PM, please restart the computer before the scheduled shutdown.

**C.** Exceptions
1. Exceptions to this policy may be necessary in certain situations, such as:
    a. System Updates: Scheduled system updates may require a temporary shutdown.
    b. Emergency situations: In case of emergencies or critical system maintenance, immediate shutdown may be required.

**D.** Policy Updates
1. This policy may be updated from time to time. Employees will be notified of any changes to the policy.

**E.** Contact
1. For questions or concerns regarding this policy, please contact the IT department.

## IV. DEFINITIONS

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

| TERM | DEFINITION |
|---|---|
| **System Updates** | Software enhancements released by the manufacturer of the device and/or Operating System |
| **Operating System** | Fundamental software that manages a computer's hardware and software resources. |
| **Software** | Set of instructions, data, or programs that a computer executes to perform specific tasks. |
| **Hardware** | Physical components of a computer or any electronic device. |
| **Applications** | Computer programs designed to perform specific tasks for users. |

| | Standards of Network Accessibility and Timely Access to Care | PNM-001 |
|---|---|---|
| **Department** | Operations | |
| **Functional Area** | Provider Network Management | |
| **Impacted Delegate** | ☒ Subcontractor ☐ NA | |

| DATES | | | |
|---|---|---|---|
| **Policy Effective Date** | 6/12/2023 | **Reviewed/Revised Date** | 5/13/2024 |
| **Next Annual Review Due** | 5/13/2025 | **Regulator Approval** | 12/28/2023 |

| APPROVALS | | |
|---|---|---|
| **Internal** | | **Regulator** |
| **Name** | Julia Hutchins | ☐ DHCS ☐ NA<br>☒ DMHC |
| **Title** | Chief Operating 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, 23-006
- **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 |
| 5/13/2024 | Policy revision to add Knox Keene provisions and DHCS APL 23-006 requirements |
| | |

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

## 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 Subcontractor 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 's Chief Compliance Officer, whose qualifications are described in CHPIV's Compliance Program, 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;

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

## 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).

~~1.~~ a. CHPIV's NETWORK PROVIDERS, SUBCONTRACTORS, and DOWNSTREAM SUBCONTRACTORS must submit a request for Alternate Access Standard (AAS) to CHPIV for review and approval.

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**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 as defined 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*.

**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.

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**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.

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

**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, .

**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. CHPIV ensures '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. |
| **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. |
| **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 |
| **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:<br>**(A)** The provider is available to provide covered services to all plan enrollees in all product lines using the designated network.<br>**(B)** The provider is one or more of the following:<br>**(i)** An employee of the plan;<br>**(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;<br>**(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; |

| TERM | DEFINITION |
|---|---|
| | **(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<br>**(v)** An individual health professional or health facility required to be part of the plan's network under any of the following circumstances;<br>**a.** a corrective action plan submitted to the Department by the plan or its delegated entity;<br>**b.** as required by the Department pursuant to section 1373.65 of the Knox-Keene Act; or<br>**c.** as otherwise required by order of the Department.<br>**(C)** The provider is accessible to enrollees of the designated network without limitations other than established:<br>**(i)** In-network referral or authorization processes; or<br>**(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.<br>**(D)** A network provider shall not include:<br>**(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;<br>**(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<br>**(iii)** Noncontracting individual health professionals, as defined in subsection (f)(5) of section 1371.9 of the Knox-Keene Act. |
| **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: |

| TERM | DEFINITION |
|---|---|
| | **(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.<br>**(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:<br>**(i)** Each instance is a violation of the same standard set forth in subsection (c) of CCR 28 § 1300.67.2.2;<br>**(ii)** Each instance involves the same network;<br>**(iii)** Each instance involves the same provider group, or subcontracted plan;<br>**(iv)** Each instance involves the same provider type;<br>**(v)** Each instance involves the same network provider;<br>**(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;<br>**(vii)** The number of enrollees in the health plan's network and the total number of instances identified as part of a pattern;<br>**(viii)** Whether each instance occurred within the same twelve-month period; or<br>**(ix)** Whether each instance involves the same category of health care services. |
| **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). |
| **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. |

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| TERM | DEFINITION |
|---|---|
| **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. |

| | Pharmacy Services | PS-001 |
|---|---|---|
| | **Department** | Health Services |
| | **Functional Area** | Pharmacy Services |
| | **Impacted Delegate** | ☒ Subcontractor ☐ NA |

| DATES | | | |
|---|---|---|---|
| **Policy Effective Date** | 10/9/2023 | **Reviewed/Revised Date** | |
| **Next Annual Review Due** | 10/9/2024 | **Regulator Approval** | |

| APPROVALS | | |
|---|---|---|
| **Internal** | | **Regulator** |
| **Name** | Dr. Gordon Arakawa | ☐ DHCS ☒ NA<br>☐ DMHC |
| **Title** | Chief Medical Officer | |

## ATTACHMENTS

- NA

## AUTHORITIES/REFERENCES

- **Internal**
  - CHPIV, Delegation Oversight Policy and Procedure, CMP-002
- **Federal**
  - 42 CFR Section 438.3(s); 42 CFR 438.900 et. seq; 42 USC Section 1396r - 8(g), and Section 1004;
- **State**
  - DHCS: DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III, Section 5.3.7.H; APL 22-012
- **Accreditation**
  - NCQA: UM 11, Elements A-E – Pharmaceutical Management Procedures

## HISTORY

| Revision Date | Description of Revision |
|---|---|
| 10/9/2023 | Policy Creation |
| 02/21/2025 | Annual Review |
| | |
| | |

| | Pharmacy Services | PS-001 |
|---|---|---|

## I. OVERVIEW

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

## II. POLICY

**A.** CHPIV will ensure the development and implementation of an effective Drug Utilization Review (DUR) and treatment outcome process, as directed in APL 17-008 and APL 19-012, to ensure that drug utilization is appropriate, MEDICALLY NECESSARY, and will not result in adverse events.

**B.** CHPIV will ensure the implementation of the following:

1. Retrospective claims review automated process to monitor when a MEMBER is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics.
2. A program to monitor the appropriate use of antipsychotic, mood stabilizers, and anti-depressant medications by all children 18 years of age and under, including foster children enrolled under the California Medicaid State Plan.
3. A fraud and abuse identification processes for potential fraud or abuse of controlled substances by MEMBERS, PROVIDERS, and pharmacies.

**C.** CHPIV will ensure the submission to DEPARTMENT OF HEALTH CARE SERVICES (DHCS) annually of a detailed report in a format specified by DHCS on their DUR Program activities.

**D.** CHPIV will ensure that its subcontractor(s) contracted for the delivery or administration of the covered outpatient drug benefit must report, as specified by CMS, the following:
1. Incurred claims; and
2. Administrative costs, fees and expenses of the subcontractor(s).

**~~C.~~E.** CHPIV will ensure that there are no imposed Quantitative Treatment Limitation (QTL) or Non-Quantitative Treatment Limitation (NQTL) more stringently for mental health and substance use disorder drugs prescriptions than for medical/surgical drugs, in accordance with 42 CFR 438.900 et. seq.

**~~D.~~F.** Effective January 1, 2022, and per Executive Order (EO) N-01-19, Medi-Cal pharmacy services transitioned from the managed care delivery system to the Fee-For-Service (FFS) delivery system known as Medi-Cal Rx offering the following benefits to MEMBERS:

1. Standardized Medi-Cal pharmacy benefit statewide.
2. Improved access to pharmacy services with a pharmacy network that includes approximately 94 percent of the state's licensed outpatient pharmacies.
3. Applied statewide utilization management protocols to all covered outpatient drugs.
4. Strengthened California's ability to negotiate state supplemental drug rebates with drug manufacturers, thereby creating additional cost-savings for the state.

**~~E.~~G.** While majority of pharmaceutical services transitioned to Medi-Cal Rx, CHPIV is responsible for a number of pharmaceutical services activities and will ensure to have processes in place for the following:

1. Processing and paying all pharmacy services billed on medical or institutional claims.
2. Overseeing and maintaining all activities necessary for MEMBER care management and coordination, and related activities consistent with legal and contractual obligations.

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3. Providing oversight and management of all the clinical aspects of pharmacy adherence, including providing disease and medication management.
4. Ensuring that claims for PADs are processed as a medical benefit. Processing and covering PADs, which are expected to be submitted on medical claims.
5. Providing retrospective DUR services.
6. Participating in the Medi-Cal Global DUR Board and other DHCS organized pharmacy committee meetings.
7. Ensuring that DUR program meets or exceeds applicable provisions of Section 1004 requirements of the SUPPORT for Patient and Communities Act: A retrospective claims review process that monitors when an individual is concurrently prescribed opioids and benzodiazepines, opioids and antipsychotics, or opioids and Medication Assisted Treatment (MAT).
8. Developing and implementing effective retrospective DUR and treatment outcome processes to assure that drug utilization is appropriate, medically necessary, and not likely to result in adverse events.
9. Reimbursing pharmacist professional services as required by Assembly Bill (AB) 1114 (Chapter 602, Statutes of 2016) in a community-based outpatient pharmacy setting.
10. Processing and payment of all pharmacist professional services allowed by AB 1114 that are billed on medical and institutional claims.

## III. PROCEDURE

**A.** CHPIV delegates applicable pharmaceutical services 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.
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 |
|---|---|
| **Department of Health Care Services (DHCS)** | The State agency responsible for administration of the federal Medicaid (referred to as Medi-Cal in California) Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP) and other health related programs. |

| | |
|---|---|
| **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).<br><br>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.<br><br>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 "ameliorate" is to "make more tolerable". Additional services must be provided if determined to be medically necessary for an individual child. |
| **Member** | A beneficiary enrolled in a CHPIV program. |
| **Provider** | 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. |
| **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. |

4

COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

# EMPLOYEE HANDBOOK

**IMPERIAL COUNTY LOCAL HEALTH AUTHORITY**
**DBA COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY**

**EFFECTIVE JANUARY 2023**

**REVISED FEBRUARY 2025**

**Table of Contents**

## INTRODUCTION

### WELCOME TO IMPERIAL COUNTY LOCAL HEALTH AUTHORITY DBA COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY!

We're very happy to welcome you to the Imperial County Local Health Authority Dba Community Health Plan of Imperial Valley (chpiv). Thanks for joining us! We would like you to feel that your employment with us will be mutually beneficial and enjoyable.

You are joining a plan that has established an outstanding reputation. Credit for this goes to every one of our employees and we hope that you will find satisfaction and take pride in your work here.

### HISTORY

The Imperial County Local Health Authority was established to provide leadership and stakeholder collaboration and coordination to reduce health disparities and address health status improvements. Established in 2014, the primary focus was in seeking creative healthcare infrastructure improvements to facilitate the continued improvement in health status of Imperial County Residents. From the drafting of the Imperial County ordinance and the Imperial County Local Health Authority bylaws it was always a goal to develop a locally owned and governed Medi-Cal health plan.

In 2020 the Department of Health Care Services announced a large-scale reapplication process for all Medi-Cal Managed Care Plans, with a specific interest in local, single-plan models. The application process began in 2021 and led to the creation of Community Health Plan of Imperial Valley as a single-plan model for Imperial County.

As we transitioned to our role as the direct contract holder in Imperial County beginning January 1, 2024, our key responsibilities changed to governance and oversight of the health plan's administration of services to Medi-Cal members. We then engaged in expanded active dialogue with the community, providers, and Medi-Cal members regarding the resources available to support members in achieving optimal health. We strive to improve understanding of members and empower them to engage in improving their health. We also continuously search for ways to improve services for the benefit of membership improvement in their health. We are always charged with assuring the sustainability of Local Health Authority priorities, mission, and vision and the sustainability of the healthcare safety net network of providers.

### MISSION AND VISION

Mission: The mission of the Community Health Plan of Imperial Valley is to work with community residents and stakeholders in both the public and private sectors to:

1. advance opportunities for improved health and access to comprehensive health care services
2. promote the long-term viability of safety net providers
3. increase prevention, education, and early intervention services

4. partner with Medi-Cal managed care plans to monitor and improve the local healthcare system.

Vision: Healthy Community, Healthy Residents

**CORE VALUES**
INTEGRITY. Honestly, Trustworthiness, hardworking, accountability for our actions, and helpful to all.
RESPECT. treating people how you would like to be treated.
RESPONSIBILITY: Own the service we provide.
TEAMWORK: Supporting your colleagues and team members when they need you and vice-versa, them being there when you need them.
SERVANT MANAGEMENT. serve the interests of all.

**HANDBOOK PURPOSE**
This employee handbook is presented as a matter of information and has been prepared to inform employees about Plan's philosophy, employment practices, policies, and the benefits provided to our valued employees, as well as the conduct expected from them. While this handbook is not intended to be a book of rules and regulations or a contract, it does include some important guidelines which employees should know. Except for the at-will employment provisions, the handbook can be amended at any time.

This employee handbook will not answer every question an employee may have, nor would the Plan want to restrict the normal question and answer interchange among us. It is in our person-to-person conversations that we can better know each other, express our views, and work together in a harmonious relationship.

We hope this guide will help employees feel comfortable with us. The Plan depends on its employees; their success is our success. Please don't hesitate to ask questions. Every manager will gladly answer them. We believe employees will enjoy their work and their fellow employees here. We also believe that employees will find the Plan a good place to work.

No one other than authorized management may alter or modify any of the policies in this employee handbook. No statement or promise by a supervisor, manager, or designee is to be interpreted as a change in policy, nor will it constitute an agreement with an employee.

Should any provision in this employee handbook be found to be unenforceable and invalid, such a finding does not invalidate the entire employee handbook, but only the subject provision. Nothing in this handbook is intended to infringe upon employee rights under Section 7 of the National Labor Relations Act (NLRA) or be incompatible with the NLRA.

We ask that employees read this guide carefully, become familiar with the Plan and our policies, and refer to it whenever questions arise.

## EMPLOYMENT

### EQUAL EMPLOYMENT

It is the policy of the Plan to provide equal employment opportunities to all qualified individuals and to administer all aspects and conditions of employment without regard to the following:

- Race and associated traits, including hairstyle.
- Color
- Age
- Sex
- Sexual orientation
- Gender
- Gender identity and gender expression
- Religion, including dress and grooming practices.
- National origin, including language use restrictions.
- Pregnancy, childbirth, or breastfeeding
- Marital status
- Genetic information, including family medical history.
- Physical or mental disability
- Military or veteran status
- Citizenship and/or immigration status
- Child or spousal support withholding
- Domestic violence, assault, or stalking victim status
- Medical conditions, including cancer and AIDS/HIV
- Lawful conduct occurring during nonworking hours not on COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY's premises.
- Prior non-conviction arrest record
- Any other protected class, in accordance with applicable federal, state, and local laws

Discriminatory, harassing, or retaliatory behavior is prohibited from coworkers, supervisors, managers, owners, and third parties, including clientele. The Plan takes allegations of discrimination, harassment, and retaliation very seriously and will promptly investigate when warranted.

Equal employment opportunity includes, but is not limited to, employment, training, promotion, demotion, transfer, leaves of absence and termination.

### BACKGROUND CHECKS

The Community Health Plan of Imperial Valley may conduct a background check on any applicant or employee with their signed consent. The background check may consist of prior employment verification, reference checks, education confirmation, criminal background, credit history, or other information, as permitted by law (if

**Commented [SL1]:** We should explicitly state what would cause an employee to be terminated or an applicant not to be hired:
-In compliance with California "Ban the Box" regulation, no background check will be run until after a conditional job offer has been made
- No felony
- No job-related misdemeanors. Give example
- If an adverse decision is made, the individual will be provided with a copy of the background check
- Background checks will be retained for the period of time dictated by state law

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permitted by AB 22). Third-party services may be hired to perform these checks. All offers of employment and continued employment are contingent upon a satisfactory background check. Refusal to consent to a background check may result in discipline, up to or including termination.

In compliance with California "Ban the Box" regulation, no background check will be run until after a conditional job offer has been made. The following conditions would cause an applicant not to be hired:

- A felony conviction of any kind
- A job-related misdemeanor conviction. Job relatedness will be determined by the CEO and hiring manager, in consultation with HR

In compliance with the organization's regulatory requirements, candidates will also be checked for exclusions in the Office of the Inspector General (OIG) database. Any exclusion against a candidate will result in the individual not being hired. Employees are subject to rechecks pursuant to regulatory requirements.

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If an adverse decision is made, the individual will be provided with a copy of the background or OIG check.

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Background checks will be retained for the period of time dictated by state law.

### AT-WILL NOTICE

The employment relationship between the Plan and employees is at-will. This means that employees are not hired for any specified period and their employment may be terminated at any time, with or without cause, and with or without notice, by either the Plan or the employee. Community Health Plan of Imperial Valley's policy requires that all employees are at-will; any implied, oral, or written agreements or promises to the contrary are void and unenforceable, unless approved by an officer with the power to create an employment contract. There is no implied employment contract created by this Handbook or any other Community Health Plan of Imperial Valley document or written or verbal statement or policy.

### ANNIVERSARY DATE AND SENIORITY

The employee's date of hire is their official employment anniversary date. Seniority is the length of continuous service starting on that date. Should an employee leave the Plan and then be rehired, previously accrued seniority will be lost, and seniority will begin to accrue again on the date of rehire. With the exception of certain protected leaves and paid time off, seniority does not accrue during leaves of absence that exceed 30 calendar days.

### IMMIGRATION LAW COMPLIANCE

All employees are required to complete Section 1 of Form I-9 on their first day of employment, and produce, within three business days, acceptable proof of their

identity and eligibility to work in the United States. Failure to produce the proper identifying documents within three days will result in termination.

**INTRODUCTORY PERIOD**

The employee's first 90 days of employment with the Plan are considered an introductory period. This introductory period will be a time for getting to know fellow employees, managers and the tasks involved in the position, as well as becoming familiar with the Plan's products and services. The supervisor or manager will work closely with each employee to help them understand the needs and processes of their job.

This introductory period is a try-out time for the employee and the Plan. During this introductory period, the Plan will evaluate employees' suitability for employment and employees can evaluate the Plan as well. At any time during these first 90 days, employees may resign. If, during this period, employee work habits, attitude, attendance, performance, or other relevant factors do not measure up to our standards, the Plan may terminate employment.

At the end of the introductory period, the supervisor or manager will discuss each employee's job performance with them. During the discussion, employees are encouraged to give their comments and ideas as well.

Completion of the introductory period does not guarantee continued employment for any specified period, nor does it require that an employee be discharged only for cause. Completion of the introductory period also does not imply that employees now have a contract of employment with the Plan, other than at-will. Successful completion of the introductory period does not alter the at-will employment relationship.

A former employee who has been rehired after a separation from the Plan of more than one year is considered an introductory employee during the first 90 days following rehire.

**EMPLOYMENT CLASSIFICATIONS**

The Community Health Plan of Imperial Valley has established the following employee classifications for compensation and benefit purposes only. An employee's supervisor or manager will inform the employee of their classification, status, and responsibilities at the time of hire, re-hire, promotion or at any time a change in status occurs. These classifications do not alter the employment at-will status.

Regular Full-Time Employee

means an employee who is regularly scheduled to work forty (40) hours per week. Such employees may be exempt or nonexempt under the Fair Labor Standards Act (FLSA) as described below. Full-time employees are eligible for benefits as described in this handbook.

Regular Part-Time Employee
An employee who is scheduled to work less than 40 hours in a work week.

Temporary Employee
An employee who is scheduled to work on a specific need of the COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY. The employee will not receive any benefits unless specifically authorized in writing.

Exempt
Employees whose positions meet specific tests established by the Fair Labor Standards Act (FLSA) and applicable state law and who are exempt from overtime pay requirements. The basic premise of exempt status is that the exempt employee is to work the hours required to meet their work responsibilities.

Non-Exempt
Employees whose positions do not meet FLSA and state exemption tests and who are paid a multiple of their regular rate of pay for overtime hours worked. Unless notified otherwise in writing by management, all employees of the Community Health Plan of Imperial Valley are non-exempt.

**PERSONNEL RECORDS**
The Community Health Plan of Imperial Valley will maintain various employment files while individuals remain employees of the Plan. Examples of these files are employee personnel files, attendance files, I-9 files, and files for medical purposes. If any changes with respect to personal information, such as a change in home address and telephone number or a change of name occur, employees are required to notify their supervisor or manager so the appropriate updates can be made to the files. The Community Health Plan of Imperial Valley will take reasonable precautions to protect employee files and employee personally identifiable information in its records.

Employee files have restricted access. Employees, their supervisor or manager, or their designated agents, may have access to those personnel files. If an employee (or former employee) wishes to review their personnel file, they must do so in the presence of a supervisor or manager.

Employees may review or obtain a copy of their personnel file or payroll records by making a written request to their supervisor or manager. The written request will become a permanent part of the personnel file and the Community Health Plan of Imperial Valley will make the contents of those records available within a reasonable time frame.

**EMPLOYEE REFERENCES**
All employee reference checks must be forwarded to Human Resources; only authorized members of management or Human Resources may provide this information. When the Community Health Plan of Imperial Valley is contacted for a reference check or employment verification, generally only positions held, and dates

of employment will be confirmed. In some circumstances, past salary, and eligibility for rehire may be provided as well.

**JOB TRANSFERS**

The Community Health Plan of Imperial Valley aspires to promote qualified internal candidates to fill open positions whenever possible and practical. When job openings occur, current employees who have been in their current role for at least 12 months are encouraged to apply.

Employees are encouraged to discuss their desire for a job transfer with their current manager. In all cases, if the hiring manager chooses to interview the employee for the vacancy, the current manager will be made aware.

Current managers are encouraged to openly discuss the employee's desire for a transfer with the employee.

Management reserves the right to place an employee in whatever job it deems useful or necessary. All job transfers, reassignments, promotions, or lateral transfers are at the discretion of the Community Health Plan of Imperial Valley.

**EMPLOYMENT OF RELATIVES**

The Community Health Plan of Imperial Valley does not have a general prohibition against hiring relatives. However, an employee will not be hired, transferred, or promoted into a position where they will be managed, directly or indirectly, by a family member or romantic partner. This includes family members of staff and LHA Commission. Other factors may also be considered when hiring a relative or romantic partner of a current employee, placing them in a particular position, or creating reporting relationships. The Community Health Plan of Imperial Valley may transfer an employee or otherwise change their employment status at any time for any reason, including to avoid the appearance of favoritism or other conflict of interest. Refer to our Conflict-of-Interest policy for more information.

## CONDUCT AND BEHAVIOR

~~**GENERAL CONDUCT GUIDELINES**~~**BEHAVIORAL EXPECTATIONS**

Employees are expected to always exercise common sense and courtesy, for the benefit of clients, co-workers, and the Community Health Plan of Imperial Valley as a whole. Professionalism is expected, as is respect for the safety and security of people and property.

All CHPIV employees are expected to maintain ethical conduct and avoid conflicts of interest in accordance with the organization's core values. At a minimum, employees are expected to demonstrate the below-listed qualities at all times. Failure to meet these expectations may be grounds for discipline, up to and including termination.

**Effective Communication:**

- It is vital to communicate in a clear and respectful manner.
- It is imperative for professionals to engage in active listening, effectively communicate, and modify their manner of looking at diverse audiences.
- Empathy, active listening, and constructive criticism all contribute to the development of healthy relationships and teams.

**Personal Accountability:**

- Professionals are expected to effectively manage their time, adhere to deadlines, and assume responsibility for their assigned duties.
- Demonstrating accountability for one's actions and outcomes instills confidence and dedication.

**Collaboration and Teamwork:**

- Effective teamwork is critical.
- Professionals ought to engage in cross-team collaboration, contribute to the collective success, and exchange knowledge.
- A collaborative mindset results in improved outcomes and novel solutions.

**Continuous Learning and Adaptability:**

- The professional environment is undergoing accelerated change.
- Professionals ought to be adaptable, continually educate themselves, and embrace change.
- Growth mindsets foster qualities such as adaptability and resilience.

**Affection and Competence in Appearance and Conduct:**

- Adopt appropriate attire for the job site.
- Strive to uphold a professional demeanor.
- Demonstrate esteem for superiors, clients, and colleagues. Avoid using offensive language and unprofessional conduct.

**Emotional Intelligence and Conflict Resolution:**

- Conflicts are inevitable. Disagreements should be addressed constructively, win-win solutions should be sought, and emotions should be managed.
- Emotional intelligence facilitates healthy relationships and the ability to navigate difficult situations.

**A Dedication to Inclusion and Diversity**:

- It is imperative that professionals uphold the value of diversity, ensure that all individuals are treated with respect, and establish an environment that fosters inclusivity.
- The incorporation of diverse viewpoints into an organization fosters innovation and success.

## STANDARDS OF CONDUCT

While it is impossible to list everything that could be considered misconduct in the workplace, what is outlined here is a list of examples of inappropriate conduct. Engaging in these behaviors may lead to discipline, up to and including termination.

Examples of misconduct include:

- Violation of the policies and procedures set forth in this handbook.
- Possessing, using, distributing, selling, or negotiating the sale of illegal drugs or other controlled substances.
- Being under the influence of alcohol or drugs during work hours, or on organization business.
- Inaccurate reporting of hours worked by you or any other employees.
- Providing knowingly inaccurate, incomplete, or misleading information when speaking on behalf of the organization or in the preparation of any employment-related documents including, but not limited to, job applications, personnel files, employment review documents, intra-organization communications, or expense records.
- Taking or destroying organizational property.
- Fighting with, or harassment of (as defined in our EEO policy), any fellow employee, vendor, or customer.
- Disclosure of organization trade secrets and proprietary and confidential commercially sensitive information (i.e., financial or sales records/reports, marketing or business strategies/plans, product development information, customer lists, patents, trademarks, etc.) of the organization or its members, contractors, suppliers, or vendors.
- Refusal or failure to follow directions or to perform a requested or required job task.
- Refusal or failure to follow safety rules and procedures.
- Excessive tardiness or absences.
- Working unauthorized overtime.
- Solicitation of fellow employees on organization premises during working hours.
- Use of obscene or harassing (as defined by our EEO policy) language in the workplace.
- Engaging in outside employment that interferes with your ability to perform your job at this organization, or that is a conflict of interest to the organization.
- Engagement in criminal activity or criminal arrest and conviction.

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### SEXUAL AND OTHER UNLAWFUL HARASSMENT

The Community Health Plan of Imperial Valley is committed to providing a work environment free of harassment in any form, including inappropriate and disrespectful behavior, intimidation, and other unwelcome conduct directed at an individual because of their inclusion in a protected class. Applicable federal and state law defines

harassment as unwelcome behavior based on someone's inclusion in a protected class. Sometimes language or actions that were not expected to be offensive or unwelcome are, so employees should err on the side of being more sensitive to the feelings of their co-workers rather than less.

The following are examples of harassment; behaviors not in this list may also be considered harassment:

- Unwanted sexual advances.
- Offering employment benefits in exchange for sexual favors.
- Retaliation or threats of retaliation for refusing advances or requests for favors.
- Leering, making sexual gestures or jokes, or commenting on an employee's body.
- Displaying sexually suggestive content.
- Displaying or sharing derogatory posters, photographs, or drawings.
- Making derogatory epithets, or slurs.
- Ongoing teasing about an employee's religious or cultural practices.
- Ongoing teasing about an employee's sex, sexual orientation, or gender identity.
- Physical conduct such as touching, assault, or impeding or blocking movements.

Sexual harassment on the job is unlawful whether it involves coworker harassment, harassment by a manager, or harassment by persons doing business with or for the Community Health Plan of Imperial Valley, such as clients, customers, or vendors.

Retaliation

Any form of retaliation against someone who has expressed concern about any form of harassment, refused to partake in harassing behavior, made a harassment complaint, or cooperated in a harassment investigation, is strictly prohibited. A complaint made in good faith will under no circumstances be grounds for disciplinary action. Individuals who make complaints that they know to be false may be subject to disciplinary action, up to and including termination.

Enforcement

***All managers and supervisors are responsible for:***

- Implementing the Community Health Plan of Imperial Valley's harassment policy.
- Ensuring that all employees they supervise have knowledge of and understand the Community Health Plan of Imperial Valley policy.
- Reporting any complaints of misconduct to the designated Community Health Plan of Imperial Valley representative, the Office & Human Resources Manager, so they may be investigated and resolved internally.
- Taking and/or assisting in prompt and appropriate corrective action when necessary to ensure compliance with the policy; and
- Conducting themselves in a manner consistent with the policy.

Addressing Issues Informally
Employees who witness offensive behavior in the workplace - whether directed at them or another employee - are encouraged, though not required, to immediately address it with the employee whose behavior they found offensive. An employee who is informed that their behavior is or was offensive should stop immediately and refrain from that behavior in the future, regardless of whether they agree that the behavior could have been offensive.

Harassment Complaint Procedure
Employees are encouraged to use the Complaint Procedure to report behavior that they feel is harassing, whether that behavior is directed at them. The Complaint Procedure provides for immediate, thorough, and objective investigation of claims of harassment. Appropriate disciplinary action will be taken against those who are determined to have engaged in harassing behavior.

**ABUSIVE CONDUCT**
Abusive conduct means malicious conduct in the workplace that a reasonable person would find hostile or offensive and unrelated to an employer's legitimate business interests. Abusive conduct may include repeated infliction of verbal abuse, such as the use of derogatory remarks, insults, and epithets, verbal, or physical conduct that a reasonable person would find threatening, intimidating, or humiliating, or the sabotage or undermining of a person's work performance. A single act will generally not constitute abusive conduct, unless especially severe.

The Community Health Plan of Imperial Valley considers abusive conduct in the workplace unacceptable and will not tolerate it under any circumstances. Employees should report abusive conduct to a manager or Human Resources. Managers are responsible for ensuring that employees are not subjected to abusive conduct. All reports will be treated seriously and investigated when appropriate. Employees who are found to have engaged in abusive conduct will be subject to discipline, up to and potentially including termination. Retaliation against an employee who reports abusive conduct or verifies that it took place is strictly prohibited.

**COMPLAINT PROCEDURE**

The Community Health Plan of Imperial Valley has established a procedure for a fair review of complaints related to any workplace controversy, conflict, or harassment. Employees may take their complaint directly to the person or department listed in Step 2 if the complaint is related to their supervisor or manager or if the employee feels the supervisor or manager would not provide an impartial resolution to the problem.

Step 1
The complaint should be submitted orally or in writing to a supervisor or manager within three working days of the incident or as soon as possible. Sooner is better, as it will assist in a more accurate investigation, but complaints will be taken seriously regardless of when they are reported. Generally, a meeting will be held within three

business days of the employee's request, depending upon scheduling availability. Attempts will be made to resolve the issue during the meeting, but regardless of whether there is an immediate resolution, the supervisor or manager will give the employee a written summary of the meeting within three business days. Resolution may take longer if further investigation of the complaint is required. If the employee is not satisfied with the resolution, they may proceed to Step 2.

Step 2
The employee may submit an oral or written request for review of the complaint and Step 1 resolution to the Human Resources Department or a designated investigator. This request should be made within three working days following the receipt of the Step 1 resolution. The Human Resources Department or the designated investigator will review the complaint and resolution and may call an additional meeting to explore the problem. If warranted, additional fact-finding will be undertaken. A final decision will be as soon as practicable, thereafter receiving the Step 2 request, and a written summary of the resolution will be provided to the employee who filed the complaint.

## EXTERNAL EEO COMPLAINTS

In addition to the organization's internal complaint procedure, employees may also contact either the Equal Employment Opportunity Commission (EEOC) or the California Civil Rights Department (CRD) to report unlawful harassment. You must file a complaint with the CRD within three years of the alleged unlawful action. The EEOC and the CRD serve as neutral factfinders and will attempt to assist the parties to voluntarily resolve their disputes. For more information, contact the nearest EEOC or CRD office.

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## CORRECTIVE ACTION

A high level of job performance and professionalism is expected from each employee. If an employee's job performance does not meet the standards established for the position, they violate Community Health Plan of Imperial Valley's policies or procedures, or their behavior is otherwise unacceptable, corrective action may ensue. Corrective action may include, but is not limited to: coaching, oral or written warnings, performance improvement plans, paid or unpaid suspension, demotion, and termination. The type and order of actions taken will be at management's sole discretion and the Community Health Plan of Imperial Valley is not required to take any disciplinary action before making an adverse employment decision, including termination.

## COMPENSATION

### PAY PERIODS

The standard seven-day payroll workweek for the Community Health Plan of Imperial Valley will begin at 12:00 a.m. Sunday. The designated pay period for all employees is bi-weekly. Paydays are bi-weekly on Friday. Except as otherwise provided, if any date of paycheck distribution falls on a weekend or holiday, employees will be paid on the preceding scheduled workday.

### TIMEKEEPING

All non-exempt employees are required to use the timekeeping system to record their hours worked. For the purposes of this policy, all forms of timekeeping will be referred to as clocking in or out.

Employees should clock in no sooner than two minutes before their scheduled shift and clock out no later than two minutes after their scheduled shift. Additionally, employees are required to clock in and out for their designated lunch periods Each hourly employee is required to take their meal break before the end of their 6$^{th}$ hour working. Lunch periods are unpaid when employees are relieved of all duties. Employees are entitled to uninterrupted meal breaks. Non-exempt employees are required to clock-out and clock-in at their lunchtimes.

Accurate timekeeping is a federal and state wage and hour requirement, and employees are required to comply. Failing to enter time into the timekeeping system in an accurate and timely manner is unacceptable job performance. Employees are required to record ALL time they are working on Plan business. Failure to do so could result in disciplinary action. Employees may not ask another employee to clock in or out for them. Should an employee miss an entry into the timekeeping system, they must notify their manager as soon as possible for correction.

Non-exempt employees are not permitted to work unscheduled times without prior authorization from their manager. This includes clocking in early or late.

Hourly employees are responsible for taking and attesting their paid 10-minute breaks. The break form is to be completed and submitted at the beginning of each pay period. These breaks are to be taken first at 10:00 am and then again at 3:30 PM.

### OVERTIME

The Community Health Plan of Imperial Valley complies with all applicable federal laws regarding payment of overtime work. Non-exempt employees will be paid overtime (one and one-half times the regular rate of pay) for all hours worked over eight in one workday, over 40 in one work week.

If the Community Health Plan of Imperial Valley approves an employee's request to make up work time, the hours of that makeup work performed in the same week that the work was lost do not count towards computing the total number of hours worked in a day.

Employees are required to work overtime when assigned. Any overtime worked must be authorized by a supervisor or manager, in advance. Working unauthorized overtime or the refusal or unavailability to work overtime is unacceptable work performance, subject to discipline including but not limited to termination.

**PAYROLL DEDUCTIONS**

The Community Health Plan of Imperial Valley complies with the salary basis requirements of the Fair Labor Standards Act (FLSA) and does not make improper deductions from the salaries of exempt employees. There are, however, certain circumstances where deductions from the salaries of exempt employees are permissible. Such circumstances include:

- When an exempt employee is absent from work for one or more full days for personal reasons other than sickness or disability
- When an exempt employee is absent for one or more full days due to sickness or disability if the deduction is made in accordance with a bona fide sick leave plan that provides compensation for salary lost due to illness.
- To offset amounts received as witness or jury fees, or for military pay.
- When an employee is on unpaid leave under the Family Medical Leave Act
- During an employee's first and last week of employment, if they work less than a full week.

If an employee believes that an improper deduction has been made, they should immediately report this to their manager or the person responsible for payroll processing. Reports will be promptly investigated and if it is determined that an improper deduction has occurred, the employee will be promptly reimbursed.

**PAY ADJUSTMENTS, PROMOTIONS AND DEMOTIONS**

All pay increases are based upon merit, market factors, and the profitability of the Community Health Plan of Imperial Valley. Any pay increases ~~are retrospectively paid from the beginning of the pay period after the employee's hire date~~ anniversary that are granted will be made in the 1st quarter of the new year. There is not an automatic annual cost of living or salary adjustment. Salary decreases may take place when there is job restructuring, job duty changes, job transfers, or adverse business economic conditions. Demotion is a reduction in responsibility, usually accompanied by a reduction in salary. If demotion occurs, employees will maintain their seniority with the Community Health Plan of Imperial Valley.

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**PERFORMANCE EVALUATION**
Performance reviews are scheduled to take place approximately thirty (30) days before or after the anniversary date of the employee. This evaluation may be either written or oral.

If the employee receives an evaluation sheet or other written document, they will be required to sign it. An employee's signature does not necessarily indicate that the employee agrees with all the comments, but that they have been given the opportunity to examine the evaluation and discuss it with their manager. The completed and signed evaluation form will be placed in the employee's personnel file and the employee will receive a copy of the performance evaluation.

In addition to performance evaluations, informal counseling sessions may be conducted from time to time.

**WORK ASSIGNMENTS**
On occasion employees may be required to perform duties that are not part of their job description or usual tasks. This may happen because a co-worker is absent, a position is temporarily vacant, the business or department is particularly busy, or for other reasons. Employees are expected to perform these additional duties in a timely fashion and to the best of their ability. Should questions about process or procedure arise, employees should speak with their manager. Unless informed otherwise, employees will be paid at their regular rate of pay.

**EXPENSE REIMBURSEMENT**
The Community Health Plan of Imperial Valley will cover all reasonable, business-related expenses. Any cost that does not fall within the guidelines below must be approved by the appropriate manager *before* the expense is incurred. Employees may not be reimbursed for expenses that were not approved in advance and are deemed unnecessary or extravagant.

The following types of expenses may be reimbursable under this policy:

- Lodging
- Travel expenses including airfare, reasonable airline luggage fees, train fare, bus, taxi, and related tips.
- Meals, including tips up to 20%
- Laundry and dry-cleaning expenses during trips in excess of five days
- Car rental, parking fees, and tolls
- Mileage on a personal vehicle at the current IRS reimbursement rate
- Conference and convention fees
- Business entertainment expenses, up to pre-approved limits

Reimbursable limits on each type of expense will be found in the travel request forms in the Finance Department's policies. All travel outside of Imperial County requires your manager's approval on a completed Travel Request Form.

The following expenses are examples of expenses not reimbursable under this policy:

- Airline club dues
- Traffic fines
- Tips more than 20%
- In-flight movies, mini-bar expenses, and other forms of personal entertainment
- First-class airfare
- Alcohol Drinks

No policy can anticipate every situation that might give rise to legitimate business expenses. Reasonable and necessary expenses not listed above may be reimbursable. When prior approval is required, managers should use their best judgment to determine if an unlisted expense is reimbursable under this policy.

Credit Cards

Community Health Plan of Imperial Valley issued credit cards are to be used for purchases on behalf of the Plan and for any travel expenses incurred while traveling on Community Health Plan of Imperial Valley business only. At no time may an employee use a Plan credit card for purchases intended for personal use; such expenses will require that the Plan be reimbursed and may lead to revocation of credit card privileges and other discipline. Credit card expenses require the same reimbursement documentation as other expenses.

Documentation

Requests for reimbursement of business expenses must be submitted on the Expense Reimbursement Form. These forms are available through deluxe. To comply with IRS regulations, all business expenses be supported with adequate records. Employees are responsible for keeping these records as expenses are incurred. These records must include:

- The amount of the expenditure
- The time and place of the expenditure
- The business purpose of the expenditure
- The names and the business relationships of individuals for whom the expenditures were made.

Requests for reimbursement lacking this information will not be processed and will be returned to the employee. While original receipts are preferred for all expenses, they are required for those greater than $25.00. Requests for exceptions to this policy should explain why the exception is necessary and be approved by management.

Approvals

Expense reimbursement forms, together with required documentation, and the approved Travel Request Form must be submitted to the employee's manager for review and approval. Once the expense reimbursement has been approved, it should

be submitted for processing no more than 30 days after the expenses occurred. Managers approving expense reports are responsible for ensuring that the expense report has been filled out correctly with the required documentation and that the expenses submitted are allowable under this policy.

**ADVANCES AND LOANS**
The Community Health Plan of Imperial Valley does not give advances or loans to employees.

## BENEFITS

**HOLIDAYS**
Regular full-time employees are entitled to the following paid holidays observed by The Community Health Plan of Imperial Valley:

- New Year's Day
- Martin Luther King Jr. Day
- President's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving
- Friday after Thanksgiving
- Christmas Day

Other days or parts of days may be designated as holidays with or without pay. No holiday pay will be paid to an employee who is on an unpaid status. If a holiday falls on a Sunday, the holiday may be observed on the following Monday. If the holiday falls on a Saturday, the holiday may be observed on the preceding Friday.

**VACATION**
Vacations provide a break beneficial to both the Community Health Plan of Imperial Valley and employees. Vacation time is available to all employees after their 90$^{th}$ day of employment. Therefore, employees are encouraged to take vacations annually. Eligible employees include:

- Full-time exempt
- Full Time Non Exempt

**Employees Vacation Accrual is as follows:**

| Vacation | Executive | Directors | Managers | Others |
|---|---|---|---|---|
| Year 1 | 17 | 12 | 10 | 10 |
| Year 2 | | | | |
| Year 3 | | | | |
| Year 4 | 18 | 13 | 11 | 10 |
| Year 5 | | | | |
| Year 6 | 19 | 14 | 12 | 11 |
| Year 7 | | | | |
| Year 8 | 20 | 15 | 13 | 12 |
| Year 9 | | | | |
| Year 10 | 22 | 17 | 15 | 12 |

Unused vacation will be carried over each year with a maximum accrual bank of twice the amount allowed to accrual annually. For example, someone who accrues 12 days of vacation a year, can have a max accrual bank of 192 hours. Unused vacation will be paid out upon employment separation.

Vacations are to be requested through your manager/supervisor with 30 days advance notice prior to days out of the office. Employees are responsible for submitting time-off requests and hours used for vacation or sick-leave through Rippling.

**SICK LEAVE**

Each employee is entitled to 5 days (40 hours) of paid time off immediately after the date of hire. Sick time does not accrue and is on a use it or lose it basis. If employees have no more sick time left, they may use their vacation time or choose to take unpaid time off.

Sick leave may be used for diagnosis, care, or treatment of an existing health condition of, or preventive care for, an employee or an employee's family member, or by an employee who is a victim of domestic violence, sexual assault, or stalking. Unused sick leave will not be compensated for at the end of employment. Employees rehired within one year of separation will have their previously accrued sick leave restored.

Employees are responsible for advising their manager no later than 1 hour before the start of their shift when calling out sick.

Employees are encouraged to stay home when sick. This is to protect the health and safety of other employees.

The Plan requires employees to use paid sick leave under this policy in minimum increments of two hours.

**HEALTH AND WELFARE BENEFITS**

The Community Health Plan of Imperial Valley complies with all applicable federal and state laws with regard to benefits administration. All regular employees scheduled and generally working at least 40 hours a week are entitled to health insurance and other plan-sponsored health benefits, when in effect. The Community Health Plan of Imperial Valley reserves the right to change or terminate health plans or other benefits at any time.

New qualifying employees will be eligible for coverage on the 1st of the month after the employee starts. New employees may elect not to be covered, with the permission of The Community Health Plan of Imperial Valley provided the percentage of employees not covered is within the benefit plan specifications.

**CONTINUATION OF BENEFITS**

Under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), or a state mini-COBRA law, employees may be allowed to continue their health insurance benefits, at their own expense, for a set number of months after experiencing a qualifying event. Length of coverage may be dependent upon the qualifying event. (defined by COBRA regulations?)

To qualify for continuation of health benefits, the covered individual must experience a qualifying event that would otherwise cause them to lose group health coverage. The following are qualifying events:

<u>For Employees</u>

- Voluntary or involuntary termination of employment for reasons other than gross misconduct
- Reduction in number of hours worked.

<u>For Spouses</u>

- Loss of coverage by the employee because of one of the qualifying events listed above.
- Covered employees become eligible for Medicare.
- Divorce or legal separation of the covered employee
- Death of the covered employee

For Dependent Children

- Loss of coverage because of any of the qualifying events listed for spouses.
- Loss of status as a dependent child under the plan rules

See Human Resources for additional information.

**STATE DISABILITY INSURANCE**

The State of California has a partial wage-replacement insurance plan for California workers. The cost of this insurance is fully paid by the employee through payroll deductions. The SDI program includes both Disability Insurance and Paid Family Leave.

Disability Insurance (DI)

Employees who lose wages when an illness, injury or pregnancy-related disability prevents them from working and who meet all the state eligibility requirements can collect disability insurance benefits.

The benefits are calculated as a percentage of employee salary up to a weekly maximum as specified by law, for up to 52 weeks.

Employees are responsible for filing their claim and other forms promptly and accurately with the Employment Development Department. A claim form may be obtained from the Employment Development Department online, by telephone, or in person.

Paid Family Leave (PFL)

Employees may be eligible for partial wage replacement benefits under the Paid Family Leave Act for up to a maximum of eight weeks for the following reasons:

- To bond with a new child after birth or placement for adoption or foster care
- To care for a serious health condition of an employee's child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, or registered domestic partner
- To participate in a qualifying event related to a family member's deployment to a foreign country.

The Paid Family Leave Act provides benefits based on past earnings. The cost of the insurance is fully paid by the employee. The 12-month period begins on the first day an employee submits a claim.

To be eligible for benefits, employees may be required to provide medical and/or other information that supports a claim for time off to bond with a new child or to care for a family member with a serious health condition.

The employee is responsible for filing their claim for family leave insurance benefits and other forms promptly and accurately with the Employment Development

Department. A claim form may be obtained from the Employment Development Department by telephone, letter, the Internet or in person. All eligibility and benefit determinations are made by the Employment Development Department.

Employees may not be eligible for Paid Family Leave benefits if they are receiving Disability Insurance, Unemployment Compensation Insurance or Workers' Compensation benefits.

The Paid Family Leave Act does not provide a right to leave, job protection or return to work rights. Further, this policy does not provide additional time off; rather, family leave insurance may provide compensation during an approved leave pursuant to any employer-provided leave.

**TEMPORARY DISABILITY LEAVE**

The Community Health Plan of Imperial Valley recognizes that a temporary disability may prevent employees from coming to work for a period of time. In such cases, the Community Health Plan of Imperial Valley may grant temporary disability leave. This leave does not have a minimum or maximum time frame. Rather, the Community Health Plan of Imperial Valley will attempt to reasonably accommodate the needs of the employee as well as the needs of the Community Health Plan of Imperial Valley. If leave is granted, any extensions will be subject to the same considerations.

Employees requesting temporary disability leave must document their request in writing. That request should be accompanied by a doctor's statement identifying how the temporary disability limits the employee's ability to work, the date and the estimated date of return and, where appropriate, diagnosis and prognosis. Should the employee's expected return date change, the employee should notify the Community Health Plan of Imperial Valley as soon as possible. Prior to returning to employment with the Community Health Plan of Imperial Valley, employees will be required to submit written medical certification of their ability to work, including any restrictions. Upon returning to work, if employees qualify, they will be reinstated to their former position or one that is substantially the same, depending upon the availability of any position at that time.

The leave will be unpaid, except that employees must use any available paid sick leave concurrently and may choose to use other accrued paid time off concurrently once their sick leave has been exhausted.

**MILITARY LEAVE**

If employees are on an extended military leave of absence, they are entitled to be restored to their previously held position or similar position, if available, without loss of any rights, privileges or benefits provided the employee meets the requirements specified in the Uniformed Services Employment and Reemployment Rights Act (USERRA).

**VOLUNTEER EMERGENCY RESPONDER LEAVE**

Employees who are volunteer firefighters, reserve peace officers, or emergency rescue personnel will be allowed to take temporary unpaid leaves of absence for the purpose of performing emergency duties. Employees who are volunteer emergency responders should inform their supervisor so that they are aware that the employee may need to take time off for emergency duty. When an employee is called to an emergency and needs to miss work, they should alert their supervisor before doing so whenever possible. Whether or not such leave is paid shall depend on federal and state law.

**JURY SERVICE LEAVE**

If an employee is summoned to report for jury duty, they will be granted a leave of absence when they notify and submit a copy of the original summons for jury duty to their supervisor or manager. The Community Health Plan of Imperial Valley reserves the right to request that they seek to be excused from or request postponement of jury service if the absence from work would create a hardship to the Community Health Plan of Imperial Valley

Any fees received for jury duty, including travel fees, are to be submitted to the Community Health Plan of Imperial Valley in exchange for paid leave provided by Community Health Plan of Imperial Valley. Employees are to report to work on any day, or portion thereof that is not actually spent in the performance of jury service. For each week of jury duty, a certificate of jury service must be certified by the Court and filed with the Community Health Plan of Imperial Valley no later than Wednesday of the following week. The leave is paid.

**WITNESS LEAVE**

If an employee is absent from work to serve as a witness in a judicial proceeding in which they are the victim, or in response to a subpoena or other order of the court, the employee will be granted leave without pay for such time as it is necessary to comply with the request. The Community Health Plan of Imperial Valley may request proof of the need for leave.

**VOTING LEAVE**

If an employee cannot vote because of their scheduled work hours, then the employee will be given additional time off to vote in any state or federal election.

Employees must apply for leave at least two days before Election Day. The Community Health Plan of Imperial Valley may specify the time during the day that leave can be taken. Generally, time off will be at the beginning or end of their shift, whichever allows the freest time for voting and the least time off from the regular working shift, unless otherwise mutually agreed upon.

Up to two hours will be compensated for at the employee's regular rate of pay. Additional time off, if necessary, will be unpaid. Exempt employees will be paid in accordance with the Fair Labor Standards Act.

**CRIME VICTIM LEAVE AND ACCOMMODATIONS**

An employee who is the victim of crime or abuse, or whose family member has died ~~has died~~ as a result of a crime, will be allowed to take time off work to attend court proceedings or to seek a restraining order or other relief for their or their child's health, safety, or welfare. Information regarding these rights and reporting requirements can be found here

~~Employees should provide reasonable notice of their absence if the need for leave is foreseeable. If an employee is unable to give advance notice, the Community Health Plan of Imperial Valley may require documentation of the need for leave after it has been taken.~~

~~This leave is unpaid, but employees may use any vacation hours towards the leave. Exempt employees will be paid in accordance with state and federal wage and hour laws.~~

~~The Community Health Plan of Imperial Valley will also make reasonable accommodations for victims of domestic violence, sexual assault, or stalking, including but not limited to the implementation of safety measures. Employees should contact the Office Manager/HR for additional information.~~

Employees who may potentially have a need for this leave should discuss the situation with their manager or Human Resources.

**SCHOOL LEAVE FOR DISCIPLINARY MATTERS**

The Community Health Plan of Imperial Valley will grant unpaid time off for employees who are parents or guardians of school-age children who need time off to attend to school issues. More information about this leave can be found here ~~pursuant to Labor Code 230.8. Employees are required to give reasonable notice to the Community Health Plan of Imperial Valley that they need to take time off.~~

The employee must use available vacation or personal leave for school visitation and must take leave without pay if no paid leave is available. Exempt employees may be provided time off with pay when necessary to comply with state and federal wage and hour laws.

**BEREAVEMENT LEAVE**

A regular employee of the Community Health Plan of Imperial Valley may request a leave of absence with pay for a maximum of 3 Days working day(s) upon the death of a member of their immediate family. Employees will be offered up to 5 days total, 3 days paid, 2 days unpaid of Bereavement Leave. Members of the immediate family are defined as parents, spouse, domestic partner, child, sibling, grandchild, grandparent, parent-in-law, and corresponding step-relatives. Proof of the need for leave may be required.

## BONE MARROW AND ORGAN DONATION LEAVE

Community Health Plan of Imperial Valley will provide employees who have been employed with the organization for at least 90 days, with a paid leave of absence for the purpose of donating organs or bone marrow. More information about this leave can be found here.

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## HEALTH, SAFETY, AND SECURITY

### NON-SMOKING

California law prohibits smoking in any public building or within 20 feet of a main entrance, exit, or window of a public building. The Community Health Plan of Imperial Valley does not permit smoking in any Community Health Plan of Imperial Valley buildings, facilities, work sites, or vehicles. Employees wishing to smoke should do so during their break times, outside Community Health Plan of Imperial Valley buildings in designated areas, and in accordance with local ordinances.

### DRUG AND ALCOHOL

The Community Health Plan of Imperial Valley is dedicated to providing employees with a workplace that is free of drugs and alcohol. While on Community Health Plan of Imperial Valley premises, whether during work time or non-work time, employees are prohibited from being under the influence of drugs or alcohol. There are limited exceptions for the use of prescription drugs (not including marijuana), as long as they do not create safety issues or impair an employee's ability to do their job, and the moderate use of alcohol at Community Health Plan of Imperial Valley-sponsored or sanctioned events.

Employees are strictly prohibited from possessing illegal drugs, cannabis, or excessive quantities of prescription or over-the-counter drugs while on Community Health Plan of Imperial Valley premises, performing Community Health Plan of Imperial Valley-related duties, or operating any Community Health Plan of Imperial Valley equipment. Any drugs confiscated that are suspected of being illegal will be turned over to the appropriate law enforcement.

Employees taking medication should consult a medical professional to determine whether the drug may affect their personal safety or ability to perform their job and should advise their manager of any resulting job limitations. Once notified, the Community Health Plan of Imperial Valley will make reasonable efforts to accommodate the limitation.

The Community Health Plan of Imperial Valley reserves the right to test any employee for the use of illegal drugs, marijuana, or alcohol, in accordance with applicable law. Employees in safety-sensitive positions may be subject to regular or random drug testing. Drug or alcohol tests may also be conducted after an accident in which drugs or alcohol could reasonably be involved, or when behavior or impairment on the job

creates reasonable suspicion of use. Under those circumstances, the employee may be driven to a certified lab for testing at the Community Health Plan of Imperial Valley's expense. Refusal to be tested for drugs or alcohol will be treated the same as a positive test result.

Violation of this policy may result in discipline, up to and including termination.

To the extent that any federal, state, or local law or regulation limits or prohibits the application of any provision of this policy, then that particular provision will be ineffective in that jurisdiction only, while the remainder of the policy remains in effect.

**EMPLOYER-SPONSORED SOCIAL EVENTS**

Community Health Plan of Imperial Valley holds periodic social events for employees. Be advised that your attendance at these events is voluntary and does not constitute part of your work-related duties.

The organization does not provide complimentary alcoholic beverages, but alcoholic beverages may be available for purchase at these events. If you choose to drink alcoholic beverages, you must do so in a responsible manner. Do not drink and drive. Instead, please call a taxi/ rideshare or appoint a designated driver.

**OFF-DUTY USE OF EMPLOYER PROPERTY OR PREMISES**

For your safety, it is organizational policy to control off-duty and nonworking hour use of facilities either for business or personal reasons. Access to facilities during off-duty or non-working hours is limited to employees who have a legitimate business reason to be on the premises.

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**REASONABLE ACCOMMODATIONS**

If the Community Health Plan of Imperial Valley is made aware of an employee's disability and resulting need for accommodation, Human Resources or the employee's manager will engage with them in the interactive process. This process will determine what, if any, accommodation is necessary and reasonable to assist the employee in doing the essential functions of their job. Whether accommodation is reasonable will be determined based on a number of factors, including whether it will effectively assist the employee in doing the essential functions of their job, the cost, and the effect on business operations. In most cases, employees will be required to provide documentation from an appropriate healthcare provider. Human Resources will provide employees with the necessary form.

All employees are required to comply with safety standards. Employees who pose a direct threat to the health or safety of themselves or others in the workplace may be temporarily moved into another position or placed on leave until it is determined if reasonable accommodation(s) will effectively mitigate the risk.

## ACCOMMODATIONS FOR PREGNANT EMPLOYEES

Community Health Plans of Imperial Valley will provide reasonable accommodation to pregnant employees for known limitations related to pregnancy, childbirth, or other related medical conditions following the federal Pregnant Workers Fairness Act (PWFA).

Examples of potential reasonable accommodations include:

- Flexible hours;
- Leave or time off to recover from childbirth;

If you require an accommodation, notify your manager. If the need for a particular accommodation is not obvious, you may be asked to include relevant information such as:

- The reason you need an accommodation.
- A description of the proposed accommodation.
- How the accommodation will address limitations caused by pregnancy, childbirth, or related medical conditions.

The organizations will comply with state or local laws that provide additional protections beyond the PWFA.

## INJURY AND ACCIDENT RESPONSE AND REPORTING

If an employee is injured or witnesses an injury at work, they must report it immediately to the nearest available manager. Employees should render any assistance requested by that manager. When any accident, injury, or illness occurs while an employee is at work, regardless of the nature or severity, the employee must complete an injury reporting form and return it to Human Resources as soon as possible. Reporting should not be allowed to delay necessary medical attention. Once the accident is reported, follow-up will be handled by Human Resources or the designated Safety Officer, including a determination as to whether the injured employee may return to work. (Do we have an "Injury Report Form"?)

Questions asked by law enforcement or fire officials making an investigative report should be answered giving only information and avoiding speculation. Liability for personal injury or property damage should never be admitted in answering an investigatory question asked by law enforcement or fire officials.

In addition to compliance with safety measures imposed by federal Occupational Safety and Health Act (OSHA) and state law, the Community Health Plan of Imperial Valley has an independent interest in making its facilities a safe and healthy place to work. The Community Health Plan of Imperial Valley recognizes that employees may be able to notice dangerous conditions and practices and therefore encourages employees to report such conditions, as well as non-functioning or hazardous equipment, to a manager immediately. Appropriate remedial measures will be taken when possible and appropriate. Employees will not be retaliated against or discriminated against for reporting accidents, injuries, or illnesses, filing of safety-related complaints, or requesting to see injury and illness logs.

**WORKERS' COMPENSATION**

The Community Health Plan of Imperial Valley carries insurance that covers work-related injuries and illnesses. The workers' compensation insurance carrier governs the benefits provided. These benefits will not be limited, expanded, or modified by any statements of Community Health Plan of Imperial Valley personnel or Community Health Plan of Imperial Valley documents. In the case of any discrepancy, the insurance carrier's documents will be checked.

**WORKPLACE VIOLENCE AND SECURITY**

The Community Health Plan of Imperial Valley expects all employees to conduct themselves in a non-threatening, non-abusive, and professional manner always. No direct, conditional, or veiled threat of harm to any employee, customer, business partner, or Community Health Plan of Imperial Valley property will be acceptable. Acts of violence or intimidation of others will not be tolerated. Any employee who commits, or threatens to commit, a violent act against any person while on Community Health Plan of Imperial Valley premises, will be subject to discipline, up to immediate termination.

Employees share the responsibility of identifying and alleviating threatening or violent behaviors. Any employee who is subjected to or threatened with violence, or who is aware of another individual who has been subjected to or threatened with violence, should immediately report this information to a manager. Threats will be investigated, and appropriate remedial or disciplinary action will be taken.

CHPIV maintains a Workplace Violence Prevention Program. All new hires will be required to complete training on workplace violence prevention. Employees will be required to retrain on the topic annually. The organization also maintains a log of workplace violence incidents that is available for review by any employee upon request to Human Resources.

**DRIVING SAFETY**

Employees who drive on Community Health Plan of Imperial Valley business are expected to drive safely and responsibly and to use common sense and courtesy. Employees are also subject to the following rules and conditions:

1. All employees are responsible for submitting a valid auto-insurance policy copy to the Human Resources department, the employer may request a copy from the employee at any time.
2. A valid driver's license must be maintained as a condition of continued employment for positions that require driving. The Community Health Plan of Imperial Valley may request to see an employee's license at any time.
3. Employees may not use a Community Health Plan of Imperial Valley vehicle without express authorization from management.
4. If Community Health Plan of Imperial Valley vehicles are generally used for business, employees must receive authorization from management to use their personal vehicle instead.
5. Let's summarize the Community Health Plan of Imperial Valley insurance coverage as it applies to employee use of personal vehicles for Community Health Plan of Imperial Valley business, Employees who drive their own vehicles for work must maintain the minimum amount of insurance required by state law as a condition of continued employment. The Community Health Plan of Imperial Valley may request proof of insurance at any time.
6. Employees must always wear seat belts, whether they are the driver or a passenger.
7. Except for a phone being used only for navigation purposes, employees are required to turn off cell phones or put them on silent before starting their car.
8. Employees who are using a device for navigation purposes should complete all the set up before starting the vehicle.
9. Use of electronic devices for purposes other than navigation is strictly prohibited. This includes, but is not limited to, making, or receiving phone calls unless hand-free technology is applied, sending, or receiving text messages or e-mails, browsing the internet, reading books, and downloading information from the web. If an employee needs to engage in any of these activities while driving, they must pull over to a safe location and stop the vehicle prior to using any device.
10. Employees should not engage in other distracting activities such as eating, shaving, or putting on makeup, even in stopped or slow-moving traffic.
11. The use of alcohol, drugs, or other substances that in any way impair driving ability is prohibited. This includes, but is not limited to, over-the-counter cold or allergy medications and sleep aids that have a residual effect.
12. Employees must follow all driving laws and safety rules, such as adherence to posted speed limits and directional signs, use of turn signals, and avoidance of confrontational or offensive behavior while driving.
13. All passengers must be approved by management in advance of travel.
14. Employees must not allow anyone to ride in any part of the vehicle not specifically intended for passenger use or any seat that does not have a working seat belt.
15. Employees must promptly report any accidents to local law enforcement as well as the Community Health Plan of Imperial Valley.
16. Employees must promptly report any moving or parking violations received while driving on Community Health Plan of Imperial Valley vehicles or business.

**INCLEMENT WEATHER AND OUTAGES**

This policy establishes guidelines for the Community Health Plan of Imperial Valley operations during periods of extreme weather and similar emergencies. The Community Health Plan of Imperial Valley will remain open in all but the most extreme circumstances. Unless an emergency closing is announced, all employees are expected to report to work. However, the Community Health Plan of Imperial Valley does not advise employees to take unwarranted risks when traveling to work in the event of inclement weather or other emergencies. Each employee should exercise their best judgment with regard to road conditions and other safety concerns.

Designation of Emergency Closing

Only with the authorization of the CEO or designated managers will the Community Health Plan of Imperial Valey will cease operations due to emergency circumstances. If severe weather conditions develop during working hours, it is at the discretion of Management to release employees. Employees will generally be expected to remain at work until the appointed closing time.

Procedures during Closings

If weather or traveling conditions delay or prevent an employee's reporting to work, their immediate supervisor should be notified as soon as possible. If possible, such notification should be made by telephone directly with the supervisor. If direct contact is not possible, leaving a detailed voicemail message or message with another employee is acceptable.

An employee who is unable to report to work may use any accrued time off or take the day off without pay.

Pay and Leave Practices

When a partial or full-day closing is authorized by Management, the following pay and paid leave practices apply:

- Non-exempt hourly employees will be sent home for partial days with the option of using paid time off for the remainder of the day. If paid time off is not available, employees will be excused from work without pay and without disciplinary action.
- Exempt employees will be expected to continue work from home if their job duties allow. The Community Health Plan of Imperial Valley will pay the exempt employee's regular salary regardless of, as outlined in the Payroll Deductions policy.
- Exempt and non-exempt employees already scheduled to be off during emergency closings are charged such leave as was scheduled.

Other Work Options

Supervisors may approve requests for employees to temporarily work from home, if doing so allows completion of work assignments.

## WORKPLACE GUIDELINES

### HOURS OF WORK

Employees are expected to be at their work area and ready to work at their scheduled time. Employees will be given their work hours upon hire and at the time of any change in position. If the normal work hours are changed or if the COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY changes its operating hours, employees will be given notice.

### OFF-THE-CLOCK WORK

Non-exempt employees must accurately record all time worked, regardless of when and where the work is performed. Off-the-clock work (doing work that is not reported in the timekeeping system) is prohibited. No member of management may request, require, or authorize non-exempt employees to perform work without compensation. Any possible violations should be reported promptly to a member of management.

Salaried and hourly in-office staff are required to complete their responsibilities from the hours of 8:00 – 5:00 pm.

### MEAL PERIODS

All employees are entitled to take a non-compensated meal period of at least 30 minutes each workday. No employee will be scheduled to work more than five consecutive hours in a workday without taking a meal period. In no case may any meal period be waived to shorten an employee's work hours or to be used in lieu of time without pay.

When the work period is 10 hours per day, a second meal period of at least 30 minutes will be provided. If the total hours worked is 12 or fewer, the second meal period may be waived by mutual consent of the Community Health Plan of Imperial Valley and the employee only if the first meal period was not waived. If the nature of the work prevents relief from all duties, then the on-duty meal period will be compensated.

All mealtimes require the non-exempt employee to clock out and back in when their meal is finished, and they've returned to work.

### REST PERIODS

Employees will take a 10-minute rest period during each half of a full workday or major fraction thereof. However, a rest period need not be authorized for employees whose total daily work time is less than three and one-half hours. Any variances in rest periods are subject to advance management approval. All hourly employees are required to fill out and submit the employee break-period tracking form and submit to Human Resources Bi-weekly on the Monday before payroll.

## LACTATION ACCOMMODATION

The Community Health Plan of Imperial Valley provides a supportive environment to enable breastfeeding employees to express their milk during work hours. Accommodation under this policy includes a private place (other than a bathroom) as well as unpaid time to express milk. If a dedicated lactation space is not possible, a multi-use area will be made available, and a lactating employee will be given priority.

Employees should request lactation accommodations through their manager or Human Resources in person or by phone or email. Managers who receive requests for lactation accommodations should contact Human Resources or a member of the leadership team if they have any doubt about their ability to accommodate the request. The Community Health Plan of Imperial Valley will respond to the request either by providing the requested accommodation in full or by providing what is possible and giving the employee a written explanation as to why any other part of the request could not be granted.

When possible, employees should take their lactation breaks concurrently with their meal and rest breaks, if applicable. Employees will be paid for the duration of their standard rest breaks, and additional time will be unpaid. Exempt employee pay will not be affected by lactation break time.

Any form of discrimination or harassment related to breastfeeding is unacceptable and will not be tolerated. Employees who believe they are not being provided with accommodations as required by law may file a complaint with the Labor Commissioner.

If you feel the organization is not providing you with adequate break time and/or a place to express milk as provided for in Labor Code § 1030, you may file a report/claim with the Labor Commissioner's Bureau of Field Enforcement (BOFE) at the BOFE office nearest your place of employment. The complaint must be filed within three years of the alleged unlawful action.

## ATTENDANCE AND TARDINESS

Employees are expected to be at work and ready to go when their scheduled shift begins or resumes. If an employee is unable to be at work on time, or at all, they must notify their manager no later than 30 minutes before the start of their scheduled workday. If an employee's manager is not available, the employee should contact another member of management. If an employee is physically unable to contact the Community Health Plan of Imperial Valley, they should ask another person to make contact on their behalf. Leaving a message with a co-worker or answering service is not considered proper notification. Excessive tardiness or absences are unacceptable job performance and subject to disciplinary action up to and including termination.

When an employee calls in absent, they should provide their expected time or date of return. The Community Health Plan of Imperial Valley reserves the right to request

proof of the need for absence, if allowed by law. If an employee is absent for three consecutive days and has not provided proper notification, the Community Health Plan of Imperial Valley assumes that the employee has voluntarily quit their position and will proceed with the termination process.

If an employee becomes ill during their scheduled workday and feels they may need to leave before the end of their shift, they should notify their manager immediately. If an employee is unable to perform their job to an acceptable level, they may be sent home until they are well enough to work.

Absences should be arranged as far in advance as possible. When an employee needs to be absent during the workday, they should attempt to schedule their outside appointment or obligation so that their absence has the smallest impact possible on business operations.

**TELECOMMUTING**

The Community Health Plan of Imperial Valley maintains a Remote Work Policy to ensure continued productivity, collaboration, and security of information regardless of work location. The policy can be found here [insert]

~~Employees are permitted to work from home (WFH) occasionally or regularly, depending on several factors and the arrangements they've made with their manager. Working from home is a privilege that may be revoked at any time. The Community Health Plan of Imperial Valley may request that an employee be present in the office at any time (regardless of scheduled WFH time) or deny a request to work from home based on business needs, employee performance, or viability of doing the work from home. To be eligible to WFH, an employee must be salaried and have access to reliable internet and a space that is free from excessive noise or distraction.~~

~~Submitting Requests~~

~~Employees must submit their remote work request to their supervisor and notify appropriate team members. Requests for recurring or extended WFH arrangements will be considered after 3 months of employment, or in the case of a public health emergency.~~

~~Employees wishing to request additional remote workdays in any given workweek are required to speak with their manager in advance for approval. If approved, the employee must submit their request to their supervisor and notify appropriate team members.~~

~~Costs~~

~~The Community Health Plan of Imperial Valley will supply the employee with appropriate office supplies and reimburse the employee for all other reasonable business related expenses. Employees must get pre-approval for expenses associated with working from home if they are more than $40 in total. Any equipment supplied by the Community Health Plan of Imperial Valley is to be used for business purposes~~

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~~only, unless otherwise specified. Employees must take appropriate action to protect these items from damage or theft.~~

~~The Community Health Plan of Imperial Valley is not responsible for costs associated with the initial setup of the employee's home office such as remodeling, furniture, or lighting, or for repairs or modifications to the home office space.~~

~~Security~~

~~As with employees working in the office, those who WFH will be expected to ensure the protection of proprietary Community Health Plan of Imperial Valley and customer information through use of locking doors, desks, file cabinets, and media storage, regular password maintenance, and any other steps appropriate for the job and the environment. Unless you live alone, computers should be locked when you walk away, and other household members should not be allowed access to or use of Community Health Plan of Imperial Valley property.~~

~~Expectations~~

~~When working from home employees must:~~

- ~~Work their full, typical schedule.~~
- ~~Attending all meetings in a virtual capacity.~~
- ~~Achieve the same level of production as in the office.~~
- ~~Maintain equivalent availability for colleague and client communication, supervisor questions, etc.~~
- ~~Be available online and by phone for the duration of their usual workday, minus breaks, and rest periods.~~
- ~~Respond promptly to communication via messaging app, email, and phone.~~
- ~~Take all required breaks and rest periods, as if they were in the office.~~
- ~~Communicate consistently regarding their workload and status (break, lunch, working on a project, etc.)~~
- ~~Follow all Community Health Plan of Imperial Valley procedures and policies.~~
- ~~Refrain from using alcohol or illegal drugs. Refer to section above.~~

**PERSONAL APPEARANCE AND HYGIENE**

Employees are expected to present a professional image, both through behavior and appearance. Accordingly, employees must wear work-appropriate attire during the workday or any time they are representing the Community Health Plan of Imperial Valley. Clothing does not need to be expensive but should be clean and neat in appearance. Employees should consider their level of customer and public contact and the types of meetings they are scheduled to attend in determining what attire is appropriate. The Dress code for Community Health Plan of Imperial Valley is Business Casual. Community Health Plan of Imperial Valley allows and encourages Casual Fridays. Keeping in mind the following below is unacceptable on casual Fridays as well.

The following are not acceptable:

- Bare feet or flip flops
- Spandex, sweats, or work out attire.
- Sagging pants, shorts, or
- Sexually provocative clothing or exposed undergarments
- Clothing with offensive slogans or pictures
- Clothing that shows excessive wear and tear.
- Any clothing or accessories that would present a safety hazard.

All Community Health Plan of Imperial Valley employees are expected to maintain appropriate oral and bodily hygiene. Hair (including facial hair) should be clean and neat. Accessories should not interfere with an employee's work. The excessive use of perfume or cologne is unacceptable, as are odors that are disruptive or offensive to others or may exacerbate allergies.

The Human Resources Department is responsible for enforcing dress and grooming standards for their department. Any employee whose appearance does not meet these standards may be counseled. If their appearance is unduly distracting or the clothing is unsafe, the employee may be sent home to change into something more appropriate.

Reasonable accommodation will be made for employees who hold religious beliefs and disabilities when such accommodations do not cause an undue burden. Employees who would like to request accommodation or have other questions about this policy should contact the Office and Human Resources Manager.

**CONFIDENTIALITY**

Employees may not disclose any confidential information or trade secrets to anyone outside the Community Health Plan of Imperial Valley without the appropriate authorization. Confidential information may include internal reports, financials, client lists, methods of production, or other internal business-related communications. Trade secrets may include information regarding the development of systems, processes, products, design, instrument, formulas, and technology. Confidential information may only be disclosed or discussed with those who need the information. Conversation of a confidential nature should not be held within earshot of the public or clients.

When any inquiry is made regarding an employee, former employee, client, or customer, the inquiry should be forwarded to ~~a manager or the Office and Human~~ Resources without comment from the employee.

This policy is intended to always alert employees to the need for discretion and is not intended to inhibit normal business communications. In addition, nothing in this policy is intended to infringe upon employee rights under Section 7 of the National Labor Relations Act.

In accordance with California law, Community Health Plan of Imperial Valley will not:

- Prohibit you from:
  - Disclosing your own wages;
  - Discussing the wages of others; or
  - Inquiring about another's wages.
- Require you to sign a waiver or other document that proposes to deny you the right to disclose the amount of your wages.
- Discharge, formally discipline, or otherwise discriminate or retaliate against you for disclosing the amount of your wages.

However, if you have access to or knowledge of the private compensation information of other employees as a part of your role and essential job functions, you may not disclose that information to individuals who do not otherwise have access to it, unless the disclosure is:

- In response to a formal complaint or charge;
- Part of an investigation, proceeding, hearing, or action, including an investigation conducted by the organization; or
- Consistent with the legal duty of the organization to furnish information.

If you believe that you have been discriminated against or retaliated against in violation of this policy, immediately report your concerns to your direct Manager or Human Resources.

Nothing in this policy will be enforced to interfere with, restrain or coerce, or retaliate against employees regarding their rights under the National Labor Relations Act.

**SOLICITATION AND DISTRIBUTION**

Solicitation during work time and in work areas is prohibited. Solicitation is defined as the act of asking for something, selling something, urging someone to do something, petitioning, or distributing persuasive materials. This could include, but is not limited to, asking for donations for a child's school (including through sales of a product), attempting to convert someone to or from a religion, distributing political materials, or collecting signatures. Work time includes time when either the person soliciting, or being solicited to, is scheduled to be performing their work duties. Work areas include areas where employees generally do work, such as cubicles, offices, or conference rooms, and does not include areas such as the lunch or break room.

This policy does not prevent employees from using their approved breaks and rest periods to solicit outside of working areas and is not intended to infringe an employee's Section 7 of the National Labor Relations Act rights. Those not employed by the Community Health Plan of Imperial Valley are always prohibited from solicitation on Community Health Plan of Imperial Valley property.

**BUSINESS GIFTS**
Employees are prohibited from directly or indirectly requesting or accepting a gift for themselves or the Community Health Plan of Imperial Valley that has a value of $50 or more. If an employee is offered or given anything of value from any client, prospective client, vendor, or business partner in connection with Community Health Plan of Imperial Valley business, they should alert their manager immediately.

**OUTSIDE ACTIVITIES**
Employees are not allowed to engage in outside employment during non-working hours without written permission of the CEO. If written permission is granted, such outside employment would not interfere with their job performance or constitute a conflict of interest. Prior to accepting outside employment, employees should notify their Senior Leader in writing. The Senior Leader would either deny, or forward to the CEO for discussion and decision. The notice must include the name of the outside Community Health Plan of Imperial Valley, the title and nature of the position, the number of working hours per week, and the time of scheduled work hours. If the position constitutes a conflict of interest or interferes with the employee's job at any time, they may be required to limit or end their outside employment.

**REPORTING IRREGULARITIES**
Employees should immediately report any actual or suspected theft, fraud, embezzlement, or misuse of Community Health Plan of Imperial Valley funds or property, as well as suspicious behavior. An employee who is aware of such activity but does not report will be disciplined accordingly.

**INSPECTIONS AND SEARCHES**
Any items brought to or taken off Community Health Plan of Imperial Valley premises, whether property of the employee, the Community Health Plan of Imperial Valley or a third party, are subject to inspection or search unless prohibited by state law. Desks, lockers, workstations, work areas, computers, USB drives, files, e-mails, voice mails, etc. are also subject to inspection or search, as are all other assets owned or controlled by Community Health Plan of Imperial Valley Any inspection or search conducted by the Community Health Plan of Imperial Valley may occur at any time, with or without notice. Failure to submit to a search will be grounds for discipline.

**HARDWARE AND SOFTWARE USE**
The following guidelines have been established for using the Internet and email in an ethical and professional manner. For this policy, Community Health Plan of Imperial Valley Internet includes productivity software, instant messaging applications, the Community Health Plan of Imperial Valley cloud and networks, the intranet, and any other tool or program provided by or through the Community Health Plan of Imperial Valley or its internet connection.

- Community Health Plan of Imperial Valley Internet and email may not be used for transmitting, retrieving, or storing any communications of a defamatory, discriminatory, harassing, or obscene nature.

- Telephones should only be used for Community Health Plan of Imperial Valley business. Employees should always be professional and conscientious when using Community Health Plan of Imperial Valley phones or when using a personal phone for Community Health Plan of Imperial Valley business.
- Use of personal cell phones or other devices should be held to a reasonable limit. Reasonableness will be determined by management.
- Disparaging, abusive, profane, and offensive language are forbidden.
- Employees must respect all copyrights and may not copy, retrieve, modify, or forward copyrighted materials, except with permission or as a single copy for reference only. Almost every piece of content is or could be copyrighted (a notice of copyright is not required), so employees should proceed with caution when using or reproducing materials.
- Unless necessary for work, employees should avoid sending or receiving large files, watching videos, mass-forwarding emails, or engaging in other activities that either consume large amounts of bandwidth or create electronic clutter.
- Employees may not download any programs, applications, browser extensions, or any other files without prior approval or upon request of a manager.
- Each employee is responsible for the content of all text, audio, or images they place on or send over the Community Health Plan of Imperial Valley's internet and email system. Employees may not send messages in which they are not identified as the sender.
- Email is not guaranteed to be private or confidential. Community Health Plan of Imperial Valley reserves the right to examine, monitor, and regulate email messages, directories, and files, as well as internet usage.
- Internal and external email messages are considered business records and may be subject to discovery in the event of litigation.

All Community Health Plan of Imperial Valley-issued hardware and software, as well as the email system and Internet connection, are Community Health Plan of Imperial Valley-owned. Therefore, all Community Health Plan of Imperial Valley policies are always in effect when they are in use. Access to the internet through the Community Health Plan of Imperial Valley's network is a privilege of employment that may be limited or revoked at any time.

**SOCIAL MEDIA**

The Guiding Rule

Conduct that negatively affects an employee's job performance, the job performance of fellow employees, or the Community Health Plan of Imperial Valley legitimate business interests—including its reputation and ability to make a profit—may result in disciplinary action up to and including termination.

Below are some guidelines for the use of social media. These guidelines are not intended to infringe on an employee's Section 7 of the National Labor Relations Act rights and any adverse action taken in accordance with this policy will evaluate whether employees were engaged in protected concerted activity.

Avoiding Harassment
Employees must not use statements, photographs, video, or audio that could reasonably be viewed as malicious, obscene, threatening, or intimidating toward customers, employees, or other people or organizations affiliated with the Community Health Plan of Imperial Valley. This includes, but is not limited to, posts that could contribute to a hostile work environment based on race, sex, sexual orientation, disability, religion, national origin, or any other status protected by state or federal law.

Avoiding Defamation
Employees must not post anything they know or suspect to be false about Community Health Plan of Imperial Valley or anyone associated with it, including fellow employees and clients. Writing something that is untrue and harmful to any person or organization is defamation and can lead to significant financial liability for the person who makes the statement.

Confidentiality
Employees must maintain the confidentiality of Community Health Plan of Imperial Valley trade secrets and confidential information. Trade secrets include, but are not limited to, information regarding the development of systems, products, and technology. Private and confidential information includes, but is not limited to, customer lists, financial data, and private personal information about other employees or clients that they have not given the employee permission to share.

Representation
Employees must not represent themselves as a spokesperson for the Community Health Plan of Imperial Valley unless requested to do so by management. If the Community Health Plan of Imperial Valley is a subject of the content being created—whether by an employee or third party—employees should be clear and open about the fact that they are employed with the Community Health Plan of Imperial Valley but that their views do not necessarily represent those of Community Health Plan of Imperial Valley.

Accounts
Employees must not use Community Health Plan of Imperial Valley email addresses to register for social media accounts unless doing so at the request of management. Employees who manage social media accounts on behalf of the Community Health Plan of Imperial Valley ensure that at least one member of management has all the login information needed to access the account in their absence.

**PERSONAL CELL PHONE USE**

The use of personal cell phones, or work cell phones for personal matters, should be held to a reasonable limit during work hours and not interfere with an employee's

productivity or the productivity of their coworkers. Reasonableness will be determined by management.

**PERSONAL PROPERTY**
The Community Health Plan of Imperial Valley is not liable for lost, misplaced, or stolen property. Employees should take all precautions necessary to safeguard their personal possessions. Employees should not have their personal mail sent to the Community Health Plan of Imperial Valley, as it may be automatically opened, and should check with their manager before having larger items delivered to the workplace.

**PARKING**

~~The Community Health Plan of Imperial Valley has reserved covered parking spots which are reserved for the CEO, the Office & HR Manager, the Chief Medical Officer, and Chief Financial Officer. The remaining parking.~~ The parking lot is ~~areas are~~ first come first serve. All parking is at an employee's own risk. Employees and visitors should lock their vehicles and take appropriate safeguards to protect their valuables, including removing them from the vehicle if appropriate under the circumstances. Employees are not permitted to park in areas reserved for visitors.

## EMPLOYMENT SEPARATION

**RESIGNATION**
The Community Health Plan of Imperial Valley requests that employees provide at least two weeks' written notice of their intent to resign. This notice should be submitted to the employee's manager. Dependent upon the circumstances, an employee may be asked to not work any or all their notice period, in which case they will be allowed to use up to two weeks of accrued paid time off, if available, from the time notice is given. An exit interview may be requested. If available accrued paid time off is not available and management chooses to terminate employment prior to the end of the two-week notice period, the Community Health Plan of Imperial Valley shall compensate for the remainder of the two-week notice period provided, but not in excess of two weeks.

**TERMINATION**
All employment with the Community Health Plan of Imperial Valley is "at-will." This means that either the Community Health Plan of Imperial Valley or the employee may terminate the employment relationship at any time, with or without notice, and for any reason allowed by law or for no reason at all. An employee's at-will status can only be changed by written contract, signed by both the employee and the CEO or Commission Chairperson.

**PERSONAL POSSESSIONS AND RETURN OF COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY PROPERTY**
All Community Health Plan of Imperial Valley property, such as computer equipment, keys, tools, parking passes, or credit cards, must be returned immediately at the time of termination. Employees may be responsible for any lost or damaged items. When

leaving, employees should ensure that they take all their personal belongings with them.

## EMPLOYEE HANDBOOK ACKNOWLEDGEMENT

**IMPERIAL COUNTY LOCAL HEALTH AUTHORITY DBA COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY**

I acknowledge receipt of the Community Health Plan of Imperial Valley Employee Handbook and agree to follow the guidelines within it. I also acknowledge the following:

1. Receipt of this handbook does not create a contract of employment or in any way alter my at-will employment status; the Community Health Plan of Imperial Valley or I can end the employment relationship at any time, with or without notice, and with or without cause.

2. I am not entitled to any sequence of disciplinary measures prior to termination.
3. Except for the at-will employment policy, this handbook may be modified at any time.
4. Violation of any policy in this handbook, or any policy included as an addendum, may be grounds for discipline, up to and including termination.
5. This handbook does not include every process, policy, and expectation applicable to employees, or my position specifically; I may be counseled, disciplined, or terminated for poor behavior or performance even if the behavior or performance issue is not addressed in the handbook.
6. Should any provision in this handbook conflict with federal, state, or local law, that provision only will be considered ineffective, while the rest of the handbook remains effective.
7. If I have questions regarding any policy in this handbook, or other expectations related to my behavior or performance, it is my responsibility to speak with my manager or the Human Resources department.

_____
Signature

_____
Printed Name

_____
Date

Community Health Plan OF IMPERIAL VALLEY

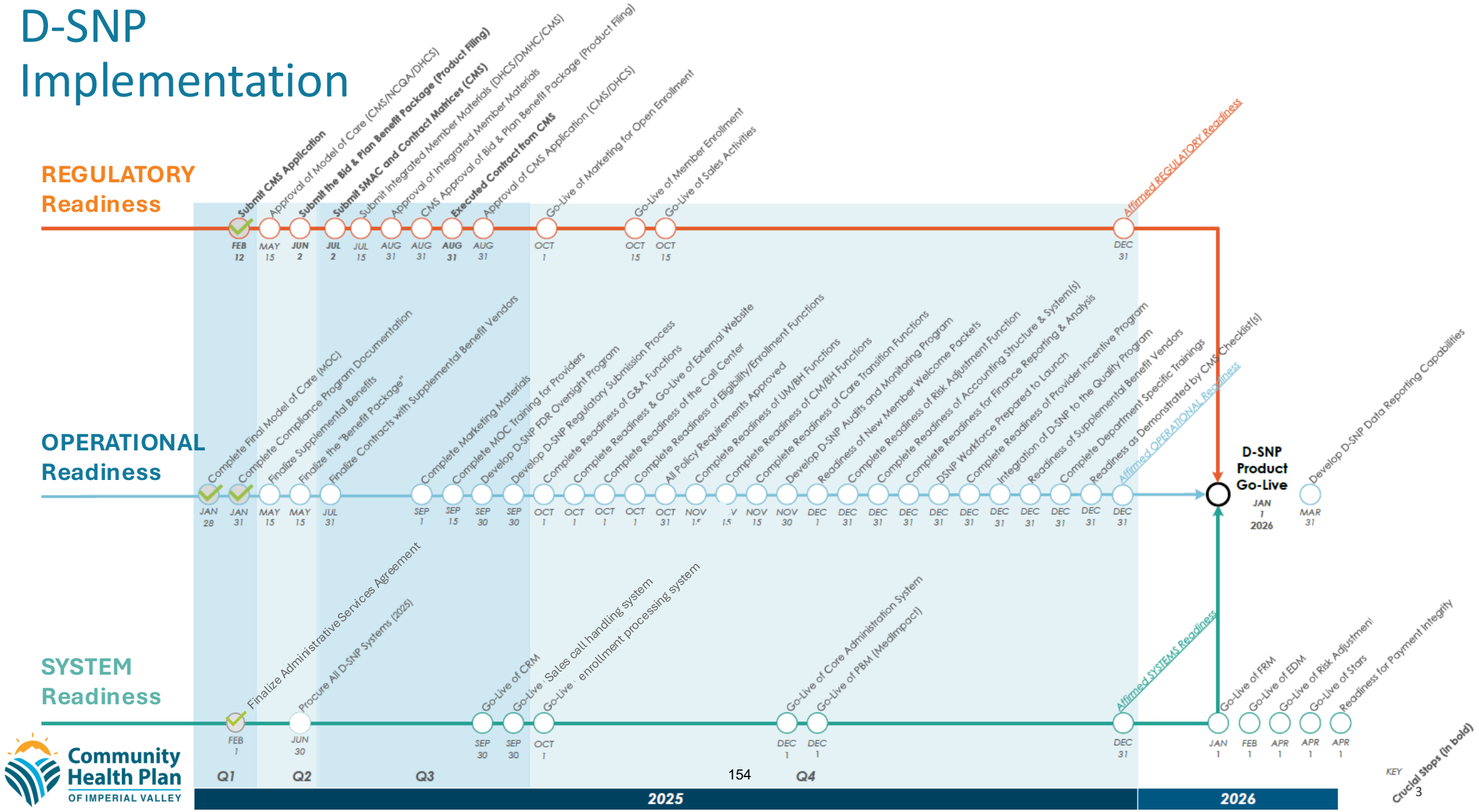
# Operations Report

Imperial County Local Health Authority
Commission Meeting

April 2025

# Community Advantage Plus Implementation

# D-SNP Implementation




Community Health Plan OF IMPERIAL VALLEY

# Imperial County Direct Provider Network

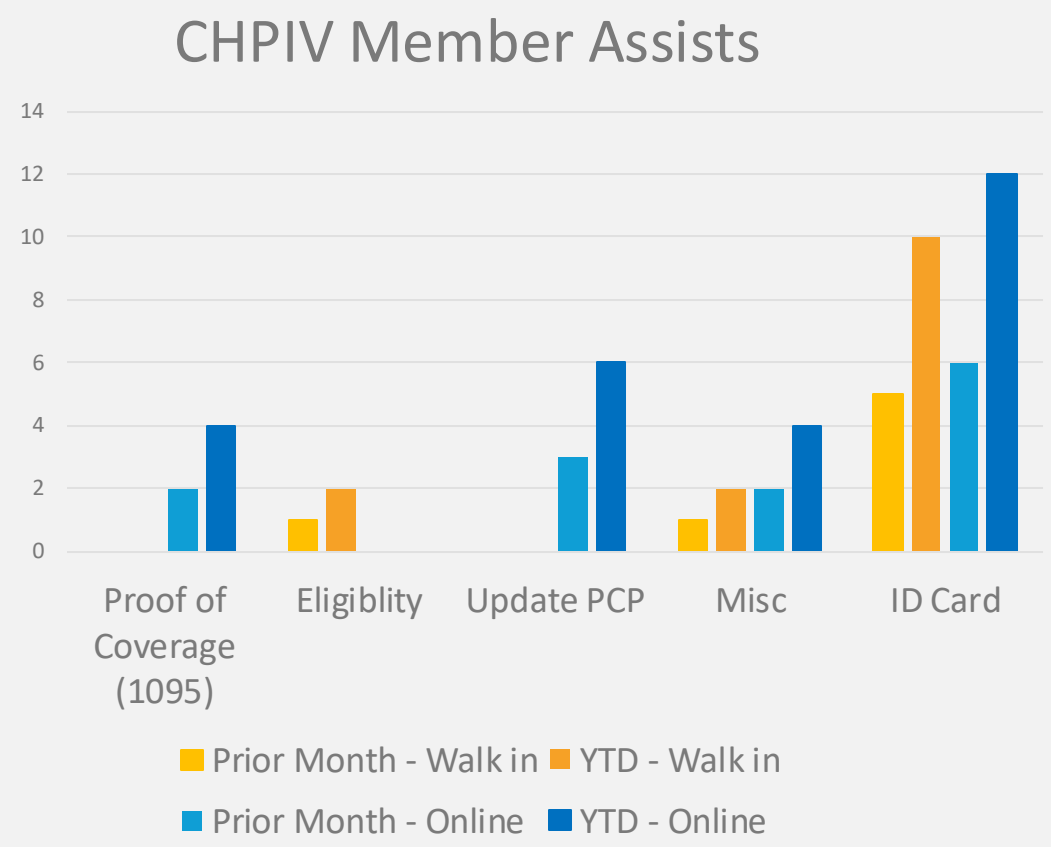
| Imperial County Medical Society | CHPIV Direct Letter of Agreement | CHPIV - Credentialing Process | Health Net Medi-Cal Network (12/2024) | DHCS Medi-Cal Providers | CMS Medicare Providers |
|---|---|---|---|---|---|
| 27 | 2 | | 45 | 73 | 57 |
| 23 | 3 | | 337 | 333 | 137 |
| 6 | 27 | 27 | 2 | 9 | |
| - | 6 | | 62 | - | |
| | | | | | |

*Includes Family Practice, General Medicine, Internal Medicine, Pediatrics, and Gerontology

Community Health Plan OF IMPERIAL VALLEY

# Marketing & Communications

# Member Experience




## Net Promoter Score (NPS)

| Promoters | Neutral | Detractors | NPS Score |
|---|---|---|---|
| 13 | 2 | 0 | 87% |
| 87% | 13% | 0 | |

*The Net Promoter Score (NPS) serves as a benchmarking instrument for assessing member satisfaction. Our Member Experience team focused on calling members to inquire about their overall experience with CHPIV. The health insurance Industry has an average NPS of 27%.*

# Marketing & Communications

- Conducted stakeholder interviews to identify communication gaps and challenges
  - Internal and external confusion about what CHPIV does and relationship to Health Net
  - Clear, consistent communication is critical to closing gaps in perception and engagement
- Developing a structured, multi-channel communication strategy targeting members, providers and internal staff

| Phase | Key Actions |
|---|---|
| Core Messaging | • Develop unified messaging and FAQs **(draft attached)**<br>• Develop provider communication materials **(draft 1-pager attached)**<br>• Determine highest value community events for staff to attend |
| Brand Awareness | • Expand internal staff training and onboarding documents<br>• Expand digital outreach and target social media outreach<br>• Develop first annual report for regulators and community stakeholders<br>• Continue building member trust through education and engagement |
| D-SNP Marketing | • Website<br>• Marketing collateral<br>• Provider & stakeholder education<br>• Prospective member events |

Community Health Plan OF IMPERIAL VALLEY

COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

# CHPIV MESSAGING GUIDE

DRAFT APRIL 2025

## Boilerplate

Community Health Plan of Imperial Valley (CHPIV) is the local, community-based health plan dedicated to improving the health and well-being of Imperial Valley residents. We provide accessible, high-quality health coverage and personalized care coordination, with services designed around the unique needs of the people who live and work here.
Managed by a local team and guided by a deep understanding of the region, CHPIV ensures that more health care dollars stay in the community, strengthening vital services, supporting providers, and expanding access to care across the county.

CHPIV leads with strategic direction, compliance oversight, quality improvement, and trusted community partnerships, while offering in-person support to help members and providers navigate care with ease. As we grow, we are expanding in-house services like care management, provider contracting, and health education, bringing more health care resources and jobs home to Imperial Valley.

More than a health plan, CHPIV is a trusted local partner—committed to building a healthier, stronger Imperial Valley for generations to come.

**Elevator pitch:** CHPIV is a local health plan for people in Imperial Valley who get their health care benefits from Medi-Cal. Our local team sets the policy direction, ensures compliance to State and federal standards, and works with our plan partners to address local health care priorities. CHPIV is now expanding in-house operations to deliver more personalized, community-based care to members who also qualify for Medicare.

## Value Proposition

- **We are local.** CHPIV is not a distant, national organization. We're based right here in Imperial Valley, making us uniquely equipped to understand and address the needs of our community.
- **We are accessible.** Real support, from real people, is just a phone call or visit away. No automated systems, no confusion—just friendly, bilingual assistance tailored to you.
- **We are partners.** We collaborate closely with local providers and organizations to maximize local health care resources ensure that our members receive comprehensive, quality care.
- **We are growing.** Medi-Cal coverage is currently provided through a subcontract with HealthNet, and CHPIV is actively bringing more operations in-house to enhance local support and care coordination, bringing more jobs to Imperial Valley. Our focus is on strengthening personalized, community-based services for Imperial Valley residents, ensuring that care is accessible, responsive, and aligned with local needs.

## Understanding the Relationship Between CHPIV and HealthNet

- **CHPIV sets the direction, HealthNet delivers the service.** CHPIV is the local health plan for Imperial Valley and holds the contract with the California Department of Health Care Services (DHCS) to provide Medi-Cal managed care in Imperial County. CHPIV contracts with HealthNet to deliver services to CHPIV's Medi-Cal members. CHPIV sets the policy direction, ensures compliance to State and federal standards, and holds HealthNet accountable to local priorities—similar to how Covered California sets rules and health plans follow them.
- **CHPIV provides strategic oversight and is expanding in-house services.** Today, CHPIV leads on strategy, oversight, quality improvement, community engagement, and support for both members and providers for all lines of business. We also provide a walk-in office and resolve issues when HealthNet is unable to. As we grow, especially with the launch of our Medi-Medi plan, CHPIV is building internal capacity to include a direct provider network, local outreach and navigation support, enhanced provider services, personalized care management, and health education. This allows us to bring more care and resources home to Imperial Valley.

## Key Organizational Messaging Pillars

**1. Local Leadership & Community Focus**
**"We are Imperial Valley's health plan."**
CHPIV is deeply rooted in Imperial Valley—working in partnership with local leaders, organizations, and providers to meet the unique health needs of our community.

CHPIV is deeply committed to collaborating with local partners, including our Commission, community-based organizations (CBOs), public health agencies, and providers, to address the distinct geographic, cultural, and health care challenges of Imperial Valley. Our focus is on strengthening health access, improving outcomes, and enhancing the well-being of the entire community.

**2. Provider Partnership & Support**
**"We're here to invest in better outcomes—supporting providers and improving care for our community."**
CHPIV's collaborative approach ensures seamless partnerships with providers. By combining local insights with transparent communication, we support health care professionals in delivering the best possible care to patients.

CHPIV is committed to reinvesting health care dollars locally to strengthen access and improve the quality of care for Imperial Valley residents. Our approach ensures that more resources stay within the community, supporting providers through sustainable partnerships, faster payments, and fewer administrative burdens. By aligning with providers on shared goals, we aim to enhance both patient outcomes and long-term financial sustainability.

**3. Member Advocacy & Accessibility**
**"Health care support you can count on, from people who care."**
Our bilingual, community-based team makes navigating health easier. At CHPIV, we advocate for you every step of the way, so you feel empowered and supported.

**4. Growth & Future Development**
**"Building for a better tomorrow, right here in Imperial Valley."**
CHPIV is expanding its services to enhance health care in the region. We're bringing care management and other services in-house, ensuring personalized, local support that prioritizes your needs.

## Enhanced Messaging for Q&A

**Q: Is CHPIV different from HealthNet?**
A: Yes. CHPIV is Imperial Valley's local health plan, dedicated to serving our community. Because HealthNet currently manages our Medi-Cal plan—CHPIV can focus on providing personalized, local service and support. This approach allows us to offer the best of both worlds: the strength and efficiency of a large partner for complex operations, combined with personalized, community-focused care that reflects the unique needs of Imperial Valley.

**Q: Why should providers work with CHPIV instead of other health plans?**
A: CHPIV is deeply rooted in Imperial Valley, providing health insurance to nearly 50% of the county's residents. For Medicare, we offer local service, faster payments, and less hassle. More of the dollars we manage stay within the community, helping us build additional local services and support. As your local partner, we're committed to reducing administrative burdens and strengthening healthcare access right here in Imperial Valley.

**Q: How is CHPIV making health care easier for members?**
A: CHPIV combines local presence with personalized service. Our bilingual team provides clear, friendly guidance to help members understand their benefits, access care, and receive support tailored specifically to the Imperial Valley community.

**Q: How does CHPIV support the Imperial Valley?**
CHPIV was built for Imperial Valley, with staff, operations, and services rooted in the community. We bring a unique understanding of local challenges and opportunities. Every decision we make prioritizes the health and well-being of our neighbors and friends. A portion of our revenue is reinvested directly back into the community through our Community Reinvestment Fund, supporting programs and services that enhance local health outcomes and well-being. This approach helps ensure that more dollars stay in Imperial Valley, strengthening the community we serve.

# Community Advantage Plus: A New Medi-Medi Plan Coming to Imperial Valley

Community Health Plan of Imperial Valley (CHPIV) is delighted to announce the introduction of **Community Advantage Plus (HMO D-SNP)**, a Medicare Advantage plan specifically tailored to individuals eligible for both Medicare and Medi-Cal. This new plan will be effective on January 1, 2026. It is offered directly by CHPIV and will not be administered by Health Net, CHPIV's Medi-Cal subcontractor.

## Why is CHPIV Starting a New Medi-Medi Plan in Imperial Valley?

By January 1, 2026, the California Department of Health Care Services' (DHCS) CalAIM program mandates that all Medi-Cal health plans provide an Exclusively Aligned Enrollment Dual-eligible Special Needs Plan (EAE D-SNP). **D-SNPs** are Medicare Advantage plans that serve individuals who have both Medicare and Medi-Cal coverage.

## Plans offered by CHPIV

**CHPIV**

- Strategic Direction
- Compliance Monitoring & Oversight
- Quality Improvement
- Community Relations
- Member Walk-In & Online Support
- Provider & Member Issue Resolution

Oversight & Direction ↓ | In Transition/ Expansion ↓

**Medi-Cal (Health Net)**

- Provides Medi-Cal Coverage
- Processes Claims & Authorizations
- Manages Provider Contracts
- Reports to CHPIV

**CHPIV Expansion: Medi-Medi Plan**

- Directly Contracted Provider Network
- Local Member Outreach & Enrollment
- Benefit Navigation Support
- More Local Provider Support
- Personalized Care Management
- Health Education

*CHPIV provides local leadership and oversight, while HealthNet currently administers Medi-Cal services. CHPIV is now expanding in-house operations to deliver more personalized, community-based care* ***in partnership with Community Health Group.***

## Why Should I Become a D-SNP Provider with CHPIV?

**D-SNPs** offer significant advantages to healthcare providers by simplifying care delivery and enhancing patient outcomes. **Here's how D-SNPs and working with CHPIV can add value to your practice:**

- **Simplified Insurance Processes:** Work with a single insurer, the CHPIV's Community Advantage Plus plan, instead of navigating both Medicare and Medi-Cal. This saves time and reduces administrative complexity and burden for you and your staff.
- **Streamlined Care Management:** **D-SNP** members are assigned to local CHPIV care managers. This reduces administrative burdens for your staff and allows you to focus on providing quality care.
- **Efficient Coordination for Complex Patients:** Effectively manage the intricate needs of dual-eligible patients through comprehensive care coordination to ensure no aspect of their healthcare is overlooked.
- **Fewer Avoidable Readmissions:** By leveraging a coordinated care system, **D-SNPs** help reduce preventable hospital readmissions. This positively impacts your revenue by minimizing penalties under traditional Fee-For-Service (FFS) Medicare.
- **Addressing Social Determinants of Health:** **D-SNPs** tackle critical social factors like housing, food insecurity, and transportation. This holistic approach enhances patients' well-being while easing the overall care burden on providers.

## Providers also benefit from improved patient engagement and outcomes?

- **Lower Out-of-Pocket Costs:** **D-SNPs** minimize dual-eligible patients' healthcare expenses. They also encourage adherence to treatment plans and increase satisfaction.
- **More Access to Local Providers and Services:** Expanding health care resources leads to greater convenience for patients, better access to care, and improved outcomes. When care is easier to reach, patients are more likely to engage in their health, resulting in stronger provider relationships and better health results.

## We are enthusiastic about the opportunity to work with local IPAs and providers in Imperial Valley.

TO CONTRACT WITH US TODAY FOR OUR NEW MEDI-MEDI PLAN, PLEASE REACH OUT TO US AT PROVIDER@CHPIV.ORG.

*Click the QR code above to see more D-SNP FAQs for Providers*

# HUMAN RESOURCES REVIEW
# April 14, 2025

## THE MONTH IN REVIEW

- Began work on new employee and annual performance evaluations.
    - Organizational wish list:
        - Automated system to replace paper forms. Rippling is a possibility.
        - A system that facilitates goal setting
        - More frequent, less intensive check-ins
        - A comprehensive year-end evaluation
    - Target implementation end of Q2
- 1 new hire, Delegation Program Manager beginning April 28.
- 3 current open positions: Compliance Manager, Compliance Coordinator, Sales Manager
    - Introduced the employee referral bonus program for the Sales Manager position
- Continued work on community partnerships.
    - SDSU healthcare event on April 26
    - Meetings scheduled with workforce development center and Chamber of Commerce for the last week of April

## HR REVIEW (OCTOBER 2024-MARCH 2025)

| | | |
|---|---|---|
| **Current number of employees** | 21 | |
| **Growth by department (FTE only)** | Compliance<br>Executive<br>Finance<br>IT<br>Health Services<br>Operations<br><br>**Net growth** | -3<br>No change<br>+1<br>No change<br>+3<br>+2<br><br>+3 |
| **Employee demographics** | Female 66%<br>Male 33%<br>Average age 42 | |
| **Turnover rate** | 11% | Benchmark 12-15%* |

| | |
|---|---|
| **Key insights from exit interviews** | Both employees left for career advancement opportunities<br><br>Both employes cited that the cost of benefits was one consideration in their decision to leave<br><br>Key words used to describe the organization's culture: teamwork, collaboration, mission driven |

* Deloitte 2025 Global Insurance Outlook

## AREAS TO WATCH/ ENHANCE

| | |
|---|---|
| **Watch:** Department growth and timing occur according to budget | • Both the CEO and CFO approve positions before they are open.<br>• Any overage in salary offers is approved before the offer is given. |
| **Watch:** Exit interview trends | • Some benchmarking of benefit cost as a percentage of payroll is likely appropriate |