IMPERIAL COUNTY
Local Health Authority Commission

Regulatory Compliance Oversight Committee of the Commission

AGENDA

Date/Time: March 25, 2025, 12:00 PM
Location: Community Health Plan of Imperial Valley, 512 West Aten Road, Imperial, CA 92251

Members of the committee, staff and the public can attend the meeting in person at the address listed above. Public comments can be made live and in person at the meeting. To listen to the meeting via videoconference please join by calling +1 469-998-7368 (audio only, Phone Conference ID: 843002905#) or clicking on the link below:

Click here to join the meeting
Meeting ID: 246 108 303 117
Passcode: Na7bk2Ud

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

Committee Members	Representing	Present
Dr. Allan Wu (Chair)	LHA Commissioner and Regulatory Compliance Oversight Committee Chair Chief Medical Officer, Innercare	
Dr. Theodore Affue	LHA Commissioner Chief Medical Officer, County of Imperial	
Pablo Velez	LHA Commissioner Chief Executive Officer, El Centro Regional Medical Center	
CHPIV Staff	**Job Title**	**Present**
Lawrence Lewis	Chief Executive Officer	
Elysse Tarabola	Chief Compliance Officer	
Dr. Gordon Arakawa	Chief Medical Officer	
David Wilson	Chief Financial Officer	
Julia Hutchins	Chief Operating Officer	
Michelle Ortiz-Trujillo	Senior Manager, Marketing and Communications	
Jeanette Crenshaw	Executive Director of Healthcare Services	
Cynthia Mesa	Interim Director of Delegation Oversight	
Jessica Espinoza	Member Experience Coordinator	
Donna Ponce	Executive Assistant/Commission Clerk	

1. Call to Order — Dr. Allan Wu, *Chair*
2. Roll Call — Donna Ponce, *Executive Assistant/Commission Clerk*
3. Approval of the Agenda — Dr. Allan Wu, *Chair*
    a. Items to be pulled or added from the Consent/Information/Action/Closed Session Calendar
    b. Approval of the order of the agenda
4. Public Comment — *Chair*

    This is an opportunity for members of the public to address the Commission on any subject matter within the Commission's jurisdiction. Any action taken as a result of public comment shall be limited to the direction to staff. When

addressing the Commission, state your name for the record prior to providing your comments. Please address the Commission as a whole, through the Chairman. Individuals will be given 3 minutes to address the Commission; groups or topics will be given a maximum of 15 minutes. Public comments will be limited to a maximum of 30 minutes. If additional time is required for public comments, they will be heard at the end of the meeting.

5. Approval of Minutes from November 12, 2025 — *Chair*

6. Chairperson's Report

7. Chief Compliance Officer Report — Elysse Tarabola, *Chief Compliance Officer*

   a. Approve Updated and New Policies & Procedures — Elysse Tarabola, *Chief Compliance Officer*; David Wilson, *Chief Finance Officer*; Shannon Long, *HR Consultant*; Dr. Gordon Arakawa, *Chief Medical Officer*

   b. Approve Updated Compliance Program — Elysse Tarabola, *Chief Compliance Officer*

   c. Approve Delegation Oversight Audit & Monitoring Program — Cynthia Mesa, *Interim Director of Delegation Oversight*

   d. Approve Employee Handbook — Shannon Long, *HR Consultant*

   e. New All Plan Letters (APLs) and Status — Elysse Tarabola, *Chief Compliance Officer*

   f. Delegation Oversight Program: Quarter 3 Results and Corrective Action Plans — Cynthia Mesa, *Interim Director of Delegation Oversight*

8. Adjourn to Closed Session — Dr. Allan Wu, *Chair*
   Pursuant to Welfare and Institutions Code § 14087.38 (m)

9. Reconvene in Open Session — *Chair*

10. Adjournment — *Chair*

Regulatory Compliance Oversight Committee (RCOC)

March 25, 2024

Community Health Plan
OF IMPERIAL VALLEY

Introductions/Quorum

- ***Chair:*** Dr. Allan Wu; LHA Commissioner and Regulatory Compliance Oversight Committee Chair & Chief Medical Officer, Innercare
- Dr. Theodore Affue; LHA Commissioner & Chief Medical Officer, County of Imperial
- Pablo Velez; LHA Commissioner & Chief Executive Officer, El Centro Regional Medical Center

Agenda

ACTION ITEMS – Review and request approval of the following:

- RCOC Meeting Minutes (November 12, 2024)
- Updated & New Policies and Procedures
- Updated Compliance Program
- New Delegation Oversight Audit & Monitoring Program
- Employee Handbook

INFORMATIONAL

- New All Plan Letters (APLs) Released and Status
- Delegation Oversight Program – Updated Quarter 3 Results and CAPs

Updated and New Policies and Procedures

Review/Approve RCOC Minutes – November 12, 2025

See Exhibit A - 11/12/2024 LHA RCOC Meeting Minutes

Updated and New P&Ps

Updated and New P&Ps

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
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
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
HR005	New Positions	Human Resources	Administration	Updated policy
HR-009	Remote Work	Human Resources	Administration	New Policy
HR-010	Promotions	Human Resources	Administration	New Policy

Updated Compliance Program

See Exhibit C – Redline and Clean

Updated Compliance Program

- Updated to meet CMS/Medicare requirements
- Streamlined language for clarity and consistency
- Added self-disclosure process of noncompliance to regulators
- Further clarified roles and responsibilities of the Compliance department, CCO, and other stakeholders in implementing the Compliance Program
- Included additional references to applicable federal and state regulations and contract terms

New Delegation Oversight Audit & Monitoring Program

See Exhibit D

DO Audit & Monitoring Program

Reviews Audit & Monitoring process and how they integrate

Risk scoring and ranking to determine frequency and methodology of oversight

- Annual
- Quarterly monitoring

Annual Audit and Monitoring Process Overview

Remediation of Deficiencies

Employee Handbook

See Exhibit E

Employee Handbook Updates

Topic	New or revised	Content
Background checks	Revised	Adds wording to comply with California's "Ban the Box" legislation Defines reasons a candidate would not be hired 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 Adds manager notification requirements
Standards of Conduct	New	Provides examples of conduct that are prohibited
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

Employee Handbook Updates

Topic	New or revised	Content
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

New All Plan Letters (APLs) Released and Status

New APLs Released and Status

In-House Function

Delegated Function

In-House & Delegated Function

APL	TITLE	REGULATOR	FUNCTIONAL AREA	SUMMARY	STATUS
24-016	**Diversity, Equity, and Inclusion Training Program Requirements (Supersedes APL 23-025)**	**DHCS**	UM, Care Management, Member Services, Appeals & Grievances	The purpose of APL 24-016 is to provide guidance regarding the Diversity, Equity, and Inclusion (DEI) training program requirements.	**Complete**
24-017	**Transgender, Gender Diverse or Intersex Cultural Competency Training Program and Provider Directory Requirements**	**DHCS**	Care Management, Provider Network Management, Pharmacy, Credentialing & Claims	The purpose of APL 24-017 is to provide guidance regarding the transgender, gender diverse, intersex (TGI) cultural competency training program and Provider Directory changes required by Senate Bill (SB) 923 (Chapter 822, Statutes of 2022). This APL outlines the TGI Working Group's recommendations and requirements regarding the implementation of SB 923	**Complete**
24-018	**Medical Loss Ratio Requirements for Subcontractors and Downstream Subcontractors**	**DHCS**	Finance	Provides guidance to MCPs regarding the implementation of Medical Loss Ratio (MLR) requirements for their subcontractors and downstream subcontractors. This directive aligns with federal regulations and the CalAIM Section 1915(b) waiver's Special Terms and Conditions	**In progress** *CHPIV P&P under DHCS review, Attestation validating Subcontractors are compliant due 4/1/2025*

New APLs Released and Status

In-House Function

Delegated Function

In-House & Delegated Function

APL	TITLE	REGULATOR	FUNCTIONAL AREA	SUMMARY	STATUS
24-019	**Minor Consent to Outpatient Mental Health Treatment or Counseling**	**DHCS**	Behavioral Health	Informs MCPs about the changes introduced by AB 665 concerning minors aged 12 and older consenting to non-specialty outpatient mental health services without parental or guardian consent.	**In Progress**
APL 25-001	**2024-2025 Medi-Cal Managed Care Health Plan Meds/834 Cutoff and Processing Schedule**	**DHCS**	Enrollment	Provides MCPs with the 2024-2025 Medi-Cal Eligibility Data System (MEDS)/834 cutoff and processing schedule	**Complete**
APL 25-002	**Skilled Nursing Facility Workforce Quality Incentive Program**	**DHCS**	Care Management, Claims, Provider Network	Inform MCPs with instructions on the payment and data sharing process required for the SNF Workforce and Quality Incentive Program (WQIP) for Rating Periods between January 1, 2023, and December 31, 2026. The Calendar Year (CY) Rating Period is referred to as Program Year (PY).	**In Progress**
APL 25-003	**Establishing Dual Eligible Special Needs Plans by 2026**	**DHCS**	Operations	Mandates that by January 1, 2026, all MCPs in counties not previously part of the Coordinated Care Initiative (CCI) must operate or affiliate with a Dual Eligible Special Needs Plan (D-SNP). This initiative aims to provide integrated care for individuals eligible for both Medicare and Medi-Cal, enhancing coordination between MCPs and D-SNPs.	**In Progress**

New APLs Released and Status

In-House Function

Delegated Function

In-House & Delegated Function

APL	TITLE	REGULATOR	FUNCTIONAL AREA	SUMMARY	STATUS
APL 25-004	**Community Reinvestment Requirements**	DHCS	Finance, Quality Management, Member Services	Provides guidance regarding the DHCS contract requirement that MCPs reinvest a minimum level of the net income into the local communities	**In Progress**
APL 24-019	**Amendments to Rule 1300.67.2.2 and the Incorporated Annual Network Submission IM and Report Forms for RY 2025**	DMHC	Enrollment, Care Management, Provider Network, Appeals & Grievance	Provides guidance of the new amendments to 28 CCR § 1300.67.2.2 and the incorporated Annual Network Submission Instruction Manual and Annual Network Report Forms for the reporting year (RY) 2025 Annual Network Report submission.	**In Progress**
APL 24-020	**RY 2026/MY 2025 Provider Appointment Availability Survey Manual and Report Form Amendments**	DMHC	Network	Requirement to use the version of the PAAS Manual, PAAS Report Forms, and TA Instruction Manual noticed on the DMHC's website.	**In Progress**
APL 24-021	**Network Adequacy Standards and Methodology for RY 2025**	DMHC	Network	Provides notice of new and amended network adequacy requirements, standards, and methodologies, including new standards related to measuring the adequacy of primary care physicians and specialist physicians in plan networks, and updates to the mental health network adequacy standards.	**In Progress**

DO Monitoring Program: Quarter 3 Results and Corrective Actions

See Exhibit E – Q3 Monitoring Scorecard

Delegation Oversight Monitoring Program

Quarterly KPI Metrics (Q3 2024) – Actions Required

FUNCTIONAL AREA	ACTION	DUE DATE
APPEALS	None	NA
CLAIMS	None	NA
CONTINUITY OF CARE	None	NA
GRIEVANCES	None	NA
MEMBER SERVICES	None	NA
PROVIDER DISPUTE RESOLUTION	None	NA
UTILIZATION MANAGEMENT	Corrective Action Plan (CAP)	*(Pending)*

UM Member Notification Timeliness
Corrective Action Plan Implementation

Key Performance Indicator (KPI)

UM002: Member Notification Timeliness

Finding

Health Net failed to meet the compliance threshold of 95% for timely notification to member with Q2 scores at **94.6%** and Q3 scores at **94.1%.**

Current Status

CHPIV and the HN UM team are currently working collaboratively on the UM002: Member Notification Timeliness CAP.

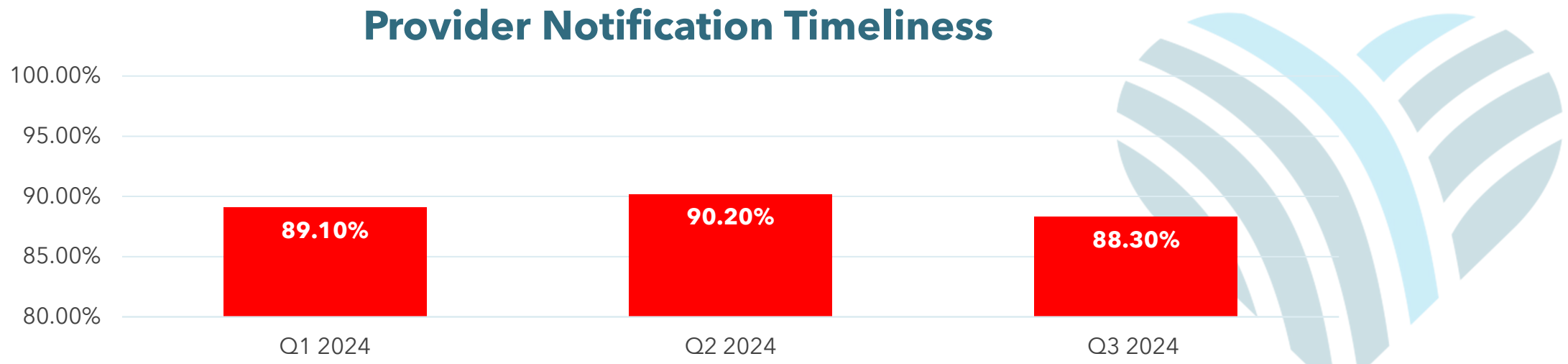
UM Provider Notification Timeliness
Corrective Action Plan Implementation Update

CAP Milestones

- All corrective action plans implemented as of **10/11/2024**

Next Steps

- Continuous monitoring for tracking implementation effectiveness
- Ongoing evaluation to assess compliance in timeliness requirements



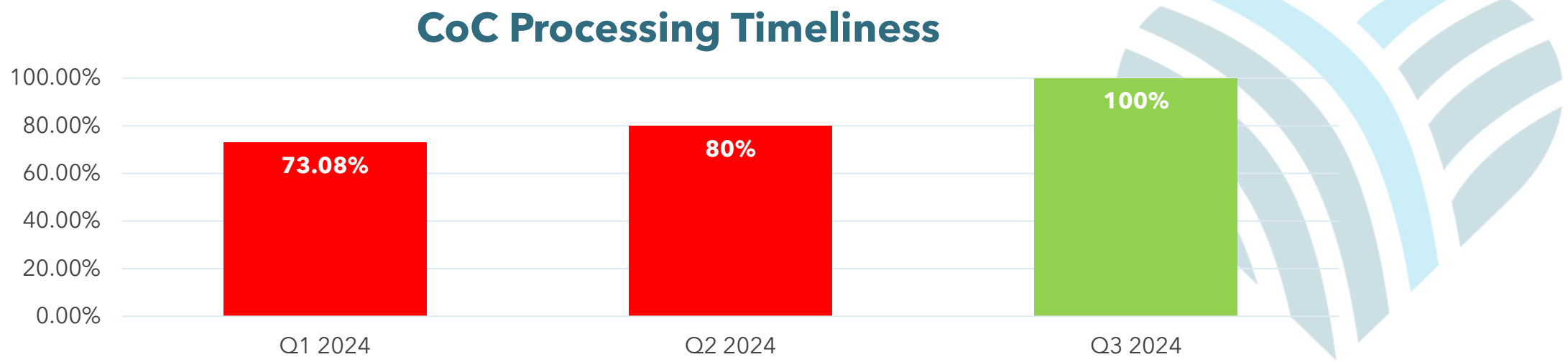
CoC Processing Timeliness
Corrective Action Plan Implementation Update

CAP Milestones

- All corrective action plans implemented as of 10/31/2024
- Q3 2024 preliminary CoC processing timeliness: 100%

Partnership Success

- Effective collaboration to identify and address non-compliance
- Proactive approach to improve processes
- Achieved 100% processing timeliness in Q3 2024

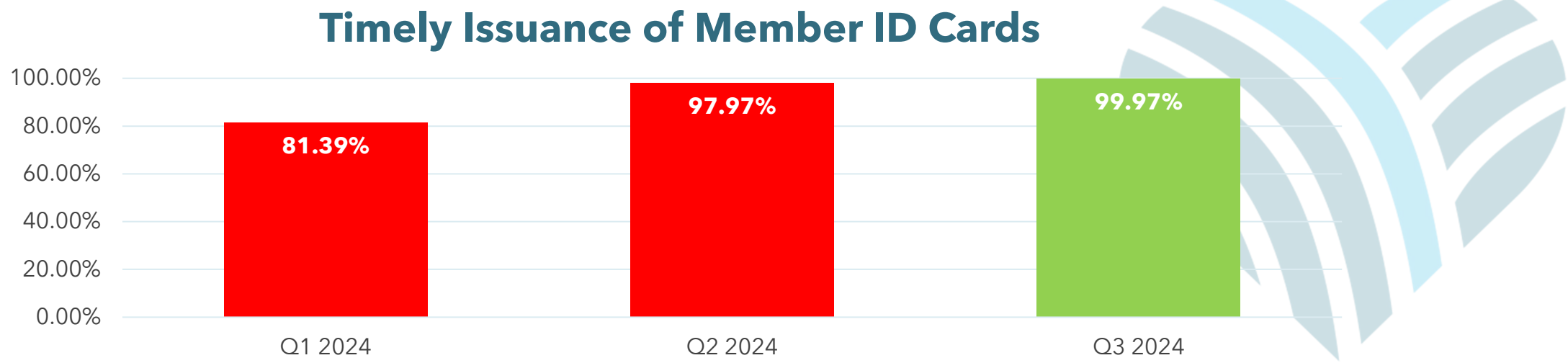


Member ID Card Issuance
Corrective Action Plan Implementation Update
CAP Milestones

- All corrective action plans implemented as of 10/15/2024
- Adding EDI File dates column reveals significant Q2 & Q3 improvements in ID card issuance

Next Steps

- Continue to discuss potential changes to the 100% KPI threshold. Objective is to identify systemic issues; Agree that 100% is not required to meet this objective. A slightly lower threshold can still effectively flag systemic issues.



Questions

COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

COMPLIANCE & POLICY COMMITTEE

Date/Time	November 8, 2024, 11:00pm-12:00pm
	Microsoft Teams meeting Meeting ID: 263 539 725 561 Passcode: xwiJkG Dial in by phone: +1 469-998-7368,,303836297#
Members	☒ ***Chair:*** Elysse Tarabola, Chief Compliance Officer ☒ Larry Lewis; Chief Executive Officer ☒ Dr. Gordon Arakawa; Chief Medical Officer ☒ David Wilson, Chief Financial Officer ☒ Julia Hutchins, Chief Operating Officer
Presenters/ Guests	☒ Michelle Stephanie Ortiz-Trujillo, Senior Director of Human Resources and Community Relations ☒ Jeanette Crenshaw; Senior Director of Healthcare Services ☒ Julia Hutchins; Executive Director of Strategic Planning, D-SNP ☒ Jadira Alcaraz; Delegation Oversight Manager ☒ Rosa Sanchez; Compliance Advisor ☒ Amanda Delgado; Compliance Coordinator ☒ Fernanda Ortega; Delegation Oversight Specialist

AGENDA			
Topic	**Presenter**	**Minutes**	**Action**
Agenda Introduction/ Roll Call	Chelsea Hardy	*Elysse Tarabola, opened the meeting with a complete Quorum.* Mrs. Tarabola officially commenced the meeting of the Compliance Policy Committee for the Community Health Plan of Imperial Valley at 11:00pm	
Review and approve CPC Meeting Minutes (*July 23*, 2024)	*Chelsea Hardy*	The CPC meeting minutes from 07.23.2024 were reviewed and approved	Motion was approved by Larry Lewis and second by Dr. Gordon Arakawa
Updated and New Policies & Procedures	*Chelsea Hardy*	Mrs. Hardy presented new and existing policies and procedures. She highlighted that redlines when applicable are indicated changes in the policies. • CMP-005 Confidentiality and Member Privacy • CMP-012 Notice of Privacy Practices • CMP-013 Key Personnel Change	Motion was approved by Larry Lewis and second by Dr. Gordon Arakawa

COMPLIANCE & POLICY COMMITTEE

AGENDA			
Topic	**Presenter**	**Minutes**	**Action**
		• UM-004 Appropriate Professionals and Use of Board-Certified Physician Consultants in Utilization Management Decision Making • UM-005 Medical Necessity Criteria, Technology Assessment and Hierarchy of Resources • UM-006 Utilization Management System Controls • UM-007 Collection of Ethnicity & Diversity Data • GA-001 Grievances Process • PNM-002 Provider Directory • CR-001 Credentialing and Recredentialing • CR-002 Credentialing Appeals Process • MS-001 Language Assistance Program • IT-001 Device Tracking and Management Using Microsoft Intune • HR-006 Diversity, Equity & Inclusion	
New All Plan Letters (APLs) and Status	Rosa Sanchez	Rosa Sanchez explained how new and updated APLs are disseminated to CHPIV through our regulators and provides updates and guidance on requirement changes and how plans are expected to submit updated policies or specific documentation to confirm APL implementation. She continued to explain how the compliance team prepares the regulatory notices to summarize the APLs. These notices are disseminated to both Health Net and the leadership of CHPIV. She informed the committee of the release of 9 APLs in the third quarter. Six of these were issued by DHCS and three by DMHC. Seven of the APLs pertain to functions delegated to Health Net, one was related to delegated and in-house functions, while one was relevant to in-house functions. Mrs.Tarabola inquired if the committee wanted to discuss in more detail the APL to which everyone replied no.	
Regulatory Submissions	Rosa Sanchez	Mrs. Sanchez reported a total of 118 regulatory submissions, with 58 ad hoc requests, five APL requests, and 55 recurring submissions. All regulatory submissions	

COMPLIANCE & POLICY COMMITTEE

AGENDA			
Topic	**Presenter**	**Minutes**	**Action**
		were completed on time. In addition, she explained the ad hoc request breakdown by impacted functional area and expressed DHCS main focus was on care management and provider network. Mrs. Tarabola requested further clarification on the provided graph. Mrs. Sanchez proceeded to explain care management focused on foster youth readiness, doula services survey, health services functions, reporting templates on care management, and draft APL's. While Provider network focused on the 274 monthly data check updates, primary care physician assignment files, and semi-annual provider directory. Mrs. Tarabola asked the committee for feedback on data reporting methods. Mr. Lewis, Julia Hutchins, and Dr. Arakawa found the information helpful.	
Regulatory Member Issues	Rosa Sanchez	Mrs. Sanchez discussed how regulatory member issues arise when members report directly to regulators. She reported ten issues in Q3, with no trends requiring corrective actions. All were DMHC complaints. Larry Lewis inquired about the acronym FWA to which Mrs. Sanchez explained it stood for Fraud Waste and Abuse Mrs. Tarabola added that during the executive commission meeting, there was a request for a detailed breakdown of grievances, which will first be reviewed by the RCOC. As a result, the Delegation Oversight Department will produce this report. She invited Dr. Arakawa and Julia to join the initial analysis.	
Health Net Deliverables	Fernanda Ortega	Fernanda Ortega reported a total of 213 submissions in Q3. An extension was requested for three regulatory	

COMPLIANCE & POLICY COMMITTEE

AGENDA			
Topic	**Presenter**	**Minutes**	**Action**
		deliverables but as Mrs. Sanchez had previously stated they were submitted on time to the regulators.	
Delegation Oversight Program: Updated Quarter 1 Results	Fernanda Ortega Jadira Alcaraz	Ms. Ortega emphasized that the results were updated following the required revised submission for claims and PDR, which successfully passed data validation. She noted that both Claims and Provider Resolution Timeliness achieved scores above the 95% threshold. David Wilson inquired about the specific condition under which Health Net was requesting to reduce the threshold from 100% to 96%. Mrs. Tarabola responded that the condition prompting Health Net to request a reduction in the threshold from 100% to 96% was related to issues with the Member ID Cards. <u>Quarter 2 Data Log Issues</u> Jadira Alcaraz presented the Q2 Data log issues, highlighting formatting problems in claims and reporting logic issues, including cases that should be excluded. She informed David that Health Net is expected to submit the claims by Wednesday, November 13th. <u>Quarter 2 Data Validation Results</u> Mrs. Alcaraz explained that appeals, continuity of care, grievances, member services-ID, PDR, and UM all passed, except for Claims, which failed data validation due to non-reportable claims Mrs. Tarabola then inquired if anyone had any questions. Mrs. Hutchins explained her understanding of the explanations provided at the DOM meeting. Mr. Wilson concurred, stating that his understanding was the same. Mrs. Hutchins further noted that it was positive news, as the issue was not systemic, allowing them to move forward successfully. Mr. Wilson added that it seemed the process had changed, and it was more of a reporting	

COMPLIANCE & POLICY COMMITTEE

AGENDA			
Topic	**Presenter**	**Minutes**	**Action**
		issue. Mrs. Alcaraz added that MHN legally ceased to exist after January 1, 2024, which is why they are no longer considered Health Net. She explained that claims were being processed in two different systems, and anything after Q4 would be processed in one system. <u>Utilization Management</u> Mrs. Alcaraz explained that UM has three KPIs, and both member notification timeliness and provider notification timeliness failed. The root cause was identified as a training gap in deadline management for provider notification requirements for OB cases. The Corrective Action Plan (CAP) included training relevant staff on notification timelines and OB admissions, implementing notification sending for OB cases, and creating KPI monitoring tools to ensure timeliness and identify any missed deadlines. This was implemented on October 11, 2024. <u>Appeals</u> Due to time constraints, Appeals was not presented. Mrs. Tarabola suggested moving forward to Member Services, as it required further discussion. <u>Member Services</u> Mrs. Tarabola handed the discussion over to Mr. Wilson and Mrs. Hutchins. Mr. Wilson acknowledged that Health Net's concern about being set up for failure was valid, as achieving a 100% threshold was unrealistic. He expressed his willingness to adjust the percentage, noting that 100% seemed like an oversight. Mrs. Hutchins mentioned that Dr. Lang had suggested changing the threshold to 96%. Mrs. Tarabola added that the first step should be to amend the monitoring program to avoid issuing a Corrective Action Plan (CAP). Mr. Wilson added the oversight program was different form the operating agreement and maybe didn't cause any issues	

COMPLIANCE & POLICY COMMITTEE

AGENDA			
Topic	**Presenter**	**Minutes**	**Action**
		Mr. Lewis added it was not worthy, and the appropriate percent could be at what other plans were operating at. Mr. Wilson noted that there was no disagreement about lowering the percentage. Dr. Arakawa suggested a 95% threshold, explaining that a 1 in 20 ratio is commonly used in scientific contexts. Mrs. Hutchins inquired about the regulatory percentage, to which Mrs. Tarabola responded that there wasn't one. Mr. Wilson asked if the NCQA had any guidance on this matter. Dr. Arakawa recommended consulting Jeanette Crenshaw. Mr. Lewis cautioned that a 5% threshold would mean 5,000 individuals receiving their Member ID cards late. <u>Continuity of Care</u> Mrs. Tarabola informed the committee that a Corrective Action Plan (CAP) had also been issued for Continuity of Care (CoC) and asked if there were any inquiries. The committee remained silent. <u>DO monitoring Program: Quarter 3</u> Chelsea Hardy noted that the last slide pertained to Q3. Mrs. Tarabola added that the scorecard should be ready to send to Health Net by November 27th.	
Reminders/ Adjourn		Mrs. Tarabola adjourned the meeting at 12:08 pm.	

	Community Donations and Support	ADM-001
Department	Executive Services	
Functional Area	Administration	
Impacted Delegate	☐ Subcontractor ☒ NA	

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

APPROVALS			
Internal		**Regulator**	
Name	Lawrence E. Lewis	☐ DHCS ☒ NA ☐ DMHC	
Title	Chief Executive Officer		

ATTACHMENTS

- None

AUTHORITIES/REFERENCES

- California Constitution Article 16, §6
- California Government Code, §8314

HISTORY

Revision Date	Description of Revision
10/9/2023	Policy Creation

I. OVERVIEW

A. This policy establishes guidelines for Community Health Plan of Imperial Valley's (CHPIV) PARTICIPATION in community events, programs, projects, and activities involving external entities.

II. POLICY

A. CHPIV recognizes the value of partnering with external entities to provide additional health care related services to benefit the local community, while still upholding its fiscal responsibilities as a steward of public funds. Requests for CHPIV's PARTICIPATION in community events involving external entities, financially, or otherwise, shall be approved only if aligned with CHPIV's mission, vision, and values.

B. An external entity may be eligible for CHPIV's PARTICIPATION in its event if the entity is a community-based, non-profit organization, health care partner, public or government entity (collectively, "external entities") that serves CHPIV's members or supports CHPIV's health's mission, vision, and values. Religious organizations are not eligible for CHPIV's PARTICIPATION unless the event is open to the general public and is for a non-sectarian purpose.

C. The expenditure of CHPIV's funds shall only be made for a direct and primary public purpose within CHPIV's authority and jurisdiction. Absent a legitimate and direct public purpose within CHPIV's authority and jurisdiction, CHPIV shall not use public funds to make monetary contributions to external entities solely for the purpose of goodwill, showing support, networking, public relations, or relationship building. External entities may not use CHPIV's PARTICIPATION in any manner to donate, or endorse, political candidates to elected office, or to support/oppose a position on proposed legislation, ballot initiative, or proposition.

D. CHPIV's PARTICIPATION shall include at least one (1) of the following:

1. Speaking engagement for a CHPIV representative
2. A presentation, or panel presentation, by a CHPIV representative
3. A booth, or table, designated for CHPIV at the event to distribute CHPIV information to members and/or potential members who could be enrolled in any of CHPIV's programs; or
4. Other opportunity to promote CHPIV's services and increase awareness about CHPIV.

E. There may be circumstances where financial PARTICIPATION for external entities, such as charitable organizations, or activities (*e.g.,* United Way, etc.), may be permitted based on a finding by the CHPIV Commission that the request for financial PARTICIPATION falls within CHPIV's authority and purpose, and meets one (1) of the following criteria:

1. The financial PARTICIPATION will be used by the external entity to provide a service that complements, or enhances, one that CHPIV provides; or
2. There is an identifiable benefit to CHPIV and/or its members.

F. The expenditure of CHPIV funds and the use of resources, staff time, and CHPIV facilities shall not be inconsistent with, or in conflict with, CHPIV's obligations under applicable state and federal laws and contracts.

G. Requests for PARTICIPATION by CHPIV in an event proposed by an external entity shall require approval as follows:

1. Requests for Participation, other than financial contributions, such as hosting booths at health fairs, conducting education programs and presentations, or organizing community/town hall meetings:
    a. Requests for non-financial PARTICIPATION from external entities shall be submitted no less than fourteen (14) calendar days in advance of the date of the event.
    b. The CHIEF EXECUTIVE OFFICER (CEO) or his/her designee is authorized to approve non-financial requests from external entities for community/member-oriented events that meet the eligibility requirements as provided in this Policy.
    c. Non-financial PARTICIPATION requests from external entities for community/member-oriented events such as health fairs, educational events, and/or community/town hall forums shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:
        i. Member interaction/enrollment – The activity shall include PARTICIPATION from CHPIV members and/or potential members that could be enrolled in any of CHPIV's programs, or be in furtherance of CHPIV's mission, vision & values, programs, and/or purpose; and
        ii. Inclusion of Details of the Event – Information about the organization and event, including name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator's contact information, expected number of attendees, primary demographics of people served, purpose and outcome of the proposed event, and description of CHPIV's PARTICIPATION in the event.
2. Requests for financial Participation, up to and including, a cumulative value of one thousand dollars ($1,000) per organization per fiscal year, which shall include all materials and supplies:
    a. Requests for financial PARTICIPATION in an amount up to and including one thousand dollars ($1,000) per organization per fiscal year, inclusive of all materials and supplies, shall be submitted no less than twenty-one (21) calendar days in advance of the date of the event, or if in a shorter amount of time, at the discretion of the CEO, or his/her designee, so long as such request is submitted to the CEO, or his/her designee, in a reasonable and sufficient amount of time so that CHPIV can complete a meaningful review and evaluation of the request.
    b. The CEO or his/her designee is authorized to approve requests for financial PARTICIPATION for qualifying external entities and events for a cumulative amount of up to and including one thousand dollars ($1,000) per organization per fiscal year, subject to availability of budgeted funds.
    c. All requests for financial PARTICIPATION sent to CHPIV from external entities shall meet the standards set forth above in Sections II. A. through F. along with the following criteria:

i. Member interaction/enrollment – The activity shall include PARTICIPATION from CHPIV members and/or potential members that could be enrolled in any of CHPIV's programs or be in furtherance of CHPIV's mission, vision & values, programs, and/or purpose; and

ii. Inclusion of Details of the Event – Information about the organization and event, including the name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator's contact information, expected number of attendees, primary demographics of people served, purpose and outcome of the proposed event, description of CHPIV's PARTICIPATION in the event, and/or how CHPIV's financial PARTICIPATION will be used, etc.

d. The CEO or his/her designee is authorized to purchase and use in-kind contributions of items branded with CHPIV's logo for the purpose of outreach and promoting CHPIV's role and services in the community.

e. The CEO or his/her designee will report all approved PARTICIPATION in events involving financial PARTICIPATION in an amount up to and including one thousand dollars ($1,000) per organization per fiscal year to the CHPIV Commission in the CEO's regular CEO Report to the Commission.

f. The use of CHPIV staff time (*e.g.,* in their capacity as a CHPIV employee) to attend events such as health fairs, educational or community events;

g. The use of CHPIV resources (*e.g.,* CHPIV facilities);

h. The use of current, or future, CHPIV eligible funds; and

i. The value of items donated with the CHPIV master brand/logo.

H. In no event shall approval of CHPIV's PARTICIPATION in an event, or with an external entity, constitute an Endorsement of the external entity hosting the event, nor shall such PARTICIPATION constitute Endorsement of any message, or initiative, commercial product, or service, and/or any message advocated by the external entity.

I. The CEO or his/her designee shall report any PARTICIPATION approved by the CEO to the CHPIV Commission, in writing, at the next available regularly scheduled Commission meeting after such approval.

J. The CEO or CEO'S designee shall provide members of the CHPIV Commission with advanced notice to provide them the opportunity to attend events in which CHPIV participates.

K. Payment for actual and necessary expenses incurred in performing services for CHPIV, including expenses incurred in the course of attending functions of external entities, shall be reimbursed, or paid in accordance with CHPIV Travel Policy, to the extent there is a clear nexus between the attendance of the employee at such a function and the performance of the service for which such employees is regularly employed. In no event shall CHPIV pay or reimburse a CHPIV employee for expenses arising from personal expenses, political campaigns or activities, charitable contributions, or events (including fundraisers, galas, dinners, unless expressly approved by the CHPIV Commission), family expenses, entertainment expenses, or religious activities.

III. PROCEDURE

A. All requests for PARTICIPATION shall be submitted within the timeframe specified above, and include the following information, as appropriate:

1. Description of the external entity requesting Participation, including, but not limited to: whether the external entity is a non-profit organization, religious organization, for-profit organization, or other health care partner (including valid by-laws filed with the Secretary of State of the State of California); how long the external entity has been operating; where the external entity's principal office and base of operations is located; external entity's service area, etc.;
2. Description of the event such as name of the event, day/date, start and end time, location, event coordinator's contact information, expected number of attendees, primary language of attendees, primary demographics of people served, purpose, and outcome of the proposed event;
3. The purpose of the event, including, but not limited to, a copy of any event materials, or description of the program or project;
4. Description of the relationship between external entity's work, or event, and CHPIV's programs/lines of business, mission, vision & values, programs, and/or purpose;
5. Description, background, and pertinent information (*e.g.*, names of members of the Commission) regarding the requesting entity and any other entity having a substantial role in the event;
6. A list of other individuals, or entities, supporting the event;
7. Event budget information; and
8. Purpose, role, and anticipated time commitment for CHPIV's involvement in the event, if applicable.

B. Upon receipt of a complete request for Participation, CHPIV's Compliance Department shall:

1. Review and analyze the request to ensure each policy criteria is met;
2. Complete the Event PARTICIPATION Request Form and place the completed form and all supporting documentation in a folder within five (5) business days of the date of receipt of completed request;
3. Submit the request to the CEO, his/her designee for consideration. If the request is denied, the requestor shall be notified.

C. Upon receipt of the approved request for PARTICIPATION from the CEO, his/her designee, , CHPIV's Office Manager shall:

1. Notify the requesting entity of CHPIV's determination; and
2. Process the financial request and any necessary documents within three (3) business days of the determination date.
3. Any payments for approved financial requests shall be issued only through checks paid directly to the external entity, and no cash disbursements will be made for events covered by this Policy.

D. Requests for In-Kind Contributions of Items Branded with the CHPIV Logo:

1. Requests shall be submitted to the CEO's Office, in writing, at least thirty (30) calendar days in advance of the date for which an entity wishes to distribute items branded with the CHPIV master logo.

2. Upon receipt of a completed request to distribute items branded with the CHPIV's master logo, the CEO's office shall review and analyze the request with input from appropriate internal departments within five (5) business days.
3. CEO shall approve donations of items valued at five dollars ($5) or less, and up to and including a cumulative total of five hundred dollars ($500) worth of goods. Requests to distribute items that exceed a cumulative total of five hundred dollars ($500) shall require the prior approval of the CHPIV Commission.
4. The CEO's office shall notify the requesting entity, in writing, after CHPIV's determination is made.
5. The CEO's Office shall process an approved request to distribute items branded with the CHPIV's master logo within three (3) business days of approval.
6. The requesting entity shall agree to return any items that it does not distribute at the conclusion of the event for which the item was used.

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 (CEO)	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.
Participation	Financial, Goods & Services, Staff, or other CHPIV resources provided to an external entity.

	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 ☐ 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 ☒ 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 Compliance
Encounters;	Finance/Operations Compliance
Information systems management;	Finance/Operations Compliance
Cultural and linguistic services/language assistance;	Health Services Compliance
Compliance Program;	Compliance
Care Delivery Model (e.g., Model of Care and Practice Guidelines);	Health Services Compliance
Provider disputes and claim appeals;	Finance/Operations Compliance
MEMBER rights;	Health Services Compliance
MEMBER service;	Health Services Compliance
Network management, including provider relations and provider network contracting;	Finance/Operations Compliance
Access and availability, including Americans with Disabilities Act (ADA);	Finance/Operations Compliance
Systems;	Finance/Operations Compliance
Ownership and control disclosures; 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. 2. To identify potential conflicts of interest, CHPIV will collect and review their DELEGATED ENTITIES ownership and control disclosures. 3. CHPIV will require and ensure DELEGATED ENTITIES accurately provide all required information in their disclosures such as: a. Date of Birth b. Social security number for each person with ownership or control interest c. Social security number for each managing employee	Compliance

Oversight Activities	Responsible Department
Policies and procedures: DELEGATED ENTITIES shall facilitate and document an annual review of all policies and procedures to ensure compliance with regulatory, statutory, and contractual requirements. DELEGATED ENTITIES shall review and obtain approval from all applicable executive management staff and from a regulatory agency, as appropriate. 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 Compliance
Provider relations;	Finance/Operations Compliance
Translation Services;	Health Services Compliance
Insurance;	Finance/Operations 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 Compliance
Regulatory initiatives, including but may not be limited to, Whole Child Model, California Advancing and Innovating Medi-Cal (CalAIM).	Health Services 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. 1. External Audit – Evaluation of CHPIV as conducted by an external regulatory or accreditation body; 2. Internal Audit – Evaluation of CHPIV operational areas, department, or systems as conducted by Regulatory Affairs and Compliance (RAC); or 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: 1. CHPIV responsibilities; 2. Duration of the agreement; 3. Termination of the agreement; 4. Delegated Entity responsibilities and Delegated Services; 5. Types and frequency of reporting to the Delegated Entity; 6. Process by which the CHPIV evaluates the Delegated Entity's performance (Performance Measurements); 7. Use of confidential CHPIV information including Member Protected Health Information (PHI) by the Delegated Entity; and 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: 1. Regular reports (utilization, timeliness, complaints/grievances, network certification, etc.); 2. Regulatory or accreditation deliverables; 3. Program descriptions and/or evaluations; or 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.

	Implementation of Regulatory Notifications	CMP-004
	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 ☐ DMHC	
Title	Chief Compliance Officer		

ATTACHMENTS

- Attachment A – Regulatory Compliance Notice Template
- Attachment B – Implementation Plan Form Template

AUTHORITIES/REFERENCES

- NA

HISTORY

Revision Date	Description of Revision
10/9/2023	Policy Creation
	Annual Review

I. OVERVIEW

A. Community Health Plan of Imperial Valley (CHPIV) will follow the process outlined herein, for organization-wide implementation of all REGULATORY NOTIFICATIONS released by CHPIV's REGULATORY AGENCIES.

II. POLICY

A. REGULATORY AGENCIES release REGULATORY NOTIFICATIONS to health plans to provide new or revised guidance with which the health plans must comply.
B. REGULATORY NOTIFICATIONS can be released in draft or final version.
C. As a health plan, CHPIV must comply with all applicable REGULATORY NOTIFICATIONS, as they are released by REGULATORY AGENCIES in final version, and by the effective dates indicated by the REGULATORY AGENCIES.
D. CHPIV must notify their DELEGATES when the DELEGATED ENTITIES are impacted by released REGULATORY NOTIFICATIONS.
E. As part of full implementation of REGULATORY NOTIFICATIONS, CHPIV must ensure that the DELEGATED ENTITIES comply with the REGULATORY NOTIFICATIONS, as they are released, and by the effective dates indicated by the REGULATORY AGENCIES and/or CHPIV.

III. PROCEDURE

A. Draft REGULATORY NOTIFICATIONS
1. Compliance may receive draft REGULATORY NOTIFICATIONS from the DEPARTMENT OF HEALTH CARE SERVICES (DHCS) or DEPARTMENT OF MANAGED HEALTH CARE (DMHC).
2. Compliance may also receive the same REGULATORY NOTIFICATIONS through one of the health plan associations, California Association of Health Plans (CAHP) and/or Local Health Plans of California (LHPC).
3. When draft REGULATORY NOTIFICATIONS are distributed, and comments are requested by DHCS, DMHC, and/or one of the health plan associations, Compliance will dissect and analyze the distributed draft REGULATORY NOTIFICATIONS, highlight pertinent requirements for the health plans, and identify the differences between any previous versions of the guidance, if applicable.
4. Compliance will send the draft REGULATORY NOTIFICATIONS, along with any supplemental documentation to the impacted business units and DELEGATED ENTITIES within two (2) business days of receipt of the draft REGULATORY NOTIFICATIONS.
5. Impacted business units will submit their comments back to Compliance, in the format and timeframe requested.
6. SUBCONTRACTORS will submit their comments on draft REGULATORY NOTIFICATIONS directly to DHCS and/or the health plan association, in the format and timeframe requested by DHCS and/or the health plan association.

7. Once comments are received from the impacted business units, Compliance will compile all CHPIV comments into one document and submit them to DHCS, DMHC, and/or the health plan association by the requested due dates, on behalf of CHPIV.

B. Final REGULATORY NOTIFICATIONS

1. When final REGULATORY NOTIFICATIONS are distributed, Compliance will dissect and analyze the distributed final REGULATORY NOTIFICATIONS, and draft a Regulatory Compliance Notice that, at minimum, highlights the requirements for the health plans and the differences between any previous versions of the guidance, if applicable.
2. If implementation is required, Compliance will require the business owners and/or DELEGATED ENTITIES to complete an Implementation Plan Form.
    a. The Implementation Plan Form shall include a needs assessment, required tasks (e.g. development of policies and procedures, system changes), task owners, timelines, supporting/evidentiary documentation, and expected completion dates.
        i. Expected completion dates shall adhere to regulatory due dates, as applicable.
3. Compliance will collect the Implementation Plan Form and provide feedback and guidance, as needed.
4. Once the Implementation Plan Form is approved by Compliance, Compliance will monitor the tasks for timeliness and ensure effective and complete implementation.
5. Compliance will submit all required documents to evidence implementation to DHCS and DMHC, as required.
    a. If implementation is delayed or incomplete, Compliance will escalate to CHPIV Leadership, COMPLIANCE AND POLICY COMMITTEE (CPC), and/or the Regulatory Oversight Committee of the COMMISSION for further discussion and potential DISCIPLINARY ACTION.
6. Compliance may validate effectiveness of the approved Implementation Plan through an audit.

IV. DEFINITIONS

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

TERM	DEFINITION
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 Entities (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.
Department of	The State agency responsible for administration of the federal Medicaid

TERM	DEFINITION
Health Care Services (DHCS)	(referred to 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.
Department of Managed Health Care (DMHC)	The state agency responsible for administering the "Knox-Keene Health Care Service Plan Act of 1975.
Disciplinary Action	A formal action taken in response to unacceptable performance or misconduct.
Compliance and Policy Committee (CPC)	An internal committee of CHPIV management staff that monitors compliance activities and makes recommendations for action to CHPIV staff, including CHPIV's executive staff, and the Commission
Regulatory Agencies	State and federal governing bodies overseeing consumer rights to quality health care. This includes, but is not limited to, the Department of Managed Health Care (DMHC), the California Department of Health Care Services (DHCS), and the Centers for Medicare and Medicaid Services (CMS).
Regulatory Notification	Notices released by the Department of Health Care Services and Centers for Medicare and Medicaid Services (All Plan Letter (APL), Policy Letter (PL), Duals Plan Letter (DPL) and Health Plan Management System (HPMS) Memos), to aid health plans in implementing programmatic and policy changes.
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 ☐ 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.

	Escalation of Noncompliance Issues	CMP-007
Department	Compliance	
Functional Area	Compliance	
Impacted Delegate	☒ Subcontractor ☐ NA	

DATES			
Policy Effective Date	10/09/2023	**Reviewed/Revised Date**	
Next Annual Review Due	10/09/2024	**Regulator Approval**	08/25/2023

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

ATTACHMENTS

- NA

AUTHORITIES/REFERENCES

- CMP-001 Corrective Action Plan
- 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
- Title 42, Code of Federal Regulations (C.F.R.), §438.230

HISTORY

Revision Date	Description of Revision
10/09/2023	Policy creation
	Annual review

I. OVERVIEW

A. The purpose of this policy is to establish a clear and structured framework for handling noncompliance issues within Community Health Plan of Imperial Valley (CHPIV). Noncompliance refers to instances where MEMBERS, providers, or employees fail to adhere to the established rules, regulations, and policies, which may lead to potential risks or disruptions in the provision of healthcare services. This policy aims to address noncompliance promptly and efficiently while promoting transparency, fairness, and compliance with all applicable laws and regulations.

II. POLICY

A. The policy ensures a systematic approach to identify, report, investigate, and resolve noncompliance issues promptly and effectively. By following this policy, we aim to uphold the highest standards of ethics, quality of care, and compliance with all relevant laws and regulations.

III. PROCEDURE

A. Identification of Noncompliance: Noncompliance issues may arise from DELEGATED ENTITIES, providers, or employees failing to follow established policies, contractual obligations, ethical guidelines, or relevant laws and regulations. Noncompliance can be identified through AUDITS, MONITORING, feedback from MEMBERS and providers, or self-reporting.

B. Reporting Noncompliance: Any individual who becomes aware of a noncompliance issue must report it immediately to their immediate supervisor, any MEMBER of the leadership team, Chief Compliance Officer, or Compliance department. Anonymous reporting is available through the CHPIV website and Compliance Hotline.

C. Initial Assessment: Upon receiving a report of noncompliance, the Compliance department shall conduct an initial assessment to determine the severity and legitimacy of the reported issue.

D. Investigation: The Compliance department will lead a formal investigation, document findings, and require a CORRECTIVE ACTION PLAN, as appropriate.

E. Executive Management Involvement: All compliance issues will be escalated to the Chief Compliance Officer. Compliance issues that pose a significant risk to CHPIV's integrity will be brought to the attention of the Chief Executive Officer for discussion. Upon the Chief Executive Officer's agreement, the Compliance Issue will progress through successive levels of escalation, involving the COMPLIANCE & POLICY COMMITTEE, Leadership Team, the Commission, and the regulatory agencies. Additionally, the CCO has the authority and direct access to the Commission should they choose to escalate matters directly at that level.

F. Self-Disclosures to Regulatory Agencies: CHPIV encourages a culture of transparency and self-policing. If noncompliance issues identified have regulatory implications, CHPIV is responsible for self-disclosing matters to the appropriate regulatory authorities.

G. Training: Employees may undergo training related to the noncompliance.

H. Corrective Action Plans: CORRECTIVE ACTION PLANS are required to correct noncompliance issues in accordance with CAP requirements set forth in CHPIV P&P CMP-003 CORRECTIVE ACTION PLANS.

1. The elements of the CAP must be resolved in accordance with CHPIV P&P CMP-003: CORRECTIVE ACTION PLANS.
2. 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.
    a. 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.
3. CORRECTIVE ACTION PLANS are monitored in accordance with CHPIV P&P CMP-003: CORRECTIVE ACTION PLANS.

I. Disciplinary actions: CHPIV may impose progressive disciplinary actions with consistent performance issues or findings regarding significant compliance issues.

1. Staff: In addition to CORRECTIVE ACTION PLANS, noncompliance issues involving CHPIV staff may result in the following disciplinary actions:
    a. Additional Training: Employees may undergo additional training related to the violation.
    b. Verbal and Written Warnings: For minor noncompliance, a verbal and written warning will be issued to remind the employee of the expected standards of conduct, outlining the violation and potential consequences.
    c. Probationary Period: Serious or repeated noncompliance may result in probation with close MONITORING for improvement.
    d. Suspension: Significant noncompliance may lead to a temporary suspension as a serious warning.
    e. Termination: Severe or repeated noncompliance may lead to employment termination.
2. Noncompliance issues and disciplinary actions related to DELEGATED ENTITIES are further outlined in P&P CMP-002 Delegation Oversight.

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

TERM	DEFINITION
	(NCQA) requirements. 1. External Audit – Evaluation of CHPIV as conducted by an external regulatory or accreditation body; 2. Internal Audit – Evaluation of CHPIV operational areas, department, or systems as conducted by Regulatory Affairs and Compliance (RAC); or 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.
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.
Delegation Agreement	Mutually agreed upon document, signed by both parties, which includes, without limit: 1. CHPIV responsibilities; 2. Duration of the agreement; 3. Termination of the agreement; 4. Delegated Entity responsibilities and Delegated Services; 5. Types and frequency of reporting to the Delegated Entity; 6. Process by which the CHPIV evaluates the Delegated Entity's performance (Performance Measurements); 7. Use of confidential CHPIV information including Member Protected Health Information (PHI) by the Delegated Entity; and 8. Remedies available to the CHPIV if the Delegated Entity does not fulfill its obligations.
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.

	Selecting a Chief Compliance Officer	CMP-008
	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	Larry Lewis	☒ DHCS ☐ NA ☐ DMHC	
Title	Chief Executive Officer		

ATTACHMENTS

- NA

AUTHORITIES/REFERENCES

- DHCS Contract Section 1.3.1 Compliance Program

HISTORY

Revision Date	Description of Revision
10/9/2023	Policy Creation
	Annual Review

I. OVERVIEW

A. This policy establishes a clear and standardized process for the selection of a CHIEF COMPLIANCE OFFICER (CCO) who will ensure adherence to all contractual requirements.

II. POLICY

A. The designated CHIEF COMPLIANCE OFFICER (CCO) must be independent. This means the CCO should not serve in a dual capacity, especially in both compliance and operational roles. Examples of conflicting roles include the Chief Operating Officer, Finance Officer, or General Counsel.

B. The CCO will report directly to the CHIEF EXECUTIVE OFFICER (CEO) and the Commission (governing board).

III. PROCEDURE

A. Job Description

1. CHPIV will maintain a detailed job description for the CCO position.
2. This description will include roles, responsibilities, authority, qualifications required, and other relevant information.

B. Selection Process

1. A selection committee, consisting of the CHIEF EXECUTIVE OFFICER and representatives from HR and senior management, will review applications.
2. Suitable candidates will undergo a series of interviews with the selection committee.
3. The final candidate will be vetted for potential conflicts of interest to ensure their independence.

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 (COO)	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 (CEO)	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

TERM	DEFINITION
	integrity, all while being accountable to the Commission.

	Fraud, Waste, and Abuse Program	CMP-009
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 ☐ DMHC
Title	Chief Compliance Officer	

ATTACHMENTS

- NA

AUTHORITIES/REFERENCES

- Program Integrity Requirements - 42 CFR §438.608(a)(4) and §438.608(a)(8)
- DHCS APL 15-026 – Actions Following Notice of Credible Allegation of Fraud
- DHCS APL 17-003 – Treatment of Recoveries Re: Overpayments to Providers
- DHCS APL 21-003 – Medi-Cal Network Provider & Subcontractor Terminations
- PLAN- 2024 DHCS Contract Exhibit A, Attachment III, Subsection 1.3.4.D CHPIV's Obligations Regarding Suspended, Excluded and Ineligible Providers – Actions to be taken where Credible Allegation of Fraud
- PLAN- 2024 DHCS Contract Exhibit E Section 1.3.7.B Federal False Claims Act Compliance and Support – Cooperation with the Office of Attorney Genera Division of Medi-Cal Fraud & Elder Abuse ('DMFEA") and the U.S. Department of Justice ("DOJ") Investigations and Prosecutions
- U.S. Department of Health and Human Services (HHS) Office of Inspector General ("OIG")
- PLAN- 2024 DHCS Contract Exhibit E Section 3.1.6.A.10 Requirements for Network Provider Agreements, Subcontractor Agreements and Downstream Subcontractor Agreements
- Anti-Kickback Regulations – 42 U.S.C.A. § 1320a-7b(b)
- Mail and Wire Fraud – 18 U.S.C. § 1341
- False Claims Act – 31 U.S.C. § 3729 *et seq.*
- Program Fraud Civil Remedies Act – 31 U.S.C. §§ 3801-3812
- Deficit Reduction Act of 2005
- CA False Claims Act - CA Code § 12650 *et seq.*
- HIPAA – 45 CFR, Part 164
- Provider Self-Disclosure Protocol – 63 Fed. Reg. 58, 399-403 (1998)

HISTORY

Revision Date	Description of Revision
10/9/2023	Policy Creation

	Annual Review

I. OVERVIEW

A. The purpose of this FRAUD Prevention Program policy (this "Policy) is to ensure compliance with the Fraud Prevention Program requirements in the MEDI-CAL CONTRACT. This Policy applies to CHPIV and its Staff, NETWORK PROVIDERS, SUBCONTRACTORS, DOWNSTREAM SUBCONTRACTORS, and any other individual or entity providing services for CHPIV under the MEDI-CAL CONTRACT. This Policy defines the framework, responsibilities, and guiding principles for identifying fraudulent activities and reducing related health care costs. This policy is intended to: (i) protect CHPIV, its MEMBERS and other stakeholders by preventing, detecting, investigating, and reporting suspected health care FRAUD, WASTE, and ABUSE ("FWA"); and (ii) establish CHPIV's oversight responsibilities of NETWORK PROVIDERS, SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS regarding the creation and maintenance of policies and procedures related to the underlying authorities and references set forth above.

B. CHPIV recognizes the importance of protecting the integrity of the Medi-Cal program and is committed to conducting all activities in accordance with high ethical standards and in compliance with all applicable laws and regulations as stated herein. Our Fully Delegated SUBCONTRACTOR is delegated to implement and maintain a fraud prevention program consistent with these standards and requirements outlined within this policy. As such, CHPIV will:

1. Ensure that all Staff, NETWORK PROVIDERS, SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS or agents are educated regarding the federal and state false claims laws and the role of such laws in preventing and detecting FWA;
2. Ensure communication of all requirements of this Policy, and referenced obligations, to its NETWORK PROVIDERS, SUBCONTRACTORS, and DOWNSTREAM SUBCONTRACTORS, and will have a process to ensure its NETWORK PROVIDERS, SUBCONTRACTORS, and DOWNSTREAM SUBCONTRACTORS acknowledge receipt and understanding of the requirements contained within this Policy;
3. Perform audits that include reviewing, researching and documenting potential FWA activities within the organization;
4. Ensure identification and investigation of potential FRAUD from reports and referrals;
5. Ensure implementation of a process to conduct timely inquiry into potential violations;
6. Conduct FWA awareness training for Staff;
7. Ensure documentation and retention of all records pertaining to corrective actions imposed as a result of violations;
8. Ensure that NETWORK PROVIDERS, SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS have a robust FWA program in place, which includes the requirements of this Policy and ongoing monitoring and mandatory annual training;

9. Fully disclose to State and federal regulatory agencies any FRAUD or misconduct within the Plan, NETWORK PROVIDERS, SUBCONTRACTORS or DOWNSTREAM SUBCONTRACTORS; and
10. Fully cooperate with DHCS, DMFEA, OIG, and DOJ investigations and prosecutions in the event of allegations of FRAUD.

B. Retaliation or intimidation toward the reporter(s) of FWA will be strictly prohibited, and this Policy supports reporting of any such retaliation to the Compliance Officer/Fraud Prevention Officer.

C. CHPIV requires that its SUBCONTRACTORS comply with the requirements and provisions of this Policy and, also, that its SUBCONTRACTORS require in their written contracts with NETWORK PROVIDERS and DOWNSTREAM SUBCONTRACTORS that they comply with the requirements and provisions of this Policy to the extent applicable and required by law or regulation.

II. POLICY

A. Fraud Prevention

1. CHPIV provides a confidential FRAUD hotline for FRAUD reports from Staff, MEMBERS, SUBCONTRACTORS, DOWNSTREAM SUBCONTRACTORS, NETWORK PROVIDERS, and any other individuals with a need to report suspected FRAUD and ensures that its SUBCONTRACTORS provide a confidential FRAUD hotline for FRAUD reports from their staff, MEMBERS, NETWORK PROVIDERS, DOWNSTREAM SUBCONTRACTORS, and any other individuals with a need to report suspected FRAUD.
2. CHPIV provides multiple mechanisms for reporting, including the confidential hotline, Staff exit interview surveys, email reporting, and a dedicated address for submission via U.S. Mail.
3. CHPIV ensures FRAUD prevention activities and suspected FRAUD are reported directly to regulatory and law enforcement agencies as required by law.
4. FRAUD activities and suspected FRAUD identified by NETWORK PROVIDERS, SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS are communicated to CHPIV.
5. CHPIV ensures FRAUD and ABUSE Activities include, but are not limited to:
    a. Complying with 42 CFR Part 455, §§ 455.104 (Disclosure by Medicaid providers and fiscal agents: Information on ownership and control), 455.105 (Disclosure by providers: Information related to business transactions), 455.106 (Disclosure by providers: Information on persons convicted of crimes), and 42 CFR section 438.610 (Prohibited affiliations);
    b. Ensure that SUBCONTRACTORS are requiring NETWORK PROVIDERS and DOWNSTREAM SUBCONTRACTORS to enroll and remain enrolled in the Medi-Cal program, to the extent required under the MEDI-CAL CONTRACT;
    c. Ensure that SUBCONTRACTORS are confirming the identity of NETWORK PROVIDERS, and any Person with an Ownership or Control Interest or who is an agent or Managing Employee of a Network Provider, upon contract execution or renewal and credentialing, through routine checks of State and federal databases;

The databases to be checked are the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES) and the Excluded Provider Lists maintained by the State;

d. Tracking SUBCONTRACTORS and ensuring SUBCONTRACTORS are tracking NETWORK PROVIDERS and DOWNSTREAM SUBCONTRACTORS through review of the following exclusionary databases and lists no less frequently than monthly and upon contract execution or renewal, and upon provider credentialing, taking appropriate action in accordance with ALL PLAN LETTER (APL) 15-026, and APL 21-003:
    i. List of suspended and ineligible providers located at https://files.medi-cal.ca.gov/pubsdoco/SandILanding.aspx,
    ii. List of OIG Excluded Individuals and Entities (LEIE) located at https://oig.hhs.gov/exclusions/exclusions_list.asp,
    iii. Excluded Parties List System (EPLS) within the HHS System for Award Management (SAM) database located at https://sam.gov/content/home;
e. Ensuring training of Staff, directors, NETWORK PROVIDERS, and SUBCONTRACTORS (and ensuring NETWORK PROVIDERS and SUBCONTRACTORS ensure training of DOWNSTREAM SUBCONTRACTORS) on FRAUD schemes, FRAUD detection and FRAUD prevention activities at least annually. Training may consist of an online course, in-person sessions, and/or distribution of written materials. Training topics will also include:
    i. Federal and State FALSE CLAIMS ACT statutes,
    ii. Federal remedies for false claims and statements,
    iii. State laws containing civil or criminal penalties for false statements
    iv. WHISTLEBLOWER protections,
    v. How to handle instances of suspected health care FRAUD;
f. Ensuring that FRAUD prevention efforts are communicated in provider manuals, NETWORK PROVIDER and MEMBER newsletters, internal newsletters or information blasts, targeted mailings or in-service meetings;
g. Ensuring that a method is maintained to verify, by sampling or other methods, that services that have been represented to have been delivered by NETWORK PROVIDERS were in fact received by MEMBERS (42 CFR §438.608(a)(5)). CHPIV will provide proof of compliance with this requirement when requested by DHCS, in a form and manner specified by DHCS through APL, or other similar instruction.
h. Ensuring that there is monitoring and oversight of activities and reports to detect and deter fraudulent behavior, such as:
    i. MEMBER and provider grievances,
    ii. Claims review, including
        A. Clinical edits for invalid gender, out of normal age range, invalid diagnosis for procedure billed, redundant billing, and others
        B. Billings for non-covered benefits
        C. Claims for ineligible individuals
        D. Reviews for emergency diagnosis, emergency place of service and conformance to the definition of "emergency" and "medical necessity"
        E. Claims pended for review by the Claims Supervisor

1. All claims received from other countries
2. All MEMBER reimbursements for proper documentation,

iii. Medical management audits,
iv. Utilization management activities, including checking out-of-area claims to ensure the MEMBER lives within the service area,
v. Quality management activities,
vi. Operational reviews conducted by CHPIV's internal audit department, including eligibility audits,
vii. Financial audits to ensure compliance with State and federal rules for reinsurance and the identification and return of overpayments;

i. Communicating an email address and an address for U.S. Mail to report suspicious behavior of FWA, confidentially or otherwise. Also, maintaining a toll-free hotline (866)685-8664 for confidential reporting of suspected FRAUD and ABUSE. The hotline is monitored by Staff. All reports of suspected FRAUD received from Staff, NETWORK PROVIDERS, SUBCONTRACTORS, DOWNSTREAM SUBCONTRACTORS, MEMBERS, or other credible sources will be logged, investigated, and tracked;
j. Ensuring investigation and resolution of all reported and/or suspected instances of FRAUD and taking action against confirmed FRAUD, including, but not limited to, reporting to law enforcement agencies as required by the MEDI-CAL CONTRACT, termination of the MEMBER or Staff, termination of the contract with a Network Provider, Subcontractor, or Downstream Subcontractor, and/or removal of a NETWORK PROVIDER from the network;
k. Reporting suspected FRAUD as required under section titled "Reporting" in this Policy;
l. Filing an annual written report with DHCS and DMHC and other entities as required by law of CHPIV's efforts to deter, detect and investigate FRAUD; a log of all cases reported to government agencies; and the number of cases known to be prosecuted;
m. If DHCS, DMFEA, or DOJ, or any other authorized State or federal agency, determines there is a credible allegation of Fraud against a Network Provider, SUBCONTRACTOR or Downstream Subcontractor:
    i. CHPIV complies with the MEDI-CAL CONTRACT, all applicable State and federal laws, APL 15-026, and APL 21-003,
    ii. CHPIV ensures there are procedures in place to ensure immediate suspension of payments to the Network Provider, Subcontractor, or DOWNSTREAM SUBCONTRACTOR for which a State or federal agency determines there is a credible allegation of FRAUD (42 CFR § 438.608(a)(8)),
    iii. CHPIV may conduct additional monitoring, require temporary suspension, and/or termination of the Network Provider, SUBCONTRACTOR or Downstream Subcontractor,
    iv. When DHCS notifies CHPIV that a credible allegation of FRAUD has been found against a provider relating to provision of Fee-For-Service Medi-Cal services and that provider is also a Network Provider, one or more of the following four actions must be taken with submission of all supporting documentation to the MCQMD@dhcs.ca.gov inbox

A. Termination of the NETWORK PROVIDER from the network
B. Temporary suspension of the NETWORK PROVIDER from the network pending resolution of the FRAUD allegation
C. Temporary suspension of payment to the NETWORK PROVIDER pending resolution of the FRAUD allegation, and/or
D. Additional monitoring, including audits of the Network Provider's claims history and future claims submissions for appropriate billing,

v. CHPIV must notify DHCS as to which of the above four actions are taken. No action will be required that would interfere with State or federal criminal investigations,
vi. In the event of a Network Provider, Subcontract or, or DOWNSTREAM SUBCONTRACTOR termination, CHPIV will ensure all the requirements and guidance listed in APL 21-003: Medi-Cal NETWORK PROVIDER and SUBCONTRACTOR Terminations are followed,
vii. CHPIV will fully cooperate in any investigation or prosecution conducted by the DMFEA and the DOJ. CHPIV's cooperation must include without limitation
   A. Providing upon request, information, and access to records, and
   B. Making available Staff or, to the extent appropriate, SUBCONTRACTOR for in-person interviews, consultation, grand jury proceedings, pre-trial conference, depositions, and hearings at DHCS headquarters in Sacramento,
viii. CHPIV litigation support for CMS, DMFEA, and other agencies includes
   A. Ensuring that NETWORK PROVIDERS timely gather, preserve, and provide to DHCS, CMS, DMFEA, and any authorized State or federal regulatory agencies, any records in Network Provider's possession, and
   B. Ensuring that SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS timely gather, preserve, and provide to DHCS, CMS, DMFEA, and any authorized State or federal regulatory agencies, any records in their possession.

6. CHPIV's expectations of NETWORK PROVIDERS and SUBCONTRACTORS for FRAUD prevention and detection include, but are not limited to:
   a. Developing a FRAUD program, implementing FRAUD prevention activities, and communicating such program and activities to its DOWNSTREAM SUBCONTRACTORS consistent with this Policy.
   b. Training staff, employed and contracted health care providers, including but not limited to physicians and other affiliated or ancillary providers and DOWNSTREAM SUBCONTRACTORS on FRAUD prevention activities at least annually, and ensuring that its DOWNSTREAM SUBCONTRACTORS also comply with this provision in any further downstream agreements.
   c. Communicating FRAUD awareness, including identification of FRAUD schemes, detection methods and monitoring activities, to internal personnel, DOWNSTREAM SUBCONTRACTORS, and CHPIV.
   d. Notifying CHPIV of suspected fraudulent behavior.
   e. Taking action against suspected or confirmed FRAUD, including referring such instances to law enforcement and reporting activity to CHPIV.
   f. Cooperating with CHPIV in FRAUD detection and awareness activities, including

monitoring and reporting.

B. Administration

1. CHPIV ensures all potential FWA cases are logged, investigated, and monitored.
2. CHPIV's Fully Delegated Subcontractor's Compliance Officer/Fraud Prevention Officer shall attend and participate in DHCS's quarterly integrity meetings, as scheduled.
3. CHPIV ensures DHCS is notified of any changes in Member's circumstances that impact Medi-Cal coverage pursuant to Medi-Cal program eligibility requirements, including changes in the Member's residence, income, insurance status, and death (42 CFR § 438.608(a)(3)) in a form and manner specified by DHCS through APL or other similar instructions.
4. CHPIV ensures a report of potential instance of FWA is received, an inquiry is initiated as expeditiously as reasonably necessary, but no later than two weeks after the date that the potential misconduct is reported.
    a. If an individual believes that the response to his or her report is completed within a reasonable period of time, he or she is required to bring the matter to the attention of the Compliance Officer/Fraud Prevention Officer.
    b. Failure to report and disclose, or assist, in an investigation of FWA is a breach of the duty that all Staff have to CHPIV and CHPIV's Fully Delegated SUBCONTRACTOR and may result in disciplinary action, up to and including termination.
        i. The CHPIV Compliance Hotline number is (866) 685-8664.
        ii. Written reports may be mailed to: Centene Special Investigations Unit 7700 Forsyth Blvd. Clayton, MO 63105.
5. Files containing investigation materials must be kept in a confidential locked and secured location. Files must be retained a minimum of ten (10) years, unless a longer period of time is required by law or regulation.
6. All parties to the investigation: MEMBERS, NETWORK PROVIDERS, SUBCONTRACTORS, DOWNSTREAM SUBCONTRACTORS, Staff MEMBERS or others named in any form or fashion within the investigation are to be kept confidential to the extent allowable by law.
7. All parties having information relating to the subject of the investigation must hold all information strictly confidential to the extent allowable by law; failure to do so will result in disciplinary action up to and including termination.
8. CHPIV protects as "confidential information" all information shared by or received from DHCS, other State agencies, and federal agencies, and other Medi-Cal managed care plans in connection with any FWA referral, until formal criminal proceedings are made public. CHPIV receives the confidential information as a DHCS business associate in order to facilitate CHPIV's contractual obligations to maintain a FWA prevention program. PHCIV receives and maintains this confidential information in its capacity as a Medi-Cal managed care plan and uses such confidential information only for conducting an investigation into any potential FWA activities and in furtherance of any other program integrity activities.
9. Preliminary and quarterly reports are to be kept confidential and submitted to the DHCS Program Integrity Unit.
10. In the event CHPIV is required to share investigative information with a Network Provider, Subcontractor, or Downstream Subcontractor, CHPIV ensures that the Network Provider, Subcontractor, or DOWNSTREAM SUBCONTRACTOR acknowledges and

agrees that such information will be kept confidential by the Network Provider, Subcontractor, or Downstream Subcontractor.

C. Investigations

1. CHPIV ensures a complete investigation is conducted for all FWA referrals received from DHCS, other State agencies, federal agencies, and other Medi-Cal managed care plans, relating to CHPIV's NETWORK PROVIDERS, SUBCONTRACTORS, and DOWNSTREAM SUBCONTRACTORS. CHPIV submits to DHCS a completed investigation report and a quarterly status report, as set forth in this policy or otherwise required by DHCS in connection with all DHCS, State and federal agency, and Medi-Cal managed care plan referrals of FWA.
2. CHPIV ensures the prompt and thorough investigation of actual or potential FWA, and requires all Staff to assist in such investigations. Investigations may include but not be limited to the following activities:
    a. On-site visits to NETWORK PROVIDERS and SUBCONTRACTORS.
    b. On-site visits to CHPIV MEMBER homes. These visits could be accomplished in conjunction with the audit and/or medical review Staff, or State survey and certification Staff.
    c. Telephone calls or written questionnaires to a sample of CHPIV MEMBERS asking them to confirm the services they received.
    d. Telephone calls or written questionnaires to providers confirming the need for the services rendered.
    e. Telephone calls, correspondence or on-site visits to other pertinent entities.
3. The Compliance Officer/Fraud Prevention Officer must conclude investigations of potential misconduct within a reasonable time period after discovery of the alleged fraudulent activity and complete a FWA Investigation Report form.
4. Unless otherwise specified, the Compliance Officer/Fraud Prevention Officer shall complete a FWA Investigation Report form that includes, to the extent available, the following:
    a. Plan name, organization, and contact information for follow up
    b. Summary of the issue including
        i. The basic who, what, when, where, how, and why
        ii. Any potential legal violations
    c. Specific statutes and allegations including
        i. A list of civil, criminal, and administrative code or rule violations, State and federal
        ii. A detailed description of the allegations or pattern of FWA
    d. Incidents and Issues including
        i. A list of incidents and issues related to the allegations
    e. Background information
        i. Contact information for the complainant, the perpetrator or subject of the investigation, and beneficiaries, pharmacies, providers, or other entities involved
        ii. Additional background information that may assist investigators, such as names and contact information of informants, relators, witnesses, websites, geographic locations, corporate relationships, networks
        iii. The legal and administrative disposition of the case, if available, including

actions taken by law enforcement officials to whom the case has been referred

f. Perspectives of interested parties
    i. Perspective of CHPIV, DHCS, CMS, Member, and other interested parties
g. Data
    i. Existing and potential data sources
    ii. Graphs and trending
    iii. Maps
    iv. Financial impact estimates
h. Recommendations in pursuing the case
    i. Next steps, special considerations, cautions.

5. Within no more than ten (10) working days of completing the investigation, CHPIV shall submit to DHCS reports signed by an executive officer of CHPIV.
    a. Such prompt reporting demonstrates CHPIV's good faith efforts and willingness to work with the government to correct and remedy the problem. CHPIV will also make good faith efforts to cooperate with law enforcement regarding any misconduct reported to the government, including FRAUD and ABUSE.
    b. If an investigation results in a reasonably suspected case of FWA, or confirms that an incident of FWA has been committed, CHPIV will report the incident as deemed appropriate and required by law or regulation to the following government agencies:
        i. CMS
        ii. OIG (Medicare/Medicaid FRAUD)
        iii. California Department of Justice, Bureau of Medi-Cal FRAUD
        iv. California Department of Health Care Services, Program Integrity Unit
        v. California Department of Managed Health Care (DMHC)
        vi. Medical Board of California or other professional licensing regulatory body
        vii. Local law enforcement agencies
        viii. California Health Benefits Exchange
6. The Compliance Officer/Fraud Prevention Officer, with the assistance of legal counsel, review the case and determine if the reported allegation is a violation of State law, federal law, and/or CHPIV Code of Conduct.
7. CHPIV ensures appropriate corrective actions (for example, repayment of overpayments and disciplinary actions against responsible individuals) are taken in response to the potential violation referenced above.
    a. If an overpayment is of significant magnitude (to be determined on a case by case basis), legal counsel will be sought to determine if self-disclosure to a relevant regulatory agency is warranted.
        i. CHPIV has a duty to promptly conduct a reasonable inquiry upon receipt of information that a potential overpayment has occurred. Failure to make reasonable inquiry may be found to be reckless disregard or deliberate ignorance of the overpayment. When overpayment is identified, the Compliance Officer/Fraud Prevention Officer must report the overpayment to DHCS within 60 calendar days after the date on which the overpayment was identified (the 60-day clock does not start running until after CHPIV's

Fully Delegated SUBCONTRACTOR has had an opportunity to undertake reasonable inquiry into the basis of the alleged overpayment).

b. All overpayments should be reported using the self-reported overpayment refund process (SRORP).
c. The Compliance Officer/Fraud Prevention Officer must provide DHCS and/or CMS, in writing, the following information:
    i. Reason for overpayment (incorrect service date, duplicate payment, incorrect CPT code, insufficient documentation, lack of medical necessity, etc.)
    ii. How the error was identified
    iii. Claim number, as appropriate
    iv. Description of the corrective action plan to ensure the error does not occur again
d. CHPIV must report and refund overpayments received during the prior ten (10) years, and in accordance with APL 17-003 and the MEDI-CAL CONTRACT. CHPIV must comply with guidelines issued by DHCS pertaining to retention policies for the treatment of recoveries of all overpayments from CHPIV to a provider, including the treatment of recoveries of overpayments due to FWA.
e. The Claims Department or its delegate must send a letter, accompanied by supporting documentation, to the person who received an overpayment, recognizing the overpayment and providing a date on which the appropriate funds must be returned. The funds must be returned to CHPIV within 60 calendar days after the date on which the overpayment is identified.
f. Failing to report or return overpaid funds within the required timeframe may result in liability under the FALSE CLAIMS ACT and civil monetary penalties up to and including exclusion from participation in federal health care programs. An overpayment which is properly reported and explained, but is not timely repaid, will not give rise to FALSE CLAIMS ACT liability, unless there is evidence of improper avoidance.

D. Reporting

1. In accordance with 42 CFR § 438.608(a)(7), CHPIV ensures all FWA activities are referred, investigated, and reported to DHCS' Program Integrity Unit (PIU), in a manner prescribed by PIU as follows:

a. Preliminary FWA Reports: CHPIV files a preliminary report with DHCS' PIU detailing any suspected FWA identified by or reported to CHPIV, its NETWORK PROVIDERS, SUBCONTRACTORS, or its DOWNSTREAM SUBCONTRACTORS within ten working days of CHPIV's discovery or notice of such FWA. CHPIV submits a preliminary report in accordance with requirements set forth in an APL or other similar instructions. Subsequent to the filing of the preliminary report, a complete investigation of all reported or suspected FWA activities is promptly conducted;
b. Completed Investigation Report: Within ten working days of completing the FWA investigation (including both CHPIV-initiated and DHCS-initiated referrals), CHPIV submits a completed report to DHCS' PIU. This report includes CHPIV's findings, actions taken, and all documentation necessary to support any action taken by

PCHPIV, and any additional documentation as requested by DHCS or other State and federal agencies;

c. Quarterly FWA Status Report: CHPIV submits a quarterly report to DHCS' PIU on all FWA investigative activities ten working days after the close of every calendar quarter. The quarterly report contains the status of all preliminary, active, and completed investigations, and both CHPIV-initiated and DHCS-initiated referrals. In addition to quarterly reports, CHPIV provides updates and available documentation as DHCS may request from time to time;

d. Manner of Report Submission: CHPIV electronically submits all FWA reports in a form and manner specified by DHCS through APL, or other similar instructions. The required report submission includes without limitation the preliminary FRAUD report, the completed investigation report, and the quarterly status report, including all supporting documents, and any additional documents requested by DHCS.

E. Disciplinary Guidelines and Enforcement

1. CHPIV is committed to communicating clear and concise standards as well as executing the disciplinary process when required.

2. Any employee included in suspected violation of the Compliance Program (including its Fraud Prevention Program, Code of Conduct, policies and procedures), laws, regulations or other types of misconduct, is expected to cooperate fully with the investigation process and assist in its resolution.

3. CHPIV prohibits retaliation against any individual who reports suspected violations to the Compliance Program (including its Fraud Prevention Program, Code of Conduct, policies, and procedures), laws, regulations, or other types of misconduct.

4. Anyone who knowingly violates the Compliance Program (including its Fraud Prevention Program, Code of Conduct, policies and procedures), laws, regulations or other types of misconduct, will be subject to disciplinary action up to and including termination of employment criminal or civil prosecution, and or monetary penalties.

5. Discipline and corrective action shall be applied and enforced consistently, fairly, and without prejudice, in a timely manner. Disciplinary action will be based on the seriousness of the violation. The following activities may lead to disciplinary action up to and including termination of employment or termination of a contract with contracted Staff:

a. A Staff member authorizes or participates in actions that knowingly violate CHPIV's Compliance Program (including its Fraud Prevention Program, Code of Conduct, policies and procedures), or laws or regulations;

b. A Staff member deliberately provides misleading information about violations of the Fraud Prevention Program, Code of Conduct, policies or procedures, or laws or regulations;

c. A Staff member fails to report suspected or known violations of the Fraud Prevention Program and/or Code of Conduct;

d. A Staff member is found to have engaged in intentional or reckless non-compliance;

e. A manager's or supervisor's actions reflect inadequate supervision or lack of diligence regarding violations of the Fraud Prevention Program and/or Code of Conduct, policies or procedures, or laws or regulations; and/or

f. Any manager or supervisor retaliates, directly or indirectly, or encourages others to retaliate against an associate who reports a violation of the Fraud

Prevention Program and/or Code of Conduct, policies or procedures, or laws or regulations.

6. NETWORK PROVIDERS, SUBCONTRACTORS, and DOWNSTREAM SUBCONTRACTORS also have the duty to follow the Fraud Prevention Program and Code of Conduct or similar standards that comply with all laws and regulations and to report any potential non-compliant, unethical, or fraudulent behavior without the fear of retaliation. Failure to comply may result in corrective or disciplinary action up to and including termination of a NETWORK PROVIDER or termination of a contract with a SUBCONTRACTOR or Downstream Subcontractor, and/or referral to governmental authority.
7. The Compliance Officer/Fraud Prevention Officer and the Compliance Committee shall be responsible for determining appropriate corrective action after being informed, briefed, and fully reviewing a complaint regarding potential FRAUD. The Compliance Officer/Fraud Prevention Officer and the Compliance Committee are responsible for all discipline or corrective actions relating to serious violations of the Code, policies or procedures, laws and regulations or other acts of wrongdoing, including possible criminal or civil FRAUD activities.
8. Expectations and disciplinary guidelines are well publicized through a variety of methods, including, but not limited to: the Code of Conduct, supporting policies and procedures, Compliance Program, Fraud Prevention Program, training (including Compliance, FWA, and HIPAA), CHPIV's policy CMP-007 Escalation of Noncompliance Issues.
9. Disciplinary records are retained for a period of ten (10) years, unless a longer time period is required by law or regulation, and reviewed periodically to ensure disciplinary actions are appropriate to the violation and consistently administered.

III. PROCEDURE

A. Delegation Oversight

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

IV. DEFINITIONS

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

TERMS	DEFINITION
Abuse	Practices that are inconsistent with sound fiscal and business practices

TERMS	DEFINITION
	or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program.
All Plan Letter (APL)	The means by which Medi-Cal Managed Care conveys information or interpretation of changes in policy or procedures at the Federal or State levels. APLs provide instruction, if applicable, on how to implement changes on an operational basis.
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.
False Claims Act (FCA)	Federal and state statutes that generally prohibit making, using, or presenting a false statement or document in order to get the federal or state government to pay money. It also applies where false statements or documents are used to avoid paying money to the Government that would otherwise be owed, or for failing to identify and return an overpayment.
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.
Member	A beneficiary enrolled in a CHPIV program.
Network Provider	Provider or entity that has a Network Provider Agreement with Contractor, Contractor's Subcontractor, or Contractor's Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under this Contract. A Network Provider is not a SUBCONTRACTOR or Downstream SUBCONTRACTOR by virtue of the Network Provider Agreement.
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.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare, Medicaid

TERMS	DEFINITION
	or any health care benefit program. Waste is generally not considered to be caused by criminally negligent actions.
Whistleblower	Someone who reports wrongdoing (by a co-worker, employer, or other person or company) to a person in a position of authority or publicly, such as to the media. More specifically, in a legal sense, it usually means someone who observes or learns of illegal activity, or at least activity believed to be unlawful, and reports it either to (1) a supervisor or other designated reporting recipient in the organization where the Whistleblower is employed or (2) to a governmental agency with responsibility to investigate or enforce laws regarding the alleged wrongdoing.

	Effective Lines of Communication	CMP-010
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 ☐ DMHC	
Title	Chief Compliance Officer		

ATTACHMENTS

- NA

AUTHORITIES/REFERENCES

- Title 42 Code of Regulations (CFR): 422.503(b)(4)(vi); 423.504(b)(4(vi)
- Prescription Drug Benefit Manual, Chapter 9 – Compliance Program Guidelines
- Medicare Managed Care Manual, Chapter 21 – Compliance Program Guidelines, Sections 40 and 50.
- CHPIV Compliance Program

HISTORY

Revision Date	Description of Revision
10/9/2023	Policy creation
	Annual review

I. OVERVIEW

A. Community Health Plan of Imperial Valley (CHPIV) is dedicated to conducting business in an ethical and legal manner. CHPIV's Compliance Program describes our comprehensive and effective compliance program, including measures to prevent, detect, and correct program noncompliance and FRAUD, WASTE, and ABUSE. CHPIV has written policies, procedures and standards of conduct that mandate every employee will comply with all applicable Medi-Cal, Medicare, federal and state standards. CHPIV pursues allegations of health care FRAUD, WASTE and ABUSE and matters of noncompliance. In this regard, CHPIV enforces effective lines of communication as a primary component of its Compliance Program.

B. CHPIV's Compliance Program is overseen by Compliance Department which is led by the CHIEF COMPLIANCE OFFICER (CCO), who reports directly to the Chief Executive Officer and has the authority to report compliance issues directly to the Commission.

C. The CCO ensures that policies and procedures relating to compliance, FRAUD, WASTE and ABUSE promote effective interdepartmental and external lines of communication. In addition, the CCO ensures processes are in place to monitor and oversee activities performed by operational areas and Delegates. With the support of CHPIV leadership and the Compliance & Policy Committee, the CCO ensures consistent disciplinary guidelines are enforced for incidents of non-compliance with company standards.

II. POLICY

A. The purpose of this policy is to establish and reinforce effective lines of communication, ensuring confidentiality, between the CHIEF COMPLIANCE OFFICER, members of the Compliance & Policy Committee, CHPIV employees, managers, the Commission, and business partners. Such lines of communication are accessible to all and allow compliance issues to be reported including a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified.

III. PROCEDURE

A. For a Compliance Program to be effective, employees must be able to ask questions and report problems. Supervisors play a key role in responding to employee concerns and it is appropriate that they serve as a first line of communications.

B. CHPIV supports an open-door policy in order to foster dialogue between management and employees. CHPIV also distributes training and policies to encourage communications, confidentiality and non-retaliation to all employees.

C. The CHIEF COMPLIANCE OFFICER serves as a contact point for reporting problems and initiating appropriate responsive action.

D. The Compliance Department also maintains the Compliance Hotline and online form to foster an open atmosphere for employees and others to report issues and concerns anonymously and free from retaliation.

E. Employees, subcontractors, providers, and members may report suspected cases of FRAUD anonymously, or they may use the Compliance Hotline and other communication systems to report issues or concerns regarding FRAUD, WASTE, ABUSE or other violations of or concerns related to the Code of Conduct.

F. The Compliance Hotline is available twenty-four (24) hours a day, seven (7) days a week. Callers may choose to remain anonymous. All calls are investigated and remain confidential. Written confidentiality and non-retaliation policies have been developed to encourage open communication and the reporting of incidents of suspected FRAUD, WASTE, ABUSE or other concerns of noncompliance.

G. The Compliance Department distributes in writing any modifications of, or amendments to, the Compliance Plan, standards of conduct or applicable policies.

H. All business units are responsible for escalating concerns to the Compliance Department as necessary.

I. Committee and Commission Reporting

1. All issues discovered by and reported to the Compliance Department are tracked through resolution and status is reported to the Compliance & Policy Committee.
2. There is a Compliance & Policy Committee (CPC) meeting that serves as a medium to exchange information between the Compliance Department and the rest of the organization. The CPC is established by and reports to the Regulatory Compliance Committee of the Commission to assist the Commission in fulfilling its oversight responsibilities.
3. The CPC periodically reports to the Commission on the state of CHPIV's compliance functions, including a summary of the results of any compliance investigations conducted, potential patterns of noncompliance identified, any significant disciplinary actions against any personnel or any other issues that may reflect any systemic or widespread problems in compliance or regulatory matters exposing the organization to substantial compliance risk. In advance of such reports, CPC and other Committees can, through their respective chairs or otherwise, shall confer on any matters of mutual interest considering their respective responsibilities.

J. Reporting of Noncompliance to Regulators

1. If the investigation confirms the existence of non-compliance that falls under the purview of DEPARTMENT OF HEALTHCARE SERVICES (DHCS) and DEPARTMENT OF MANAGED HEALTH CARE (DMHC) regulations, the CHIEF COMPLIANCE OFFICER, in coordination with senior management, will prepare and submit a formal self-disclosure to the respective regulatory authorities.

K. Confidentiality and Non-Retaliation:

1. Confidentiality: CHPIV will treat all reporting of noncompliance issues and related investigations with the utmost confidentiality to the extent allowed by law.
2. Non-Retaliation: CHPIV strictly prohibits any form of retaliation against employees or agents who make good-faith noncompliance reporting. Any such retaliation will be subject to disciplinary action.

IV. DEFINITIONS

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

TERM	DEFINITION
Abuse	Abuse involves payment for items or services where there is no legal entitlement to that payment and the one receiving the payment has not knowingly and/or intentionally misrepresented facts to obtain payment.
Chief Compliance Officer	CHPIV staff member who serves as the focal point for compliance activities as well as manages the Compliance Department of CHPIV. The Chief Compliance Officer reports directly to the Chief Executive Officer and the Commission. The Chief Compliance Officer is responsible for, without limitation, 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, assisting in the formulation of corrective action plans, and overseeing and/or verifying implementation of corrective action.
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.
Department of Managed Health Care (DMHC)	The State agency responsible for administering the "Knox-Keene Health Care Service Plan Act of 1975."
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.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare, Medicaid or any health care benefit program. Waste is generally not considered to be caused by criminally negligent actions.

	Breach Notification	CMP-011
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 ☐ DMHC
Title	Chief Compliance Officer	

ATTACHMENTS

- NA

AUTHORITIES/REFERENCES

- CHPIV Contract with the Department of Health Care Services (DHCS) for Medi-Cal
- CHPIV Compliance Plan
- HIPAA Breach Notification Rules, 45 CFR §164.400 et seq.
- HHS Commentary Re: Breach Notification Rules, 74 FR 42740 (Aug. 24, 2009) and 78 FR 5638 (Jan. 25, 2013)
- HHS Guidance for Securing Protected Health Information, 74 FR 42741 (Aug. 24, 2009); also available at www.hhs.gov/ocr/privacy.
- Information Practices Act at California Civil Code section 1798.3(a)

HISTORY

Revision Date	Description of Revision
10/9/2023	Policy creation
	Annual review

I. OVERVIEW

A. The purpose of this policy is to enable CHPIV to comply with applicable state and federal laws and regulations governing notice to affected persons in the event of a breach of Member privacy.

B. Violation of this Policy may result in disciplinary action, up to and including termination of employment and/or contract, civil and/or criminal action, and other legal and other remedies available to CHPIV.

II. POLICY

A. The Senior Director of Compliance serves as CHPIV's Privacy Officer.

B. CHPIV workforce members will maintain the privacy and security of MEMBERS' PROTECTED HEALTH INFORMATION (PHI) consistent with CHPIV's policies, procedures, and applicable laws and regulations. CHPIV will notify the Member, U.S. Department of Health and Human Services (HHS), DEPARTMENT OF HEALTH CARE SERVICES (DHCS), and in some cases, local media if there is a breach of unsecured PHI unless CHPIV can demonstrate a low probability that the information has been compromised.

C. This Policy applies to all CHPIV workforce members, including CHPIV administration, medical staff, clinical and administrative workforce members, volunteers, and CHPIV's business associates.

D. Breaches of PHI. This policy applies only if there is a breach of a Member's individually identifiable health information. For purposes of this policy, a breach is presumed if there is an unauthorized access, acquisition, use or disclosure of unsecured PHI unless, (1) CHPIV can demonstrate that there is a low probability that the information was compromised based on a risk assessment of certain factors described below, or (2) the situation fits within one of the following exceptions to the breach notification rule:

1. Any unintentional acquisition, access or use of PHI by a CHPIV workforce member or a person acting under CHPIV's authority if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in violation of the HIPAA PRIVACY RULES.
2. Any inadvertent disclosure by a person who is authorized to access PHI at CHPIV to another person authorized to access Member information at CHPIV and the Member information disclosed is not further used or disclosed in violation of the HIPAA PRIVACY RULES.
3. A disclosure of PHI if CHPIV has a good faith belief that the person to whom the disclosure was made would not reasonably have been able to retain such information.
4. The use or disclosure involves PHI that has been "secured" according to standards published by HHS. Currently, this only applies to electronic Member information that has been properly encrypted consistent with standards published by HHS. HHS will publish future guidance for securing Member information on its website, https://www.hhs.gov/hipaa/index.html. (45 CFR § 164.402)

III. PROCEDURE

A. Mitigating Potential Breaches. If CHPIV workforce members improperly access, acquire, use or disclose PHI and immediate action may cure or mitigate the effects of such use or disclosure, CHPIV workforce members should take such action. For example, if CHPIV workforce members improperly access or acquire PHI, they should immediately stop, close,

and/or return the information. If CHPIV workforce members mistakenly disclose PHI to the wrong person, they should immediately request the return of the information and confirm that no further improper disclosures will be made. If the potential breach is significant or requires further action to mitigate its effects, CHPIV workforce members should immediately contact their supervisor and the Senior Director of Compliance for assistance and direction.

B. Reporting Potential Breaches to the Senior Director of Compliance. CHPIV workforce members shall immediately report any suspected breach of PHI in violation of HIPAA PRIVACY RULES or CHPIV's privacy policies to the Senior Director of Compliance. Failure to timely report suspected breaches may result in sanctions as described below.

C. Anonymously reporting HIPAA Violations. Potential breaches may be reported anonymously to CHPIV through the Compliance Hotline (800-919-4947)

D. Investigating Potential Breaches. The Compliance department shall promptly investigate any reported privacy breach or related Member complaint to determine whether there has been a "breach" of PHI as defined above, and if so, how notice should be given. To determine whether a breach has occurred, the Compliance department shall consider:

1. Whether the alleged breach involved PHI.
2. Whether the alleged breach violates the HIPAA PRIVACY RULES. Disclosures that are incidental to an otherwise permissible use or disclosure (e.g., a Member overhears a customer service representative speaking with another MEMBER, or sees information about another MEMBER on a whiteboard or sign-in sheet) does not violate the privacy rule so long as CHPIV implemented reasonable safeguards to avoid improper disclosures. (45 CFR § 164.502(a)(1)(iii))
3. Whether there is a low probability that the PHI has been compromised considering relevant factors, including at least the following: (1) the nature and extent of the information involved; (2) the unauthorized person who used or received the information; (3) whether the information was actually acquired or viewed; and (4) the extent to which the risk to the information has been mitigated. (45 CFR § 164.402)
4. Whether the alleged breach fits within one of the exceptions identified in Section II.3 (a)-(d), above. (45 CFR § 164.402) The Senior Director of Compliance shall document his or her investigation and conclusions, including facts relevant to the risk assessment. (45 CFR §§ 164.414 and 164.530)

E. Notice—In General. If the Compliance department determines that a breach of unsecured PHI has occurred, the Senior Director of Compliance shall notify the MEMBER, HHS, DHCS, and the media (if required) consistent with this policy and the requirements of 45 CFR §§ 164.404 et seq. Any notice provided pursuant to this policy must be approved and directed by the Senior Director of Compliance and/or CHPIV senior leadership. No other CHPIV workforce members are authorized to provide the notice required by this policy unless expressly directed by the Senior Director of Compliance .

F. Notice to MEMBERS. If a breach of PHI has occurred, the Compliance department shall notify the affected MEMBER(S) without unreasonable delay and in no case later than 60 days after the breach is discovered. The notice shall include to the extent possible: (1) a brief description of what happened (e.g., the date(s) of the breach and its discovery); (2) a description of the types of information affected (e.g., whether the breach involved names, social security numbers, birthdates, addresses, diagnoses, etc.); (3) steps that affected MEMBERS should take to protect themselves from potential harm resulting from the breach; (4) a brief description of what CHPIV is doing to investigate, mitigate, and protect against further harm or breaches; and (5) contact procedures for affected persons to ask questions

and receive information, which shall include a toll-free telephone number, e-mail address, website, or postal address at which the person may obtain more information. The notice shall be written in plain language. (45 CFR § 164.404)

1. Notice by Mail or Email. The Compliance department shall notify the MEMBER by first class mail to the Member's last known address. If the MEMBER agrees, the notice may be sent by e-mail. The notice may be sent by one or more mailings as information is available. (45 CFR § 164.404(d))
2. Substitute Notice. If CHPIV lacks sufficient contact information to provide direct written notice by mail to the MEMBER, the Compliance department must use a substitute form of notice reasonably calculated to reach the MEMBER. (45 CFR § 164.404(d))
    a. Fewer than 10 affected MEMBERS. If there is insufficient contact information for fewer than 10 affected MEMBERS, the Compliance department shall provide notice by telephone, e-mail, or other means. If the Compliance department lacks sufficient information to provide any such substitute notice, the Compliance department shall document same. (45 CFR § 164.404(d)(2)(i))
    b. 10 or more affected MEMBERS. If there is insufficient contact information for 10 or more affected MEMBERS, the Compliance department shall do one of the following after consulting with CHPIV senior leadership: (1) post a conspicuous notice on the home page of CHPIV's website for 90 days with a hyperlink to the additional information required to be given to individuals as provided above; or (2) publish a conspicuous notice in major print or broadcast media in the area where affected MEMBERS reside. The notice must include a toll-free number that remains active for at least 90 days so individuals may call to learn whether their PHI was breached. (45 CFR § 164.404(d)(2)(ii))
3. Immediate Notice. If the Senior Director of Compliance believes that PHI is subject to imminent misuse, the Senior Director of Compliance may provide immediate notice to the MEMBER by telephone or other means. Such notice shall be in addition to the written notice described above. (45 CFR § 164.404(d)(3))

G. Deceased MEMBER; Notice to Next of Kin. If the MEMBER is deceased and CHPIV knows the address for the Member's next of kin or personal representative, the Compliance department shall mail the written notice described above to the next of kin or personal representative. If the CHPIV does not know the address for the next of kin or personal representative, CHPIV is not required to provide any notice to the next of kin or personal representative. The Compliance department shall document the lack of sufficient contact information. (45 CFR § 164.404(d)(1))

H. Notice to Regulators.

1. Notice to HHS. If the Compliance department determines that a breach of PHI has occurred, the Compliance department shall also notify HHS of the breach as described below.
    a. Fewer than 500 Affected MEMBERS. If the breach involves the PHI of fewer than 500 MEMBERS, the Compliance department may either (1) report the breach immediately to HHS as described in subsection (b), or (2) maintain a log of such breaches and submit the log to HHS annually within 60 days of the end of the calendar year. Instructions for maintaining and submitting the log are posted on the HHS website. (45 CFR § 164.408(c))
    b. 500 or More Affected MEMBERS. If the breach involves 500 or more persons, the Compliance department shall notify HHS of the breach at the same time the

Compliance department notifies the MEMBER or next of kin. Instructions for maintaining and submitting the log are posted on the HHS website. (45 CFR § 164.408(b))

2. Notice to DHCS.
   a. CHPIV shall notify DHCS immediately upon the discovery of a suspected breach or security incident that involves Social Security Administration data. This notification will be provided by email upon discovery of the breach. If CHPIV is unable to provide notification by email, then CHPIV shall provide notice by telephone to DHCS.
   b. CHPIV shall notify DHCS within 24 hours by email (or by telephone if CHPIV is unable to email DHCS) of the discovery of:
      i. Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;
      ii. Any suspected security incident which risks unauthorized access to PHI and/or other confidential information;
      iii. Any intrusion or unauthorized access, use or disclosure of PHI in violation of the DHCS Contract; or
      iv. Potential loss of confidential data affecting the DHCS Contract.
   c. Notice shall be provided to CHPIV's DHCS Contract Manager. Further, CHPIV shall also notify the DHCS Privacy Office and the DHCS Information Security Office (collectively, "DHCS Contacts") using the DHCS Contact Information noted below.

DHCS Privacy Officer	DHCS Information Security Office
Privacy Office c/o: Office of HIPM Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov	Information Security Office DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov

   d. Notice shall be made using the current DHCS "Privacy Incident Reporting Form" ("PIR Form;" the initial notice of a security incident or breach that is submitted is referred to as an "Initial PIR Form") and shall include all information known at the time the incident is reported. The form is available online at https://www.dhcs.ca.gov/formsandpubs/laws/priv/Documents/Privacy-Incident-Report-PIR.pdf.
   e. DHCS requires CHPIV to immediately investigate a security incident or confidential breach. CHPIV must provide a complete report of the investigation to the DHCS contacts within ten (10) working days of the discovery of the security incident or breach. This "Final PIR Form" must include any applicable additional information not included in the Initial PIR Form. The Final PIR Form shall include an assessment of all known factors relevant to a determination of whether a breach occurred under the HIPAA PRIVACY RULES and other applicable federal and state laws. The report shall also include a full, detailed corrective action plan, including its implementation date and information on mitigation measures taken to halt and/or contain the improper use or disclosure. If DHCS requests

information in addition to that requested through a PIR Form, business associate shall make reasonable efforts to provide DHCS with such information. A "Supplemental PIR Form" may be used to submit revised or additional information after the Final PIR Form is submitted. DHCS will review and approve or disapprove CHPIV's determination of whether a breach occurred, whether the security incident or breach is reportable to the appropriate entities, if individual notifications are required, and CHPIV's corrective action plan. If CHPIV does not complete a Final PIR Form within the ten (10) working day timeframe, CHPIV must request approval from DHCS within the ten (10) working day timeframe of a new submission timeframe for the Final PIR Form.

f. Upon discovery of a breach or suspected security incident, intrusion, or unauthorized access, use or disclosure of PHI, CHPIV shall take:
   i. Prompt action to mitigate any risks or damages involved with the security incident or breach; and
   ii. Any action pertaining to such unauthorized disclosure required by applicable federal and state law.

I. Notice to Media. If a breach of PHI involves more than 500 residents in the state of California, CHPIV will also notify prominent media outlets in California. The notice shall be provided without unreasonable delay but no later than 60 days after discovery of the breach. The notice shall contain the same elements of information as required for the notice to the MEMBERS described above. The Senior Director of Compliance shall work with CHPIV senior leadership to develop an appropriate press release concerning the breach. (45 CFR § 164.406)

J. Notice from CHPIV Business Associate. If CHPIV's business associate discovers a breach of PHI, the business associate shall immediately notify the CHPIV Senior Director of Compliance of the breach. The business associate shall, to the extent possible, identify each person whose information was breached and provide such other information as needed by CHPIV to comply with this policy. Unless the Senior Director of Compliance directs otherwise and with the approval of the Senior Director of Compliance in writing such as via email, the business associate shall notify MEMBERS, HHS, DHCS, and, in appropriate cases, the media as described above after review and approval of any such notifications by CHPIV. (45 CFR § 164.410)

K. Delay of Notice Per Law Enforcement's Request. The Senior Director of Compliance shall delay notice to the MEMBER, HHS, DHCS, and the media if a law enforcement official states that the notice would impede a criminal investigation or threaten national security. If the officer's statement is in writing and specifies the time for which the delay is required, the Senior Director of Compliance shall delay the notice for the required time. If the officer's statement is verbal, the Senior Director of Compliance shall document the statement and the identity of the officer, and shall delay the notice for no more than 30 days from the date of the statement unless the officer provides a written statement confirming the need and time for delay. (45 CFR § 164.412)

L. Training Workforce Members. CHPIV shall train its workforce members concerning this Policy, including workforce members' obligation to immediately report suspected privacy violations. The Senior Director of Compliance shall ensure that this policy is included in training given to new workforce members, and thereafter in periodic training as relevant to the workforce members' job duties. (45 CFR § 164.530)

M. Sanctions. CHPIV workforce members may be sanctioned for a violation of this policy, including but not limited to the failure to timely report a suspected privacy violation. CHPIV may impose the sanctions it deems appropriate under the circumstances, including but not limited to termination of employment or contract. (45 CFR § 164.530)

N. Documentation. The Compliance department shall prepare and maintain documentation required by this Policy for a period of six (6) years or such other period of time as required by law or CHPIV's retention policy, including but not limited to reports or complaints of privacy violations; results of investigations, including facts and conclusions relating to the risk assessment; required notices; logs of privacy breaches to submit to HHS and DHCS; sanctions imposed; etc. (45 CFR § 164.530)

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) Contract	The written agreement between CHPIV and the Department of Health Care Services (DHCS) pursuant to which CHPIV is obligated to arrange and pay for the provision of covered services to Members in the CHPIV Medi-Cal program, i.e., California's Medicaid health care program that pays for medical services for children and adults with limited income and resources and is supported by federal and state funding.
HIPAA Privacy Rules	Federal regulations promulgated under the Health Insurance Portability and Accountability Act provisions related to the privacy protection of Member PHI (45 CFR Part 160 and Part 164)
Member	A beneficiary enrolled in a CHPIV Medi-Cal program.
Protected Health Information (PHI)	*Individually identifiable health information* that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. *Individually identifiable health information* relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care. The information either identifies an individual or there is reasonable basis to believe the information can be used to identify the individual. (45 CFR § 160.103)

	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 ☐ 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 ☐ 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.

	Delegation of Authority	EXC-002
Department	Executive Services	
Functional Area	Executive 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	Larry Lewis	☐ DHCS ☒ NA ☐ DMHC	
Title	Chief Executive Officer		

ATTACHMENTS

- None

AUTHORITIES/REFERENCES

- DHCS Contract Section 1.7 Delegation of Authority, Exhibit E, Section 1.12 (*Notices*)

HISTORY

Revision Date	Description of Revision
10/9/2023	Policy creation

I. OVERVIEW

A. This policy outlines the procedures and guidelines for the delegation of authority within the contract between the DEPARTMENT OF HEALTH CARE SERVICES (DHCS) and the Community Health Plan of Imperial Valley (CHPIV). It establishes the roles and responsibilities of the DHCS Contracting Officer and the CHPIV's Representative, as well as the process for delegating authority to AUTHORIZED REPRESENTATIVES.

II. POLICY

A. The DHCS Contracting Officer shall be appointed by the Director of DHCS and will serve as the single administrator responsible for implementing this Contract on behalf of DHCS. The DHCS Contracting Officer is authorized to make all determinations and take all actions necessary under this Contract, subject to compliance with applicable federal and State laws and regulations. The DHCS Contracting Officer may delegate their authority to act on behalf of DHCS to an AUTHORIZED REPRESENTATIVE through written notice to CHPIV.

B. CHPIV designates the Chief Executive Officer as the single administrator known as the "CHPIV's Representative" to implement the DHCS Contract on behalf of CHPIV. CHPIV's Representative is authorized to make all determinations and take all actions necessary to fulfill the obligations of CHPIV under the DHCS Contract, subject to the limitations specified within the Contract, as well as applicable federal and State laws and regulations.

C. CHPIV's Representative is empowered to legally bind CHPIV to all agreements reached with DHCS. CHPIV's Representative may delegate their authority to act on behalf of CHPIV to an AUTHORIZED REPRESENTATIVE through written notice to the DHCS Contracting Officer.

III. PROCEDURE

A. Delegation of Authority to AUTHORIZED REPRESENTATIVES

1. The delegation of authority by the DHCS Contracting Officer or CHPIV's Representative to an AUTHORIZED REPRESENTATIVE must be done in writing.
2. The written notice of delegation shall clearly state the scope and limitations of the authority being delegated to the AUTHORIZED REPRESENTATIVE.
3. The DHCS Contracting Officer and CHPIV's Representative shall maintain records of all delegations of authority and provide a copy of the written notice to the other party.

B. Designation and Notification Process

1. CHPIV shall designate CHPIV's Representative in writing and submit the designation to the DHCS Contracting Officer.
2. All notices required under this Contract, including the designation of CHPIV's Representative and any delegation of authority, must be in writing
3. Notices sent via certified mail must be addressed to the following:

DHCS Address:
California Department of Health Care Services
Managed Care Operations Division
Attn: DHCS Contract Manager
MS 4407

P.O. Box 997413
Sacramento, CA 95899-7413

4. Both DHCS and CHPIV shall designate email addresses for notices sent via email and provide these addresses to each other.
    a. CHPIV designates Compliance@chpiv.org as the email address for these notices.
5. Notices sent via email are deemed given upon successful transmission, while notices sent via certified mail are deemed given upon receipt.

C. By implementing this Delegation of Authority Policy, DHCS and CHPIV ensure effective contract management throughout the duration of the DHCS Contract 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
Authorized Representative	Means any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member.
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.

	Delegated Entity Financial Solvency Oversight Process	**FIN-001**
	Department	Finance & Informatics
	Functional Area	Finance
	Impacted Delegate	☒ Subcontractor ☐ NA

DATES			
Policy Effective Date	10/9/2023	**Reviewed/Revised Date**	
Next Annual Review Due	10/9/2024	**Regulator Approval**	6/2/2023

APPROVALS			
Internal		**Regulator**	
Name	David Wilson	☒ DHCS ☐ NA ☐ DMHC	
Title	Chief Financial officer		

ATTACHMENTS

- None

AUTHORITIES/REFERENCES

- **State**
  - California Health and Safety Code Sections
  - 1300.75.4-1300.75.4.8 and 1300.76 of Title 28 of the California Code of Regulations (These regulations were promulgated pursuant to authority in sections 1344 and 1375.4 of the California Health and Safety Code)

- **Related Policices**
  - FIN-002 Delegated Provider Financial Solvency CAP Process
  - Pre-Contractual Due Diligence

HISTORY

Revision Date	Description of Revision
10/9/2023	Policy creation
	Annual

I. OVERVIEW

A. Community Health Plan of Imperial Valley (CHPIV) monitors the financial solvency of delegated entities to establish that they are in compliance with the CHPIV financial solvency criteria, related contractual requirements and that their financial status is stable and not deteriorating over time.

II. POLICY

A. This policy applies to any SUBCONTRATCOR (including any Plan-to-Plan, or P2P, SUBCONTRACTORS), DOWNSTREAM SUBCONTRACTOR, or NETWORK PROVIDER who has accepted and been delegated financial risk for the provision of Covered Services for one or more lines of business. For purposes of this policy only, they shall collectively be referred to as "delegated entities." The purpose of this policy is to outline the Community Health Plan of Imperial County's ("CHPIV" or "Plan") process to continuously review and monitor the financial solvency of its delegated entities for the purpose of early identification and intervention with delegated entities who may be financially unstable and therefore unable to meet their obligations to members and their downstream entities.

III. PROCEDURE

A. CHPIV has adopted the following process to ensure that consistent review, analysis, and communication of delegated entity's financial condition are performed on a regular basis (monthly, quarterly, annually, as identified) and measured against financial standards established by CHPIV, the DEPARTMENT OF MANAGED HEALTH CARE (DMHC) and other regulatory or licensing agencies, as applicable.

B. In order to determine the overall financial solvency of the delegated entities, the process includes the review, and analysis of the delegated entity's audited and unaudited FINANCIAL STATEMENTS, including at a minimum, a balance sheet, an income statement, a statement of cash flows, and for audited FINANCIAL STATEMENTS, footnote disclosures prepared in accordance with GENERALLY ACCEPTED ACCOUNTING PRINCIPLES (GAAP).

C. Financial Solvency Review Process

1. Delegated entities are required to submit quarterly and/or annual audited FINANCIAL STATEMENTS to CHPIV. If a delegated entity is not meeting the financial solvency requirements, they may be asked to also provide monthly FINANCIAL STATEMENTS to CHPIV.
    a. Quarterly and annual audited FINANCIAL STATEMENTS are due to CHPIV as follows:
        i. Quarterly FINANCIAL STATEMENTS are due within 45 days of the end of each calendar quarter.
        ii. Audited annual FINANCIAL STATEMENTS are due within 150 days of the end of each fiscal year.
    b. Prior to each due date, CHPIV requests delegated entities to submit the applicable FINANCIAL STATEMENTS.
        i. Reminders are sent to delegated entities who have not responded.

ii. Non-responsive delegated entities will be reviewed to determine if additional actions are required (i.e., escalate to the appropriate oversight committee).

c. CHPIV assesses the financial solvency of each delegated provider based on CHPIV's established criteria and the DMHC required grading criteria. Delegated providers must meet the minimum acceptable liquidity, profitability, efficiency, and stop-loss protection levels.

i. Financial analysis of complete financial packages is done within 45 working (63 calendar) days of receipt; however, financial review timing may be impacted due to financial review priority of high-risk RISK BEARING ORGANIATIONS (RBOs), RBO self-initiated CAPs and pre-contractual RBOs.

A. Upon initial review if additional information is required, CHPIV will request the information from the delegated provider. Further review will not be finalized until the additional information is received.

B. If a delegated entity's financial position does not meet CHPIV's benchmarks, information on the delegated entity will be provided to the appropriate oversight committee and/or department to use as a basis for making decisions to remediate the delegated entities' noncompliance or inadequate performance. Refer to policy Delegated Entity Financial Solvency CAP Process for an overview of the corrective action process.

C. Results of the financial analysis may be communicated to the delegated entity upon their request by CHPIV.

D. Based on the review of the FINANCIAL STATEMENTS, the delegated entities are classified into one of the following rating categories:

1. Meet Standards = 1 (all ratios are compliant)
2. Satisfactory = 2 (one or more ratios are partially compliant but no non-compliant ratios)
3. Observe/Acceptable = 3 (one or more ratios are non-compliant)
4. Moderately High Risk of Insolvency = 4 (three or more key ratios are non-compliant (i.e., cash-to-payable, average claims reserves, MEDICAL COST RATIO (MCR); CHPIV may place the entity on an internal CORRECTIVE ACTION PLAN (CAP))
5. High Risk of Insolvency = 5 (one or more DMHC-mandated ratios are non-compliant (i.e., TANGIBLE NET EQUITY (TNE), WORKING CAPITAL (WC), CASH-TO-CLAIMS RATIO (CCR); entity is under a DMHC self-initiated CAP) and entity is being closely monitored)

2. CHPIV shall also review all Financial Solvency reviews performed by its Plan-to-Plan SUBCONTRACTOR. The process employed by the P2P SUBCONTRACTOR shall meet all DMHC requirements and timelines for reporting. CHPIV shall place the P2P SUBCONTRACTOR on a CORRECTIVE ACTION PLAN (CAP) if it fails to meet the financial solvency oversight requirements described above for its delegated entities.

D. DMHC RBO Non-Filer Process

1. Following the end of a reporting period, the DMHC will provide a list of RBO non-filers to CHPIV, as appropriate. The non-filers are RBOs who failed to file quarterly or annual audited financial surveys to the DMHC within the required timeframe.
    a. Upon receipt of the notification from the DMHC, CHPIV informs applicable department contacts regarding the RBO identified by DMHC as a "Non-Filer." CHPIV notifies the RBO directly to advise the RBO to comply within the required time frame. The notice to the RBO shall include a punitive statement such as,"... failure by RBO to comply within the required time frame shall result in an administrative action against the health plan by DMHC's Office of Enforcement, including freeze of membership assignment and other possible sanctions, up to and including termination of contract."
    b. CHPIV will respond to the DMHC regarding CHPIV's policies and procedures to make sure it complies with the requirements.
    c. CHPIV communicates the RBO's status to the applicable oversight committees, as needed, until the delegated entity completes the required filing
    d. If an RBO does not comply with DMHC requirements, CHPIV may be sanctioned by the DMHC. For these situations, CHPIV keeps the applicable oversight committees and/or departments in the loop on the progress or non-progress of the RBO. The applicable oversight committee is responsible for determining final decisions to remediate RBO noncompliance up to and including termination that is based on a decision-making criteria process.

E. Financial Solvency Reporting Process

1. Regularly scheduled and ad hoc reporting is prepared by CHPIV reflecting delegated entities' financial solvency status. Claims timeliness status is included in some of these reports. These reports are confidential and proprietary information of CHPIV.

F. Pre-contractual Due Diligence Financial Solvency Review Process

1. Prior to new capitated provider contracts being executed, CHPIV performs a pre-contractual due diligence on RBOs and HOSPITALS that include reviewing the new provider's FINANCIAL STATEMENTS. Refer to policy Pre-Contractual Due Diligence for the detailed process.
    a. When pre-contractual financial reviews are needed, CHPIV staff is notified and will coordinate obtaining the financial information from the regional team to perform the review.
    b. Pre-contractual reviews are a priority for CHPIV. Results and recommendations are communicated to the applicable departments who will make the final determination if CHPIV will finalize a contract with the entity.
    c. If it is determined that the prospective partner, a legal entity affiliated with a parent company, is not financially viable based on the latest financial review, additional financial information may be required, including an executed "Financial Guarantee" agreement from the officer(s) of parent company or a DMHC approved SPONSORING ORGANIZATIONS to move forward with contracting. CHPIV will coordinate to obtain the information from the prospective partner.

IV. DEFINITIONS:

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

TERM	DEFINITION
Cash-to-Claims Ratio (CCR)	Provider's cash, readily available marketable securities, and receivables, excluding all risk pool, risk- sharing, incentive payment program and pay -for- performance receivables, reasonably anticipated to be collected within sixty (60) days divided by Provider 's unpaid claims liability.
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.
Department of Managed Health Care (DMHC)	The State agency responsible for administering the "Knox-Keene Health Care Service Plan Act of 1975."
Downstream Subcontractor	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.
Financial Statements	A balance sheet, an income statement, a statement of cash flows, and footnote disclosures.
Generally Accepted Accounting Principles (GAAP)	GAAP is the adopted accounting framework of the U.S. Securities and Exchange Commission and the Internal Revenue Service for healthcare accounting
Hospital	Refers to delegated or risk-bearing hospitals only
Medical Cost Ratio (MCR)	Metric used in managed health care and health insurance to measure medical costs as a percentage of premium revenues
Network Provider	Provider or entity that has a Network Provider Agreement with Contractor, Contractor's Subcontractor, or Contractor's Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under this Contract. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement.
Risk Bearing	A risk bearing organization (RBO) is either a professional medical

TERM	DEFINITION
Organization (RBO)	corporation, other form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempt from licensure pursuant to subdivision (l) of Section 1206 of the Health and Safety Code, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services. An RBO does not include an individual or a health care service plan. An RBO does all of the following
Sponsoring Organization	A sponsoring organization is one that has a tangible net equity of a level to be established by the director that is in excess of all amounts that it has guaranteed to any person or entity.
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.
Tangible Net Equity (TNE)	Net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; obligations of officers, directors, owners, or affiliates which are not fully secured, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with nonaffiliates and which are not more than sixty (60) days past due; long term prepayments of deferred charges, and nonreturnable deposits.
Working Capital (WC)	The difference between current assets and current liabilities

	Delegated Entity Financial Solvency Corrective Action Plan Process	FIN-002
	Department	Finance & Informatics
	Functional Area	Finance
	Impacted Delegate	☒ Subcontractor ☐ NA

DATES			
Policy Effective Date	10/9/2023	**Reviewed/Revised Date**	
Next Annual Review Due	10/9/2024	**Regulator Approval**	6/2/2023

APPROVALS		
Internal		**Regulator**
Name	David Wilson	☒ DHCS ☐ NA ☐ DMHC
Title	Chief Financial Officer	

ATTACHMENTS

- None

AUTHORITIES/REFERENCES

- **State**
  - California Health and Safety Code Sections
  - 1300.75.4-1300.75.4.8 and 1300.76 of Title 28 of the California Code of Regulations (These regulations were promulgated pursuant to authority in sections 1344 and 1375.4 of the California Health and Safety Code)
- **Related Policies**
  - Delegated Provider Financial Solvency Oversight Process

HISTORY

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

I. OVERVIEW

A. This policy applies to any SUBCONTRATCOR (including any Plan-to-Plan, or P2P, SUBCONTRACTORS), DOWNSTREAM SUBCONTRACTOR, or NETWROK PROVIDER who has accepted and been delegated financial risk for the provision of Covered Services for one or more lines of business. For purposes of this policy only, they shall collectively be referred to as "delegated entities".
The purpose of this policy is to outline the Community Health Plan of Imperial County's ("CHPIV" or "Plan") process to request, review and monitor CORRECTIVE ACTION PLANS (CAPs) required by delegated providers who are not in compliance with the CHPIV's financial solvency standard benchmarks, contracts, and the legal requirements set forth in the California Health & Safety Code.

II. POLICY

A. CHPIV monitors the financial solvency of delegated entities to establish that they are in compliance with CHPIV's financial solvency criteria, related contractual requirements and that their financial status is stable and not deteriorating over time.

B. When a delegated entity is determined to be noncompliant, a CORRECTIVE ACTION PLAN (CAP) is required to bring the delegated entity into compliance. If the CAP actions do not bring the delegated entity into compliance, additional disciplinary actions up to and including termination will be taken. For California, RISK BEARING ORGANIZATIONS (RBOs) reporting deficiencies in any of the five DEPARTMENT OF MANAGED HEALTH CARE (DMHC) grading criteria are required to simultaneously submit a self-initiated CAP proposal electronically to CHPIV and the DMHC.

III. PROCEDURE

A. CHPIV has adopted the following process to request, review and monitor CAPs required by delegated entities who are not in compliance with CHPIV's financial solvency standard benchmarks, contracts, and the legal requirements set forth in the California Health & Safety Code that is administered by the DMHC. These CAPs may be self-initiated by RBOs or requested by CHPIV.

B. Plan Requests Delegated Provider to Submit a CAPCHPIV is responsible to assess the financial solvency of each delegated entity based on established criteria.

1. If the delegated entity's financial position does not meet CHPIV's benchmarks, information on the delegated entity will be provided to the appropriate oversight committee and/or department to use as a basis for making decisions needed to monitor and remediate the delegated entities' non-compliance or inadequate performance.
    a. A meeting between CHPIV and the delegated entity or RISK BEARING ORGANIZATION (RBO) may be scheduled to discuss the evidence and determine next steps.
2. If it is determined that a CAP is needed, CHPIV will notify the delegated entity by email and include CHPIV Financial Oversight CAP Request letter.
    a. The delegated entity will develop and implement a CAP within 30 days from the date of the CAP request letter. If clarification or additional

documentation is needed, CHPIV may arrange a meeting with the delegated entity or RBO to review.

3. Depending on the deficiency(ies), the delegated entity will submit CAP updates to CHPIV on a regular basis (monthly or quarterly) until compliance is achieved. CHPIV will review the CAP updates to determine if compliance is achieved.

C. RBO Self-Initiated CAP to the DMHCEvery contract involving a risk arrangement between CHPIV and a delegated subcontracted entity or RBO shall require both to comply with the process outlined in the California Health & Safety Code and administered by the DMHC for the development and implementation of CAPs.

1. RBOs reporting deficiencies in any of the DMHC grading criteria shall simultaneously submit a self-initiated CAP proposal, in an electronic format, to the DMHC and CHPIV that meets the following requirements:
    a. Identify which of the DMHC grading criteria that the RBO has failed to meet.
        i. Cash to Claims Ratio – RBO shall maintain a ratio equal to or greater than 0.75.
        ii. WORKING CAPITAL – RBO shall maintain a positive working capital.
        iii. TANGIBLE NET EQUITY (TNE) – RBO shall maintain a positive TNE. Delegated Plan-to-Plan SUBCONTRATCORSs shall maintain TNE at least equal to the requirements of the DMHC requirements for Knox-Keene licensed full-service health plans as specified in California Code of Regulations, tit. 28, §§ 1300.84.1, 1300.84.2, 1300.84.03, and 1300.84.3.
        iv. Required Positive TNE – RBO shall maintain a positive TNE at least equal to the greater of: (A) one percent (1%) of annualized revenues; or (B) four percent (4%) of annualized non-capitated medical expenses.
        v. Estimated & documented INCURRED BUT NOT REORTED (IBNR) pursuant to a method specified in California Health & Safety code section 1300.77.2 - Estimate & document IBNR on a monthly basis; maintain books on an accrual accounting basis.
        vi. IBNR estimates used in FINANCIAL STATEMENTS - IBNR estimates are used in the FINANCIAL STATEMENT submission.
        vii. Claims Timeliness – RBO shall maintain 95% compliance of contested or denied claims within 45 working days.
    b. Identify the amount by which the delegated entity or RBO has failed to meet the DMHC grading criteria.
    c. Identify all plans with which the RBO has contracts involving a risk arrangement, including the identification of the name, title, telephone and facsimile numbers, and postal and email addresses for the person responsible at each contracting health plan for monitoring compliance with the final CAP.
    d. Describe the specific actions the delegated entity or RBO has taken or will take to correct any deficiency identified including any written representations made by contracting health plans to assist the RBO in the implementation of its CAP. The actions shall be appropriate and reasonable

in scope and breadth depending upon the nature and degree of the deficiency, and acceptable to DMHC.

e. Describe the timeframe for completing the corrective actions and specify a schedule for submitting progress reports to the DMHC and the RBO's contracting health plans. Except in situations where the RBO can demonstrate to the DMHC's satisfaction and written approval that an extended period of time is necessary and appropriate to correct the deficiency:
    i. Timeframes for correcting WORKING CAPITAL deficiencies shall not exceed 12 months.
    ii. Timeframes for correcting TNE deficiencies shall not exceed 12 months.
    iii. Timeframes for IBNR deficiencies shall not exceed three months.
    iv. Timeframes for correcting claims timeliness deficiencies shall not exceed six months.
    v. Timeframes for correcting cash-to-claims ratio deficiencies shall not exceed 12 months.
f. Identify the name, title, telephone and facsimile numbers, and postal and email addresses for the person responsible at the delegated entity or RBO for ensuring compliance with the final CAP.
g. An RBO may avoid submitting a self-initiated CAP proposal if it demonstrates to the DMHC that necessary and prudent capital investments have caused or may cause a temporary deficiency in its TNE, working capital, or cash-to-claims ratios and that the RBO has implemented an appropriate business plan that will correct the deficiency within a reasonable time period without causing a deficiency in the RBO's claims processing timeliness. The RBO shall seek and receive written approval from the DMHC to avoid submitting a self-initiated CAP proposal.

2. To the extent possible, the self-initiated CAP proposal shall be set forth in a single document that addresses the concerns of all plans with which the RBO maintains a contract that includes a risk arrangement.
3. The DMHC will notify CHPIV when a delegated entity or RBO has submitted a self-initiated proposed CAP. Upon receipt of this notification, CHPIV shall log onto the DMHC secured web portal to access the latest message and instruction pertaining to the CAP from the DMHC and RBO. CHPIV also downloads a copy of the delegated entity's or RBO's proposed CAP or on-going CAP update from the portal. CHPIV is responsible for tracking and monitoring CAP status.
    a. Applicable committees and/or departments are notified when the CAP is available for review to determine if the CAP adequately addresses the identified deficiencies and provide a recommendation to accept or object/suggest changes back to the RBO and the DMHC.
    b. In an event the initial or on-going CAP submitted has inadequate financial projection, i.e., less than three (3) quarter projections required by the DMHC and by recommendation from CHPIV, CHPIV will automatically request from the RBO additional projections. This action will be done without filing an objection by the health plan to the DMHC. The DMHC will

take similar action by requesting the same information from the RBO before proceeding with its review and determination.

c. Per ICE guidelines, health plans can object to CAP and require the delegated entity or RBO to submit two or more additional projections as it deemed necessary based on the CAP review results.
d. All CAPs are saved in the secure Financial Oversight network drive. Each delegated provider has a separate folder where current and archived copies are stored.
    i. If the CAP is related to claims timeliness, it's forwarded to the oversight department.
    ii. CHPIV is responsible for filing the health plan response to the DMHC via the web portal. CHPIV response is either to Accept or Object to the CAP as determined by CHPIV.
e. Within 15 calendar days of receipt of the RBO's self-initiated CAP proposal, CHPIV will provide written notice to the DMHC (filed electronically through the DMHC Web portal) accepting the CAP or stating the reason for its objections and recommendations for revisions. If CHPIV does not respond within this timeline, the self-initiated CAP shall be considered a final CAP; however, it is CHPIV's intent and process to always provide a response within this timeline.

4. In the event that CHPIV files a written objection with the DMHC and a delegated entity or RBO, the DMHC shall, within 10 calendar days, review the objections and inform the delegated entity or RBO if revisions to the CAP proposal are needed or if the objections can be resolved. If the objections can be resolved, the self-initiated CAP proposal shall be considered the final CAP subject to approval by the DMHC. If revisions to the CAP proposal are required, the delegated entity or RBO will have 10 calendar days to do the following:
    a. Implement all corrective action strategies contained in its self-initiated CAP proposal that were not objected to by CHPIV or another contracted plan; and,
    b. Submit to the DMHC a revised CAP proposal that addresses the concerns raised by the objecting contracting health plan including CHPIV. To the extent possible, the revised CAP proposal shall be prepared as a single document that addresses the concerns of all plans including CHPIV with which the subcontracted entity or RBO maintains a contract that includes a risk arrangement. Upon receipt of the auto notification from DMHC, CHPIV will access and download a copy of the revised CAP from the DMHC web portal.
5. Within seven calendar days of receipt of the revised self-initiated CAP proposal, CHPIV will provide to the delegated entity or RBO and the DMHC its acceptance or objections and recommended revisions, in an electronic format prepared by the DMHC, to the self-initiated revised CAP proposal. If there are no objections, the self-initiated revised CAP proposal shall become the final CAP subject to approval by the DMHC.
    a. CHPIV performs the review of the revised CAP proposal to determine if the revised CAP adequately addresses the identified deficiencies and provide a

recommendation to accept or object/suggest changes back to the delegated entity or RBO and the DMHC.

b. If CHPIV needs clarification or additional documentation regarding the revised CAP, CHPIV may arrange a meeting or conference call with the delegated entity or RBO representatives. CHPIV may require the delegated entity or RBO to submit supporting documentation to any new CAP relevant information discussed prior to or during the meeting.
c. CHPIV is responsible for notifying the DMHC regarding its recommendations.

6. Within seven calendar days of receipt of any contracting health plans' including CHPIV's objections and recommended revisions to the revised CAP proposal, the DMHC shall schedule a meeting ("CAP Settlement Conference") with the delegated entity or RBO and all of its contracting health plans including CHPIV to discuss and reconcile the differences.
7. Within seven calendar days of the CAP Settlement Conference, the delegated entity or RBO shall submit a final self-initiated CAP proposal to all of its contracting health plans including CHPIV and the DMHC.
8. Within 20 calendar days of receipt of the delegated entity's or RBO's final self-initiated CAP proposal, the EXTERNA PARTY shall submit its recommendation to the DMHC to approve, disapprove or modify the RBO's final self-initiated CAP proposal.
9. Within seven calendar days of receipt of the External Party's recommendation, the DMHC shall approve, disapprove, or modify the delegated entity's or RBO's final self-initiated CAP proposal, which shall then become the final CAP. If the DMHC does not act upon the recommendations of the EXTERNA PARTY within seven calendar days, the External Party's recommendations shall be deemed approved.
10. A final CAP shall remain in effect until the delegated entity or RBO demonstrates compliance with the requirements of the CAP, or the CAP expires in accordance with its own terms.
11. In addition to the CAP requirements specified in A.1. above, the DMHC may direct a delegated entity or RBO to initiate a CAP whenever it determines that the RBO has experienced an event that materially alters its ability to remain compliant with the DMHC grading criteria or when the DMHC's review process indicates that the RBO may lack sufficient financial capacity to meet its contractual obligations consistent with the financial solvency requirements.

D. CAP Reporting

1. Each periodic progress report prepared pursuant to a final CAP shall be submitted to the DMHC and CHPIV and shall include a written verification stating that the periodic progress report is true and correct to the best knowledge and belief of a principal officer of the RBO.
2. In addition to the quarterly progress reports specified in a CAP, every contract involving a risk arrangement between CHPIV and a RBO shall require that:
    a. The delegated entity or RBO shall advise CHPIV and the DMHC within five calendar days if the delegated entity or RBO experiences an event that materially alters the delegated entity's or RBO's ability to remain compliant with the requirements of a final CAP, and

b. The RBO, upon DMHC's request, will provide additional documentation to the DMHC and CHPIV to demonstrate the delegated entity's or RBO's progress towards fulfilling the requirements of a CAP.

3. Non-disclosure of CAP documentation and supporting work papers:
   a. All draft, preliminary and final CAPs and all CAP compliance reports required by a final CAP, including supporting documentation and supplemental financial information, submitted to the DMHC shall be received and maintained on a confidential basis and shall not be disclosed, except for the information outlined in section 1300.75.4.4(c)(3) to any party other than the RBO and, as necessary, to its contracting health plans including CHPIV that are participating in the CAP.
4. CHPIV communicates delegated entity or RBO CAP status to the applicable committees and/or departments on a monthly or quarterly basis, as defined.

E. Plan Obligation

1. CHPIV shall advise the DMHC and the RBO in writing within five days of becoming aware that (H&S Code 1300.75.4.5.(a)(5)):
   a. A delegated entity or RBO is not in compliance with the requirements of a final CAP; or when,
   b. A delegated entity's or RBO's conduct may cause CHPIV to be subject to disciplinary action pursuant to Health and Safety Code section 1386.
2. If a delegated entity or RBO fails to substantially comply with the requirements of a final CAP for a period of more than 90 calendar days, as determined by the DMHC, then appropriate actions will be identified by the DOW. If the additional actions identified by the DOW are not successful, the matter will be escalated to the DOC for decision.
   a. CHPIV is responsible for notifying the applicable committees and/or departments of the DMHC notice of Cease-and-Desist order and pursues obtaining additional information from the RBO as needed.
      i. CHPIV shall notify the delegated entity or RBO of any administrative action handed down by the DMHC to the health plan related to the CAP. If the administrative action requires a response from the delegated entity or RBO, the health plan notice shall include a statement such as,"... failure by delegated entity or RBO to comply with the requirement, shall result in an administrative action against the health plan by DMHC's Office of Enforcement, including freeze of membership assignment and other possible sanctions, up to and including termination of contract."
      ii. The DMHC prohibition shall take effect 30 calendar days after the date of the DMHC's notification to CHPIV and shall remain in effect until the DMHC notifies CHPIV in writing that the delegated entity's or RBO's non-compliance has been remedied.
   b. CHPIV is responsible for submitting a formal response to the DMHC regarding the action(s) taken by CHPIV.

F. Delegated Entity or RBO Obligation

1. The delegated entity or RBO will advise CHPIV and the DMHC within five business days after discovering that the RBO experienced any event that materially alters

the RBO's financial situation or threatens the RBO's solvency (H&S Code 1300.75.4.2.(f)).

2. CHPIV will advise the DMHC and the delegated entity or RBO within five business days from discovering that any of its RBOs experienced any event which materially alters the organization's financial situation or threatens its solvency (H&S Code 1300.75.4.3.(e)).
3. If the subcontracted delegated entity is a Knox-Keene licensed health plan with a Plan-to-Plan contract with CHPIV, then the subcontracted P2P will report to CHPIV all of its outstanding CORRECTIVE ACTION PLANS (CAPs) to CHPIV no less than on a quarterly basis.

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 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.
Department of Managed Health Care (DMHC)	The State agency responsible for administering the "Knox-Keene Health Care Service Plan Act of 1975."
Financial Statements	A balance sheet, an income statement, a statement of cash flows, and footnote disclosures (footnote disclosure required when submitting CPA-reviewed and audited financial statements).
Incurred But Not Reported (IBNR)	The amount owed by an insurer to all valid claimants who have had a covered loss but have yet reported it.
Risk Bearing Organization (RBO)	A risk bearing organization (RBO) is either a professional medical corporation, other form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempts from licensure pursuant to subdivision (l) of Section 1206 of the Health and Safety Code, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services. An RBO does not include an individual or a health care service plan.
Subcontractor	An individual or entity that has a subcontract with the MCP that relates directly or indirectly to the performance of the MCP's

TERM	DEFINITION
	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.
Tangible Net Equity (TNE)	Net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; obligations of officers, directors, owners, or affiliates which are not fully secured, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with nonaffiliates and which are not more than sixty (60) days past due; long term prepayments of deferred charges, and nonreturnable deposits.

	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 ☐ DMHC	
Title	Chief Financial Officer		

ATTACHMENTS
NA

AUTHORITIES/REFERENCES

• **Federal**
  ○ 42 Code of Federal Regulations ("CFR") 438.8(j)
  ○ Welfare and Institutions Code (W&I) section 14197 .2
• **State**
  ○ CalAIM Section 1915(b), STC A11
  ○ 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.

	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 ☐ 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**

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 ☐ 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 ☐ 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.

	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 ☐ 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

	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	

	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 ☒ 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

HISTORY	

I. OVERVIEW

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

II. POLICY

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

B. Access to NETWORK PROVIDERS and Covered Services

1. Primary Care

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

2. Specialists

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

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

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

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

C. NETWORK Capacity

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

D. NETWORK Composition

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

4. CHPIV contracts with a sufficient number of and include at least one FQHC, one RHC, and one FBC in the NETWORK, where available in Contractor's Service Area(s), to the extent that the FQHC, RHC, and FBC Providers are licensed and recognized under State law.
5. CHPIV offers to contract with all IHS available in Imperial County in accordance with 22 CCR section 55120. If CHPIV is unable to contract with an IHS, it must allow eligible members to obtain services from out-of-network IHS as per 42 CFR section 438.14.
6. CHPIV continually ensures that the composition of its NETWORK meets the ethnic, cultural, and linguistic needs of CHPIV's Members.
7. CHPIV ensures it has an adequate number of NSMHS Providers to provide Medically Necessary, NSMHS based on current and anticipated utilization trends for its Members.
8. CHPIV includes in its NETWORK any traditional and Safety-Net Provider that is willing to contract under the same terms and conditions that CHPIV offers to any other similar Provider in accordance with 22 CCR section 53800(b)(2)(C)(1).
9. CHPIV ensures that every LTC Provider in its Service Area is licensed by the California Department of Public Health (CDPH) as a qualified LTC Provider is included in their NETWORK, to the extent that the Provider remains licensed, certified, operating, and is willing to enter into a NETWORK Provider Agreement on mutually agreeable terms and meets Credentialing and quality standards. If CHPIV determines that additional LTC Providers are necessary to meet the needs of its Members, it will offer to contract or enter into a letter of agreement with any additional CDPH licensed LTC Providers in its Service Area or in adjoining Service Areas.
10. CHPIV receives a preapproval or assessment of suitability from CDPH prior to the execution of a NETWORK Provider Agreement for LTC Providers undergoing a change of ownership. NETWORK Provider Agreements must have a clause that LTC Providers must notify CHPIV if it is undergoing a change of ownership to obtain preapproval or assessment of suitability from CDPH.
11. CHPIV contracts with a sufficient number of Community-Based Adult Service (CBAS) Providers to timely meet the needs of Members who are CBAS eligible. CHPIV must have an adequate number of CBAS Providers that are geographically located within one hour's transportation time and that are appropriate for and proficient in addressing CBAS-eligible Members' specialized health needs and acuity, communication, cultural, and language needs and preferences. CHPIV must also meet expected CBAS utilization without a waitlist. CHPIV may, but is not obligated to, contract with CBAS Providers licensed as Adult Day Health Cares (ADHC) and certified by California Department of Aging (CDA) to provide CBAS on or after April 1, 2012.
12. CHPIV's 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;

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.

9. Federally Qualified Health Center, Rural Health Clinic, and Freestanding Birthing Center Services
- **a.** CHPIC meets meet federal requirements for access to FQHC, RHC, and FBC services consistent with 42 USC section 1396b(m) and Medicaid State Health Official Letter #16-006.

10. Community Based Adult Services
- **a.** CHPIV provides Members with access to CBAS as set forth in the California Medi-Cal 2020 Demonstration, Number 11-W-00193/9 Special Terms and Conditions, amended December 29, 2020, or as set forth in any subsequent demonstration amendment or renewal, or successor demonstration, waiver, or other Medicaid authority.
  - **i.** Without limitation, CHPIV ensures it does the following:
    - **A.** Provides and coordinates the provision of unbundled CBAS services for affected CBAS recipients as needed for continuity of care if there is a 5 percent reduction in CBAS Provider capacity in a county within the Service Area relative to the capacity that existed on April 1, 2012; and
    - **B.** Arranges Medically Necessary Covered Services for Members with similar clinical conditions as CBAS recipients if there is insufficient CBAS Provider capacity in a county in which ADHC was available prior to April 1, 2012, and coordinate their access to community resources to assist them to remain in the community.

L. NETWORK and Access Changes to Covered Services

1. DHCS Notification Requirements
- **a.** CHPIV provides notification to DHCS immediately upon discovery of a NETWORK PROVIDER initiated termination or at least 60 calendar days before any change occurs in the availability or location of services Contractor's Covered Services.
- **b.** CHPIV provides this notice if the change impacts more than 2,000 Members or impacts the ability to meet NETWORK adequacy standards in accordance with APL 21-003. In the event of an emergency or other unforeseeable circumstance,
- **c.** CHPIV notifies DHCS of the change in the availability or location of services as expeditiously as possible.
- **d.** CHPIV provides notification to DHCS immediately, or within 10 calendar days of learning of a Provider's exclusionary status from any database or list included in APL 21-003 or subsequent revisions.
- **e.** CHPIV notifies DHCS when it is unable to contract with a certified CBAS Provider or upon termination of a CBAS NETWORK PROVIDER Agreement. If the CBAS Provider cannot come to an agreement on terms, CHPIV ensures notification DHCS within five Working Days of decision to exclude the CBAS Provider from its NETWORK. DHCS may attempt to resolve the contracting issue when appropriate.
- **f.** In accordance with APL 21-003, CHPIV ensures it notifies DHCS within 60 calendar days of termination of a LTC NETWORK PROVIDER or immediately if the termination is a result of the LTC NETWORK PROVIDER having been decertified by CDPH. DHCS will attempt to resolve the contracting issue when appropriate. If termination of a LTC

NETWORK PROVIDER Agreement is for a cause related to Quality of Care or patient safety concerns, CHPIV may expedite termination of the LTC NETWORK PROVIDER Agreement and transfer Members to an appropriate, contracted LTC Provider in an expeditious manner. DHCS must be notified of the termination within 72 hours of said termination. CHPIV must not continue to assign or refer Members to a LTC NETWORK PROVIDER during the 60 calendar days between notifying DHCS and the termination effective date.

2. Member Notification Requirements
   a. Pursuant to 42 CFR section 438.10(f), CHPIV ensures Members are notified in writing of any changes in the availability or location of Covered Services, of any termination of a NETWORK PROVIDER, Subcontractor, or DOWNSTREAM SUBCONTRACTOR, or any other changes in information listed in 42 CFR section 438.10(f), either 30 calendar days prior to the effective date of the contract termination or at least 15 calendar days after receipt of issuance of the termination notice, whichever is longer, unless directed by DHCS. The notification must be provided to each Member who received Primary Care from, or was seen on a regular basis by, the terminated Provider. This notification must also be submitted to DHCS in writing for approval before its release.
   b. CHPIV obtains DHCS approval before sending a notice of termination to its Members no later than 60 calendar days prior to the effective date of the termination. CHPIV may use a member notice template previously approved by DHCS. Any changes from the approved template must be submitted to DHCS 60 calendar days prior to the effective date of the termination for review and approval before mailing the notice. In the event of an emergency or other unforeseeable circumstance, Contractor must provide notice of the emergency or other unforeseeable circumstance to DHCS as soon as possible.

M. Access Rights

1. Equal Access for Linguistic Services
   a. CHPIV ensures equal access to the provision of high-quality interpreter and linguistic services for LEP Members and Potential Members, and for Members and Potential Members with disabilities, in compliance with federal and State law, and APL 21-004.
2. Linguistic Services
   a. CHPIV complies with W&I Code section 14029.91 and ensure that all monolingual, non-English-speaking, or LEP Members and Potential Members receive 24-hour interpreter services at all key points of contact, as defined in Paragraph B.4) of this Provision, either through interpreters, telephone language services, or other legally compliant electronic options.
   b. CHPIV shall provide interpreter services to be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment without imposing delay on the scheduling of the appointment.
   c. CHPIV ensures that any lack of interpreter services does not impede or delay a Member's timely access to care.

d. CHPIV complies with Title VI of the Civil Rights Act of 1964 and 42 CFR section 438.10(d) and have the capacity to provide, at minimum, the following linguistic services at no cost to Members or Potential Members:
e. Oral interpreters, sign language interpreters, or bilingual Providers and Provider staff at all key points of contact. These services must be provided in all languages spoken by Members and Potential Members and not limited to the Threshold or Concentration Standards languages;
f. Full and immediate translation of written materials pursuant to 42 CFR sections 438.10(d)(3), 438.404, and 438.408; W&I Code 14029.91; 22 CCR sections 53876 and 53884 for LEP Members and Potential Members who speak Threshold or Concentration Standard Languages, fully translated Member Information, including: the Member Handbook, Provider Directory, welcome packets, marketing information, Member rights information, form letters and individual notices, including Notice of Action (NOA) letters, all notices related to Grievances and Appeals including Grievance and Appeal acknowledgement and resolution letters, and any other materials as required by Title VI of the Civil Rights Act of 1964 and APL 21-004;
g. Referrals to culturally and linguistically appropriate community service programs; and
h. Auxiliary Aids such as Telephone Typewriters (TTY)/ Telecommunication Devices for the Deaf (TDD), qualified interpreters including American Sign Language interpreters, and information in alternative formats including Braille, large print text (20 point font or larger), audio, and electronic formats.
i. Key points of contact include:
j. Medical care settings, such as telephone, advice and Urgent Care transactions, and outpatient Encounters with Providers; and
k. Non-medical care settings, such as Member services, orientations, and appointment scheduling.

3. Access for Persons with Disabilities

a. CHPIV complies with the requirements of Titles II and III of the Americans with Disabilities Act of 1990, section 1557 of the Affordable Care Act of 2010, sections 504 and 508 of the Rehabilitation Act of 1973, Government Code sections 11135 and 7405, and all applicable implementing regulations, and must ensure access for people with disabilities including, without limitation, accessible web and electronic content, ramps, elevators, accessible restrooms, designated parking spaces, and accessible drinking water.

N. Cultural and Linguistic Programs and Committees

1. Cultural and Linguistic Program

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

b. CHPIV has in place and continually monitors, improves and evaluates cultural and linguistic services that support the delivery of Covered Services to Members. CHPIV ensures it has proper policies and procedures in place to provide appropriate cultural and linguistic services for all of its Members.
c. CHPIV takes immediate action to improve the delivery of culturally and linguistically appropriate services when deficiencies are noted.
d. CHPIV ensures it is active in recruiting and retaining culturally and linguistically competent Providers that reflect the needs of the Medi-Cal population in the CHPIV's Service Area.
e. CHPIV ensures it has a cultural and linguistic services program, as required by 22 CCR section 53876, that incorporates all requirements of applicable federal and state law, including without limitation those requirements cited in Exhibit A, Attachment III, Subsection 5.2.10 (Access Rights), 22 CCR sections 51202.5 and 51309.5(a), 28 CCR sections 1300.67.04(c)(2)(A) - (B) and 1300.67.04 (c)(2)(G)(v) - (c)(4), and 42 CFR section 438.206(c)(2). CHPIV ensures immediate translation of all critical Member Information as required by 42 CFR sections 438.10 and 438.404 and W&I Code section 14029.91.
f. CHPIV must review and update its cultural and linguistic services programs to align with the Population Needs Assessment (PNA). CHPIV ensures its NETWORK PROVIDERS, SUBCONTRACTORS, DOWNSTREAM SUBCONTRACTORS cultural and Health Equity linguistic services programs also align with the PNA.
g. CHPIV ensures it implements and maintains a written description of its cultural and linguistic services program which must include, at a minimum, the following:
h. Its organizational commitment to deliver culturally and linguistically appropriate health care services;
i. Services that comply with Title VI of the Civil Rights Act of 1964, section 1557 of the Affordable Care Act of 2010, 42 CFR section 438.10, Exhibit A, Attachment III, Section 5.2.10 (Access Rights), and APL 21-004
j. Use of National standards for Culturally and Linguistically Appropriate Services (CLAS) for reference;
k. An organizational chart showing the key staff with overall responsibility for cultural and linguistic services programs;
l. A narrative explaining the organizational chart and describing the oversight and direction to the Community Advisory Committee (CAC), requirements for support staff and reporting relationships. Qualifications of staff, including appropriate education, experience, and training must also be included;
m. The role of the PNA to inform cultural and linguistic services program priorities in compliance with Exhibit A, Attachment III, Subsection 4.3.3 (Population Needs Assessment);
n. The implementation and maintenance of annual sensitivity, diversity, communication skills, Health Equity, and cultural competency training and related trainings (e.g., providing gender affirming care) for employees and

contracted staff (clinical and non-clinical), as determined by Section C of this Provision, Diversity, Equity, and Inclusion Training; and

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

2. Linguistic Capability of Employees and Contracted Staff

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

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

c. Policies and procedures for language assistance;

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

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

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

O. NETWORK Reports

1. Annual NETWORK Certification Report

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

b. CHPIV ensures it demonstrates how it will arrange for Covered Services to Members through the use of NEMT, NMT, and Telehealth if it does not meet time or distance standards for adult and pediatric PCPs, core Specialist and outpatient mental health Providers in accordance with W&I Code section 14197(f)(2).

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

2. NETWORK Access Profile

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

3. SUBCONTRACTOR Network Certification

a. CHPIV ensures it annually submits its SUBCONTRACTOR Network Certification (SNC) report to DHCS. The SNC report must demonstrate compliance with network adequacy and access for the Provider Networks of CHPIV's DELEGATES and/or SUBCONTRACTORS' that have assumed risk per

the DELEGATES and/or SUBCONTRACTORS' Agreements in accordance with CalAIM 1915(b) Waiver STCs, and APL 23-006.

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

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

d. CHPIV will submit the required SNC documentation to DHCS with the correct file naming conventions through the DHCS Secure File Transfer Protocol site no later than 45 days following the RY (calendar year) or if the date falls on a weekend, the next Working Day.
- SNC submission consists of three parts (1) the Subcontractor Network Exemptions Request template, (2) the Network Adequacy and Access Assurances Report (NAAAR), and (3) verification documents.
- Failure to submit complete and accurate SNC documentation to DHCS by the SNC annual submission date, CHPIV will be subject to the imposition of a corrective action plan (CAP) and/or other enforcement actions by DHCS.

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

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

g. CHPIV found non-compliant with the SNC requirements.
- CHPIV will respond to the initial CAP response, no later than 30 calendar days after the issuance of the CAP notification letter, that details a plan of action and sets forth steps CHPIV will take to correct the deficiencies identified.

- CHPIV will ensure all deficiencies are corrected within 6 months during which CHPIV will provide DHCS with monthly status updates that demonstrate action steps the MCP is undertaking to address the CAP.

P. Periodic Reporting Requirements

1. CHPIV reports to DHCS any time there is a Significant Change to its NETWORK that affects NETWORK capacity and Contractor's ability to provide health care services, such as the following:
2. Change in Covered Services or benefits;
3. Change in geographic Service Area;
4. Change in the composition of, or the payments to, its NETWORK PROVIDERS, SUBCONTRACTORS, or DOWNSTREAM SUBCONTRACTORS; or enrollment of a new population.
5. CHPIV provides supporting documentation detailing any Significant Change to DHCS. DHCS will determine what information must be provided it reports a Significant Change to its NETWORK pursuant to 42 CFR section 438.207.
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: **(A)** The provider is available to provide covered services to all plan enrollees in all product lines using the designated network. **(B)** The provider is one or more of the following: **(i)** An employee of the plan; **(ii)** An individual health professional or health facility contracted directly with the plan consistent with the Knox-Keene Act and implementing regulations, including the contractual requirements for providers within sections 1348.6, 1367(h), 1367.04, 1367.27, 1367.62, 1373.65(f), 1375.7, 1379 and subsection (d) of section 1351; **(iii)** An individual health professional or health facility contracted with the plan through an association, provider group, or other entity, consistent with the Knox-Keene Act and implementing regulations, including the contractual requirements for providers within sections 1348.6, 1367(h), 1367.04, 1367.27, 1367.62, 1373.65(f), 1375.5, 1379, and subsection (d) of 1351;

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 **(v)** An individual health professional or health facility required to be part of the plan's network under any of the following circumstances; **a.** a corrective action plan submitted to the Department by the plan or its delegated entity; **b.** as required by the Department pursuant to section 1373.65 of the Knox-Keene Act; or **c.** as otherwise required by order of the Department. **(C)** The provider is accessible to enrollees of the designated network without limitations other than established: **(i)** In-network referral or authorization processes; or **(ii)** Processes for changing provider groups consistent with section 1373.3 of the Knox-Keene Act, in networks where enrollees are assigned to a provider group. **(D)** A network provider shall not include: **(i)** Providers made available through single-case agreements, letters of intent, or contract agreements that do not include the provider contracting requirements of the Knox-Keene Act as described in subsection (b)(10)(B)(ii) and (iii) of CCR 28 § 1300.67.2.2; **(ii)** For any line-of-business that includes an out-of-network benefit (e.g., preferred provider organization (PPO) or point-of-service (POS)), providers who are available to enrollees only at non-participating or out-of-network cost-share levels; or **(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. **(B)** The Department receives information establishing that the plan was unable to deliver timely, available, or accessible health care services to enrollees. The Department may consider any of the following factors in evaluating whether each instance identified is part of a pattern of non-compliance that is reasonably related: **(i)** Each instance is a violation of the same standard set forth in subsection (c) of CCR 28 § 1300.67.2.2; **(ii)** Each instance involves the same network; **(iii)** Each instance involves the same provider group, or subcontracted plan; **(iv)** Each instance involves the same provider type; **(v)** Each instance involves the same network provider; **(vi)** Each instance occurs in the same region. For purposes of this subsection, a region is a county in which a network provider practices, and the counties next to or adjoining that county; **(vii)** The number of enrollees in the health plan's network and the total number of instances identified as part of a pattern; **(viii)** Whether each instance occurred within the same twelve-month period; or **(ix)** Whether each instance involves the same category of health care services.
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.

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 ☐ 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). For individuals under 21 years of age, EPSDT service is considered medically necessary or a medical necessity when it is necessary to correct or ameliorate defects and physical and mental illnesses and conditions that are discovered by screening services. A service need not cure a condition in order to be covered under EPSDT. Services that maintain or improve the child's current health condition are also covered under EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. The common definition of "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.

	Quality Improvement Health Equity Committee (QIHEC)	QM-002
	Department	Health Services
	Functional Area	Quality 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 ☐ DMHC	
Title	Chief Medical Officer		

ATTACHMENTS

- N/A

AUTHORITIES/REFERENCES

- DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III, 2.2.2 and 2.2.3 QIHEC
- NCQA Health Plan Accreditation Standard QI 1: Program Structure and Operations

HISTORY

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

I. OVERVIEW

The QUALITY IMPROVEMENT AND HEALTH EQUITY COMMITTEE (QIHEC) is responsible for oversight of CHPIV's QUALITY IMPROVEMENT and HEALTH EQUITY efforts (QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM). The purpose of this policy is to specify the role, structure, and function of Community Health Plan of Imperial Valley's (CHPIV) QUALITY IMPROVEMENT AND HEALTH EQUITY COMMITTEE (QIHEC).

II. POLICY

A. CHPIV implements and maintains a QIHEC designated and overseen by its Board of Directors.
B. CHPIV's Commission appoints the QIHEC as an accountable entity responsible for the oversight of CHPIV's QUALITY IMPROVEMENT and HEALTH EQUITY initiatives.
C. The QIHEC is responsible for oversight of the QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM (QIHETP). Associated committees and subcommittees may also participate in these activities.
D. CHPIV's Commission appoints a liaison to the QIHEC to ensure effective oversight of the QIHETP and facilitate communication between the Commission and QIHEC.
E. The QIHEC's activities are supervised by CHPIV's Chief Medical Officer, or the Chief Medical Officer's designee, in collaboration with CHPIV's Chief Health Equity Officer.

III. PROCEDURE

A. CHPIV's Chief Medical Officer serves as the Chief Health Equity Officer
B. CHPIV's Chief Health Equity Officer chairs the QIHEC.
C. CHPIV ensures a broad range of NETWORK PROVIDERS, including but not limited to hospitals, clinics, county partners, physicians, SUBCONTRACTORS, DOWNSTREAM SUBCONTRACTORS, NETWORK PROVIDERS, and members, actively participate in the QIHEC or in any sub-committee that reports to the QIHEC.
D. Participating SUBCONTRACTORS, DOWNSTREAM SUBCONTRACTORS, and NETWORK PROVIDERS must be representative of the composition of CHPIV's NETWORK PROVIDERS and include, at a minimum, NETWORK PROVIDERS who provide health care services to:
    1. Members affected by Health Disparities;
    2. Limited English Proficiency (LEP) members;
    3. Children with Special Health Care Needs (CSHCN);
    4. Seniors and Persons with Disabilities (SPDs); and
    5. Persons with chronic conditions.
E. CHPIV's QIHEC includes representatives from fully delegated entity.
F. The QIHEC's responsibilities include, but are not limited to, the following:
    1. Analyze and evaluate the results of QUAILITY IMPROVEMENT and HEALTH EQUITY activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, delegation oversight reports and activities, and the findings and activities of other CHPIV committees such as the Community Advisory Committee (CAC) and Provider Advisory Committee (PAC).

2. Institute actions to address performance deficiencies, including policy recommendations.
3. Ensure appropriate follow-up and remediation of identified performance deficiencies.

G. CHPIV ensures member confidentiality is maintained in QI discussions and ensures avoidance of conflict of interest among QIHEC members.

H. The QIHEC meets at least quarterly, and more frequently if needed.

I. A written summary of QIHEC activities, as well as QIHEC activities of its FULLY DELEGATED SUBCONTRACTOR and DOWNSTREAM FULLY DELEGATED SUBCONTRACTOR findings, recommendations, and actions, is prepared after each meeting.

1. CHPIV submits the written summary of QIHEC activities to the Board of Directors.
2. CHPIV makes the written summary of QIHEC activities publicly available on CHPIV's website at least quarterly.
3. Upon request, CHPIV submits written summaries of QIHEC proceedings to DHCS.

J. CHPIV ensures that its FULLY DELEGATED SUBCONTRACTOR and DOWNSTREAM FULLY DELEGATED SUBCONTRACTOR maintains a QIHEC that meets the requirements set forth above.

K. CHPIV ensures its FULLY DELEGATED SUBCONTRACTOR and DOWNSTREAM FULLY DELEGATED SUBCONTRACTOR report to CHPIV's QIHEC quarterly, at a minimum.

IV. DEFINITIONS

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

TERM	DEFINITION
Downstream Fully Delegated Subcontractor	A Downstream Subcontractor that contractually assumes all duties and obligations of Contractor under the Contract, through the Subcontractor, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A managed care plan can operate as a Downstream Fully Delegated Subcontractor.
Downstream Subcontractor	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.
Fully Delegated Subcontractor	A subcontractor that contractually assumes all duties and obligations of Contractor under the Contract, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A managed care plan can operate as a Fully Delegated Subcontractor.

TERM	DEFINITION
Health Equity	The reduction or elimination of Health Disparities, Health Inequities, or other disparities in health that adversely affect vulnerable populations.
Network Provider	Provider or entity that has a Network Provider Agreement with Contractor, Contractor's Subcontractor, or Contractor's Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under this Contract. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement.
Quality Improvement (QI)	Means a systematic and continuous actions that lead to measurable improvements in the way health care is delivered and outcomes for Members.
Quality Improvement and Health Equity Committee (QIHEC)	Means a committee facilitated by CHPIV's medical director, or the medical director's designee, in collaboration with the Health Equity officer, to meet at least quarterly to direct all QIHETP findings and required actions.
Quality Improvement and Health Equity Transformation Program (QIHETP)	The systematic and continuous activities to monitor, evaluate, and improve upon the Health Equity and health care delivered to Members in accordance with the standards set forth in applicable laws, regulations, and the DHCS Medi-Cal Managed Care 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

Compliance & Policy Committee Approval on: ~~08/10/23~~XX/XX/XXXX
Commission Approval on: ~~08/14/23~~XX/XX/XXXX

Community Health Plan OF IMPERIAL VALLEY

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I. Compliance Program Overview

Local Health Authority of Imperial County (hereafter, "Community Health Plan of Imperial Valley" or "CHPIV") is committed to establishing and maintaining its business operations in compliance with ethical standards, contractual obligations, and all-applicable Federal and State standards, statutes, regulations and rules, including those pertaining to the State of California requirements and the Medicare program. CHPIV's compliance commitment extends to its own internal business operations, as well as its oversight and monitoring responsibilities of its delegated entities.

CHPIV's Compliance Program is structured to proactively prevent and detect violations of ethical standards, contractual obligations, and laws. It functions independently of operational areas, focusing on fostering accountability and promptly addressing compliance issues. It applies to all stakeholders, including Commissioners, employees, and contractors, and covers Knox-Keene licensed health plans, participating providers, downstream entities, and all lines of business including Medi-Cal, Medicare Parts C and D.

As part of our commitment, CHPIV has formalized its compliance activities by developing a comprehensive Compliance Program. It is implemented through a structured framework as detailed in the following sections. The Compliance Program undergoes regular evaluations by the Chief Compliance Officer, Compliance & Policy Committee and the CHPIV Commission at least annually to ensure its effectiveness and alignment with regulatory requirements.

~~Our aim is to foster a culture of integrity and ensure the highest standards of compliance throughout the organization.CHPIV has formalized its compliance activities through the establishment of a comprehensive Compliance Program. This program is designed to proactively prevent and detect any violations of ethical standards, contractual obligations, and applicable laws, involving both the CHPIV Commission and executive staff. Operating independently from operational and program areas, CHPIV's Compliance Program is focused on identifying deficiencies and expediting remedial actions. It integrates existing compliance elements and functions while also enhancing them to elevate the overall quality of CHPIV's compliance efforts. Our aim is to foster a culture of integrity and ensure the highest standards of compliance throughout the organization.~~

~~The Compliance Program is reviewed and approved by the Compliance & Policy Committee and the CHPIV Commission at least biennially.~~ A copy is available on CHPIV's website.

II. Compliance Organizational Structure

A. Chief Compliance Officer

The Chief Compliance Officer serves as the focal point for all compliance activities. The Chief Compliance Officer is charged with the responsibility of developing, operating, and monitoring the Compliance Program. The Chief Compliance Officer reports to the Chief

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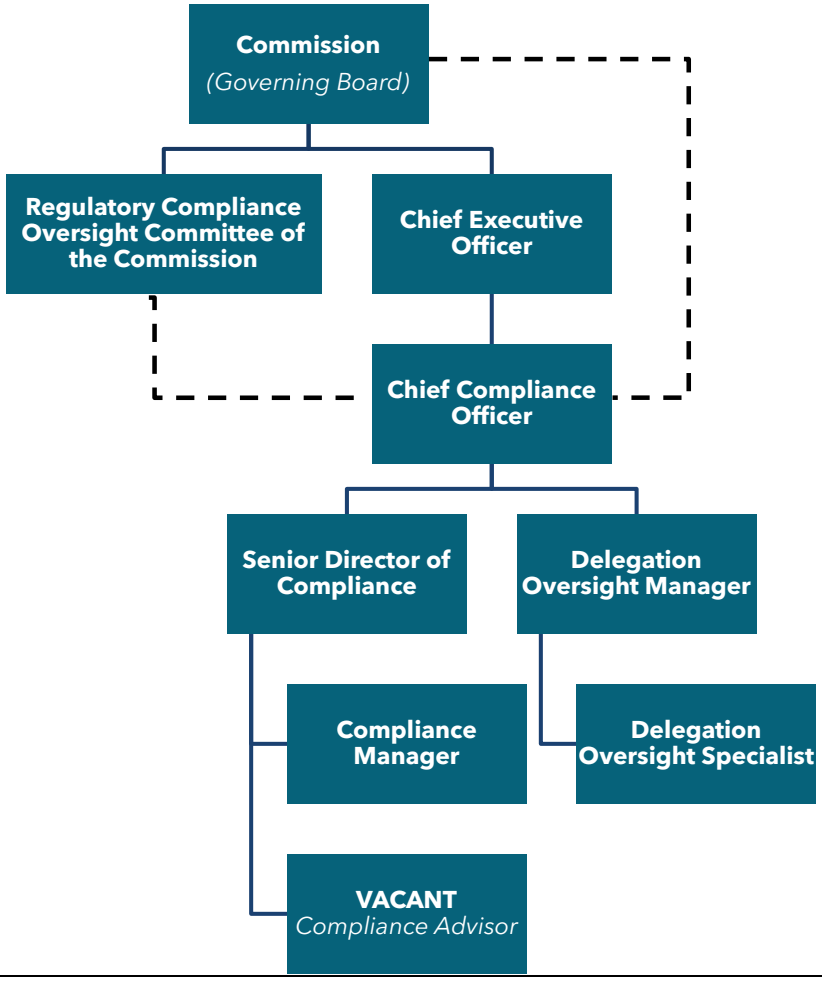
Executive Officer ("CEO") but has the authority to report directly to the Commission, as necessary.

The Chief Compliance Officer ("CCO"), vested with the day-to-day operations of the compliance program, must be ~~is~~ an employee of CHPIV and may not be an employee of CHPIV's first tier, downstream or related entities. ~~and~~ The CCO reports directly and periodically to the Commission on the activities and status of the compliance program, including issues identified, investigated, and resolved by the Compliance Program.

The Chief Compliance Officer shall ensure that the following fundamental elements of compliance are incorporated into the program:

1. Written Policies, Procedures and Code of Conduct
2. Compliance Officer, Compliance Committee, Commission Governing Body
3. Effective Training and Education
4. Effective Lines of Communication
5. Effective Systems for Routine Monitoring and Auditing
6. Procedures and Systems for Promptly Responding to Compliance Issues
7. CHPIV's Accountability for Delegation Oversight

B. Organizational Chart



II. Authority & Responsibility

A. ~~CHPIV's Compliance Program ensures adherence to all federal and state rules, regulations, contracts, and standards as mandated by relevant regulatory agencies. This program also extends its coverage to~~

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~~subcontractors. Notably, the Compliance Program encompasses the following requirements:~~

- ~~Rules and Regulations of the Department of Managed Health Care.~~
- ~~Rules and Regulations of the Centers for Medicare & Medicaid Services.~~
- ~~All applicable federal rules and regulations governing health care services provision.~~
- ~~Terms and conditions as set forth in CHPIV contracts with California, private foundations, and other payer organizations for healthcare services delivery.~~
- ~~The right of State and Federal Governments to access premises for compliance verification with the Contract(s) and other reasonable purposes, with or without prior notice to CHPIV.~~

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CHPIV Commission

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The CHPIV Commission actively oversees and monitors the organization's compliance efforts. The Commission is knowledgeable about the content and operation of the Compliance Program and exercises reasonable oversight with respect to its implementation and effectiveness. ~~It holds the responsibility of~~This includes regularly evaluating CHPIV's overall performance, reviewing reports on compliance activities, and providing necessary directions in response to instances of non-compliance. The Regulatory Compliance Committee of the Commission is a subcommittee of the Commission that supports this oversight by ~~is focused on~~ ensuring the effectiveness of the Compliance Program and addressing issues as they arise.

B. Compliance & Policy Committee (CPC)

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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. Their efforts include monitoring the implementation of policies and procedures that require compliance with all applicable laws, regulations, contractual requirements, and internal policies.

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~~IV. Compliance Program Elements~~Scope

~~To ensure that all CHPIV members receive high quality and medically appropriate healthcare services, the Compliance department performs ongoing activities to maintain and evaluate compliance with all contractual and regulatory requirements. The main objective of the Compliance department is to put measures in place to prevent, detect, and correct any potential occurrences of noncompliance or barriers to compliance.~~

IIIV. ~~1. Written Policies, Procedures and Code of Conduct~~

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~~2. Compliance Officer, Compliance Committee, Commission Governing Body~~

~~3. Effective Training and Education~~

~~4. Effective Lines of Communication~~

~~5. Effective Systems for Routine Monitoring and Auditing~~

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

~~7. CHPIV's Accountability for Delegation Oversight~~

CHPIV's Compliance Program ensures a structured and efficient approach to identifying, investigating, and resolving compliance concerns. This framework is designed to minimize risk, address noncompliance effectively, and demonstrate accountability to regulators and stakeholders.

CHPIV has implemented mechanisms to detect potential compliance issues and unethical behavior, including routine audits, monitoring activities, and reports from its confidential hotline. This includes discovering evidence of misconduct related to payment or delivery of items/services. Once an issue is identified, standardized investigation protocols are followed to ensure thorough, impartial, and consistent handling. High-risk or complex issues are escalated to appropriate leadership, ensuring timely resolution and compliance with regulatory reporting requirements when necessary.

CHPIV may impose progressive disciplinary actions to address consistent performance issues, unethical behavior, or significant compliance violations. Corrective Action Plans (CAPs) are issued, developed and executed to address noncompliance, with a focus on implementing remediation to prevent recurrence. All compliance issues are documented and tracked, enabling CHPIV to monitor trends, evaluate the program's effectiveness, and continuously refine its policies and processes.

~~CHPIV may impose progressive disciplinary actions to address consistent performance issues or significant compliance violations.~~ For staff, this includes measures such as additional training, verbal and written warnings for minor violations, probationary periods with close monitoring for serious or repeated noncompliance, temporary suspension for significant violations, and termination for severe or repeated offenses. In addition to corrective action plans, these steps ensure accountability and alignment with compliance standards. Noncompliance issues involving delegated entities are addressed in detail in P&P CMP-002 Delegation Oversight.

Written Policies, Procedures and Code of Conduct

a. Policy Management

- Oversee the review process of policies and procedures (P&Ps).
- Ensure P&Ps undergo a minimum annual review.
- Facilitate collaboration with relevant stakeholders for policy development and updates.
- Maintain a centralized repository for all approved and current P&Ps.

Periodically communicate policy updates to all relevant stakeholders.Code of Conduct

- Adherence to applicable laws, regulations, and industry best practices.
- Identify and manage potential conflicts to ensure impartiality.
- Safeguard sensitive information and personal data.
- Prohibits workplace discrimination and harassment.
- Encouraging reporting of suspected violations and protecting whistleblowers.
- Require annual acknowledgment of understanding and commitment.
- Regular reinforcement of the Code's principles through training.

Regulatory Implementation and Change Management

- Disseminate regulatory changes and guidance to internal and external stakeholders promptly and comprehensively.

Review implementation plans, updating policies, procedures, and workflows to align with new regulations. Maintain documentation of the implementation process.

IV. Effective Systems for Routine Monitoring and Auditing

A.

Risk-Based Monitoring

CHPIV employs a comprehensive risk-based monitoring process to ensure adherence to regulatory and contractual obligations, including compliance with DHCS, DMHC, and CMS requirements and the overall effectiveness of the compliance program. This process extends to evaluating the performance of first-tier entities, as required, to ensure their compliance with DHCS, DMHC, and CMS requirements. This process begins with conducting risk assessments and risk ranking to prioritize areas of concern, which informs the development of a risk-based monitoring

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program and plan. Key performance indicators (KPIs) are developed and maintained to measure compliance effectively, including quantitative metrics with defined calculations for critical areas such as authorization decision timeliness and grievance resolution timeliness and other key areas. Scorecards are utilized to track and clearly communicate compliance status, along with additional tools that are used to proactively identify trends, patterns, and potential compliance issues. This structured approach allows Compliance to address risks efficiently and maintain high standards of performance.~~Conduct risk assessments and risk ranking to develop a risk-based monitoring program and plan.~~

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- ~~B. Develop and maintain key performance indicators (KPIs) based on regulatory and contractual requirements, including quantitative KPIs with defined calculations for measuring performance (e.g., authorization decision timeliness, grievance resolution timeliness).~~

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- ~~Create scorecards to track and communicate compliance status effectively.~~
- ~~Implement tools and to proactively identify trends, patterns, and potential compliance issues.~~

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Audits

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- CHPIV's audit program is built using a structured and proactive approach to ensure regulatory compliance and operational integrity. The program includes internal audits, as well as external audits when appropriate, to evaluate CHPIV's compliance with DHCS, DMHC, and CMS requirements and the performance of its first-tier entities. An annual audit plan is developed and presented for review and approval by the Compliance & Policy Committee and the Commission, detailing all scheduled audits for the year. The plan is periodically reviewed and updated to address emerging risks and changing regulatory requirements. Detailed audit reports are prepared following each audit, with findings shared with leadership, the Compliance & Policy Committee, and the Commission. Findings are used to evaluate the overall effectiveness of the compliance program and identify areas for

improvement. These reports will prompt necessary corrective actions to resolve identified concerns and prevent recurrence of any issues.~~Develop an annual audit plan, subject to review and approval by the Compliance & Policy Committee and the Commission, outlining all audits scheduled for the year.~~

- ~~Periodically review and update the audit plan to address emerging risks and changing regulatory requirements.~~
- ~~Prepare detailed audit reports and findings, sharing the results with leadership, the Compliance & Policy Committee, and the Commission. These reports will prompt necessary corrective actions to address identified concerns and prevent recurrence of any issues.~~

~~*Regulatory Affairs*~~

- ~~Act as the primary point of contact for CHPIV with regulators, ensuring efficient communication for inquiries and urgent matters.~~
- ~~Engage in regular interactions with regulatory authorities and related workgroups to foster positive relationships and stay abreast of industry updates.~~
- ~~Implement a process for tracking and managing regulatory inquiries and responses to ensure timely and accurate communication with regulators.~~
- ~~Proactively disclose instances of noncompliance to regulators in a transparent and responsible manner.~~

~~Manage notices of noncompliance and enforcement matters, coordinating appropriate responses and actions to address regulatory concerns.~~

VI. CHPIV's Accountability for Delegation Oversight

~~Delegation Oversight~~

- CHPIV maintains accountability for delegation oversight by managing the Delegation Reporting and Plan, updating it at least annually to adapt to the evolving needs of health plan operations. The Compliance Department oversees all aspects of the delegation oversight process, including audits and ongoing monitoring, and has developed a robust framework for evaluating potential delegate entities to ensure they meet compliance standards before entering into agreements. Clear performance metrics and benchmarks are established to monitor delegated entities' compliance performance, with periodic training sessions provided to enhance their understanding of requirements and expectations. CHPIV fosters open and transparent communication with delegates, addressing concerns and ensuring alignment with compliance obligations.~~Manage Delegation Reporting and Plan and update at least annually to address the continually evolving nature of health plan needs and operations.~~

- ~~Oversee and manage all aspects of the delegation oversight process, including audits and monitoring.~~
- ~~Develop a robust framework for evaluating potential delegate entities before *entering into* delegation arrangements, ensuring they meet the necessary compliance standards.~~
- ~~Establish clear performance metrics and benchmarks for delegated entities, monitoring their ongoing compliance performance.~~
- ~~Conduct periodic training sessions for delegates to enhance their understanding of compliance requirements and expectations.~~

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- ~~Maintain an open and transparent line of communication with delegates, addressing any concerns or questions related to compliance matters.~~Delegation Oversight Reporting and Plan (available on website)
- Delegation Oversight Audit & Monitoring Program

VI~~I~~. Privacy

CHPIV is committed to ensuring compliance with Federal and State privacy and security rules by continuously monitoring regulations and updating privacy and security policies to safeguard protected health information (PHI). The organization provides clear guidelines and procedures for the proper handling and protection of PHI and conducts regular HIPAA training for all workforce members to reinforce these standards. Additionally, CHPIV has established procedures for reporting and managing data breaches or unauthorized disclosures of PHI to maintain accountability and uphold privacy obligations.~~Monitoring Federal and State privacy and security rules to ensure compliance.~~

- ~~VI~~I. ~~Developing and updating privacy and security policies to safeguard protected health information (PHI).~~
- ~~Providing guidelines and procedures for the proper handling and protection of PHI.~~
- ~~Conducting regular and ongoing HIPAA training for all CHPIV workforce members.~~
- ~~Establish procedures for reporting and managing data breaches or unauthorized disclosures of PHI.~~

Fraud, Waste, and Abuse

- CHPIV's Fraud, Waste, and Abuse (FWA) program is designed to prevent, detect, and correct fraudulent activities. The program includes thorough investigations of all suspected fraud, waste, and abuse allegations to identify and address potential issues promptly. Clear and accessible guidelines are established to standardize and promote consistent reporting procedures, encouraging employees, contractors, and stakeholders to report potential violations. Comprehensive training and educational programs are provided to raise awareness about FWA, equipping employees with the knowledge to detect and prevent fraudulent activities. Corrective actions are implemented as necessary to address identified issues and ensure they do not recur, maintaining the integrity of CHPIV's operations.~~Conduct thorough investigations of all suspected fraud, waste, and abuse allegations.~~
- ~~Develop clear and accessible guidelines for reporting potential fraudulent activities to ensure consistency in reporting procedures.~~

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- Provide training and educational programs for employees to raise awareness about fraud, waste, and abuse and ways to detect and prevent them.

OIG & GSA Exclusion List Monitoring

Regularly monitor and cross-reference CHPIV's employees, contractors, vendors, and business partners against the OIG and GSA exclusion lists to verify their eligibility for engagement.

- Maintain comprehensive documentation of exclusion list screening results and actions taken to demonstrate compliance with exclusion list monitoring obligations.

VIIIX. Effective Training & Education & Training

- The Training and Education Program is designed to provide comprehensive training for employees, delegates, the chief executive officer, senior administrators, and commission members. These sessions focus on legal and ethical obligations under applicable laws, regulations, policies, and federal health program requirements. Training is conducted at least annually and is incorporated into the orientation process for new employees, senior administrators, and governing body members. The program ensures effective communication of CHPIV's standards, policies, and procedures to all personnel impacted by them, fostering a culture of compliance and ethical responsibility throughout the organization.Conduct comprehensive training sessions for employees and delegates, focusing on their legal and ethical obligations under relevant laws, regulations, and policies, including federal health program requirements.
- Ensure effective communication of CHPIV's standards, policies, and procedures to all personnel who may be affected by them.

Code of Conduct

- Adherence to applicable laws, regulations, and industry best practices.
- Identify and manage potential conflicts to ensure impartiality.
- Safeguard sensitive information and personal data.
- Prohibits workplace discrimination and harassment.
- Encouraging reporting of suspected violations and protecting whistleblowers.
- Require annual acknowledgment of understanding and commitment.
- Regular reinforcement of the Code's principles through training.

V. Compliance Work Plan

The Annual Compliance Work Plan is a collaborative effort with staff and incorporates the following components:

- Planned activities with measurable goals and benchmarks for the upcoming year.
- Designation of responsible staff member(s) for each activity.
- Defined timeframes for accomplishing each activity.
- Comprehensive review of key findings, interventions, and progress, along with monitoring of previously identified issues.
- Alignment of work plan activities with the organization's strategic objectives and compliance priorities.
- Flexibility to adapt to emerging compliance challenges or regulatory changes throughout the year.

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~~XIX~~. ~~Compliance~~ Policies and Procedures and ~~Relevant Documents~~Code of Conduct

A.

Policies & Procedures (P&Ps)

~~Compliance~~ Policies and Procedures serve as the foundation for ensuring adherence to all Federal and State standards. These documents outline clear expectations, responsibilities, and processes for all compliance activities within the organization. The Compliance Department oversees the review process for CHPIV's policies and procedures (P&Ps), ensuring each undergoes an annual review. This process includes collaboration with relevant stakeholders for policy development and updates, maintaining a centralized repository for all approved and current P&Ps, and periodically communicating policy updates to all relevant stakeholders.

The Compliance Policies and Procedures listed below serve as a foundational framework for implementing and operationalizing CHPIV's Compliance Program. These policies ~~Each policy is~~provide detailed guidance on how compliance activities are carried out, ensuring that all program elements are effectively executed. Each policy outlines specific processes, roles, and responsibilities that support the daily operations of the Compliance Program. ~~designed to address specific areas of compliance, providing guidance to mitigate risks, promote ethical behavior, and uphold the integrity of the compliance program. The Compliance Department oversees the review process for policies and procedures (P&Ps), ensuring each undergoes an annual review. This process includes collaboration with relevant stakeholders for policy development and updates, maintaining a centralized repository for all approved and current P&Ps, and periodically communicating policy updates to all relevant stakeholders.~~

Policy #	Policy Title	Policy Description
CMP-001	Writing and Processing Policies and Procedures	Outlines CHPIV's process for managing policies to ensure compliance with regulations, contracts, and accreditation, with the Compliance Department as the responsible unit.
CMP-002	Delegation Oversight	Sets standards for overseeing delegated entities to ensure compliance with regulations, contracts, and CHPIV policies, with ongoing assessments to verify compliance.
CMP-003	Corrective Action Plans	Establishes the process for developing and implementing corrective action plans to address noncompliance, including identifying root causes, initiating corrective measures, and verifying their effectiveness.

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Policy #	Policy Title	Policy Description
CMP-004	Implementation of Regulatory Notifications	Outlines the process for organization-wide implementation of regulatory notifications issued by regulatory agencies.
CMP-005	Confidentiality and Member Privacy	Outlines CHPIV's requirements and procedures for maintaining confidentiality and protecting member privacy, including safeguarding PHI, PII, and demographic data such as race, ethnicity, language, gender identity, and sexual orientation.
CMP-006	Compliance Training	Outlines the requirements for CHPIV's Compliance Training Program, applicable to all employees, subcontractors, and downstream subcontractors.
CMP-007	Escalation of Noncompliance Issues	Establishes a framework for addressing noncompliance at CHPIV, including instances where members, providers, or employees fail to adhere to rules, regulations, or policies. It provides clear guidance to employees and others on identifying and addressing potential compliance issues and outlines how such issues should be communicated to the appropriate compliance personnel. The policy details the process for investigating and resolving compliance concerns promptly and transparently, ensuring adherence to applicable laws and regulations while mitigating risks and promoting fairness. CHPIV encourages a culture of transparency and self-policing. If noncompliance issues (including potential fraud or misconduct) identified have regulatory implications, CHPIV is responsible for self-disclosing matters to the appropriate regulatory authorities.
CMP-008	Selecting a Chief Compliance Officer	Establishes a clear and standardized process for the selection of a Chief Compliance Officer who will ensure adherence to all contractual requirements.
CMP-009	Fraud Waste and Abuse	Establishes CHPIV's Fraud Prevention Program to ensure compliance and prevent, detect, and address fraud, waste, and abuse (FWA). It applies to all staff, network providers, and subcontractors, outlining responsibilities for training, monitoring, reporting, and maintaining compliance.
~~DRAFT~~CMP-010	Effective Lines of Communication	Ensures that CHPIV fosters open, accessible, and confidential channels for reporting compliance concerns and promoting ethical and legal business practices. It establishes clear processes for employees, delegates, and other stakeholders to report potential issues, including fraud, waste, and abuse (FWA), without fear of intimidation or retaliation. The policy outlines mechanisms for investigating and resolving compliance issues,

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Policy #	Policy Title	Policy Description
		supports ongoing monitoring, and ensures that all stakeholders understand their role in maintaining compliance through regular communication and training.
CMP-011	Breach Notification	Ensures CHPIV's compliance with state and federal laws regarding notifying affected individuals in the event of a breach of member privacy.
CMP-012	Notice of Privacy Practices	Outlines the content and distribution process for CHPIV's Notice of Privacy Practices (NPP) to its members. It ensures compliance with federal and state privacy and security requirements through ongoing monitoring and audits of both internal operations and business associates.
CMP-013	Key Personnel Change	Establishes a process for CHPIV to disclose changes in executive-level personnel to the Department of Healthcare Services (DHCS) and the Department of Managed Health Care (DMHC).
~~HR-XXX~~	~~Exclusion Monitoring~~	

Staff can view current policies and procedures in the CHPIV Policies & Procedures Repository

B. ~~Relevant Documents~~Code of Conduct

The Code of Conduct provides a framework for maintaining the highest standards of ethical behavior and compliance within the organization. It emphasizes adherence to applicable laws, regulations, and industry best practices while safeguarding sensitive information and personal data. The Code requires the identification and management of potential conflicts to ensure impartiality and prohibits workplace discrimination and harassment. It encourages the reporting of suspected violations, with protections in place for whistleblowers, and mandates annual acknowledgment of understanding and commitment. Regular training reinforces the Code's principles, ensuring all employees uphold its values and contribute to a respectful and compliant workplace.

- Code of Conduct (available on website)

~~Regulatory Implementation and Change Management~~

~~The Regulatory Implementation and Change Management of CHPIV's Compliance Program ensures the organization remains aligned with evolving regulatory requirements through comprehensive written standards. This program focuses on promptly disseminating regulatory changes and guidance to internal and external stakeholders, updating policies, procedures, and workflows to reflect new~~

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requirements. These activities are central to maintaining up-to-date guidance for the organization and its stakeholders, ensuring effective implementation and alignment with regulations. Comprehensive implementation plans are reviewed and maintained, with thorough documentation of the process to support compliance and provide clarity across all levels of the organization.

- Delegation Oversight Reporting and Plan (available on website)
- Delegation Oversight Audit & Monitoring Program

XI. Effective Lines of CommunicationResources

CHPIV's Compliance Program is designed to foster a culture of transparency, accountability, and trust. It ensures that employees, managers, the governing body, contractors, and other stakeholders, including first-tier, downstream, and related entities, have accessible and confidential channels to seek guidance, report concerns, and clarify regulatory or policy expectations without fear of retaliation.

A. Reporting Compliance Issues

CHPIV has established multiple avenues for communication, including a confidential hotline, designated compliance email, and other reporting mechanisms. These channels are available to all employees, managers, members of the governing body, and first-tier, downstream, and related entities. They are regularly communicated to staff and stakeholders through training, emphasizing their importance in maintaining compliance and ethical conduct.

The program safeguards confidentiality and provides assurance that all reports and inquiries will be handled promptly and appropriately. Additionally, CHPIV encourages a two-way dialogue by soliciting feedback on the compliance program's effectiveness and fostering open communication on compliance-related matters. This component plays a critical role in identifying potential risks early, addressing noncompliance, and ensuring the ongoing integrity of CHPIV's operations.

CHPIV may impose progressive disciplinary actions to address consistent performance issues or significant compliance violations. For staff, this includes measures such as additional

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~~training, verbal and written warnings for minor violations, probationary periods with close monitoring for serious or repeated noncompliance, temporary suspension for significant violations, and termination for severe or repeated offenses. In addition to corrective action plans, these steps ensure accountability and alignment with compliance standards. Noncompliance issues involving delegated entities are addressed in detail in P&P CMP-002 Delegation Oversight.~~CHPIV's Confidential Compliance Hotline is accessible to Commission members, employees, contractors, providers, members, first tier, downstream, related entities, and other concerned parties. It allows for confidential and anonymous reporting of potential violations or suspicions related to:

- Incidents of fraud, waste, and abuse.
- Criminal activity (fraud, kickback, embezzlement, theft, etc.).
- Conflict of interest concerns.
- Code of Conduct violations.
- Privacy and information security incidents

Verbal or written communications to the Compliance Hotline or the Compliance Department are treated confidentially within the bounds of applicable laws and circumstances. Anonymity is respected, and callers/reporters are not required to provide their names. Communications are handled with appropriate privilege in accordance with relevant legal provisions.

Compliance Hotline	800-919-4947
Chief Compliance Officer	Elysse Tarabola, Chief Compliance Officer Email: ETarabola@chpiv.org Direct Line: (760) 232-5021
Compliance Department	Compliance@chpiv.org
Human Resources	Shannon Long, HR Consultant Email: SLong@chpiv.org Direct Line: 760-970-5072
Online Reporting Form	~~–~~Committed to Compliance – Community Health Plan of Imperial County~~chpiv.org/compliance-program~~

B. Voluntarily Self-Reporting of Noncompliance

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CHPIV must voluntarily self-report noncompliance, including potential fraud, waste, abuse (FWA), or misconduct to the appropriate regulatory agencies, including but not limited to CMS, the Department of Managed Health Care (DMHC), and other oversight entities.

Internal Reporting & Evaluation: All employees, contractors, and delegated entities must report suspected fraud, misconduct, or compliance violations to CHPIV's Compliance Department via the Compliance Hotline, email, or direct contact with the Chief Compliance Officer (CCO). The Compliance Department will assess the issue and determine if self-reporting to regulators is required. Investigations will be documented, including findings and corrective actions.

Criteria for Self-Reporting: CHPIV will voluntarily report issues when (1) there is evidence of intentional fraud, misconduct, or systemic non-compliance, (2) the issue results in improper payments, regulatory violations, or potential harm to members, and (3) reporting is required by law, contract, or at the request of a regulator.

Self-Disclosure of Noncompliance: If an issue meets self-reporting criteria, CHPIV will prepare and submit a Self-Disclosure Report using the designated reporting method (e.g, CMS HPMS, DMHC online portal, direct email to DHCS Contract Manager), including the following:

- A summary of the issue, parties involved, and potential impact.
- Root cause and corrective actions taken or planned.
- Supporting documentation.

CHPIV will fully cooperate with regulatory follow-up and implement additional corrective actions as needed. The Compliance Department will track all reported issues and resolutions.

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C~~A~~. Disciplinary Standards

CHPIV maintains disciplinary standards and enforcement procedures that promote compliance, accountability, and ethical conduct across all levels of the organization. These standards are designed to encourage good faith participation in the compliance program by setting clear expectations for behavior, defining consequences for noncompliance, and ensuring consistent enforcement of policies.

CHPIV may impose progressive disciplinary actions to address consistent performance issues or significant compliance violations. For staff, this includes measures such as additional training, verbal and written warnings for minor violations, probationary periods with close monitoring for serious or repeated noncompliance, temporary suspension for significant violations, and termination for severe or repeated offenses. In addition to corrective action plans, these steps ensure accountability and alignment with compliance standards.

These disciplinary standards are widely publicized through compliance policies, employee handbooks, training, and ongoing compliance communications. By reinforcing expectations and accountability, CHPIV ensures that all employees and stakeholders understand their responsibilities and the consequences of noncompliance.

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~~Regulatory Affairs~~

~~The Regulatory Affairs function of CHPIV's Compliance Program ensures open, transparent, and timely communication with regulators, serving as the primary liaison for inquiries, urgent matters, and ongoing engagement. This function fosters positive relationships with regulatory authorities through regular interactions and participation in industry workgroups to stay informed of updates~~ **~~and industry updates. It implements a structured process to track and manage regulatory inquiries and ensure timely and accurate responses to regulator requests~~**~~. Emphasizing transparency, the function proactively discloses instances of noncompliance and manages notices and enforcement actions, coordinating timely responses and corrective measures to address regulatory concerns effectively.Act as the primary point of contact for CHPIV with regulators, ensuring efficient communication for inquiries and urgent matters.~~

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- ~~B. Engage in regular interactions with regulatory authorities and related workgroups to foster positive relationships and stay abreast of industry updates.~~
- ~~Implement a process for tracking and managing regulatory inquiries and responses to ensure timely and accurate communication with regulators.~~
- ~~Proactively disclose instances of noncompliance to regulators in a transparent and responsible manner.~~

- Manage notices of noncompliance and enforcement matters, coordinating appropriate responses and actions to address regulatory concerns.

Report Compliance Issues

CHPIV's Confidential Compliance Hotline is accessible to Commission members, employees, contractors, providers, members, first tier, downstream, related entities, and other concerned parties. It allows for confidential and anonymous reporting of potential violations or suspicions related to:

- Incidents of fraud, waste, and abuse.
- Criminal activity (fraud, kickback, embezzlement, theft, etc.).
- Conflict of interest concerns.
- Code of Conduct violations.
- Privacy and information security incidents

Verbal or written communications to the Compliance Hotline or the Compliance Department are treated confidentially within the bounds of applicable laws and circumstances. Anonymity is respected, and callers/reporters are not required to provide their names. Communications are handled with appropriate privilege in accordance with relevant legal provisions.

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Compliance Department	Compliance@chpiv.org
Human Resources	Michelle Ortiz, Office & HR Manager Email: MOrtiz@chpiv.org Direct Line: 760-970-5072
Online Reporting Form	chpiv.org/compliance-program

Staff can view current policies and procedures in the CHPIV Policies & Procedures Repository

XII. Conclusion

CHPIV's Compliance Program is an adaptive framework designed to ensure the organization's adherence to policies, procedures, and performance standards. It encompasses CHPIV's employees and contracted entities, guiding them to act in full compliance with all relevant laws, regulations, and contractual obligations. The Compliance Program is subject to continuous improvements and updates to align with the Compliance department's activities and to maintain CHPIV's compliance with applicable laws, regulations, industry guidelines, and policies. Through consistent updates, we work to maintain strong ethical standards and integrity within our organization.

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Compliance Program

Compliance & Policy Committee Approval on: XX/XX/XXXX
Commission Approval on: XX/XX/XXXX

Community Health Plan
OF IMPERIAL VALLEY

Table of Contents

Compliance Program Overview

Local Health Authority of Imperial County (hereafter, "Community Health Plan of Imperial Valley" or "CHPIV") is committed to establishing and maintaining its business operations in compliance with ethical standards, contractual obligations, and all-applicable Federal and State standards, statutes, regulations and rules, including those pertaining to the State of California requirements and the Medicare program. CHPIV's compliance commitment extends to its own internal business operations, as well as its oversight and monitoring responsibilities of its delegated entities.

CHPIV's Compliance Program is structured to proactively prevent and detect violations of ethical standards, contractual obligations, and laws. It functions independently of operational areas, focusing on fostering accountability and promptly addressing compliance issues. It applies to all stakeholders, including Commissioners, employees, and contractors, and covers Knox-Keene licensed health plans, participating providers, downstream entities, and all lines of business including Medi-Cal, Medicare Parts C and D.

As part of our commitment, CHPIV has formalized its compliance activities by developing a comprehensive Compliance Program. It is implemented through a structured framework as detailed in the following sections. The Compliance Program undergoes regular evaluations by the Chief Compliance Officer, Compliance & Policy Committee and the CHPIV Commission at least annually to ensure its effectiveness and alignment with regulatory requirements.

A copy is available on CHPIV's website.

I. Compliance Organizational Structure

A. Chief Compliance Officer

The Chief Compliance Officer serves as the focal point for all compliance activities. The Chief Compliance Officer is charged with the responsibility of developing, operating, and monitoring the Compliance Program. The Chief Compliance Officer reports to the Chief Executive Officer ("CEO") but has the authority to report directly to the Commission, as necessary.

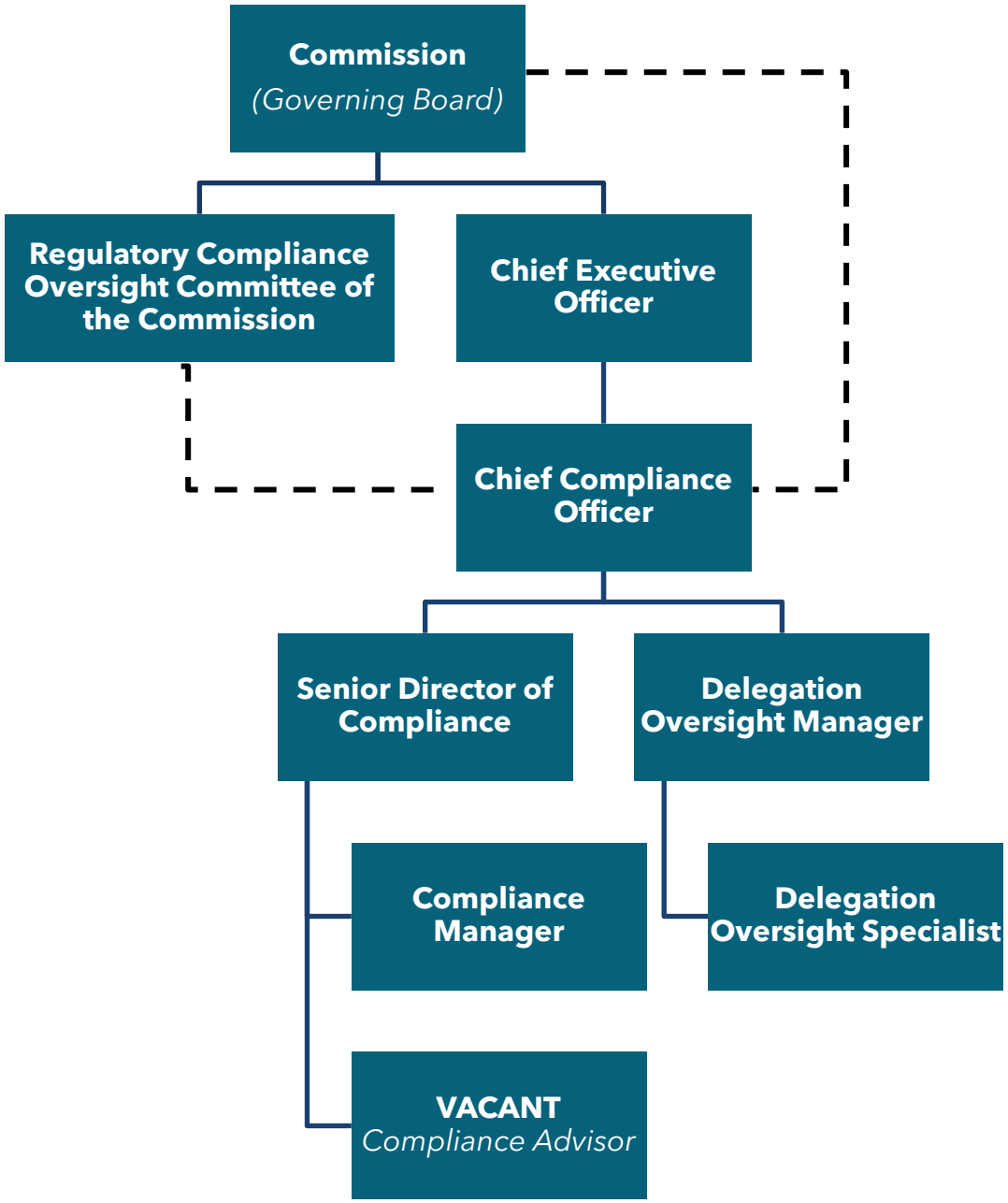
The Chief Compliance Officer ("CCO"), vested with the day-to-day operations of the compliance program, must be an employee of CHPIV and may not be an employee of CHPIV's first tier, downstream or related entities. The CCO reports directly and periodically to the Commission on the activities and status of the compliance program, including issues identified, investigated, and resolved by the Compliance Program.

The Chief Compliance Officer shall ensure that the following fundamental elements of compliance are incorporated into the program:

1. Written Policies, Procedures and Code of Conduct
2. Compliance Officer, Compliance Committee, Commission Governing Body
3. Effective Training and Education
4. Effective Lines of Communication

5. Effective Systems for Routine Monitoring and Auditing
6. Procedures and Systems for Promptly Responding to Compliance Issues
7. CHPIV's Accountability for Delegation Oversight

B. Organizational Chart



II. Authority & Responsibility

A. CHPIV Commission

The CHPIV Commission actively oversees and monitors the organization's compliance efforts. The Commission is knowledgeable about the content and operation of the Compliance Program and exercises reasonable oversight with respect to its implementation and effectiveness. This includes regularly evaluating CHPIV's overall performance, reviewing

reports on compliance activities, and providing necessary directions in response to instances of non-compliance. The Regulatory Compliance Committee of the Commission is a subcommittee of the Commission that supports this oversight by ensuring the effectiveness of the Compliance Program and addressing issues as they arise.

B. 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. Their efforts include monitoring the implementation of policies and procedures that require compliance with all applicable laws, regulations, contractual requirements, and internal policies.

III. Procedures and Systems for Promptly Responding to Compliance Issues

CHPIV's Compliance Program ensures a structured and efficient approach to identifying, investigating, and resolving compliance concerns. This framework is designed to minimize risk, address noncompliance effectively, and demonstrate accountability to regulators and stakeholders.

CHPIV has implemented mechanisms to detect potential compliance issues and unethical behavior, including routine audits, monitoring activities, and reports from its confidential hotline. This includes discovering evidence of misconduct related to payment or delivery of items/services. Once an issue is identified, standardized investigation protocols are followed to ensure thorough, impartial, and consistent handling. High-risk or complex issues are escalated to appropriate leadership, ensuring timely resolution and compliance with regulatory reporting requirements when necessary.

CHPIV may impose progressive disciplinary actions to address consistent performance issues, unethical behavior, or significant compliance violations. Corrective Action Plans (CAPs) are issued, developed and executed to address noncompliance, with a focus on implementing remediation to prevent recurrence. All compliance issues are documented and tracked, enabling CHPIV to monitor trends, evaluate the program's effectiveness, and continuously refine its policies and processes. For staff, this includes measures such as additional training, verbal and written warnings for minor violations, probationary periods with close monitoring for serious or repeated noncompliance, temporary suspension for significant violations, and termination for severe or repeated offenses. In addition to corrective action plans, these steps ensure accountability and alignment with compliance standards. Noncompliance issues involving delegated entities are addressed in detail in P&P CMP-002 Delegation Oversight.

IV. Effective Systems for Routine Monitoring and Auditing

A. Risk-Based Monitoring

CHPIV employs a comprehensive risk-based monitoring process to ensure adherence to regulatory and contractual obligations, including compliance with DHCS, DMHC, and CMS requirements and the overall effectiveness of the compliance program. This process extends to evaluating the performance of first-tier entities, as required, to ensure their compliance with DHCS, DMHC, and CMS requirements. This process begins with conducting risk assessments and risk ranking to prioritize areas of concern, which informs the development of a risk-based monitoring program and plan. Key performance indicators (KPIs) are developed and maintained to measure compliance effectively, including quantitative metrics with defined calculations for critical areas such as authorization decision timeliness and grievance resolution timeliness and other key areas. Scorecards are utilized to track and clearly communicate compliance status, along with additional tools that are used to proactively identify trends, patterns, and potential compliance issues. This structured approach allows Compliance to address risks efficiently and maintain high standards of performance.

B. Audits

CHPIV's audit program is built using a structured and proactive approach to ensure regulatory compliance and operational integrity. The program includes internal audits, as well as external audits when appropriate, to evaluate CHPIV's compliance with DHCS, DMHC, and CMS requirements and the performance of its first-tier entities. An annual audit plan is developed and presented for review and approval by the Compliance & Policy Committee and the Commission, detailing all scheduled audits for the year. The plan is periodically reviewed and updated to address emerging risks and changing regulatory requirements. Detailed audit reports are prepared following each audit, with findings shared with leadership, the Compliance & Policy Committee, and the Commission. Findings are used to evaluate the overall effectiveness of the compliance program and identify areas for improvement. These reports will prompt necessary corrective actions to resolve identified concerns and prevent recurrence of any issues.

V. CHPIV's Accountability for Delegation Oversight

CHPIV maintains accountability for delegation oversight by managing the Delegation Reporting and Plan, updating it at least annually to adapt to the evolving needs of health plan operations. The Compliance Department oversees all aspects of the delegation oversight process, including audits and ongoing monitoring, and has developed a robust framework for evaluating potential delegate entities to ensure they meet compliance standards before entering into agreements. Clear performance metrics and benchmarks are established to monitor delegated entities' compliance performance, with periodic training sessions provided to enhance their understanding of requirements and expectations. CHPIV fosters open and transparent communication with delegates, addressing concerns and ensuring alignment with compliance obligations.

- Delegation Oversight Reporting and Plan (available on website)
- Delegation Oversight Audit & Monitoring Program

VI. Privacy

CHPIV is committed to ensuring compliance with Federal and State privacy and security rules by continuously monitoring regulations and updating privacy and security policies to safeguard protected health information (PHI). The organization provides clear guidelines and procedures for the proper handling and protection of PHI and conducts regular HIPAA training for all workforce members to reinforce these standards. Additionally, CHPIV has established procedures for reporting and managing data breaches or unauthorized disclosures of PHI to maintain accountability and uphold privacy obligations.

VII. Fraud, Waste, and Abuse

CHPIV's Fraud, Waste, and Abuse (FWA) program is designed to prevent, detect, and correct fraudulent activities. The program includes thorough investigations of all suspected fraud, waste, and abuse allegations to identify and address potential issues promptly. Clear and accessible guidelines are established to standardize and promote consistent reporting procedures, encouraging employees, contractors, and stakeholders to report potential violations. Comprehensive training and educational programs are provided to raise awareness about FWA, equipping employees with the knowledge to detect and prevent fraudulent activities. Corrective actions are implemented as necessary to address identified issues and ensure they do not recur, maintaining the integrity of CHPIV's operations.

VIII. Effective Training & Education

The Training and Education Program is designed to provide comprehensive training for employees, delegates, the chief executive officer, senior administrators, and commission members. These sessions focus on legal and ethical obligations under applicable laws, regulations, policies, and federal health program requirements. Training is conducted at least annually and is incorporated into the orientation process for new employees, senior administrators, and governing body members. The program ensures effective communication of CHPIV's standards, policies, and procedures to all personnel impacted by them, fostering a culture of compliance and ethical responsibility throughout the organization.

IX. Policies and Procedures and Code of Conduct

A. Policies & Procedures (P&Ps)

Policies and Procedures serve as the foundation for ensuring adherence to all Federal and State standards. These documents outline clear expectations, responsibilities, and processes for all compliance activities within the organization. The Compliance Department oversees the review process for CHPIV's policies and procedures (P&Ps), ensuring each undergoes an annual review. This process includes collaboration with relevant stakeholders for policy development and updates, maintaining a centralized repository for all approved and current P&Ps, and periodically communicating policy updates to all relevant stakeholders.

The Compliance Policies and Procedures listed below serve as a foundational framework for implementing and operationalizing CHPIV's Compliance Program. These policies provide detailed guidance on how compliance activities are carried out, ensuring that all program

elements are effectively executed. Each policy outlines specific processes, roles, and responsibilities that support the daily operations of the Compliance Program.

Policy #	Policy Title	Policy Description
CMP-001	Writing and Processing Policies and Procedures	Outlines CHPIV's process for managing policies to ensure compliance with regulations, contracts, and accreditation, with the Compliance Department as the responsible unit.
CMP-002	Delegation Oversight	Sets standards for overseeing delegated entities to ensure compliance with regulations, contracts, and CHPIV policies, with ongoing assessments to verify compliance.
CMP-003	Corrective Action Plans	Establishes the process for developing and implementing corrective action plans to address noncompliance, including identifying root causes, initiating corrective measures, and verifying their effectiveness.
CMP-004	Implementation of Regulatory Notifications	Outlines the process for organization-wide implementation of regulatory notifications issued by regulatory agencies.
CMP-005	Confidentiality and Member Privacy	Outlines CHPIV's requirements and procedures for maintaining confidentiality and protecting member privacy, including safeguarding PHI, PII, and demographic data such as race, ethnicity, language, gender identity, and sexual orientation.
CMP-006	Compliance Training	Outlines the requirements for CHPIV's Compliance Training Program, applicable to all employees, subcontractors, and downstream subcontractors.
CMP-007	Escalation of Noncompliance Issues	Establishes a framework for addressing noncompliance at CHPIV, including instances where members, providers, or employees fail to adhere to rules, regulations, or policies. It provides clear guidance to employees and others on identifying and addressing potential compliance issues and outlines how such issues should be communicated to the appropriate compliance personnel. The policy details the process for investigating and resolving compliance concerns promptly and transparently, ensuring adherence to applicable laws and regulations while mitigating risks and promoting fairness. CHPIV encourages a culture of transparency and self-policing. If noncompliance issues (including potential fraud or misconduct) identified have regulatory implications, CHPIV is responsible for self-disclosing matters to the appropriate regulatory authorities.
CMP-008	Selecting a Chief Compliance Officer	Establishes a clear and standardized process for the selection of a Chief Compliance Officer who

Policy #	Policy Title	Policy Description
		will ensure adherence to all contractual requirements.
CMP-009	Fraud Waste and Abuse	Establishes CHPIV's Fraud Prevention Program to ensure compliance and prevent, detect, and address fraud, waste, and abuse (FWA). It applies to all staff, network providers, and subcontractors, outlining responsibilities for training, monitoring, reporting, and maintaining compliance.
CMP-010	Effective Lines of Communication	Ensures that CHPIV fosters open, accessible, and confidential channels for reporting compliance concerns and promoting ethical and legal business practices. It establishes clear processes for employees, delegates, and other stakeholders to report potential issues, including fraud, waste, and abuse (FWA), without fear of intimidation or retaliation. The policy outlines mechanisms for investigating and resolving compliance issues, supports ongoing monitoring, and ensures that all stakeholders understand their role in maintaining compliance through regular communication and training.
CMP-011	Breach Notification	Ensures CHPIV's compliance with state and federal laws regarding notifying affected individuals in the event of a breach of member privacy.
CMP-012	Notice of Privacy Practices	Outlines the content and distribution process for CHPIV's Notice of Privacy Practices (NPP) to its members. It ensures compliance with federal and state privacy and security requirements through ongoing monitoring and audits of both internal operations and business associates.
CMP-013	Key Personnel Change	Establishes a process for CHPIV to disclose changes in executive-level personnel to the Department of Healthcare Services (DHCS) and the Department of Managed Health Care (DMHC).

Staff can view current policies and procedures in the CHPIV Policies & Procedures Repository

B. Code of Conduct

The Code of Conduct provides a framework for maintaining the highest standards of ethical behavior and compliance within the organization. It emphasizes adherence to applicable laws, regulations, and industry best practices while safeguarding sensitive information and personal data. The Code requires the identification and management of potential conflicts to ensure impartiality and prohibits workplace discrimination and harassment. It encourages the reporting of suspected violations, with protections in place for whistleblowers, and mandates annual acknowledgment of understanding and commitment. Regular training reinforces the Code's principles, ensuring all employees uphold its values and contribute to a respectful and compliant workplace.

- Code of Conduct (available on website)

X. Effective Lines of Communication

CHPIV's Compliance Program is designed to foster a culture of transparency, accountability, and trust. It ensures that employees, managers, the governing body, contractors, and other stakeholders, including first-tier, downstream, and related entities, have accessible and confidential channels to seek guidance, report concerns, and clarify regulatory or policy expectations without fear of retaliation.

A. Reporting Compliance Issues

CHPIV has established multiple avenues for communication, including a confidential hotline, designated compliance email, and other reporting mechanisms. These channels are available to all employees, managers, members of the governing body, and first-tier, downstream, and related entities. They are regularly communicated to staff and stakeholders through training, emphasizing their importance in maintaining compliance and ethical conduct.

The program safeguards confidentiality and provides assurance that all reports and inquiries will be handled promptly and appropriately.

CHPIV's Confidential Compliance Hotline is accessible to Commission members, employees, contractors, providers, members, first tier, downstream, related entities, and other concerned parties. It allows for confidential and anonymous reporting of potential violations or suspicions related to:

- Incidents of fraud, waste, and abuse.
- Criminal activity (fraud, kickback, embezzlement, theft, etc.).
- Conflict of interest concerns.
- Code of Conduct violations.
- Privacy and information security incidents

Verbal or written communications to the Compliance Hotline or the Compliance Department are treated confidentially within the bounds of applicable laws and circumstances. Anonymity is respected, and callers/reporters are not required to provide their names. Communications are handled with appropriate privilege in accordance with relevant legal provisions.

Compliance Hotline	800-919-4947
Chief Compliance Officer	Elysse Tarabola, Chief Compliance Officer Email: ETarabola@chpiv.org Direct Line: (760) 232-5021
Compliance Department	Compliance@chpiv.org
Human Resources	Shannon Long, HR Consultant Email: SLong@chpiv.org Direct Line: 760-970-5072
Online Reporting Form	Committed to Compliance – Community Health Plan of Imperial County

B. Voluntarily Self-Reporting of Noncompliance

CHPIV must voluntarily self-report noncompliance, including potential fraud, waste, abuse (FWA), or misconduct to the appropriate regulatory agencies, including but not limited to CMS, the Department of Managed Health Care (DMHC), and other oversight entities.

Internal Reporting & Evaluation: All employees, contractors, and delegated entities must report suspected fraud, misconduct, or compliance violations to CHPIV's Compliance Department via the Compliance Hotline, email, or direct contact with the Chief Compliance Officer (CCO). The Compliance Department will assess the issue and determine if self-reporting to regulators is required. Investigations will be documented, including findings and corrective actions.

Criteria for Self-Reporting: CHPIV will voluntarily report issues when (1) there is evidence of intentional fraud, misconduct, or systemic non-compliance, (2) the issue results in improper payments, regulatory violations, or potential harm to members, and (3) reporting is required by law, contract, or at the request of a regulator.

Self-Disclosure of Noncompliance: If an issue meets self-reporting criteria, CHPIV will prepare and submit a Self-Disclosure Report using the designated reporting method (e.g, CMS HPMS, DMHC online portal, direct email to DHCS Contract Manager), including the following:

- A summary of the issue, parties involved, and potential impact.
- Root cause and corrective actions taken or planned.
- Supporting documentation.

CHPIV will fully cooperate with regulatory follow-up and implement additional corrective actions as needed. The Compliance Department will track all reported issues and resolutions.

C. Disciplinary Standards

CHPIV maintains disciplinary standards and enforcement procedures that promote compliance, accountability, and ethical conduct across all levels of the organization. These standards are designed to encourage good faith participation in the compliance program by setting clear expectations for behavior, defining consequences for noncompliance, and ensuring consistent enforcement of policies.

CHPIV may impose progressive disciplinary actions to address consistent performance issues or significant compliance violations. For staff, this includes measures such as additional training, verbal and written warnings for minor violations, probationary periods with close monitoring for serious or repeated noncompliance, temporary suspension for significant violations, and termination for severe or repeated offenses. In addition to corrective action plans, these steps ensure accountability and alignment with compliance standards.

These disciplinary standards are widely publicized through compliance policies, employee handbooks, training, and ongoing compliance communications. By reinforcing expectations and accountability, CHPIV ensures that all employees and stakeholders understand their responsibilities and the consequences of noncompliance.

Conclusion

CHPIV's Compliance Program is an adaptive framework designed to ensure the organization's adherence to policies, procedures, and performance standards. It encompasses CHPIV's employees and contracted entities, guiding them to act in full compliance with all relevant laws, regulations, and contractual obligations. The Compliance Program is subject to continuous improvements and updates to align with the Compliance department's activities and to maintain CHPIV's compliance with applicable laws, regulations, industry guidelines, and policies. Through consistent updates, we work to maintain strong ethical standards and integrity within our organization.

Delegation Oversight

Audit & Monitoring Program

Community Health Plan
OF IMPERIAL VALLEY

Table of Contents

I. Introduction

CHPIV's Delegation Oversight Audit and Monitoring Program is a comprehensive framework designed to assess, evaluate, and continuously monitor delegated functions. The Audit and Monitoring Program follows a risk-based approach and identifies, prioritizes, and addresses risks within Delegate processes, operations, and activities. This program's primary objective is to consistently measure performance, promote transparency, and mitigate potential risks arising. Through a combination of periodic audits and ongoing monitoring mechanisms, the program seeks to identify areas of improvement, ensure adherence to established policies and regulations, and reinforce accountability.

II. Audit and Monitoring Program

The Audit and Monitoring Program ensures ongoing prevention, detection, and correction of noncompliance issues through a risk-based approach. Areas that are deemed to have high and critical risk levels will undergo continuous monitoring. These key areas will be subject to both quantitative and qualitative reviews on an ongoing basis. Areas identified as having low to medium risk levels will be subjected to periodic audits.

To streamline our monitoring and auditing processes, areas that are already monitored throughout the year will still be included in the audit scope. However, we have implemented an "auto-score" mechanism for these areas based on the monitoring activities conducted. This approach significantly reduces the administrative burden associated with repetitive assessments while still ensuring that critical areas receive the necessary attention based on their risk levels.

By adopting this risk-based monitoring strategy, we can allocate our resources more effectively and efficiently, focusing on critical areas while still maintaining oversight on other segments. This approach empowers us to stay proactive in managing risks, strengthen our organization's resilience, and optimize our risk management efforts in a dynamic and ever-changing environment.

III. Risk-Based Approach

The Audit and Monitoring Program covers the same scope and areas of review, with the frequency of assessments determined based on the level of risk associated with each area. The program uses specific criteria to measure risk and areas with higher risk levels are subject to more frequent and ongoing monitoring, ensuring continuous oversight. Areas with lower risk levels are audited on an annual basis, ensuring comprehensive assessments are conducted periodically. This approach allows us to maintain a robust control framework, prioritize areas requiring immediate attention, and aims to meet the highest level of compliance.

IV. Audit and Monitoring Cycle

By following this cyclical approach, CHPIV ensures proactive risk management, continuous improvement, and optimal allocation of resources to address critical areas effectively.

1. **Risk Assessment:** Identify and assess potential risks across the organization.
2. **Risk Prioritization:** Rank risks based on member impact, regulatory focus, and known deficiencies. High-risk areas become the focus of the monitoring plan.
3. **Monitoring Plan:** Design a targeted plan concentrating efforts on areas with higher risk exposure.
4. **Monitoring Execution:** Conduct quantitative reviews in high-risk areas.
5. **Annual Audit Plan:** The Annual Audit Plan encompasses all oversight elements, including any findings from previous regulatory agency reviews, to address qualitative and quantitative KPI scoring along with overall program evaluation. Scores from the Monitoring Plan reviews are integrated into the Annual Audit Report.
6. **Annual Audit Execution:** Assess effectiveness of internal controls, adherence to policies and regulations, and conduct case file reviews for compliance confirmation. Audit findings inform the risk assessment, and high-impact elements may be added to the monitoring plan for the next review period.

Loop Back to Risk Assessment: Continuously reassess risks, update priorities, and adjust the monitoring and audit plans based on findings.

V. Risk Scoring and Ranking

A. Components of the Risk Ranking and Scoring Methodology

The Risk Ranking/Scoring Methodology is designed to assess and prioritize risks by considering existing deficiencies, regulatory focus, and high member impact. This section

outlines the step-by-step process to implement the methodology effectively. The methodology comprises three main components, each contributing to the overall risk score of an area. The scoring for each component is determined by the following criteria, with scores ranging from 1 to 3.

Member Impact Score: This score assesses the potential impact of an area on patient outcomes and member safety. Risks are categorized as low, medium, or high impact, based on the severity of consequences.	
Low (1 point)	Areas in which non-compliance may indirectly impact member safety or well-being.
Medium (2 points)	Areas in which non-compliance may cause adverse effects on member safety or well-being but are not of such a severe nature that members' immediate health and safety is affected.
High (3 points)	Areas in which noncompliance may result in a member's lack of access to medications and/or services or posed an immediate threat to an enrollee's health and safety.

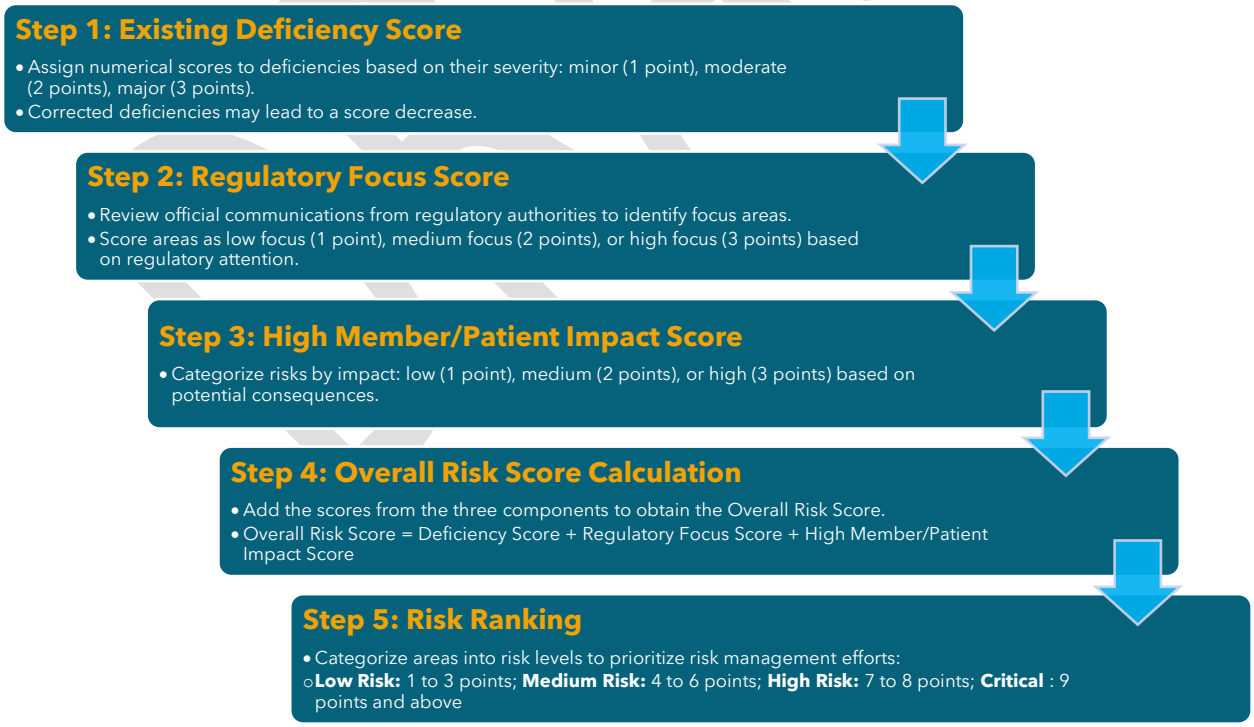
Regulatory Focus Score: This score evaluates regulatory focus areas identified by authorities like DHCS and DMHC. These areas highlight pain points and challenges in California's healthcare system, providing insights into high-risk compliance areas. By aligning our risk levels with their focus, we can proactively address vulnerabilities and optimize compliance. Regulatory Focus is categorized as low, medium, or high, each assigned a specific numerical score.	
Low (1 point)	If regulators have indicated some attention to the area by including it in routine audit scope and ongoing reporting, it can be categorized as low focus.
Medium (2 points)	The area has been specifically targeted in a DHCS or DMHC's focus audit scope, highlighted it as an area of importance in recent communications (APLs, policy guides, etc.), and included in specific guidance or requirements issued by regulators, indicating moderate focus.
High (3 points)	If regulators have specifically highlighted the area as a top priority, dedicated substantial resources, or targeted this area for scrutiny, it

	can be categorized as high focus. This indicates that the area is of significant importance and is a priority for regulators.

Deficiency Score: This score evaluates the severity of existing deficiencies identified through oversight activities such as regulatory audits and delegation oversight audits. Deficiencies are categorized into minor, moderate, and major, each assigned a specific numerical score.	
Minor (1 point)	A minor deficiency refers to an isolated incident or a minor deviation from established policies or procedures. The deficiency is non-systemic and can be rectified immediately.
Moderate (2 points)	A moderate deficiency indicates non-compliance or gap in processes and is identified as a repeat audit finding.
Major (3 points)	A major deficiency represents a significant non-compliance or gap in processes, tied to regulatory notices of noncompliance and subject to monetary penalties or sanctions.

B. Step-by-Step Implementation

Audit and Monitoring Scope: All delegated functions (oversight elements) are audited, except those receiving auto credit (based on ongoing monitoring scores). Monitoring focuses on high-risk oversight elements, and audit deficiencies may trigger the need for monitoring.



C. Oversight Elements and Risk Ranking

Oversight Element	A. Audit Deficiency Score	B. Regulatory Focus Score	C. Member Impact Score	Risk score (A+B+C)	Risk level
A	3 (Major)	3 (High)	3 (High)	9	Critical
B	1 (Minor)	3 (High)	3 (High)	7	High
C	3 (Major)	1 (Low)	1 (Low)	4	Low
D	2 (Moderate)	2 (Medium)	2 (Medium)	6	Medium

VI. Annual Audits

CHPIV conducts annual audits of Delegates to ensure compliance with all federal, state statutory, regulatory, contractual, and National Committee for Quality Assurance (NCQA) accreditation requirements related to Delegated Activities including but not limited to:

- Access & availability/Provider network,
- Appeals
- Behavioral health/Mental health and substance abuse disorder,
- Cultural and linguistic services/language assistance,
- Grievances
- Health education,
- Provider qualifications (credentialing, training)
- Quality improvement, and
- Utilization management

Delegates will allow CHPIV, DHCS, CMS, DHHS Inspector General, the Comptroller General, DOJ, and the DMHC, or their designees, to audit, inspect, and evaluate information related to CHPIV Members. The Subcontractor must make available for the purposes of any audit, evaluation or inspection of its premises, physical facilities, equipment, books, records, contracts, computers, or other electronic systems related to the services rendered to CHPIV Members and/or Delegated Activities performed. Unless a longer time is specified by a law, rule or regulation, the right to audit will exist 10 years from the final date of the contract period, or from the date of completion of any audit, whichever is later as required by State and Federal laws, regulations, and guidance.

I. Monitoring

The purpose of the monitoring program is to oversee CHPIV's Delegates on an ongoing basis and more frequently than annual audits. The monitoring program focuses on critical and high-risk areas and utilizes data (that CHPIV validates for accuracy and completeness) to score quantitative KPIs and case file reviews to score qualitative KPIs.

Reports used for quantitative KPIs have detailed report templates and specifications that must be followed to measure performance. The reports are detailed in the *CHPIV Monitoring Protocol* and include information related to the Report Name, Report ID, File Naming Convention, and Data Specifications. Qualitative case file reviews may be conducted through collection of case files and/or live system walk throughs.

A. Establishing Key Performance Indicators (KPIs)

CHPIV aims to establish KPIs that fully align with regulatory and contractual requirements and regulatory audit protocols. CHPIV ensures the following steps are taken to fully implement a KPI:

KPI Intake	•Regulatory requirement(s) •Compliance calculation •Thresholds
Data Analysis and Implementation	•Evaluate regulatory reports and existing operational reports •Gap analysis and revisions •Establish frequency and log templates with delegates
Design Data Assessment Testing	•Logic for an Data Assessment •Define data elements required to score KPIs, invalid data for these data elements trigger a "Non-Reportable" score
Design Monitoring Tools	•Data Validation •Quarterly Case File Reviews
Dashboard and Scorecards	•Automation: ingestion of raw data and calculation of scores •Dashboard •Delegate Scorecards/Reports

B. Summary of Monitoring Process and Timeline

Phase I: Log Submission and Data Accuracy Tests

- **Frequency:** Quarterly
- Delegated entities submit required logs
- Data assessment for completeness, formatting and logic
- Live data validation, 5 samples per log, 80% threshold

Phase II: Performance Evaluation

- **Frequency:** Quarterly
- Calculations for quantitative KPIs.
- Case file reviews for qualitative KPIs.*
  - Selection of sample cases to be reviewed. Case file reviews or live in Delegate's system via webinar

Phase III: Monitoring Reports

- **Frequency:** Quarterly
- Dashboard
- Scorecards/reports

Phase IV: Remediation

- **Frequency:** As required
- Discussions
- Warning Letters
- Notice of Non-Compliance and CAP Issuance

*To be implemented after the first Delegation Oversight Full-Scope Audit

C. Monitoring Phases

The monitoring process consists of four phases:

I. Log Submission and Data Validation
II. Performance Evaluation
III. Monitoring Reports
IV. Remediation

The following sections describe important milestones in each phase of the monitoring process.

Phase I: Log Submission and Data Accuracy Tests

The report submission and automated data assessment is the first phase of monitoring. Key milestones within Phase I are summarized below in detail.

Log Submission – On the 20th of every month (or the next business day after if the 20th lands on a weekend/holiday), each Delegate is required to submit the logs in accordance with the current *CHPIV Monitoring Protocol.*

Data Assessment – Logs undergo a data assessment, which is a review of Delegates' submitted logs for completeness, data formatting, and logic. If the data assessment identifies errors within the log submission, Delegates are required to resubmit. Delegates have 3 attempts or until the 20th of the month to submit a valid log. If the log does not pass the data assessment after 3 attempts or by the 20th of the month, this will be documented as an "NR" or "Non-Reportable" for all applicable KPIs.

Data Validation – For the first submission of the calendar year, a webinar will be held to verify that the data provided in the logs are accurate. The Delegates should have available the information and documents necessary to demonstrate that the data provided in the reports are accurate. Specific documents in live systems will be reviewed during the webinar.

5 samples are randomly selected for each log. All fields within one sample must match the systems for one case to pass. The report is deemed "accurate" if 4 out of 5 samples (80%) pass. If there are less than 5 cases in the report, all cases must be reviewed for data validation.

If the log does not pass data validation after 3 attempts or by the 25th of the month, this will be documented as an "NR" or "Non-Reportable" for all applicable KPIs. Further, the Delegate will be required to undergo data validation monthly to ensure processes have been corrected to pull accurate data.

NOTE: Worst-Case Scenario Mailing Policy – In instances where systems are programmed to capture the date letters are generated (as opposed to the "mailing date"), the worst-case scenario mailing policy can apply. The delegates can apply its mailing policy to populate the "Notification Date" fields.

Phase II: Performance Evaluation

(A) Quantitative (Automated Scoring)

Scoring – Monthly, all records/cases are reviewed for compliance using calculations for each KPI. The score for each KPI is calculated by dividing the total number of records/cases in the selection by the number of compliant records/cases. The score will be populated in the scorecards monthly. As noted above, scores may result in an "NR" or "non-reportable" if the corresponding log is deemed inaccurate during the live data validation and/or data assessment.

(B) Qualitative (Case File Reviews) – *Qualitative reviews will be implemented after completion of the first Delegation Oversight Full Scope Audit*

Sample Selection – Quarterly, targeted samples are selected from reports submitted to test qualitative KPIs (e.g. clinical decision making). Specific sample sizes vary by functional area and element and are listed within the *CHPIV Monitoring Protocol*. If an "NR" or "Non-Reportable" is cited for any KPI, samples will still be selected for this portion of the monitoring process.

Samples can either be reviewed via webinar through live systems while others can be reviewed through case file reviews.

Notification of Sample Selection – The notification of sample selections timing is dependent on the type of review conducted: For live reviews, notification of sample selections is sent to the Delegates on the day the case file reviews are conducted via email approximately one hour before the start of the webinar. For case file reviews, notification of sample selections is sent to the Delegates 7 calendar days prior to reviews. Delegates have 7 days to complete and submit the case files.

Webinar Reviews –During the webinar reviews, the Delegates are expected to present its supporting documentation while the auditors evaluate sample cases live in the system(s) to determine whether the case is compliant. For cases deemed pended or non-compliant, the Delegate must take screen shots and submit the case to the reviewers.

Phase III: Monitoring Reports – Compliance Scores

Issuance of the Final Monitoring Report: The final monitoring report contains the final score and classification of findings noted during the monitoring review period.

Classifications and Scoring: Each KPI has defined compliance calculations and thresholds. Each KPI score is assigned levels of scoring based on the definitions below.

Classification	Definition
RED: Non-Reportable (NR)	Logs used to measure performance were deemed inaccurate during data accuracy testing.
RED	Systemic deficiencies are identified. The deficiency may have resulted in a member's lack of access to medications and/or services or posed an immediate threat to a member's health and safety.
YELLOW	These issues may affect members, they are not of such a severe nature that enrollees' immediate health and safety is affected. Generally, this involves non-compliance with respect to non-existent or inadequate policies and procedures, systems, internal controls, training, operations, or staffing.
GREEN	Cases are found to be compliant. Cases may also be found to be non-compliant, but issues are non-systemic, or represent an anomaly or "one-off" issue. These would be noted as observations and would result in continued monitoring.

Phase IV: Remediation

Remediation: Remediation is required for areas of non-compliance as outlined below:

Classification	Actions Required
RED: Non-Reportable (NR)	An NR is cited for each element that cannot be tested due to failure to submit an accurate or complete report. For example, if dates and times on a report are deemed inaccurate timeliness KPIs would receive an "NR" or 0% timeliness score. NRs will be noted in the report and immediate corrective action must be taken to stop or prevent the data errors from recurring.
RED	• 1 quarter RED: CHPIV will send the delegate a Warning Letter requiring the delegate to initiate remediation activities to improve noncompliance. • Delegate is required to discuss remediation activities during the Delegation Oversight Meeting (DOM). • 2 consecutive quarters RED: CHPIV will issue a Notice of Non-Compliance (NONC). Delegates are required to formally submit

Classification	Actions Required
	Corrective Action Plans (CAPs) in the CHPIV CAP Template describing the root causes and corresponding actions taken to remediate the non-compliance within one week of the issuance of the report. CHPIV will monitor the CAPs for implementation and completion. • 3 consecutive quarters RED: If this exceeds the specified timeframe, CHPIV will either perform an ad hoc focused review for noncompliance or integrate the focused review into the annual audit.
YELLOW	Delegates must conduct root cause analyses and complete corrective actions. Documentation will not be submitted to CHPIV but must be tracked and monitored by the delegate. CHPIV will continue to monitor the KPIs to ensure improvement and conduct focused audits, as needed. • 3 consecutive quarters YELLOW: CHPIV will ensure a focused review of the area is conducted during the annual audit.
GREEN	No remediation action is required. • 4 consecutive quarters GREEN: May result in lower risk score (Deficiency Score) and decreased frequency of oversight.

Committee Reporting and Escalation: Monitoring results and corrective action plans will be reported to the Compliance & Policy Committee on an ongoing basis. Delegates may be referred to the Compliance & Policy Committee and the Regulatory Compliance Oversight Committee of the Commission to determine if an enforcement action (money penalties, sanction, or contract termination) is warranted.

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

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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

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-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 6th 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 90th 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

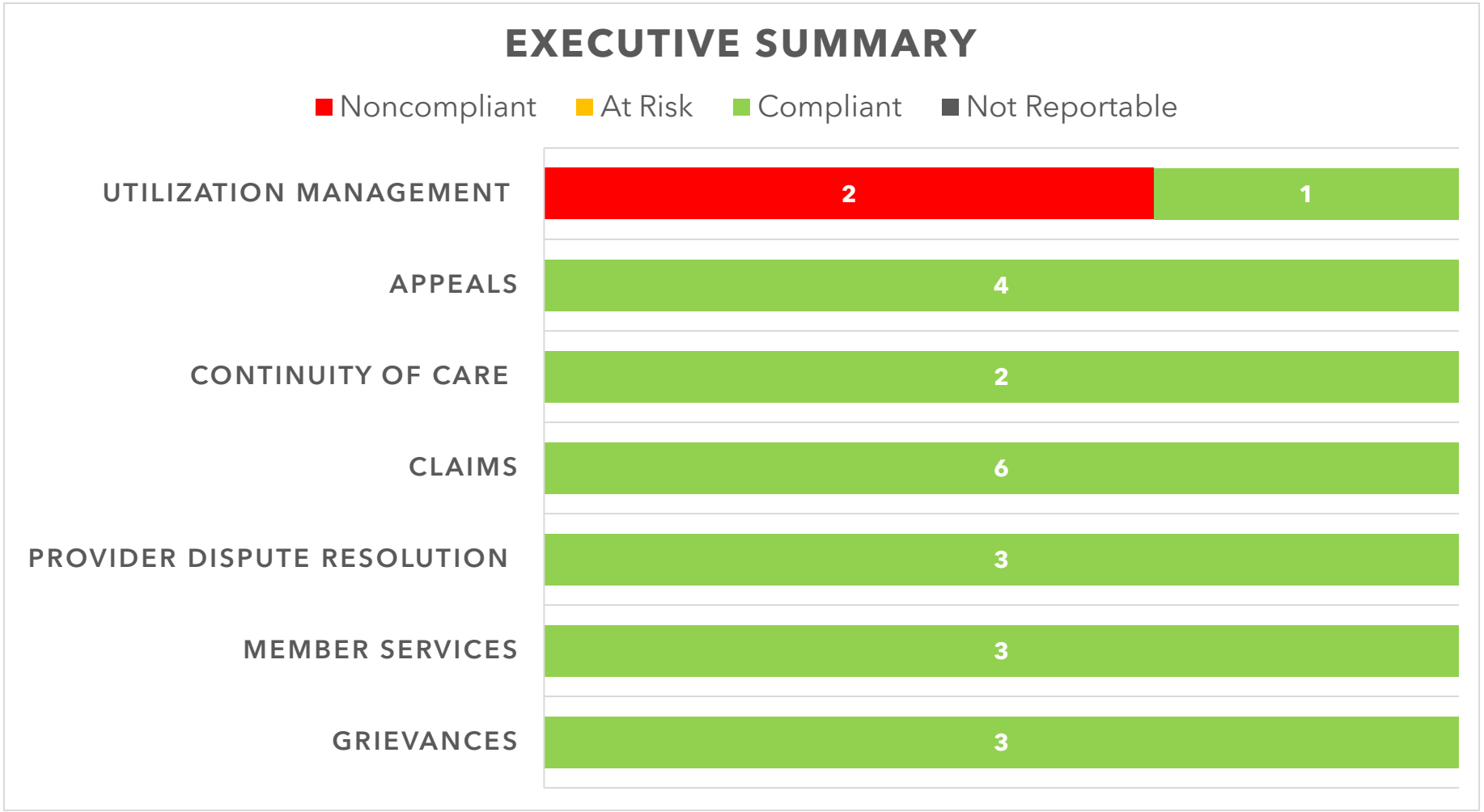
_____
Date

DELEGATION OVERSIGHT

Health Net 2024 Quarter 3 Final Scorecard

Report Issued: November 27, 2024

The CHPIV Delegation Oversight Monitoring Program ensures continuous oversight of high-risk and critical delegated activities that have high member impact and regulatory focus. The Executive Summary provides a concise overview of the performance metrics and categorizes each area into compliant (green), areas at risk (yellow), non-compliant (red), and not reportable (grey) giving a clear snapshot of where performance is strong and where improvements are needed. The thresholds are defined in Exhibit 1, in accordance with the Plan-to-Plan agreement. KPIs that are deemed not reportable are due to CHPIV being unable to calculate compliance because the data was either unavailable or inaccurate.



DELEGATION OVERSIGHT

Health Net 2024 Quarter 3 Final Scorecard

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This section provides an overview of Health Net's high-performing areas, non-compliant areas, and necessary actions. It highlights the sections where the program excels, identifies specific areas needing improvement, highlights logs that could not be validated, and outlines next steps.

HIGH PERFORMING AREAS

- ✓ 100% Appeals Acknowledgement, Decision, Effectuation of Overturned Appeals and Member Notification Timeliness
- ✓ 100% Continuity of Care Processing and Notification Timeliness
- ✓ 98.07% Calls Answered within 30 seconds
- ✓ 1.79% Call Center Abandonment Rate Level
- ✓ 100% Timely Issuance of Member ID Cards
- ✓ 100% Grievance Acknowledgement, Resolution and Member Notification Timeliness
- ✓ 99.95% PDR Acknowledgement Timeliness
- ✓ 99.28% PDR Written Determination Timeliness
- ✓ 100% Interest Payment on Late PDRs Timeliness
- ✓ 99.4% UM Decision Timeliness
- ✓ 96.66% 30 C- Days, 99.50% 45 W-Days and 100% 90 C- Days Claims Payment Timeliness
- ✓ 99.99% Claims Acknowledgment Timeliness
- ✓ 99.82% Misdirected Claims Timeliness
- ✓ 99.85% Timeliness of Interest Payment on Late Claims

NON-COMPLIANT AREAS

- ☒ 94.1% UM Member Notification Timeliness
- ☒ 88.3% UM Provider Notification Timeliness

ACTIONS REQUIRED

FUNCTIONAL AREA	ACTION	DUE DATE
UTILIZATION MANAGEMENT	Corrective Action Plan (CAP)	12/13/2024
APPEALS	None	NA
CONTINUITY OF CARE	None	NA
CLAIMS	None	NA
PROVIDER DISPUTE RESOLUTION	None	NA
MEMBER SERVICES	None	NA
GRIEVANCES	None	NA

DELEGATION OVERSIGHT

Health Net 2024 Quarter 3 Final Scorecard

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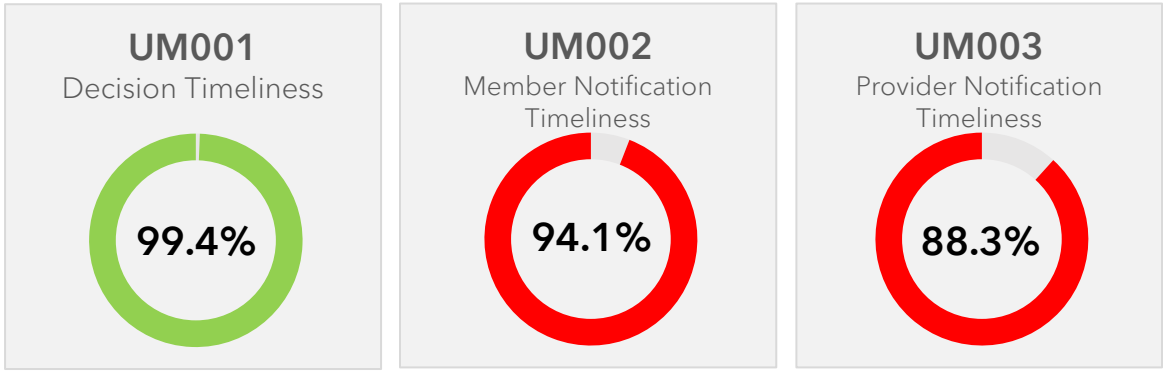
UTILIZATION MANAGEMENT



KPI #	KPI	Quarter 1	Quarter 2	Quarter 3	Quarter 4
UM001	**Decision Timeliness**	**98.3%**	**99.6%**	**99.4%**	
UM001SP	▸ Standard Preservice	98.3%	98.3%	97.6%	
UM001EP	▸ Expedited Preservice	95.2%	100%	100%	
UM001C	▸ Concurrent	98.9%	100%	100%	
UM001R	▸ Retrospective	100%	100%	100%	
UM001PS	▸ Post Stabilization	No cases	No cases	No Cases	
UM002	**Member Notification Timeliness**	**96%**	**94.6%**	**94.1%**	
UM002SP	▸ Standard Preservice	100%	98.3%	91.3%	
UM002EP	▸ Expedited Preservice	86.8%	66.7%	71.4%	
UM002C	▸ Concurrent	97%	93.2%	98.9%	
UM002R	▸ Retrospective	100%	100%	83.3%	
UM003	**Provider Notification Timeliness**	**89.1%**	**90.2%**	**88.3%**	
UM003SP	▸ Standard Preservice	89.7%	100%	96.4%	
UM003EP	▸ Expedited Preservice	85.4%	100%	100%	
UM003C	▸ Concurrent	89.2%	86.4%	84.7%	
UM003R	▸ Retrospective	100%	100%	83.3%	

DELEGATION OVERSIGHT

Health Net 2024 Quarter 3 Final Scorecard

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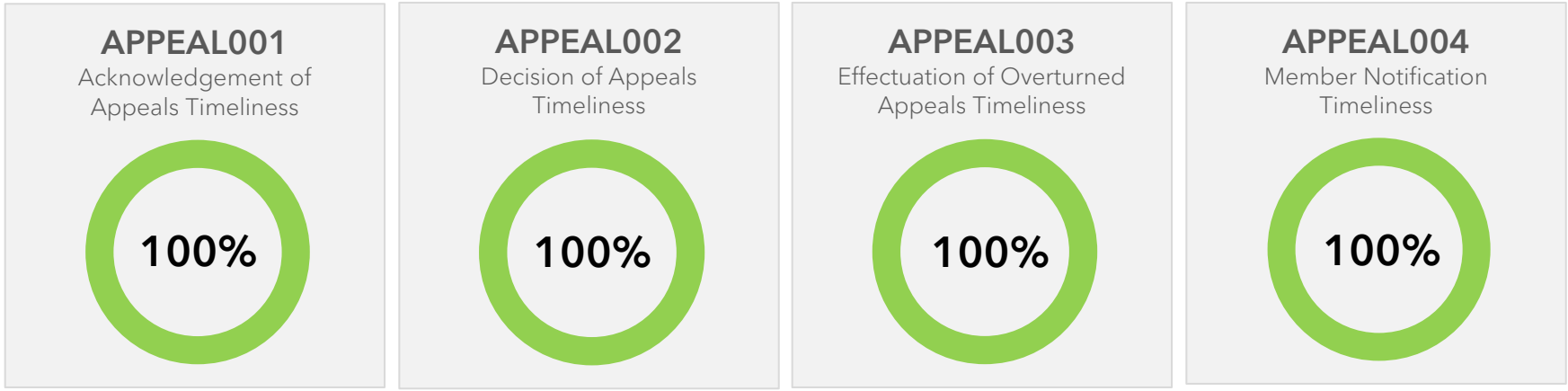
APPEALS



KPI #	KPI	Quarter 1	Quarter 2	Quarter 3	Quarter 4
APPEAL001	**Acknowledgement of Appeals Timeliness**	**100%**	**100%**	**100%**	
APPEAL002	**Decision of Appeals Timeliness**	**100%**	**100%**	**100%**	
APPEAL002S	▸ Standard	100%	100%	100%	
APPEAL002E	▸ Expedited	No cases	100%	100%	
APPEAL003	**Effectuation of Overturned Appeals Timeliness**	**80%**	**100%**	**100%**	
APPEAL004	**Member Notification Timeliness**	**100%**	**100%**	**100%**	
APPEAL004S	▸ Standard	100%	100%	100%	
APPEAL004E	▸ Expedited	No cases	100%	100%	

DELEGATION OVERSIGHT

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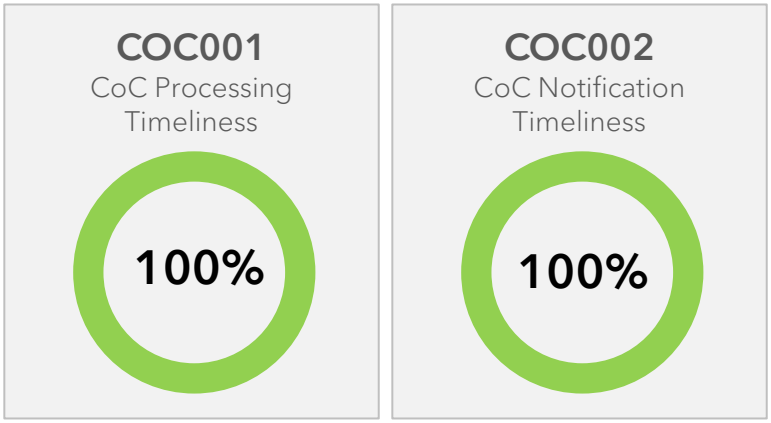
CONTINUITY OF CARE



KPI #	KPI	Quarter 1	Quarter 2	Quarter 3	Quarter 4
COC001	**CoC Processing Timeliness**	**73.08%**	**80%**	**100%**	
COC001N	▸ Non-Urgent	100%	80%	100%	
COC001I	▸ Immediate	No Cases	No Cases	No Cases	
COC001U	▸ Urgent	36.36%	No Cases	No Cases	
COC002	**CoC Notification Timeliness**	**100%***	**100%**	**100%**	
COC002N	▸ Non-Urgent	100%	100%	100%	
COC002I	▸ Immediate	No Cases	No Cases	No Cases	
COC002U	▸ Urgent	100%	No Cases	No Cases	

DELEGATION OVERSIGHT

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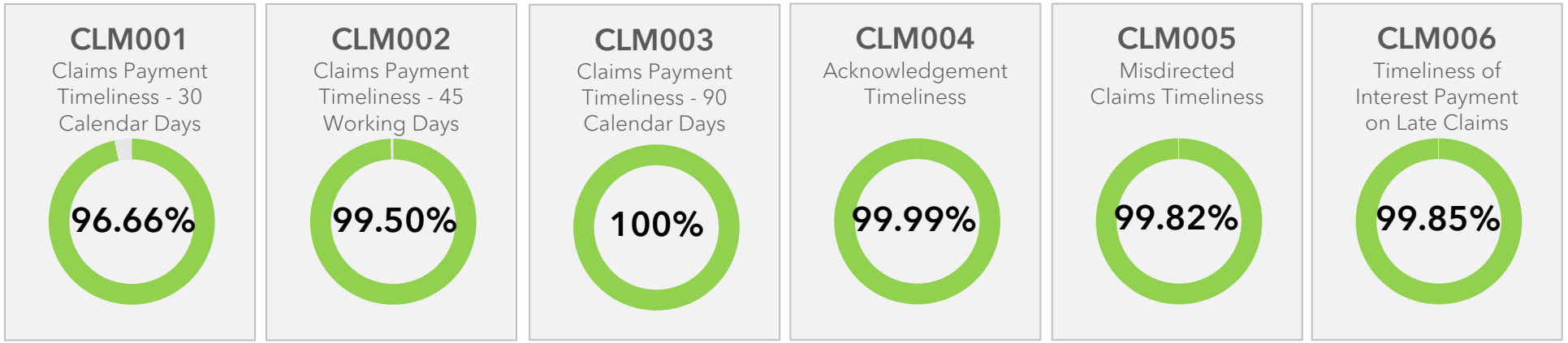
CLAIMS



KPI #	KPI	Quarter 1	Quarter 2	Quarter 3	Quarter 4
CLM001	**Claims Payment Timeliness - 30 Calendar Days**	**99.86%**	**99.92%**	**96.66%**	
CLM002	**Claims Payment Timeliness - 45 Working Days**	**100%**	**100%**	**99.50%**	
CLM003	**Claims Payment Timeliness - 90 Calendar Days**	**100%**	**100%**	**100%**	
CLM004	**Acknowledgement Timeliness**	**99.76%**	**99.99%**	**99.99%**	
CLM004E	▸ Acknowledgement Timeliness - Electronic	100%	100%	100%	
CLM004P	▸ Acknowledgement Timeliness - Paper	93.69%	99.76%	99.52%	
CLM005	**Misdirected Claims Timeliness**	**99.9%**	**99.84%**	**99.82%**	
CLM006	**Timeliness of Interest Payment on Late Claims**	**100%**	No Cases	**99.85%**	

DELEGATION OVERSIGHT

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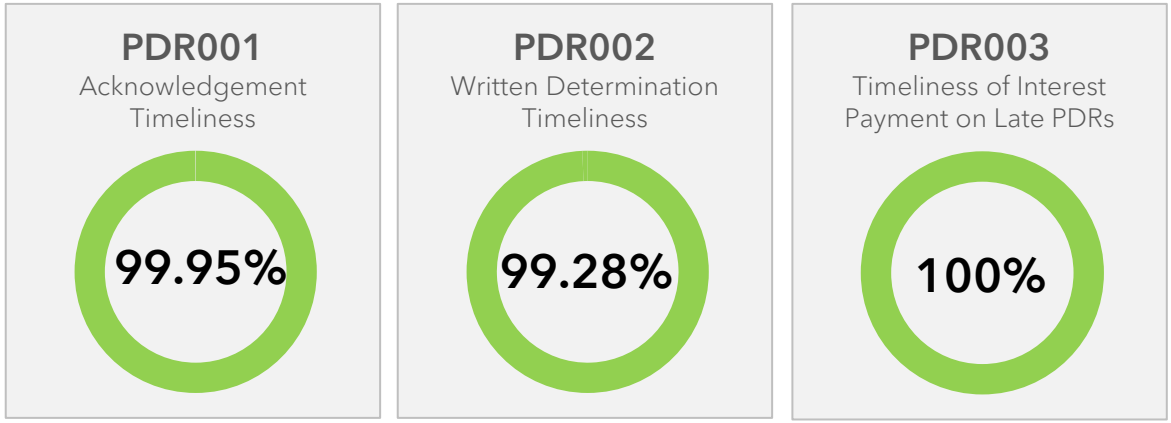
PROVIDER DISPUTE RESOLUTION



KPI #	KPI	Quarter 1	Quarter 2	Quarter 3	Quarter 4
PDR001	**Acknowledgement Timeliness**	**99.25%**	**100%**	**99.95%**	
PDR001E	▸ Acknowledgement Timeliness - Electronic	No Cases	No Cases	No Cases	
PDR001P	▸ Acknowledgement Timeliness - Paper	99.25%	100%	99.95%	
PDR002	**Written Determination Timeliness**	**100%**	**99.92%**	**99.28%**	
PDR003	**Timeliness of Interest Payment on Late PDRs**	**100%**	**100%**	**100%**	

DELEGATION OVERSIGHT

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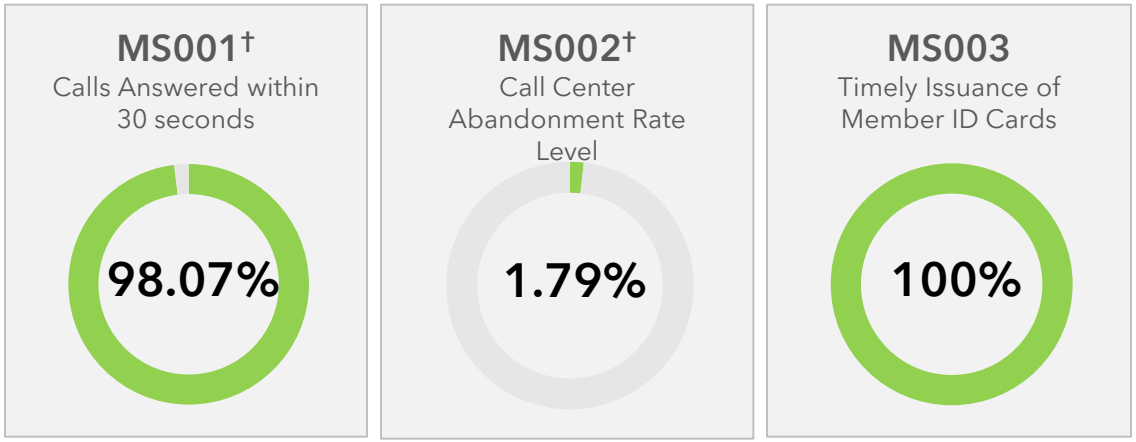
MEMBER SERVICES



KPI #	KPI	Quarter 1	Quarter 2	Quarter 3	Quarter 4
MS001	**Calls Answered within 30 seconds**	**83.17%†**	**98.11%†**	**98.07%**	
MS002	**Call Center Abandonment Rate Level**	**3.42%†**	**0.78%†**	**1.79%**	
MS003	**Timely Issuance of Member ID Cards**	**81.27%**	**90.61%**	**100%**	

† Self-reported compliance rate

Community Health Plan OF IMPERIAL VALLEY

DELEGATION OVERSIGHT

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GRIEVANCES

KPI #	KPI	Quarter 1	Quarter 2	Quarter 3	Quarter 4
GRV001	**Acknowledgement Letter Timeliness**	**95.3%**	**97.9%**	**100%**	
GRV002	**Grievance Resolution Timeliness**	**100%**	**100%**	**100%**	
GRV002S	▸ Standard	100%	100%	100%	
GRV002E	▸ Expedited	100%	100%	100%	
GRV003	**Member Notification Timeliness**	**100%**	**100%**	**100%**	
GRV003S	▸ Standard	100%	100%	100%	
GRV003E	▸ Expedited	100%	100%	100%	

Appendix 1 – KPI Details

This appendix provides comprehensive details for each Key Performance Indicator (KPI), including the KPI type, predefined thresholds, and the specific log used to calculate the KPI compliance rate.

Functional Area	KPI Type	KPI #	KPI	Thresholds			Log
				Green	Yellow	Red	
Utilization Management (UM)	Quantitative	UM001	Decision Timeliness	>96%	95-96%	<95%	UM Authorizations Log
Utilization Management (UM)	Quantitative	UM002	Member Notification Timeliness	>96%	95-96%	<95%	UM Authorizations Log
Utilization Management (UM)	Quantitative	UM003	Provider Notification Timeliness	>96%	95-96%	<95%	UM Authorizations Log
Appeals	Quantitative	APPEAL01	Timely Acknowledgement of Appeals	>96%	95-96%	<95%	Appeal Log
Appeals	Quantitative	APPEAL02	Timely Decision of Appeals	>96%	95-96%	<95%	Appeal Log
Appeals	Quantitative	APPEAL03	Timely Effectuation of Overturned Appeals	>96%	95-96%	<95%	Appeal Log
Appeals	Quantitative	APPEAL04	Member Notification Timeliness	>96%	95-96%	<95%	Appeal Log
Continuity of Care	Quantitative	COC001	CoC Processing Timeliness	>96%	95-96%	<95%	CoC Log
Continuity of Care	Quantitative	COC002	CoC Notification Timeliness	>96%	95-96%	<95%	CoC Log
Claims	Quantitative	CLM001	Claims Payment Timeliness - 30 Calendar Days	>91%	90-91%	<90%	Claims Log
Claims	Quantitative	CLM002	Claims Payment Timeliness - 45 Working Days	>96%	95-96%	<95%	Claims Log
Claims	Quantitative	CLM003	Claims Payment Timeliness - 90 Calendar Days	>99%	99%	<99%	Claims Log
Claims	Quantitative	CLM004	Claims Acknowledgement Timeliness	>96%	95-96%	<95%	Claims Log
Claims	Quantitative	CLM005	Misdirected Claims Timeliness	>96%	95-96%	<95%	Claims Log
Claims	Quantitative	CLM006	Timely Interest Payment on Late Claims	>96%	95-96%	<95%	Claims Log

DELEGATION OVERSIGHT

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Functional Area	KPI Type	KPI #	KPI	Thresholds			Log
				Green	Yellow	Red	
Provider Dispute Resolution (PDR)	Quantitative	PDR001	PDR Acknowledgement Timeliness	>96%	95-96%	<95%	PDR Log
Provider Dispute Resolution (PDR)	Quantitative	PDR002	PDR Written Determination Timeliness	>96%	95-96%	<95%	PDR Log
Provider Dispute Resolution (PDR)	Quantitative	PDR003	Timeliness of Interest Payment on Late PDRs	>96%	95-96%	<95%	PDR Log
Member Services	Quantitative	MS001	Calls Answered within 30 seconds	>90%	80%-90%	<80%	Call Center SLA Log
Member Services	Quantitative	MS002	Call Center Abandonment Rate Level	less than 5%	5%	>5%	Call Center SLA Log
Member Services	Quantitative	MS003	Timely Issuance of Member ID cards	100%	NA	<100%	Member ID Cards Log
Grievances	Quantitative	GRV001	Timely Acknowledgement Letter	>96%	95-96%	<95%	Grievance Log
Grievances	Quantitative	GRV002	Timely Grievance Resolution	>96%	95-96%	<95%	Grievance Log Call Log
Grievances	Quantitative	GRV003	Member Notification Timeliness	>96%	95-96%	<95%	Grievance Log