COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

# AGENDA

## Local Health Authority Commission

## October 13, 2025

## 5:30 PM

## 512 W. Aten Rd., Imperial, CA 92251

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

**Microsoft Teams**
Join the meeting now
Meeting ID: 217 028 464 542
Passcode: 7KD7N4Yy

| Committee Members | Representing | Present |
|---|---|---|
| **Dr. Bushra Ahmad** | LHA Commissioner-CMO at County of Imperial | |
| **Dr. Kathleen Lang** | LHA Commissioner-CEO at County of Imperial | |
| **Dr. Majid Mani** | LHA Commissioner-Imperial County Medical Society | |
| **Dr. Carlos Ramirez** | LHA Commissioner-CEO/Senior Consultant DCRC | |
| **Dr. Unnati Sampat** | LHA Commissioner-President of Imperial County Medical Society | |
| **Dr. Allan Wu** | LHA Commissioner-CMO at Innercare & President of CCIPA | |
| **Yvonne Bell** | LHA Vice-Chair-CEO at Innercare and CCIPA | |
| **Christopher Bjornberg** | LHA Commissioner-CEO of Imperial Valley Healthcare District | |
| **Lee Hindman** | LHA Chair-Joint Chambers of Commerce representing the public | |
| **Ryan Kelley** | LHA Commissioner-Board of Supervisors, County of Imperial | |
| **Paula Llanas** | LHA Commissioner-Director of Social Services at County of Imperial | |
| **Pablo Velez** | LHA Commissioner-CEO of El Centro Regional Medical Center | |

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

A. Roll Call *Donna Ponce, Commission Clerk*

B. Approval of Agenda

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

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

Public Comment is limited to items NOT listed on the agenda. This is an opportunity for members of the public to address the Commission on any matter within the Commission's jurisdiction. Any action taken as a result of public comment shall be limited to the direction of staff. When addressing the Commission, state your name for the record prior to providing your comments. Please address the Commission as a whole, through the Chairperson. Individuals will be given three (3) minutes to address the board.

**3. CONSENT AGENDA**

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

A. Approval of Minutes from 9/8/2025……. pg. 6-10

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

1. Executive Summary……pg. 11-12
2. Enrollment Report …… pg. 13
3. Statement of Revenues, Expenses, and Changes in Net Position……. pg. 14
4. Product Profit & Loss Statement……. pg. 15
5. Statement of Net Position……. pg. 16
6. Summarized TNE Calculation ……. pg. 17
7. Cash Transaction Report ……. pg. 18-19

**4. ACTION**

*A.* Motion to approve the SOW for annual financial audit performed by Baker Tilly, formerly Moss Adams, not to exceed **$87,000**…. pg. 41-54
*(David Willson, CFO)*

B. Motion to approve the establishment of a new account with JP Morgan Chase for the management of claims payment and reserves for the D-SNP line of business…. pg. 55
*(David Wilson, CFO)*

C. Motion to approve the charter of the Credentialing Oversight Subcommittee (COS) of the Quality Improvement Health Equity and Compliance (QIHEC) Committee for D-SNP Line of Business only
*(Dr. Gordon Arakawa, CMO)* …pg. 56-58

**5. COMMITTEE CHAIR REPORTS**

A. Quality Improvement Health & Equity Committee-*Quarterly*
*(Dr. Gordon Arakawa, CMO)* *no meeting*

B. Finance Committee-*Monthly*
*(Dr. Carlos Ramirez, Chair)*

C. Regulatory Compliance & Oversight Committee-*Quarterly…….* pg. 60-132
*(Dr. Allan Wu, Chair)*

D. Community Advisory Committee-*Quarterly*……pg. 133
*(Julia Hutchins)*

**6. INFORMATION**

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

B. Compliance Report *(Elysse Tarabola, CCO)*

C. Operations Report *(Julia Hutchins, COO) ……* pg. 135-136

D. Human Resources Report *(Shannon Long, HR Consultant) …….* pg.137

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

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

**7. CLOSED SESSION**

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

A. Compliance Report *(Elysse Tarabola, CCO)*

B. Strategic Plan Update *(Larry Lewis, CEO)*

C. Public Employee Annual Performance Evaluation *(Restricted to commissioners)*

**8. RECONVENE OPEN SESSION**

A. Report on actions taken in closed session.

**9. ADJOURNMENT**

Next meeting: November 10, 2025

# Consent Agenda

COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

# MINUTES

## Local Health Authority Commission

## September 8, 2025

## 5:30 PM

## 512 W. Aten Rd., Imperial, CA 92251

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

**Microsoft Teams**
Join the meeting now
Meeting ID: 217 028 464 542
Passcode: 7KD7N4Yy

| Committee Members | Representing | Present |
|---|---|---|
| **Dr. Majid Mani** | LHA Commissioner- Imperial County Medical Society | ✓ |
| **Dr. Bushra Ahmad** | LHA Commissioner- County of Imperial – CMO | ✓ |
| **Dr. Carlos Ramirez** | LHA Commissioner - CEO/Senior Consultant DCRC | ✓ |
| **Dr. Unnati Sampat** | LHA Commissioner - President of Imperial County Medical Society | ✓ |
| **Dr. Allan Wu** | LHA Commissioner - Innercare, CMO and President of CCIPA | ✓ |
| **Dr. Kathleen Lang** | LHA Commissioner - County of Imperial –CEO | ✓ |
| **Christopher Bjornberg** | LHA Commissioner- Imperial Valley Healthcare District-CEO | ✓ |
| **Paula Llanas** | LHA Commissioner - County of Imperial – Director of Social Services | A |
| **Ryan E. Kelley** | LHA Commissioner - County of Imperial – Board of Supervisors | A |
| **Pablo Velez** | LHA Commissioner - ECRMC CEO | ✓ |
| **Yvonne Bell** | LHA Vice-Chair - CEO – Innercare and CCIPA | ✓ |
| **Lee Hindman** | LHA Chair-Joint Chambers of Commerce representing the public | ✓ |

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

Meeting called to order at 5:31 p.m.

A. Roll Call *Donna Ponce, Commission Clerk*

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

B. Approval of Agenda

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

(Sampat/Mani) Approved the order of the agenda. Motion carried.

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

Public Comment is limited to items NOT listed on the agenda. This is an opportunity for members of the public to address the Commission on any matter within the Commission's jurisdiction. Any action taken as a result of public comment shall be limited to the direction of staff. When addressing the Commission, state your name for the record prior to providing your comments. Please address the Commission as a whole, through the Chairperson. Individuals will be given three (3) minutes to address the board.
No public comment.

A. Introduction Athena Chapman-Strategic Planning Consultant
Chief Executive Officer, Larry Lewis introduced Athena Chapman and Donna Cullinan of Chapman Consulting. Chapman Consulting will be working with Community Health Plan of Imperial Valley on goals and strategic planning. Larry noted that Athena and Donna will be facilitating leadership discussion focused on the 2026-2028 strategic plan and encouraged the commission to forward any thoughts or input regarding the strategic planning process.

**3. CONSENT AGENDA**

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

A. Approval of Minutes from 8/11/2025……. *pg. 4-7*

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

1. Executive Summary……*pg. 8-9*
2. Enrollment Report ……. *pg. 10*
3. Statement of Revenues, Expenses, and Changes in Net Position……. *pg. 11*
4. Product Profit & Loss Statement……. pg. *12*
5. Statement of Net Position……. *pg. 13*
6. Summarized TNE Calculation ……. *pg. 14*
7. Cash Transaction Report ……. *pg. 15*

C. Motion to approve payment to the LHPC 2025-2026 Annual Dues Assessment of $133,791.65 as reviewed and accepted by the Executive Committee
*pg.16-21* *(Larry Lewis, CEO)*

D. Motion to approve a $2,500 donation in support of the Cancer Resource Center of the Desert's fundraising dinner, "An Evening of Hope" as reviewed and accepted by the Executive Committee
pg. 22-24 (*Larry Lewis, CEO)*

**4. ACTION-***No action items.*

**5. COMMITTEE CHAIR REPORTS**

A. Quality Improvement Health & Equity Committee-*Quarterly*
*(Dr. Gordon Arakawa, CMO) no meeting*

B. Finance Committee-*Monthly*
*(Dr. Carlos Ramirez, Chair)*
Chair Ramirez provided an update on October 7, 2025, Finance Committee meeting.

C. Regulatory Compliance & Oversight Committee-*Quarterly*
*(Dr. Allan Wu, Chair) no meeting*

D. Community Advisory Selection Committee-*Biannual*
*(Dr. Carlos Ramirez, Chair) no meeting*

**6. INFORMATION**

A. Health Services Report *(Dr. Gordon Arakawa, CMO and Jeanette Crenshaw, Executive Director of Health Services) ……. pg. 25-39*
Chief Medical Officer (CMO) Dr. Gordon Arakawa presented a report on Enhanced Care Management (ECM.)
Member of the public, Dr. Mervat Kelada, inquired whether CHPIV will be managing ECM for patients. Dr. Arakawa responded that more information is needed to assess patterns and provider capacity. Dr. Arakawa concluded the meeting by stating that if providers are able manage care independently, they are encouraged to do so. Otherwise, ECM will provide support by handling specific functions as needed.

Member Sampat requested an update on Project Food Box and why it is no longer provided to patients. CEO Larry Lewis explained the shift in focus toward medically tailored meals instead of produce boxes from farmers. Member Lang added that the decision was influenced by the State's review of community support service utilization. Dr. Arakawa will follow up and provide a clearer explanation.
Dr. Arakawa announced that CHPIV has received full health equity as well as a full health plan accreditation.

B. Compliance Report *(Elysse Tarabola, CCO) ……pg. 40-42*
Chief Compliance Officer (CCO) Elysse Tarabola provided the following updates :

- On-site Department of Managed Health Care (DMHC) Routine Survey scheduled for September 30-October 2, 2025.
- Network Adequacy Validation (NAV) audit overview.
- Pre-Delegation Audits for Dual Eligibility Special Needs Plan (D-SNP)
- Annual Audit of Health Net
- Delegation Oversight Monitoring Program : 2024 Quarter 4 Key Performance Indicator (KPI)
- Staffing Updates-New Hires
  - Miriam Botello, Compliance Advisor
  - Rickesha (Ricki) Collins, Nurse Auditor
  - Joe Escobar, Compliance Auditor
  - Lulu Gallegos, Nurse Auditor

C. Operations Report *(Julia Hutchins, COO) ……. pg. 43-46*
Chief Operations Officer (COO) Julia Hutchins provided the following updates:

- Go-Live January 1, 2026, with D-SNP Offering, Community Advantage Plus
- University of San Diego (UCSD) contract negotiations
- Direct network contracting
- Member and Provider Experience
- Staffing Update-New Hire-Denise Pasillas, Community Liaison
- Upcoming licensing exam for Sales Team.

D. Human Resources Report *(Shannon Long, HR Consultant) ……. pg. 47*
Human Resource Consultant Shannon Long provided updates on the following:

- Eight new hires.
- Five current open positions: Senior Compliance Advisor, Member Experience Coordinator, and three Care Coordinators.

E. CEO Report (*Larry Lewis, CEO)*
CEO Larry Lewis reported on the following:

- HR1 Rural Health Transformation Grant Opportunity
- Congressional Committee letter sent to Governor Newsom requesting detailed information on healthcare services provided to undocumented immigrants. Requested data includes program lists, enrollment policies, denial statistics, procedure costs, and charity programs. The response is due by September 17, 2025.
- Sponsorships for Harvest Bowl Foodbank and Pioneers Memorial Healthcare District Gala

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

**7. CLOSED SESSION**

Pursuant to Welfare and Institutions Code § 14087.38 (n) Report Involving Trade Secret new product discussion (estimated date of disclosure, 10/2026)

A. Compliance Report *(Elysse Tarabola, CCO)*
Chair Hindman announced that the Commission will enter into closed session.

**8. RECONVENE OPEN SESSION**

A. Report on actions taken in closed session.
Chair Hindman announced that the Commission has reconvened into open session and reports no action taken.

**9. ADJOURNMENT**
Meeting was adjourned at 6:49 p.m.
Next meeting: October 13, 2025

# Financial Result

*August 2025*

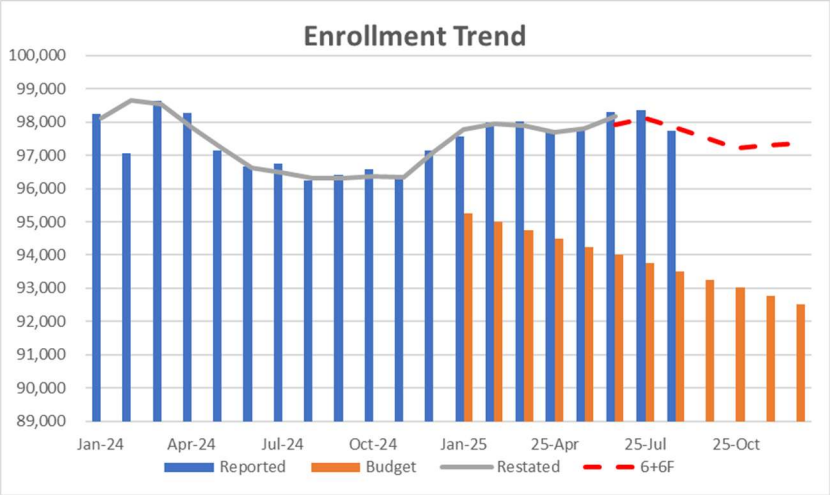
## Executive Summary

### Membership

August Medi-Cal reported membership was in-line with the 6+6 forecast expectations at 97.7K. On a restated basis, membership is underperforming by -0.3K.

Early reporting for September suggests membership will continue to decline slightly greater than the forecast.

Year-to-date, membership remains favorable to budget by 28.4K member months.




### Gross Margin

Monthly revenue exceeded forecasts by $5.5M, primarily due to retroactive 2024 Hospital Quality Incentive Pool (QIP) payments. Total QIP payments of $4.5M were fully passed through to Health Net for distribution to area hospitals.

**Membership Mix & Rate:** Rate variance was favorable by $1.1M due to retroactive Maternity kick payments, largely associated with 2025 service months.

**Volume:** Volume adjustments for the current period were slightly below forecast, resulting in a minor unfavorable revenue variance of $14K.

| | Revenue (Current Month Reported) | | | | | |
|---|---|---|---|---|---|---|
| **Category of Aid (COA)*** | **Current** | **Prior Period** | **Forecast** | **Variance** | **Vol** | **Rate** |
| Child | $ 4,558,056 | $ 496,861 | $ 4,591,898 | $ (33,842) | $ (28,706) | $ (5,136) |
| Adult | $ 3,875,013 | $ 1,746,034 | $ 3,982,608 | $ (107,595) | $ 15,257 | $ (122,852) |
| Adult Expansion | $ 7,411,814 | $ 1,981,839 | $ 7,453,173 | $ (41,359) | $ (25,398) | $ (15,961) |
| SPD | $ 4,211,492 | $ 1,397,620 | $ 4,140,788 | $ 70,703 | $ 69,949 | $ 754 |
| SPD Dual | $ 6,364,516 | $ 48,371 | $ 6,409,973 | $ (45,457) | $ (46,148) | $ 691 |
| LTC | $ 15,657 | $ 6,499 | $ 13,710 | $ 1,947 | $ 1,966 | $ (20) |
| LTC Dual | $ 36,904 | $ (769) | $ 37,673 | $ (769) | $ (769) | $ 0 |
| **Total Medicaid** | **$ 26,473,451** | **$ 5,676,455** | **$ 26,629,823** | **$ (156,371)** | **$ (13,849)** | **$ (142,522)** |

Overall, Gross margin was generally in line with forecast, favorable by $29K for the month of August; gross margin was favorable $1.1M YTD.

**Administrative Expenses**

In aggregate, administrative expenses were slightly unfavorable to forecast, less than 1% unfavorable or ($6K). Within the total, uncapitalized repairs and maintenance to the CHPIV facility were the largest unplanned variance at ($24K). These costs are associated with meeting space demands for the company due to the DSNP expansion. Additional costs are expected in September and October as the work is completed. Excluding these remodel expenses, all other administrative costs were favorable by $17K.

On a YTD basis, administrative costs are favorable by $213K relative to the budget.

**Other**

Investment income was favorable by $4K in August and is anticipated to run favorably for the remainder of the year. Year-to-date, investment income is $151K above budget.

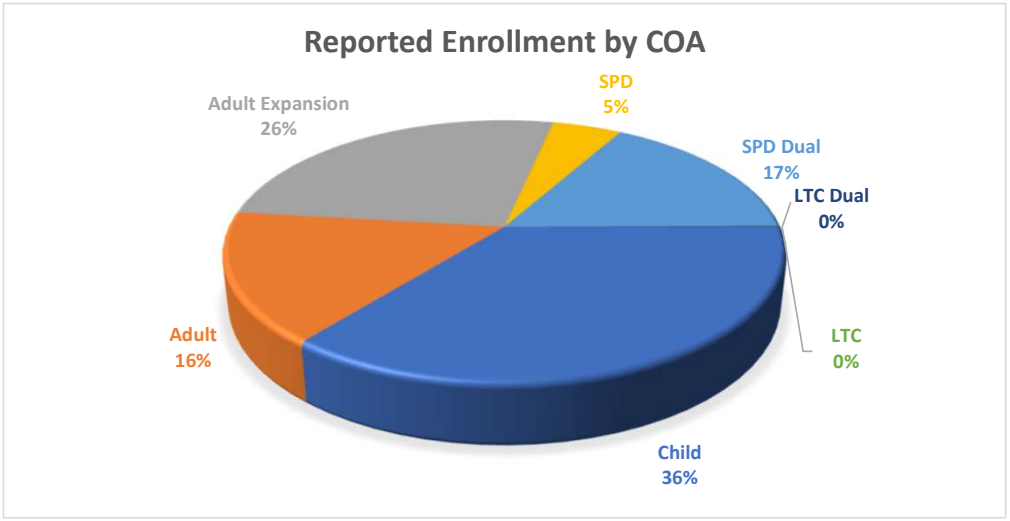
**Tangible Net Equity (TNE)**

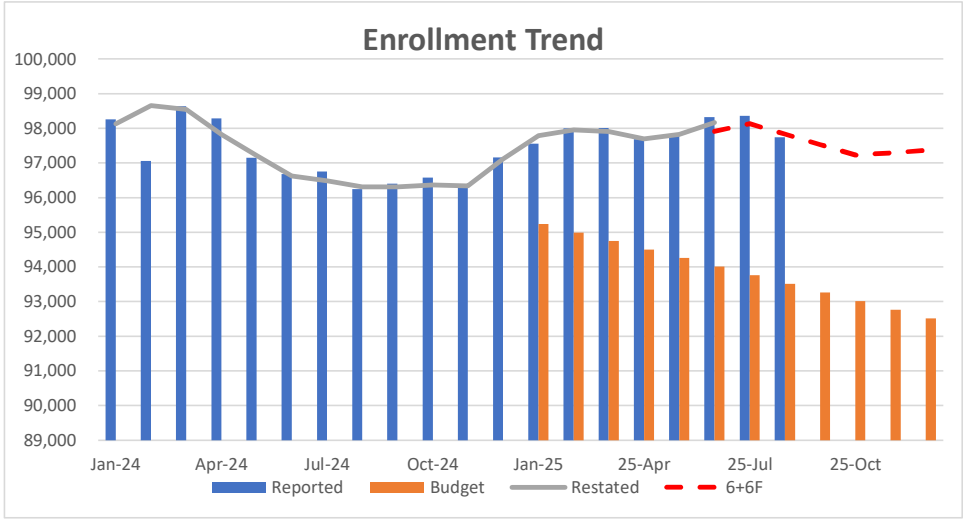
For the month of August, TNE was $23M, representing 479% of the required $4.8M. On a restated basis, TNE stands at 488% of the required levels.

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

| | 2024 | | | | 2025 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | August | | | | August (YTD) | | | |
| | | | | | | | | | B/(W) | | | | B/(W) | |
| Category of Aid (COA)* | Q1-24 | Q2-24 | Q3-24 | Q4-24 | Q1-25 | Q2-25 | Actual | 6+6F | # | % | Actual | Budget | # | % |
| Child | 34,607 | 34,589 | 34,424 | 34,551 | 35,139 | 35,129 | 34,826 | 35,032 | (206) | -1% | 280,568 | 267,144 | 13,424 | 5% |
| Adult | 16,997 | 15,767 | 15,675 | 15,768 | 15,801 | 15,754 | 15,558 | 15,401 | 157 | 1% | 125,833 | 120,479 | 5,355 | 4% |
| Adult Expansion | 26,579 | 25,784 | 25,733 | 26,019 | 25,995 | 26,028 | 25,945 | 26,117 | (172) | -1% | 207,622 | 202,220 | 5,403 | 3% |
| SPD | 5,007 | 5,041 | 5,085 | 5,139 | 4,671 | 4,784 | 4,647 | 4,499 | 148 | 3% | 37,517 | 40,410 | (2,893) | -7% |
| SPD Dual | 14,433 | 14,760 | 15,007 | 15,288 | 16,283 | 16,514 | 16,659 | 16,668 | (9) | 0% | 130,987 | 123,684 | 7,303 | 6% |
| LTC | 12 | 15 | 19 | 22 | 22 | 6 | 15 | 14 | 1 | 7% | 140 | 238 | (98) | -41% |
| LTC Dual | 79 | 87 | 92 | 104 | 98 | 100 | 94 | 98 | (4) | -4% | 772 | 838 | (66) | -8% |
| Total Medicaid | 97,714 | 96,043 | 96,035 | 96,891 | 98,009 | 98,315 | 97,744 | 97,829 | (85) | 0% | 783,439 | 755,012 | 28,427 | 4% |
| *Monthly/Quarterly Change* | | *-1.7%* | *0.0%* | *0.9%* | *1.2%* | *0.3%* | *0.9%* | *1.0%* | | | | | | |

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



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

| | August | | | August (YTD) | | | |
|---|---|---|---|---|---|---|---|
| | Actual | Forecast (6+6) | Variance - B/(W) | Actual | Budget | Variance - B/(W) | Current Month Explanations |
| **REVENUE** | | | | | | | |
| Premium | $ 27,317,750 | $ 26,337,582 | **$ 980,169** | $ 219,763,157 | $ 182,513,381 | **$ 37,249,776** | - Premium Revenue was favorable by $1M primarily driven by current year maternity rate adjustments |
| Pass-Through | $ 4,832,156 | $ 292,241 | **$ 4,539,915** | $ 8,082,340 | $ 2,757,455 | **$ 5,324,884** | |
| HN Settlements | | | **$ -** | | | **$ -** | - Pass-Through was favorable by $4.5M due to QIP adjustments for H1-2024 |
| **TOTAL REVENUE** | **$ 32,149,906** | **$ 26,629,823** | **$ 5,520,083** | **$ 227,845,497** | **$ 185,270,836** | **$ 42,574,660** | |
| **HEALTH CARE COSTS** | $ 31,330,374 | $ 25,839,695 | **$ (5,490,678)** | $ 221,252,602 | $ 179,795,435 | **$ (41,457,167)** | |
| **Gross Margin** | **$ 819,533** | **$ 790,127** | **$ 29,405** | **$ 6,592,895** | **$ 5,475,401** | **$ 1,117,493** | |
| **ADMINISTRATIVE EXPENSE** | | | | | | | |
| Salaries & Wages | $ 401,225 | $ 416,879 | **$ 15,654** | $ 2,798,769 | $ 2,915,028 | **$ 116,260** | - Salaries were favorable largely due to timing of new hires in IT and Member & Provider services departments |
| Benefits Expense | $ 25,264 | $ 33,492 | **$ 8,228** | $ 203,889 | $ 221,761 | **$ 17,871** | |
| Other Labor Expense | $ 1,424 | $ 1,424 | **$ -** | $ 12,061 | $ 10,179 | **$ (1,882)** | |
| Total Labor Costs | $ 427,913 | $ 451,796 | **$ 23,882** | $ 3,014,719 | $ 3,146,968 | **$ 132,249** | |
| Consulting, Legal, & Other Professional | $ 60,325 | $ 84,000 | **$ 23,675** | $ 552,100 | $ 693,171 | **$ 141,071** | - Favorable due to timing of consulting cost related to DSNP |
| Outside Services | $ 32,022 | $ 30,450 | **$ (1,572)** | $ 284,248 | $ 259,270 | **$ (24,978)** | |
| Advertising & Marketing | $ 50 | $ 2,300 | **$ 2,250** | $ 6,129 | $ 36,681 | **$ 30,552** | |
| Information Technology | $ 12,115 | $ 1,500 | **$ (10,615)** | $ 88,804 | $ 46,771 | **$ (42,032)** | - Unfavorable variance reflects the ramp in computers and hardware associated with new hires |
| Membership and Subscriptions | $ 11,009 | $ 11,344 | **$ 335** | $ 80,300 | $ 75,580 | **$ (4,720)** | |
| Regulatory Fees | $ 25,339 | $ 25,339 | **$ -** | $ 207,257 | $ 223,238 | **$ 15,982** | |
| Travel | $ 7,121 | $ 5,558 | **$ (1,562)** | $ 52,423 | $ 62,492 | **$ 10,069** | |
| Meals & Entertainment | $ 1,271 | $ 1,550 | **$ 279** | $ 15,554 | $ 6,300 | **$ (9,254)** | |
| Occupancy & Facility | $ 28,582 | $ 4,691 | **$ (23,890)** | $ 62,470 | $ 37,737 | **$ (24,733)** | - Occupancy costs exceeded forecast due to uncapitalized remodel costs of CHPIV facility |
| Office Expense | $ 8,057 | $ 2,305 | **$ (5,752)** | $ 39,389 | $ 53,079 | **$ 13,690** | |
| Other Admin | $ 20,088 | $ 6,883 | **$ (13,205)** | $ 111,523 | $ 86,798 | **$ (24,724)** | |
| **Total Administrative Expense** | **$ 633,893** | **$ 627,717** | **$ (6,176)** | **$ 4,514,914** | **$ 4,728,085** | **$ 213,171** | |
| **Non-Operating Income** | | | | | | | |
| Dividend, Interest & Investment Income | $ 109,496 | $ 105,775 | **$ 3,721** | $ 849,849 | $ 699,130 | **$ 150,720** | - Favorable investment income due to higher portfolio balance (i.e., Premium Revenue) relative to forecast. |
| Rental Income | $ 1,494 | $ 1,494 | **$ -** | $ 11,948 | $ 11,600 | **$ (348)** | |
| **Total Non-Operating Income** | $ 110,990 | $ 107,269 | **$ 3,721** | $ 861,797 | $ 710,730 | **$ 151,068** | |
| **Depreciation & Amortization** | $ 10,656 | $ 11,000 | **$ (344)** | $ 85,244 | $ 88,000 | **$ (2,756)** | |
| **Change in Net Position** | **$ 285,974** | **$ 258,679** | **$ 27,295** | **$ 2,854,534** | **$ 1,370,046** | **$ 1,484,488** | |
| **Key Metrics** | | | | | | | |
| Enrollment | 97,744 | 97,835 | **(91)** | 783,439 | | **#VALUE!** | |
| Revenue PMPM | $328.92 | $272.19 | **$56.73** | $290.83 | #VALUE! | **#VALUE!** | |
| MLR | 97.45% | 97.0% | **(42) bps** | 97.1% | 97.0% | **(6) bps** | |
| Admin Ratio | 2.0% | 2.3% | **38 bps** | 2.0% | 2.5% | **57 bps** | |
| FTEs | 38 | 34 | **(4)** | 204 | 219 | **15** | |
| Net Income PMPM | $2.93 | $2.64 | **$0.28** | $3.64 | #VALUE! | **#VALUE!** | |
| Net Income % | 0.9% | 1.0% | **(8) bps** | 1.2% | 0.7% | **51 bps** | |

# Imperial County Local Health Authority
# DBA Community Health Plan of Imperial Valley
# Product P&L
# For August 2025

| | August | | | | | | | | August (YTD) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Medi-Cal | | | | Medicare | | | | | | | % of Total | |
| | Actual | 6+6F | Variance B/(W) | % Var | Actual | 6+6F | Variance B/(W) | % Var | Medi-Cal | Medicare | Total | Medi-Cal | Medicare |
| **REVENUE** | | | | | | | | | | | | | |
| Premium | $ 27,317,750 | $ 26,337,582 | **$ 980,169** | 4% | $ - | $ - | **$ -** | N/A | $ 219,763,157 | $ - | **$ 219,763,157** | 100% | 0% |
| Pass-Through | $ 4,832,156 | $ 292,241 | **$ 4,539,915** | 1553% | $ - | $ - | **$ -** | N/A | $ 8,082,340 | $ - | **$ 8,082,340** | 100% | 0% |
| **TOTAL REVENUE** | **$ 32,149,906** | **$ 26,629,823** | **$ 5,520,083** | **21%** | **$ -** | **$ -** | **$ -** | **N/A** | **$ 227,845,497** | **$ -** | **$ 227,845,497** | **100%** | **0%** |
| **HEALTH CARE COSTS** | $ 31,330,374 | $ 25,839,695 | **$ (5,490,678)** | -21% | $ - | $ - | **$ -** | N/A | $ 221,252,602 | $ - | **$ 221,252,602** | 100% | 0% |
| **Gross Margin** | **$ 819,533** | **$ 790,127** | **$ 29,405** | **4%** | **$ -** | **$ -** | **$ -** | **N/A** | **$ 6,592,895** | **$ -** | **$ 6,592,895** | **100%** | **0%** |
| **ADMINISTRATIVE EXPENSE** | | | | | | | | | | | | | |
| Healthcare Services | $ 44,134 | $ 46,532 | **$ 2,398** | 5.2% | $ 49,769 | $ 52,473 | **$ 2,704** | 5.2% | $ 448,439 | $ 538,687 | **$ 987,126** | 45.4% | 54.6% |
| Care Management | $ - | $ - | **$ -** | N/A | $ 45,976 | $ 36,157 | **$ (9,819)** | -27.2% | $ - | $ 191,136 | **$ 191,136** | 0.0% | 100.0% |
| Compliance | $ 104,890 | $ 98,219 | **$ (6,672)** | -6.8% | $ 17,075 | $ 15,989 | **$ (1,086)** | -6.8% | $ 541,996 | $ 88,232 | **$ 630,227** | 86.0% | 14.0% |
| Operations | $ 6,859 | $ 4,878 | **$ (1,981)** | -40.6% | $ 61,734 | $ 43,906 | **$ (17,829)** | -40.6% | $ 41,473 | $ 373,259 | **$ 414,733** | 10.0% | 90.0% |
| Member & Provider Services | $ 6,270 | $ 25,507 | **$ 19,237** | 75.4% | $ 6,270 | $ 25,507 | **$ 19,237** | 75.4% | $ 75,550 | $ 75,550 | **$ 151,101** | 50.0% | 50.0% |
| Sales & Marketing | $ 1,753 | $ 1,775 | **$ 22** | 1.2% | $ 33,307 | $ 33,723 | **$ 415** | 1.2% | $ 6,256 | $ 118,873 | **$ 125,129** | 5.0% | 95.0% |
| Executive | $ 49,211 | $ 50,122 | **$ 911** | 1.8% | $ 16,404 | $ 16,427 | **$ 23** | 0.1% | $ 391,728 | $ 130,576 | **$ 522,304** | 75.0% | 25.0% |
| Finance | $ 55,635 | $ 67,412 | **$ 11,778** | 17.5% | $ 18,545 | $ 22,471 | **$ 3,926** | 17.5% | $ 508,403 | $ 300,595 | **$ 808,998** | 62.8% | 37.2% |
| Corporate | $ 61,122 | $ 43,518 | **$ (17,604)** | -40.5% | $ 26,037 | $ 7,448 | **$ (18,589)** | -249.6% | $ 385,834 | $ 84,636 | **$ 470,470** | 82.0% | 18.0% |
| Information Technology | $ 9,512 | $ 13,339 | **$ 3,827** | 28.7% | $ 10,060 | $ 14,164 | **$ 4,104** | 29.0% | $ 76,662 | $ 60,720 | **$ 137,382** | 55.8% | 44.2% |
| Human Resources | $ 4,534 | $ 3,953 | **$ (581)** | -14.7% | $ 4,795 | $ 4,197 | **$ (598)** | -14.2% | $ 42,784 | $ 33,524 | **$ 76,308** | 56.1% | 43.9% |
| **Total Administrative Expense** | **$ 343,921** | **$ 355,256** | **$ 11,334** | **3%** | **$ 289,972** | **$ 272,462** | **$ (17,510)** | **-6%** | **$ 2,519,126** | **$ 1,995,788** | **$ 4,514,914** | **56%** | **44%** |
| **Non-Operating Income** | | | | | | | | | | | | | |
| Dividend & Interest Income | $ 109,496 | $ 105,775 | **$ 3,721** | 4% | $ - | $ - | **$ -** | N/A | $ 849,849 | $ - | **$ 849,849** | 100% | 0% |
| Rental Income | $ 1,494 | $ 1,494 | **$ -** | 0% | $ - | $ - | **$ -** | N/A | $ 11,948 | $ - | **$ 11,948** | 100% | 0% |
| **Total Non-Operating Income** | $ 110,990 | $ 107,269 | **$ 3,721** | 3% | $ - | $ - | **$ -** | N/A | $ 861,797 | $ - | **$ 861,797** | 100% | 0% |
| **Depreciation & Amortization** | $ 5,179 | $ 11,000 | **$ 5,821** | 53% | $ 5,477 | $ - | **$ (5,477)** | N/A | $ 74,727 | $ 10,517 | **$ 85,244** | 88% | 12% |
| **Change in Net Position** | **$ 581,423** | **$ 531,140** | **$ 50,282** | **9%** | **$ (295,449)** | **$ (272,462)** | **$ (22,987)** | **-8%** | **$ 4,860,839** | **$ (2,006,305)** | **$ 2,854,534** | **170%** | **-70%** |
| **Key Metrics** | | | | | | | | | | | | | |
| Enrollment | 97,744 | 97,835 | (91) | | - | - | - | | 783,439 | - | 783,439 | 100% | 0% |
| Revenue PMPM | $328.92 | $272.19 | $56.73 | | N/A | N/A | N/A | | $290.83 | N/A | $290.83 | | |
| MLR | 97.45% | 97.03% | 42 bps | | N/A | N/A | N/A | | 97.11% | N/A | 97.11% | | |
| Admin Ratio | 1.1% | 1.3% | 26 bps | | N/A | N/A | N/A | | 1.1% | N/A | 2.0% | | |
| Net Income PMPM | $5.95 | $5.43 | $0.52 | | N/A | N/A | N/A | | $6.20 | N/A | $3.64 | | |
| Net Income % | 1.8% | 2.0% | -18 bps | | N/A | N/A | N/A | | 2.1% | N/A | 1.2% | | |

# Imperial County Local Health Authority dba
# Community Health Plan of Imperial Valley
# Statement of Net Position

| | July 2025 | August 2025 | Change |
|---|---|---|---|
| **ASSETS** | | | |
| **Current Assets** | | | |
| **Cash and Investments** | | | |
| Chase - Checking | $ 200,000 | $ 200,000 | $ - |
| Chase - Money Market | $ 2,916,239 | $ 2,834,537 | $ (81,701) |
| JPMorgan Securities | $ 15,409,556 | $ 16,044,176 | $ 634,620 |
| First Foundation Bank | $ 306,190 | $ 152,913 | $ (153,277) |
| **Receivables** | | | |
| Dividend Receivable | $ 8,573 | $ 9,227 | $ 654 |
| Interest Receivable | $ 103,246 | $ 100,270 | $ (2,976) |
| Capitation Receivable | $ 27,889,154 | $ 27,317,750 | $ (571,404) |
| Pass-Through Receivable | $ 414,982 | $ 4,832,156 | $ 4,417,173 |
| Pass-Through Receivable - Other | $ 1,144 | $ 0 | $ (1,144) |
| **Other Current Assets** | | | |
| Prepaid Expenses | $ 449,911 | $ 406,404 | $ (43,508) |
| **Total Current Assets** | **$ 47,698,995** | **$ 51,897,433** | **$ 4,198,437** |
| **Noncurrent Assets** | | | |
| **Restricted Deposit** | | | |
| First Foundation Bank - Restricted | $ 300,000 | $ 300,000 | $ - |
| **Capital Assets** | | | |
| Buildings - Net | $ 2,892,041 | $ 2,883,212 | $ (8,829) |
| Computer Equipment / Software - Net | $ 6,555 | $ 6,387 | $ (168) |
| Improvements - Net | $ 43,138 | $ 42,730 | $ (408) |
| Intangible Assets | $ 60,209 | $ 58,959 | $ (1,250) |
| Operating ROU Asset (Copier) - Net | $ 10,134 | $ 10,134 | $ - |
| **Total Noncurrent Assets** | **$ 3,312,077** | **$ 3,301,422** | **$ (10,656)** |
| **Total Assets** | **$ 51,011,073** | **$ 55,198,854** | **$ 4,187,782** |
| **LIABILITIES** | | | |
| **CURRENT LIABILITIES** | | | |
| **Payables** | | | |
| Accounts Payable | $ 364,468 | $ 368,277 | $ 3,809 |
| Capitation Payable | $ 27,052,479 | $ 26,498,218 | $ (554,261) |
| Pass-Through Payable | $ 414,982 | $ 4,832,156 | $ 4,417,173 |
| Pass-Through Payable - Other | $ 1,144 | $ 0 | $ (1,144) |
| Credit Card Payable | $ 28,778 | $ 3,711 | $ (25,066) |
| **Other Current Liabilities** | | | |
| Short Term Lease Liability - Copier | $ 3,500 | $ 3,516 | $ 16 |
| Bonus Accrual | $ 123,325 | $ 140,943 | $ 17,618 |
| Salaries Accrual | $ 170,665 | $ 202,569 | $ 31,904 |
| Vacation Accrual | $ 175,618 | $ 187,678 | $ 12,061 |
| **Total Current Liabilities** | **$ 28,334,960** | **$ 32,237,069** | **$ 3,902,108** |
| **NON-CURRENT LIABILITIES** | | | |
| Long Term Lease Liability - Copier | $ 1,210 | $ 910 | $ (300) |
| **Total Noncurrent Liabilities** | **$ 1,210** | **$ 910** | **$ (300)** |
| **Total Liabilities** | **$ 28,336,170** | **$ 32,237,978** | **$ 3,901,808** |
| **NET POSITION** | | | |
| Restricted by Legislative Authority | $ 300,000 | $ 300,000 | $ - |
| Unrestricted | $ 19,806,342 | $ 19,806,342 | $ - |
| YTD Net Revenue | $ 2,568,560 | $ 2,854,534 | $ 285,974 |
| **Total Net Position** | **$ 22,674,902** | **$ 22,960,876** | **$ 285,974** |
| **Total Liabilities and Net Position** | **$ 51,011,073** | **$ 55,198,854** | **$ 4,187,782** |

**Imperial County Local Health Authority dba**
**Community Health Plan of Imperial Valley**
**Summarized Tangible Net Equity Calculation**
**As of August 2025**

| | | |
|---|---|---|
| | Net Equity | $ 22,960,876 |
| | Add: Subordinated Debt and Accrued Subordinated Interest | $ 0 |
| | Less: Report 1, Column B, Line 27 including: Unsecured Receivables from officers, directors, and affiliates; Intangibles | $ 0 |
| | Tangible Net Equity (TNE) | $ 22,960,876 |
| | Required Tangible Net Equity * | $ 4,796,447 |
| | TNE Excess (Deficiency) | $ 18,164,428 |

| | Full Service Plan | | * Calculated Required Tangible Net Equity | |
|---|---|---|---|---|
| | | 1 | $ 329,644,736 | - Q1 |
| **A.** | Minimum TNE Requirement | $ 1,000,000 | $ 329,644,736 | - Annualized |
| **B.** | REVENUES: | | | |
| | | | $ 150,000,000 | |
| | 2% of the first $150 million of | | x 2% | |
| | annualized premium revenues | $ 3,000,000 | $ 3,000,000 | |
| | (lines 1, 2, 4, 5, 7, 9 from Income Statement) | | | |
| | Plus | | | |
| | | | $ 179,644,736 | |
| | 1% of annualized premium revenues | | x 1% | |
| | in excess of $150 million | $ 1,796,447 | $ 1,796,447 | |
| | Total | $ 4,796,447 | $ 4,796,447 | - Required TNE |

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

| Date | Account | Vendor | Memo/Description | Amount |
|---|---|---|---|---|
| **Chase Checking** | | | | |
| 8/1/2025 | Chase Checking | Great America Financial Services | Inv 39696146-- bill.com Check Number: 79834538 | $ (306.01) |
| 8/6/2025 | Chase Checking | Epstein Becker & Green, P.C. | Multiple inv. (details on stub)-- bill.com Check Number: 79854811 | (6,137.00) |
| 8/6/2025 | Chase Checking | Oracle America, Inc. | Multiple invoices | (13,569.99) |
| 8/6/2025 | Chase Checking | Lee Hindman | Commissioner Stipend - Check Number: 79854530 | (700.00) |
| 8/6/2025 | Chase Checking | Carlos Ramirez | Commissioner Stipend - Check Number: 79852540 | (700.00) |
| 8/6/2025 | Chase Checking | Bushra Ahmad | Commissioner Stipend - Check Number: 79854827 | (300.00) |
| 8/6/2025 | Chase Checking | Pablo Velez | Commissioner Stipend - Check Number: 79854167 | (200.00) |
| 8/6/2025 | Chase Checking | Economic Group Pension Services | Multiple invoices (details on stub)-- bill.com Check Number: 79852498 | (1,108.25) |
| 8/6/2025 | Chase Checking | Bonde & Associates, LLC | Inv 1003 | (9,000.00) |
| 8/6/2025 | Chase Checking | Ryan Kelley | Inv JUNE2025-- bill.com Check Number: 79852631 | (100.00) |
| 8/6/2025 | Chase Checking | Law Office of William S. Smerdon | Inv 2798 | (1,100.00) |
| 8/6/2025 | Chase Checking | Allan Wu | Inv JUNE2025-- bill.com Check Number: 79853757 | (300.00) |
| 8/6/2025 | Chase Checking | Mayra Widmann | Inv JUNE2025-- bill.com Check Number: 79854933 | (100.00) |
| 8/6/2025 | Chase Checking | Republic Services | Inv 0467-001753024 | (146.82) |
| 8/6/2025 | Chase Checking | Employers Preferred Ins. Co. | Inv Invoice 1 PN: EIG 5696223 01-- bill.com Check Number: 79853816 | (468.00) |
| 8/6/2025 | Chase Checking | Imperial Irrigation District | Inv JULY2025-- bill.com Check Number: 79853439 | (2,012.95) |
| 8/6/2025 | Chase Checking | Vic's Air Conditioning & Electrical | Inv 102198-- bill.com Check Number: 79852717 | (522.50) |
| 8/6/2025 | Chase Checking | Imperial Desert Landscape | Inv 25-291-- bill.com Check Number: 79854490 | (250.00) |
| 8/6/2025 | Chase Checking | Quench USA | Inv INV09298742-- bill.com Check Number: 79853926 | (129.30) |
| 8/7/2025 | Chase Checking | Zamosky Communication | Inv 0000044 | (8,000.00) |
| 8/7/2025 | Chase Checking | City of Imperial | Acct 80683 - Inv 1455709-- bill.com Check Number: 79860322 | (215.12) |
| 8/7/2025 | Chase Checking | 360 Business Products | CashFlow 360 Payment - Duplicate | (242.44) |
| 8/7/2025 | Chase Checking | JPMorgan Chase | Dividend Income - July 2025 | 8,572.53 |
| 8/7/2025 | Chase Checking | JPMorgan Chase | Service Charges Investment Sweep - August 2025 | (564.28) |
| 8/7/2025 | Chase Checking | JPMorgan Chase | 08/04/25 - Credit Card Payment | (28,777.71) |
| 8/8/2025 | Chase Checking | Kaz-Bros Design Shop | Inv 12727-- bill.com Check Number: 79869773 | (326.22) |
| 8/8/2025 | Chase Checking | Liebert Cassidy Whitmore | Inv 293408-- bill.com Check Number: 79871785 | (132.00) |
| 8/8/2025 | Chase Checking | Junior's Cafe | Inv 13-18579-- bill.com Check Number: 79872685 | (487.16) |
| 8/8/2025 | Chase Checking | Shannon Long | Inv 17 | (6,000.00) |
| 8/8/2025 | Chase Checking | Wakely consulting Group | Inv 211734 - 0000008-- bill.com Check Number: 79871729 | (8,820.00) |
| 8/14/2025 | Chase Checking | Manifest MedEx | Inv INV-3253 | (24,578.75) |
| 8/14/2025 | Chase Checking | Pillsbury Winthrop Shaw Pittman LLP | Inv 8667306-- bill.com Check Number: 79897987 | (1,837.00) |
| 8/14/2025 | Chase Checking | Brawley Rotary Club | Inv July Statement-- bill.com Check Number: 79897221 | (185.00) |
| 8/14/2025 | Chase Checking | America's Finest Fire Pro | Inv 26M 927253-- bill.com Check Number: 79898363 | (860.30) |
| 8/14/2025 | Chase Checking | Brawley Rotary Club | Credit Return - Brawley Rotary Club | 175.00 |
| 8/14/2025 | Chase Checking | Department of Health Care Services | 8/14/25 - Receipt - DHCS (July 2025 Revenue) | 27,346,548.45 |
| 8/14/2025 | Chase Checking | Department of Health Care Services | 8/14/25 - Receipt - DHCS (July 2025 Revenue) | 870,253.24 |
| 8/14/2025 | Chase Checking | Department of Health Care Services | 8/14/25 - Receipt - DHCS (July 2025 Revenue) | 59,405.44 |
| 8/14/2025 | Chase Checking | Department of Health Care Services | 8/14/25 - Receipt - DHCS (July 2025 Revenue) | 26,340.84 |
| 8/14/2025 | Chase Checking | Department of Health Care Services | 8/14/25 - Receipt - DHCS (July 2025 Revenue) | 1,588.42 |
| 8/14/2025 | Chase Checking | Department of Health Care Services | 8/14/25 - Receipt - DHCS (July 2025 Revenue) | 1,144.22 |
| 8/14/2025 | Chase Checking | Mid Atlantic Trust Company | Mid Atlantic | (8,513.85) |
| 8/14/2025 | Chase Checking | JPMorgan Chase | 8/14/25 - Interbank Transfer: Portfolio Funding | (28,000,000.00) |
| 8/19/2025 | Chase Checking | Health Management Associates, Inc. | Inv 206100 - 0000026 | (1,712.50) |
| 8/19/2025 | Chase Checking | Sparkling Clean | Inv AUGUST2025 | (900.00) |
| 8/20/2025 | Chase Checking | Kaz-Bros Design Shop | Multiple invoices (details on stub)-- bill.com Check Number: 79924782 | (367.45) |
| 8/20/2025 | Chase Checking | I.V. Termite & Pest Control | Inv 0354308-- bill.com Check Number: 79924377 | (120.00) |
| 8/20/2025 | Chase Checking | Total Carpet Care | Inv 962 | (1,509.90) |
| 8/21/2025 | Chase Checking | AM Copiers Inc. | Inv IN8024 | (480.38) |
| 8/21/2025 | Chase Checking | JPMorgan Chase | Account Analysis Settlement Charge | (8.18) |
| 8/21/2025 | Chase Checking | State Compensation Insurance Fund | Workers Compensation Payment | (1,424.41) |
| 8/21/2025 | Chase Checking | JPMorgan Chase | Chase Credit Card Payment | (14,208.88) |
| 8/21/2025 | Chase Checking | Health Net | Rental Income - June 2025 | 1,493.50 |
| 8/22/2025 | Chase Checking | Inerglo Creative | Inv INV-00628 | (3,000.00) |
| 8/25/2025 | Chase Checking | Great America Financial Services | Inv 39925060-- bill.com Check Number: 79948919 | (306.01) |
| 8/25/2025 | Chase Checking | ECG Management Consultants | Inv 4211.001 - 73826-- bill.com Check Number: 79948111 | (4,599.00) |
| 8/25/2025 | Chase Checking | Imperial Irrigation District | Inv 8011741107 | (331.27) |
| 8/25/2025 | Chase Checking | Vic's Air Conditioning & Electrical | Inv 102407-- bill.com Check Number: 79947678 | (285.00) |
| 8/25/2025 | Chase Checking | Rick's Roadrunner Lock & Safe | Inv 23664-- bill.com Check Number: 79947535 | (94.71) |
| 8/25/2025 | Chase Checking | Imperial Painters, Inc. | Inv 25-064-- bill.com Check Number: 79948325 | (18,950.00) |
| 8/25/2025 | Chase Checking | Imperial County Treasurer-Tax Collect | Inv Property Tax 2025-- bill.com Check Number: 79949155 | (982.57) |
| 8/26/2025 | Chase Checking | Imperial Irrigation District | Void Of Bill Payment #P25082301 - 1513999 | 331.27 |
| 8/29/2025 | Chase Checking | Stericycle, Inc. | Inv 8011741107-- bill.com Check Number: 79976034 | (331.27) |
| 8/29/2025 | Chase Checking | Smartsheet, Inc. | Inv NV2495507 | (5,200.00) |
| 8/31/2025 | Chase Checking | JPMorgan Chase | Chase Credit Card Payment | (6,634.99) |
| 8/31/2025 | Chase Checking | Mid Atlantic Trust Company | Payroll Date: 08/22/25 Retirement Contribution | (9,417.12) |

| First Foundation Bank | | | | |
|---|---|---|---|---|
| 8/8/2025 | FFB Payroll | Rippling | Employee net pay for check date 08/08/2025 | (103,414.00) |
| 8/8/2025 | FFB Payroll | Rippling | Payroll taxes paid via Rippling for check date 08/08/2025 | (53,420.83) |
| 8/15/2025 | FFB Payroll | Blue Shield of California | Blue Shield Insurance | (22,353.83) |
| 8/15/2025 | FFB Payroll | Rippling | Employee Reimbursement - L. Lewis | (105.83) |
| 8/15/2025 | FFB Payroll | Rippling | People Center Bill | (298.00) |
| 8/15/2025 | FFB Payroll | Rippling | People Center Check | (58.22) |
| 8/15/2025 | FFB Payroll | Rippling | Employee Reimbursement - D. O'Campo & E. Montejano | (147.73) |
| 8/15/2025 | FFB Payroll | Rippling | Employee Reimbursement - D. Wilson & E. Montejano | (1,350.27) |
| 8/15/2025 | FFB Payroll | First Foundation Bank | Wire Fee | (10.00) |
| 8/15/2025 | FFB Payroll | UNUM | UNUM Invoice 08/01/25 - 08/31/25 | (685.95) |
| 8/22/2025 | FFB Payroll | Rippling | Employee net pay for check date 08/22/2025 | (112,158.42) |
| 8/22/2025 | FFB Payroll | Rippling | Payroll taxes paid via Rippling for check date 08/22/2025 | (54,942.80) |
| 8/31/2025 | FFB Payroll | Rippling | Employee Reimbursement - D. Wilson | (402.85) |
| 8/31/2025 | FFB Payroll | Rippling | Employee Reimbursement - J. Hutchins | (1,130.91) |
| 8/31/2025 | FFB Payroll | Rippling | Employee Reimbursement - C. Hardy & J. Garcia | (623.02) |
| 8/31/2025 | FFB Payroll | Rippling | Employee Reimbursement - E. Tarabola & S. Long | (153.86) |
| 8/31/2025 | FFB Payroll | Rippling | Employee Reimbursement - S. Long | (1,445.75) |
| 8/31/2025 | FFB Payroll | Rippling | Employee Reimbursement - S. Long | (39.99) |
| 8/31/2025 | FFB Payroll | Rippling | Employee Reimbursement - L. Lewis | (162.10) |
| 8/31/2025 | FFB Payroll | Rippling | Employee Reimbursement - C. hardy & J. Garcia | (373.02) |

| J.P. Morgan Securities | | | | |
|---|---|---|---|---|
| 8/31/2025 | Chase Bond Portfolio | Health Net | May Health Net Payment | (27,468,605.99) |
| 8/31/2025 | Chase Bond Portfolio | JPMorgan Chase | Accrued Investment Income - July 2025 | 103,245.78 |
| 8/31/2025 | Chase Bond Portfolio | JPMorgan Chase | Bank Fee - July 2025 (Portfolio) | $ (20.00) |

# Community Health Plan of Imperial Valley

## 2025 Audit Planning

## Discussion with Management and the Audit Committee

# Agenda

1. Your Service Team
2. Scope of Services
3. Auditor's Responsibility in a Financial Statement Audit
4. Significant Risks Identified
5. Risks Discussion
6. Consideration of Fraud in a Financial Statement Audit
7. Audit Timeline
8. Audit Deliverables
9. Expectations
10. Recent Accounting Developments
11. Executive Health Care Conference
12. Executive Session

# Your Service Team

Stelian Damu
*Regional Industry Group Leader*

Stelian.Damu@bakertilly.com
(310) 295-3380

Kyle Rogers
*Engagement Reviewer*

Kyle.Rogers@bakertilly.com
(858) 627-1449

Rianne Suico
*Concurring Reviewer*

Rianne.Suico@bakertilly.com
(415) 677-8202

## Other team members:

**Nick Scott,** *Assurance Manager*
**Renee Navarro,** *Assurance Senior*
**Javier Zamora,** *Assurance Staff*
**Nicole Martin,** *Assurance Staff*

# Scope of Services

Relationships between Baker Tilly and Community Health Plan of Imperial Valley:

## Annual Audit

- Annual financial statement audit of Community Health Plan of Imperial Valley for the year ended December 31, 2025.

## Non-Attest Services

- Assist in drafting the financial statements and related footnotes as of and for the year ended December 31, 2025.

# Auditor's Responsibilities in a Financial Statement Audit

Auditor is responsible for:

- Forming and expressing an opinion on whether the financial statements are prepared, in all material respects, in conformity with U.S. generally accepted accounting principles;
- Performing an audit in accordance with generally accepted auditing standards issued by the American Institute of Certified Public Accountants;
- Communicating significant matters, as defined by professional standards, arising during the audit that are relevant to you; and
- When applicable, communicating particular matters required by law or regulation, by agreement with you, or by other requirements applicable to the engagement.

The audit of the financial statements doesn't relieve management or you of your responsibilities.

The auditor is not responsible for designing procedures for the purpose of identifying other matters to communicate to you.



# Significant Risks Identified

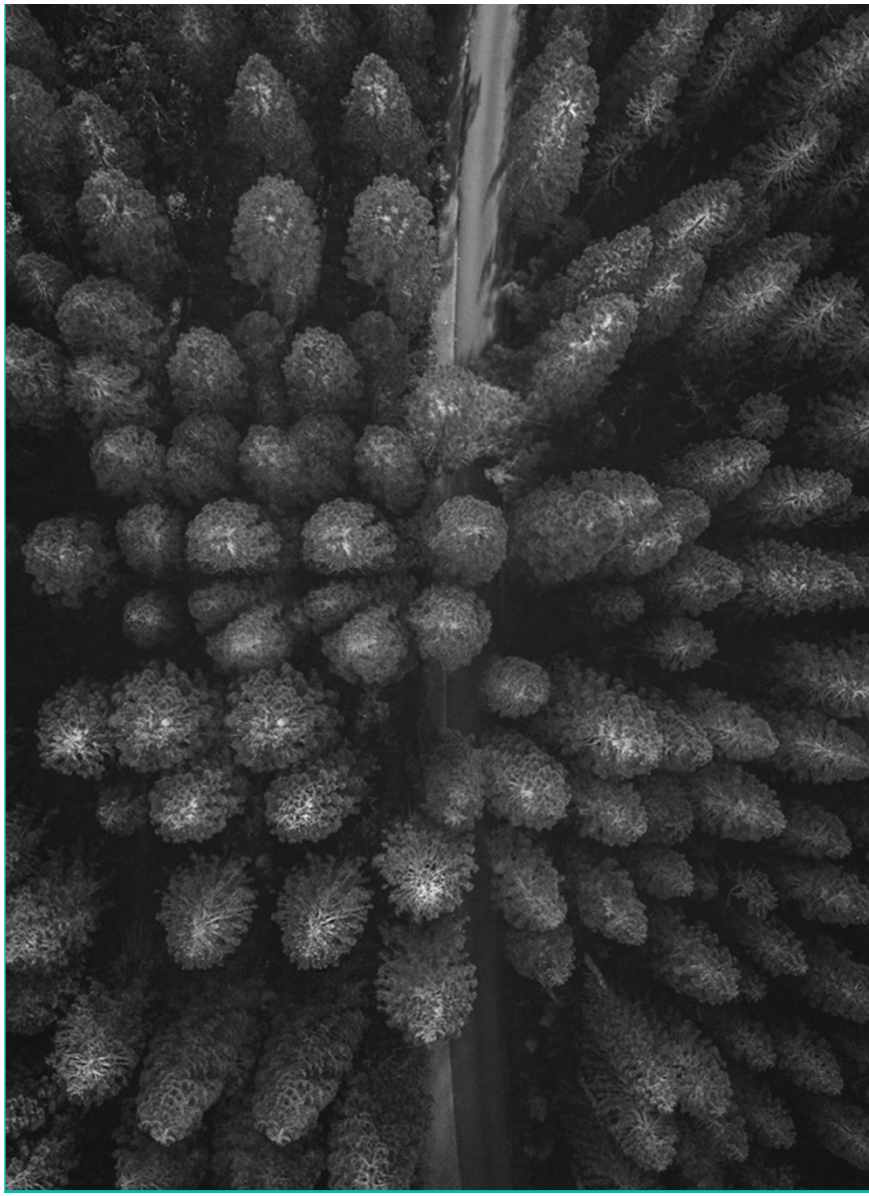
During the planning of the audit, we have identified the following significant risks:

| Significant Risks | Procedures |
|---|---|
| **Management Override of Controls** | During journal entry testing, we will test the workflow of the users entering and posting journal entries to verify that manual adjustments are reviewed and approved. Additionally, we will perform required fraud inquiries with various levels of management and those charged with governance (TCWG). |
| **Capitation Revenue** | We will perform test of details of capitation revenue by comparing YTD capitation revenue recorded to cash receipts and investigating significant differences. |



# Risks Discussion

1. What are your views regarding:
   - Community Health Plan of Imperial Valley's objectives, strategies, and business risks that may result in material misstatements
   - Significant communications between the entity and regulators
   - Attitudes, awareness, and actions concerning:
     - Community Health Plan of Imperial Valley's internal control and importance
     - How those charged with governance oversee the effectiveness of internal control
     - Detection or the possibility of fraud
     - Other matters relevant to the audit
2. Do you have any areas of concern?



# Consideration of Fraud in a Financial Statement Audit

Auditor's responsibility: Obtain reasonable assurance the financial statements as a whole are free from material misstatement – whether caused by fraud or error

| To identify fraud-related risks of material misstatement, we: |
| --- |
| • Brainstorm with team<br>• Conduct personnel interviews<br>• Document understanding of internal control<br>• Consider unusual or unexpected relationships identified in planning and performing the audit |

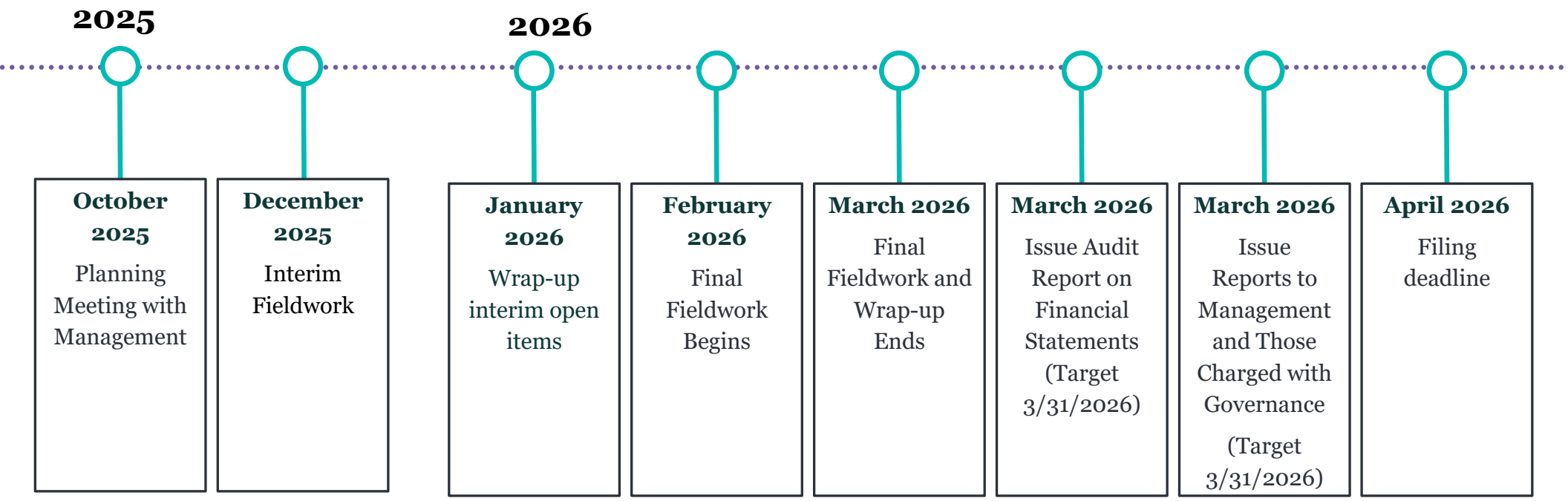
| Procedures we perform: |
| --- |
| • Examine general journal entries for nonstandard transactions<br>• Evaluate policies and accounting for revenue recognition<br>• Test and analyze significant accounting estimates for biases<br>• Evaluate rationale for significant unusual transactions |

# Prior Year Report to Management

During the prior year audit we noted the following material weaknesses:

| | |
|---|---|
| **Financial Close and Reporting** | Lack of timely reconciliations on various major accounts. |
| **Formal documentation of policies, procedures, and accounting conclusions** | Lack formal documentation of various policies and procedures for the full year-ended December 31, 2024. |
| **QuickBooks** | Quickbook users are able to re-open and adjust previous accounting periods; the software does not maintain robust documentation trails (for management review); and there is a lack of segregation of duties. |
| **Segregation of duties** | Employees with access to cash receipts and disbursement areas of the general ledger should not have the authority to sign checks or have access to the check stock. Implement controls to review and approve posted journal entries. |

# Audit Timeline

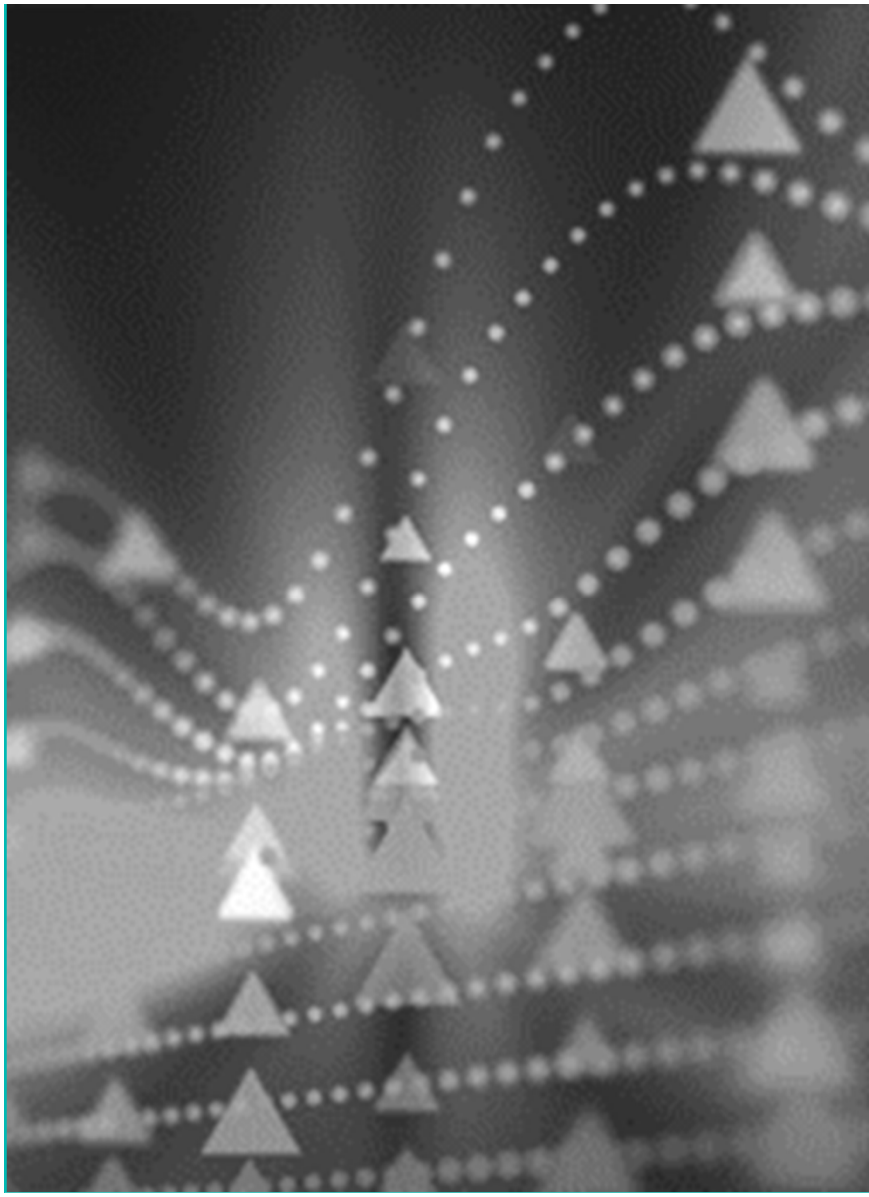


# Audit Deliverables

**Report of Independent Auditors**
on financial statements for Community Health Plan of Imperial Valley for the year ended December 31, 2024

**Report to Management**
(communicating internal control related matters identified in an audit)

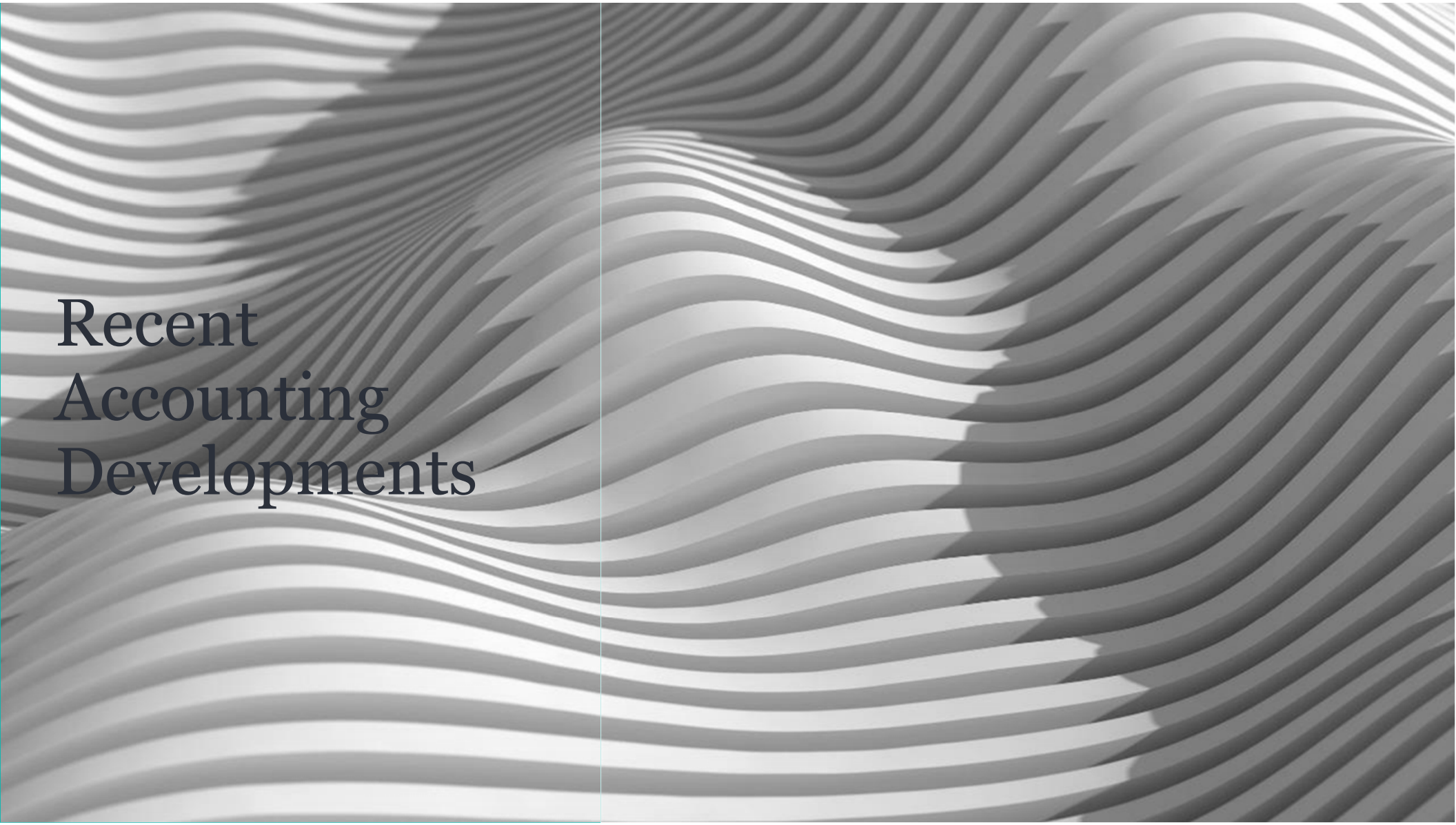
**Report to Those Charged With Governance**
(communicating required matters and other matters of interest)



# Expectations

| CHPIV will: |
| --- |
| • Have no adjusting journal entries after beginning of field work.<br>• Close books and records before beginning of field work.<br>• Provide auditor requested information in request portal one week prior to the beginning of fieldwork. |

| Baker Tilly will: |
| --- |
| • Communicate proposed adjustments with management when identified.<br>• Communicate control deficiencies with management when identified.<br>• Discuss any additional fees over the estimate in engagement letter with management. |



# Recent Accounting Developments

# Accounting Standards Update – GASB

| Statement | Title | Effective |
|---|---|---|
| No. 102 | *Certain Risk Disclosures* - The objective of this Statement is to provide users of government financial statements with essential information about risks related to a government's vulnerabilities due to certain concentrations or constraints.<br><br>This Statement defines a concentration as a lack of diversity related to an aspect of a significant inflow of resources or outflow of resources. A constraint is a limitation imposed on a government by an external party or by formal action of the government's highest level of decision-making authority. | Fiscal years beginning after June 15, 2024 (Effective for FY25). |
| No. 103 | *Financial Reporting Model Improvements* – The objective of this Statement is to improve key components of the financial reporting model to enhance its effectiveness in providing information that is essential for decision making and assessing a government's accountability. This Statement also addresses certain application issues. | Fiscal years beginning after June 15, 2025 (Effective for FY26). |
| No. 104 | *Disclosure of Certain Capital Assets* – State and local governments are required to provide detailed information about capital assets in notes to financial statements. Statement No. 34, Basic Financial Statements—and Management's Discussion and Analysis—for State and Local Governments, requires certain information regarding capital assets to be presented by major class. | Fiscal years beginning after June 15, 2025 (Effective for FY26). |

# Insights and Resources

In today's fast-paced world, we know how precious your time is. We also know that knowledge is key. These resources offer what you need to know, when you need to know it, and are presented in the format that fits your life.

We'll keep you informed to help you stay abreast of critical industry issues.

Baker Tilly closely monitors regulatory agencies, participates in industry and technical forums, and writes about a wide range of relevant accounting, tax, and business issues to keep you informed.

We also offer CPE webinars and events, which are archived and available on demand, allowing you to watch them on your schedule.



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# 2025 Executive Health Care Conference

30th Anniversary Event – November 12-14, 2025

bakertilly

# 2025 Executive Health Care Conference

Join C-suite professionals from across the health care ecosystem to discuss the state of the industry and prepare leaders for 2026.

**HIGHLIGHTS**

Nov 12: Women's Executive Healthcare Leadership Forum

Nov 13: State of the Union Political Point-Counterpoints Reception with Keynotes

Nov 14: Economic Forecast

**November 12-14, 2025**

**Red Rock Casino Resort & Spa**
**Las Vegas, NV**

**REGRISTRATION OPENS APRIL 2025**

# What 2024 attendees said:

> *Caliber of presenters phenomenal.*

> *The whole conference for a board member was interesting. I wish it were something I had done early on.*

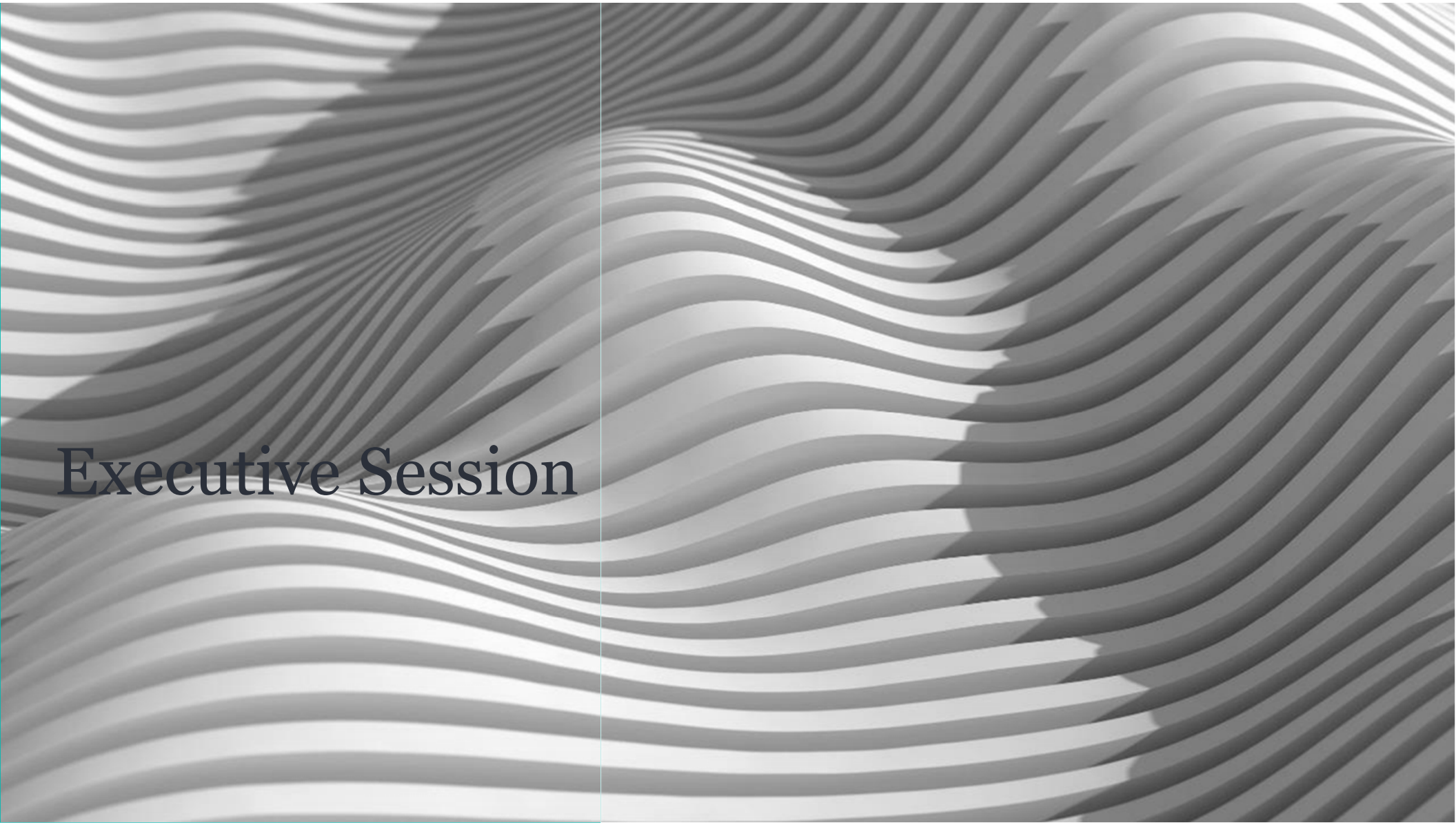
> *Hearing from experts who have intimate knowledge on what the payer landscape looks like, their challenges and goals, helps us help our physicians.*

> *Great speakers and very engaging discussion topics.*

> *Extremely beneficial to blend in the political perspective to the session and how it may impact the industry and our work overall.*

> *It was great to get a broader perspective of the healthcare ecosystem beyond my region.*

> *Attending the Women's Executive Leadership Forum prior to the conference was most valuable. The industry, economic, and political presentations/panels were the most intriguing and engaging.*


Executive Session

# THANK YOU

# Action Items

COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

**Fact Sheet**

**Annual Financial Audit – Baker Tilly, LLP**

**October 13, 2025**

## Recommendations

Motion to approve the SOW for annual financial audit performed by Baker Tilly, formerly Moss Adams, not to exceed **$87,000**.

## Background

As required by regulatory agencies, CHPIV is required to conduct an audit of its financial statements no less than once per year. Baker Tilly was utilized for the 2023 and 2024 audits and performed satisfactorily. As a result, we seek to re-engage Baker Tilly for the 2025 audit.

## Scope

Baker will perform an audit of CHPIV's Net Position, as of December 31, 2025, related revenue and expenses, Change in Net Position, Statement of Cash Flows, and related notes. Baker will not issue an opinion on whether CHPIV's management discussions and analysis (presented as supplementary information) is fairly stated.

In addition to the audit, Baker will assist CHPIV in drafting the final year-end financial statements and related footnotes for 2025. These will be non-attest services.

## Objectives & Auditor Responsibility

The objective of the audit is to obtain reasonable assurances about whether the financial statements, as a whole, are free from material misstatement, whether due to fraud or error, and to issue a report of opinion as to the auditor's findings.

The auditor will have the responsibility of identifying and assessing key risks of material misstatement of the financials, understanding and reporting on internal controls, evaluating the appropriateness of accounting policies, and conclude whether there are conditions or events that could raise substantial doubt about CHPIV's ability to continue as a going concern.

At the conclusion of the audit, Baker Tilly will prepare a written report, addressed to the Commission, detailing the results of their findings.

**Financial Impact**

The fees for this engagement were estimated by Baker Tilly to be $87,000, plus expenses. It is the opinion of CHPIV that this amount is sufficient to complete the work and reflects a fair value given the size of the organization and scope of the engagement

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United States of America

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bakertilly.com

October 9, 2025

David Wilson, Chief Financial Officer
Community Health Plan of Imperial Valley
1224 State Street, Suite B
El Centro, CA 92243

Re: Audit and Nonattest Services

Dear Mr. Wilson:

Thank you for the opportunity to provide services to Community Health Plan of Imperial Valley. This engagement letter ("Engagement Letter") and the attached Professional Services Agreement, which is incorporated by this reference (collectively, the "Agreement"), confirm our acceptance and understanding of the terms and objectives of our engagement, and limitations of the services that Baker Tilly US, LLP ("Firm," "we," "us," and "our") will provide to Community Health Plan of Imperial Valley ("you," "your," and "Company").

## Scope of Services – Audit

You have requested that we audit the Company's financial statements, which comprise the statements of net position as of December 31, 2025, and the related statements of revenue, expenses, and changes in net position, and cash flows for the year then ended, and the related notes to the financial statements. We have not been engaged to report on whether the management's discussion and analysis, presented as supplementary information, is fairly stated, in all material respects, in relation to the financial statements as a whole.

## Scope of Services and Limitations – Nonattest

We will provide the Company with the following nonattest services:

1) Assist you in drafting the financial statements and related footnotes as of and for the year ended December 31, 2025.

Our professional standards require that we remain independent with respect to our attest clients, including those situations where we also provide nonattest services such as those identified in the preceding paragraphs. As a result, Company management must accept the responsibilities set forth below related to this engagement:

- Assume all management responsibilities.
- Oversee the service by designating an individual, preferably within senior management, who possesses skill, knowledge, and/or experience to oversee our nonattest services. The individual is not required to possess the expertise to perform or reperform the services.
- Evaluate the adequacy and results of the nonattest services performed.

- Accept responsibility for the results of the nonattest services performed.

It is our understanding that you have been designated by the Company to oversee the nonattest services and that in the opinion of the Company you are qualified to oversee our nonattest services as outlined above. If any issues or concerns in this area arise during the course of our engagement, we will discuss them with you prior to continuing with the engagement.

## Timing

Kyle Rogers is responsible for supervising the engagement and authorizing the signing of the report. We expect to begin our audit on approximately February 9, 2026, complete fieldwork on approximately March 13, 2026, and issue our report no later than April 30, 2026. As we reach the conclusion of the audit, we will coordinate with you the date the audited financial statements will be available for issuance. You understand that (1) you will be required to consider subsequent events through the date the financial statements are available for issuance, (2) you will disclose in the notes to the financial statements the date through which subsequent events have been considered, and (3) the subsequent event date disclosed in the footnotes will not be earlier than the date of the management representation letter and the date of the report of independent auditors.

Our scheduling depends on your completion of the year-end closing and adjusting process prior to our arrival to begin the fieldwork. We may experience delays in completing our services due to your staff's unavailability or delays in your closing and adjusting process. You understand our fees are subject to adjustment if we experience these delays in completing our services.

## Fees

We estimate that our fees for the services will be the following:

| Description | Amount |
|---|---|
| Financial Statement Audit | $84,000 |
| Netsuite Implementation Testing | 3,000 |
| **Total** | **$ 87,000** |

You will also be billed for expenses.

In addition to fees, we will charge you for expenses. Our invoices include a flat expense charge, calculated as five percent (5%) of fees, to cover expenses such as copying costs, postage, administrative billable time, report processing fees, filing fees, and technology expenses. Travel expenses and client meals/entertainment expenses will be billed separately and are not included in the 5% charge.

Our ability to provide services in accordance with our estimated fees depends on the quality, timeliness, and accuracy of the Company's records, and, for example, the number of general ledger adjustments required as a result of our work. To assist you in this process, we will provide you with a Client Audit Preparation Schedule that identifies the key work you will need to perform in preparation for the audit. We will also need your accounting staff to be readily available during the engagement to respond in a timely manner to our requests. Lack of preparation, poor records, general ledger adjustments, and/or untimely assistance will result in an increase of our fees.

**Reporting**

We will issue a written report upon completion of our audit of the Company's financial statements. Our report will be addressed to the Board of Commissioners of the Company. We cannot provide assurance that an unmodified opinion will be expressed. Circumstances may arise in which it is necessary for us to modify our opinion, add an emphasis-of-matter or other-matter paragraph(s), or withdraw from the engagement. Our services will be concluded upon delivery to you of our report on your financial statements for the year ended December 31, 2025.

---

We appreciate the opportunity to be of service to you. If you agree with the terms of our engagement as set forth in the Agreement, please sign the enclosed copy of this letter and return it to us with the Professional Services Agreement.

Very truly yours,

Baker Tilly US, LLP

Baker Tilly US, LLP

Enclosures

**Accepted and Agreed:**

This Engagement Letter and the attached Professional Services Agreement set forth the entire understanding of Community Health Plan of Imperial Valley with respect to this engagement and the services to be provided by the Firm:

Signature:_____

Print Name:_____

Title:_____

Date:_____

Client: #888790
v. 06/18/2025

**PROFESSIONAL SERVICES AGREEMENT**
**Audit and Nonattest Services**

This Professional Services Agreement (the "PSA") together with the Engagement Letter, which is hereby incorporated by reference, represents the entire agreement (the "Agreement") relating to services that the Firm will provide to the Company. Any undefined terms in this PSA shall have the same meaning as set forth in the Engagement Letter.

## Objectives of the Audit

The objectives of our audit are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

## The Auditor's Responsibility

We will conduct our audit in accordance with U.S. GAAS. As part of an audit conducted in accordance with U.S. GAAS, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control or to identify deficiencies in the design or operation of internal control. However, we will communicate to you in writing concerning any significant deficiencies or material weaknesses in internal control relevant to the audit of the financial statements that we have identified during the audit.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements, including the disclosure, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation
- Conclude, based on the audit evidence obtained, whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for a reasonable period of time

If our opinion is other than unmodified, we will discuss the reasons with you in advance. If, for any reason, we are unable to complete the audit or are unable to form or have not formed an opinion, we may decline to express an opinion or to issue a report as a result of this engagement.

## Procedures and Limitations

Our procedures may include tests of documentary evidence supporting the transactions recorded in the accounts, tests of the physical existence of inventories, and direct confirmation of certain receivables and certain other assets, liabilities and transaction details by correspondence with selected customers, creditors, and financial institutions. We may also request written representations from your attorneys as part of the engagement, and they may bill you for responding to this inquiry. At the conclusion of our audit, we will require certain written representations from management about the financial statements and related matters. Management's failure to provide representations to our satisfaction will preclude us from issuing our report.

An audit includes examining evidence, on a test basis, supporting the amounts and disclosures in the financial statements. Therefore, our audit will involve judgment about the number of transactions to be examined and the areas to be tested. Material misstatements may include errors, fraudulent financial reporting, misappropriation of assets, or noncompliance with the provisions of laws or regulations that are attributable to the entity or to acts by management or employees acting on behalf of the entity that may have a direct financial statement impact. Because of the inherent limitations of an audit, together with the inherent limitations of internal control, an unavoidable risk exists that some material misstatements and noncompliance may not be detected, even though the audit is properly planned and performed in accordance with U.S. GAAS. An audit is not designed to detect immaterial misstatements or noncompliance with the provisions of laws or regulations that do not have a direct and material effect on the financial statements. However, we will inform you of any material errors, fraudulent financial reporting, misappropriation of assets, and noncompliance with the provisions of laws or regulations that come to our attention, unless clearly inconsequential. Our responsibility as auditors is limited to the period covered by our audit and does not extend to any time period for which we are not engaged as auditors.

We may assist management in the preparation of the Company's financial statements. Regardless of any assistance we may render, all information included in the financial statements remains the representation of management. We may issue a preliminary draft of the financial statements to you for your review. Any preliminary draft financial statements should not be relied upon, reproduced, or otherwise distributed without the written permission of the Firm.

## Management's Responsibility for Financial Statements

As a condition of our engagement, management acknowledges and understands that management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America. We may advise management about appropriate accounting principles and their application and may assist in the preparation of your financial statements, but management remains responsible for the financial statements. Management also acknowledges and understands that management is responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to error or fraud. This responsibility includes the maintenance of adequate records, the selection and application of accounting principles, and the safeguarding of assets. You are responsible for informing us about all known or suspected fraud affecting the Company involving: (a) management, (b) employees who have significant roles in internal control, and (c) others where the fraud could have a material effect on the financial statements. You are responsible for informing us of your knowledge of any allegations of fraud or suspected fraud affecting the Company received in communications from employees, former employees, regulators or others. Management is responsible for adjusting the financial statements to correct material misstatements and for confirming to us in the management representation letter that the effects of any uncorrected misstatements aggregated by us during the current engagement and pertaining to the latest period presented are immaterial, both individually and in the aggregate, to the financial statements as a whole. Management is also responsible for identifying and ensuring that the Company complies with applicable laws and regulations.

Management is responsible for making all financial records and related information available to us and for the accuracy and completeness of that information. Management agrees that as a condition of our engagement, management will provide us with:

- access to all information of which management is aware that is relevant to the preparation and fair presentation of the financial statements, whether obtained from within or outside of the general and subsidiary ledgers (including all information relevant to the preparation and fair presentation of disclosures), such as records, documentation, and other matters;
- additional information that we may request from management for the purpose of the audit; and
- unrestricted access to persons within the Company from whom we determine it necessary to obtain audit evidence.

## Management's Responsibility to Notify Us of Affiliates

Our professional standards require that we remain independent of the Company as well as any "affiliate" of the Company. Professional standards define an affiliate as follows:

- a fund, component unit, fiduciary activity or entity that the Company is required to include or disclose, and is included or disclosed in its basic financial statements, in accordance with generally accepted accounting principles (U.S. GAAP);
- a fund, component unit, fiduciary activity or entity that the Company is required to include or disclosed in its basic financial statements in accordance with U.S. GAAP, which is material to the Company but which the Company has elected to exclude, and for which the Company has more than minimal influence over the entity's accounting or financial reporting process;
- an investment in an investee held by the Company or an affiliate of the Company, where the Company or affiliate controls the investee, excluding equity interests in entities whose sole purpose is to directly enhance the Company's ability to provide government services;
- an investment in an investee held by the Company or an affiliate of the Company, where the Company or affiliate has significant influence over the investee and for which the investment is material to the Company's financial statements, excluding equity interests in entities whose sole purpose is to directly enhance the Company's ability to provide government services

In order to fulfill our mutual responsibility to maintain auditor independence, you agree to notify the Firm of any known affiliate relationships, to the best of your knowledge and belief. Additionally, you agree to inform the Firm of any known services provided or relationships between affiliates of the Company and the Firm or any of its employees or personnel.

### Other Information Included in an Annual Report

When financial or nonfinancial information, other than financial statements and the auditor's report thereon, is included in an entity's annual report, management is responsible for that other information. Management is also responsible for providing the document(s) that comprise the annual report to us as soon as it is available.

Our opinion on the financial statements does not cover the other information, and we do not express an opinion or any form of assurance thereon. Our responsibility is to read the other information and consider whether a material inconsistency exists between the other information and the audited financial statements. If we identify that a material inconsistency or misstatement of the other information exists, we will discuss it with you; if it is not resolved U.S. GAAS requires us to take appropriate action.

### Key Audit Matters

U.S. GAAS does not require the communication of key audit matters in the audit report unless engaged to do so. You have not engaged us to report on key audit matters, and the Agreement does not contemplate the Firm providing any such services. You agree we are under no obligation to communicate key audit matters in the auditor's report.

If you request to engage the Firm to communicate key audit matters in the auditor’s report, before accepting the engagement we would discuss with you the additional fees to provide any such services, and the impact to the timeline for completing the audit.

### Dissemination of Financial Statements

Our report on the financial statements must be associated only with the financial statements that were the subject of our engagement. You may make copies of our report, but only if the entire financial statements (including related footnotes and supplementary information, as appropriate) are reproduced and distributed with our report. You agree not to reproduce or associate our report with any other financial statements, or portions thereof, that are not the subject of this engagement.

### Offering of Securities

This Agreement does not contemplate the Firm providing any services in connection with the offering of securities, whether registered or exempt from registration, and the Firm will charge additional fees to provide any such services. You agree not to incorporate or reference our report in a private placement or other offering of your equity or debt securities without our express written permission. You further agree we are under no obligation to reissue our report or provide written permission for the use of our report at a later date in connection with an offering of securities, the issuance of debt instruments, or for any other circumstance. We will determine, at our sole discretion, whether we will reissue our report or provide written permission for the use of our report only after we have conducted any procedures we deem necessary in the circumstances. You agree to provide us with adequate time to review documents where (a) our report is requested to be reissued, (b) our report is included in the offering document or referred to therein, or (c) reference to our firm is expected to be made. If we decide to reissue our report or provide written permission to the use of our report, you agree that the Firm will be included on each distribution of draft offering materials and we will receive a complete set of final documents. If we decide not to reissue our report or withhold our written permission to use our report, you may be required to engage another firm to audit periods covered by our audit reports, and that firm will likely bill you for its services. While the successor auditor may request access to our engagement documentation for those periods, we are under no obligation to permit such access.

### Changes in Professional or Accounting Standards

To the extent that future federal, state, or professional rule-making activities require modification of our audit approach, procedures, scope of work, etc., we will advise you of such changes and the impact on our fee estimate. If we are unable to agree on the additional fees, if any, that may be required to implement any new accounting and auditing standards that are required to be adopted and applied as part of our engagement, we may terminate this Agreement as provided herein, regardless of the stage of completion.

### Representations of Management

During the course of our engagement, we may request information and explanations from management regarding, among other matters, the Company’s operations, internal control, future plans, specific transactions, and accounting systems and procedures. At the conclusion of our engagement, we will require, as a precondition to the issuance of our report, that management provide us with a written representation letter confirming some or all of the representations made during the engagement. The procedures that we will perform in our engagement will be heavily influenced by the representations that we receive from management. Accordingly, false representations could cause us to expend unnecessary efforts or could cause a material error or fraud to go undetected by our procedures. In view of the foregoing, you agree that we will not be responsible for any misstatements in the Company’s financial statements that we fail to detect as a result of false or misleading representations, whether oral or written, that are made to us by the Company’s management. While we may assist management in the preparation of the representation letter, it is management’s responsibility to carefully review and understand the representations made therein.

In addition, because our failure to detect material misstatements could cause others relying upon our audit report to incur damages, the Company further agrees to indemnify and hold us harmless from any liability and all costs (including legal fees) that we may incur in connection with claims based upon our failure to detect material misstatements in the Company's financial statements resulting in whole or in part from knowingly false or misleading representations made to us by any member of the Company's management.

## Fees and Expenses

The Company acknowledges that the following circumstances will result in an increase of our fees:

- Failure to prepare for the audit as evidenced by accounts and records that have not been subject to normal year-end closing and reconciliation procedures;
- Failure to complete the audit preparation work by the applicable due dates;
- Significant unanticipated transactions, audit issues, or other such circumstances;
- Delays causing scheduling changes or disruption of fieldwork;
- After audit or post fieldwork circumstances requiring revisions to work previously completed or delays in resolution of issues that extend the period of time necessary to complete the audit;
- Issues with the prior audit firm, prior year account balances or report disclosures that impact the current year engagement; and
- An excessive number of audit adjustments.

We will endeavor to advise you in the event these circumstances occur, however we may be unable to determine the impact on the estimated fee until the conclusion of the engagement. We will bill any additional amounts based on the experience of the individuals involved and the amount of work performed.

Billings are due upon presentation and become delinquent if not paid within 30 days of the invoice date. Any past due fee under this Agreement shall bear interest at the highest rate allowed by law on any unpaid balance. In addition to fees, you may be billed for expenses and any applicable sales and gross receipts tax. Direct expenses may be charged based on out-of-pocket expenditures, per diem allotments, and mileage reimbursements, depending on the nature of the expense. Indirect expenses, such as processing time and technology expenses, may be passed through at our estimated cost and may be billed as a flat charge or a percentage of fees. If we elect to suspend our engagement for nonpayment, we may not resume our work until the account is paid in full. If we elect to terminate our services for nonpayment, or as otherwise provided in this Agreement, our engagement will be deemed to have been completed upon written notification of termination, even if we have not completed our work. You will be obligated to compensate us for fees earned for services rendered and to reimburse us for expenses. You acknowledge and agree that in the event we stop work or terminate this Agreement as a result of your failure to pay on a timely basis for services rendered by the Firm as provided in this Agreement, or if we terminate this Agreement for any other reason, we shall not be liable to you for any damages that occur as a result of our ceasing to render services.

## Company Information

All information provided by you or on your behalf ("Company Information") will be accurate and complete. You represent the provision of Company Information to us will not infringe any intellectual property, privacy, proprietary, or other third-party rights. You also represent that you have obtained all necessary consents and have provided all necessary notifications to the extent required by applicable law in connection with the provision of Company Information to us. The Firm will use at least the same degree of care to protect the confidentiality of Company Information as it employs in maintaining in confidence its own confidential information of a similar nature, but in no event less than a reasonable degree of care. The Firm will not disclose Company Information to any third party without your consent, except we may disclose Company Information: (1) as required by law or regulation, or to respond to governmental inquiries, or in accordance with applicable professional standards or rules, or in connection with litigation or arbitration pertaining hereto; (2) to the extent such information (i) is or becomes publicly available other than as the result of a disclosure in breach hereof, (ii) becomes available to the Firm on a nonconfidential basis from a source that the Firm believes is not prohibited from disclosing such information to the Firm, or (iii) is already known by the Firm without any obligation of confidentiality with respect thereto; (3) to contractors providing administrative, infrastructure, and other support services to the Firm and subcontractors providing services in connection with this engagement, in each case, whether located within or outside of the United States, provided that such contractors and subcontractors have agreed to be bound by confidentiality obligations related to Company Information; or (4) as otherwise permitted under this Agreement. This paragraph replaces and supersedes any prior confidentiality or non-disclosure agreements entered into by the Firm or its affiliates with respect to Company Information.

## Data Privacy and Security

To the extent the Services require the Firm to receive personal data or personal information from Company, the Firm may process, and engage subcontractors to assist with processing, any personal data or personal information, as those terms are defined in applicable privacy laws, and such processing shall be in accordance with the requirements of the applicable privacy laws relevant to the processing in providing Services hereunder, including Services performed to meet the business purposes of the Company, such as the Firm's tax, advisory, and other consulting services. Applicable privacy laws may include any local, state, federal or international laws, standards, guidelines, policies or regulations governing the collection, use, disclosure, sharing or other processing of personal data or personal information with which the Firm or its clients must comply. Such privacy laws may include (i) the EU General Data Protection Regulation 2016/679 (GDPR); (ii) the California Consumer Privacy Act of 2018 (CCPA); and/or (iii) other laws regulating marketing communications, requiring security breach notification, imposing minimum security requirements, requiring the secure disposal of records, and other similar requirements applicable to the processing of personal data or personal information. The Firm is acting as a Service Provider/Data Processor, as those terms are defined respectively under the CCPA/GDPR, in relation to Company personal data and personal information. As a Service Provider/Data Processor processing personal data or personal information on behalf of Company, the Firm shall, unless otherwise permitted by applicable privacy law, (a) follow Company instructions; (b) not sell personal data or personal information collected from the Company or share the personal data or personal information for purposes of targeted advertising; (c) process personal data or personal information solely for purposes related to the Company's engagement and not for the Firm's own commercial purposes; and (d) cooperate with and provide reasonable assistance to Company to ensure compliance with applicable privacy laws. Company is responsible for notifying the Firm of any applicable privacy laws the personal data or personal information provided to the Firm is subject to, and Company represents and warrants it has all necessary authority (including any legally required consent from individuals) to transfer such information and authorize the Firm to process such information in connection with the Services described herein. Company further understands the Firm, Baker Tilly Advisory Group, LP and Moss Adams Advisory Group, LP and their affiliated entities (collectively, the "Firm Entities") may co-process Company data as necessary to perform the Services, pursuant to the alternative practice structure in place among the entities, and by executing this Agreement, you hereby consent to the sharing of Company data, Company files, workpapers and work product with such Firm Entities. Baker Tilly Advisory Group, LP maintains custody of client files for the Firm. The Firm Entities are bound by the same confidentiality obligations as the Firm. The Firm is responsible for notifying Company if the Firm becomes aware that it can no longer comply with any applicable privacy law and, upon such notice, shall permit Company to take reasonable and appropriate steps to remediate personal data or personal information processing. Company agrees that the Firm Entities have the right to utilize Company data to improve internal processes and procedures and to generate aggregated/de-identified data from the data provided by Company to be used for the Firm Entities' business purposes and with the outputs owned by the Firm Entities. For clarity, the Firm Entities will only disclose aggregated/de-identified data in a form that does not identify Company, Company employees, or any other individual or business entity and that is stripped of all persistent identifiers. Company is not responsible for the Firm Entities' use of aggregated/de-identified data.

The Firm has established information security related operational requirements that support the achievement of our information security commitments, relevant information security related laws and regulations and other information security related system requirements. Such requirements are documented in the Firm's policies and procedures. Information security policies have been implemented that define our approach to how systems and data are protected. Company is responsible for providing timely written notification to the Firm of any additions, changes or removals of access for Company personnel to the Firm provided systems or applications. If Company becomes aware of any known or suspected information security or privacy related incidents or breaches related to this Agreement, Company should timely notify the Firm via email at dataprotectionofficer@bakertilly.com.

## Subpoena or Other Release of Documents

As a result of our services to you, we may be required or requested to provide information or documents to you or a third-party in connection with governmental regulations or activities, or a legal, arbitration or administrative proceeding (including a grand jury investigation), in which we are not a party. You may, within the time permitted for our firm to respond to any request, initiate such legal action as you deem appropriate to protect information from discovery. If you take no action within the time permitted for us to respond or if your action does not result in a judicial order protecting us from supplying requested information, we will construe your inaction or failure as consent to comply with the request. Our efforts in complying with such requests or demands will be deemed a part of this engagement and we shall be entitled to additional compensation for our time and reimbursement for our out-of-pocket expenditures (including legal fees) in complying with such request or demand.

### Document Retention Policy

At the conclusion of this engagement, we will return to you all original records you supplied to us. Your Company records are the primary records for your operations and comprise the backup and support for the results of this engagement. Our records and files, including our engagement documentation whether kept on paper or electronic media, are our property and are not a substitute for your own records. Our firm policy calls for us to destroy our engagement files and all pertinent engagement documentation after a retention period of seven years (or longer, if required by law or regulation), after which time these items will no longer be available. We are under no obligation to notify you regarding the destruction of our records. We reserve the right to modify the retention period without notifying you. Catastrophic events or physical deterioration may result in our firm's records being unavailable before the expiration of the above retention period.

Except as set forth above, you agree that the Firm may destroy paper originals and copies of any documents, including, without limitation, correspondence, agreements, and representation letters, and retain only digital images thereof.

### Use of Electronic Communication

In the interest of facilitating our services to you, we may communicate by facsimile transmission or send electronic mail over the Internet. Such communications may include information that is confidential. We employ measures in the use of electronic communications designed to provide reasonable assurance that data security is maintained. While we will use our best efforts to keep such communications secure in accordance with our obligations under applicable laws and professional standards, you recognize and accept we have no control over the unauthorized interception of these communications once they have been sent. Unless you issue specific instructions to do otherwise, we will assume you consent to our use of electronic communications to your representatives and other use of these electronic devices during the term of this Agreement as we deem appropriate.

### Enforceability

In the event that any portion of this Agreement is deemed invalid or unenforceable, said finding shall not operate to invalidate the remainder of this Agreement.

### Entire Agreement

This Professional Services Agreement and Engagement Letter constitute the entire agreement and understanding between the Firm and the Company. The Company agrees that in entering into this Agreement it is not relying and has not relied upon any oral or other representations, promise or statement made by anyone which is not set forth herein.

In the event the parties fail to enter into a new Agreement for each subsequent calendar year in which the Firm provides services to the Company, the terms and conditions of this PSA shall continue in force until such time as the parties execute a new written agreement or terminate their relationship, whichever occurs first.

### Use of the Firm's Name

The Company may not use any of the Firm's or its affiliates' names, trademarks, service marks or logos in connection with the services contemplated by this Agreement or otherwise without the prior written permission of the Firm, which permission may be withheld for any or no reason and may be subject to certain conditions.

### Use of Nonlicensed Personnel

Certain engagement personnel who are not licensed as certified public accountants may provide services during this engagement.

### Resolution of Disagreements

In the unlikely event that differences concerning services, fees, this Agreement or any services subsequently provided to Company by the Firm should arise ("Dispute(s)") that are not resolved by mutual agreement, both parties agree to attempt in good faith to settle the Dispute by mediation administered by the American Arbitration Association (AAA) under its mediation rules for professional accounting and related services disputes before resorting to litigation or any other dispute-resolution procedure. Each party shall bear their own expenses from mediation, and the parties shall share equally in the mediator's fees and expenses.

If mediation does not settle the Dispute, then the parties agree that the Dispute shall be settled by binding arbitration to be initiated by the party seeking damages or other permitted relief in any form (the "Claimant"). The arbitration proceeding shall take place in the city in which the Firm office providing the services in Dispute is located, unless the parties mutually agree to a different location. The proceeding shall be governed by the provisions of the Federal Arbitration Act (FAA) and will proceed in accordance with the Arbitration Rules for Professional Accounting and Related Disputes of the AAA (the "Rules") as amended and effective February 1, 2015, except that no prehearing discovery shall be permitted unless specifically authorized by the arbitrator. Any issue concerning the extent to which the Dispute is subject to arbitration, or concerning the applicability, interpretation, or enforceability of any of these procedures, shall be governed by the FAA and resolved by the arbitrators. The arbitration will be conducted before a panel of three (3) arbitrators, with experience in accounting and auditing matters or resolving accounting and auditing matters. In the thirty (30) days after the arbitration is initiated, the parties shall attempt to mutually agree on the three (3) arbitrators, including one arbitrator who will serve as chair of the panel, and all of whom may be selected from AAA, JAMS, the Center for Public Resources, or any other internationally or nationally-recognized organization mutually agreed upon by the parties. If the parties cannot agree on a panel of three (3) arbitrators within the thirty (30) day period, the three (3) arbitrators shall be selected according to Rules A-16(a) and (b) of the Rules except that the AAA shall send an identical list of fifteen (15) names to the parties to the arbitration. The arbitrator shall have no authority to award nonmonetary or equitable relief and will not have the right to award punitive damages or statutory awards. Furthermore, in no event shall the arbitrator have power to make an award that would be inconsistent with this Agreement or any amount that could not be made or imposed by a court deciding the matter in the same jurisdiction. The award of the arbitration shall be in writing and shall be accompanied by a well-reasoned opinion. The award issued by the arbitrator may be confirmed in a judgment by any federal or state court of competent jurisdiction. Discovery shall be permitted in arbitration only to the extent, if any, expressly authorized by the arbitrators upon a showing of substantial need. Each party shall be responsible for their own costs associated with the arbitration, except that the costs of the arbitrators shall be equally divided by the parties. Both parties agree and acknowledge that they are each giving up the right to have any Dispute heard in a court of law before a judge and a jury, as well as any appeal. The arbitration proceeding and all information disclosed during the arbitration shall be maintained as confidential, except as may be required for disclosure to professional or regulatory bodies or in a related confidential arbitration. The arbitrators shall apply the limitations period that would be applied by a court deciding the matter in the same jurisdiction, including the contractual limitations set forth in this Agreement, and shall have no power to decide the Dispute in any manner not consistent with such limitations period. The arbitrators shall be empowered to interpret the applicable statutes of limitations subject to the choice of law provision set forth herein.

However, in the event of a receivership or delinquency proceeding commenced against the Company, the mediation or arbitration agreement may operate at the option of the Department of Justice or may be disavowed by the statutory receiver.

## Limitations

IN NO EVENT WILL EITHER PARTY BE LIABLE TO THE OTHER FOR ANY SPECIAL, INDIRECT, INCIDENTAL, OR CONSEQUENTIAL DAMAGES IN CONNECTION WITH OR OTHERWISE ARISING OUT OF THIS AGREEMENT, EVEN IF ADVISED OF THE POSSIBILITY OF SUCH DAMAGES. IN NO EVENT SHALL EITHER PARTY BE LIABLE FOR EXEMPLARY OR PUNITIVE DAMAGES ARISING OUT OF OR RELATED TO THIS AGREEMENT.

THE LIABILITY (INCLUDING ATTORNEY'S FEES AND ALL OTHER COSTS) OF THE FIRM AND ITS PRESENT OR FORMER PARTNERS, PRINCIPALS, AGENTS OR EMPLOYEES RELATED TO ANY CLAIM FOR DAMAGES RELATING TO THE SERVICES PERFORMED UNDER THIS AGREEMENT SHALL NOT EXCEED THE FEES PAID TO THE FIRM FOR THE PORTION OF THE WORK TO WHICH THE CLAIM RELATES, EXCEPT TO THE EXTENT FINALLY DETERMINED TO HAVE RESULTED FROM THE WILLFUL MISCONDUCT OR FRAUDULENT BEHAVIOR OF THE FIRM RELATING TO SUCH SERVICES. THIS LIMITATION OF LIABILITY IS INTENDED TO APPLY TO THE FULL EXTENT ALLOWED BY LAW, REGARDLESS OF THE GROUNDS OR NATURE OF ANY CLAIM ASSERTED, INCLUDING THE NEGLIGENCE OF EITHER PARTY.

EACH PARTY FURTHER AGREES THAT ANY LEGAL PROCEEDINGS ARISING OUT OF OR RELATED TO THIS AGREEMENT MUST BE COMMENCED WITHIN ONE (1) YEAR AFTER THE CAUSE OF ACTION ARISES.

## Termination

This Agreement may be terminated by either party, with or without cause, upon ten (10) days' written notice. In such event, we will stop providing services hereunder except on work, mutually agreed upon in writing, necessary to carry out such termination. In the event of termination: (a) you shall pay us for services provided and expenses incurred through the effective date of termination, (b) we will provide you with all finished reports that we have prepared pursuant to this Agreement, (c) neither party shall be liable to the other for any damages that occur as a result of our ceasing to render services, and (d) we will require any new accounting firm that you may retain to execute access letters satisfactory to the Firm prior to reviewing our files.

### Hiring of Employees
Any offer of employment to members of the audit team prior to issuance of our report may impair our independence, and as a result, may result in our inability to complete the engagement and issue a report.

### Regulatory Access to Documentation
The documents created or incorporated into our documentation for this engagement are the property of the Firm and constitute confidential information. However, we may be requested to make certain engagement related documents available to regulatory agencies pursuant to authority given to them by law or regulation. If requested and in our opinion a response is required by law, access to such engagement related documents will be provided under the supervision of the Firm personnel. Furthermore, upon request, we may provide photocopies of selected engagement related documents to regulatory agencies. The regulatory agencies may intend, or decide, to distribute the photocopies or information contained therein to others, including other government agencies.

### No Legal Advice Provided
The services performed under this Agreement do not include the provision of legal advice and the Firm makes no representations regarding questions of legal interpretation. You should consult with your attorneys with respect to any legal matters or items that require legal interpretation under federal, state or other type of law or regulation.

### Governing Law
This Agreement shall be governed by and construed in accordance with the laws of the state of Illinois, without giving effect to the provisions relating to conflict of laws**.**

### Alternative Practice Structure: Baker Tilly International
Baker Tilly US, LLP and Baker Tilly Advisory Group, LP and its subsidiary entities provide professional services through an alternative practice structure in accordance with the AICPA Code of Professional Conduct and applicable laws, regulations and professional standards. Baker Tilly US, LLP is a licensed independent CPA firm that provides attest services to clients. Baker Tilly Advisory Group, LP and its subsidiary entities provide tax and business advisory services to their clients. Baker Tilly Advisory Group, LP and its subsidiary entities are not licensed CPA firms.

Baker Tilly Advisory Group, LP and its subsidiaries and Baker Tilly US, LLP, trading as Baker Tilly, are independent members of Baker Tilly International. Baker Tilly International Limited is an English company. Baker Tilly International provides no professional services to clients. Each member firm is a separate and independent legal entity and each describes itself as such. Baker Tilly Advisory Group, LP and Baker Tilly US, LLP are not Baker Tilly International's agents and do not have the authority to bind Baker Tilly International or act on Baker Tilly International's behalf. None of Baker Tilly International, Baker Tilly Advisory Group, LP, Baker Tilly US, LLP, nor any of the other member firms of Baker Tilly International has any liability for each other's acts or omissions. The name Baker Tilly and its associated logo is used under license from Baker Tilly International Limited.

**Fact Sheet**

**New Bank Account for DSNP Line of Business**

**October 13, 2025**

## Recommendations

Motion to approve the establishment of a new account with JP Morgan Chase for the management of claims payment and reserves for the DSNP line of business.

Financial impact: None

## Background

CHPIV requires the establishment of a separate bank account for the DSNP product. This account will serve as a funding account for claim liability, and the account CHG will use to debit bi-weekly claims invoices, as authorized by CHPIV.

To establish the account, JP Morgan Chase requires an officer of the company (David Wilson, CFO or Larry Lewis, CEO) attest to the following:

1. I am authorized to sign this document on the Customer's behalf;
2. I am authorized in accordance with applicable law or other authority to establish and administer the Accounts and to take all actions and enter into all agreements described in this Authorization;
3. Government Entity only: Bank has been designated a depository for funds of Customer in the manner required by applicable law; and
4. All statements in this document are correct and consistent with its organizational and governing documents.

**Fact Sheet**

**Credentialing Oversight Subcommittee (COS) Charter**

**October 13, 2025**

## Recommendations

Motion to approve the charter of the Credentialing Oversight Subcommittee (COS) of the Quality Improvement Health Equity and Compliance (QIHEC) Committee for D-SNP Line of Business only

## Background

The D-SNP Credentialing Oversight Subcommittee (COS) is a subcommittee of the Quality, Improvement, Health Equity, and Compliance (QIHEC) Committee, established to provide oversight of credentialing and recredentialing activities specific to the Dual Eligible Special Needs Plan (D-SNP) line of business. The subcommittee is responsible for ensuring that credentialing activities delegated to external entities, such as CHG, meet Medicare Advantage requirements under **42 CFR §422.204**, and adhere to **CMS and NCQA-equivalent credentialing standards**.

## Scope

This subcommittee oversees only the credentialing functions for the D-SNP line of business. It does **not** govern or oversee credentialing activities related to the Medi-Cal line of business. Responsibilities include:

- Oversight of delegated credentialing entities performing D-SNP credentialing.
- Review of credentialing delegation audits and performance for the D-SNP network.
- Ensuring the plan retains ultimate accountability for compliance with CMS requirements.

## Responsibilities

The COS Committee shall have the authority and responsibilities described below.

1. **Delegation Oversight**
    - Review and approve delegation agreements related to D-SNP credentialing.
    - Conduct oversight of delegated entities through:
        - Initial and annual audits.
        - Ongoing performance monitoring.
        - Review of compliance with recredentialing timeframes (at least every 3 years).
    - Validate that all credentialing decisions by the delegate follow NCQA-equivalent standards.

2. **Audit Review**
    - Review results of credentialing audits conducted on the delegate.
    - Approve or recommend corrective action plans where non-compliance is identified.
    - Monitor CAP implementation and resolution timelines.
3. **Policy and Procedure Review**
    - Review and endorse credentialing and recredentialing policies applicable to D-SNP.
    - Confirm policies reflect CMS Medicare Advantage and NCQA standards.
4. **Ongoing Monitoring**
    - Ensure Monthly, review of federal and state exclusion/sanction lists for all D-SNP providers, including not limited to:
        - OIG List of Excluded Individuals/Entities (LEIE)
        - Medicare Opt-Out list
        - System for Award Management (SAM)
        - State Medicaid Suspended and Ineligible Provider List
    - If any exclusion or sanction is identified during these scheduled monthly reviews, the Credentialing Oversight Subcommittee will be alerted. While the subcommittee meets quarterly, it may convene on an ad hoc basis to review and respond to any urgent findings. This ensures timely assessment, appropriate action, and continued compliance with regulatory expectations. All findings and actions will be documented and reported at the next scheduled subcommittee meeting.

5. **Reporting and Escalation**
    - Report high-risk issues, including compliance gaps or delegate performance concerns, to QIHEC and Compliance Leadership.
    - Recommend continuation, suspension, or revocation of delegation authority as appropriate.

**Reporting Structure**

1. The Credentialing Oversight Subcommittee reports directly to the QIHEC Committee.
2. Summary reports must include:
    a. Status of credentialing delegation oversight
    b. Key performance indicators (e.g., timeliness, audit pass rates)
    c. Status of corrective actions, if any
3. Critical compliance issues must be escalated immediately to the Chief Compliance Officer and Medicare Compliance team.

**Attendees:**

The following individuals and departments are regular attendees of the COS. Additional stakeholders may be invited to attend COS meetings as needed.

1. **Voting Committee Members**

    - Committee Chair - Chief Medical Officer (CMO) / Chief Health Equity Officer (CHEO).
    - Director of Delegation Oversight Network
    - Regulatory Compliance
    - Development/Contracting – D-SNP representative
    - Quality Improvement – D-SNP representative

2. **Non-Voting/Advisory Members**:

    - Representative from CHG or other credentialing delegate (as needed)
    - Legal or Compliance Officer (as needed)

**Meeting Frequency & Structure**

The COS will convene quarterly or more frequently as needed based on audit cycles and findings. Meetings are subject to:

- **Quorum**: A simple majority of voting members
- **Documentation**: Meeting minutes must be maintained and submitted to QIHEC for review
- **Attendance**: Active participation required of all voting members.

| **Approval** | |
|---|---|
| First Issued | |
| Approved | |
| Revised | |

# Committee Chair Reports

# Regulatory Compliance & Oversight Committee Report, Qtr 3

## Meeting Date: Sep 22, 2025, 12-1pm

## Agenda Items Reviewed:

- Notices of Noncompliance
  - Health Net: Untimely Submissions
  - Health Net: Undisclosed Sub-delegation
- Regulatory Audits
  - 2025 DMHC Routine Survey
  - 2025 Network Adequacy Validation (NAV) Audit
- Delegation Oversight Audits
  - Pre-Delegation Audits of Community Health Group and IPAs
  - Annual Audit of Health Net
- Department of Healthcare Services (DHCS) and Department of Managed Health Care (DMHC) All Plan Letters
- Fraud and Abuse Q2 Summary
- Privacy Incidents Q2 Summary

## Key Observations:

- CHPIV issued two Notices of Noncompliance to Health Net (June 30 & August 21, 2025) due to (1) repeated delays in regulatory deliverables and (2) failure to disclose sub-delegation of functions, which hindered oversight.
  - Corrective actions required (1) direct subject matter engagement with CHPIV Compliance, revised submission workflows and (2) oversight of additional subdelegated entities.
- DMHC Routine Survey onsite occurred on September 30, 2025 – October 2, 2025, focusing on access and availability, grievances and appeals, utilization management, emergency services, post stabilization, quality assurance, and continuity of care; and CHPIV's oversight of Health Net. CHPIV continues to submit additional documentation to DMHC.

- CHPIV continues to conduct the pre-delegation audits of Community Health Group, Premier Patient Care, Community Care IPA, Imperial County Physicians Group, and Primary Health Care Medical Group.
- Delegation Oversight Annual Audit of Health Net preliminary report will be issued on October 10, 2025.

## Actions Taken:

- Approval of Q2 meeting minutes
- Approval of New and Updated Policies & Procedures

| P&P | Policy Name | Department | Functional Area | Summary of Changes |
|---|---|---|---|---|
| ADM-001 | Community Donations and Support | Executive Services | Administration | Updated to reflect DHCS requirements outlined in APL 25-004 |
| ADM-003 | Community Reinvestments | Executive Services | Administration | New Policy |
| PS-002 | Medicare Transition Process | Health Services | Pharmacy Services | New Policy |
| GA-001 | Grievance Process | Health Services | Grievance & Appeals | Updated to comply with DMHC APL-25-007 |
| CLM-001 | Claims and Provider Dispute Resolution | Operations | Claims, Provider Dispute Resolution | Updated to comply with DMHC APL-25-007 |

| | 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** | 03/25/2025 |
| **Next Annual Review Due** | 03/25/2026 | **Regulator Approval** | NA |

| APPROVALS | | |
|---|---|---|
| **Internal** | | **Regulator** |
| **Name** | Lawrence E. Lewis | ☐ DHCS ☒ NA<br>☐ 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 |
| 03/25/2025 | Annual Review |
| | Update for Community Investments APL 25-004 |
| | |

| | Community Donations and Support | ADM-001 |
|---|---|---|

## 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.

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**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.**~~**E.** 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.**~~**F.** 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:

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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.~~**G.** 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.~~**H.** 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.~~**I.** 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.

**J.** 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.

**K.** 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. Investments qualifying as "Community Reinvestment" under the Department of Health Services APL 25-004. (Exhibit-A)
   a. Included in the "Tri-Annual Community Reinvestment Plan" must be approved by the Commission and DHCS.
   b. Other support in excess of the "Triannual Community Reinvestment Plan and approved by the Commission in serious consideration of the annual budget.
2. The financial PARTICIPATION will be used by the external entity to provide a service that complements, or enhances, one that CHPIV provides; or
   a. There is an identifiable benefit to CHPIV and/or its members.
   b. Financial contributions should be for sustainable operations/services
      i. Requests must be accompanied by a business plan and financial plan

~~K.~~L.

## 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. |

| | Community Donations and Support | ADM-001 |
|---|---|---|

| | |
|---|---|
| **Participation** | Financial, Goods & Services, Staff, or other CHPIV resources provided to an external entity. |

7

| | 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** | 03/25/2025 |
| **Next Annual Review Due** | 03/25/2026 | **Regulator Approval** | NA |

| APPROVALS | | |
|---|---|---|
| **Internal** | | **Regulator** |
| **Name** | Lawrence E. Lewis | ☐ DHCS ☒ NA<br>☐ 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 |
| 03/25/2025 | Annual Review |
| | Update for Community Investments APL 25-004 |
| | |

## 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.** 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.

**F.** 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.

**G.** 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.

**H.** 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.

**I.** 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.

**J.** 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.

**K.** 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. Investments qualifying as "Community Reinvestment" under the Department of Health Services APL 25-004. (Exhibit-A)

a. Included in the "Tri-Annual Community Reinvestment Plan" must be approved by the Commission and DHCS.

b. Other support in excess of the "Triannual Community Reinvestment Plan and approved by the Commission in serious consideration of the annual budget.

2. The financial PARTICIPATION will be used by the external entity to provide a service that complements, or enhances, one that CHPIV provides; or

a. There is an identifiable benefit to CHPIV and/or its members.

b. Financial contributions should be for sustainable operations/services

i. Requests must be accompanied by a business plan and financial plan

**L.**

## 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. |

| | Community Reinvestments | ADM-003 |
|---|---|---|
| | **Department** | Executive Services |
| | **Functional Area** | Administration |
| | **Impacted Delegate** | ☒ Subcontractor ☒ NA |

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

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

## ATTACHMENTS

- None

## AUTHORITIES/REFERENCES

- DHCS All Plan Letter 25-004, "Community Reinvestment Requirements."
- 2024 Managed Care Contract, Exhibit B, §§ 1.1.17 (Community Reinvestment) & 1.1.18 (Quality Achievement Requirement).
- APL 24-018, Medical Loss Ratio reporting requirements for subcontractors (defines "Qualifying Subcontractor")
- APL 23-012, Managed Care Accountability Set enforcement framework that establishes quality tiers.
- 42 CFR § 438.8(e)(3), federal definition of quality-improvement activities excluded from allowable spending.
- DHCS Comprehensive Quality Strategy (state quality improvement roadmap).
- DHCS Population Health Management Policy Guide (community health assessment alignment).

## HISTORY

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

## I. OVERVIEW

**A.** CHPIV shall reinvest a specified portion of its annual net income into locally driven initiatives that improve member health and advance equity beginning with calendar-year **2025** earnings.

**B.** This requirement applies to CHPIV itself and any Qualifying Subcontractor that assumes risk for ≥100,000 members or ≥50 percent of CHPIV's Medi-Cal members in a county.

## II. POLICY

**A.** Funding Obligations
   a. BASE COMMUNITY REINVESTMENT: 5 percent of net income ≤ 7.5 percent of revenues and 7.5 percent of net income > 7.5 percent of revenues each year CHPIV reports positive income.
   b. QUALITY ACHIEVEMENT COMMUNITY REINVESTMENT: an additional 7.5 percent of net income assigned to counties in ENFORCEMENT TIERS 2 or 3, with 100 percent of those dollars invested in the "Cultivating Improved Health" category

**B.** **Permitted use categories:** Cultivating 1) **Neighborhoods** & Built **Environment**, 2) Health-Care **Workforce**, 3) Well-Being for **Priority Populations**, 4) **Local Communities**, and 5) **Improved Health**; each Community Reinvestment activity must fall into at least one category.

**C.** Prohibited expenditures: Medi-Cal covered services, activities defined as quality improvement at 42 CFR 438.8(e)(3), administrative costs, procedural planning costs, and member incentives or grants

**D.** Planning and **engagement**
   a. CHPIV must consult **Community Advisory Committees** and its **Chief Medical & Health Equity Officer**; activities must align with Local Health Jurisdiction (Imperial County Public Health Department) "**Community Health Assessments**" and carry **signed attestations from Public Health and County Behavioral Health Directors.**
   b. CHPIV shall coordinate with other MCPs and may engage broader stakeholders during planning.

**E.** **Community Reinvestment Plan** (CRP)
   a. Initial three-year CRP due early Q3 2027 and every three years thereafter; annual updates each Q3.
   b. Each submission must list activities, dollar allocations, populations served, evaluation metrics, stakeholder input, and required attestations.
   c. DHCS approval is required, and the approved CRP must be posted publicly within 30 days.

**F.** Funding **calculation** & county **allocation**
   a. DHCS uses annual Medical Loss Ratio reports to calculate obligations and notifies CHPIV in Q2 2026 and annually thereafter.
   b. Base dollars: 5 percent distributed equally across counties, 95 percent proportional to Medi-Cal membership; Quality dollars apportioned only to Tier 2/3 counties by membership share.

**G.** **Implementation** timeline

a. Approved activities must start no later than the end of the approval year; funds tied to CY 2025-27 income must be spent by 12/31/2030 unless DHCS authorizes carry-over.

**H.** Reporting and compliance

a. A public Community Reinvestment Report is due Q2 2031 and **every three years** thereafter summarizing spending and outcomes and including CAC letters.

## III. PROCEDURE

**A.** Annual determination of funding obligations

a. DHCS derives CHPIV's Base and Quality Achievement amounts from the prior-year MLR reports and issues a notice in Q2; CHPIV must relay any subcontractor obligations within seven calendar days.

b. Base dollars are allocated 5 % equally across counties and 95 % by Medi-Cal membership, while Quality dollars are apportioned only to Tier 2/3 counties in proportion to membership.

**B.** Planning & community engagement

a. Starting early CY 2026, CHPIV must solicit input from its Community Advisory Committees, Chief Health Equity Officer, Local Health Jurisdictions' Community Health Assessments, County Behavioral Health, and coordinate with other MCPs serving the same county.

**C.** Community Reinvestment Plan (CRP) submission

a. File the initial three-year CRP in early Q3 2027 and every three years thereafter, with annual updates each Q3, using Appendix B templates and including signed Public Health and Behavioral Health attestations.

b. DHCS reviews within ~60 days; CHPIV must post the approved CRP on its website within 30 days.

**D.** Implementation of activities

a. Begin funding approved initiatives no later than December 31 of the approval year, and expend all dollars tied to CY 2025-27 income by 12/31/30 unless DHCS approves a carry-over.

b. Reporting & evaluation – Publish a public Community Reinvestment Report in Q2 2031 and every three years thereafter detailing spending, outcomes, alignment with guiding principles, and including CAC letters; maintain evidence that funds were not used for prohibited costs. 10 12

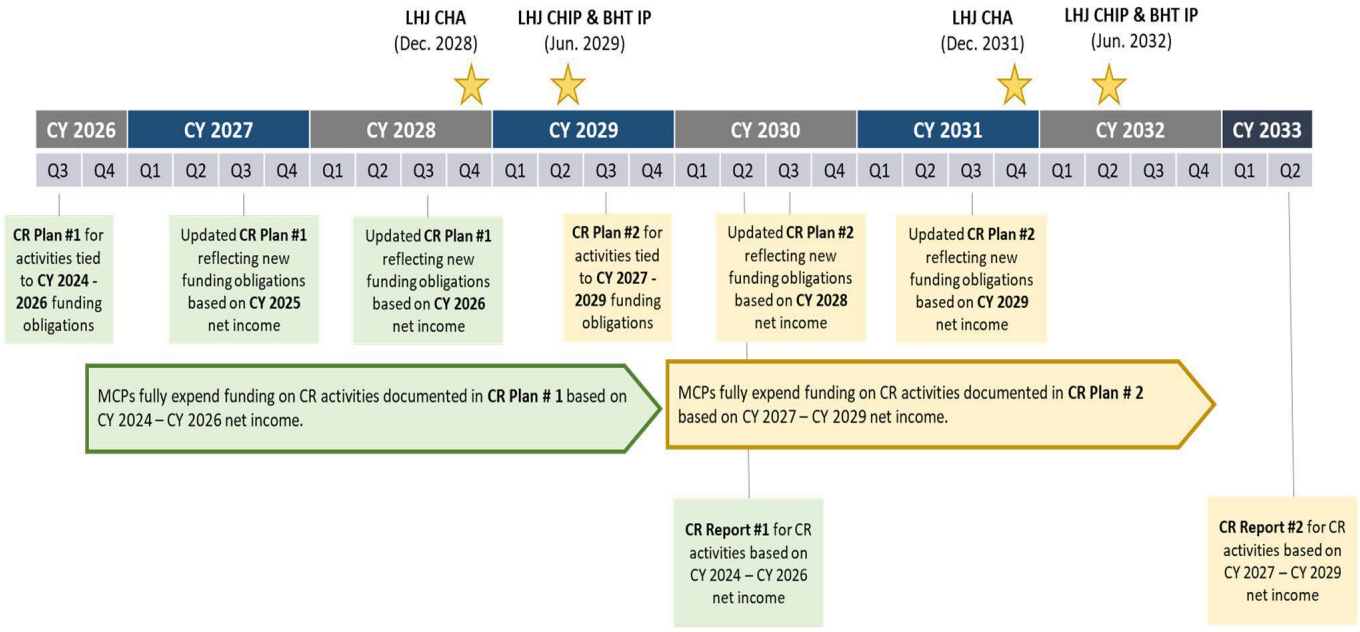
**E.** Non-compliance may trigger corrective action plans or sanctions.

## IV. DEFINITIONS

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

| TERM | DEFINITION |
|---|---|
| **Base Community Reinvestment** | minimum annual funding equal to 5 percent of net income up to 7.5 percent of revenues and 7.5 percent of net income above that threshold |
| **Enforcement Tiers** | county-level quality status—Tier 1 (≥1 measure below MPL), Tier 2 (≥2 below within one domain), Tier 3 (≥3 below in ≥2 domains) |

| TERM | DEFINITION |
|---|---|
| **Quality Achievement Community Reinvestment** | additional 7.5 percent of net income CHPIV must invest in Tier 2 or 3 counties, exclusively in the Cultivating Improved Health category. |



| | Claims and Provider Dispute Resolution | CLM-001 |
|---|---|---|
| **Department** | Operations | |
| **Functional Area** | Claims, Provider Dispute Resolution | |
| **Impacted Delegate** | ☒ Subcontractor ☐ NA | |

| DATES | | | |
|---|---|---|---|
| **Policy Effective Date** | 6/12/2023 | **Reviewed/Revised Date** | 6/30/2025 |
| **Next Annual Review Due** | 6/30/2026 | **Regulator Approval** | 12/15/2023 |

| APPROVALS | | |
|---|---|---|
| **Internal** | | **Regulator** |
| **Name** | Julia Hutchins | ☐ DHCS ☐ NA<br>☒ DMHC |
| **Title** | Chief Operating Officer | |

## ATTACHMENTS

NA

## AUTHORITIES/REFERENCES

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

## HISTORY

| Revision Date | Description of Revision |
|---|---|
| 6/12/2023 | Policy creation |
| 5/13/2024 | Policy revision to include additional Knox Keene provisions |

| | |
|---|---|
| 6/30/2025 | Updates to procedure |
| | Updated to comply with DMHC APL 25-007 |

## I. OVERVIEW

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

## II. POLICY

A. CHPIV ensures payment of all CLEAN CLAIMS submitted by Network Providers in accordance with the Department of Health Care Services (DHCS) Medi-Cal Contract, and federal and state laws and regulations, unless agreed in writing to an alternate payment schedule.

B. CHPIV ensures compliance with 42 USC section 1396u-2(f) and Health and Safety Code sections 1371-1371.36 and their implementing regulations, unless agreed in writing to an alternate payment schedule. CHPIV shall be subject to any penalties and sanctions, including interest payments, provided by law if CHPIV fails to meet the standards specified in the DHCS Medi-Cal Contract.

C. Beginning January 1, 2026, CHPIV and the CHPIV's delegated entities will reimburse a complete claim, or portion of a claim, received on or after January 1, 2026, as soon as practicable, but no later than 30 calendar days after the DATE OF RECEIPT of the claim by CHPIV. For purposes of determining timeliness, the DATE OF RECEIPT shall be the date CHPIV receives the claim, as indicated by CHPIV's date stamp on the claim. The date of CHPIV's payment shall be the date of CHPIV's check or other form of payment.

D. If a claim or portion thereof does not meet the criteria for a complete claim or the criteria for coverage under the plan contract, the claimant shall be notified, in writing, that the claim or portion thereof is contested or denied, as soon as practicable, but no later than 30 calendar days after receipt of the claim by the plan. The notice that a claim or portion thereof is contested will identify the portion of the claim that is contested, by procedure or revenue code, and the specific information needed from the provider to reconsider the claim, including any defect or impropriety or additional information needed to adjudicate the claim. CHPIV may not contest a claim that is consistent with the procedure or revenue codes and services approved by prior authorization with appropriate documentation included on the claim. If a claim or portion thereof is contested on the basis that CHPIV has not received information reasonably necessary to determine payer liability for the claim or portion thereof, reconsideration of the claim must be completed within 30 calendar days after receipt of the additional information.

E. CHPIV will automatically pay interest on complete claims received on or after January 1, 2026, that are not reimbursed within 30 calendar days at a rate of 15 percent per year beginning on the first calendar day after the 30-calendar-day period. Failure to comply with this requirement on a claim will trigger payment by CHPIV to the claimant a fee of the greater of an additional fifteen dollars ($15) or 10 percent (10%) of the accrued interest on the claim.

F. CHPIV maintains procedures for pre-payment and post-payment claims review, including review of any data associated with Providers, MEMBERS, and the Covered Services for which payment is claimed, to ensure the proper and efficient payment of claims.
G. CHPIV ensures sufficient claims processing, tracking, and payment systems capability to comply with applicable State and federal law, regulations, and Contract requirements, to determine the status of received claims and to estimate incurred and unreported claims (IBNR) amounts as specified by 28 CCR sections 1300.77.1 and 1300.77.2.
H. CHPIV ensures development and maintenance of protocols for payment of claims to Out-of-Network Providers, and for communicating and interacting with Out-of-Network Providers regarding services and claims payment.
I. CHPIV ensures clinical protocols and evidence-based practice guidelines governing Prior Authorization, Utilization Management and Retrospective Review are provided to all Out-of-Network Providers providing services to its MEMBERS. Contractor must arrange to provide these protocols and guidelines at the time that Contractor enters into an agreement with an Out-of-Network Provider or anytime an Out-of-Network Provider submits a claim for services provided to Contractor's MEMBERS.
J. CHPIV ensures in accordance with the Health and Safety (H&S) Code section 1367, Contractor must have a fast, fair, and cost-effective dispute resolution process in place for Providers, Network Providers, Subcontractors, and Downstream Subcontractors to submit disputes. CHPIV maintains separate dispute resolution mechanism for contracted and non-contracted provider disputes and separate dispute resolution mechanisms for claims and other types of billing and contract disputes.
K. CHPIV ensures there is a formal procedure to accept, acknowledge, and resolve Provider, Network Provider, Subcontractor, and Downstream Subcontractor disputes. The resolution process must occur in accordance with the timeframes set forth in H&S Code sections 1371 and 1371.35 for both contracted and non-contracted Providers. Any Provider of Medi-Cal services may submit a dispute to Contractor regarding:
    1. The authorization or denial of a service;
    2. The processing of a payment or non-payment of a claim by Contractor; or
    3. The timeliness of the reimbursement on an uncontested CLEAN CLAIM and any interest Contractor is required to pay on claims reimbursement.
L. Contractor's Provider Dispute Resolution process must be set forth in all Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements.
M. Any provider that submits a claim dispute to the plan's capitated provider's dispute resolution mechanism involving an issue of medical necessity or utilization review shall have an unconditional right of appeal for that claim dispute to CHPIV's dispute resolution process for a de novo review and resolution for a period of 60 working days from the capitated provider's DATE OF DETERMINATION.
N. CHPIV assumes the responsibility for the processing and timely reimbursement of provider claims if the claims processing organization or the capitated provider fails to timely and accurately reimburse its claims (including the payment of interest and penalties). CHPIV obligation to assume responsibility for the processing and timely reimbursement of a capitated provider's provider claims may be altered to the extent that the capitated provider has established an approved corrective action plan.

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

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

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

Q. Contractor must submit a Provider Dispute Resolution Report annually to DHCS which includes information on the number of Providers who utilized the dispute resolution mechanism, delineated by Providers, Network Providers, Subcontractors, and Downstream Subcontractors and a summary of the disposition of those disputes, in accordance with H&S Code section 1367(h)(3).

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

## III. PROCEDURE

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

B. CHPIV retains the right to resolve claims payment disputes in the event that Health Net fails to timely and accurately reimburse its claims, including the payment of interest and penalties, or fails to timely resolve provider disputes including the issuance of a written decision.

C. Delegation Oversight

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

## IV. DEFINITIONS

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

| TERM | DEFINITION |
|---|---|
| **Member** | A beneficiary enrolled in a CHPIV program. |
| **Authorized Representative** | Means any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member. |
| **Clean Claim** | Means a claim that can be processed without obtaining additional information from the Provider or from a third party. |
| **Contracted Provider Dispute or Appeal** | A contracted provider's written notice to the Plan and/or its delegate HNCS challenging, appealing or requesting post-service reconsideration of a claim (including a bundled group of substantially similar multiple claims that are individually numbered) that has been denied (including due to being "not medically necessary"), adjusted or contested, or seeking resolution of a billing determination or other contract dispute (or a bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered) or a request for reimbursement of an overpayment of a claim. The dispute must contain, at a minimum, the following information: the provider's name; the provider's identification number; contact information; and<br>• If the appeal concerns a claim or a request for reimbursement of an overpayment of a claim, a clear identification of the disputed item, including the original claim ID or submission ID number, the date of service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect;<br>• If the appeal is not about a claim, a clear explanation of the issue and the provider's position thereon (e.g. not medically necessary denial or contract dispute); and/or<br>• If the appeal involves a member or group of members: the name and identification number(s) of the member or members, a clear explanation of the disputed item, including the date of service, original claim ID or submission ID number, and the provider's position thereon. |
| **Contested Claim** | When the Plan and/or its delegated HNCS has determined that it has not received the Complete Claim and all of the information necessary to determine payer liability for the claim, or has not been granted reasonable access to information concerning practitioner services. Information necessary to determine payer liability for the claim includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for the Plan and/or its |

| TERM | DEFINITION |
|---|---|
| | delegate HNCS to determine the medical necessity for the health care services provided. The notice that a claim, or portion thereof, is contested by the Plan and/or its delegate HNCS will identify the portion of the claim that is contested, by revenue code, and the specific information needed from the provider to reconsider the claim. |
| **Date of Contest/Date of Denial/Date of Notice** | The date of postmark or electronic mark accurately setting forth the date when the contest, denial, or notice was electronically transmitted or deposited in the US Mail or another mail or delivery service, correctly addressed to the claimant's office or other address of record with proper postage. |
| **Date of Determination** | The date of postmark or electronic mark on the written provider dispute determination or amended provider dispute determination that is delivered, by physical or electronic means, to the claimant's office or other address of record. To the extent that a postmark or electronic mark is unavailable to confirm the Date of Determination, the Plan and/or its delegate HNCS will consider the date the check is printed for any monies determined to be due and owing to the provider and the date the check is presented for payment. |
| **Date of Receipt** | The Working Day when the provider dispute or amended provider dispute, by physical or electronic means, is first delivered to the Plan and/or its delegate HNCS' designated Provider Appeals Unit or post office box. |
| **Non-Contracted Provider Dispute or Appeal** | A non-contracted provider's written notice to the Plan and/or its delegate HNCS challenging, appealing or requesting post-service reconsideration of a claim (including a bundled group of substantially similar claims that are individually numbered), which has been denied (including for not being "not medically necessary"), adjusted or contested, or disputing a request for reimbursement of an overpayment of a claim. The dispute must contain, at a minimum, the following information: the provider's name, the provider's identification number, contact information and:<br>• If the dispute concerns a claim or a request for reimbursement of an overpayment of a claim, a clear identification of the disputed item, including the original claim ID or submission ID number, including the date of service, and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, contest, denial, request for reimbursement of an overpayment of a claim or other action is incorrect.<br>• If the dispute is not about a claim, a clear explanation of the issue and the provider's position thereon (e.g. medical necessity); and<br>• If the dispute involves a member or group of members, the name and identification number(s) of the member or members, a clear explanation of the disputed item, including the date of service, original claim ID or submission ID number, and the provider's position thereon. |
| **Overpayment** | Reimbursement of a claim that has been determined to have been |

| TERM | DEFINITION |
|---|---|
| | overpaid. The Plan and/or its delegate HNCS notifies the provider in writing through a separate notice identifying the overpayment and the amount of the overpayment, the provider shall reimburse the Plan and/or its delegate HNCS within 30 working days of receipt by the provider of the notice of overpayment unless the overpayment or portion thereof is contested by the provider in which case the Plan and/or its delegate HNCS shall be notified, in writing, within 30 working days. The provider's notice contesting the validity of an overpayment shall identify the portion of the overpayment that is contested and the specific reasons for contesting the overpayment. |
| **Reasonably Relevant Information** | The minimum amount of itemized, accurate and material information generated by or in the possession of the provider related to the billed services that enables a claims adjudicator with appropriate training, experience, and competence to timely and accurately process claims to determine the nature, cost, if applicable, and extent of the Plan and/or its delegate HNCS' liability, if any, and to comply with any governmental information requirements. |
| **Working Days** | Means Monday through Friday, except for state holidays as identified at the California Department of Human Resources State Holidays page. |

| | Claims and Provider Dispute Resolution | CLM-001 |
|---|---|---|
| **Department** | Operations | |
| **Functional Area** | Claims, Provider Dispute Resolution | |
| **Impacted Delegate** | ☒ Subcontractor ☐ NA | |

| DATES | | | |
|---|---|---|---|
| **Policy Effective Date** | 6/12/2023 | **Reviewed/Revised Date** | 6/30/2025 |
| **Next Annual Review Due** | 6/30/2026 | **Regulator Approval** | 12/15/2023 |

| APPROVALS | | | |
|---|---|---|---|
| **Internal** | | **Regulator** | |
| **Name** | Julia Hutchins | ☐ DHCS ☐ NA<br>☒ DMHC | |
| **Title** | Chief Operating Officer | | |

## ATTACHMENTS

NA

## AUTHORITIES/REFERENCES

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

## HISTORY

| Revision Date | Description of Revision |
|---|---|
| 6/12/2023 | Policy creation |
| 5/13/2024 | Policy revision to include additional Knox Keene provisions |

| | |
|---|---|
| 6/30/2025 | Updates to procedure |
| | Updated to comply with DMHC APL 25-007 |

## I. OVERVIEW

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

## II. POLICY

A. CHPIV ensures payment of all CLEAN CLAIMS submitted by Network Providers in accordance with the Department of Health Care Services (DHCS) Medi-Cal Contract, and federal and state laws and regulations, unless agreed in writing to an alternate payment schedule.

B. CHPIV ensures compliance with 42 USC section 1396u-2(f) and Health and Safety Code sections 1371-1371.36 and their implementing regulations, unless agreed in writing to an alternate payment schedule. CHPIV shall be subject to any penalties and sanctions, including interest payments, provided by law if CHPIV fails to meet the standards specified in the DHCS Medi-Cal Contract.

~~C.~~ Beginning January 1, 2026, CHPIV and the CHPIV's delegated entities will reimburse a complete claim, or portion of a claim, received on or after January 1, 2026, as soon as practicable, but no later than 30 calendar days after the DATE OF RECEIPT of the claim by CHPIV.~~CHPIV ensures payment of 90% of all CLEAN CLAIMS from Providers within 30 calendar days of the DATE OF RECEIPT, and 99% of all CLEAN CLAIMS from Providers' claims, within 90 calendar days of the DATE OF RECEIPT.~~ For purposes of determining timeliness, the DATE OF RECEIPT shall be the date CHPIV receives the claim, as indicated by CHPIV's date stamp on the claim. The date of CHPIV's payment shall be the date of CHPIV's check or other form of payment.

C.

D. If a claim or portion thereof does not meet the criteria for a complete claim or the criteria for coverage under the plan contract, the claimant shall be notified, in writing, that the claim or portion thereof is contested or denied, as soon as practicable, but no later than 30 calendar days after receipt of the claim by the plan. The notice that a claim or portion thereof is contested will identify the portion of the claim that is contested, by procedure or revenue code, and the specific information needed from the provider to reconsider the claim, including any defect or impropriety or additional information needed to adjudicate the claim. CHPIV may not contest a claim that is consistent with the procedure or revenue codes and services approved by prior authorization with appropriate documentation included on the claim. If a claim or portion thereof is contested on the basis that CHPIV has not received information reasonably necessary to determine payer liability for the claim or portion thereof, reconsideration of the claim must be completed within 30 calendar days after receipt of the additional information.

~~D.~~E. CHPIV will automatically pay interest on complete claims received on or after January 1, 2026, that are not reimbursed within 30 calendar days at a rate of 15 percent per year

beginning on the first calendar day after the 30-calendar-day period~~ensures accrued interest at the rate of 15% per annum for non-paid CLEAN CLAIMS beginning with the first calendar day after 45-working-days from the DATE OF RECEIPT~~. Failure to comply with this requirement on a claim will trigger payment by CHPIV to the claimant a fee of the greater of an additional fifteen dollars ($15) or 10 percent (10%) of the accrued interest on the claim.

~~E.~~F. CHPIV maintains procedures for pre-payment and post-payment claims review, including review of any data associated with Providers, MEMBERS, and the Covered Services for which payment is claimed, to ensure the proper and efficient payment of claims.

~~F.~~G. CHPIV ensures sufficient claims processing, tracking, and payment systems capability to comply with applicable State and federal law, regulations, and Contract requirements, to determine the status of received claims and to estimate incurred and unreported claims (IBNR) amounts as specified by 28 CCR sections 1300.77.1 and 1300.77.2.

~~G.~~H. CHPIV ensures development and maintenance of protocols for payment of claims to Out-of-Network Providers, and for communicating and interacting with Out-of-Network Providers regarding services and claims payment.

~~H.~~I. CHPIV ensures clinical protocols and evidence-based practice guidelines governing Prior Authorization, Utilization Management and Retrospective Review are provided to all Out-of-Network Providers providing services to its MEMBERS. Contractor must arrange to provide these protocols and guidelines at the time that Contractor enters into an agreement with an Out-of-Network Provider or anytime an Out-of-Network Provider submits a claim for services provided to Contractor's MEMBERS.

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

~~J.~~K. CHPIV ensures there is a formal procedure to accept, acknowledge, and resolve Provider, Network Provider, Subcontractor, and Downstream Subcontractor disputes. The resolution process must occur in accordance with the timeframes set forth in H&S Code sections 1371 and 1371.35 for both contracted and non-contracted Providers. Any Provider of Medi-Cal services may submit a dispute to Contractor regarding:

1. The authorization or denial of a service;
2. The processing of a payment or non-payment of a claim by Contractor; or
3. The timeliness of the reimbursement on an uncontested CLEAN CLAIM and any interest Contractor is required to pay on claims reimbursement.

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

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

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

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

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

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

~~P.~~Q. Contractor must submit a Provider Dispute Resolution Report annually to DHCS which includes information on the number of Providers who utilized the dispute resolution mechanism, delineated by Providers, Network Providers, Subcontractors, and Downstream Subcontractors and a summary of the disposition of those disputes, in accordance with H&S Code section 1367(h)(3).

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

## III. PROCEDURE

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

B. CHPIV retains the right to resolve claims payment disputes in the event that Health Net fails to timely and accurately reimburse its claims, including the payment of interest and penalties, or fails to timely resolve provider disputes including the issuance of a written decision.

C. Delegation Oversight

1. CHPIV shall provide oversight and continually assess the aforementioned functions, responsibilities, processes, and performance of Health Net. CHPIV ensures Health Net's compliance with regulatory and contractual requirements through the following activities which are detailed in *CHPIV Policy CMP-002: Delegation Oversight Policy and Procedure*:
   a. Ongoing monitoring
   b. Performance reviews

c. Data analysis
d. Utilization of benchmarks, if available
e. Annual desktop and on-site audits

## IV. DEFINITIONS

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

| TERM | DEFINITION |
|---|---|
| **Member** | A beneficiary enrolled in a CHPIV program. |
| **Authorized Representative** | Means any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member. |
| **Clean Claim** | Means a claim that can be processed without obtaining additional information from the Provider or from a third party. |
| **Contracted Provider Dispute or Appeal** | A contracted provider's written notice to the Plan and/or its delegate HNCS challenging, appealing or requesting post-service reconsideration of a claim (including a bundled group of substantially similar multiple claims that are individually numbered) that has been denied (including due to being "not medically necessary"), adjusted or contested, or seeking resolution of a billing determination or other contract dispute (or a bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered) or a request for reimbursement of an overpayment of a claim. The dispute must contain, at a minimum, the following information: the provider's name; the provider's identification number; contact information; and<br>• If the appeal concerns a claim or a request for reimbursement of an overpayment of a claim, a clear identification of the disputed item, including the original claim ID or submission ID number, the date of service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect;<br>• If the appeal is not about a claim, a clear explanation of the issue and the provider's position thereon (e.g. not medically necessary denial or contract dispute); and/or<br>• If the appeal involves a member or group of members: the name and identification number(s) of the member or members, a clear explanation of the disputed item, including the date of service, original claim ID or submission ID number, and the provider's position thereon. |
| **Contested Claim** | When the Plan and/or its delegated HNCS has determined that it has not received the Complete Claim and all of the information necessary to |

| TERM | DEFINITION |
|---|---|
| | determine payer liability for the claim, or has not been granted reasonable access to information concerning practitioner services. Information necessary to determine payer liability for the claim includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for the Plan and/or its delegate HNCS to determine the medical necessity for the health care services provided. The notice that a claim, or portion thereof, is contested by the Plan and/or its delegate HNCS will identify the portion of the claim that is contested, by revenue code, and the specific information needed from the provider to reconsider the claim. |
| **Date of Contest/Date of Denial/Date of Notice** | The date of postmark or electronic mark accurately setting forth the date when the contest, denial, or notice was electronically transmitted or deposited in the US Mail or another mail or delivery service, correctly addressed to the claimant's office or other address of record with proper postage. |
| **Date of Determination** | The date of postmark or electronic mark on the written provider dispute determination or amended provider dispute determination that is delivered, by physical or electronic means, to the claimant's office or other address of record. To the extent that a postmark or electronic mark is unavailable to confirm the Date of Determination, the Plan and/or its delegate HNCS will consider the date the check is printed for any monies determined to be due and owing to the provider and the date the check is presented for payment. |
| **Date of Receipt** | The Working Day when the provider dispute or amended provider dispute, by physical or electronic means, is first delivered to the Plan and/or its delegate HNCS' designated Provider Appeals Unit or post office box. |
| **Non-Contracted Provider Dispute or Appeal** | A non-contracted provider's written notice to the Plan and/or its delegate HNCS challenging, appealing or requesting post-service reconsideration of a claim (including a bundled group of substantially similar claims that are individually numbered), which has been denied (including for not being "not medically necessary"), adjusted or contested, or disputing a request for reimbursement of an overpayment of a claim. The dispute must contain, at a minimum, the following information: the provider's name, the provider's identification number, contact information and:<br>• If the dispute concerns a claim or a request for reimbursement of an overpayment of a claim, a clear identification of the disputed item, including the original claim ID or submission ID number, including the date of service, and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, contest, denial, request for reimbursement of an overpayment of a claim or other action is incorrect.<br>• If the dispute is not about a claim, a clear explanation of the issue and the provider's position thereon (e.g. medical necessity); and |

| TERM | DEFINITION |
|---|---|
| | • If the dispute involves a member or group of members, the name and identification number(s) of the member or members, a clear explanation of the disputed item, including the date of service, original claim ID or submission ID number, and the provider's position thereon. |
| **Overpayment** | Reimbursement of a claim that has been determined to have been overpaid. The Plan and/or its delegate HNCS notifies the provider in writing through a separate notice identifying the overpayment and the amount of the overpayment, the provider shall reimburse the Plan and/or its delegate HNCS within 30 working days of receipt by the provider of the notice of overpayment unless the overpayment or portion thereof is contested by the provider in which case the Plan and/or its delegate HNCS shall be notified, in writing, within 30 working days. The provider's notice contesting the validity of an overpayment shall identify the portion of the overpayment that is contested and the specific reasons for contesting the overpayment. |
| **Reasonably Relevant Information** | The minimum amount of itemized, accurate and material information generated by or in the possession of the provider related to the billed services that enables a claims adjudicator with appropriate training, experience, and competence to timely and accurately process claims to determine the nature, cost, if applicable, and extent of the Plan and/or its delegate HNCS' liability, if any, and to comply with any governmental information requirements. |
| **Working Days** | Means Monday through Friday, except for state holidays as identified at the California Department of Human Resources State Holidays page. |

| | Grievance Process | GA-001 |
|---|---|---|
| **Department** | Health Services | |
| **Functional Area** | Grievances & Appeals | |
| **Impacted Delegate** | ☒ Subcontractor ☐ NA | |

| DATES | | | |
|---|---|---|---|
| **Policy Effective Date** | 6/12/2023 | **Reviewed/Revised Date** | 11/18/2024 |
| **Next Annual Review Due** | 11/19/2025 | **Regulator Approval** | 12/15/2023 |

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

## ATTACHMENTS

N/A

## AUTHORITIES/REFERENCES

- **Internal**
  - CHPIV, Delegation Oversight Policy and Procedure, CMP-002
- **Federal**
  - 42 CFR Sections 438.3, 438.400, 438.402, 438.406, 438.408, 438.410, 438.416, 438.420, 438.424, 18446
- **State**
  - California Health and Safety Code Sections ("H&S Code") 1367.01, 1367.042, 1368, 1368.01, 1368.015, 1368.016, 1368.02, 1368.2, 1370.F2, 1374.31, 1374.34
  - California Welfare and Institutions Code Sections ("W&I Code") 10950
  - Title 22 California Code of Regulations Rules ("CCR") 51014.1, 51014.2, 53858
  - Title 28 CCR Rules 1300.68, 1300.68.01, 1300.74.30
  - DMHC All Plan Letter ("APL") 22-021
  - 2024 DHCS Contract Exhibit A, Attachment III, 4.6 Member Grievance and Appeal System
  - DHCS APLs 21-011, 21-004, 20-022, 20-020, 20-015
- **Accreditation**
  - NCQA: Member Experience (ME) 7, Element A and Elements C-F

## HISTORY

| Revision Date | Description of Revision |
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| | Grievance Process | GA-001 |
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| 6/12/2023 | Policy creation |
| 7/10/2023 | Added the requirements related to expedited grievances |
| 10/01/2024 | Annual review- no changes |
| 11/12/2024 | Updated to align with NCQA standards |
| 11/18/2024 | Updated to align with NCQA standards |
| | Updated to comply with DMHC APL 25-007 |

## I. OVERVIEW

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

## II. POLICY

A. CHPIV ensures establishment and maintenance of a GRIEVANCE Process as outlined below pursuant to which a MEMBER, or a provider or AUTHORIZED REPRESENTATIVE acting on behalf of a MEMBER and with the MEMBER's written consent, may submit a GRIEVANCE for review and RESOLUTION:
   1. CHPIV ensures MEMBERS are allowed to file a GRIEVANCE at any time to express dissatisfaction about any matter other than a notice of ABD:
      a. GRIEVANCES may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the MEMBER's right to dispute an extension of time proposed by the MCP to make an authorization decision.
      b. A COMPLAINT is the same as a GRIEVANCE. If the MCP is unable to distinguish between a GRIEVANCE and an INQUIRY, it must be considered a GRIEVANCE.
      c. An INQUIRY is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other MCP processes.
      d. A COMPLAINT made by an MEMBER to a plan about a delay or denial of a payment of a claim will be treated by the plan as a GRIEVANCE, regardless of whether the MEMBER uses the term "grievance" as part of the COMPLAINT.
   2. CHPIV ensures MEMBERS are allowed to file a GRIEVANCE to contest the unilateral decision to extend the timeframe for RESOLUTION of an APPEAL or expedited APPEAL.
   3. CHPIV ensures every GRIEVANCE involving clinical issues is reported to qualified medical professionals with appropriate clinical expertise and is escalated to the MEDICAL DIRECTOR as needed, to ensure the GRIEVANCE is properly handled.
   4. CHPIV ensures GRIEVANCES are monitored to identify issues that require Corrective Action. GRIEVANCES related to medical Quality of Care issues must be referred to qualified medical professionals with appropriate clinical expertise and is escalated to the MEDICAL DIRECTOR as needed.
   5. CHPIV ensures written acknowledgement is provided within five (5) calendar days of receipt of the GRIEVANCE. The acknowledgement letter must advise the MEMBER that the GRIEVANCE has been received, provide the date of the receipt, and provide

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the name, telephone number, and address of the representative who the MEMBER or their Provider or AUTHORIZED REPRESENTATIVE may contact about the GRIEVANCE.

6. The GRIEVANCES Process shall address the receipt, handling, and disposition of MEMBER GRIEVANCES and APPEALS, in accordance with the Department of Health Care Services (DHCS) Contract and applicable state and federal statutes, regulations and DHCS All Plan Letters.
7. CHPIV will ensure The Plan's GRIEVANCE system is established in writing (approved by the Department of Health Care Services (DHCS) Title 22 CCR Section 53858(a)(1)) and provides for procedures that receive, review and resolve GRIEVANCES as quickly as MEMBER'S health condition requires, not to exceed 30 calendar days of receipt by the plan, or any provider or entity with delegated authority to administer and resolve the plan's GRIEVANCE system [Title 28, CCR1300.68(a), §438.408(b)(1), RR3.A.4]. The Plan's internal GRIEVANCE process includes only one level of review [Title 28, CCR 1300.68(a) (4)(A)].
8. The GRIEVANCE and APPEAL process ensures that MEMBERS s are given a reasonable opportunity to present evidence and testimony, and make legal or factual arguments, in person, by telephone or in writing, in support of their GRIEVANCE or APPEAL. The Plan will inform MEMBERS that they must submit additional evidence for Contractor to consider within the 30-calendar day review timeframe for an APPEAL and within 72 hours timeframe for resolving an expedited APPEAL. In the case of a GRIEVANCE subject to expedited review, MEMBER Services informs the MEMBER of the limited time available to present evidence. Specific to APPEALS, the process provides the MEMBER and his or her representative opportunity, before and during APPEALS process, to examine the MEMBER'S case file, including medical records, and any other documents and records considered during the APPEALS process or within 30 calendar days for an APPEAL and within 72 hours for an expedited APPEAL. [§ 438.406(b)(3), DHCS Contract Exhibit A, Attachment 14, 2H, DHCS Contract Exhibit A, Attachment 14, 4C].
9. Medi-Cal MEMBERS are notified within 7 days of enrollment and annually thereafter about The Plan's GRIEVANCE process, including information on the plan's procedures for filing and resolving an issue, and the toll-free telephone number and address for obtaining forms, requesting information or presenting an issue [Title 28, CCR 1300.68(b)(2), 1300.68(b)(4), Title 22 CCR Section 53858(a)(2)(A)]. Notices additionally include:
    a. A statement that GRIEVANCE forms are available in the office of each primary care provider, or in each MEMBER services department of the plan [Title 22 CCR Section 53858(a)(2)(B)].
    b. A statement that GRIEVANCES may be filed in writing (by mail, facsimile, email, or The Plan's website) or verbally (by telephone) or in person directly at The Plan's local office or with the plan in which the MEMBER is enrolled or at any office or facility of the contracted plan's providers [Title 22 CCR Section 53858(a)(2)(C)].
    c. An explanation of the state's Medi-Cal Managed Care Ombudsman program and the program's voice number [Title 22 CCR Section 53858(a)(2)(F)].

10. CHPIV provides forms for GRIEVANCESs to be given to subscribers and enrollees who wish to register written GRIEVANCES. The forms are approved by the regulator director in advance as to formal [1368(a)(3)] and are available at primary care providers' offices [Title 22 CCR Section 53858(f)].
11. The MEMBER Handbook also informs MEMBERS s of their right to file a GRIEVANCE directly with the Department of Managed Health Care (DMHC), the California Department of Health Care Services (DHCS) Ombudsman Program, and the California Department of Social Services (DSS) Hearing process.
12. CHPIV allows our MEMBERS, or a Provider or AUTHORIZED REPRESENTATIVE with the MEMBER'S written consent, to file a GRIEVANCE, or request an APPEAL either orally, or in writing, or online through CHPIV's MEMBER web portal, or by completing a MEMBER
    GRIEVANCE Form. A description of the GRIEVANCE procedure and GRIEVANCE. Form are available on The Plan's Medi-Cal MEMBER website [Title 28, CCR 1300.68(b)(7)]. The Plan's MEMBER Services Representatives are available to assist the MEMBERS by filling out the form over the telephone and all other procedural steps. No fees are imposed on the MEMBER for filing a GRIEVANCE.
13. CHPIV provides assistance in filing GRIEVANCES at each site where GRIEVANCES may be submitted [Title 28, CCR1300.68(b) (6)]. Each practitioner site is given an Operations Manual that includes a description of the GRIEVANCE procedures, instructions as to how MEMBERS may file an issue, the telephone number and address at The Plan for filing a GRIEVANCE, a GRIEVANCE Form, and whom they or the MEMBER may contact The Plan for assistance in filing a GRIEVANCE. The Operations Manual is updated at least annually.
    [Title 28, CCR 1300.68(b) (7)]
14. CHPIV will ensure The Plan provides:
    a. Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats) [Section 508 of the Rehabilitation Act of 1973 (29 United States Code (USC) section 794d) and the Americans with Disabilities Act of 1990 (ADA) (42 USC sections 12101, et seq.)].
    b. Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages [DHCS APL 21-011].
15. CHPIV ensures that every GRIEVANCE involving clinical issues is submitted and reported to qualified medical professionals with appropriate clinical expertise and is escalated to The Plan's MEDICAL DIRECTOR as needed, to ensure the GRIEVANCE is properly handled. The Plan ensures that the individuals who make decisions on GRIEVANCES and APPEALS are individuals [§ 438.406(a)(3), DHCS Contract Exhibit A, Attachment 14, 2D, E and G]:
    a. Who were not involved in any previous level of review or decision-making.
    b. Who is not a subordinate of someone who has participated in a prior decision; and
    c. Who, if deciding any of the following, are health care professionals who has clinical expertise in treating a MEMBER'S condition or disease if any of the following apply:

i. An APPEAL of a denial that is based on lack of medical necessity.
ii. A GRIEVANCE regarding denial of expedited RESOLUTION of an APPEAL.
iii. A GRIEVANCE or APPEAL that involves clinical issues.

d. Who has authority to require corrective action.

16. Although, existing state regulations [Title 28, CCR, Section 1300.68(b)(9)] limits the timeframe for filing GRIEVANCES of at least 180 calendar days from the date of the incident subject to the enrollee's dissatisfaction, The Plan shall allow enrollees to file GRIEVANCES anytime and according to the current federal regulations [Title 42, CFR, Section 438.402(c)(2)(i)]. The GRIEVANCE process is a 30-calendar-day maximum process, from the date the initial request was received by The Plan, until written response is sent to the COMPLAINANT [Title 28, CCR 1300.68(d)(3), 1368.01(a), Title 22 CCR Section 53858(g)(1), DHCS Contract Exhibit A, Attachment 14,
    a. If the case exceeds the 30-calendar daytime requirement, it is considered out of compliance and the MEMBER is sent a letter notifying them of the reason for delay and is given an expected timeframe for RESOLUTION.
    b. The delay notice includes a statement notifying the MEMBERS that they may exercise their right to request a DSS hearing [Title 22 CCR Section 53858(g)(3)].
17. CHPIV will ensure the GRIEVANCE process addresses the linguistic and cultural needs of the MEMBER, as well as the needs of MEMBERS with disabilities, including but not limited to any described in contracts between The Plan and DHCS [Title 22 CCR Section 53858(e)(6)] but more specifically, The Plan provides assistance, including but not limited to, translation of APPEAL and GRIEVANCE procedures, forms, and plan responses to issues, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate [Title 28, CCR 1300.68(b)(3), § 438.406(a)(1), DHCS Contract Exhibit A, Attachment 14, 2B].
18. CHPIV will ensure GRIEVANCE processing varies based on whether the MEMBER'S GRIEVANCE is an Administrative GRIEVANCE or Clinical GRIEVANCE. The Plan investigates the substance of all GRIEVANCES, including any clinical aspects [RR3. A.2]. PQI issues are internally investigated using the plan's GRIEVANCE investigation protocols.
19. Although there may be multiple reasons for a GRIEVANCE within one COMPLAINT (such as interpersonal, wait time and administrative issues), a primary reason should be identified. The following methodology can be used to select the primary reason. If there is a perceived quality of care failure, the case should be filed as a quality-of-care issue even though administrative or interpersonal issues may be associated. However, all concerns are to be noted in the file documentation and RESOLVED with the provider and/or PPG, as appropriate. Multiple cases may be generated from one COMPLAINT to address all issues raised by the MEMBER.
20. CHPIV will ensure Timeframes for resolving GRIEVANCES and sending written RESOLUTION
to the beneficiary are delineated in both federal [Title 42, CFR, Section 438.408(b)(1)] and state [HSC Section 1368.01(a); Title 28, CCR, Sections 1300.68(a) and (d)(3)] regulations. Federal regulations, which remain unchanged, allow the State to establish a timeframe for GRIEVANCE RESOLUTION that does not exceed 90 calendar days from the date of receipt of the GRIEVANCE. The State's established timeframe is 30

calendar days. The Plan shall continue to comply with the State's established timeframe of 30 calendar days for GRIEVANCE RESOLUTION [DHCS APL 21-011].

a. "RESOLVED" means that the GRIEVANCE has reached a final conclusion with respect to the beneficiary's submitted GRIEVANCE as delineated in existing state regulations [Title 28, CCR, Section 1300.68(a)(4)]
b. CHPIV's written RESOLUTION shall contain a clear and concise explanation of the CHPIV's decision [HSC Section 1368(a)(5); Title 28, CCR, Section 1300.68(d)(3)] [UM12 Element B2].
c. In the event that RESOLUTION of a standard GRIEVANCE is not reached within 30 calendar days as required, The Plan shall make reasonable efforts to provide the MEMBER with oral notice of the delay [Title 42, CFR, Section 438.408(c)(2)(i)]. The MEMBER is sent a written notification within two (2) calendar days and notify the MEMBER of the right to file a GRIEVANCE if the MEMBER disagrees with the extension [Title 42, CFR, Section 438.408(c)(2)(ii)].

21. CHPIV will ensure the GRIEVANCE process also supports procedures for the expedited review of GRIEVANCESs may involve an imminent and serious threat to the health of a beneficiary, including, but not limited to, severe pain or potential loss of life, limb or major bodily function that do not involve the APPEAL of an Adverse Benefit Determination, yet are "urgent" or "expedited" in nature [DHCS APL 21-011, Title 28, CCR 1300.68.01(a), Title 22 CCR Section 53858(e)(7), RR3.A.4]. The Plan's GRIEVANCE system and procedures for the expedited review of GRIEVANCESs includes consideration of the MEMBER'S's medical condition when determining the response time [Title 28, CCR 1300.68.01(a) (3)]. At minimum, The Plan will:
    a. Immediately notify the MEMBER of his/her right to contact the DMHC regarding the GRIEVANCE. The plan expedites the review when the MEMBER, an AUTHORIZED REPRESENTATIVE, or treating physician provides notice to the plan. The notice need not be in writing but may be accomplished by a documented telephone call [Title 28, CCR 1300.68.01(a) (1)].
    b. The written statement to the Department and the MEMBER on the disposition or pending status of the urgent GRIEVANCE within 72 hours based on the specific time and date of receipt of the GRIEVANCE [DHCS APL 21-011, Title 28, CCR 1300.68.01(a)(2)]. The Plan attempt to provide oral notice of the RESOLUTION of an expedited GRIEVANCE to the MEMBER, provider or AUTHORIZED REPRESENTATIVE within 72 hours, followed up with a written notice [DHCS Contract Exhibit A, Attachment 14, 2A] [Title 42, CFR, Section 438.408(d)(2)(ii)].
        i. "If you need help with a GRIEVANCE involving an emergency, a GRIEVANCE that has not been satisfactorily RESOLVED by your health plan, or a GRIEVANCE that has remained unresolved for more than 30 days, you may call the department for assistance."
22. CHPIV will ensure all appeals and grievances are documented within The Plan's on-line system and contains date received, member's name, plan representative receiving or recording the appeal, case substance and description, actions taken including follow-up activities, resolution, name of the person resolving the case, date member was notified of the resolution, case correspondence, medical records, Member Handbook, research, issue determination (disposition), complaint history and other relevant information upon which the plan relied in reaching its decision

B. Standard GRIEVANCES
   1. CHPIV ensures GRIEVANCES are RESOLVED within the state's established timeframe of 30 calendar days.
   2. "RESOLVED" means that the GRIEVANCE has reached a conclusion with respect to the MEMBER'S submitted GRIEVANCE as delineated in state regulations.
   3. The written RESOLUTION must contain a clear and concise explanation of the MCP's decision.
   4. If RESOLUTION of a standard GRIEVANCE is not reached within 30 calendar days as required, the MEMBER must be notified in writing of the status of the GRIEVANCE and the estimated date of RESOLUTION.

C. Expedited GRIEVANCES
   1. For instances that may involve an imminent and serious threat to the health of a MEMBER – including, but not limited to, severe pain or potential loss of life, limb or major bodily function – that do not involve the APPEAL of an ADVERSE BENEFIT DETERMINATION yet are "urgent" or "expedited" in nature, CHPIV ensures GRIEVANCES are RESOLVED within a timeframe of 72 hours.
   2. The 72-hour timeframe requires the date and time of receipt of the GRIEVANCE is recorded as the specific time of receipt dictates the timeframe for RESOLUTION.
   3. CHPIV ensures reasonable efforts are made to provide the MEMBER with oral notice of the expedited RESOLUTION.
   4. CHPIV ensures that the MEMBER, or a provider or AUTHORIZED REPRESENTATIVES acting on behalf of a MEMBER and with the MEMBER'S written consent with a written statement on the disposition or pending status of the GRIEVANCE no later than three days from receipt of the GRIEVANCE.
   5. CHPIV ensures that the MEMBER, or a provider or AUTHORIZED REPRESENTATIVES are immediately notified in writing of their right to notify DMHC of the GRIEVANCE.
   6. CHPIV ensures all other state requirements pertaining to expedited GRIEVANCE handling comply in accordance with state law.

D. Exempt GRIEVANCES
   1. GRIEVANCES received over the telephone that are not coverage disputes or disputed health care services involving medical necessity or experimental or investigational treatment, and that are RESOLVED by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response. CHPIV ensures the maintenance of a log of all such GRIEVANCES containing the date of the call, the name of the COMPLAINANT, MEMBER identification number, nature of the GRIEVANCE, nature of the RESOLUTION, and the name of the representative who took the call and RESOLVED the GRIEVANCE.
   2. The information contained in the log must be reviewed by CHPIV.
   3. CHPIV ensures exempt GRIEVANCES are incorporated into the quarterly GRIEVANCE and APPEAL report that is submitted to DHCS.
   4. Under federal regulations, coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment qualify as APPEALS and not GRIEVANCES. Therefore, APPEALS are not exempt from written acknowledgment and RESOLUTION.

E. CHPIV ensures prompt review and investigation of MEMBER GRIEVANCES are conducted by the appropriate department and/or staff delegated the responsibility to handle CHPIV's internal GRIEVANCE operations.
F. CHPIV ensures that every GRIEVANCE submitted by a MEMBER, or a provider or AUTHORIZED REPRESENTATIVE acting on behalf of a MEMBER and with the MEMBER's written consent, is reported to an appropriate level within its network (i.e., quality of care versus quality of service).
G. CHPIV ensures the immediate referral of all medical quality of care issues to a MEDICAL DIRECTOR or Designee for review.
H. CHPIV ensures MEMBERS, MEMBER's AUTHORIZED REPRESENTATIVES, or providers are not discriminated against or retaliated against on grounds that he or she filed a GRIEVANCE as required by federal and State nondiscrimination law.
I. CHPIV ensures GRIEVANCES alleging discrimination are forwarded to the Department of Health Care Services (DHCS) Office of Civil Rights (OCR).
J. CHPIV GRIEVANCES processed for pharmacy services rendered or requested before implementation of Medi-Cal Rx.
K. CHPIV ensures the maintenance and availability for DHCS review, GRIEVANCE logs, including GRIEVANCE logs delineated by Subcontractor and Downstream Subcontractor. The record of each GRIEVANCE must contain, at a minimum, all the following information and must be accurately maintained in a manner accessible to the state and available upon request to CMS:
    1. A general description of the reason for the GRIEVANCE.
    2. The date received.
    3. The date of each review or, if applicable, review meeting.
    4. A description of the action taken by the plan or provider to investigate and resolve the GRIEVANCE.
    5. RESOLUTION at each level of the GRIEVANCE, if applicable.
    6. The name of the plan provider or staff person responsible for resolving the GRIEVANCE
    7. Date of RESOLUTION at each level, if applicable.
    8. Name of the covered person for whom the GRIEVANCE was filed.
L. CHPIV will ensure that The Plan has established a system that provides for the prompt receipt of DMHC contacts regarding urgent GRIEVANCESs and APPEALS twenty-four (24) hours a day, seven (7) days a week. During normal business hours, the system provides for The Plan to contact the DMHC within 30 minutes following the DMHC contact regarding an urgent issue [Title 28, CCR 1300.68.01(b)]. After normal business hours, on weekends or holidays, the system provides for The Plan to contact the DMHC within one (1) hour following the DMHC contact regarding an urgent issue. This system provides for the availability of The Plan's representative with authority on the plan's behalf to resolve urgent GRIEVANCES and authorize the provision of health care services covered under the MEMBER'S contract in a medically appropriate and timely manner. Such authority includes making financial decisions for expenditure of funds on behalf of The Plan without first having to obtain approval from supervisors or other superiors within the plan. Refer to compliance filing: Title 28, CCR Section 1300.68.01(b)(1).
M. CHPIV will ensure after either completing the GRIEVANCE process or participating in the process for at least 30 days, a subscriber or enrollee may submit the GRIEVANCE to the DMHC for review. In any case determined by DMHC to be a case involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, the

potential loss of life, limb, or major bodily function, cancellations, rescissions, or the nonrenewal of a health care service plan contract, or in any other case where the department determines that an earlier review is warranted, a subscriber or enrollee shall not be required to complete the GRIEVANCE process or to participate in the process for at least 30 days before submitting a GRIEVANCE to the DMHC for review [1368(b)(1)(A)].

N. The Intake Specialist verifies that an urgent care issue does not exist according to the MEMBER'S perception, with support from the A&G CLIINICAL SPECIALIST II as necessary. This is noted in the file documentation. CASE COORDINATOR shall immediately refer any clinically urgent care issues related to medical quality of care to a A&G CLIINICAL SPECIALIST II for the referral to the plan's Medical/Dental Director for decision or action and to arrange medical care for MEMBER, if required (see B. Procedure for Handling and Resolving Clinical GRIEVANCES).

O. CHPIV will ensure written communications to MEMBERSs are provided in the threshold languages defined by the DHCS [RR3. A.5] [DHCS APL 21-011]. Written communications shall also be provided in alternative formats (including Braille, large-size print font no smaller than 20-point, or audio format) and through auxiliary aids upon request and in a timely fashion appropriate for the format being requested and taking into consideration the special needs of MEMBERS with disabilities or LEP [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]. Written notices to MEMBERS also enclose information regarding The Plan's Notice of Nondiscrimination, Notice of Language Assistance, and DMHC Independent Medical Review/ COMPLAINT application form and process.

P. Procedures for Handling and Resolving Clinical GRIEVANCES
   1. A MEMBER'S concern is received orally or in writing by the health plan.
   2. The Intake Specialist shall immediately refer any Clinically Urgent quality of care GRIEVANCE case to the A&G CLIINICAL SPECIALIST II (A&G Nurse) who will present the case immediately to the plan MEDICAL DIRECTOR to arrange medical care for the MEMBER (see Attachment 3) [Title 22 CCR Section 53858(e)(2)].
      a. All situations where the MEMBER has been determined to have a serious or imminent health risk and has voiced a concern about the quality of care that they are currently receiving, applicable alternative treatment arrangements will be made by the plan MEDICAL DIRECTOR, A&G CLIINICAL SPECIALIST II or PPG 72 hours based on the specific time and date of receipt of the GRIEVANCE [DHCS APL 21-011], depending upon the clinical urgency and applicability.
      b. Upon completion of the immediate actions and interventions, the case will then be handled via the process as outlined below. The actions and interventions taken will be documented in the file.
   3. CASE COORDINATOR acknowledges receipt of the Clinical GRIEVANCE in writing to the MEMBER mailed and postmarked within five (5) calendar days [§ 438.406(a)(2)] [DHCS APL 21-011, Health & Safety Code, Section 1368(a)(4)(A); Title 28, CCR, Section 1300.68(d)(1)]. The acknowledgement advises the MEMBER that the GRIEVANCE has been received, the date of the receipt, and provides the name of the plan representative, telephone number and address of the plan representative who may be contacted about the GRIEVANCE [Title 28, CCR 1300.68(d)(1), 1368(a)(4)(A)]. Information is included informing the MEMBER of his or her right to request a DSS hearing or APPEAL to the DHCS or DMHC [Title 22 CCR Section 53858(e)(5)].

4. Written communications to MEMBERS s are provided in the threshold languages as defined by the DHCS [RR3. A.5]. Written communications shall also be provided in alternative formats (including Braille, large-size print font no smaller than 20-point, or audio format) and through auxiliary aids upon request and in a timely fashion appropriate for the format being requested and taking into consideration the special needs of MEMBERS with disabilities or LEP [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].
5. The case is then assigned to a CASE COORDINATOR for handling.
6. The CASE COORDINATOR determines the appropriate GRIEVANCE Type Code for entry into the on-line system according to requirements for tracking and reporting purposes. (See Attachment 2) The CASE COORDINATOR'S logging includes:
    a. A description of the MEMBER'S issue (MEMBER Issue)
    b. A description of the actions taken by the plan or provider to investigate the GRIEVANCE. (Action Taken).
    c. The proposed RESOLUTION by the plan or provider, (RESOLUTION Notes)
    d. The name of the person responsible for resolving the GRIEVANCE, and
    e. The date of the notification to the MEMBER.
7. The CASE COORDINATOR uses a Provider Information Request (PIR) to obtain the response, and any other pertinent information required for review, including medical records. The CASE COORDINATOR then creates a summary of the GRIEVANCE that provides specific information on the Provider(s), date of service and information needed with the PPG's written response. The CASE COORDINATOR sends the PIR to the appropriate PPG/Provider or hospital contact.
8. The PPG/Provider has seven (7) calendar days to respond to the request for information. If no response has been received, the CASE COORDINATOR contacts his/her manager for assistance. The plan may send a copy service for medical records.
9. Upon receipt of medical records, information and responses from the PPG, the CASE COORDINATOR forwards the case to the A&G CLIINICAL SPECIALIST II.
10. The A&G CLIINICAL SPECIALIST II verifies that all information has been received. The A& Clinical Specialist II summarizes the COMPLAINT and forwards all cases to the plan MEDICAL DIRECTOR for review. The summary includes the MEMBER'S perception with pertinent information along with the PPG's response and records, if applicable.
11. A determination is made as to the specialty required to review the case.
12. If needed the practitioner in a similar specialty that would typically treat the medical condition, performs the procedure or provides the treatment at issue, will be consulted and documentation of the consult will be included with the GRIEVANCE file.
13. The MEDICAL DIRECTOR may request that the case be referred to the plan's contracted third-party review organization for a similar specialty review. Refer to desktop protocol: A&G Department Protocol Consultation Review.
14. The plan MEDICAL DIRECTOR Review:
    a. The Plan's MEDICAL DIRECTOR conducts a peer review assessment of the care provided. The MEDICAL DIRECTOR conducting the review for the proposed RESOLUTION of the GRIEVANCE will not have participated in any prior decisions related to the GRIEVANCE. The MEDICAL DIRECTOR will code the peer review form with an appropriate severity outcome level code.

b. The Plan's MEDICAL DIRECTOR, upon completion of the review of the case returns the case to the A&G CLIINICAL SPECIALIST II. The A&G CLIINICAL SPECIALIST II takes any appropriate follow-up action on behalf of the MEDICAL DIRECTOR. In any case where the MEDICAL DIRECTOR has severity outcome level coded the case to be a moderate or major quality of care event (e.g., severity outcome level code 3 and 4), the A&G CLIINICAL SPECIALIST II will refer the case to QI for intervention and next steps.
c. Corrective actions will be followed by the QI team to RESOLUTION [28 CCR sections 1300.70(b)(2)(H) and (c)].

15. A final RESOLUTION letter is sent to the MEMBER that clearly and concisely describes any administrative or service outcome information [1368(a)(5)]. The RESOLUTION letter is sent within 30 calendar days of receipt of the GRIEVANCE [Health & Safety Code, Section 1368.01(a); Title 28, CCR, Sections 1300.68(a) and (d)(3)]. Additionally, the RESOLUTION letter describes the MEMBER'S options if the MEMBER is not satisfied with the GRIEVANCE outcome. The final letter advises the MEMBER of The Plans determination without releasing peer-protected information. Information is included informing the MEMBER of his or her right to APPEAL to the DHCS or DMHC [Title 22 CCR Section 53858(e)(5), RR3. A.3].
16. MEMBERS have the right to APPEAL an adverse decision. If CHPIV makes an adverse decision as part of resolving a COMPLAINT, it notifies MEMBERS s of the decision and of their right to APPEAL. If the organization cannot resolve a COMPLAINT within the time frame stated in its policies or cannot notify the MEMBER of the final decision for legal or statutory reasons, at a minimum, it must notify the MEMBER that the COMPLAINT was received and investigated.
17. Written communications to the MEMBER are provided in the threshold languages defined by the DHCS [RR3. A.5]. Written communications shall also be provided in alternative formats (including Braille, large-size print font no smaller than 20-point, or audio format) and through auxiliary aids upon request and in a timely fashion appropriate for the format being requested and taking into consideration the special needs of MEMBERS with disabilities or LEP [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]. Written notices to MEMBERS also enclose information regarding The Plan's Notice of Nondiscrimination, Notice of Language Assistance, and DMHC Independent Medical Review/ COMPLAINT application form and process.
18. The PPG/Provider receives a copy of the final MEMBER letter.
19. When applicable, final letters should contain specific information for referrals generated during the GRIEVANCE process, such as the name of the specialist and for what timeframe the MEMBER has been referred.
20. The CASE COORDINATOR documents in the file and the online system after review has been conducted and proposed RESOLUTIONS have been determined:
    a. The date the case was sent to the A&G CLIINICAL SPECIALIST II for review.
    b. The date of the A&G CLIINICAL SPECIALIST II review
    c. The date the case was sent to the plan MEDICAL DIRECTOR for review.
    d. The date of the plan MEDICAL DIRECTOR Review
    e. The date of notification to the MEMBER of the RESOLUTION
    f. A description of the MEMBER'S issue (MEMBER Issue)

g. A description of the actions taken by the plan or provider to investigate the GRIEVANCE. (Action taken)
h. The proposed RESOLUTION by the plan or provider, (RESOLUTION Notes)
i. The name of the person responsible for resolving the GRIEVANCE, and
j. The date of the notification to the MEMBER.

## III. PROCEDURE

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

## IV. DEFINITIONS

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

| TERM | DEFINITION |
|---|---|
| **Member** | A beneficiary enrolled in a CHPIV program. |
| **Adverse Benefit Determination ("ABD")** | Means any of the following actions taken by Contractor:<br>• The denial or limited authorization of a requested service, including determinations based on the type or level of a Covered Service, Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service.<br>• The reduction, suspension, or termination of a previously authorized Covered Service.<br>• The denial, in whole or in part, of payment for a Covered Service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of Clean Claim is not an Adverse Benefit Determination.<br>• The failure to provide Covered Services in a timely manner.<br>• The failure to act within the required timeframes for standard resolution of Grievances and Appeals.<br>• The denial of the Member's request to obtain services out of Network when a Member is in an area with only one Medi-Cal managed care health plan; or<br>The denial of a Member's request to dispute financial liability. |

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|---|---|
| **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. |
| **Grievance** | Means an oral or written expression of dissatisfaction about any matter other than an ABD, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or Contractor's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by Contractor to make an authorization decision. |
| **Inquiry** | An inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CHPIV processes. |
| **Resolution** | Means that the Grievance has reached a conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the grievance system, including entities with delegated authority. |
| **State Fair Hearing (SFH)** | Means a hearing with a State Administrative Law Judge to resolve a member's dispute about an action taken by Contractor, its Network Providers, Subcontractors, or Downstream Subcontractors. |
| **Appeal** | Is federally defined as a review by The Plan of an adverse benefit determination [42 CFR 438.400(b)]. While California regulations do not explicitly define the term "appeal," they do delineate specific requirements for certain types of grievances that would fall under the federal definition of appeal be-cause they involve the delay, modification, or denial of services based on medical necessity or a determination that the requested service is not a covered benefit [28 CCR 1300.68(d)(4)-(5)]. The Plan shall treat these grievances as appeals under federal regulations. |
| **Notice Of Appeal Resolution (NAR)** | A formal letter from The Plan informing a member of the outcome of the appeal of an adverse benefit determination [42 CFR 438.408(d)(2)]. The NAR informs the member whether The Plan has overturned or upheld its decision on the adverse benefit determination. The contents of the NAR shall meet all the language and accessibility standards including translation, font, and format requirements as set forth in DHCS APL 21-004 [Title 42 CFR section 438.10, 438.402(c)(1)(i)(A), 438.404, and 438.408(c)(3) and (i); WIC 14029.91 and 10951(b)(1)(A); and Title 45 CFR, Part 92]. |
| **A&G Clinical Specialist II** | A Registered Nurse who provides clinical expertise in Clinical Grievance resolution and coordinates case as appropriate with the Medical/Dental Director, PPG/Provider and Third-Party Reviewer Organization. |

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|---|---|
| **Case Coordinator** | A non-clinician knowledgeable associate involved in grievance resolution. |
| **Complaint** | is the same as "grievance." |
| **Complainant** | is the same as "grievant," and means the person who filed the grievance including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee. |
| **Medical Director** | A physician reviewer who is involved in grievance review and resolution. |
| **Resolved** | Means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the plan's grievance system, including entities with delegated authority. |

| | Grievance Process | GA-001 |
|---|---|---|
| **Department** | Health Services | |
| **Functional Area** | Grievances & Appeals | |
| **Impacted Delegate** | ☒ Subcontractor ☐ NA | |

| DATES | | | |
|---|---|---|---|
| **Policy Effective Date** | 6/12/2023 | **Reviewed/Revised Date** | 11/18/2024 |
| **Next Annual Review Due** | 11/19/2025 | **Regulator Approval** | 12/15/2023 |

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

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

**AUTHORITIES/REFERENCES**

- **Internal**
  - CHPIV, Delegation Oversight Policy and Procedure, CMP-002
- **Federal**
  - 42 CFR Sections 438.3, 438.400, 438.402, 438.406, 438.408, 438.410, 438.416, 438.420, 438.424, 18446
- **State**
  - California Health and Safety Code Sections ("H&S Code") 1367.01, 1367.042, 1368, 1368.01, 1368.015, 1368.016, 1368.02, 1368.2, 1370.F2, 1374.31, 1374.34
  - California Welfare and Institutions Code Sections ("W&I Code") 10950
  - Title 22 California Code of Regulations Rules ("CCR") 51014.1, 51014.2, 53858
  - Title 28 CCR Rules 1300.68, 1300.68.01, 1300.74.30
  - DMHC All Plan Letter ("APL") 22-021
  - 2024 DHCS Contract Exhibit A, Attachment III, 4.6 Member Grievance and Appeal System
  - DHCS APLs 21-011, 21-004, 20-022, 20-020, 20-015
- **Accreditation**
  - NCQA: Member Experience (ME) 7, Element A and Elements C-F

| HISTORY | |
|---|---|
| **Revision Date** | **Description of Revision** |

| | Grievance Process | GA-001 |
|---|---|---|

| | |
|---|---|
| 6/12/2023 | Policy creation |
| 7/10/2023 | Added the requirements related to expedited grievances |
| 10/01/2024 | Annual review- no changes |
| 11/12/2024 | Updated to align with NCQA standards |
| 11/18/2024 | Updated to align with NCQA standards |
| | Updated to comply with DMHC APL 25-007 |

## I. OVERVIEW

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

## II. POLICY

A. CHPIV ensures establishment and maintenance of a GRIEVANCE Process as outlined below pursuant to which a MEMBER, or a provider or AUTHORIZED REPRESENTATIVE acting on behalf of a MEMBER and with the MEMBER's written consent, may submit a GRIEVANCE for review and RESOLUTION:

1. CHPIV ensures MEMBERS are allowed to file a GRIEVANCE at any time to express dissatisfaction about any matter other than a notice of ABD:
    a. GRIEVANCES may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the MEMBER's right to dispute an extension of time proposed by the MCP to make an authorization decision.
    b. A COMPLAINT is the same as a GRIEVANCE. If the MCP is unable to distinguish between a GRIEVANCE and an INQUIRY, it must be considered a GRIEVANCE.
    c. An INQUIRY is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other MCP processes.
    ~~c.~~d. A COMPLAINT made by an MEMBER to a plan about a delay or denial of a payment of a claim will be treated by the plan as a GRIEVANCE, regardless of whether the MEMBER uses the term "grievance" as part of the COMPLAINT.
2. CHPIV ensures MEMBERS are allowed to file a GRIEVANCE to contest the unilateral decision to extend the timeframe for RESOLUTION of an APPEAL or expedited APPEAL.
3. CHPIV ensures every GRIEVANCE involving clinical issues is reported to qualified medical professionals with appropriate clinical expertise and is escalated to the MEDICAL DIRECTOR as needed, to ensure the GRIEVANCE is properly handled.
4. CHPIV ensures GRIEVANCES are monitored to identify issues that require Corrective Action. GRIEVANCES related to medical Quality of Care issues must be referred to qualified medical professionals with appropriate clinical expertise and is escalated to the MEDICAL DIRECTOR as needed.
5. CHPIV ensures written acknowledgement is provided within five (5) calendar days of receipt of the GRIEVANCE. The acknowledgement letter must advise the MEMBER

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that the GRIEVANCE has been received, provide the date of the receipt, and provide the name, telephone number, and address of the representative who the MEMBER or their Provider or AUTHORIZED REPRESENTATIVE may contact about the GRIEVANCE.

6. The GRIEVANCES Process shall address the receipt, handling, and disposition of MEMBER GRIEVANCES and APPEALS, in accordance with the Department of Health Care Services (DHCS) Contract and applicable state and federal statutes, regulations and DHCS All Plan Letters.
7. CHPIV will ensure The Plan's GRIEVANCE system is established in writing (approved by the Department of Health Care Services (DHCS) Title 22 CCR Section 53858(a)(1)) and provides for procedures that receive, review and resolve GRIEVANCES as quickly as MEMBER'S health condition requires, not to exceed 30 calendar days of receipt by the plan, or any provider or entity with delegated authority to administer and resolve the plan's GRIEVANCE system [Title 28, CCR1300.68(a), §438.408(b)(1), RR3.A.4]. The Plan's internal GRIEVANCE process includes only one level of review [Title 28, CCR 1300.68(a) (4)(A)].
8. The GRIEVANCE and APPEAL process ensures that MEMBERS s are given a reasonable opportunity to present evidence and testimony, and make legal or factual arguments, in person, by telephone or in writing, in support of their GRIEVANCE or APPEAL. The Plan will inform MEMBERS that they must submit additional evidence for Contractor to consider within the 30-calendar day review timeframe for an APPEAL and within 72 hours timeframe for resolving an expedited APPEAL. In the case of a GRIEVANCE subject to expedited review, MEMBER Services informs the MEMBER of the limited time available to present evidence. Specific to APPEALS, the process provides the MEMBER and his or her representative opportunity, before and during APPEALS process, to examine the MEMBER'S case file, including medical records, and any other documents and records considered during the APPEALS process or within 30 calendar days for an APPEAL and within 72 hours for an expedited APPEAL. [§ 438.406(b)(3), DHCS Contract Exhibit A, Attachment 14, 2H, DHCS Contract Exhibit A, Attachment 14, 4C].
9. Medi-Cal MEMBERS are notified within 7 days of enrollment and annually thereafter about The Plan's GRIEVANCE process, including information on the plan's procedures for filing and resolving an issue, and the toll-free telephone number and address for obtaining forms, requesting information or presenting an issue [Title 28, CCR 1300.68(b)(2), 1300.68(b)(4), Title 22 CCR Section 53858(a)(2)(A)]. Notices additionally include:
    a. A statement that GRIEVANCE forms are available in the office of each primary care provider, or in each MEMBER services department of the plan [Title 22 CCR Section 53858(a)(2)(B)].
    b. A statement that GRIEVANCES may be filed in writing (by mail, facsimile, email, or The Plan's website) or verbally (by telephone) or in person directly at The Plan's local office or with the plan in which the MEMBER is enrolled or at any office or facility of the contracted plan's providers [Title 22 CCR Section 53858(a)(2)(C)].
    c. An explanation of the state's Medi-Cal Managed Care Ombudsman program and the program's voice number [Title 22 CCR Section 53858(a)(2)(F)].

10. CHPIV provides forms for GRIEVANCESs to be given to subscribers and enrollees who wish to register written GRIEVANCES. The forms are approved by the regulator director in advance as to formal [1368(a)(3)] and are available at primary care providers' offices [Title 22 CCR Section 53858(f)].
11. The MEMBER Handbook also informs MEMBERS s of their right to file a GRIEVANCE directly with the Department of Managed Health Care (DMHC), the California Department of Health Care Services (DHCS) Ombudsman Program, and the California Department of Social Services (DSS) Hearing process.
12. CHPIV allows our MEMBERS, or a Provider or AUTHORIZED REPRESENTATIVE with the MEMBER'S written consent, to file a GRIEVANCE, or request an APPEAL either orally, or in writing, or online through CHPIV's MEMBER web portal, or by completing a MEMBER
    GRIEVANCE Form. A description of the GRIEVANCE procedure and GRIEVANCE. Form are available on The Plan's Medi-Cal MEMBER website [Title 28, CCR 1300.68(b)(7)]. The Plan's MEMBER Services Representatives are available to assist the MEMBERS by filling out the form over the telephone and all other procedural steps. No fees are imposed on the MEMBER for filing a GRIEVANCE.
13. CHPIV provides assistance in filing GRIEVANCES at each site where GRIEVANCES may be submitted [Title 28, CCR1300.68(b) (6)]. Each practitioner site is given an Operations Manual that includes a description of the GRIEVANCE procedures, instructions as to how MEMBERS may file an issue, the telephone number and address at The Plan for filing a GRIEVANCE, a GRIEVANCE Form, and whom they or the MEMBER may contact The Plan for assistance in filing a GRIEVANCE. The Operations Manual is updated at least annually.
    [Title 28, CCR 1300.68(b) (7)]
14. CHPIV will ensure The Plan provides:
    a. Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats) [Section 508 of the Rehabilitation Act of 1973 (29 United States Code (USC) section 794d) and the Americans with Disabilities Act of 1990 (ADA) (42 USC sections 12101, et seq.)].
    b. Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages [DHCS APL 21-011].
15. CHPIV ensures that every GRIEVANCE involving clinical issues is submitted and reported to qualified medical professionals with appropriate clinical expertise and is escalated to The Plan's MEDICAL DIRECTOR as needed, to ensure the GRIEVANCE is properly handled. The Plan ensures that the individuals who make decisions on GRIEVANCES and APPEALS are individuals [§ 438.406(a)(3), DHCS Contract Exhibit A, Attachment 14, 2D, E and G]:
    a. Who were not involved in any previous level of review or decision-making.
    b. Who is not a subordinate of someone who has participated in a prior decision; and
    c. Who, if deciding any of the following, are health care professionals who has clinical expertise in treating a MEMBER'S condition or disease if any of the following apply:

i. An APPEAL of a denial that is based on lack of medical necessity.
ii. A GRIEVANCE regarding denial of expedited RESOLUTION of an APPEAL.
iii. A GRIEVANCE or APPEAL that involves clinical issues.

d. Who has authority to require corrective action.

16. Although, existing state regulations [Title 28, CCR, Section 1300.68(b)(9)] limits the timeframe for filing GRIEVANCES of at least 180 calendar days from the date of the incident subject to the enrollee's dissatisfaction, The Plan shall allow enrollees to file GRIEVANCES anytime and according to the current federal regulations [Title 42, CFR, Section 438.402(c)(2)(i)]. The GRIEVANCE process is a 30-calendar-day maximum process, from the date the initial request was received by The Plan, until written response is sent to the COMPLAINANT [Title 28, CCR 1300.68(d)(3), 1368.01(a), Title 22 CCR Section 53858(g)(1), DHCS Contract Exhibit A, Attachment 14,
    a. If the case exceeds the 30-calendar daytime requirement, it is considered out of compliance and the MEMBER is sent a letter notifying them of the reason for delay and is given an expected timeframe for RESOLUTION.
    b. The delay notice includes a statement notifying the MEMBERS that they may exercise their right to request a DSS hearing [Title 22 CCR Section 53858(g)(3)].
17. CHPIV will ensure the GRIEVANCE process addresses the linguistic and cultural needs of the MEMBER, as well as the needs of MEMBERS with disabilities, including but not limited to any described in contracts between The Plan and DHCS [Title 22 CCR Section 53858(e)(6)] but more specifically, The Plan provides assistance, including but not limited to, translation of APPEAL and GRIEVANCE procedures, forms, and plan responses to issues, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate [Title 28, CCR 1300.68(b)(3), § 438.406(a)(1), DHCS Contract Exhibit A, Attachment 14, 2B].
18. CHPIV will ensure GRIEVANCE processing varies based on whether the MEMBER'S GRIEVANCE is an Administrative GRIEVANCE or Clinical GRIEVANCE. The Plan investigates the substance of all GRIEVANCES, including any clinical aspects [RR3. A.2]. PQI issues are internally investigated using the plan's GRIEVANCE investigation protocols.
19. Although there may be multiple reasons for a GRIEVANCE within one COMPLAINT (such as interpersonal, wait time and administrative issues), a primary reason should be identified. The following methodology can be used to select the primary reason. If there is a perceived quality of care failure, the case should be filed as a quality-of-care issue even though administrative or interpersonal issues may be associated. However, all concerns are to be noted in the file documentation and RESOLVED with the provider and/or PPG, as appropriate. Multiple cases may be generated from one COMPLAINT to address all issues raised by the MEMBER.
20. CHPIV will ensure Timeframes for resolving GRIEVANCES and sending written RESOLUTION
to the beneficiary are delineated in both federal [Title 42, CFR, Section 438.408(b)(1)] and state [HSC Section 1368.01(a); Title 28, CCR, Sections 1300.68(a) and (d)(3)] regulations. Federal regulations, which remain unchanged, allow the State to establish a timeframe for GRIEVANCE RESOLUTION that does not exceed 90 calendar days from the date of receipt of the GRIEVANCE. The State's established timeframe is 30

calendar days. The Plan shall continue to comply with the State's established timeframe of 30 calendar days for GRIEVANCE RESOLUTION [DHCS APL 21-011].

a. "RESOLVED" means that the GRIEVANCE has reached a final conclusion with respect to the beneficiary's submitted GRIEVANCE as delineated in existing state regulations [Title 28, CCR, Section 1300.68(a)(4)]
b. CHPIV's written RESOLUTION shall contain a clear and concise explanation of the CHPIV's decision [HSC Section 1368(a)(5); Title 28, CCR, Section 1300.68(d)(3)] [UM12 Element B2].
c. In the event that RESOLUTION of a standard GRIEVANCE is not reached within 30 calendar days as required, The Plan shall make reasonable efforts to provide the MEMBER with oral notice of the delay [Title 42, CFR, Section 438.408(c)(2)(i)]. The MEMBER is sent a written notification within two (2) calendar days and notify the MEMBER of the right to file a GRIEVANCE if the MEMBER disagrees with the extension [Title 42, CFR, Section 438.408(c)(2)(ii)].

21. CHPIV will ensure the GRIEVANCE process also supports procedures for the expedited review of GRIEVANCESs may involve an imminent and serious threat to the health of a beneficiary, including, but not limited to, severe pain or potential loss of life, limb or major bodily function that do not involve the APPEAL of an Adverse Benefit Determination, yet are "urgent" or "expedited" in nature [DHCS APL 21-011, Title 28, CCR 1300.68.01(a), Title 22 CCR Section 53858(e)(7), RR3.A.4]. The Plan's GRIEVANCE system and procedures for the expedited review of GRIEVANCESs includes consideration of the MEMBER'S's medical condition when determining the response time [Title 28, CCR 1300.68.01(a) (3)]. At minimum, The Plan will:
    a. Immediately notify the MEMBER of his/her right to contact the DMHC regarding the GRIEVANCE. The plan expedites the review when the MEMBER, an AUTHORIZED REPRESENTATIVE, or treating physician provides notice to the plan. The notice need not be in writing but may be accomplished by a documented telephone call [Title 28, CCR 1300.68.01(a) (1)].
    b. The written statement to the Department and the MEMBER on the disposition or pending status of the urgent GRIEVANCE within 72 hours based on the specific time and date of receipt of the GRIEVANCE [DHCS APL 21-011, Title 28, CCR 1300.68.01(a)(2)]. The Plan attempt to provide oral notice of the RESOLUTION of an expedited GRIEVANCE to the MEMBER, provider or AUTHORIZED REPRESENTATIVE within 72 hours, followed up with a written notice [DHCS Contract Exhibit A, Attachment 14, 2A] [Title 42, CFR, Section 438.408(d)(2)(ii)].
        i. "If you need help with a GRIEVANCE involving an emergency, a GRIEVANCE that has not been satisfactorily RESOLVED by your health plan, or a GRIEVANCE that has remained unresolved for more than 30 days, you may call the department for assistance."
22. CHPIV will ensure all appeals and grievances are documented within The Plan's on-line system and contains date received, member's name, plan representative receiving or recording the appeal, case substance and description, actions taken including follow-up activities, resolution, name of the person resolving the case, date member was notified of the resolution, case correspondence, medical records, Member Handbook, research, issue determination (disposition), complaint history and other relevant information upon which the plan relied in reaching its decision

B. Standard GRIEVANCES
   1. CHPIV ensures GRIEVANCES are RESOLVED within the state's established timeframe of 30 calendar days.
   2. "RESOLVED" means that the GRIEVANCE has reached a conclusion with respect to the MEMBER'S submitted GRIEVANCE as delineated in state regulations.
   3. The written RESOLUTION must contain a clear and concise explanation of the MCP's decision.
   4. If RESOLUTION of a standard GRIEVANCE is not reached within 30 calendar days as required, the MEMBER must be notified in writing of the status of the GRIEVANCE and the estimated date of RESOLUTION.

C. Expedited GRIEVANCES
   1. For instances that may involve an imminent and serious threat to the health of a MEMBER – including, but not limited to, severe pain or potential loss of life, limb or major bodily function – that do not involve the APPEAL of an ADVERSE BENEFIT DETERMINATION yet are "urgent" or "expedited" in nature, CHPIV ensures GRIEVANCES are RESOLVED within a timeframe of 72 hours.
   2. The 72-hour timeframe requires the date and time of receipt of the GRIEVANCE is recorded as the specific time of receipt dictates the timeframe for RESOLUTION.
   3. CHPIV ensures reasonable efforts are made to provide the MEMBER with oral notice of the expedited RESOLUTION.
   4. CHPIV ensures that the MEMBER, or a provider or AUTHORIZED REPRESENTATIVES acting on behalf of a MEMBER and with the MEMBER'S written consent with a written statement on the disposition or pending status of the GRIEVANCE no later than three days from receipt of the GRIEVANCE.
   5. CHPIV ensures that the MEMBER, or a provider or AUTHORIZED REPRESENTATIVES are immediately notified in writing of their right to notify DMHC of the GRIEVANCE.
   6. CHPIV ensures all other state requirements pertaining to expedited GRIEVANCE handling comply in accordance with state law.

D. Exempt GRIEVANCES
   1. GRIEVANCES received over the telephone that are not coverage disputes or disputed health care services involving medical necessity or experimental or investigational treatment, and that are RESOLVED by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response. CHPIV ensures the maintenance of a log of all such GRIEVANCES containing the date of the call, the name of the COMPLAINANT, MEMBER identification number, nature of the GRIEVANCE, nature of the RESOLUTION, and the name of the representative who took the call and RESOLVED the GRIEVANCE.
   2. The information contained in the log must be reviewed by CHPIV.
   3. CHPIV ensures exempt GRIEVANCES are incorporated into the quarterly GRIEVANCE and APPEAL report that is submitted to DHCS.
   4. Under federal regulations, coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment qualify as APPEALS and not GRIEVANCES. Therefore, APPEALS are not exempt from written acknowledgment and RESOLUTION.

E. CHPIV ensures prompt review and investigation of MEMBER GRIEVANCES are conducted by the appropriate department and/or staff delegated the responsibility to handle CHPIV's internal GRIEVANCE operations.
F. CHPIV ensures that every GRIEVANCE submitted by a MEMBER, or a provider or AUTHORIZED REPRESENTATIVE acting on behalf of a MEMBER and with the MEMBER's written consent, is reported to an appropriate level within its network (i.e., quality of care versus quality of service).
G. CHPIV ensures the immediate referral of all medical quality of care issues to a MEDICAL DIRECTOR or Designee for review.
H. CHPIV ensures MEMBERS, MEMBER's AUTHORIZED REPRESENTATIVES, or providers are not discriminated against or retaliated against on grounds that he or she filed a GRIEVANCE as required by federal and State nondiscrimination law.
I. CHPIV ensures GRIEVANCES alleging discrimination are forwarded to the Department of Health Care Services (DHCS) Office of Civil Rights (OCR).
J. CHPIV GRIEVANCES processed for pharmacy services rendered or requested before implementation of Medi-Cal Rx.
K. CHPIV ensures the maintenance and availability for DHCS review, GRIEVANCE logs, including GRIEVANCE logs delineated by Subcontractor and Downstream Subcontractor. The record of each GRIEVANCE must contain, at a minimum, all the following information and must be accurately maintained in a manner accessible to the state and available upon request to CMS:
    1. A general description of the reason for the GRIEVANCE.
    2. The date received.
    3. The date of each review or, if applicable, review meeting.
    4. A description of the action taken by the plan or provider to investigate and resolve the GRIEVANCE.
    5. RESOLUTION at each level of the GRIEVANCE, if applicable.
    6. The name of the plan provider or staff person responsible for resolving the GRIEVANCE
    7. Date of RESOLUTION at each level, if applicable.
    8. Name of the covered person for whom the GRIEVANCE was filed.
L. CHPIV will ensure that The Plan has established a system that provides for the prompt receipt of DMHC contacts regarding urgent GRIEVANCESs and APPEALS twenty-four (24) hours a day, seven (7) days a week. During normal business hours, the system provides for The Plan to contact the DMHC within 30 minutes following the DMHC contact regarding an urgent issue [Title 28, CCR 1300.68.01(b)]. After normal business hours, on weekends or holidays, the system provides for The Plan to contact the DMHC within one (1) hour following the DMHC contact regarding an urgent issue. This system provides for the availability of The Plan's representative with authority on the plan's behalf to resolve urgent GRIEVANCES and authorize the provision of health care services covered under the MEMBER'S contract in a medically appropriate and timely manner. Such authority includes making financial decisions for expenditure of funds on behalf of The Plan without first having to obtain approval from supervisors or other superiors within the plan. Refer to compliance filing: Title 28, CCR Section 1300.68.01(b)(1).
M. CHPIV will ensure after either completing the GRIEVANCE process or participating in the process for at least 30 days, a subscriber or enrollee may submit the GRIEVANCE to the DMHC for review. In any case determined by DMHC to be a case involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, the

potential loss of life, limb, or major bodily function, cancellations, rescissions, or the nonrenewal of a health care service plan contract, or in any other case where the department determines that an earlier review is warranted, a subscriber or enrollee shall not be required to complete the GRIEVANCE process or to participate in the process for at least 30 days before submitting a GRIEVANCE to the DMHC for review [1368(b)(1)(A)].

N. The Intake Specialist verifies that an urgent care issue does not exist according to the MEMBER'S perception, with support from the A&G CLIINICAL SPECIALIST II as necessary. This is noted in the file documentation. CASE COORDINATOR shall immediately refer any clinically urgent care issues related to medical quality of care to a A&G CLIINICAL SPECIALIST II for the referral to the plan's Medical/Dental Director for decision or action and to arrange medical care for MEMBER, if required (see B. Procedure for Handling and Resolving Clinical GRIEVANCES).

O. CHPIV will ensure written communications to MEMBERSs are provided in the threshold languages defined by the DHCS [RR3. A.5] [DHCS APL 21-011]. Written communications shall also be provided in alternative formats (including Braille, large-size print font no smaller than 20-point, or audio format) and through auxiliary aids upon request and in a timely fashion appropriate for the format being requested and taking into consideration the special needs of MEMBERS with disabilities or LEP [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]. Written notices to MEMBERS also enclose information regarding The Plan's Notice of Nondiscrimination, Notice of Language Assistance, and DMHC Independent Medical Review/ COMPLAINT application form and process.

P. Procedures for Handling and Resolving Clinical GRIEVANCES
   1. A MEMBER'S concern is received orally or in writing by the health plan.
   2. The Intake Specialist shall immediately refer any Clinically Urgent quality of care GRIEVANCE case to the A&G CLIINICAL SPECIALIST II (A&G Nurse) who will present the case immediately to the plan MEDICAL DIRECTOR to arrange medical care for the MEMBER (see Attachment 3) [Title 22 CCR Section 53858(e)(2)].
      a. All situations where the MEMBER has been determined to have a serious or imminent health risk and has voiced a concern about the quality of care that they are currently receiving, applicable alternative treatment arrangements will be made by the plan MEDICAL DIRECTOR, A&G CLIINICAL SPECIALIST II or PPG 72 hours based on the specific time and date of receipt of the GRIEVANCE [DHCS APL 21-011], depending upon the clinical urgency and applicability.
      b. Upon completion of the immediate actions and interventions, the case will then be handled via the process as outlined below. The actions and interventions taken will be documented in the file.
   3. CASE COORDINATOR acknowledges receipt of the Clinical GRIEVANCE in writing to the MEMBER mailed and postmarked within five (5) calendar days [§ 438.406(a)(2)] [DHCS APL 21-011, Health & Safety Code, Section 1368(a)(4)(A); Title 28, CCR, Section 1300.68(d)(1)]. The acknowledgement advises the MEMBER that the GRIEVANCE has been received, the date of the receipt, and provides the name of the plan representative, telephone number and address of the plan representative who may be contacted about the GRIEVANCE [Title 28, CCR 1300.68(d)(1), 1368(a)(4)(A)]. Information is included informing the MEMBER of his or her right to request a DSS hearing or APPEAL to the DHCS or DMHC [Title 22 CCR Section 53858(e)(5)].

4. Written communications to MEMBERS s are provided in the threshold languages as defined by the DHCS [RR3. A.5]. Written communications shall also be provided in alternative formats (including Braille, large-size print font no smaller than 20-point, or audio format) and through auxiliary aids upon request and in a timely fashion appropriate for the format being requested and taking into consideration the special needs of MEMBERS with disabilities or LEP [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].
5. The case is then assigned to a CASE COORDINATOR for handling.
6. The CASE COORDINATOR determines the appropriate GRIEVANCE Type Code for entry into the on-line system according to requirements for tracking and reporting purposes. (See Attachment 2) The CASE COORDINATOR'S logging includes:
    a. A description of the MEMBER'S issue (MEMBER Issue)
    b. A description of the actions taken by the plan or provider to investigate the GRIEVANCE. (Action Taken).
    c. The proposed RESOLUTION by the plan or provider, (RESOLUTION Notes)
    d. The name of the person responsible for resolving the GRIEVANCE, and
    e. The date of the notification to the MEMBER.
7. The CASE COORDINATOR uses a Provider Information Request (PIR) to obtain the response, and any other pertinent information required for review, including medical records. The CASE COORDINATOR then creates a summary of the GRIEVANCE that provides specific information on the Provider(s), date of service and information needed with the PPG's written response. The CASE COORDINATOR sends the PIR to the appropriate PPG/Provider or hospital contact.
8. The PPG/Provider has seven (7) calendar days to respond to the request for information. If no response has been received, the CASE COORDINATOR contacts his/her manager for assistance. The plan may send a copy service for medical records.
9. Upon receipt of medical records, information and responses from the PPG, the CASE COORDINATOR forwards the case to the A&G CLIINICAL SPECIALIST II.
10. The A&G CLIINICAL SPECIALIST II verifies that all information has been received. The A& Clinical Specialist II summarizes the COMPLAINT and forwards all cases to the plan MEDICAL DIRECTOR for review. The summary includes the MEMBER'S perception with pertinent information along with the PPG's response and records, if applicable.
11. A determination is made as to the specialty required to review the case.
12. If needed the practitioner in a similar specialty that would typically treat the medical condition, performs the procedure or provides the treatment at issue, will be consulted and documentation of the consult will be included with the GRIEVANCE file.
13. The MEDICAL DIRECTOR may request that the case be referred to the plan's contracted third-party review organization for a similar specialty review. Refer to desktop protocol: A&G Department Protocol Consultation Review.
14. The plan MEDICAL DIRECTOR Review:
    a. The Plan's MEDICAL DIRECTOR conducts a peer review assessment of the care provided. The MEDICAL DIRECTOR conducting the review for the proposed RESOLUTION of the GRIEVANCE will not have participated in any prior decisions related to the GRIEVANCE. The MEDICAL DIRECTOR will code the peer review form with an appropriate severity outcome level code.

b. The Plan's MEDICAL DIRECTOR, upon completion of the review of the case returns the case to the A&G CLIINICAL SPECIALIST II. The A&G CLIINICAL SPECIALIST II takes any appropriate follow-up action on behalf of the MEDICAL DIRECTOR. In any case where the MEDICAL DIRECTOR has severity outcome level coded the case to be a moderate or major quality of care event (e.g., severity outcome level code 3 and 4), the A&G CLIINICAL SPECIALIST II will refer the case to QI for intervention and next steps.
c. Corrective actions will be followed by the QI team to RESOLUTION [28 CCR sections 1300.70(b)(2)(H) and (c)].

15. A final RESOLUTION letter is sent to the MEMBER that clearly and concisely describes any administrative or service outcome information [1368(a)(5)]. The RESOLUTION letter is sent within 30 calendar days of receipt of the GRIEVANCE [Health & Safety Code, Section 1368.01(a); Title 28, CCR, Sections 1300.68(a) and (d)(3)]. Additionally, the RESOLUTION letter describes the MEMBER'S options if the MEMBER is not satisfied with the GRIEVANCE outcome. The final letter advises the MEMBER of The Plans determination without releasing peer-protected information. Information is included informing the MEMBER of his or her right to APPEAL to the DHCS or DMHC [Title 22 CCR Section 53858(e)(5), RR3. A.3].
16. MEMBERS have the right to APPEAL an adverse decision. If CHPIV makes an adverse decision as part of resolving a COMPLAINT, it notifies MEMBERS s of the decision and of their right to APPEAL. If the organization cannot resolve a COMPLAINT within the time frame stated in its policies or cannot notify the MEMBER of the final decision for legal or statutory reasons, at a minimum, it must notify the MEMBER that the COMPLAINT was received and investigated.
17. Written communications to the MEMBER are provided in the threshold languages defined by the DHCS [RR3. A.5]. Written communications shall also be provided in alternative formats (including Braille, large-size print font no smaller than 20-point, or audio format) and through auxiliary aids upon request and in a timely fashion appropriate for the format being requested and taking into consideration the special needs of MEMBERS with disabilities or LEP [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]. Written notices to MEMBERS also enclose information regarding The Plan's Notice of Nondiscrimination, Notice of Language Assistance, and DMHC Independent Medical Review/ COMPLAINT application form and process.
18. The PPG/Provider receives a copy of the final MEMBER letter.
19. When applicable, final letters should contain specific information for referrals generated during the GRIEVANCE process, such as the name of the specialist and for what timeframe the MEMBER has been referred.
20. The CASE COORDINATOR documents in the file and the online system after review has been conducted and proposed RESOLUTIONS have been determined:
    a. The date the case was sent to the A&G CLIINICAL SPECIALIST II for review.
    b. The date of the A&G CLIINICAL SPECIALIST II review
    c. The date the case was sent to the plan MEDICAL DIRECTOR for review.
    d. The date of the plan MEDICAL DIRECTOR Review
    e. The date of notification to the MEMBER of the RESOLUTION
    f. A description of the MEMBER'S issue (MEMBER Issue)

g. A description of the actions taken by the plan or provider to investigate the GRIEVANCE. (Action taken)
h. The proposed RESOLUTION by the plan or provider, (RESOLUTION Notes)
i. The name of the person responsible for resolving the GRIEVANCE, and
j. The date of the notification to the MEMBER.

## III. PROCEDURE

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

## IV. DEFINITIONS

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

| TERM | DEFINITION |
|---|---|
| **Member** | A beneficiary enrolled in a CHPIV program. |
| **Adverse Benefit Determination ("ABD")** | Means any of the following actions taken by Contractor:<br>• The denial or limited authorization of a requested service, including determinations based on the type or level of a Covered Service, Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service.<br>• The reduction, suspension, or termination of a previously authorized Covered Service.<br>• The denial, in whole or in part, of payment for a Covered Service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of Clean Claim is not an Adverse Benefit Determination.<br>• The failure to provide Covered Services in a timely manner.<br>• The failure to act within the required timeframes for standard resolution of Grievances and Appeals.<br>• The denial of the Member's request to obtain services out of Network when a Member is in an area with only one Medi-Cal managed care health plan; or<br>The denial of a Member's request to dispute financial liability. |

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| **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. |
| **Grievance** | Means an oral or written expression of dissatisfaction about any matter other than an ABD, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or Contractor's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by Contractor to make an authorization decision. |
| **Inquiry** | An inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CHPIV processes. |
| **Resolution** | Means that the Grievance has reached a conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the grievance system, including entities with delegated authority. |
| **State Fair Hearing (SFH)** | Means a hearing with a State Administrative Law Judge to resolve a member's dispute about an action taken by Contractor, its Network Providers, Subcontractors, or Downstream Subcontractors. |
| **Appeal** | Is federally defined as a review by The Plan of an adverse benefit determination [42 CFR 438.400(b)]. While California regulations do not explicitly define the term "appeal," they do delineate specific requirements for certain types of grievances that would fall under the federal definition of appeal be-cause they involve the delay, modification, or denial of services based on medical necessity or a determination that the requested service is not a covered benefit [28 CCR 1300.68(d)(4)-(5)]. The Plan shall treat these grievances as appeals under federal regulations. |
| **Notice Of Appeal Resolution (NAR)** | A formal letter from The Plan informing a member of the outcome of the appeal of an adverse benefit determination [42 CFR 438.408(d)(2)]. The NAR informs the member whether The Plan has overturned or upheld its decision on the adverse benefit determination. The contents of the NAR shall meet all the language and accessibility standards including translation, font, and format requirements as set forth in DHCS APL 21-004 [Title 42 CFR section 438.10, 438.402(c)(1)(i)(A), 438.404, and 438.408(c)(3) and (i); WIC 14029.91 and 10951(b)(1)(A); and Title 45 CFR, Part 92]. |
| **A&G Clinical Specialist II** | A Registered Nurse who provides clinical expertise in Clinical Grievance resolution and coordinates case as appropriate with the Medical/Dental Director, PPG/Provider and Third-Party Reviewer Organization. |

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|---|---|
| **Case Coordinator** | A non-clinician knowledgeable associate involved in grievance resolution. |
| **Complaint** | is the same as "grievance." |
| **Complainant** | is the same as "grievant," and means the person who filed the grievance including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee. |
| **Medical Director** | A physician reviewer who is involved in grievance review and resolution. |
| **Resolved** | Means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the plan's grievance system, including entities with delegated authority. |

| | Medicare Transition Process | PS-002 |
|---|---|---|
| **Department** | Health Services | |
| **Functional Area** | Pharmacy Services | |
| **Impacted Delegate** | ☒ Subcontractor ☐ NA | |

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

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

| ATTACHMENTS |
|---|
| • NA |

**AUTHORITIES/REFERENCES**

- **Federal**
  - 42 CFR § 423.120(b)(3)
  - Medicare Prescription Drug Benefit Manual, Chapter 6 – Part D Drugs and Formulary Requirements
  - MA-PD Soliciation
  - CMS Transition Process Requirements for Part D Sponsors, April 2007
  - CMS Medicare MA-PD Sponsor Par D Audit Guide Version 1.0, April 10, 2006

| HISTORY | |
|---|---|
| **Revision Date** | **Description of Revision** |
| | Policy Creation |
| | |
| | |
| | |

## I. OVERVIEW

Community Health Plan of Imperial Valley's ("CHPIV" or the "Plan") is responsible for ensuring compliance with established CMS transition requirements.

1. To ensure access to needed drugs for:

    a. New enrollees transitioning into Community Health Plan of Imperial Valley (CHPIV) following the annual coordinated election period,
    b. Newly eligible beneficiaries transitioning from other coverage,
    c. Individuals transitioning from one plan to another after the start of a contract year,
    d. Current enrollees affected by negative formulary changes across contract years; and
    e. Enrollees residing in long-term care (LTC) facilities.

    CHPIV transition policy will apply to non-formulary drugs, meaning both (1) drugs that are not on the plan's formulary and (2) drugs that are on the plan's formulary but require prior authorization or step therapy, or that have an approved quantity limit lower than the MEMBER'S current dose, under CHPIV's utilization management rules. CHPIV's policy addresses procedures for review of non-formulary drug requests, and when appropriate, a process for switching new MMP enrollees to therapeutically appropriate formulary alternatives failing an affirmative medical necessity determination.

    In accordance with CMS requirements, CHPIV will ensure that drugs excluded from Part D coverage due to Medicare statute are not eligible through the transition process. However, to the extent that CHPIV covers certain excluded drugs under an Enhanced benefit, those drugs should be treated the same as Part D for the purposes of the transition process.

2. To accommodate the immediate needs of an enrollee, as well as to allow CHPIV and/or the enrollee sufficient time to work with the prescriber to switch to a therapeutically equivalent medication or the completion of an exception request to maintain coverage of an existing drug based on reasons of medical necessity.

## II. POLICY

1. CHPIV will ensure to have an appropriate transition process in place for new and existing enrollees who are prescribed Part D drugs that are not on CHPIV's integrated formulary (non-formulary drugs), drugs previously approved for coverage under an exception once the exception expires, and drugs that are on the integrated formulary but require prior authorization or step therapy (formulary with utilization management rules), or that have an approved quantity limit lower than the beneficiary's current dose, and are not otherwise excluded from coverage.

2. CHPIV's policy and process will be consistent with written policy guidelines and other instructions from Centers for Medicare and Medicaid Services (CMS).

3. This policy applies to the following CHPIV MEMBERS:

    a. new enrollees into prescription drug plans on January 1, of each year following the annual coordinated election period;

    b. newly eligible beneficiaries transitioned from other coverage;

c. individuals transitioning from one plan to another after January 1;

d. enrollees residing in long-term care (LTC) facilities;

e. and enrollees whose drugs will be affected by negative formulary changes across contract years.

4. CHPIV will ensure to expedite transitions to formulary drugs for enrollees who change treatment settings due to changes in level of care.

5. CHPIV will ensure to provide a temporary supply fill anytime during the first 90 days of a beneficiary's enrollment from the effective date of coverage, including long-term care facility resident enrollees. CHPIV will provide a temporary 31-day fill when a beneficiary presents at a retail pharmacy or Long Term Care (LTC) pharmacy to request a refill of a non-formulary drug, drugs previously approved for coverage under an exception once the exception expires, or a formulary drug requiring prior authorization or step therapy or that have an approved quantity limit lower than the beneficiary's current dose under CHPIV's utilization management rules. If the enrollee presents with a prescription written for less than a 31-day supply, CHPIV will allow multiple fills to provide up to a 31-day supply of medication.

Commented [FO1]: Attestation 7.

6. CHPIV, through its Pharmacy Benefit Manager (PBM), has established on-line edits associated with temporary supplies of non-formulary drugs at the point of sale to ensure that the beneficiary is able to leave the pharmacy with a sufficient quantity of medication. Only the following drug utilization management edits may apply during a beneficiary's transition period:

a. Edits to help determine Part A or B vs. Part D coverage

b. Edits to help determine Part D drugs and products coverage and to prevent coverage of non-part D (i.e. excluded drugs)

c. Edits to promote safe utilization of a Part D drug (e.g., quantity limits based upon FDA maximum recommended daily dose; early refill edits).

7. If a utilization management edit is overridden at the point of sale for transition purposes only, but not permanently, the beneficiary must be notified so that he or she can begin the exception process if necessary.

8. CHPIV may implement quantity limits for safety purposes or drug utilization edits that are based upon approved product labeling during a beneficiary's transition period. To the extent that the prescription is dispensed for less than the written amount due to a plan edit, CHPIV will provide refills for that transition supply (up to a 31-day supply in a retail setting and a 31-day supply in a long-term care setting).

9. These edits are subject to exceptions and appeals and CHPIV will expeditiously process such exception requests so that beneficiaries will not experience unintended interruptions in medically necessary Part D and and/or inappropriately pay additional cost-sharing associated with multiple fills of lesser quantities when the originally prescribed doses of Part D drugs are medically necessary.

10. If a distinction cannot be made at the pharmacy whether the beneficiary is presenting with a refill of on-going medication therapy vs. a new prescription for a non-formulary drug at the point of sale, CHPIV will ensure to apply all transition process standards specified by CMS.

11. CHPIV will ensure to provide enrollees with appropriate notice regarding their transition process within three (3) business days of providing a temporary supply of non-formulary Part D drugs (including Part D drugs that are on the formulary but require prior authorization or step therapy under CHPIV's utilization management rules or that have an approved quantity limit lower than the beneficiary's current dose). For long term care residents dispensed multiple supplies of a Part D drug in increments of 14 days or less, the written notice will be provided within three (3) business days after adjudication of the first temporary transition fill. CHPIV uses the CMS model Transition Notice via the file-and-use process or will submit a non-model Transition Notice to CMS for marketing review subject to a 45-day review. CHPIV does not delegate the sending of required transition fill notices to network long term care pharmacies. CHPIV will ensure to send a written notice, via U.S. first class mail, to each enrollee who receives a transition fill.

    The notice will include the following elements:

    a. An explanation of the temporary nature of the transition supply that the enrollee received;
    b. Instructions for working with CHPIV and the enrollee's prescriber to satisfy utilization management requirements or to identify appropriate therapeutic alternatives that are on CHPIV's formulary;
    c. An explanation of the enrollee's right to request a formulary exception;
    d. A description of the procedures for requesting a formulary exception;
    e. Reason for the transition fill; and
    f. Alternate formulary drugs.

    CHPIV will ensure that reasonable efforts are made to notify prescribers of affected enrollees who receive a transition notice. Prescribers receive a written and faxed notification when affected enrollees receive a transition notice.

Commented [FO2]: Attestation 11.

12. CHPIV will ensure to make authorization or exception request forms available upon request to both enrollees and prescribing physicians via a variety of mechanisms including mail, fax, e-mail, and CHPIV's web site.

13. CHPIV will ensure to make general information about the transition process available to beneficiaries via a link from the Medicare Prescription Drug Plan Finder to CHPIV's web site and will include information about the policy in pre- and post-enrollment marketing materials as directed by CMS.

14. For a new enrollee in the LTC setting, CHPIV will ensure to provide a 31-day fill consistent with the applicable dispensing increment in the long-term care setting (unless the enrollee presents with a prescription written for less), with refills provided if needed during the first 90 days of a beneficiary's enrollment. However, to the extent that an enrollee in an LTC is

outside his or her 90-day transition period, CHPIV will provide an emergency supply of non-formulary drugs (or those on formulary with utilization management rules) while an exception or prior authorization is being requested. These emergency fills will be for at least 31 days of medication, unless the prescription is written for less than 31 days.

15. For unplanned transitions, e.g., enrollee discharged from the hospital to an LTC or home, CHPIV will ensure to make coverage determinations and re-determinations as expeditiously as the enrollee's health condition requires. Enrollees involved in unplanned transitions will be provided an emergency supply of non-formulary drugs, including Part D formulary drugs requiring utilization management.

16. CHPIV will ensure to not reject claims based on early refill edits when an enrollee is admitted or discharged from an LTC facility. This means that early refill edits are not used to limit appropriate and necessary access to their Part D benefit, and such enrollees are allowed to access a refill upon admission or discharge.

17. For current enrollees whose drugs are no longer on CHPIV's formulary, or remain on the formulary but to which new prior authorization or step therapy restrictions are applied, CHPIV will ensure to provide a transition process consistent with the transition process required for new enrollees beginning in the new contract year.

18. If a beneficiary enroll in a plan with an effective enrollment date of either November 1 or December 1 and need access to a transition supply, CHPIV will extend the transition policy across contract years.

## III. PROCEDURE

1. CHPIV delegates the Medicare transition process to its Subcontractor, Community Health Group.

2. Delegation Oversight

   A. CHPIV shall provide oversight and continually assess the delegated functions, responsibilities, processes, and performance of Community Health Group. CHPIV ensures Community Health Group'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

3. The PBM will apply the transition process to all non-formulary Part D drugs and integrated formulary drugs that have step therapy, quantity limits or prior authorization as part of CHPIV's utilization management rules. During transition, MEMBERS will be allowed fills of these drugs

automatically, at the point of sale, by establishing a point of service (POS) transition edit. The number of transition days and quantity day supply for both retail and long term care settings will be set. Claims for drugs allowed through the transition process will be marked in such a way that allows them to be tracked and reported to beneficiaries and to CMS.

4. Notification will happen in two ways:

   a. **Point of Sale notification:** Shall go to the pharmacy at time of adjudication with messaging that may be passed to the MEMBER regarding the status of the particular non-formulary drug or drug with utilization management rules. The transition messaging goes to pharmacies in a retail setting (including home infusion, safety-net and Indian Tribal Union) as well as pharmacies in an LTC setting. The transition messaging is passed in the proper messaging fields as specified by CMS and NCPDP standards.

   b. **Daily File extract**: the PBM will supply CHPIV with a daily file of any MEMBERS with a transition claim and provided with formulary alternate therapy options. CHPIV will ensure to notify the MEMBER and/or provider with these options and/or information on pursuing a medical exception request as described above. CHPIV also contracts with a print vendor. The print vendor receives the transition care notification file from the PBM and facilitates the fulfillment process of MEMBER notification.

5. For low-income subsidy (LIS) eligible MEMBERS, the cost-sharing amount applied during claims adjudication does not exceed the statutory maximum co-payment amounts. For non-LIS eligible MEMBERS, CHPIV will ensure that cost-sharing for a temporary supply of drugs provided under the transition process is consistent with approved cost-sharing tiers and is consistent with cost-sharing for non-formulary drugs approved under a coverage exception and the same cost sharing for formulary drugs subject to utilization management edits provided during the transition that would apply once the utilization management criteria are met.

6. Drugs dispensed during the transitional period will be reported as covered integrated formulary drugs with appropriate plan and beneficiary cost sharing amounts on the prescription drug event (PDE).

7. Enrollees transitioning to CHPIV on a drug within the six (6) therapeutic classes listed below will be allowed continued coverage of therapy for the duration of treatment, up to the full duration of active enrollment in CHPIV Utilization management restrictions (PA, step therapy and non-formulary status), which may apply to new patients naive to therapy, will not apply to enrollees transitioning to the MMP plan on agents within these key categories:
   a. Antidepressants
   b. Antipsychotics
   c. Anticonvulsants
   d. Antineoplastics
   e. Immunosuppressants (for prophylaxis of organ transplant rejection)
   f. Antiretroviral

For new MEMBERS, protected class drug logic will always override transition logic

to process the claim. Additionally for new MEMBERS, a 120-day transition period from their MEMBER start date is provided.

8. CHPIV's PBM will follow an overall transition plan for Part D beneficiaries. A component will include the exceptions process. The PBM's exceptions process will integrate with the overall transition plan for Part D beneficiaries in the following areas:

   a. PBM's exceptions process will complement other processes and strategies to support the overall transition plan. The exception process will follow the guidelines set forth by the transition plan when applicable.

   b. When evaluating an exception request for transitioning beneficiaries from a non-formulary drug, CHPIV's medical review process will consider the clinical aspects of the drug, including any risks involved in switching to therapeutically appropriate formulary alternatives.

   c. The exception policy includes a process for switching new Part D plan enrollees to therapeutically appropriate formulary alternatives failing an affirmative medical necessity determination.

      1. The Prescriber Transition Letter provides prescribers with instructions to access the Plan's formulary, as well as instructions on additional information to provide in a supporting statement for an exception request.
      2. When evaluating an exception request for transitioning MEMBERS, the Plan's exception evaluation process includes a medical review that considers the clinical aspects of the drug, including any risks involved in switching.
         a. This medical review process includes the following steps:
            i. Outreach is made to the provider to offer therapeutically appropriate formulary alternatives.
            ii. This provides the prescriber an opportunity to switch the MEMBER to a covered formulary medication.
            iii. If the prescriber feels the formulary alternatives are not clinically appropriate for the MEMBER, they can provide attestation that the alternatives would not be as effective or would cause adverse effects which would lead to an approval of the requested medication.

9. **Transition Extension:** CHPIV will ensure to make arrangements to continue to provide necessary Part D drugs to enrollees via an extension of the transition period, on a case-by-case basis, to the extent that an exception request or appeal has not been processed by the end of the minimum transition period and until such time as a transition has been made (either through a switch to an appropriate formulary drug or a decision on an exception request).

10. **Transition Across Contract Years:** For current enrollees whose drugs will be affected by negative formulary changes in the upcoming year, CHPIV will effectuate a meaningful transition by either: 1) providing a transition process at the start of the new contract year or 2) effectuating a transition prior to the start of the new contract year. The PBM's Point of Sale (POS) logic is able to accommodate option #1 by allowing current MEMBERS to access transition supplies at the point-of-sale when their claims history from the previous calendar year contains an approved claim for the same drug that the MEMBER is attempting to fill through the transition and the drug is considered a negative change from one plan year to the next. To accomplish this, POS will look back 180 days for Part D claims in the MEMBER'S claim history that were approved prior to January 1 of the new plan year, and that have the same HICL value as the transition claim. Additionally, if a brand medication is being filled under transition, the previous claim must also be brand (based on the NSDE marketing status). If a generic medication is being filled under transition, the previous claim can be either brand or generic (based on NSDE marketing status). Negative changes are changes to a formulary that result in a potential reduction in benefit to MEMBERS. These changes can be associated with removing the covered Part D drug from the formulary, changing its preferred or tiered cost-sharing status, or adding utilization management. The transition across contract years is applicable to all drugs associated to mid-year and across plan-year negative changes.

    Since CHPIV has adopted a standard PBM formulary for its Medicare beneficiaries, the PBM's Pharmacy and Therapeutics (P&T) Committee (vs. CHPIV's P&T Committee) maintains a role in the transition process in the following areas:

    a. The PBM's P&T Committee reviews and recommends all PBM formulary step therapy and prior authorization guidelines for clinical considerations; and

    b. The PBM's P&T Committee reviews and recommends procedures for medical review of non-formulary drug requests, including the PBM's exception process.

11. The majority of the membership of the PBM's P&T Committee used to develop and review the formulary submission for each benefit year is comprised of practicing physicians and/or practicing pharmacists. Membership includes at least one practicing physician and at least one practicing pharmacist who are experts in the care of the elderly or disabled persons and at least one practicing physician and at least one practicing pharmacist who are both free of conflict with respect to Community Health Group and pharmaceutical manufacturers.

12. CHPIV will ensure that the parameters of the transition plan are accurately reflected in the PBM's POS system. Additionally, CHPIV will validate that the PBM's customer service notes and documentation accurately reflect CHPIV's plan and that the PBM customer service and prior authorization staff are trained on CHPIV's transition plan.

13. CHPIV will ensure to regularly conduct training with its internal customer service and case management staff to ensure that as they work with enrollees on their individual care plans or when transitioning MEMBERS between treatment settings, staff is aware of the transition policy.

This will provide staff with the opportunity to proactively work with enrollees and CHPIV's pharmacy services staff to facilitate transition to a formulary drug, where applicable

14. Until such time as alternative transactional coding is implemented in a new version of the HIPAA standard, CHPIV will promptly implement either:
    a. Appropriate systems changes to achieve the goals of any additional new messaging approved by the industry through NCPDP to address clarifying information needed to adjudicate a Part D claim, or

    b. Alternative approaches that achieve the goals intended in the messaging guidance.

15. CHPIV works closely with its PBM to ensure accurate implementation within the claims adjudication system. The following is an implementation statement that is included in the PBM policy, "Transition Process Requirements for Medicare Part D".

    a. **Claims Adjudication System:** MedImpact has systems capabilities that allow MedImpact to provide a temporary supply of non-formulary Part D drugs in order to accommodate the immediate needs of an enrollee, as well as to allow the plan and/or the enrollee sufficient time to work with the prescriber to make an appropriate switch to the therapeutically equivalent medication or the completion of an exception request to maintain coverage of an existing drug based on medical necessity reasons.

    a) **Pharmacy Notification at Point-of-Sale:** Until such time as alternative transaction coding is implemented in new version of the HIPAA standard, MedImpact will promptly implement either:

    1. Appropriate systems changes to achieve the goals of any additional new messaging approved by the industry through NCPDP to address clarifying information needed to adjudicate a Part D claim (see the 5.1 Editorial Document), or

16. Alternative approaches that achieve the goals intended in the messaging guidance.

    a. **Edits During Transition:** During an enrollee's transition period, the only edits that are enforced by MedImpact's claims adjudication system are:
        1) Edits to help determine Part A or B vs. Part D coverage,
        2) Edits to help determine Part D drugs and products coverage to help prevent Coverage of non-Part D drugs (i.e., excluded drugs), and
        3) Edits to help promote safe utilization of a Part D drug (i.e., quantity limits based on FDA maximum recommended daily dose, early refill edits.

    MedImpact will ensure that the transition policy provides refills for transition prescriptions dispensed for less than the written amount due to quantity limits

for safety purposes or drug utilization edits that are based on approved product labeling.

b. **Pharmacy Overrides at Point-of-Sale:** During the MEMBER'S transition period, all edits (with the exception of those outlined in Part C above) associated with non-formulary drugs are automatically overridden by MedImpact's claims adjudication system at the point-of-sale.

MedImpact will ensure that pharmacies can override step therapy and prior authorization edits – other than those that are in place to determine Part A or B vs. Part D coverage, determine Part D coverage and prevent coverage of non-Part D drugs, and promote safe utilization of a Part D drug (e.g., quantity limits based on FDA maximum recommended dose, early refill edits) – during transition at point-of-sale.

Pharmacies can also contact MedImpact's Pharmacy Help Desk directly for immediate assistance with point-of-sale overrides, MedImpact can also accommodate overrides at point-of-sale for emergency fills as described in section 1.6.

## IV. DEFINITIONS

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

| TERM | DEFINITION |
|---|---|
| **Centers for Medicare & Medicaid Services (CMS)** | The federal agency responsible for the administration of Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace. CMS develops and enforces regulations, oversees health care quality standards, and ensures compliance for public health insurance programs nationwide. |
| **Medically Necessary/Medical Necessity** | Means all Covered Services that are reasonable and necessary to protect life, prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity per Title 22 CCR Section 51303(a) and 42 CFR 438.210(a)(5).When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and W & I Code Section 14132 (v).<br><br>For individuals under 21 years of age, EPSDT service is considered medically necessary or a medical necessity when it is necessary to correct or ameliorate defects and physical and mental illnesses and conditions that are discovered by screening services.<br><br>A service need not cure a condition in order to be covered under |

| | |
|---|---|
| | EPSDT. Services that maintain or improve the child's current health condition are also covered under EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. The common definition of "ameliorate" is to "make more tolerable". Additional services must be provided if determined to be medically necessary for an individual child. |
| **Member** | A beneficiary enrolled in a CHPIV program. |
| **Provider** | Individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. |
| **Subcontractor** | An individual or entity that has a subcontract with the MCP that relates directly or indirectly to the performance of the MCP's obligations under the contract with DHCS. A network provider is not a subcontractor by virtue of the network provider agreement, as per 42 CFR § 438.2. |

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# Community Advisory Committee Report, Qtr 3

## Meeting Date: Sep 16, 2025, 12-2pm

## Agenda Items Reviewed:

- PNA/SMART goal update: enhance access to medical and dental care for all members
- Non-specialty mental health outreach and education plan
- Health literacy program overview
- DayOut El Centro program overview, Guest: Maribell Menendez
- Community sharing and open forum

## Key Observations:

- The last two meetings have been run in Spanish, and we are receiving more active member participation.
- Members commented on challenges with getting behavioral health meds through PCPs, lack of access to oral health specialists, and challenges arranging transportation through the plan.

## Actions Taken:

- Approval of Q2 meeting minutes
- Approval of charter amendments to conform with regulatory changes

## Recommendations:

- Once member seat is filled on Commission, may want that Commissioner to serve as Chair of Community Advisory Committee.
- Staff are preparing a Cultural and Linguistic score card to be reviewed by the Community Advisory Committee in Quarter 4. This scorecard could inform selection of 2026 CAC goals.

# Information Items

# Operations Report, October 2025

## Period Covered: Sep 2025

## Highlights:

- Team: Veronica Arroyo, receptionist, promoted to Member Experience Representative. Hiring now for receptionist position.
- Community Advisory Committee (CAC) Goal: Increase member utilization of treatment for depression and anxiety by 10%.
    - Scheduling in-person member education sessions across the county on how to access tele-mental health and other non-specialty mental health services.
- D-SNP Go Live:
    - Community Care Advantage marketing for 2026 has begun. Supplemental benefits include:
        - Non- emergency transportation to local doctor appointments.
        - $0 copay for certain generic and chronic medications.
        - Debit card benefit:
            - $55 per month for qualified over the counter medications or use for fitness expenses.
            - $55 per month for eligible members for food and groceries (not all members will qualify).
        - $2,000 dental benefit for crowns and dentures.
        - Eye exam + $250 for glasses/frames every 2 years.
    - All CHPIV Sales reps are licensed and trained, enrollment begins 10/15.
    - Sales phone lines are operational and ring first to CHPIV office and then roll over to Community Health Group member services if no local staff are available.
    - Community Advantage Plus website scheduled to be live by 10/15.
    - First CHPIV credentialing committee meeting on 10/14 (tentative).
- Engage CBOs: Project plans approved for:
    - DayOut (El Centro & Brawley)
        - Coordinate quarterly on-site member education sessions.
        - Participate in senior wellness activities and events.

        - Develop a referral process for members requiring adult day services.
        - Provide branded outreach materials for both sites.
    - Imperial County Behavioral Health (ICBH)
        - Align CHPIV care management team with ICBH for warm handoffs.
        - Collaborate on behavioral health awareness workshops.
        - Partner on crisis intervention awareness initiatives.
        - Hold quarterly coordination meetings between CHPIV and ICBH leadership.
- **Medi-Cal:** Established Joint Operating Committee with Health Net. Receiving additional operational reporting. Member escalation process implemented.

## Key Metrics:

| Status | Category | Goal | Prior Month Performance |
|---|---|---|---|
| | Provider Network | 100% of direct provider contracts are signed by 1/1 | 90% submitted to credentialing |
| | Member engagement | 20 outbound member calls per month | 13, NPS = 92% [NPS = Net Promoter Score] |
| | Enrollment | 417 new enrollments between 10/15 and 12/31 | n/a |
| | Community Advisory Committee | Increase # of members receiving care for depression & anxiety by 10% from 327 in 2024 to 360 in 2025 | 565 members treated as of Sep 30, 2025 |

## Issues/Risks:

- UCSD counter-counter offer sent 10/3.
- IPA implementation and contracts behind schedule, but top priority in the next month.

## Next 30 Days:

- IPA implementation and contracts.
- Enroll 85 new Community Advantage Plus members.

COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

# HUMAN RESOURCES REVIEW
# October 13, 2025

## THE MONTH IN REVIEW

- 7 new hires (6 local!)
- 2 current open positions: Senior Compliance Advisor, Receptionist
- Assisting CHG with hiring a UM Nurse
- Continued work on benefit changes and enhancements for November open enrollment
- Implemented a platform that will automatically check licenses and exclusions monthly
- Planning 2026 wage budget

## A PREVIEW OF THE NEXT MONTH

- Benefit open enrollment in mid-November
- Performance review and goal setting planning for December

## HR NUMBERS AT A GLANCE (THROUGH OCTOBER 13, 2025)

| | |
|---|---|
| **Total number of employees** | 43 |
| Local | 31 |
| Remote | 12 |
| **Number of exits in 2025** | 4 (+1) No new exits this month<br>- 1 involuntary<br>- 1 not returning from leave<br>- 2 personal reasons |