COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

AGENDA

Executive Committee

December 3, 2025

12:00 p.m.

512 W. Aten Rd., Imperial, CA 92251

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

Microsoft Teams

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Meeting ID: 259 514 478 66

Passcode: vULVTd

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

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 Committee on any matter within the Committee's jurisdiction. Any action taken as a result of public comment shall be limited to the direction of staff. When addressing the Committee, state your name for the record prior to providing your comments. Please address the Committee as a whole, through the Chairperson. Individuals will be given three (3) minutes to address the board.

3. CONSENT CALENDAR

All items appearing on the consent calendar are recommended for approval and will be acted upon by bone 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 11/5/2025…pg. 6-9

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. 10-11
    2. Enrollment Report…pg. 12
    3. Statement of Revenues, Expenses, and Changes in Net Position.pg.13
    4. Product Profit & Loss Statement…pg. 14
    5. Statement of Net Position…pg. 15
    6. Summarized TNE Calculation…pg. 16
    7. Cash Transaction Report…pg. 17-18

C. Motion to recommend to the full commission authority to the CEO to execute agreements with external agencies to assist in enrolling eligible members in CHPIV's D-SNP plan as reviewed and accepted by the Finance Committee. …pg. 19

4. ACTION

A. Motion to recommend to the full commission authority to the CEO to execute provider agreements, including execution of contracts with the County of Imperial, and specifically a provider agreement with Imperial County Behavioral Health (ICBH) to provide Medicare-covered behavioral health services for Community Advantage Plus members *(Julia Hutchins, COO)* ...pg. 21

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*
(Dr. Allan Wu, Chair) *No meeting*

D. Community Advisory Committee-*Quarterly*
(Julia Hutchins, COO) *No meeting*

6. INFORMATION

A. Health Services Report *(Dr. Gordon Arakawa, CMO and Laura Galvin, Manager of Care Management)*

B. Compliance Report *(Elysse Tarabola, CCO and Chelsea Hardy, Senior Director of Compliance)* ...pg. 24-65

C. Operations Report *(Julia Hutchins, COO)* ...pg. 66-69

D. Human Resources Report *(Shannon Long, HR Consultant)* ...pg. 70

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

F. Other new of 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, 10/2026)

A. Compliance Report

8. RECONVENE OPEN SESSION

A. Report on actions taken in closed session.

9. ADJOURNMENT

Next meeting: January 7, 2026

Consent Agenda

COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

MINUTES

Executive Committee

November 5, 2025

12:00 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: 259 514 478 66
Passcode: vULVTd

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

1. CALL TO ORDER *Lee Hindman, Chair*

Meeting called to order at 12:05 a.m.

A. Roll Call *Donna Ponce, Commission Clerk*

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

B. Approval of Agenda

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

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

2. PUBLIC COMMENT *Lee Hindman, Chair*

Public Comment is limited to items NOT listed on the agenda. This is an opportunity for members of the public to address the Commission on any matter within the Commission's jurisdiction. Any action taken as a result of public comment shall be limited to the direction of staff. When addressing the Commission, state your name for the record prior to providing your comments. Please address the Commission as a whole, through the Chairperson. Individuals will be given three (3) minutes to address the board. None.

3. CONSENT AGENDA

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

A. Approval of Minutes from 10/7/2025……. *pg. 5-9*

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. 10-11*
2. Enrollment Report ……. *pg. 12*
3. Statement of Revenues, Expenses, and Changes in Net Position *pg. 13*
4. Product Profit & Loss Statement……. *pg. 14*
5. Statement of Net Position……. *pg. 15*
6. Summarized TNE Calculation ……. *pg. 16*
7. Cash Transaction Report ……. *pg. 17-18*

C. Motion to recommend to the full commission approval of the new Purchasing Policy, as outlined in the draft attachment, replacing the current policy adopted in 2023 as reviewed and accepted by the Finance Committee *(David Wilson, CFO) …pg. 19-26*

D. Motion to recommend to the full commission the Wakely Statement of Work for CY 27 Medicare Bid preparation, not to exceed $265,000 as reviewed and accepted by the Finance Committee. *(David Wilson, CFO)* …pg. 27-28

4. ACTION

No action items.

5. COMMITTEE CHAIR REPORTS

A. Quality Improvement Health & Equity Committee-*Quarterly*
(Dr. Gordon Arakawa, CMO)
Chief Medical Officer (CMO) Dr. Gordon Arakawa provided a brief update on topics related to October 15, 2025, QIHEC meeting. A power point presentation will be provided at the LHA Commission meeting on November 10, 2025.

B. Finance Committee-*Monthly*
(Dr. Carlos Ramirez, Chair)
Member Ramirez provided updated on the November 5, 2025, Finance Committee meeting.

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

D. Community Advisory Committee-*Quarterly*
(Julia Hutchins) *No meeting*

6. INFORMATION

A. Health Services Report *(Dr. Gordon Arakawa, CMO and Jeanette Crenshaw, Executive Director of Health Services)*
CMO Dr. Gordon Arakawa provided updates on Health Services and NCQA. He added that Health Services is now fully staffed with six Care Coordinators and three Care Managers.

B. Compliance Report *(Elysse Tarabola, CCO and Chelsea Hardy, Senior Director of Compliance) …pg. 31-33*
Chief Compliance Officer Elysse Tarabola presented updates regarding Notices on Non-Compliance and Delegation Oversight. Senior Direct of Compliance Chelsea Hardy provided updates on Regulatory Audits.
Elysse Tarabola concluded the report by noting that the DHCS audit report is expected to be released within the next few weeks and that the Heath Net annual audit has been completed.

C. Operations Report *(Julia Hutchins, COO) ……. pg. 34-35*
Chief Compliance Officer Julia Hutchins provided updates on D-SNP Go-Live and noted that the Community Advantage Plus website is live. She reported ongoing collaboration with CHG to ensure proper claims submission. Additional updates included IPA implementation readiness, Community Based Organizations engagements, and the upcoming community newsletter, which will be released next week and continue monthly. Dr. Sampat inquired whether questions from PCPs regarding contracts are being addressed. Julia confirmed that CHPIV has initiated outreach to respond to these inquiries. Dr. Sampat also requested clarification on CHG timelines and credentialing.

D. Human Resources Report *(Shannon Long, HR Consultant)*
To be presented at the November 10, 2025, LHA Commission meeting.

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

Chief Executive Officer (CEO) Larry Lewis provided updates on the following:

- Medical Society dinner scheduled for November 12, 2025.
- No sanctions for the health plan, indicating that Health Net operated in compliance with applicable guidelines.
- New credentialing standards were discussed, including a requirement for health plans to notify providers upon receipt of a completed application, ensuring clarity on when the review timeline begins.
- TNE planning efforts underway.
- LHPC webinars designed specifically for commissioners. Once available, commissioners will be notified.

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, 10/2025)

Chair Hindman announces that the committee will enter into closed session.

A. Strategic Plan Update *(Larry Lewis, CEO)*
B. Employee Benefits *(Larry Lewis, CEO/Shannon Long, Human Resources Consultant)*
C. Compliance Report *(Elysse Tarabola, CCO)*
D. Public Employee Evaluation *(restricted to Commissioners)*

8. RECONVENE OPEN SESSION

A. Report on actions taken in closed session.

Chair Hindman announces that the committee will reconvene into open session.

Information provided with no action taken.

9. ADJOURNMENT

The meeting was adjourned at 1:40 p.m.

Next meeting: December 3, 2025

Financial Result

October 2025

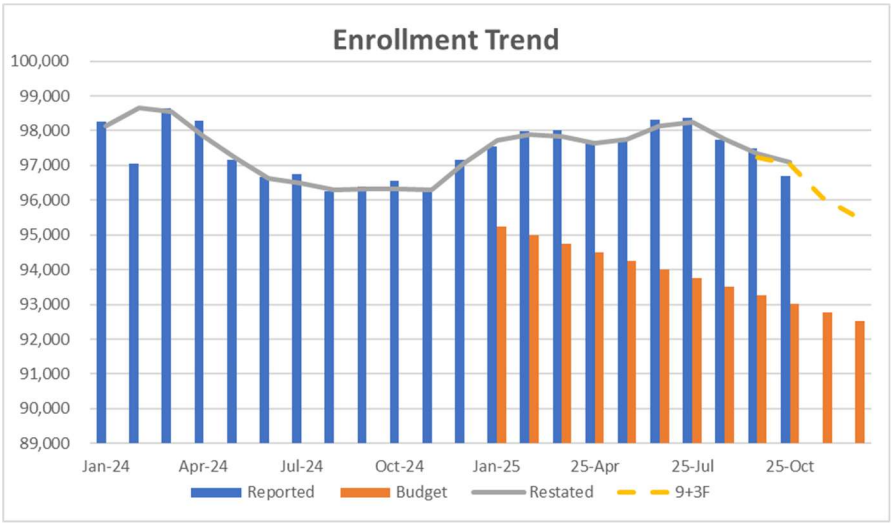
Executive Summary

Membership

October Medi-Cal reported membership was 96.7K, approximately 0.3K members lower than the 9+3 forecast. On a restated basis, membership is in line with expectations.

Early reporting for November and December suggests membership will continue to decline for the remainder of the year consistent with the forecast.

Year-to-date, membership remains favorable to budget by 36.3K member months.



Gross Margin

Overall, October revenue was favorable to the forecast by $1.2M driven by favorable prior period maternity kick payments. October current period revenue (excluding prior period) was unfavorable to forecast by ($0.4M).

Membership Mix & Rate: Rate variance was unfavorable to the 9+3F by ($424K) primarily due to timing related to maternity revenue.

Volume: Overall volume adjustments for the current period were slightly ahead of forecast, resulting in minor favorable revenue variance of $15K.

	Revenue (Current Month Reported)					
Category of Aid (COA)*	**Current**	**Prior Period**	**Forecast**	**Variance**	**Vol**	**Rate**
Child	$ 4,528,961	$ (9,263)	$ 4,558,003	$ (29,042)	$ 1,451	$ (30,493)
Adult	$ 3,842,396	$ 1,276,675	$ 4,176,069	$ (333,674)	$ 13,394	$ (347,067)
Adult Expansion	$ 7,381,113	$ 172,999	$ 7,429,901	$ (48,787)	$ -	$ (48,787)
SPD	$ 4,197,630	$ 85,539	$ 4,196,646	$ 984	$ -	$ 984
SPD Dual	$ 6,389,947	$ 39,300	$ 6,389,388	$ 559	$ -	$ 559
LTC	$ 17,475	$ -	$ 17,647	$ (172)	$ -	$ (172)
LTC Dual	$ 37,673	$ (2,306)	$ 37,673	$ (0)	$ -	$ (0)
Total Medicaid	**$ 26,395,195**	**$ 1,562,944**	**$ 26,805,327**	**$ (410,132)**	**$ 14,845**	**$ (424,977)**

Overall, Gross margin was in line with forecast, favorable by $032K; on a YTD basis, gross margin was favorable to the budget by $1.4M.

Administrative Expenses

In aggregate, administrative expenses were in line with the 9+3F. Departmental spending continues to ramp in Healthcare Services and Operations (specifically Sales and Marketing) in preparation for the launch of Medicare, however, both areas are operating within the assumed forecast. Corporate departments are in line with forecast, with some pressure realized in Compliance.

On a YTD basis, administrative costs are favorable to the budget by $261K, or 4.2%.

Other

Investment income was unfavorable by $7K in October due to interest rate pressure. Year-to-date, investment income is $209K above budget.

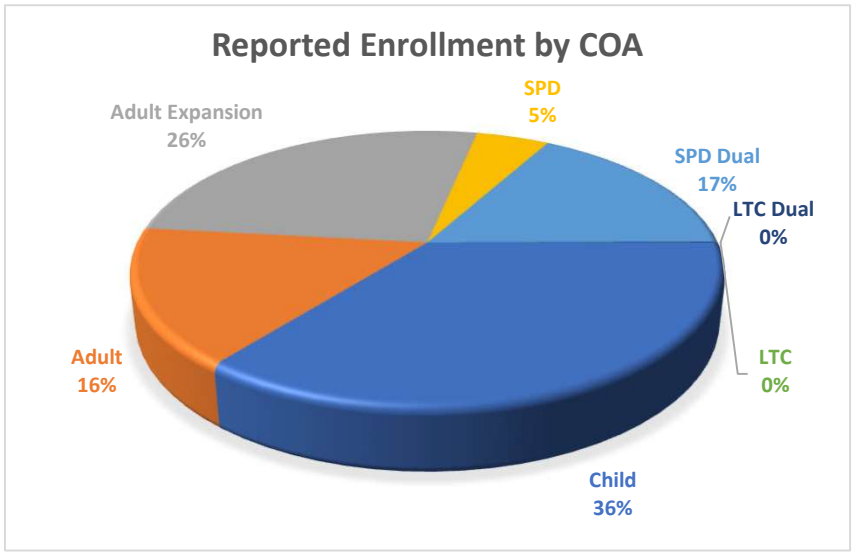
Tangible Net Equity (TNE)

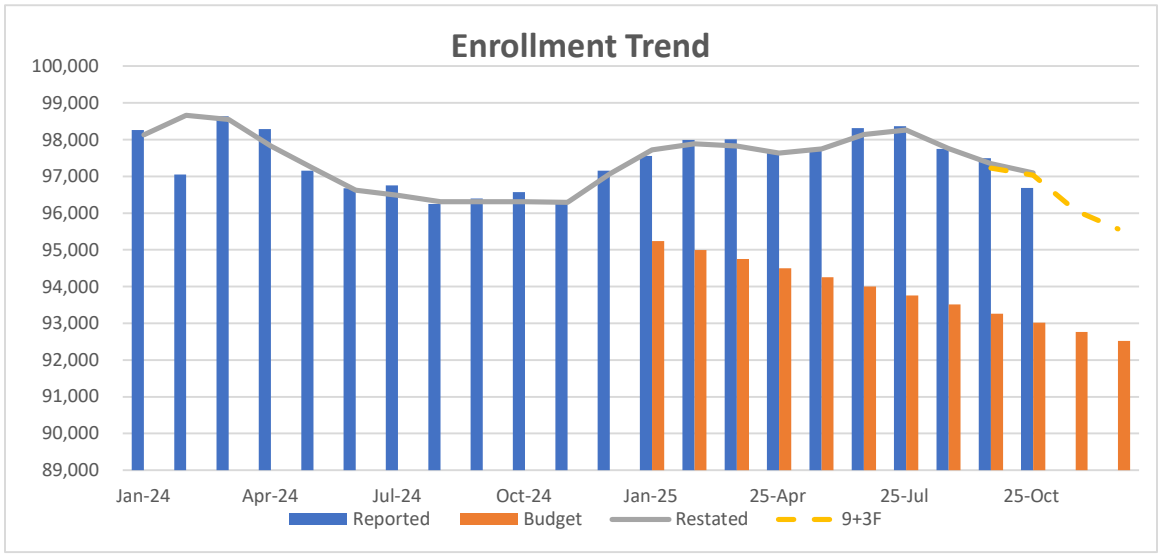
For the month of October, TNE was $23M, representing 489% of the required $4.8M. On a restated basis, TNE stands at 497% of the required levels.

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

	2024				2025			2025							
								October				October (YTD)			
										B/(W)				B/(W)	
Category of Aid (COA)*	Q1-24	Q2-24	Q3-24	Q4-24	Q1-25	Q2-25	Q3-25	Actual	9+3F	#	%	Actual	Budget	#	%
Child	34,607	34,589	34,424	34,551	35,139	35,129	34,728	33,884	34,548	(664)	-2%	349,180	332,450	16,730	5%
Adult	16,997	15,767	15,675	15,768	15,801	15,754	15,471	15,445	15,278	167	1%	156,749	149,813	6,936	5%
Adult Expansion	26,579	25,784	25,733	26,019	25,995	26,028	25,808	25,889	25,920	(31)	0%	259,319	252,180	7,140	3%
SPD	5,007	5,041	5,085	5,139	4,671	4,784	4,645	4,638	4,557	81	2%	46,800	50,418	(3,618)	-7%
SPD Dual	14,433	14,760	15,007	15,288	16,283	16,514	16,719	16,718	16,614	104	1%	164,424	155,055	9,369	6%
LTC	12	15	19	22	22	6	17	18	18	-	0%	175	313	(138)	-44%
LTC Dual	79	87	92	104	98	100	104	92	98	(6)	-6%	968	1,063	(95)	-9%
Total Medicaid	97,714	96,043	96,035	96,891	98,009	98,315	97,492	96,684	97,033	(349)	0%	977,615	941,290	36,325	4%
Monthly/Quarterly Change		*-1.7%*	*0.0%*	*0.9%*	*1.2%*	*0.3%*	*(252)*	*-0.2%*	*0.1%*						

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





Community Health Plan OF IMPERIAL VALLEY

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

	October			October (YTD)			
	Actual	Forecast (9+3)	Variance - B/(W)	Actual	Budget	Variance - B/(W)	Current Month Explanations
REVENUE							
Premium	$ 27,570,397	$ 26,492,796	**$ 1,077,601**	$ 273,585,324	$ 227,701,077	**$ 45,884,247**	- Total Revenue was favorable by $1.2M driven by prior period maternity kick payments.
Pass-Through	$ 387,741	$ 312,531	**$ 75,210**	$ 8,752,050	$ 3,439,932	**$ 5,312,118**	
HN Settlements			**$ -**			**$ -**	
TOTAL REVENUE	**$ 27,958,138**	**$ 26,805,327**	**$ 1,152,811**	**$ 282,337,374**	**$ 231,141,009**	**$ 51,196,365**	
HEALTH CARE COSTS	$ 27,131,026	$ 26,010,543	**$ (1,120,483)**	$ 274,129,814	$ 224,309,977	**$ (49,819,838)**	
Gross Margin	**$ 827,112**	**$ 794,784**	**$ 32,328**	**$ 8,207,560**	**$ 6,831,032**	**$ 1,376,527**	
ADMINISTRATIVE EXPENSE							
Salaries & Wages	$ 493,349	$ 494,254	**$ 906**	$ 3,743,476	$ 3,986,222	**$ 242,746**	
Benefits Expense	$ 33,932	$ 35,380	**$ 1,448**	$ 267,500	$ 301,719	**$ 34,219**	
Other Labor Expense	$ 1,424	$ 1,681	**$ 256**	$ 15,063	$ 12,724	**$ (2,339)**	
Total Labor Costs	$ 528,705	$ 531,315	**$ 2,610**	$ 4,026,039	$ 4,300,665	**$ 274,626**	
Consulting, Legal, & Other Professional	$ 43,302	$ 41,419	**$ (1,883)**	$ 642,056	$ 759,396	**$ 117,340**	
Outside Services	$ 37,656	$ 31,783	**$ (5,873)**	$ 364,264	$ 306,356	**$ (57,908)**	
Advertising & Marketing	$ 14,546	$ 14,000	**$ (546)**	$ 24,461	$ 46,441	**$ 21,981**	
Information Technology	$ 10,318	$ 10,770	**$ 452**	$ 115,603	$ 57,814	**$ (57,788)**	
Membership and Subscriptions	$ 11,149	$ 14,524	**$ 3,375**	$ 102,719	$ 97,480	**$ (5,239)**	
Regulatory Fees	$ 25,339	$ 25,339	**$ (0)**	$ 257,935	$ 278,432	**$ 20,497**	
Travel	$ 15,069	$ 17,293	**$ 2,225**	$ 73,159	$ 81,008	**$ 7,850**	
Meals & Entertainment	$ 4,976	$ 1,552	**$ (3,424)**	$ 23,342	$ 9,720	**$ (13,622)**	
Occupancy & Facility	$ 6,238	$ 9,416	**$ 3,178**	$ 73,964	$ 47,171	**$ (26,792)**	
Office Expense	$ 12,694	$ 12,696	**$ 2**	$ 65,587	$ 65,498	**$ (89)**	
Other Admin	$ 11,059	$ 10,836	**$ (223)**	$ 143,043	$ 122,818	**$ (20,226)**	
Total Administrative Expense	**$ 721,053**	**$ 720,944**	**$ (109)**	**$ 5,912,170**	**$ 6,172,800**	**$ 260,630**	- Administrative costs were in line with forecast
Non-Operating Income							
Dividend, Interest & Investment Income	$ 109,385	$ 116,353	**$ (6,968)**	$ 1,082,686	$ 873,912	**$ 208,773**	- Unfavorable investment income due to reductions in state payments related to declining membership
Rental Income	$ 1,494	$ 1,494	**$ -**	$ 14,935	$ 14,500	**$ (435)**	
Total Non-Operating Income	$ 110,878	$ 117,846	**$ (6,968)**	$ 1,097,621	$ 888,412	**$ 209,208**	
Depreciation & Amortization	$ 10,729	$ 11,000	**$ (271)**	$ 106,702	$ 110,000	**$ (3,298)**	
Change in Net Position	**$ 206,208**	**$ 180,687**	**$ 25,522**	**$ 3,286,308**	**$ 1,436,645**	**$ 1,849,663**	
Key Metrics							
Enrollment	96,684	97,033	**(349)**	977,615	941,290	**36,325**	
Revenue PMPM	$289.17	$276.25	**$12.92**	$288.80	$245.56	**$43.24**	
MLR	97.04%	97.0%	**(1) bps**	97.1%	97.0%	**(5) bps**	
Admin Ratio	2.6%	2.7%	**11 bps**	2.1%	2.7%	**57 bps**	
FTEs	44	45	**1**	285	297	**12**	
Net Income PMPM	$2.13	$1.86	**$0.27**	$3.36	$1.53	**$1.84**	
Net Income %	0.7%	0.7%	**6 bps**	1.2%	0.6%	**54 bps**	

Community Health Plan OF IMPERIAL VALLEY

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

	October								October (YTD)			% of Total	
	Medi-Cal				Medicare								
	Actual	9+3F	Variance B/(W)	% Var	Actual	9+3F	Variance B/(W)	% Var	Medi-Cal	Medicare	Total	Medi-Cal	Medicare
REVENUE													
Premium	$ 27,570,397	$ 26,492,796	**$ 1,077,601**	4%	$ -	$ -	**$ -**	N/A	$ 273,585,324	$ -	**$ 273,585,324**	100%	0%
Pass-Through	$ 387,741	$ 312,531	**$ 75,210**	24%	$ -	$ -	**$ -**	N/A	$ 8,752,050	$ -	**$ 8,752,050**	100%	0%
TOTAL REVENUE	**$ 27,958,138**	**$ 26,805,327**	**$ 1,152,811**	**4%**	**$ -**	**$ -**	**$ -**	**N/A**	**$ 282,337,374**	**$ -**	**$ 282,337,374**	**100%**	**0%**
HEALTH CARE COSTS	$ 27,131,026	$ 26,010,543	**$ (1,120,483)**	-4%	$ -	$ -	**$ -**	N/A	$ 274,129,814	$ -	**$ 274,129,814**	100%	0%
Gross Margin	**$ 827,112**	**$ 794,784**	**$ 32,328**	**4%**	**$ -**	**$ -**	**$ -**	**N/A**	**$ 8,207,560**	**$ -**	**$ 8,207,560**	**100%**	**0%**
ADMINISTRATIVE EXPENSE													
Healthcare Services	$ 50,671	$ 48,656	**$ (2,015)**	-4.1%	$ 57,139	$ 54,867	**$ (2,273)**	-4.1%	$ 545,211	$ 647,813	**$ 1,193,024**	45.7%	54.3%
Care Management	$ -	$ -	**$ -**	N/A	$ 95,061	$ 98,801	**$ 3,740**	3.8%	$ -	$ 350,641	**$ 350,641**	0.0%	100.0%
Compliance	$ 130,738	$ 127,504	**$ (3,235)**	-2.5%	$ 20,925	$ 20,756	**$ (169)**	-0.8%	$ 790,185	$ 127,720	**$ 917,905**	86.1%	13.9%
Operations	$ 4,736	$ 5,141	**$ 405**	7.9%	$ 42,627	$ 46,270	**$ 3,643**	7.9%	$ 51,847	$ 469,161	**$ 521,007**	10.0%	90.0%
Member & Provider Services	$ 10,901	$ 6,318	**$ (4,584)**	-72.6%	$ 10,901	$ 5,568	**$ (5,334)**	-95.8%	$ 92,123	$ 92,122	**$ 184,245**	50.0%	50.0%
Sales & Marketing	$ 10,820	$ 3,386	**$ (7,434)**	-219.5%	$ 46,810	$ 64,333	**$ 17,524**	27.2%	$ 28,562	$ 212,626	**$ 241,188**	11.8%	88.2%
Executive	$ 67,096	$ 60,002	**$ (7,094)**	-11.8%	$ 11,840	$ 10,441	**$ (1,400)**	-13.4%	$ 518,449	$ 162,291	**$ 680,740**	76.2%	23.8%
Finance	$ 62,158	$ 59,936	**$ (2,223)**	-3.7%	$ 10,969	$ 10,577	**$ (392)**	-3.7%	$ 620,921	$ 328,350	**$ 949,271**	65.4%	34.6%
Corporate	$ 48,512	$ 50,922	**$ 2,410**	4.7%	$ 15,241	$ 15,311	**$ 70**	0.5%	$ 482,598	$ 111,815	**$ 594,413**	81.2%	18.8%
Information Technology	$ 5,491	$ 10,909	**$ 5,418**	49.7%	$ 6,961	$ 11,584	**$ 4,624**	39.9%	$ 96,849	$ 82,614	**$ 179,463**	54.0%	46.0%
Human Resources	$ 5,051	$ 4,687	**$ (364)**	-7.8%	$ 6,403	$ 4,977	**$ (1,426)**	-28.6%	$ 54,041	$ 46,232	**$ 100,273**	53.9%	46.1%
Total Administrative Expense	**$ 396,176**	**$ 377,459**	**$ (18,716)**	**-5%**	**$ 324,878**	**$ 343,485**	**$ 18,607**	**5%**	**$ 3,280,784**	**$ 2,631,386**	**$ 5,912,170**	**55%**	**45%**
Non-Operating Income													
Dividend & Interest Income	$ 109,385	$ 116,353	**$ (6,968)**	-6%	$ -	$ -	**$ -**	N/A	$ 1,082,686	$ -	**$ 1,082,686**	100%	0%
Rental Income	$ 1,494	$ 1,494	**$ -**	0%	$ -	$ -	**$ -**	N/A	$ 14,935	$ -	**$ 14,935**	100%	0%
Total Non-Operating Income	$ 110,878	$ 117,846	**$ (6,968)**	-6%	$ -	$ -	**$ -**	N/A	$ 1,097,621	$ -	**$ 1,097,621**	100%	0%
Depreciation & Amortization	$ 4,731	$ 11,000	**$ 6,269**	57%	$ 5,997	$ -	**$ (5,997)**	N/A	$ 84,780	$ 21,922	**$ 106,702**	79%	21%
Change in Net Position	**$ 537,083**	**$ 524,171**	**$ 12,912**	**2%**	**$ (330,875)**	**$ (343,485)**	**$ 12,609**	**4%**	**$ 5,939,616**	**$ (2,653,308)**	**$ 3,286,308**	**181%**	**-81%**
Key Metrics													
Enrollment	96,684	97,033	(349)		-	-	-		977,615	-	977,615	100%	0%
Revenue PMPM	$289.17	$276.25	$12.92		N/A	N/A	N/A		$288.80	N/A	$288.80		
MLR	97.04%	97.03%	1 bps		N/A	N/A	N/A		97.09%	N/A	97.09%		
Admin Ratio	1.4%	1.4%	-1 bps		N/A	N/A	N/A		1.2%	N/A	2.1%		
Net Income PMPM	$5.56	$5.40	$0.15		N/A	N/A	N/A		$6.08	N/A	$3.36		
Net Income %	1.9%	1.9%	-3 bps		N/A	N/A	N/A		2.1%	N/A	1.2%		

Community Health Plan OF IMPERIAL VALLEY

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

	September 2025	October 2025	Change
ASSETS			
Current Assets			
Cash and Investments			
Chase - Checking	$ 200,000	$ 200,000	$ -
Chase - Money Market	$ 2,396,255	$ 2,390,456	$ (5,799)
JPMorgan Securities	$ 16,814,052	$ 16,983,152	$ 169,100
First Foundation Bank	$ 142,177	$ 142,177	$ -
Receivables			
Dividend Receivable	$ 6,491	$ 7,542	$ 1,051
Interest Receivable	$ 115,493	$ 100,376	$ (15,118)
Capitation Receivable	$ 26,251,770	$ 27,570,397	$ 1,318,627
Pass-Through Receivable	$ 281,969	$ 387,741	$ 105,772
Pass-Through Receivable - Other	$ 184	$ 0	$ (184)
Other Current Assets			
Prepaid Expenses	$ 386,227	$ 368,205	$ (18,022)
Total Current Assets	**$ 46,594,618**	**$ 48,150,046**	**$ 1,555,427**
Noncurrent Assets			
Restricted Deposit			
First Foundation Bank - Restricted	$ 300,000	$ 300,000	$ -
Capital Assets			
Buildings - Net	$ 2,874,383	$ 2,865,554	$ (8,829)
Computer Equipment / Software - Net	$ 6,219	$ 6,051	$ (168)
Improvements - Net	$ 68,689	$ 68,207	$ (481)
Intangible Assets	$ 57,708	$ 56,458	$ (1,250)
Operating ROU Asset (Copier) - Net	$ 10,134	$ 10,134	$ -
Total Noncurrent Assets	**$ 3,317,133**	**$ 3,306,404**	**$ (10,729)**
Total Assets	**$ 49,911,751**	**$ 51,456,450**	**$ 1,544,699**
LIABILITIES			
CURRENT LIABILITIES			
Payables			
Accounts Payable	$ 366,836	$ 401,317	$ 34,481
Capitation Payable	$ 25,464,217	$ 26,743,285	$ 1,279,069
Pass-Through Payable	$ 281,969	$ 387,741	$ 105,772
Pass-Through Payable - Other	$ 184	$ 0	$ (184)
Credit Card Payable	$ 0	$ 13,478	$ 13,478
Other Current Liabilities			
Short Term Lease Liability - Copier	$ 3,533	$ 3,549	$ 16
Bonus Accrual	$ 158,560	$ 176,178	$ 17,618
Salaries Accrual	$ 247,981	$ 140,237	$ (107,744)
Vacation Accrual	$ 201,421	$ 197,710	$ (3,712)
Total Current Liabilities	**$ 26,724,701**	**$ 28,063,495**	**$ 1,338,794**
NON-CURRENT LIABILITIES			
Long Term Lease Liability - Copier	$ 608	$ 305	$ (303)
Total Noncurrent Liabilities	**$ 608**	**$ 305**	**$ (303)**
Total Liabilities	**$ 26,725,309**	**$ 28,063,800**	**$ 1,338,490**
NET POSITION			
Net investments in Capital Assets	$ 3,017,133	$ 3,006,404	$ (10,729)
Restricted by Legislative Authority	$ 300,000	$ 300,000	$ -
Unrestricted	$ 16,789,209	$ 16,799,938	$ 10,729
YTD Net Revenue	$ 3,080,100	$ 3,286,308	$ 206,208
Total Net Position	**$ 23,186,442**	**$ 23,392,650**	**$ 206,208**
Total Liabilities and Net Position	**$ 49,911,751**	**$ 51,456,450**	**$ 1,544,699**

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

	Net Equity	$ 23,392,650
	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)	$ 23,392,650
	Required Tangible Net Equity *	$ 4,783,024
	TNE Excess (Deficiency)	$ 18,609,625

	Full Service Plan		* Calculated Required Tangible Net Equity	
		1	$ 328,302,389	- Q1
A.	Minimum TNE Requirement	$ 1,000,000	$ 328,302,389	- 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			
			$ 178,302,389	
	1% of annualized premium revenues		x 1%	
	in excess of $150 million	$ 1,783,024	$ 1,783,024	
	Total	$ 4,783,024	$ 4,783,024	- Required TNE

Community Health Plan of Imperial Valley
October 2025 Cash Transactions

Date	Account	Vendor	Memo/Description	Amount
Chase Checking				
10/7/2025	Chase Checking	Blue Shield of California	Blue Shield Insurance	$ (28,193.31)
10/7/2025	Chase Checking	JPMorgan Chase	Dividend Income - September 2025	7,958.03
10/7/2025	Chase Checking	JPMorgan Chase	Service Charges Investment Sweep - October 2025	(535.61)
10/7/2025	Chase Checking	Mid Atlantic Trust Company	Payroll Date: 10/03/25 Retirement Contribution	(10,004.40)
10/7/2025	Chase Checking	Rippling	Payroll Date: 10/02/25 Accrued Taxes	(57,537.84)
10/7/2025	Chase Checking	Rippling	Payroll Date: 10/02/25 Accrued Wages	(120,364.48)
10/7/2025	Chase Checking	Rippling	People Center	(462.53)
10/7/2025	Chase Checking	Rippling	Employee Reimbursement - D. Pasillas	(40.59)
10/7/2025	Chase Checking	Rippling	Employee Reimbursement - D. Wilson	(195.40)
10/7/2025	Chase Checking	Rippling	Employee Reimbursement - E. Tarabola	(516.70)
10/7/2025	Chase Checking	Rippling	Employee Reimbursement - J. Hutchins and L. Lewis	(1,222.13)
10/7/2025	Chase Checking	Rippling	Employee Reimbursements - E. Montejano, J. Garcia, E. Torres, S. Levy	(282.85)
10/7/2025	Chase Checking	UNUM	UNUM Invoice 10/01/25 - 10/31/25	(946.29)
10/8/2025	Chase Checking	Economic Group Pension Services	Multiple invoices (details on stub)-- bill.com Check Number: 80174281	(1,108.25)
10/8/2025	Chase Checking	Smith-Kandal Insurance	Inv 6146	(10,201.07)
10/8/2025	Chase Checking	Great America Financial Services	Inv 40146900-- bill.com Check Number: 80176285	(354.93)
10/8/2025	Chase Checking	Kaz-Bros Design Shop	Inv 13045-- bill.com Check Number: 80174323	(543.70)
10/8/2025	Chase Checking	Shannon Long	Inv 20	(6,400.00)
10/8/2025	Chase Checking	Imperial Desert Landscape	Inv 25-379-- bill.com Check Number: 80176529	(250.00)
10/8/2025	Chase Checking	Imperial Irrigation District	Inv Sep2025-- bill.com Check Number: 80174825	(1,685.80)
10/8/2025	Chase Checking	Stericycle, Inc.	Inv 8012038262-- bill.com Check Number: 80176174	(111.27)
10/8/2025	Chase Checking	Lee Hindman	Inv SEPTEMBER2025	(400.00)
10/8/2025	Chase Checking	Carlos Ramirez	Inv SEPTEMBER2025	(400.00)
10/8/2025	Chase Checking	Mayra Widmann	Inv SEPTEMBER2025-- bill.com Check Number: 80174437	(100.00)
10/8/2025	Chase Checking	Brawley Rotary Club	Inv September Statement-- bill.com Check Number: 80176318	(105.00)
10/8/2025	Chase Checking	Bushra Ahmad	Inv SEPTEMBER2025	(100.00)
10/8/2025	Chase Checking	Allan Wu	Inv SEPTEMBER2025-- bill.com Check Number: 80177236	(200.00)
10/8/2025	Chase Checking	Pablo Velez	Inv SEPTEMBER2025-- bill.com Check Number: 80176709	(100.00)
10/8/2025	Chase Checking	Imperial County Medical Society	Inv 6222813-- bill.com Check Number: 80174880	(5,000.00)
10/8/2025	Chase Checking	Pillsbury Winthrop Shaw Pittman LLP	Inv 8677909	(7,063.00)
10/8/2025	Chase Checking	Law Office of William S. Smerdon	Inv 2828	(1,430.00)
10/8/2025	Chase Checking	Zamosky Communication	Inv 0000049	(9,014.88)
10/8/2025	Chase Checking	City of Imperial	Acct 80683 - Inv 1470521-- bill.com Check Number: 80176123	(226.24)
10/14/2025	Chase Checking	NFP Retirement, Inc.	Multiple invoices	(3,750.00)
10/14/2025	Chase Checking	Department of Health Care Services	Receipt - DHCS (September 2025 Revenue)	25,589,494.11
10/14/2025	Chase Checking	Department of Health Care Services	Receipt - DHCS (September 2025 Revenue)	872,429.30
10/14/2025	Chase Checking	Department of Health Care Services	Receipt - DHCS (September 2025 Revenue)	58,512.34
10/14/2025	Chase Checking	Department of Health Care Services	Receipt - DHCS (September 2025 Revenue)	11,355.22
10/14/2025	Chase Checking	Department of Health Care Services	Receipt - DHCS (September 2025 Revenue)	1,947.98
10/14/2025	Chase Checking	Department of Health Care Services	Receipt - DHCS (September 2025 Revenue	182.93
10/14/2025	Chase Checking	Rippling	Employee Reimbursement - L. Galvin	(2,429.32)
10/14/2025	Chase Checking	Rippling	Employee Reimbursement - T. Godinez	(911.44)
10/17/2025	Chase Checking	Rippling	Employee net pay for check date 10/17/2025	(130,880.52)
10/17/2025	Chase Checking	Rippling	Payroll taxes paid via Rippling for check date 10/17/2025	(59,684.97)
10/20/2025	Chase Checking	Vic's Air Conditioning & Electrical	Multiple invoices (details on stub)-- bill.com Check Number: 80235360	(3,551.53)
10/20/2025	Chase Checking	Sparkling Clean	Inv October 2025	(990.00)
10/20/2025	Chase Checking	Republic Services	Inv 0467-001758678	(146.82)
10/20/2025	Chase Checking	Rick's Roadrunner Lock & Safe	Inv 23748-- bill.com Check Number: 80235833	(578.87)
10/20/2025	Chase Checking	ECG Management Consultants	Inv 4211.001 - 75074	(1,984.50)
10/20/2025	Chase Checking	Bonde & Associates, LLC	Inv 1005	(9,321.13)
10/20/2025	Chase Checking	Junior's Cafe	Inv 13-18841-- bill.com Check Number: 80235716	(322.88)
10/20/2025	Chase Checking	Wakely consulting Group	Inv 211734 - 0000010	(930.00)
10/20/2025	Chase Checking	Health Management Associates, Inc.	Inv 206100 - 0000028	(3,418.75)
10/20/2025	Chase Checking	MAK Solutions	Inv CHPIV-02	(10,000.00)
10/21/2025	Chase Checking	360 Business Products	Inv OE-QT-35323-1-- bill.com Check Number: 80242326	(2,842.75)
10/21/2025	Chase Checking	Mid Atlantic Trust Company	Payroll Date: 10/17/25 Retirement Contribution:	(11,135.91)
10/21/2025	Chase Checking	State Compensation Insurance Fund	Workers Compensation Payment	(1,424.41)
10/21/2025	Chase Checking	Rippling	Account Analysis Settlement Charge	(127.76)
10/21/2025	Chase Checking	JPMorgan Chase	Credit Card Payment	(23,002.39)
10/21/2025	Chase Checking	Rippling	Employee Reimbursement - D. Ponce, J. Perez, D. O'campo, J. Espinoza	(341.50)
10/21/2025	Chase Checking	Rippling	Employee Reimbursement - D. Wilson	(964.70)
10/21/2025	Chase Checking	Rippling	Employee Reimbursement - J. Crenshaw and E. Tarabola	(2,386.74)
10/21/2025	Chase Checking	Rippling	Employee Reimbursement - L. Galvin	(300.00)
10/22/2025	Chase Checking	AM Copiers Inc.	Inv IN8408	(718.13)
10/23/2025	Chase Checking	Quench USA	Inv INV09583346	(129.29)
10/23/2025	Chase Checking	Inerglo Creative	Inv INV-00647	(3,000.00)
10/28/2025	Chase Checking	Allan Wu	Void Of Bill Payment #P25080601 - 8196434	300.00
10/31/2025	Chase Checking	Rippling	[Rippling] Employee net pay for check date 10/31/2025	(139,156.09)
10/31/2025	Chase Checking	Rippling	[Rippling] Payroll taxes paid via Rippling for check date 10/31/2025	(63,087.78)
10/31/2025	Chase Checking	Rippling	Employee Reimbursement - D. Pasillas	(25.00)
10/31/2025	Chase Checking	Rippling	Employee Reimbursement - D. Wilson, E. Tarabola, J. Hutchin, J. Crens	(4,346.13)

10/31/2025	Chase Checking	Rippling	Employee Reimbursement - E. Montejano, J. Garcia, E. Torres, S. Levy	(568.61)
10/31/2025	Chase Checking	Rippling	Employee Reimbursement - J. Crenshaw	(777.18)
10/31/2025	Chase Checking	Rippling	Employee Reimbursement - L. Gutierrez	(9.38)
10/31/2025	Chase Checking	Rippling	Employee Reimbursement - S. Long	(1,131.31)
10/31/2025	Chase Checking	HealthNet	Rental Income - October 2025	1,493.50

J.P. Morgan Securities

10/31/2025	Chase Securities	Health Net	May Health Net Payment	(25,746,368.78)
10/31/2025	Chase Securities	JPMorgan Chase	Accrued Investment Income - September 2025	115,493.31
10/31/2025	Chase Securities	JPMorgan Chase	Bank Fee - September 2025 (Portfolio)	$ (25.00)

Fact Sheet/Action Items

Authority to Execute External Agency Agreements

Motion Fact Sheet

Recommendation

Motion to grant authority to the CEO to execute agreements with external agencies to assist in enrolling eligible members in CHPIV's D-SNP plan.

Background

Current enrollment levels are lower than anticipated during this first Annual Election Period (AEP). To boost enrollment and meet projections, staff recommend executing of 1-2 select and limited-scope external agency agreements. We anticipate these agreements will quickly bring us back in line with initial projections.

Why Now

We have invested in staff and infrastructure to support the D-SNP line of business. Meeting membership targets is critical to the financial and operational success of the program.

Financial Impact

Estimated financial impact of $432,000. Agreements may be extended upon mutual agreement. Broker commissions were included in the original financial forecast and 2026 bid.

Risks / Alternatives

The alternative is to continue to rely on internal sales staff for all enrollments. While internal staff are performing at levels consistent with other plans with monthly targets post 1/1, executing limited broker agreements will ensure we mitigate the financial and operational risks associated with lower-than-expected enrollment sooner rather than later. We will mitigate compliance risk through training and oversight and review performance of these contracts after the first quarter of 2026.

Items after the relevant motion to immediately follow

CEO to execute 1-2 agency agreements and initiate broker training and oversight.

Action Items

Fact Sheet/Action Items

Authority to Execute Contract with Imperial County Behavioral Health

Motion Fact Sheet

Recommendation

Motion to confirm authority of the CEO to execute provider agreements, including execution of contracts with the County of Imperial, and specifically a provider agreement with Imperial County Behavioral Health (ICBH) to provide Medicare-covered behavioral health services for Community Advantage Plus members.

Background

CHPIV is directly contracting a local network for Community Advantage Plus and has executed a Letter of Agreement with ICBH to be a contracted network provider. CHPIV has completed credentialing of ICBH providers, and the parties are now ready to execute a full provider agreement. This agreement will ensure continuity of care for Medi-Cal members who also have Medicare benefits. The agreement has been reviewed and approved by the California Department of Managed Health Care.

Why Now

County Counsel has requested proof of CEO authority to sign the ICBC provider contract.

Financial Impact

Rates are consistent with the Medicare fee schedule. Financial impact is estimated in CHPIV's bid to CMS and dependent on actual utilization.

Risks / Alternatives

N/A

Items after the relevant motion to immediately follow

CEO to execute Imperial County Behavioral Health provider agreement.

Committee Chair Reports

Information Items

Compliance Report

Period Covered: December 2025

Highlights

- Action Items – Policy Review & Approval
  - Updated FWA Program Policy (CMP-009) requires Commission approval to meet CMS, DHCS, Medi-Cal, and D-SNP regulatory updates.
  - Enhances requirements for excluded/ineligible provider oversight and ensures continued program compliance.
- CY2025 Compliance Department Year-End Highlights
  - Summarizes key accomplishments and major regulatory activities completed by Compliance in CY2025. Highlights progress in audits, delegation oversight, policy governance, enforcement actions, and D-SNP readiness.
- Regulatory Audits
  - DMHC Routine Survey
    - All 127 follow-up requests submitted; awaiting Preliminary Report; 45-day response window upon issuance.
  - DHCS Medical Audit
    - Preliminary Report received; CHPIV preparing responses and coordinating with Health Net.
  - DMHC Routine Financial Audit
    - New audit; Pre-audit deliverables due 12/12/25; fieldwork begins February 2026.
- Delegation Oversight
  - Pre-Delegation D-SNP Audits
    - Completed policy/operational reviews across CHG and five IPAs; finalized CHG audit with improved P&P scoring.
  - Annual Audit of Health Net
    - Health Net preparing formal response; CHPIV will re-review documentation before finalizing results.

Issues / Risks

- Notices of Noncompliance
  - Post-stabilization
    - Health Net completed retrospective review; CHPIV validating sample. Dedicated phone line, updated scripts, and training improvements underway. Monthly hospital admission logs added to ongoing oversight.

- Undisclosed Sub-delegation
  - NONC officially closed after Health Net provided documentation, updated subcontractor reporting, and validated membership controls.

Policy Review & Approval

To expedite the required review, we are bringing the updated **Fraud, Waste, and Abuse (FWA) Program Policy (CMP-009)** directly to the Commission for approval. This policy reflects our annual review, incorporates required federal and state regulatory updates, including alignment with CMS regulations under 42 CFR §422.503—and clarifies obligations related to excluded and ineligible providers.

Approval of this updated policy will ensure continued compliance with Medi-Cal, D-SNP, DHCS, and CMS requirements and reaffirm CHPIV's commitment to maintaining a robust FWA prevention and oversight program across all delegated functions.

CY2025 Compliance Department Year-End Highlights

CY2025 was a transformational year. The Compliance Department led CHPIV through an extensive year of regulatory oversight, audit readiness, and delegation governance since plan inception. Despite a demanding audit cycle and significant regulatory change, the department strengthened infrastructure, improved accountability, and strengthened compliance across the organization.

1. **Regulatory Audit Execution:** 2025 was a pivotal year, with Compliance leading the organization through multiple complex, high-stakes regulatory audits, all requiring deep collaboration across CHPIV, Health Net, and subdelegated entities.
   a. **DHCS Medical Audit – First Full Scope Regulatory Audit**
      i. Submitted 350+ deliverables and completed onsite activities.
      ii. Initiated and tracked corrective actions to strengthen documentation, oversight, and process alignment.
   b. **DMHC Routine Survey**
      i. Completed all pre-onsite submissions, onsite interviews, and responded to 125+ follow-up requests with near-perfect timeliness.
      ii. DMHC attention centered on delegation oversight, post-stabilization processes, hospital admissions, and ER claims — all areas Compliance proactively managed.
   c. **Network Adequacy Validation (NAV) Audit**
      i. Submitted all required materials ahead of schedule; facilitated Health Net's participation. No findings identified.

2. **Strengthened Delegation Oversight & Accountability:** 2025 marked the first year of a fully centralized Delegation Oversight (DO) program under Compliance, significantly elevating CHPlV's oversight posture.
    a. **Centralized Delegation Oversight Program**
        i. Implemented a dedicated audit structure, standardized tools, and risk-based monitoring.
    b. **Annual Audit of Health Net – First Full-Scope Audit**
        i. Completed comprehensive policy review, case file review, and operational validation across all delegated functions.
        ii. Identified systemic gaps, launched formal corrective actions, and established expectations for ongoing remediation and documentation improvement.
    c. **Pre-Delegation Audits for D-SNP Readiness**
        i. Conducted multi-week audits of CHG and five IPAs for CMS/DHCS D-SNP requirements, completing policy reviews, documentation assessments, and preliminary results.
3. **Policy Governance:** CHPIV updated and implemented over 20 policies and procedures and launched an improved P&P repository to support consistency, accessibility, and regulatory alignment.
4. **Proactive Enforcement & Issue Management:** Compliance took targeted action to address operational and delegated performance risks.
    a. **Notices of Noncompliance Issued to Health Net**
        i. **Post-Stabilization Process** (impact analysis, reversal of inappropriate denials, exclusive phone line creation, provider education).
        ii. **Undisclosed Sub-delegation** (PPG disclosure, subcontractor rosters, new delegation oversight and monitoring approach)
    b. **Fraud, Waste, and Abuse (FWA) and Privacy Oversight:** Reviewed all FWA and privacy incidents; no breaches confirmed; implemented process improvements to address late reporting. Implemented trend tracking and timeliness reporting to Compliance committees.
5. **D-SNP Readiness & Strategic Initiatives** Compliance played a critical role in preparing the organization for January 1, 2026, D-SNP go-live, focusing on regulatory alignment and delegate readiness.
    a. Completed policy assessments aligned with CMS and state requirements.
    b. Launched a comprehensive readiness review across internal departments and delegated entities.
    c. Implementing a material review process.
    d. Expanding DO Audit & Monitoring program to include internal oversight of retained functions and D-SNP key performance indicators and audit tools.
6. **Department Growth & Capacity Building:** New key hires strengthened audit and regulatory capabilities, including a Director of Delegation Oversight, Compliance Manager,

DO Manager, Compliance Coordinator, Compliance Advisor, 3 Nurse Auditors and 1 Auditor.

7. **Increased cross-departmental engagement** to embed compliance expectations into operations, member services, health services, and executive leadership committees.

Notices of Noncompliance

Health Net – Post Stabilization

Health Net has provided responses to CHPIV's notice of noncompliance and corrective action requirements:

1. Impact Analysis/Retrospective Review: Health Net completed a comprehensive retrospective review of all post-stabilization authorization requests submitted between January 1, 2024, and September 30, 2025. Health Net's review confirmed that all such requests during this period were to be explicitly identified and formally submitted as post-stabilization. Health Net found that no adjustments to authorizations were required. CHPIV is reviewing a sample of cases to validate Health Net's response.
2. Dedicated Phone Line for Post-Stabilization Requests: By Q1 2026, Health Net plans to update its phone line with a revised script specifically for post-stabilization requests. The new script confirms that the line is exclusively for post stabilization requests and directs providers to a fax number if a member has already been admitted at the time of the call.
3. Submit Updated Logs for Validation: Health Net reported that there were no post-stabilization authorizations for CHPIV during the period of May 1, 2025, to September 30, 2025. The hospital admission log for this timeframe has been provided to CHPIV for validation.
4. Ongoing Oversight and Monitoring: Health Net will begin submitting monthly Hospital Admission Logs to CHPIV. This ongoing submission is part of CHPIV's Delegation Oversight Monitoring Program to ensure emergency admissions are appropriately reviewed for potential misclassifications or inappropriate denials.
5. Clarify and Reinforce Staff Training and Internal Processes: Health Net reviewed and revised its training materials, job aids, and staff scripts to distinguish post-stabilization authorization from other reviews, reinforce that fax submissions are not valid for initiating post-stabilization requests, emphasize the 30-minute response clock initiated by a phone call, and ensure timely escalation to clinical reviewers.
6. Integration of CHPIV Provider Advisory Committee (PAC) Feedback: Health Net submitted provider communications regarding post-stabilization services and will be presented to the CHPIV Provider Advisory Committee for review and feedback on clarity, effectiveness, and potential improvements for provider understanding and compliance.

Health Net – Undisclosed Physician Provider Groups (PPGs)

CHPIV has officially closed the Sub-delegation Notice of Noncompliance (NONC) issued to Health Net, effective November 17, 2025. This decision follows CHPIV's review of documentation and follow-up provided by Health Net in response to the NONC.

Key outcomes that led to the closure include:

1. Formal Notification: CHPIV acknowledges receipt of the delegation letter and plans to inform DHCS that current subcontractors will be reflected in the revised Exhibit J for submission in Q1 2026.
2. Membership Assignments: Health Net confirmed that Alpha Care (Riverside and San Bernardino) and La Salle will continue to accept CHPIV membership assignments, and controls are being implemented to prevent assignments to non-Imperial PPGs. Additionally, members previously assigned to out-of-area PPGs have either relocated or transitioned as of January 1, 2026.
3. Monthly PPG Reporting: CHPIV has confirmed receipt of the "Enrollment Counts per Subdelegate" monthly report, which will continue to be provided routinely.
4. Audit Summary Report: CHPIV received the audit summary report, which documented retrospective oversight activities of Alpha Care and La Salle. CHPIV has requested ongoing updates from Health Net regarding PPG implementation activities, including discussions on CHPIV requirements (e.g., UM letter templates, source data reporting) and any related process or system enhancements.

Regulatory Audits

DMHC Routine Survey

To date, CHPIV has submitted all 127 follow-up requests. DMHC follow-up activity has since slowed, and we are pending the Preliminary Report, which is expected within 90 days of survey completion. We will have 45 days from receipt of the Preliminary Report to respond and submit any required Corrective Action Plan(s).

DHCS Medical Audit

CHPIV received the preliminary report of the DHCS Medical Audit for review period CY2024. The Plan has until December 8, 2025 to respond, indicating whether we agree, partially agree, or disagree with each finding, along with any supporting documentation. There were no unexpected findings, and we are currently coordinating with Health Net to prepare our response to the draft report. Once submitted, we will await the Final Report from DHCS and finalize corrective action plans.

DMHC Routine Financial

The 2025 DMHC Financial Audit will review the Plan's fiscal and administrative operations, focusing on Medi-Cal, with interviews beginning remotely on February 9, 2026. The scope includes Finance, Claims, and Provider Dispute Resolution (PDR), and will cover financial reporting through the quarter ending September 30, 2025. Pre-audit deliverables are due to Compliance by 12/12/2025.

Delegation Oversight

Pre-Delegation Audits

Pre-delegation audits are designed to validate D-SNP readiness and strengthen risk mitigation across delegated functions. CHPIV's audit tools are aligned with CMS and State requirements to ensure full compliance by January 1, 2026. The current status of each audit is summarized below.

1. **Community Health Group (CHG):** On October 17, 2025, CHG submitted additional documentation in response to the preliminary report. Documentation review is complete and the Final Report was shared with CHG on November 24, 2025. Scores reflect an update to policies and procedures improved to 75% UM policies do not fully address new regulatory requirements (e.g., 7-day prior authorization notice), health equity analysis, or transparency in coverage criteria. The final results reflect notable progress with minor gaps that require policy revisions and focused remediation to ensure full compliance.
2. **Community Care IPA – *Management Service Organization (MSO) MedPoint Management* CCIPA:** The audit is complete. Preliminary Report was sent on November 21, 2025. CCIPA has an opportunity to submit additional documentation prior to issuing a Final Report.
3. **Imperial County Physicians Medical Group (ICPMG) – *MSO MedPoint Management*:** The Preliminary Report was sent on November 21, 2025. ICPMG has an opportunity to submit additional documentation prior to issuing a Final Report.
4. **Premier Patient Care:** The Preliminary Report was sent on November 24, 2025. Premier has an opportunity to submit additional documentation prior to issuing a Final Report.
5. **Primary Health Care Medical Group IPA (PHCMG) – MSO Med MGR**: The Preliminary Audit Report is pending completion of contracting agreement.

Annual Audit of Health Net

Health Net is currently reviewing the preliminary results issued by CHPIV as part of our annual Delegation Oversight audit. This phase involves validating the cited findings, compiling supporting documentation, and preparing a formal response package. Their submission may include additional evidence for CHPIV to evaluate before the audit is finalized.

After receiving Health Net's response, CHPIV will conduct a re-review of all audit elements to confirm the accuracy of the documentation submitted and determine whether findings can be removed. This additional level of review is a routine part of our delegation oversight process.

CHPIV will incorporate Health Net's response into the final audit report and determine whether any follow-up monitoring or additional remediation is required.

	Fraud, Waste, and Abuse Program	CMP-009
Department	Compliance	
Functional Area	Compliance	
Line of Business	☒ Medi-Cal ☒ D-SNP	

DELEGATION OF FUNCTION		
☒ Health Net	☐ Community Care IPA	☐ Not Delegated
☒ Community Health Group	☐ Primary Healthcare Medical Group	
☐ Imperial County Physicians MG	☐ Premier Patient Care	

DATES			
Policy Effective Date	10/9/2023	**Reviewed/Revised Date**	3/25/2025
Next Annual Review Due	3/25/2026	**Regulator Approval**	8/25/2023

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

ATTACHMENTS

- NA

AUTHORITIES/REFERENCES

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

- Program Fraud Civil Remedies Act – 31 U.S.C. §§ 3801-3812
- Deficit Reduction Act of 2005
- CA False Claims Act - CA Code § 12650 *et seq.*
- HIPAA – 45 CFR, Part 164
- Provider Self-Disclosure Protocol – 63 Fed. Reg. 58, 399-403 (1998)
- Title 42, Code of Federal Regulations (C.F.R.), §422.503

HISTORY	
Revision Date	Description of Revision
10/9/2023	Policy Creation
3/25/2025	Annual Review
	Added language to comply with CFR 422.503; updating language to clarify exclusion of providers/entities listed on federal or state ineligibility databases

I. OVERVIEW

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

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

1. Ensure that all Staff, NETWORK PROVIDERS, SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS or agents are educated regarding the federal and state false claims laws and the role of such laws in preventing and detecting FWA;
2. Ensure communication of all requirements of this Policy, and referenced obligations, to its NETWORK PROVIDERS, SUBCONTRACTORS, and DOWNSTREAM SUBCONTRACTORS, and will have a process to ensure its NETWORK PROVIDERS, SUBCONTRACTORS, and DOWNSTREAM SUBCONTRACTORS acknowledge receipt and understanding of the requirements contained within this Policy;
3. Perform audits that include reviewing, researching and documenting potential FWA activities within the organization;

4. Ensure identification and investigation of potential FRAUD from reports and referrals;
5. Ensure implementation of a process to conduct timely inquiry into potential violations;
6. Conduct FWA awareness training for Staff;
7. Ensure documentation and retention of all records pertaining to corrective actions imposed as a result of violations;
8. Ensure that NETWORK PROVIDERS, SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS have a robust FWA program in place, which includes the requirements of this Policy and ongoing monitoring and mandatory annual training;
9. Fully disclose to State and federal regulatory agencies any FRAUD or misconduct within the Plan, NETWORK PROVIDERS, SUBCONTRACTORS or DOWNSTREAM SUBCONTRACTORS; and
10. Fully cooperate with DHCS, DMFEA, OIG, and DOJ investigations and prosecutions in the event of allegations of FRAUD.

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

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

E. CHPIV will not employ or contract with:

1. Parties excluded from participation in federal health programs per the Office of Inspector General – U.S. Department of Health and Human Services (OIG-HHS) List of Excluded Individuals and Entities (LEIE), or entities affiliated with such excluded parties.
2. Precluded providers per the CMS Preclusion List, or entities affiliated with such precluded providers.
3. Suspended and otherwise ineligible providers per the Medi-Cal Suspended and Ineligible Provider List (SIPL), or entities affiliated with such suspended or otherwise ineligible providers.
4. Providers under a payment suspension while under investigation based upon a credible allegation of fraud per the Medi-Cal Restricted Provider Database (RPD), or entities affiliated with such providers.
5. Providers contracted with the Federal Employee Health Benefit Plan (FEHBP) who are suspended or debarred per the Office of Personnel Management (OPM), or entities affiliated with such providers.
6. Parties listed on the General Services Administration's (GSA) Exclusions Extract Data Package (EEDP) as referenced through the System for Award Management (SAM) website, or entities affiliated with such parties.
7. Providers under investigation for fraud, or entities affiliated with such providers.
8. Providers otherwise ineligible to participate in a state or federal health program (*e.g.,* Medicare/Medicaid), or entities affiliated with such providers.
9. Providers who have previously been under investigation by, sanctioned by, suspended, debarred, excluded, precluded, *etc.* from a federal or state health program, or entities affiliated with such providers.

II. POLICY

A. Fraud Prevention

1. CHPIV provides a confidential FRAUD hotline for FRAUD reports from Staff, MEMBERS, SUBCONTRACTORS, DOWNSTREAM SUBCONTRACTORS, NETWORK PROVIDERS, and any other individuals with a need to report suspected FRAUD and ensures that its SUBCONTRACTORS provide a confidential FRAUD hotline for FRAUD reports from their staff, MEMBERS, NETWORK PROVIDERS, DOWNSTREAM SUBCONTRACTORS, and any other individuals with a need to report suspected FRAUD.
2. CHPIV provides multiple mechanisms for reporting, including the confidential hotline, Staff exit interview surveys, email reporting, and a dedicated address for submission via U.S. Mail.
3. CHPIV ensures FRAUD prevention activities and suspected FRAUD are reported directly to regulatory and law enforcement agencies as required by law.
4. FRAUD activities and suspected FRAUD identified by NETWORK PROVIDERS, SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS are communicated to CHPIV.
5. CHPIV ensures FRAUD and ABUSE Activities include, but are not limited to:
    a. Complying with 42 CFR Part 455, §§ 455.104 (Disclosure by Medicaid providers and fiscal agents: Information on ownership and control), 455.105 (Disclosure by providers: Information related to business transactions), 455.106 (Disclosure by providers: Information on persons convicted of crimes), and 42 CFR section 438.610 (Prohibited affiliations);
    b. Ensure that SUBCONTRACTORS are requiring NETWORK PROVIDERS and DOWNSTREAM SUBCONTRACTORS to enroll and remain enrolled in the Medi-Cal program, to the extent required under the MEDI-CAL CONTRACT;
    c. Ensure that SUBCONTRACTORS are confirming the identity of NETWORK PROVIDERS, and any Person with an Ownership or Control Interest or who is an agent or Managing Employee of a Network Provider, upon contract execution or renewal and credentialing, through routine checks of State and federal databases; The databases to be checked are the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES) and the Excluded Provider Lists maintained by the State;
    d. Tracking SUBCONTRACTORS and ensuring SUBCONTRACTORS are tracking NETWORK PROVIDERS and DOWNSTREAM SUBCONTRACTORS through review of the following exclusionary databases and lists no less frequently than monthly and upon contract execution or renewal, and upon provider credentialing, taking appropriate action in accordance with ALL PLAN LETTER (APL) 15-026, and APL 21-003:
        i. List of suspended and ineligible providers located at https://files.medi-cal.ca.gov/pubsdoco/SandILanding.aspx,
        ii. List of OIG Excluded Individuals and Entities (LEIE) located at https://oig.hhs.gov/exclusions/exclusions_list.asp,
        iii. Excluded Parties List System (EPLS) within the HHS System for Award Management (SAM) database located at https://sam.gov/content/home;
    e. Ensuring training of Staff, directors, NETWORK PROVIDERS, and SUBCONTRACTORS (and ensuring NETWORK PROVIDERS and SUBCONTRACTORS ensure training of DOWNSTREAM SUBCONTRACTORS) on FRAUD schemes, FRAUD detection and FRAUD

prevention activities at least annually. Training may consist of an online course, in-person sessions, and/or distribution of written materials. Training topics will also include:

i. Federal and State FALSE CLAIMS ACT statutes,
ii. Federal remedies for false claims and statements,
iii. State laws containing civil or criminal penalties for false statements
iv. WHISTLEBLOWER protections,
v. How to handle instances of suspected health care FRAUD;

f. Ensuring that FRAUD prevention efforts are communicated in provider manuals, NETWORK PROVIDER and MEMBER newsletters, internal newsletters or information blasts, targeted mailings or in-service meetings;

g. Ensuring that a method is maintained to verify, by sampling or other methods, that services that have been represented to have been delivered by NETWORK PROVIDERS were in fact received by MEMBERS (42 CFR §438.608(a)(5)). CHPIV will provide proof of compliance with this requirement when requested by DHCS, in a form and manner specified by DHCS through APL, or other similar instruction.

h. Ensuring that there is monitoring and oversight of activities and reports to detect and deter fraudulent behavior, such as:

i. MEMBER and provider grievances,
ii. Claims review, including
    A. Clinical edits for invalid gender, out of normal age range, invalid diagnosis for procedure billed, redundant billing, and others
    B. Billings for non-covered benefits
    C. Claims for ineligible individuals
    D. Reviews for emergency diagnosis, emergency place of service and conformance to the definition of “emergency” and “medical necessity”
    E. Claims pended for review by the Claims Supervisor
        1. All claims received from other countries
        2. All MEMBER reimbursements for proper documentation,
iii. Medical management audits,
iv. Utilization management activities, including checking out-of-area claims to ensure the MEMBER lives within the service area,
v. Quality management activities,
vi. Operational reviews conducted by CHPIV’s internal audit department, including eligibility audits,
vii. Financial audits to ensure compliance with State and federal rules for reinsurance and the identification and return of overpayments;

i. Communicating an email address and an address for U.S. Mail to report suspicious behavior of FWA, confidentially or otherwise. Also, maintaining a toll-free hotline (866)685-8664 for confidential reporting of suspected FRAUD and ABUSE. The hotline is monitored by Staff. All reports of suspected FRAUD received from Staff, NETWORK PROVIDERS, SUBCONTRACTORS, DOWNSTREAM SUBCONTRACTORS, MEMBERS, or other credible sources will be logged, investigated, and tracked;

j. Ensuring investigation and resolution of all reported and/or suspected instances of FRAUD and taking action against confirmed FRAUD, including, but not limited to,

reporting to law enforcement agencies as required by the MEDI-CAL CONTRACT, termination of the MEMBER or Staff, termination of the contract with a Network Provider, Subcontractor, or Downstream Subcontractor, and/or removal of a NETWORK PROVIDER from the network;

k. Reporting suspected FRAUD as required under section titled "Reporting" in this Policy;
l. Filing an annual written report with DHCS and DMHC and other entities as required by law of CHPIV's efforts to deter, detect and investigate FRAUD; a log of all cases reported to government agencies; and the number of cases known to be prosecuted;
m. If DHCS, DMFEA, or DOJ, or any other authorized State or federal agency, determines there is a credible allegation of Fraud against a Network Provider, SUBCONTRACTOR or Downstream Subcontractor:
    i. CHPIV complies with the MEDI-CAL CONTRACT, all applicable State and federal laws, APL 15-026, and APL 21-003,
    ii. CHPIV ensures there are procedures in place to ensure immediate suspension of payments to the Network Provider, Subcontractor, or DOWNSTREAM SUBCONTRACTOR for which a State or federal agency determines there is a credible allegation of FRAUD (42 CFR § 438.608(a)(8)),
    iii. CHPIV may conduct additional monitoring, require temporary suspension, and/or termination of the Network Provider, SUBCONTRACTOR or Downstream Subcontractor,
    iv. When DHCS notifies CHPIV that a credible allegation of FRAUD has been found against a provider relating to provision of Fee-For-Service Medi-Cal services and that provider is also a Network Provider, one or more of the following four actions must be taken with submission of all supporting documentation to the MCQMD@dhcs.ca.gov inbox
        A. Termination of the NETWORK PROVIDER from the network
        B. Temporary suspension of the NETWORK PROVIDER from the network pending resolution of the FRAUD allegation
        C. Temporary suspension of payment to the NETWORK PROVIDER pending resolution of the FRAUD allegation, and/or
        D. Additional monitoring, including audits of the Network Provider's claims history and future claims submissions for appropriate billing,
    v. CHPIV must notify DHCS as to which of the above four actions are taken. No action will be required that would interfere with State or federal criminal investigations,
    vi. In the event of a Network Provider, Subcontract or, or DOWNSTREAM SUBCONTRACTOR termination, CHPIV will ensure all the requirements and guidance listed in APL 21-003: Medi-Cal NETWORK PROVIDER and SUBCONTRACTOR Terminations are followed,
    vii. CHPIV will fully cooperate in any investigation or prosecution conducted by the DMFEA and the DOJ. CHPIV's cooperation must include without limitation
        A. Providing upon request, information, and access to records, and
        B. Making available Staff or, to the extent appropriate, SUBCONTRACTOR for in-person interviews, consultation, grand jury proceedings, pre-trial conference, depositions, and hearings at DHCS headquarters in

Sacramento,

viii. CHPIV litigation support for CMS, DMFEA, and other agencies includes
   A. Ensuring that NETWORK PROVIDERS timely gather, preserve, and provide to DHCS, CMS, DMFEA, and any authorized State or federal regulatory agencies, any records in Network Provider's possession, and
   B. Ensuring that SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS timely gather, preserve, and provide to DHCS, CMS, DMFEA, and any authorized State or federal regulatory agencies, any records in their possession.

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

B. Administration

1. CHPIV ensures all potential FWA cases are logged, investigated, and monitored.
2. CHPIV's Fully Delegated Subcontractor's Compliance Officer/Fraud Prevention Officer shall attend and participate in DHCS's quarterly integrity meetings, as scheduled.
3. CHPIV ensures DHCS is notified of any changes in Member's circumstances that impact Medi-Cal coverage pursuant to Medi-Cal program eligibility requirements, including changes in the Member's residence, income, insurance status, and death (42 CFR § 438.608(a)(3)) in a form and manner specified by DHCS through APL or other similar instructions.
4. CHPIV ensures a report of potential instance of FWA is received, an inquiry is initiated as expeditiously as reasonably necessary, but no later than two weeks after the date that the potential misconduct is reported.
   a. If an individual believes that the response to his or her report is completed within a reasonable period of time, he or she is required to bring the matter to the attention of the Compliance Officer/Fraud Prevention Officer.
   b. Failure to report and disclose, or assist, in an investigation of FWA is a breach of the duty that all Staff have to CHPIV and CHPIV's Fully Delegated SUBCONTRACTOR and may result in disciplinary action, up to and including termination.
      i. The CHPIV Compliance Hotline number is (866) 685-8664.
      ii. Written reports may be mailed to: Centene Special Investigations Unit 7700 Forsyth Blvd. Clayton, MO 63105.

5. Files containing investigation materials must be kept in a confidential locked and secured location. Files must be retained a minimum of ten (10) years, unless a longer period of time is required by law or regulation.
6. All parties to the investigation: MEMBERS, NETWORK PROVIDERS, SUBCONTRACTORS, DOWNSTREAM SUBCONTRACTORS, Staff MEMBERS or others named in any form or fashion within the investigation are to be kept confidential to the extent allowable by law.
7. All parties having information relating to the subject of the investigation must hold all information strictly confidential to the extent allowable by law; failure to do so will result in disciplinary action up to and including termination.
8. CHPIV protects as "confidential information" all information shared by or received from DHCS, other State agencies, and federal agencies, and other Medi-Cal managed care plans in connection with any FWA referral, until formal criminal proceedings are made public. CHPIV receives the confidential information as a DHCS business associate in order to facilitate CHPIV's contractual obligations to maintain a FWA prevention program. PHCIV receives and maintains this confidential information in its capacity as a Medi-Cal managed care plan and uses such confidential information only for conducting an investigation into any potential FWA activities and in furtherance of any other program integrity activities.
9. Preliminary and quarterly reports are to be kept confidential and submitted to the DHCS Program Integrity Unit.
10. In the event CHPIV is required to share investigative information with a Network Provider, Subcontractor, or Downstream Subcontractor, CHPIV ensures that the Network Provider, Subcontractor, or DOWNSTREAM SUBCONTRACTOR acknowledges and agrees that such information will be kept confidential by the Network Provider, Subcontractor, or Downstream Subcontractor.

C. Investigations

1. CHPIV ensures a complete investigation is conducted for all FWA referrals received from DHCS, other State agencies, federal agencies, and other Medi-Cal managed care plans, relating to CHPIV's NETWORK PROVIDERS, SUBCONTRACTORS, and DOWNSTREAM SUBCONTRACTORS. CHPIV submits to DHCS a completed investigation report and a quarterly status report, as set forth in this policy or otherwise required by DHCS in connection with all DHCS, State and federal agency, and Medi-Cal managed care plan referrals of FWA.
2. CHPIV ensures the prompt and thorough investigation of actual or potential FWA, and requires all Staff to assist in such investigations. Investigations may include but not be limited to the following activities:
   a. On-site visits to NETWORK PROVIDERS and SUBCONTRACTORS.
   b. On-site visits to CHPIV MEMBER homes. These visits could be accomplished in conjunction with the audit and/or medical review Staff, or State survey and certification Staff.
   c. Telephone calls or written questionnaires to a sample of CHPIV MEMBERS asking them to confirm the services they received.
   d. Telephone calls or written questionnaires to providers confirming the need for the services rendered.
   e. Telephone calls, correspondence or on-site visits to other pertinent entities.
3. The Compliance Officer/Fraud Prevention Officer must conclude investigations of potential misconduct within a reasonable time period after discovery of the alleged fraudulent activity

and complete a FWA Investigation Report form.

4. CHPIV shall conduct a timely and reasonable inquiry into any evidence of misconduct related to payment or delivery of items or services under a Medicare Advantage contract, consistent with 42 CFR § 422.503(b)(4)(vi)(G)(1)
5. CHPIV shall promptly identify and report to CMS or its designee any (i) payment suspension implemented pending investigation of credible allegations of fraud by a pharmacy, and (ii) credible evidence of suspicious activities of a provider, prescriber, or supplier, including inappropriate opioid prescribing, in accordance with 42 CFR § 422.503(b)(4)(vi)(G)(4).
6. Unless otherwise specified, the Compliance Officer/Fraud Prevention Officer shall complete a FWA Investigation Report form that includes, to the extent available, the following:
    a. Plan name, organization, and contact information for follow up
    b. Summary of the issue including
        i. The basic who, what, when, where, how, and why
        ii. Any potential legal violations
    c. Specific statutes and allegations including
        i. A list of civil, criminal, and administrative code or rule violations, State and federal
        ii. A detailed description of the allegations or pattern of FWA
    d. Incidents and Issues including
        i. A list of incidents and issues related to the allegations
    e. Background information
        i. Contact information for the complainant, the perpetrator or subject of the investigation, and beneficiaries, pharmacies, providers, or other entities involved
        ii. Additional background information that may assist investigators, such as names and contact information of informants, relators, witnesses, websites, geographic locations, corporate relationships, networks
        iii. The legal and administrative disposition of the case, if available, including actions taken by law enforcement officials to whom the case has been referred
    f. Perspectives of interested parties
        i. Perspective of CHPIV, DHCS, CMS, Member, and other interested parties
    g. Data
        i. Existing and potential data sources
        ii. Graphs and trending
        iii. Maps
        iv. Financial impact estimates
    h. Recommendations in pursuing the case
        i. Next steps, special considerations, cautions.
7. Within no more than ten (10) working days of completing the investigation, CHPIV shall submit to DHCS reports signed by an executive officer of CHPIV.
    a. Such prompt reporting demonstrates CHPIV's good faith efforts and willingness to work with the government to correct and remedy the problem. CHPIV will also make good faith efforts to cooperate with law enforcement regarding any misconduct reported to the government, including FRAUD and ABUSE.
    b. If an investigation results in a reasonably suspected case of FWA, or confirms that an incident of FWA has been committed, CHPIV will report the incident as deemed appropriate and required by law or regulation to the following government agencies:
        i. CMS

ii. OIG (Medicare/Medicaid FRAUD)
iii. California Department of Justice, Bureau of Medi-Cal FRAUD
iv. California Department of Health Care Services, Program Integrity Unit
v. California Department of Managed Health Care (DMHC)
vi. Medical Board of California or other professional licensing regulatory body
vii. Local law enforcement agencies
viii. California Health Benefits Exchange

8. The Compliance Officer/Fraud Prevention Officer, with the assistance of legal counsel, review the case and determine if the reported allegation is a violation of State law, federal law, and/or CHPIV Code of Conduct.
9. CHPIV ensures appropriate corrective actions (for example, repayment of overpayments and disciplinary actions against responsible individuals) are taken in response to the potential violation referenced above.
    a. If an overpayment is of significant magnitude (to be determined on a case by case basis), legal counsel will be sought to determine if self-disclosure to a relevant regulatory agency is warranted.
        i. CHPIV has a duty to promptly conduct a reasonable inquiry upon receipt of information that a potential overpayment has occurred. Failure to make reasonable inquiry may be found to be reckless disregard or deliberate ignorance of the overpayment. When overpayment is identified, the Compliance Officer/Fraud Prevention Officer must report the overpayment to DHCS within 60 calendar days after the date on which the overpayment was identified (the 60-day clock does not start running until after CHPIV's Fully Delegated SUBCONTRACTOR has had an opportunity to undertake reasonable inquiry into the basis of the alleged overpayment).
    b. All overpayments should be reported using the self-reported overpayment refund process (SRORP).
    c. The Compliance Officer/Fraud Prevention Officer must provide DHCS and/or CMS, in writing, the following information:
        i. Reason for overpayment (incorrect service date, duplicate payment, incorrect CPT code, insufficient documentation, lack of medical necessity, etc.)
        ii. How the error was identified
        iii. Claim number, as appropriate
        iv. Description of the corrective action plan to ensure the error does not occur again
    d. CHPIV must report and refund overpayments received during the prior ten (10) years, and in accordance with APL 17-003 and the MEDI-CAL CONTRACT. CHPIV must comply with guidelines issued by DHCS pertaining to retention policies for the treatment of recoveries of all overpayments from CHPIV to a provider, including the treatment of recoveries of overpayments due to FWA.
    e. The Claims Department or its delegate must send a letter, accompanied by supporting documentation, to the person who received an overpayment, recognizing the overpayment and providing a date on which the appropriate funds must be returned. The funds must be returned to CHPIV within 60 calendar days after the date on which the overpayment is identified.
    f. Failing to report or return overpaid funds within the required timeframe may result in

liability under the FALSE CLAIMS ACT and civil monetary penalties up to and including exclusion from participation in federal health care programs. An overpayment which is properly reported and explained, but is not timely repaid, will not give rise to FALSE CLAIMS ACT liability, unless there is evidence of improper avoidance.

CHPIV's procedure provides for the voluntary self-reporting of potential fraud, waste, or abuse to the Centers for Medicare & Medicaid Services (CMS) or its designee, in addition to any applicable State reporting requirements.

D. Reporting

1. In accordance with 42 CFR § 438.608(a)(7), CHPIV ensures all FWA activities are referred, investigated, and reported to DHCS' Program Integrity Unit (PIU), in a manner prescribed by PIU as follows:
   a. Preliminary FWA Reports: CHPIV files a preliminary report with DHCS' PIU detailing any suspected FWA identified by or reported to CHPIV, its NETWORK PROVIDERS, SUBCONTRACTORS, or its DOWNSTREAM SUBCONTRACTORS within ten working days of CHPIV's discovery or notice of such FWA. CHPIV submits a preliminary report in accordance with requirements set forth in an APL or other similar instructions. Subsequent to the filing of the preliminary report, a complete investigation of all reported or suspected FWA activities is promptly conducted;
   b. Completed Investigation Report: Within ten working days of completing the FWA investigation (including both CHPIV-initiated and DHCS-initiated referrals), CHPIV submits a completed report to DHCS' PIU. This report includes CHPIV's findings, actions taken, and all documentation necessary to support any action taken by PCHPIV, and any additional documentation as requested by DHCS or other State and federal agencies;
   c. Quarterly FWA Status Report: CHPIV submits a quarterly report to DHCS' PIU on all FWA investigative activities ten working days after the close of every calendar quarter. The quarterly report contains the status of all preliminary, active, and completed investigations, and both CHPIV-initiated and DHCS-initiated referrals. In addition to quarterly reports, CHPIV provides updates and available documentation as DHCS may request from time to time;
   d. Manner of Report Submission: CHPIV electronically submits all FWA reports in a form and manner specified by DHCS through APL, or other similar instructions. The required report submission includes without limitation the preliminary FRAUD report, the completed investigation report, and the quarterly status report, including all supporting documents, and any additional documents requested by DHCS.
   e. CHPIV shall submit all required data related to payment suspensions, opioid-prescribing investigations, and referrals through the CMS Program Integrity Portal, including referral information and actions taken, in compliance with 42 CFR § 422.503(b)(4)(vi)(G)(5).
   f. CHPIV shall notify CMS or its designee at least 7 days before implementing any payment suspension under § 422.503(b)(4)(vi)(G)(4)(i) and adhere to quarterly data-submission deadlines of January 30, April 30, July 30, and October 30 each year, consistent with § 422.503(b)(4)(vi)(G)(6)

E. Disciplinary Guidelines and Enforcement

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

2. Any employee included in suspected violation of the Compliance Program (including its Fraud Prevention Program, Code of Conduct, policies and procedures), laws, regulations or other types of misconduct, is expected to cooperate fully with the investigation process and assist in its resolution.
3. CHPIV prohibits retaliation against any individual who reports suspected violations to the Compliance Program (including its Fraud Prevention Program, Code of Conduct, policies, and procedures), laws, regulations, or other types of misconduct.
4. Anyone who knowingly violates the Compliance Program (including its Fraud Prevention Program, Code of Conduct, policies and procedures), laws, regulations or other types of misconduct, will be subject to disciplinary action up to and including termination of employment criminal or civil prosecution, and or monetary penalties.
5. Discipline and corrective action shall be applied and enforced consistently, fairly, and without prejudice, in a timely manner. Disciplinary action will be based on the seriousness of the violation. The following activities may lead to disciplinary action up to and including termination of employment or termination of a contract with contracted Staff:
    a. A Staff member authorizes or participates in actions that knowingly violate CHPIV's Compliance Program (including its Fraud Prevention Program, Code of Conduct, policies and procedures), or laws or regulations;
    b. A Staff member deliberately provides misleading information about violations of the Fraud Prevention Program, Code of Conduct, policies or procedures, or laws or regulations;
    c. A Staff member fails to report suspected or known violations of the Fraud Prevention Program and/or Code of Conduct;
    d. A Staff member is found to have engaged in intentional or reckless non-compliance;
    e. A manager's or supervisor's actions reflect inadequate supervision or lack of diligence regarding violations of the Fraud Prevention Program and/or Code of Conduct, policies or procedures, or laws or regulations; and/or
    f. Any manager or supervisor retaliates, directly or indirectly, or encourages others to retaliate against an associate who reports a violation of the Fraud Prevention Program and/or Code of Conduct, policies or procedures, or laws or regulations.
6. NETWORK PROVIDERS, SUBCONTRACTORS, and DOWNSTREAM SUBCONTRACTORS also have the duty to follow the Fraud Prevention Program and Code of Conduct or similar standards that comply with all laws and regulations and to report any potential non-compliant, unethical, or fraudulent behavior without the fear of retaliation. Failure to comply may result in corrective or disciplinary action up to and including termination of a NETWORK PROVIDER or termination of a contract with a SUBCONTRACTOR or Downstream Subcontractor, and/or referral to governmental authority.
7. The Compliance Officer/Fraud Prevention Officer and the Compliance Committee shall be responsible for determining appropriate corrective action after being informed, briefed, and fully reviewing a complaint regarding potential FRAUD. The Compliance Officer/Fraud Prevention Officer and the Compliance Committee are responsible for all discipline or corrective actions relating to serious violations of the Code, policies or procedures, laws and regulations or other acts of wrongdoing, including possible criminal or civil FRAUD activities.
8. Expectations and disciplinary guidelines are well publicized through a variety of methods, including, but not limited to: the Code of Conduct, supporting policies and procedures, Compliance Program, Fraud Prevention Program, training (including Compliance, FWA, and HIPAA), CHPIV's policy CMP-007 Escalation of Noncompliance Issues.
9. Disciplinary records are retained for a period of ten (10) years, unless a longer time period is

required by law or regulation, and reviewed periodically to ensure disciplinary actions are appropriate to the violation and consistently administered.

III. PROCEDURE

A. Delegation of Functions

1. Delegated functions covered under this policy are described in the applicable delegate's own policies and procedures governing the performance of those functions. Delegates are required to maintain compliant and current policies consistent with applicable regulatory and contractual requirements. CHPIV's oversight activities verify adherence to those standards.

B. Delegation Oversight

1. CHPIV maintains full accountability for all delegated activities and provides oversight to ensure compliance with federal, state, and contractual requirements.
2. Oversight activities are conducted in accordance with CHPIV Policy CMP-002: Delegation Oversight Policy and Procedure, and include:
   a. Ongoing monitoring
   b. Performance reviews
   c. Data analysis
   d. Utilization of benchmarks, if available
   e. Annual desktop and on-site audits

IV. DEFINITIONS

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

TERMS	DEFINITION
Abuse	Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program.
All Plan Letter (APL)	The means by which Medi-Cal Managed Care conveys information or interpretation of changes in policy or procedures at the Federal or State levels. APLs provide instruction, if applicable, on how to implement changes on an operational basis.
Downstream Subcontractor	Means an individual or an entity that has a Downstream SUBCONTRACTOR Agreement with a SUBCONTRACTOR or a Downstream Subcontractor. A Network Provider is not a Downstream SUBCONTRACTOR solely because it enters into a Network Provider Agreement.
False Claims Act (FCA)	Federal and state statutes that generally prohibit making, using, or presenting a false statement or document in order to get the federal or state government to pay money. It also applies where false statements or

TERMS	DEFINITION
	documents are used to avoid paying money to the Government that would otherwise be owed, or for failing to identify and return an overpayment.
Fraud	As defined in Title 42 Code of Federal Regulations (section 455.2) fraud is, "An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law." Fraud also includes potential violations or activities prohibited by applicable federal or state laws including, without limitation, the Federal False Claims Act, 31 U.S.C. Sections 3729-3731 and the California False Claims Act, California Government Code, Sections 12650 – 12656.
Member	A beneficiary enrolled in a CHPIV program.
Network Provider	Provider or entity that has a Network Provider Agreement with Contractor, Contractor's Subcontractor, or Contractor's Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under this Contract. A Network Provider is not a SUBCONTRACTOR or Downstream SUBCONTRACTOR by virtue of the Network Provider Agreement.
Subcontractor	An individual or entity that has a subcontract with the MCP that relates directly or indirectly to the performance of the MCP's obligations under the contract with DHCS. A network provider is not a subcontractor by virtue of the network provider agreement, as per 42 CFR § 438.2.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare, Medicaid or any health care benefit program. Waste is generally not considered to be caused by criminally negligent actions.
Whistleblower	Someone who reports wrongdoing (by a co-worker, employer, or other person or company) to a person in a position of authority or publicly, such as to the media. More specifically, in a legal sense, it usually means someone who observes or learns of illegal activity, or at least activity believed to be unlawful, and reports it either to (1) a supervisor or other designated reporting recipient in the organization where the Whistleblower is employed or (2) to a governmental agency with responsibility to investigate or enforce laws regarding the alleged wrongdoing.

	Fraud, Waste, and Abuse Program	CMP-009
Department	Compliance	
Functional Area	Compliance	
Line of Business	☒ Medi-Cal ☒ D-SNP	

DELEGATION OF FUNCTION		
☒ Health Net	☐ Community Care IPA	☐ Not Delegated
☒ Community Health Group	☐ Primary Healthcare Medical Group	
☐ Imperial County Physicians MG	☐ Premier Patient Care	

DATES			
Policy Effective Date	10/9/2023	**Reviewed/Revised Date**	3/25/2025
Next Annual Review Due	3/25/2026	**Regulator Approval**	8/25/2023

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

ATTACHMENTS

- NA

AUTHORITIES/REFERENCES

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

- Program Fraud Civil Remedies Act – 31 U.S.C. §§ 3801-3812
- Deficit Reduction Act of 2005
- CA False Claims Act - CA Code § 12650 *et seq.*
- HIPAA – 45 CFR, Part 164
- Provider Self-Disclosure Protocol – 63 Fed. Reg. 58, 399-403 (1998)
- Title 42, Code of Federal Regulations (C.F.R.), §422.503

HISTORY	
Revision Date	Description of Revision
10/9/2023	Policy Creation
3/25/2025	Annual Review
	Added language to comply with CFR 422.503; updating language to clarify exclusion of providers/entities listed on federal or state ineligibility databases

I. OVERVIEW

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

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

1. Ensure that all Staff, NETWORK PROVIDERS, SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS or agents are educated regarding the federal and state false claims laws and the role of such laws in preventing and detecting FWA;
2. Ensure communication of all requirements of this Policy, and referenced obligations, to its NETWORK PROVIDERS, SUBCONTRACTORS, and DOWNSTREAM SUBCONTRACTORS, and will have a process to ensure its NETWORK PROVIDERS, SUBCONTRACTORS, and DOWNSTREAM SUBCONTRACTORS acknowledge receipt and understanding of the requirements contained within this Policy;
3. Perform audits that include reviewing, researching and documenting potential FWA activities within the organization;

4. Ensure identification and investigation of potential FRAUD from reports and referrals;
5. Ensure implementation of a process to conduct timely inquiry into potential violations;
6. Conduct FWA awareness training for Staff;
7. Ensure documentation and retention of all records pertaining to corrective actions imposed as a result of violations;
8. Ensure that NETWORK PROVIDERS, SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS have a robust FWA program in place, which includes the requirements of this Policy and ongoing monitoring and mandatory annual training;
9. Fully disclose to State and federal regulatory agencies any FRAUD or misconduct within the Plan, NETWORK PROVIDERS, SUBCONTRACTORS or DOWNSTREAM SUBCONTRACTORS; and
10. Fully cooperate with DHCS, DMFEA, OIG, and DOJ investigations and prosecutions in the event of allegations of FRAUD.

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

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

E. CHPIV will not employ or contract with:

1. Parties excluded from participation in federal health programs per the Office of Inspector General – U.S. Department of Health and Human Services (OIG-HHS) List of Excluded Individuals and Entities (LEIE), or entities affiliated with such excluded parties.
2. Precluded providers per the CMS Preclusion List, or entities affiliated with such precluded providers.
3. Suspended and otherwise ineligible providers per the Medi-Cal Suspended and Ineligible Provider List (SIPL), or entities affiliated with such suspended or otherwise ineligible providers.
4. Providers under a payment suspension while under investigation based upon a credible allegation of fraud per the Medi-Cal Restricted Provider Database (RPD), or entities affiliated with such providers.
5. Providers contracted with the Federal Employee Health Benefit Plan (FEHBP) who are suspended or debarred per the Office of Personnel Management (OPM), or entities affiliated with such providers.
6. Parties listed on the General Services Administration's (GSA) Exclusions Extract Data Package (EEDP) as referenced through the System for Award Management (SAM) website, or entities affiliated with such parties.
7. Providers under investigation for fraud, or entities affiliated with such providers.
8. Providers otherwise ineligible to participate in a state or federal health program (*e.g.*, Medicare/Medicaid), or entities affiliated with such providers.
9. Providers who have previously been under investigation by, sanctioned by, suspended, debarred, excluded, precluded, *etc.* from a federal or state health program, or entities affiliated with such providers.

II. POLICY

A. Fraud Prevention

1. CHPIV provides a confidential FRAUD hotline for FRAUD reports from Staff, MEMBERS, SUBCONTRACTORS, DOWNSTREAM SUBCONTRACTORS, NETWORK PROVIDERS, and any other individuals with a need to report suspected FRAUD and ensures that its SUBCONTRACTORS provide a confidential FRAUD hotline for FRAUD reports from their staff, MEMBERS, NETWORK PROVIDERS, DOWNSTREAM SUBCONTRACTORS, and any other individuals with a need to report suspected FRAUD.
2. CHPIV provides multiple mechanisms for reporting, including the confidential hotline, Staff exit interview surveys, email reporting, and a dedicated address for submission via U.S. Mail.
3. CHPIV ensures FRAUD prevention activities and suspected FRAUD are reported directly to regulatory and law enforcement agencies as required by law.
4. FRAUD activities and suspected FRAUD identified by NETWORK PROVIDERS, SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS are communicated to CHPIV.
5. CHPIV ensures FRAUD and ABUSE Activities include, but are not limited to:
    a. Complying with 42 CFR Part 455, §§ 455.104 (Disclosure by Medicaid providers and fiscal agents: Information on ownership and control), 455.105 (Disclosure by providers: Information related to business transactions), 455.106 (Disclosure by providers: Information on persons convicted of crimes), and 42 CFR section 438.610 (Prohibited affiliations);
    b. Ensure that SUBCONTRACTORS are requiring NETWORK PROVIDERS and DOWNSTREAM SUBCONTRACTORS to enroll and remain enrolled in the Medi-Cal program, to the extent required under the MEDI-CAL CONTRACT;
    c. Ensure that SUBCONTRACTORS are confirming the identity of NETWORK PROVIDERS, and any Person with an Ownership or Control Interest or who is an agent or Managing Employee of a Network Provider, upon contract execution or renewal and credentialing, through routine checks of State and federal databases; The databases to be checked are the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES) and the Excluded Provider Lists maintained by the State;
    d. Tracking SUBCONTRACTORS and ensuring SUBCONTRACTORS are tracking NETWORK PROVIDERS and DOWNSTREAM SUBCONTRACTORS through review of the following exclusionary databases and lists no less frequently than monthly and upon contract execution or renewal, and upon provider credentialing, taking appropriate action in accordance with ALL PLAN LETTER (APL) 15-026, and APL 21-003:
        i. List of suspended and ineligible providers located at https://files.medi-cal.ca.gov/pubsdoco/SandILanding.aspx,
        ii. List of OIG Excluded Individuals and Entities (LEIE) located at https://oig.hhs.gov/exclusions/exclusions_list.asp,
        iii. Excluded Parties List System (EPLS) within the HHS System for Award Management (SAM) database located at https://sam.gov/content/home;
    e. Ensuring training of Staff, directors, NETWORK PROVIDERS, and SUBCONTRACTORS (and ensuring NETWORK PROVIDERS and SUBCONTRACTORS ensure training of DOWNSTREAM SUBCONTRACTORS) on FRAUD schemes, FRAUD detection and FRAUD

prevention activities at least annually. Training may consist of an online course, in-person sessions, and/or distribution of written materials. Training topics will also include:

i. Federal and State FALSE CLAIMS ACT statutes,
ii. Federal remedies for false claims and statements,
iii. State laws containing civil or criminal penalties for false statements
iv. WHISTLEBLOWER protections,
v. How to handle instances of suspected health care FRAUD;

f. Ensuring that FRAUD prevention efforts are communicated in provider manuals, NETWORK PROVIDER and MEMBER newsletters, internal newsletters or information blasts, targeted mailings or in-service meetings;

g. Ensuring that a method is maintained to verify, by sampling or other methods, that services that have been represented to have been delivered by NETWORK PROVIDERS were in fact received by MEMBERS (42 CFR §438.608(a)(5)). CHPIV will provide proof of compliance with this requirement when requested by DHCS, in a form and manner specified by DHCS through APL, or other similar instruction.

h. Ensuring that there is monitoring and oversight of activities and reports to detect and deter fraudulent behavior, such as:

i. MEMBER and provider grievances,
ii. Claims review, including
    A. Clinical edits for invalid gender, out of normal age range, invalid diagnosis for procedure billed, redundant billing, and others
    B. Billings for non-covered benefits
    C. Claims for ineligible individuals
    D. Reviews for emergency diagnosis, emergency place of service and conformance to the definition of “emergency” and “medical necessity”
    E. Claims pended for review by the Claims Supervisor
        1. All claims received from other countries
        2. All MEMBER reimbursements for proper documentation,
iii. Medical management audits,
iv. Utilization management activities, including checking out-of-area claims to ensure the MEMBER lives within the service area,
v. Quality management activities,
vi. Operational reviews conducted by CHPIV’s internal audit department, including eligibility audits,
vii. Financial audits to ensure compliance with State and federal rules for reinsurance and the identification and return of overpayments;

i. Communicating an email address and an address for U.S. Mail to report suspicious behavior of FWA, confidentially or otherwise. Also, maintaining a toll-free hotline (866)685-8664 for confidential reporting of suspected FRAUD and ABUSE. The hotline is monitored by Staff. All reports of suspected FRAUD received from Staff, NETWORK PROVIDERS, SUBCONTRACTORS, DOWNSTREAM SUBCONTRACTORS, MEMBERS, or other credible sources will be logged, investigated, and tracked;

j. Ensuring investigation and resolution of all reported and/or suspected instances of FRAUD and taking action against confirmed FRAUD, including, but not limited to,

reporting to law enforcement agencies as required by the MEDI-CAL CONTRACT, termination of the MEMBER or Staff, termination of the contract with a Network Provider, Subcontractor, or Downstream Subcontractor, and/or removal of a NETWORK PROVIDER from the network;

k. Reporting suspected FRAUD as required under section titled "Reporting" in this Policy;
l. Filing an annual written report with DHCS and DMHC and other entities as required by law of CHPIV's efforts to deter, detect and investigate FRAUD; a log of all cases reported to government agencies; and the number of cases known to be prosecuted;
m. If DHCS, DMFEA, or DOJ, or any other authorized State or federal agency, determines there is a credible allegation of Fraud against a Network Provider, SUBCONTRACTOR or Downstream Subcontractor:
    i. CHPIV complies with the MEDI-CAL CONTRACT, all applicable State and federal laws, APL 15-026, and APL 21-003,
    ii. CHPIV ensures there are procedures in place to ensure immediate suspension of payments to the Network Provider, Subcontractor, or DOWNSTREAM SUBCONTRACTOR for which a State or federal agency determines there is a credible allegation of FRAUD (42 CFR § 438.608(a)(8)),
    iii. CHPIV may conduct additional monitoring, require temporary suspension, and/or termination of the Network Provider, SUBCONTRACTOR or Downstream Subcontractor,
    iv. When DHCS notifies CHPIV that a credible allegation of FRAUD has been found against a provider relating to provision of Fee-For-Service Medi-Cal services and that provider is also a Network Provider, one or more of the following four actions must be taken with submission of all supporting documentation to the MCQMD@dhcs.ca.gov inbox
        A. Termination of the NETWORK PROVIDER from the network
        B. Temporary suspension of the NETWORK PROVIDER from the network pending resolution of the FRAUD allegation
        C. Temporary suspension of payment to the NETWORK PROVIDER pending resolution of the FRAUD allegation, and/or
        D. Additional monitoring, including audits of the Network Provider's claims history and future claims submissions for appropriate billing,
    v. CHPIV must notify DHCS as to which of the above four actions are taken. No action will be required that would interfere with State or federal criminal investigations,
    vi. In the event of a Network Provider, Subcontract or, or DOWNSTREAM SUBCONTRACTOR termination, CHPIV will ensure all the requirements and guidance listed in APL 21-003: Medi-Cal NETWORK PROVIDER and SUBCONTRACTOR Terminations are followed,
    vii. CHPIV will fully cooperate in any investigation or prosecution conducted by the DMFEA and the DOJ. CHPIV's cooperation must include without limitation
        A. Providing upon request, information, and access to records, and
        B. Making available Staff or, to the extent appropriate, SUBCONTRACTOR for in-person interviews, consultation, grand jury proceedings, pre-trial conference, depositions, and hearings at DHCS headquarters in

Sacramento,

viii. CHPIV litigation support for CMS, DMFEA, and other agencies includes
   A. Ensuring that NETWORK PROVIDERS timely gather, preserve, and provide to DHCS, CMS, DMFEA, and any authorized State or federal regulatory agencies, any records in Network Provider's possession, and
   B. Ensuring that SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS timely gather, preserve, and provide to DHCS, CMS, DMFEA, and any authorized State or federal regulatory agencies, any records in their possession.

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

B. Administration

1. CHPIV ensures all potential FWA cases are logged, investigated, and monitored.
2. CHPIV's Fully Delegated Subcontractor's Compliance Officer/Fraud Prevention Officer shall attend and participate in DHCS's quarterly integrity meetings, as scheduled.
3. CHPIV ensures DHCS is notified of any changes in Member's circumstances that impact Medi-Cal coverage pursuant to Medi-Cal program eligibility requirements, including changes in the Member's residence, income, insurance status, and death (42 CFR § 438.608(a)(3)) in a form and manner specified by DHCS through APL or other similar instructions.
4. CHPIV ensures a report of potential instance of FWA is received, an inquiry is initiated as expeditiously as reasonably necessary, but no later than two weeks after the date that the potential misconduct is reported.
   a. If an individual believes that the response to his or her report is completed within a reasonable period of time, he or she is required to bring the matter to the attention of the Compliance Officer/Fraud Prevention Officer.
   b. Failure to report and disclose, or assist, in an investigation of FWA is a breach of the duty that all Staff have to CHPIV and CHPIV's Fully Delegated SUBCONTRACTOR and may result in disciplinary action, up to and including termination.
      i. The CHPIV Compliance Hotline number is (866) 685-8664.
      ii. Written reports may be mailed to: Centene Special Investigations Unit 7700 Forsyth Blvd. Clayton, MO 63105.

5. Files containing investigation materials must be kept in a confidential locked and secured location. Files must be retained a minimum of ten (10) years, unless a longer period of time is required by law or regulation.
6. All parties to the investigation: MEMBERS, NETWORK PROVIDERS, SUBCONTRACTORS, DOWNSTREAM SUBCONTRACTORS, Staff MEMBERS or others named in any form or fashion within the investigation are to be kept confidential to the extent allowable by law.
7. All parties having information relating to the subject of the investigation must hold all information strictly confidential to the extent allowable by law; failure to do so will result in disciplinary action up to and including termination.
8. CHPIV protects as "confidential information" all information shared by or received from DHCS, other State agencies, and federal agencies, and other Medi-Cal managed care plans in connection with any FWA referral, until formal criminal proceedings are made public. CHPIV receives the confidential information as a DHCS business associate in order to facilitate CHPIV's contractual obligations to maintain a FWA prevention program. PHCIV receives and maintains this confidential information in its capacity as a Medi-Cal managed care plan and uses such confidential information only for conducting an investigation into any potential FWA activities and in furtherance of any other program integrity activities.
9. Preliminary and quarterly reports are to be kept confidential and submitted to the DHCS Program Integrity Unit.
10. In the event CHPIV is required to share investigative information with a Network Provider, Subcontractor, or Downstream Subcontractor, CHPIV ensures that the Network Provider, Subcontractor, or DOWNSTREAM SUBCONTRACTOR acknowledges and agrees that such information will be kept confidential by the Network Provider, Subcontractor, or Downstream Subcontractor.

C. Investigations

1. CHPIV ensures a complete investigation is conducted for all FWA referrals received from DHCS, other State agencies, federal agencies, and other Medi-Cal managed care plans, relating to CHPIV's NETWORK PROVIDERS, SUBCONTRACTORS, and DOWNSTREAM SUBCONTRACTORS. CHPIV submits to DHCS a completed investigation report and a quarterly status report, as set forth in this policy or otherwise required by DHCS in connection with all DHCS, State and federal agency, and Medi-Cal managed care plan referrals of FWA.
2. CHPIV ensures the prompt and thorough investigation of actual or potential FWA, and requires all Staff to assist in such investigations. Investigations may include but not be limited to the following activities:
   a. On-site visits to NETWORK PROVIDERS and SUBCONTRACTORS.
   b. On-site visits to CHPIV MEMBER homes. These visits could be accomplished in conjunction with the audit and/or medical review Staff, or State survey and certification Staff.
   c. Telephone calls or written questionnaires to a sample of CHPIV MEMBERS asking them to confirm the services they received.
   d. Telephone calls or written questionnaires to providers confirming the need for the services rendered.
   e. Telephone calls, correspondence or on-site visits to other pertinent entities.
3. The Compliance Officer/Fraud Prevention Officer must conclude investigations of potential misconduct within a reasonable time period after discovery of the alleged fraudulent activity

and complete a FWA Investigation Report form.

4. CHPIV shall conduct a timely and reasonable inquiry into any evidence of misconduct related to payment or delivery of items or services under a Medicare Advantage contract, consistent with 42 CFR § 422.503(b)(4)(vi)(G)(1)
5. CHPIV shall promptly identify and report to CMS or its designee any (i) payment suspension implemented pending investigation of credible allegations of fraud by a pharmacy, and (ii) credible evidence of suspicious activities of a provider, prescriber, or supplier, including inappropriate opioid prescribing, in accordance with 42 CFR § 422.503(b)(4)(vi)(G)(4).

~~4.~~6. Unless otherwise specified, the Compliance Officer/Fraud Prevention Officer shall complete a FWA Investigation Report form that includes, to the extent available, the following:

a. Plan name, organization, and contact information for follow up
b. Summary of the issue including
    i. The basic who, what, when, where, how, and why
    ii. Any potential legal violations
c. Specific statutes and allegations including
    i. A list of civil, criminal, and administrative code or rule violations, State and federal
    ii. A detailed description of the allegations or pattern of FWA
d. Incidents and Issues including
    i. A list of incidents and issues related to the allegations
e. Background information
    i. Contact information for the complainant, the perpetrator or subject of the investigation, and beneficiaries, pharmacies, providers, or other entities involved
    ii. Additional background information that may assist investigators, such as names and contact information of informants, relators, witnesses, websites, geographic locations, corporate relationships, networks
    iii. The legal and administrative disposition of the case, if available, including actions taken by law enforcement officials to whom the case has been referred
f. Perspectives of interested parties
    i. Perspective of CHPIV, DHCS, CMS, Member, and other interested parties
g. Data
    i. Existing and potential data sources
    ii. Graphs and trending
    iii. Maps
    iv. Financial impact estimates
h. Recommendations in pursuing the case
    i. Next steps, special considerations, cautions.

~~5.~~7. Within no more than ten (10) working days of completing the investigation, CHPIV shall submit to DHCS reports signed by an executive officer of CHPIV.

a. Such prompt reporting demonstrates CHPIV's good faith efforts and willingness to work with the government to correct and remedy the problem. CHPIV will also make good faith efforts to cooperate with law enforcement regarding any misconduct reported to the government, including FRAUD and ABUSE.
b. If an investigation results in a reasonably suspected case of FWA, or confirms that an incident of FWA has been committed, CHPIV will report the incident as deemed appropriate and required by law or regulation to the following government agencies:
    i. CMS

ii. OIG (Medicare/Medicaid FRAUD)
iii. California Department of Justice, Bureau of Medi-Cal FRAUD
iv. California Department of Health Care Services, Program Integrity Unit
v. California Department of Managed Health Care (DMHC)
vi. Medical Board of California or other professional licensing regulatory body
vii. Local law enforcement agencies
viii. California Health Benefits Exchange

~~6.~~8. The Compliance Officer/Fraud Prevention Officer, with the assistance of legal counsel, review the case and determine if the reported allegation is a violation of State law, federal law, and/or CHPIV Code of Conduct.

~~7.~~9. CHPIV ensures appropriate corrective actions (for example, repayment of overpayments and disciplinary actions against responsible individuals) are taken in response to the potential violation referenced above.

a. If an overpayment is of significant magnitude (to be determined on a case by case basis), legal counsel will be sought to determine if self-disclosure to a relevant regulatory agency is warranted.
    i. CHPIV has a duty to promptly conduct a reasonable inquiry upon receipt of information that a potential overpayment has occurred. Failure to make reasonable inquiry may be found to be reckless disregard or deliberate ignorance of the overpayment. When overpayment is identified, the Compliance Officer/Fraud Prevention Officer must report the overpayment to DHCS within 60 calendar days after the date on which the overpayment was identified (the 60-day clock does not start running until after CHPIV's Fully Delegated SUBCONTRACTOR has had an opportunity to undertake reasonable inquiry into the basis of the alleged overpayment).
b. All overpayments should be reported using the self-reported overpayment refund process (SRORP).
c. The Compliance Officer/Fraud Prevention Officer must provide DHCS and/or CMS, in writing, the following information:
    i. Reason for overpayment (incorrect service date, duplicate payment, incorrect CPT code, insufficient documentation, lack of medical necessity, etc.)
    ii. How the error was identified
    iii. Claim number, as appropriate
    iv. Description of the corrective action plan to ensure the error does not occur again
d. CHPIV must report and refund overpayments received during the prior ten (10) years, and in accordance with APL 17-003 and the MEDI-CAL CONTRACT. CHPIV must comply with guidelines issued by DHCS pertaining to retention policies for the treatment of recoveries of all overpayments from CHPIV to a provider, including the treatment of recoveries of overpayments due to FWA.
e. The Claims Department or its delegate must send a letter, accompanied by supporting documentation, to the person who received an overpayment, recognizing the overpayment and providing a date on which the appropriate funds must be returned. The funds must be returned to CHPIV within 60 calendar days after the date on which the overpayment is identified.
f. Failing to report or return overpaid funds within the required timeframe may result in

liability under the FALSE CLAIMS ACT and civil monetary penalties up to and including exclusion from participation in federal health care programs. An overpayment which is properly reported and explained, but is not timely repaid, will not give rise to FALSE CLAIMS ACT liability, unless there is evidence of improper avoidance.

~~f.~~ CHPIV's procedure provides for the voluntary self-reporting of potential fraud, waste, or abuse to the Centers for Medicare & Medicaid Services (CMS) or its designee, in addition to any applicable State reporting requirements.

D. Reporting

1. In accordance with 42 CFR § 438.608(a)(7), CHPIV ensures all FWA activities are referred, investigated, and reported to DHCS' Program Integrity Unit (PIU), in a manner prescribed by PIU as follows:
   a. Preliminary FWA Reports: CHPIV files a preliminary report with DHCS' PIU detailing any suspected FWA identified by or reported to CHPIV, its NETWORK PROVIDERS, SUBCONTRACTORS, or its DOWNSTREAM SUBCONTRACTORS within ten working days of CHPIV's discovery or notice of such FWA. CHPIV submits a preliminary report in accordance with requirements set forth in an APL or other similar instructions. Subsequent to the filing of the preliminary report, a complete investigation of all reported or suspected FWA activities is promptly conducted;
   b. Completed Investigation Report: Within ten working days of completing the FWA investigation (including both CHPIV-initiated and DHCS-initiated referrals), CHPIV submits a completed report to DHCS' PIU. This report includes CHPIV's findings, actions taken, and all documentation necessary to support any action taken by PCHPIV, and any additional documentation as requested by DHCS or other State and federal agencies;
   c. Quarterly FWA Status Report: CHPIV submits a quarterly report to DHCS' PIU on all FWA investigative activities ten working days after the close of every calendar quarter. The quarterly report contains the status of all preliminary, active, and completed investigations, and both CHPIV-initiated and DHCS-initiated referrals. In addition to quarterly reports, CHPIV provides updates and available documentation as DHCS may request from time to time;
   d. Manner of Report Submission: CHPIV electronically submits all FWA reports in a form and manner specified by DHCS through APL, or other similar instructions. The required report submission includes without limitation the preliminary FRAUD report, the completed investigation report, and the quarterly status report, including all supporting documents, and any additional documents requested by DHCS.
   e. CHPIV shall submit all required data related to payment suspensions, opioid-prescribing investigations, and referrals through the CMS Program Integrity Portal, including referral information and actions taken, in compliance with 42 CFR § 422.503(b)(4)(vi)(G)(5).
   ~~d.~~f. CHPIV shall notify CMS or its designee at least 7 days before implementing any payment suspension under § 422.503(b)(4)(vi)(G)(4)(i) and adhere to quarterly data-submission deadlines of January 30, April 30, July 30, and October 30 each year, consistent with § 422.503(b)(4)(vi)(G)(6)

E. Disciplinary Guidelines and Enforcement

1. CHPIV is committed to communicating clear and concise standards as well as executing the

disciplinary process when required.

2. Any employee included in suspected violation of the Compliance Program (including its Fraud Prevention Program, Code of Conduct, policies and procedures), laws, regulations or other types of misconduct, is expected to cooperate fully with the investigation process and assist in its resolution.
3. CHPIV prohibits retaliation against any individual who reports suspected violations to the Compliance Program (including its Fraud Prevention Program, Code of Conduct, policies, and procedures), laws, regulations, or other types of misconduct.
4. Anyone who knowingly violates the Compliance Program (including its Fraud Prevention Program, Code of Conduct, policies and procedures), laws, regulations or other types of misconduct, will be subject to disciplinary action up to and including termination of employment criminal or civil prosecution, and or monetary penalties.
5. Discipline and corrective action shall be applied and enforced consistently, fairly, and without prejudice, in a timely manner. Disciplinary action will be based on the seriousness of the violation. The following activities may lead to disciplinary action up to and including termination of employment or termination of a contract with contracted Staff:
    a. A Staff member authorizes or participates in actions that knowingly violate CHPIV's Compliance Program (including its Fraud Prevention Program, Code of Conduct, policies and procedures), or laws or regulations;
    b. A Staff member deliberately provides misleading information about violations of the Fraud Prevention Program, Code of Conduct, policies or procedures, or laws or regulations;
    c. A Staff member fails to report suspected or known violations of the Fraud Prevention Program and/or Code of Conduct;
    d. A Staff member is found to have engaged in intentional or reckless non-compliance;
    e. A manager's or supervisor's actions reflect inadequate supervision or lack of diligence regarding violations of the Fraud Prevention Program and/or Code of Conduct, policies or procedures, or laws or regulations; and/or
    f. Any manager or supervisor retaliates, directly or indirectly, or encourages others to retaliate against an associate who reports a violation of the Fraud Prevention Program and/or Code of Conduct, policies or procedures, or laws or regulations.
6. NETWORK PROVIDERS, SUBCONTRACTORS, and DOWNSTREAM SUBCONTRACTORS also have the duty to follow the Fraud Prevention Program and Code of Conduct or similar standards that comply with all laws and regulations and to report any potential non-compliant, unethical, or fraudulent behavior without the fear of retaliation. Failure to comply may result in corrective or disciplinary action up to and including termination of a NETWORK PROVIDER or termination of a contract with a SUBCONTRACTOR or Downstream Subcontractor, and/or referral to governmental authority.
7. The Compliance Officer/Fraud Prevention Officer and the Compliance Committee shall be responsible for determining appropriate corrective action after being informed, briefed, and fully reviewing a complaint regarding potential FRAUD. The Compliance Officer/Fraud Prevention Officer and the Compliance Committee are responsible for all discipline or corrective actions relating to serious violations of the Code, policies or procedures, laws and regulations or other acts of wrongdoing, including possible criminal or civil FRAUD activities.
8. Expectations and disciplinary guidelines are well publicized through a variety of methods, including, but not limited to: the Code of Conduct, supporting policies and procedures, Compliance Program, Fraud Prevention Program, training (including Compliance, FWA, and HIPAA), CHPIV's policy CMP-007 Escalation of Noncompliance Issues.

9. Disciplinary records are retained for a period of ten (10) years, unless a longer time period is required by law or regulation, and reviewed periodically to ensure disciplinary actions are appropriate to the violation and consistently administered.

III. PROCEDURE

A. Delegation of Functions

1. Delegated functions covered under this policy are described in the applicable delegate's own policies and procedures governing the performance of those functions. Delegates are required to maintain compliant and current policies consistent with applicable regulatory and contractual requirements. CHPIV's oversight activities verify adherence to those standards.

~~A.~~B. Delegation Oversight

1. CHPIV maintains full accountability for all delegated activities and provides oversight to ensure compliance with federal, state, and contractual requirements.
2. Oversight activities are conducted in accordance with CHPIV Policy CMP-002: Delegation Oversight Policy and Procedure, and include:

~~1. CHPIV delegates the Fraud Prevention Program to its SUBCONTRACTOR, Health Net.~~

~~2. CHPIV shall provide oversight and continually assess the delegated functions, responsibilities, processes, and performance of Health Net. CHPIV ensures Health Net's compliance with regulatory and contractual requirements through the following activities which are detailed in CHPIV Policy CMP-002: Delegation Oversight Policy and Procedure:~~

a. Ongoing monitoring
b. Performance reviews
c. Data analysis
d. Utilization of benchmarks, if available
e. Annual desktop and on-site audits

IV. DEFINITIONS

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

TERMS	DEFINITION
Abuse	Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program.
All Plan Letter (APL)	The means by which Medi-Cal Managed Care conveys information or interpretation of changes in policy or procedures at the Federal or State levels. APLs provide instruction, if applicable, on how to implement changes on an operational basis.
Downstream Subcontractor	Means an individual or an entity that has a Downstream SUBCONTRACTOR Agreement with a SUBCONTRACTOR or a Downstream Subcontractor. A Network Provider is not a Downstream

TERMS	DEFINITION
	SUBCONTRACTOR solely because it enters into a Network Provider Agreement.
False Claims Act (FCA)	Federal and state statutes that generally prohibit making, using, or presenting a false statement or document in order to get the federal or state government to pay money. It also applies where false statements or documents are used to avoid paying money to the Government that would otherwise be owed, or for failing to identify and return an overpayment.
Fraud	As defined in Title 42 Code of Federal Regulations (section 455.2) fraud is, "An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law." Fraud also includes potential violations or activities prohibited by applicable federal or state laws including, without limitation, the Federal False Claims Act, 31 U.S.C. Sections 3729-3731 and the California False Claims Act, California Government Code, Sections 12650 – 12656.
Member	A beneficiary enrolled in a CHPIV program.
Network Provider	Provider or entity that has a Network Provider Agreement with Contractor, Contractor's Subcontractor, or Contractor's Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under this Contract. A Network Provider is not a SUBCONTRACTOR or Downstream SUBCONTRACTOR by virtue of the Network Provider Agreement.
Subcontractor	An individual or entity that has a subcontract with the MCP that relates directly or indirectly to the performance of the MCP's obligations under the contract with DHCS. A network provider is not a subcontractor by virtue of the network provider agreement, as per 42 CFR § 438.2.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare, Medicaid or any health care benefit program. Waste is generally not considered to be caused by criminally negligent actions.
Whistleblower	Someone who reports wrongdoing (by a co-worker, employer, or other person or company) to a person in a position of authority or publicly, such as to the media. More specifically, in a legal sense, it usually means someone who observes or learns of illegal activity, or at least activity believed to be unlawful, and reports it either to (1) a supervisor or other designated reporting recipient in the organization where the Whistleblower is employed or (2) to a governmental agency with responsibility to investigate or enforce laws regarding the alleged wrongdoing.

Pre-Delegation Audit of Community Health Group

Final Report

November 24, 2025

Community Health Plan
OF IMPERIAL VALLEY

Introduction

We would like to extend our sincere thanks to Community Health Group leadership and staff for their partnership and effort in preparing for this pre-delegation audit. The team's responsiveness, openness, and commitment to compliance were evident throughout the review process. This audit represents an important milestone in the preparation for 2026 D-SNP implementation, and the materials submitted demonstrate that CHG has already laid a strong foundation to support members and meet regulatory expectations.

The purpose of this preliminary report is to provide feedback on the documentation reviewed to date, highlight areas of strength, and identify opportunities where additional clarification or refinement is needed to ensure full alignment with CMS and DHCS requirements. By addressing these findings proactively, CHG will be well-positioned for successful delegation and D-SNP readiness in advance of program launch.

Background

In 2021, DHCS approved Imperial County's move to a single plan model. In 2022, the County initiated a Knox-Keene License (KKL) to serve Medi-Cal members, and Community Health Plan of Imperial Valley (CHPIV) was formed as the County's local initiative. Per Department of Health Care Services (DHCS) direction, CHPIV must begin offering a Dual Eligible Special Needs Plan (D-SNP) line of business ahead of January 1, 2026. To support implementation, CHPIV entered a Plan-to-Plan agreement with Community Health Group as its subcontractor ("Delegate"), leveraging CHG's provider network and administrative services for Imperial County.

Audit Scope

The **Pre-Delegation Audit** was designed to assess Community Health Group of San Diego's (CHG) ability to perform critical delegated functions in alignment with the CHG - CHPIV plan-to-plan agreement, as well as the requirements of the Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS). The audit focuses on reviewing key go-live policies and procedures.

Audit Areas

- Utilization Management
- Grievances & Appeals
- Credentialing & Recredentialing
- Claims
- Provider Dispute Resolution
- Member Services
- Compliance
- Quality Improvement

Methodology

The pre-delegation audit was conducted using audit tools developed specifically for the implementation of **Dual Eligible Special Needs Plans (D-SNPs) in 2026**. These tools are derived from the regulatory requirements applicable to 2026 D-SNP operations, including:

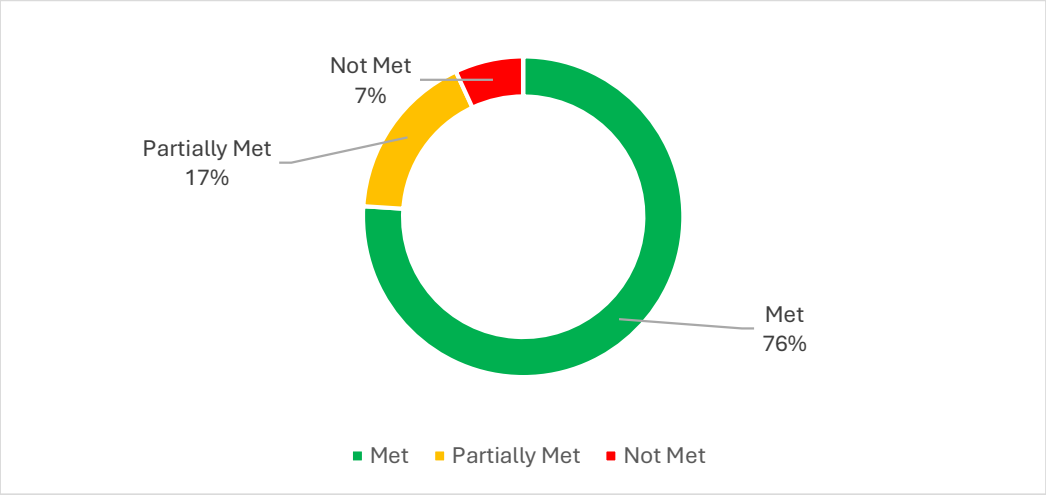
- Centers for Medicare & Medicaid Services (CMS) requirements for Medicare Advantage and Special Needs Plans, including CMS Audit Protocols
- Department of Health Care Services (DHCS) requirements, including the CalAIM D-SNP Policy Guide.
- Requirements outlined in the State Medicaid Agency Contract (SMAC).

Community Health Group (CHG) submitted policies, procedures, and other supporting documentation for review. Each document was assessed against the corresponding requirements in the audit tools to evaluate whether CHG's framework sufficiently demonstrates compliance with CMS and DHCS expectations for 2026 D-SNP operations.

The audit report presents the results in three categories:

- **Met –** Requirement was fully addressed in submitted documentation.
- **Partially Met –** Requirement was addressed in part, however, requires refinement to achieve compliance.
- **Not Met –** Requirement was not addressed in the documentation provided.

Summary of Findings



Policy Review

Compliance improved significantly from 54.4% to 75% after additional documentation was submitted, reflecting strong progress across all audit areas. While most core requirements are now met, some policies are still being updated for 2026. Continued focus on completing these updates and closing remaining gaps will be key to achieving full compliance.

Audit Area Trends

1. **Claims**
   The review shows that the organization meets core requirements for timely claims processing, interest payments on late claims, and resolution of claims from non-contracted providers within required timeframes. Policies also ensure adherence to CMS national coverage determinations, Traditional Medicare benefits, and local contractor decisions. However, some gaps remain. While internal coverage criteria are evidence-based and publicly accessible with rationale and source lists, there is no requirement to post summaries of supporting evidence online. Processes for notifying CMS when applying a single local coverage policy and uniformly applying such policies across regions are not applicable but should be monitored for future compliance. Overall, claims operations are strong, but transparency in coverage criteria and proactive disclosure of supporting evidence could be improved to enhance compliance and member trust.

2. **Compliance**
   The review shows that the organization meets all compliance program requirements with no findings. Policies and procedures are in place to prevent, detect, and correct non-compliance and fraud, waste, and abuse. The compliance structure includes a dedicated officer and committee reporting to senior leadership, supported by clear standards of conduct, annual training, and confidential reporting channels. Non-retaliation protections, disciplinary standards, and monitoring systems are documented, and internal and external audits are performed as required. Processes for timely issue resolution, enforcement, and reporting to regulators are established, ensuring full alignment with federal and state requirements.

3. **Credentialing & Recredentialing**
   The review shows that the organization meets all credentialing and recredentialing requirements with no findings. Policies and procedures are in place for initial credentialing, exclusion checks, provider selection, accreditation reviews, payment compliance, and adherence to federal standards. Processes ensure fairness in participation decisions, timely recredentialing every three years, and proper license monitoring. Declination notices include required details, and applications are signed with attestations. Additionally, the organization maintains compliance with preclusion list provisions and provides appropriate notifications to licensing authorities when necessary. Overall, credentialing operations are fully aligned with regulatory standards and demonstrate strong governance.

4. **Grievances**
   The review shows that the organization meets several requirements for informing enrollees of their rights, assisting with grievances, and providing timely written responses for quality-of-care issues. However, significant gaps remain. Policies do not fully address accurate recordkeeping for integrated grievances and appeals, including required details such as review dates, resolution at each level, and enrollee identification. Assistance for carved-out benefits is

unclear, and there is no assurance that only enrollees or authorized representatives can request integrated grievances or reconsiderations. Provider education on grievance and appeal procedures at contract execution is incomplete. Timeliness standards for expedited grievances and oral notifications of delays are not consistently documented, and written responses for oral grievances upon request are missing. Notices explaining delays do not consistently reference the right to file an integrated grievance, and processes for informing enrollees about limited time to submit evidence under expedited timeframes are absent. Addressing these gaps—particularly around recordkeeping, timeliness, enrollee rights, and provider communication—will be essential to strengthen compliance and improve member experience.

5. **Member Services**

   The review shows that the organization meets most customer service requirements, including operating hours, call response times, interpreter availability, and TTY performance standards. However, several gaps remain. There is no documented process for entering and immediately updating toll-free call center and TTY numbers in the federal HPMS system, and Non-renewal Notices do not include required contact details or hours of operation. Policies also lack clarity on holiday closure rules for October through March and do not confirm that IVR systems capture and return messages within one business day. Additionally, there is no policy ensuring effective real-time communication for individuals using TTY or relay services when automated systems are in use. Addressing these gaps—particularly around HPMS updates, notice content, holiday closure protocols, and accessibility—will be essential to ensure compliance and improve member experience.

6. **Provider Dispute Resolution**

   The review shows that the organization meets most core requirements for integrated Provider Dispute Resolutions, including timely resolution of standard and expedited cases, payment within 30 days when denials are reversed, and clear written notices explaining decisions and next appeal steps. However, gaps remain in ensuring independence of reviewers from prior decision-makers and their subordinates. Addressing these gaps particularly around reviewer independence and formalizing procedures for extensions and notifications will be essential to strengthen compliance and maintain enrollee protections.

7. **Quality Improvement**

   The review shows that the organization meets several core requirements, including maintaining an ongoing quality improvement program, evaluating its effectiveness annually, implementing activities to reduce health disparities, and using CMS-mandated tools for performance measurement. However, significant gaps remain. There is no comprehensive written plan outlining all components of the quality improvement program, and a formal chronic care improvement program targeting CMS-identified populations is missing. Systems for providing aggregated quality and outcomes data to CMS and beneficiaries for plan comparisons are incomplete, and processes for contracting CMS-approved vendors for CAHPS surveys are not documented. Additionally, policies do not fully address provider engagement in CMS and HHS

quality initiatives, nor do they ensure data reliability across all plan types. Measurement of model of care effectiveness lacks clear metrics for health risk assessments, individualized care plans, provider network expertise, and evidence-based practices. Addressing these gaps—particularly around documentation, chronic care programs, provider engagement, and transparency—will be essential to strengthen compliance and improve care quality.

8. **Utilization Management**

The review shows that the organization meets many core requirements for timely determinations, expedited processes, medical necessity reviews, and involvement of qualified clinicians. However, several gaps remain. Policies do not fully address the new 7-day prior authorization notice requirement effective January 2026, nor do they ensure uniform processes across all covered benefits. There is no documented methodology for health equity analysis of prior authorization or for comparing metrics based on social risk factors. Internal coverage criteria lack publicly accessible summaries of evidence, source lists, and rationale, and there is no process to demonstrate that added criteria outweigh potential harms or identify provisions being supplemented. Additionally, UM Committee governance needs improvement: there is no assurance of a majority of practicing physicians, independence from conflicts, or consistent documentation of decision rationale. Post-stabilization care policies are incomplete, lacking clear processes for pre-approval and ending financial responsibility for unapproved care. Addressing these gaps—particularly around transparency, equity, governance, and compliance with upcoming timeframes—will be critical to meeting regulatory standards and improving member protections.

Next Steps

Step	Description	Target Date
1. CHPIV Distributes Final Result & CAP to CHG	Share final report with CHG leadership and functional area leads for review.	11/24/2025
2. CHG Drafts Corrective Action Plan (CAP)	Develop CAP with remediation steps, responsible owners, and timelines aligned to CMS/DHCS standards.	CHG responds within 20 business days.
3. CHPIV Reviews and Approves CAP		TBD
4. CHPIV Performs CAP Validation		TBD

Operations Report, Dec 2025

Period Covered: Nov 2025

Highlights:

- **D-SNP Go Live:**
    - **Enrollment:** Current enrollment levels are consistent with monthly projections after 1/1, but lower than anticipated during this first Annual Election Period (AEP). This is due to lower than anticipated IPA patient referrals. To boost enrollment and meet projections, we are planning to:
        - Execute 1-2 select and limited-scope external agency agreements. This was contemplated as part of our initial decision if our key assumptions related to IPA referrals did not hold by this date. We anticipate these agreements will quickly bring us back in line with projections.
        - Expand activities to boost brand awareness, including:
            - Expanding our presence at community and senior-focused events with more consistent scheduling and on-site education.
            - Increasing outreach to high-potential accounts and reinforcing follow-up cadence to strengthen referral relationships.
            - Launching additional marketing materials and refreshed signage at kiosks and partner locations to improve brand recognition.
            - Coordinating targeted digital and print campaigns aimed at Medi/Medi-eligible populations in priority ZIP codes.
            - Exploring new partnerships with community organizations to diversify lead sources beyond IPA referrals.
    - **Implementation:** Implementation is currently on track with CHG and all IPAs. We are closely tracking key risk areas related to IPA implementation in the coming month:
        - File exchange and testing – eligibility, provider network, encounters, authorizations, and capitation files
        - Medi-Cal cross-over claim processing - IPAs are delegated for both Medicare and Medi-Cal payment for D-SNP members. This is a process that is unique to CHPIV since we are an integrated Medi-Medi plan.

        - IPA and CHG misdirected claim coding and testing.
        - Educating IPA providers on the process for submitting non-delegated referrals for pharmacy, inpatient, transportation, etc. This will happen in late December and early January.
        - Member Experience Reps will be trained on CHG system on Dec 11-12. Our staff will be able to submit ID card requests, change PCP, change address and demographic information, schedule transportation, order over the counter items, and add notes to Member record in system.
        - We are holding a 1-day staff training on December 15 in session in December, where Care Coordinator and Member Experience Reps will work through different member scenarios in collaboration with community partners.
    - **D-SNP Network**
        - We are waiting on credentialing approval for 400 direct network contracts. Approximately 50% of these have been pre-credentialing cleared by CHG for contracting. CHG is working overtime to move the remaining 238 providers through the pre-credentialing process by their December 12 meeting.
        - Working to finalize full hospital and IPA agreements. We have loaded agreed upon rates into CHG system, as we work through final edits to these contracts.
        - We agreed to rates with UCSD, but are awaiting execution of a letter of agreement.
        - Continuing to expand direct Community Support network. Still looking for personal care providers to support members who do not qualify for IHSS.

- **Communications and Outreach**
    - We sent out our first community newsletter last month (see attached). We will send these monthly going forward.
    - Our next community advisory committee is Dec 9 from noon-2pm. Agenda includes:
        - Imperial CHA/CHIP
        - Population Nees Assessment
        - Find Help
        - Trainings for diverse populations
        - Review and discussion of CHPIV cultural and linguistic score card

Key Metrics:

Status	Category	Goal	Prior Month Performance
	Provider Network	100% of direct provider contracts are signed by 1/1	We expect >90% of direct network providers will be cleared by credentialing for contracting by 12/15.
	Member engagement	20 outbound member calls per month	20, NPS = 85% [NPS = Net Promoter Score]
	Enrollment	417 new enrollments between 10/15 and 12/31	100 new in November; 155 YTD
	Community Advisory Committee	Increase # of members receiving care for depression & anxiety by 10% from 327 in 2024 to 360 in 2025	175 members treated for depression or anxiety in Oct.

Issues/Risks:

- Lower than projected enrollment
- Finalize direct network contracts by 1/1

Next 30 Days:

- Ramp up Sales in partnership with select external agencies
- CHG and IPA implementation and readiness

BUILDING A HEALTHIER IMPERIAL VALLEY, TOGETHER

The Annual Election Period for Community Advantage Plus, our new Dual Eligible Special Needs Plan (Medi-Medi plan), began October 15 and will continue through December 7. Because CHPIV is an integrated Medi-Medi plan for members with both Medicare and Medi-Cal, beneficiaries will still be eligible to enroll monthly throughout the year. This marks a major milestone in CHPIV's mission to bring more care, services and jobs home to Imperial County.

Community Advantage Plus was designed locally by people who know our region and understand our residents' needs. By enrolling eligible individuals—those who qualify for both Medi-Cal and Medicare—we're helping to build a stronger, more coordinated health system rooted in local relationships and accountability.

Our Imperial-based team includes four enrollment specialists, six care coordinators and two member experience representatives who support members both in the field and from our office at 512 W. Aten Road in Imperial. Partnering on Outreach and Education. We're asking clinics, community organizations and service providers to help eligible residents learn about Community Advantage Plus during open enrollment.

For questions or materials, contact:
Michelle Ramirez, Manager of Sales & Retention | hi@chpiv.org

Partnering on Outreach and Education

We're asking clinics, community organizations and service providers to help eligible residents learn about Community Advantage Plus during open enrollment.

For questions or materials, contact:
Michelle Ramirez, Manager of Sales & Retention | hi@chpiv.org

Understanding the Relationship Between CHPIV and HealthNet

CHPIV is Imperial Valley's local Medi-Cal health plan, holding Imperial County's contract with the California Department of Health Care Services (DHCS). We set policy direction and oversee compliance, while HealthNet contracts with us to deliver services to CHPIV members.

As CHPIV grows, especially with the launch of Community Advantage Plus, we're expanding our in-house capabilities: building a direct provider network, strengthening member navigation and creating local support programs that help keep care and resources in Imperial Valley.

While we continue to collaborate closely with HealthNet for Medi-Cal members, providers must contract directly with CHPIV to serve members in our new Medi-Medi plan. Our claims administrator for this line of business is Community Health Group, a licensed managed care plan based in San Diego.

To join our Medi-Medi network contact:
Daniel O'Campo, Chief of Staff | **provider@chpiv.org**

CHPIV Earns National Accreditation

We're proud to share that CHPIV has been accredited by the National Committee for Quality Assurance (NCQA), the industry's seal of approval for quality.

This recognition affirms the strength of our Medi-Cal program and the systems in place to support members, providers and partners. Earning NCQA accreditation demonstrates CHPIV's commitment to delivering safe, high-quality and equitable care for Imperial County residents.

Spotlight on Behavioral Health: Making Mental Health Checkups Routine

CHPIV's behavioral health initiative helps make mental health checkups a normal part of care, just like an annual physical.

Through local providers and Telehealth partnerships, CHPIV members have access to:

- $0 behavioral health assessments and therapy
- Medication management and crisis support
- Teladoc virtual sessions from home or clinic
- Care coordination between primary and mental health providers

CHPIV will hold member learning sessions across Imperial County to help Medi-Cal members understand their mental health benefits, connect with local providers who treat depression and anxiety and learn how to access telehealth services through the plan.

We're asking providers and community partners to help share the message that mental health is health. Together, we can make emotional wellness and preventive care a routine part of everyday health.

Interested in scheduling a member learning session?
Contact:
Denise Pasillas, Community Liaison | CAC@chpiv.org

Advancing Health Equity Through Cultural & Linguistic Care

CHPIV has launched a Cultural and Linguistic (C&L) Scorecard to measure how well we're meeting our commitment to equitable and accessible care.

The Scorecard tracks performance on key metrics, including:

- Translation of grievance and denial letters into threshold languages
- Member satisfaction with interpreter access
- Health literacy standards for written materials
- Access to bilingual providers within network standards

This data-driven approach ensures every CHPIV member—regardless of language, culture or background—receives clear, respectful and effective care. We'll be reviewing this scorecard with the members of our Community Advisory Committee on December 9th.

For more information, please reach out to:
Denise Pasillas, Community Liaison | CAC@chpiv.org

Join Our Community Advisory Committee

CHPIV is looking for new members to join its Community Advisory Committee (CAC), a group that helps us make sure our health programs truly reflect the needs of Imperial Valley.

We're especially hoping to hear from:

- Foster care youth or parents
- Members age 15-21
- Parents of Medi-Cal members under the age of 18
- LGBTQ+ community members
- Members who receive health care through Indian Health Services
- Members from outlying areas in the county
- Medi-Medi members enrolled in Community Advantage Plus

FAQ: What to Know About the Community Advisory Committee

What does the CAC do?
Members share their perspectives on what's working and what needs improvement in areas such as quality, access to care and community health programs. Their input helps CHPIV design services that meet local needs.

Who can join?
CHPIV members, parents or caregivers of members, seniors, people with disabilities, community advocates and health or social service providers who live or work in Imperial County.

How often does it meet?
Every three months, in person. Interpreter services are available with advance notice.

Is there compensation?
Yes. CHPIV members or their caregivers receive a $100 gift card for each meeting attended.

Why join?
It's a chance to make your voice heard, improve services for local families and make sure CHPIV reflects the diversity of Imperial Valley. CHPIV is a local health plan, not a government agency. Your information stays private.

Interested or know someone who might be? Contact:
Denise Pasillas, Community Liaison: **CAC@chpiv.org**

Help Spread the Word This Open Enrollment

Remember: Join us in helping more Imperial Valley residents learn about CHPIV's new Medi-Medi plan. Follow CHPIV on Facebook, Instagram and LinkedIn to stay connected.

Human Resources

Period Covered: November 11, 2025-December 8, 2025

Highlights

- No new hires
- 2 open positions: Senior Compliance Advisor and Care Coordinator
- A successful switchover to Voya as the retirement provider
- Employee benefits open enrollment December 3- December 12. Includes changes approved at the last Commission meeting
- Annual performance evaluations week of December 1, due by December 19. Includes individual goal setting.

Key Metrics

There were no new hires over this period and one resignation.

Total number of employees	44
Local	31
Remote	13
Number of exits in 2025	5 (+1 due to dissatisfaction with job and organization). Other: - 1 involuntary - 1 not returning from leave - 2 personal reasons Annualized turnover: 11% Industry benchmark: 15%*

* Mercer September 2025

Issues / Risks

- Quick turnaround time between close of open enrollment and January 1 effective date.

Next 30 Days

- Finish performance evaluations and individual goal setting
- Implement organization-wide pay increases (budget is 3.5%)
- Formalize check-ins on newly set goals (done once per quarter)