IMPERIAL COUNTY
Local Health Authority Commission

Regulatory Compliance Oversight Committee of the Commission

AGENDA

Date/Time: September 22, 2025, 12:00 PM
Location: Community Health Plan of Imperial Valley, 512 West Aten Road, Imperial, CA 92251

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

Click here to join the meeting
Meeting ID: 278 098 926 402
Passcode: 3n4Y4hc7

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

Committee Members	Representing	Present
Dr. Allan Wu (Chair)	LHA Commissioner and Regulatory Compliance Oversight Committee Chair Chief Medical Officer, Innercare	
Pablo Velez	LHA Commissioner Chief Executive Officer, El Centro Regional Medical Center	
Dr. Carlos Ramirez *Alternate*	LHA Commissioner - CEO/Senior Consultant DCRC	
Lee Hindman *Alternate*	LHA Commissioner Joint Chambers of Commerce Representing the Public	
CHPIV Staff	**Job Title**	**Present**
Lawrence Lewis	Chief Executive Officer	
Elysse Tarabola	Chief Compliance Officer	
Dr. Gordon Arakawa	Chief Medical Officer	
David Wilson	Chief Financial Officer	
Julia Hutchins	Chief Operating Officer	
Chelsea Hardy	Senior Director of Compliance	
Cynthia Mesa	Director of Internal and Delegation Oversight	
Alfredo Flores	Compliance Manager	
Kristi Wilkerson	Internal and Delegation Oversight Manager	
Joe Escobar	Compliance Auditor	
Ricky Collins	Clinical Compliance Auditor	
Lulu Gallegos	Clinical Compliance Auditor	
Priscilla Carpio	Clinical Compliance Auditor	
Miriam Botello	Compliance Advisor	
Eduardo Ron-Lopez	Compliance Coordinator	
Jeanette Crenshaw	Executive Director of Healthcare Services	
Fernanda Ortega	Project Supervisor, Healthcare Services	
Donna Ponce	Executive Assistant/Commission Clerk	

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

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

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

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

4. Public Comment — *Chair*

   This is an opportunity for members of the public to address the Commission on any subject matter within the Commission's jurisdiction. Any action taken as a result of public comment shall be limited to the direction to staff. When addressing the Commission, state your name for the record prior to providing your comments. Please address the Commission as a whole, through the Chairman. Individuals will be given 3 minutes to address the Commission; groups or topics will be given a maximum of 15 minutes. Public comments will be limited to a maximum of 30 minutes. If additional time is required for public comments, they will be heard at the end of the meeting.

5. Approval of Minutes from June 30, 2025 — *Chair*

6. Chairperson's Report

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

   a. Approve New a*nd* Updated Policies & Procedures *(Exhibit A)* — Elysse Tarabola, *Chief Compliance Officer*; Lawrence Lewis, *Chief Executive Officer*; Gordon Arakawa, *Chief Medical Officer*; Chelsea Hardy, *Senior Director of Compliance*

   b. Notices of Noncompliance — Elysse Tarabola, *Chief Compliance Officer*
      i. Health Net: Untimely Submissions
      ii. Health Net: Undisclosed Sub-delegation

   c. 2025 DMHC Routine Survey — Chelsea Hardy, *Senior Director of Compliance*

   d. 2025 Network Adequacy Validation (NAV) Audit — Chelsea Hardy, *Senior Director of Compliance*

	e. Pre-Delegation Audits of Community Health Group and IPAs	Cynthia Mesa, *Director of Internal and Delegation Oversight*
	f. Delegation Oversight Annual Audit of Health Net	Cynthia Mesa, *Director of Internal and Delegation Oversight*
	g. Delegation Oversight Monitoring Program: 2025 Q1 Final Results *(Exhibit B)* and Corrective Action Plans, Q2 Preliminary Results	Cynthia Mesa, *Director of Internal and Delegation Oversight*
8.	All Plan Letter (APL) Summary	Alfredo Flores, *Compliance Manager*
9.	Fraud and Abuse – Q2 Summary	Alfredo Flores, *Compliance Manager*
10.	Privacy Incidents – Q2 Summary	Alfredo Flores, *Compliance Manager*
11.	Adjourn to Closed Session Pursuant to Welfare and Institutions Code § 14087.38 (m)	Dr. Allan Wu, *Chair*
12.	Reconvene in Open Session	*Chair*
13.	Adjournment	*Chair*

IMPERIAL COUNTY
Local Health Authority Commission

Regulatory Compliance Oversight Committee of the Commission

MEETING MINUTES

Date/Time: June 30th, 2025, 12:13 PM – 1:20 PM

Location: Community Health Plan of Imperial Valley, 512 West Aten Road, Imperial, CA 92251

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

Committee Members	Representing	Present
Dr. Allan Wu (Chair)	LHA Commissioner and Regulatory Compliance Oversight Committee Chair Innercare, Chief Medical Officer	☒
Dr. Theodore Affue	LHA Commissioner Chief Medical Officer, County of Imperial	☐
Pablo Velez	LHA Commissioner Chief Executive Officer, El Centro Regional Medical Center	☒
Dr. Carlos Ramirez	LHA Commissioner Non-physician provider representative, DCRC Consulting	☒
Lee Hindman	LHA Chairperson, Representative of the general public and the Joint Chambers of Commerce	☒

CHPIV Staff	Job Title	Present
Lawrence Lewis	Chief Executive Officer	☐
Elysse Tarabola	Chief Compliance Officer	☒
Dr. Gordon Arakawa	Chief Medical Officer	☐
David Wilson	Chief Financial Officer	☐
Julia Hutchins	Chief Operating Officer	☐
Chelsea Hardy	Senior Director of Compliance	☒
Jeanette Crenshaw	Executive Director of Healthcare Services	☐
Daniel O'campo	Chief of Staff	☐
Cynthia Mesa	Interim Director of Delegation Oversight	☒
Alfredo Flores	Compliance Manager	☒
Kristi Wilkerson	Delegation Oversight Program Manager	☒
Eduardo Ron-Lopez	Compliance Coordinator	☒
Shannon Long	HR Consultant	☐
Donna Ponce	Executive Assistant/Commission Clerk	☒

AGENDA ITEM/ PRESENTER	MOTION/MAJOR DISCUSSIONS	ACTIONS TAKEN
Call to Order Dr. Allan Wu, Chair	Meeting called to order: 12:13PM Dr. Allan Wu called meeting to order at 12:13 PM	
Approval of the Agenda Dr. Allan Wu, Chair	A. Items to be pulled or added from the Consent/Information/Action/Closed Session Calendar	
	B. Approval of the order of the agenda	Motion to Approve by Lee Hindman Second by Dr. Carlos Ramirez
Public Comment Dr. Allan Wu, Chair		**No Public Comment**
Chairperson Dr. Allan Wu	A. Approval of Minutes from March 25th, 2025	Motion to approve by Dr. Carlos Ramirez Second by Lee Hindman
Chairperson's Report Dr. Allan Wu, Chair	No report given	
Elysse Tarabola, Chief Compliance Officer	Elysse Tarabola introduced the new Compliance Department staff: Kristi Wilkerson, Delegation Oversight Program Manager Eduardo Ron-Lopez, Compliance Coordinator Alfredo Flores, Compliance Manager A. Approve Updated and New Policies & Procedures Elysse Tarabola presented existing policies and procedures, as most of them were up for annual review. Changes were made to CMP-013 to reflect a new DHCS submission process for key personnel changes and a requirement for subcontractor and downstream entities to submit key personnel disclosures to CHPIV.	Motion to Approve by Lee Hindman Second by Dr. Allan Wu

AGENDA ITEM/ PRESENTER	MOTION/MAJOR DISCUSSIONS	ACTIONS TAKEN
	Mrs. Tarabola presented Health Services policies, BH-001 and UM-003. BH-001 was updated to align with DHCS guidelines for clarification on continuity of care for transitioning members and timely processing. UM-003 was also updated to align with DHCS and DMHC requirements, incorporating enhanced coordination with school and county programs, Mrs. Tarabola presented CLM-001. Ownership was changed from the Finance department to the Operations Department. Language was revised to conform with what is allowable under the Health Net contract. Mrs. Tarabola covered changes to BC-001, as the purpose statement was updated to define the emergency preparedness and response plan. It also clarifies that we have an oversight role of Health Net as our delegate. Language was included to reflect CHPIV's responsibility to coordinate with Imperial County's Office of Emergency Services (OES) and Cal OES. Dr. Wu inquired if the changes were relative to state or federal regulatory changes and Mrs. Tarabola responded by stating most of the updated requirements were state regulatory changes. With the implementation of D-SNP, there will be updates to reflect federal requirements, which could be seen in the upcoming quarter. Lee Hindman inquired about whether this will be going to the Commission for approval and Mrs. Tarabola stated that the Commission has delegated this committee to be able to approve policies, however a summary of the approved policies will be presented to the full Commission. Mrs. Tarabola opened the floor for questions regarding policies.	
Elysse Tarabola, Chief Compliance Officer	B. Approve Updated Employee Handbook Mrs. Tarabola presented the employee handbook changes. CHPIV cannot have a policy that states we will not hire a candidate with a felony conviction, as it is against California's Ban the Box law. Each conviction will be considered on a case-to-case basis. The second change is regarding reproductive loss leave. This was added to comply with California regulations. An employee that has a reproductive loss may take up to five unpaid days over a three-month period. These were the two changes since undergoing legal review. Dr. Wu inquired into whether this will be presented at the next full Commission. Mrs. Tarabola answered that the full committee will likely have more policies presented, needing approval. The rest of the meeting will be informational as this is the last item for review and approval.	Motion to approve by Pablo Velez Second by Lee Hindman
Elysse Tarabola, Chief Compliance Officer Cynthia Mesa, Interim Director of Delegation Oversight	C. Regulatory and Delegation Oversight i. DHCS Medical Audit Mrs. Tarabola presented a visual depicting the timeline of the regulatory and delegate oversight activities. The DHCS Onsite concluded May 13th and are still pending results. The oversight program is expanding to include D-SNP requirements, new delegates, and new internal functions being retained from the D-SNP implementation. DHCS preliminary findings were shared at the preliminary exit conference. Actions taken have included initiating internal CAPs focused on delegation oversight of Health Net. The use of those results will drive targeted local engagement and long-term strategic improvement. Final audit report is expected September 2025. The preliminary finding themes are as follows: - Strengthen oversight - Local engagement - Close the loop - P&P/ document updates Pablo Velez raised a question regarding the Health Needs Assessment currently being conducted for the Imperial Valley. Mr. Velez asked how the information is being utilized by CHPIV or the Commission as he noted that it can be a way to link the local engagement theme. Mrs. Tarabola stated the best place to make that link would be with Dr. Arakawa's Quality Improvement Health Equity Committee. Dr. Wu stated he would contact Dr. Arakawa and others involved to collaborate and ensure the programs will address the needs of the population. ii. Pre-Delegation Audits of Community Health Group and IPAs Cynthia Mesa covered initiating the pre delegation audit of Community Health Group (CHG), CCIPA and ProCare IPAs. Their entire program, including staffing, will be evaluated to ensure their readiness to manage D-SNP functions under our delegation. The policies and procedures are currently being collected. If there is non-compliance, a corrective plan will be issued, and they will have to remediate said issue by 01/01/2026.	

AGENDA ITEM/ PRESENTER	MOTION/MAJOR DISCUSSIONS	ACTIONS TAKEN
	iii. Delegation Oversight Annual Audit of Health Net Mrs. Mesa discussed the DO annual audit of Health Net and how their audit scope will entail January 1, 2024, through June 30, 2025. The pre delegation work is underway. The planned audit is for August 4 and CHPIV will have thirty days from then to submit results. The files submitted for DHCS audit will be leveraged. It will be a full scope medical audit, along with file review, for all areas delegated. If there are any findings that match any preliminary findings we received, HealthNet will receive a corrective action plan. Mr. Hindman asked if we are undergoing their annual audit in a way that will not be simultaneous to the state audit. Mrs. Mesa elaborated by stating that it does not line up perfectly. The happy medium that we came up with is auditing both elements at the same time. This is to ensure we are taking action prior to the DMHC audit. DMHC will focus on the fact that we did not audit timely but that is being acknowledged, and the purpose is to build a narrative to let the state know we are aware. Mrs. Tarabola emphasized leveraging documents received from previous audits to limit the administrative burden on Health Net as they will not have to resubmit three hundred documents. Cynthia's team is focused on reviewing those documents while collecting more data as the review period has been extended to get us up to date. iv. DMHC Routine Survey Mrs. Mesa noted the look back period for the DMHC routine survey is from 01/01/2024 to 02/21/2025. DMHC routine survey will begin September 29, 2025. Pre-work has already been completed, and they officially made their file selection. Health Net is compiling the files, and the Delegation Oversight team will be looking at the file review to see what the risks are. The goal is to be prepared and pick up on any themes before the audit. Next steps will include scheduling mock interviews with Health Net and internal departments and engaging operational leaders to reinforce themes. Mrs. Mesa opened the floor for questions.	
Elysse Tarabola, Chief Compliance Officer Cynthia Mesa, Interim Director of Delegation Oversight	D. Delegation Oversight Reorganization Mrs. Tarabola stated that the DO reorganization became effective June 2025. Elysse gave a historical summary of the shared oversight model, and how it led to delays, burdens, and missed opportunities for strategic impact. Key changes are that the DO function is now fully centralized under compliance with dedicated audit staff. Vertical departments will now use audit results instead of performing audits. Cynthia Mesa will have dedicated audit staff reporting up into her vertical. Our chiefs and their verticals will remain active in the delegation oversight function as a part of cross functional decision making. Compliance will focus on performing the audits and collaborating with Health Net on performance issues, while the other departments will have an amplified ability to create strategic initiatives and collaborate with Health Net to improve results. Internal auditing will also be brought in as some functions will be retained in house with the D-SNP Medicare line of business implementation. Dr. Wu seeked clarification on who would be a part of the internal auditing committee as the auditors cannot be the same ones doing the final reporting to the regulatory authorities. Mrs. Tarabola stated that the required separation was considered when doing the reorganization. With this new set up, Compliance will be independently responsible for oversight of Health Net's care management function as well as our new internal care management function with the same methodologies and audit procedures. This ensures consistency and independence from the actual operational area. Dr. Wu asked to compare the list of independent reviewers and compare it to who will sign off the final report to regulatory agencies. Mrs. Tarabola presented the organizational chart showing that the overall DO program will be reviewed and approved by the Compliance and Policy Committee and final authority and approval will be up to the Commission. A dotted line exists between the DO/Internal Audit function to Dr. Arakawa for clinical consulting with ultimate reporting going to the Commission. Four new positions are being added to the Delegation Oversight team, three Nurse Auditors and one Non-Clinical Auditor, all of whom will report to Kristi Wilkerson, Manager of Delegation Oversight.	
Cynthia Mesa, Interim Director of Delegation Oversight	E. Delegation Oversight Program: Quarter 4 Results and Corrective Action Plans Mrs. Mesa went over the quarterly KPI metrics and informed her that there were no findings. The utilization management CAP is open, regarding the logs that we have been receiving from Health Net. The data being received is not being pulled from the correct queues. For example, their log is being pulled from different lines and when we validate their data, it does not match what is displayed in their system.	

AGENDA ITEM/ PRESENTER	MOTION/MAJOR DISCUSSIONS	ACTIONS TAKEN
	Health Net was put on notice for this because we cannot turn this into a regulating body. Health Net failed to meet the compliance threshold of 95% for timely notification to members in Q3 with scores at 94.1% but slightly improved in Q4 with a score of 95.4%. No issues were identified for member ID card issuance. Mr. Hindman inquired whether the graphic indicated that there were no appeals during the quarter. Mrs. Mesa clarified that the graphic is not intended to reflect the number of appeals, instead, it depicts the corrective actions assigned to Health Net.	
Elysse Tarabola, Chief Compliance Officer	F. Fraud and Abuse Report From live to date, CHPIV has received seventeen cases of potential fraud, waste, and abuse. Of those seventeen cases, five have been closed – four with allegation unsupported/no findings and one with no CHPIV exposure. Twelve cases are still open. The investigations are done through Health Net's Centene Special Investigations Unit (SIU). Mr. Velez inquired whether the case with no identified CHPIV exposure implied that Health Net had exposure. Mrs. Tarabola responded that while it is possible the case involved Health Net exposure, the review specifically focused on CHPIV, including its membership and provider network, as part of the findings. Mr. Hindman inquired about whether the state will look at these cases and review to see if the findings were correct and Mrs. Tarabola confirmed. CHPIV is required to submit a notification to DHCS within ten working days when initiating or concluding an FWA investigation and when terminating a provider due to FWA concerns. Mrs. Tarabola did mention there were two untimely notifications during the audit period when there was limited compliance staffing. Dr. Wu asked Mrs. Tarabola to elaborate on lab and psych as they appear to be areas of risk. Mrs. Tarabola specified that the psychiatrists were identified and flagged as top billers and labs were billing for services not rendered. Investigations were performed on that to determine impact on CHPIV. We will be trending over/under utilization by categories, so we can understand and do a focused audit. Mr. Velez asked about the complaint process, and Mrs. Tarabola explained that there are several ways to identify potential fraud, waste, and abuse (FWA). Mrs. Tarabola noted that Health Net conducts extensive data mining and accepts grievances. Mrs. Tarabola offered to bring more information to the next meeting, emphasizing that HN has a comprehensive system in place to detect FWA. Mrs. Tarabola stated that this was a brief overview of how the SIU works.	
Elysse Tarabola, Chief Compliance Officer	G. Privacy Incidents Mrs. Tarabola stated that privacy incidents will be reported quarterly, like fraud and abuse. Mrs. Tarabola defined privacy incidents as any potential unauthorized access, use, or disclosure of member data. Incidents are reviewed and investigated. Non breach is when PHI is not compromised, and all eighteen incidents received by CHPIV from go live to date have been determined as "non-breach". Mrs. Tarabola covered the three different types of Privacy Incident Reports (PIRs). The initial PIR must be within 24 hours, the investigative PIR within 72 hours of discovery, and the final PIR within 10 business days. There are three levels of reporting. Mr. Hindman asked how incidents are reported and Mrs. Tarabola responded by stating most of the instances are self-reported. Dr. Wu asked who is responsible for determining whether an incident needs to be reported to OIG. Mrs. Tarabola explained that there is a certain threshold where it does have to be reported to OIG. Health Net's classification of non-breach can be amended. The submission to OIG would occur after the investigation, so both parties would remain in real time communication, regarding the need for reporting. Mr. Velez inquired whether the investigation is conducted by the Department of Public Health. Mrs. Tarabola clarified that the PIR is submitted to the state, which holds the authority to review and make the final determination. The state may disagree with the findings and provide feedback. Additionally, they review internal CAPs and may offer feedback. Mrs. Tarabola stated that CHPIV had two untimely cases for the initial PIR. Health Net reported the incident to their DHCS CM in January, but CHPIV was not identified as impacted until March when their investigation was done, leading to a delay in CHPIV's required reporting, as a result, this led to requiring HN to include CHPIV in reporting for potential impact. The second case had 3-day TAT as Health	

AGENDA ITEM/ PRESENTER	MOTION/MAJOR DISCUSSIONS	ACTIONS TAKEN
	Net failed to report to CHPIV, but the issue has since been resolved after working with HN Privacy team. There were three untimely cases for investigative PIR, but the first two cases were the same issues and same remediation. The third case was CHPIV's first case however the investigative PIR was skipped, and the team went straight to the final PIR. We re-educated the staff on the reporting requirements to ensure investigative PIR is being submitted. Mrs. Tarabola stated that the Compliance department's current priorities are revamping the regulatory report process and material review process to be more efficient. These are reports that we receive from HN. Readily, a new compliance tool, is an easy way to digest regulatory guidance, and it will include our delegation and regulatory audit activity, as well. The Delegation Oversight Meeting (DOM) will be shifting to a broader scope under operations. Julia Hutchins will be leading the Joint Operations Meeting (JOM) with Health Net. Delegation Oversight will report up to the meeting, but there will not be as much of a focus on compliance. Mr. Hindman raised a question regarding denied claims and whether the denial is investigated. Mrs. Mesa explained that audits are conducted through sampling, however there is a lot of volume as we receive 500 thousand claims a quarter. If a patient complains about a specific claim, it will be investigated and reviewed as a part of the grievance process. If it is investigated in the auditing process, over/under utilization will be analyzed. Mr. Hindman asked if the denied claims are grouped in any categories and Mrs. Mesa stated the claims are grouped by CPT code, by diagnosis, by revenue, etc. and Readily will be able to analyze these 500 thousand claims per quarter.	
Adjourn to Closed Session Dr. Allan Wu, Chair	The meeting was adjourned for a closed session at 1:19 pm.	
Reconvene in Open Session Dr. Allan Wu, Chair	NA	
Adjournment Dr. Allan Wu, Chair	Meeting was adjourned at 1:20 pm	

Community Health Plan
OF IMPERIAL VALLEY

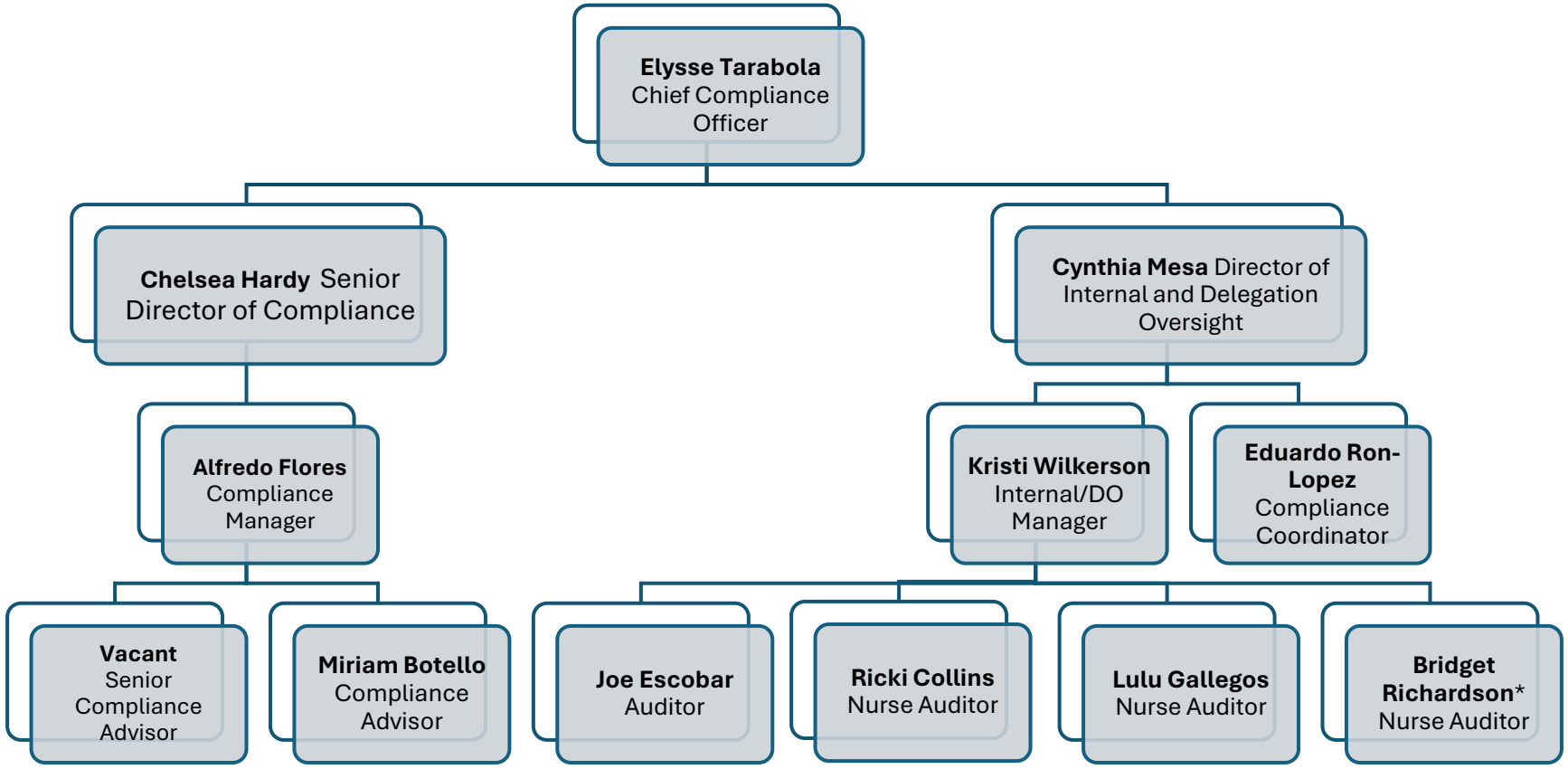
Regulatory Compliance & Oversight Committee

Quarter 3 2025

September 22, 2025

Introductions: Compliance Department Update

- DO
  - 3 new auditors
  - *1 nurse auditor starting on 9/29
- Regulatory Compliance
  - 1 new Compliance Advisor



Community Health Plan OF IMPERIAL VALLEY

Agenda

ACTION ITEMS – Review and request approval of the following:

- Updated P&Ps

INFORMATIONAL

- Notices of Noncompliance
- Regulatory and Delegation Oversight Audits
- Delegation Oversight Program – 2025 Quarter 1 and 2 Results
- All Plan Letter Summary
- Fraud and Abuse
- Privacy Incidents

ATTACHMENTS

- New All Plan Letters (APLs) Released and Status

Updated and New Policies and Procedures

New and Updated P&Ps

See Exhibit A – Policy Packet

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

Notices of Noncompliance

Health Net – Untimely Submissions

Background

- June 30, 2025: CHPIV issued a **Notice of Noncompliance** to Health Net for repeated delays in audit deliverables, oversight requests, AIRs, and APL responses
- Root cause: all submissions routed through a single individual, creating bottlenecks and late responses.

Corrective Action Required

1. **Direct SME Engagement** – CHPIV must be able to work directly with subject matter experts.
2. **Revised Submission Workflow** – SMEs to submit deliverables directly to CHPIV-designated system/folders.
3. **Biographical Contact Sheet** – List of SME contacts (name, role, email, phone).
4. **Limit Centralized Routing** – Hybrid model acceptable if Health Net wants oversight visibility.

CHPIV Internal Updates

- Established direct submission folders with deadlines.
- Clarified CHPIV contact points by function (Regulatory Compliance vs. Delegation Oversight).

Community Health Plan OF IMPERIAL VALLEY

Health Net – Undisclosed Subdelegates

Background

- August 21, 2025: CHPIV issued a Notice of Noncompliance to Health Net for undisclosed sub-delegation of claims/UM/credentialing to out-of-area PPGs
- Failure to disclose undermined CHPIV's ability to perform required oversight.

Follow-Up Findings

- Partial responses received Aug 28–29, 2025: delegated functions table (9 PPGs), member assignment counts, confirmation of no oversight performed
- Claims/encounter logs incomplete, not in CHPIV template.
- Delegation oversight not conducted for these groups.
- Continuity of Care outreach confirmed but no progress reporting provided.

Outstanding Issues

- Final Delegated Functions Table – reconcile true delegated entities.
- Claims Logs – full logs in CHPIV format from 1/1/2024–present.
- Delegation Oversight – Health Net must immediately perform and report results.
- COC Member Transfers – status report on outreach, transitions, and timeline.

Next Steps

- Health Net required to submit all outstanding deliverables by September 19, 2025.CHPIV to monitor closely and escalate if noncompliance persists.

Community Health Plan OF IMPERIAL VALLEY

Regulatory and Delegation Oversight Audits

DMHC Routine Survey

Onsite will take place September 30, 2025-October 2, 2025

- **Scope:** Comprehensive routine survey by DMHC covering all core functions (e.g., access, quality, utilization, member rights).
- **Current Status:**
  - CHPIV responding to DMHC's follow-up document requests
  - Pre-audit discussions held with CHPIV and Health Net
    - Focus areas: PQIs, ER claims denials, post-stabilization authorization process
- **Next Steps:**
  - Conduct mock interviews with staff (including Health Net)
  - Perform risk assessment to identify potential issues pre-onsite
  - Collaborate with Health Net leaders to ensure interview readiness
  - Compliance prioritizing timely, complete, and accurate DMHC responses

Community Health Plan OF IMPERIAL VALLEY

2025 NAV Audit

- **Purpose:** To validate the accuracy, completeness, and consistency of the plan's 2024 network adequacy reporting.
- Review period: 2024
- Virtual review took place on 9/11/2025
- CHPIV received **no preliminary findings** for the 2025 Network Adequacy Validation (NAV) Audit.
- Results:

Audit Topic	Findings
Member Enrollment Data Processing	No preliminary findings
Provider Data Processing	No preliminary findings
Delegated Entity Review	No preliminary findings
Network Adequacy Monitoring	No preliminary findings

Next Steps: We will receive the final report by February 2026

Community Health Plan OF IMPERIAL VALLEY

Pre-Delegation Audit of CHG and IPAs

Delegate	Audit Engagement Date	Status	Next Steps
Community Health Group	5/30/2025	Complete	Preliminary results complete pending internal review and disseminations
Premier Patient Care	6/13/2025	In Progress	On Target, issue prelim reports due by 9/26/25
Community Care IPA (MedPoint)	6/20/2025	In Progress	On Target, issue prelim reports due by 9/26/25
Imperial County Physicians Medical Group (MedPoint)	6/20/2025	In Progress	On Target, issue prelim reports due by 9/26/25
Primary Health Care Medical Group	9/3/2025	In Progress	Pending document submission to start audit.

Community Health Plan OF IMPERIAL VALLEY

DO Annual Audit of Health Net - Preliminary Findings

- **Review Period:** 1/1/2024-6/30/2025
- Trend: Documentation inconsistency to validate in file review to meet requirements under DMHC and DHCS
  - CCM and ECM*
    - Care plans not consistently provided
    - “Close the loop” verification missing
  - UM and Appeals/Grievance*
    - Lack of written notification to providers
    - Peer to Peer Line inconsistency
    - Clean and Concise
    - 6th Grade readability

*These are preliminary findings based off what has been audited so far.

Community Health Plan OF IMPERIAL VALLEY

DO Annual Audit of Health Net – Next Steps

Preliminary Report: Will be shared with Health Net on 10/10/2025.

Pre-CAP/Rebuttal: Health Net may respond to the preliminary report with additional documents on 10/24/2025.

Final Report: Will be issued to Health Net on 10/31/2025.

CAP Required for all deficiencies identified.

P&Ps must be revised.

DO will validate CAPs meet regulatory and contractual standards.

DO Program evaluation and revisions based on final findings.

Ongoing monitoring post go-live to ensure processes are compliant.

Community Health Plan OF IMPERIAL VALLEY

DO Monitoring Program:
Quarter 1 and 2
Results and Corrective Actions

See Exhibit B – Q1 Monitoring Scorecard
See Exhibit C – Preliminary Q2 Monitoring Scorecard

Delegation Oversight Monitoring Program

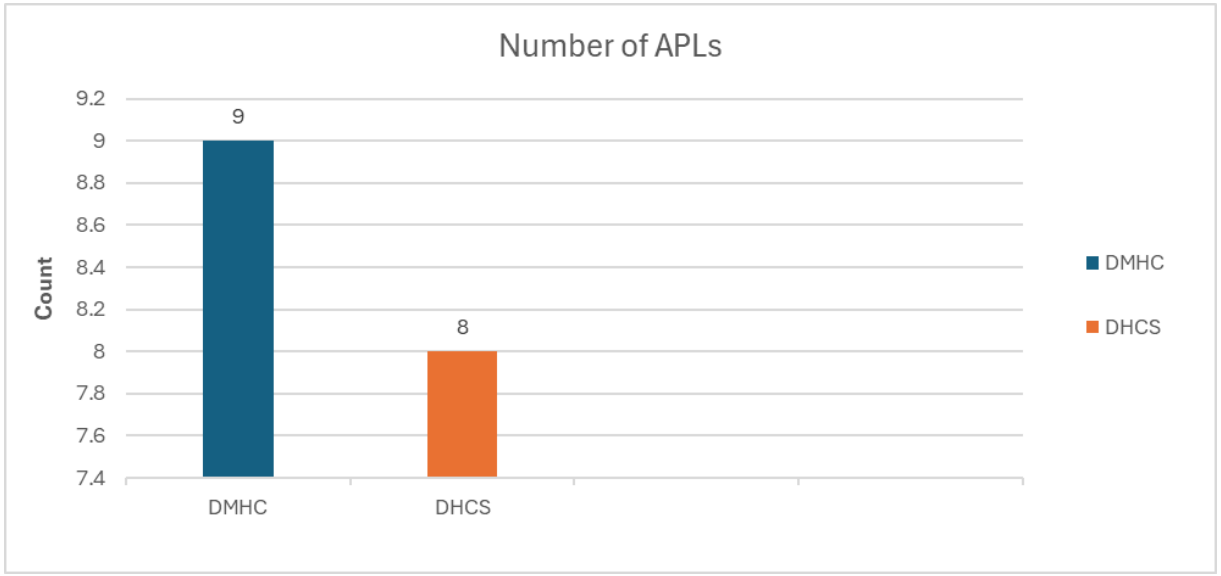
Quarter 1 and Preliminary Quarter 2 Results: Highlights

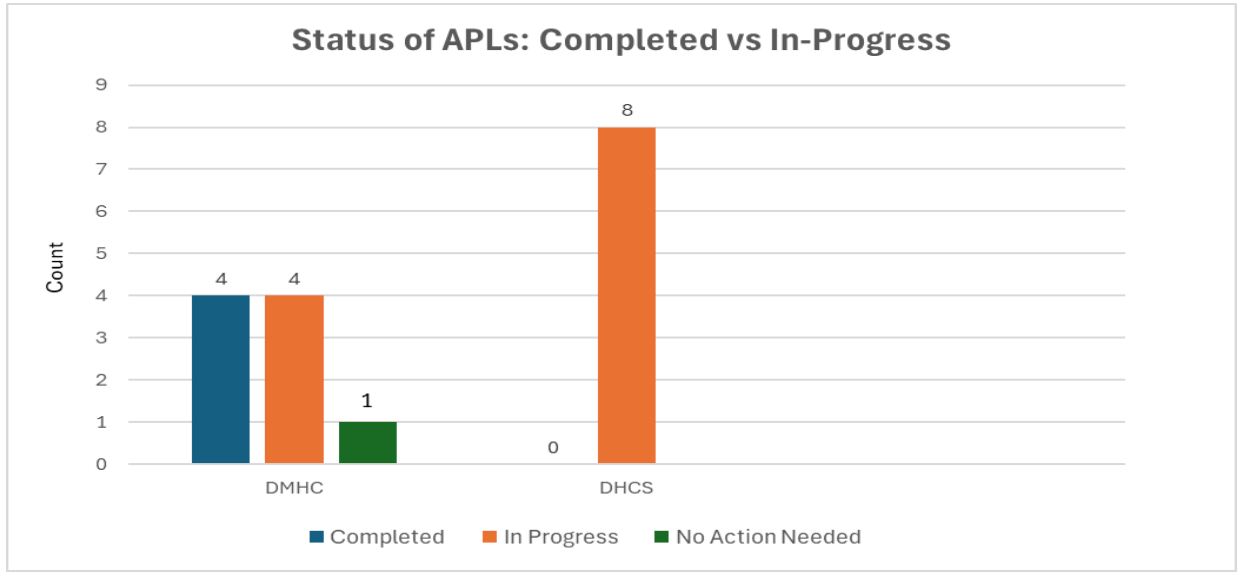
FUNCTIONAL AREA	ACTION
APPEALS	Member notification timeliness - **Improvement** from 74% Q1 2025 to 100% Q2 2025
CLAIMS	Timely acknowledgement of paper claims **dropped** from 99.9% to 83.6%. Timeliness of interest payment on late claims **dropped** from 100% to 0%.
GRIEVANCES	Member notification timeliness **improved** from 70% Q1 to 100% Q2
UTILIZATION MANAGEMENT	Q1 Health Net **failed** data validation 3 times and CHPIV was unable to score all UM KPIs. Q2 Preliminary results **below threshold** for all KPIs: • Decision Timeliness 64% • Member Notification 95% • Provider Notification 77%

Community Health Plan OF IMPERIAL VALLEY

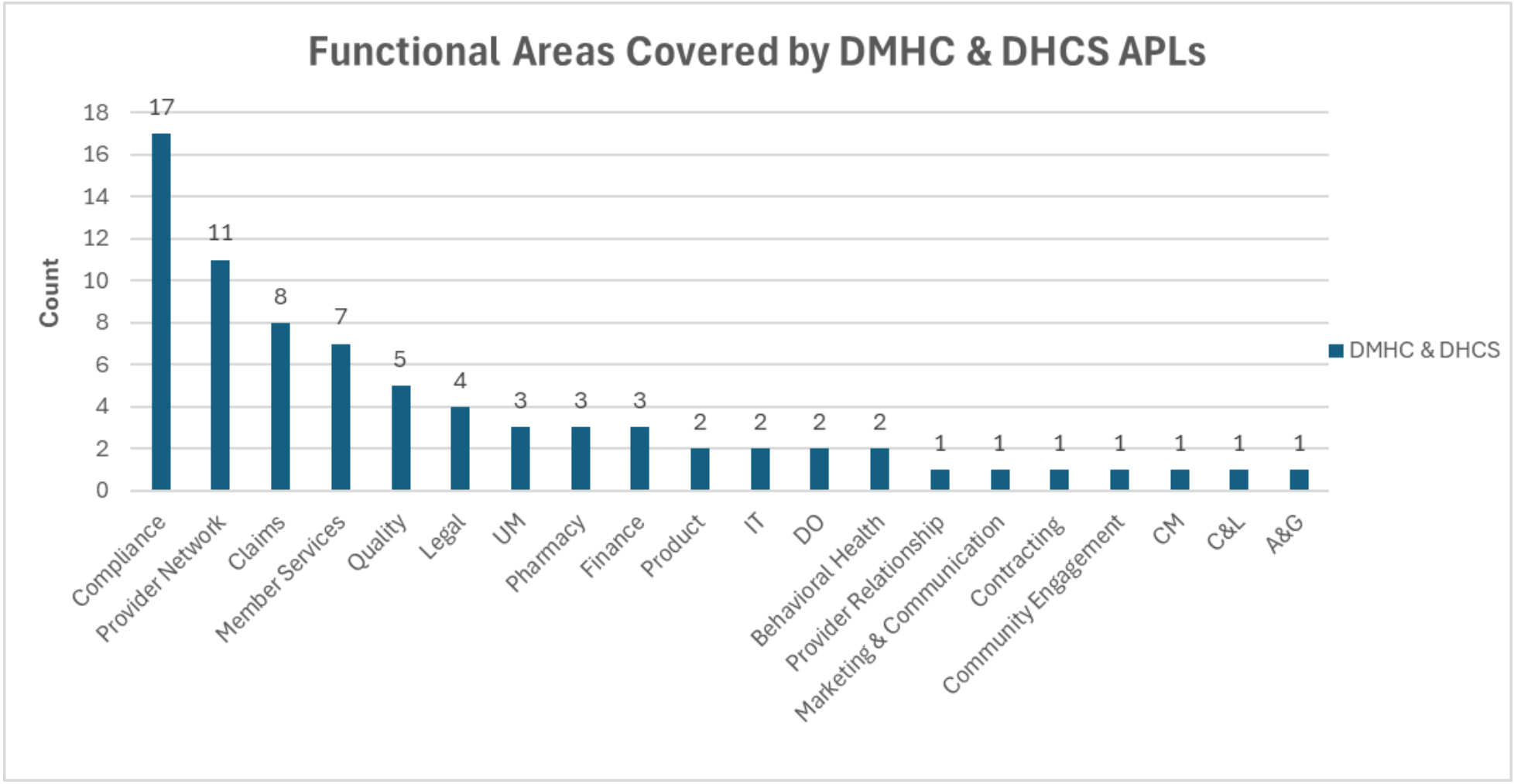
All Plan Letters

All Plan Letter (APL) Summary



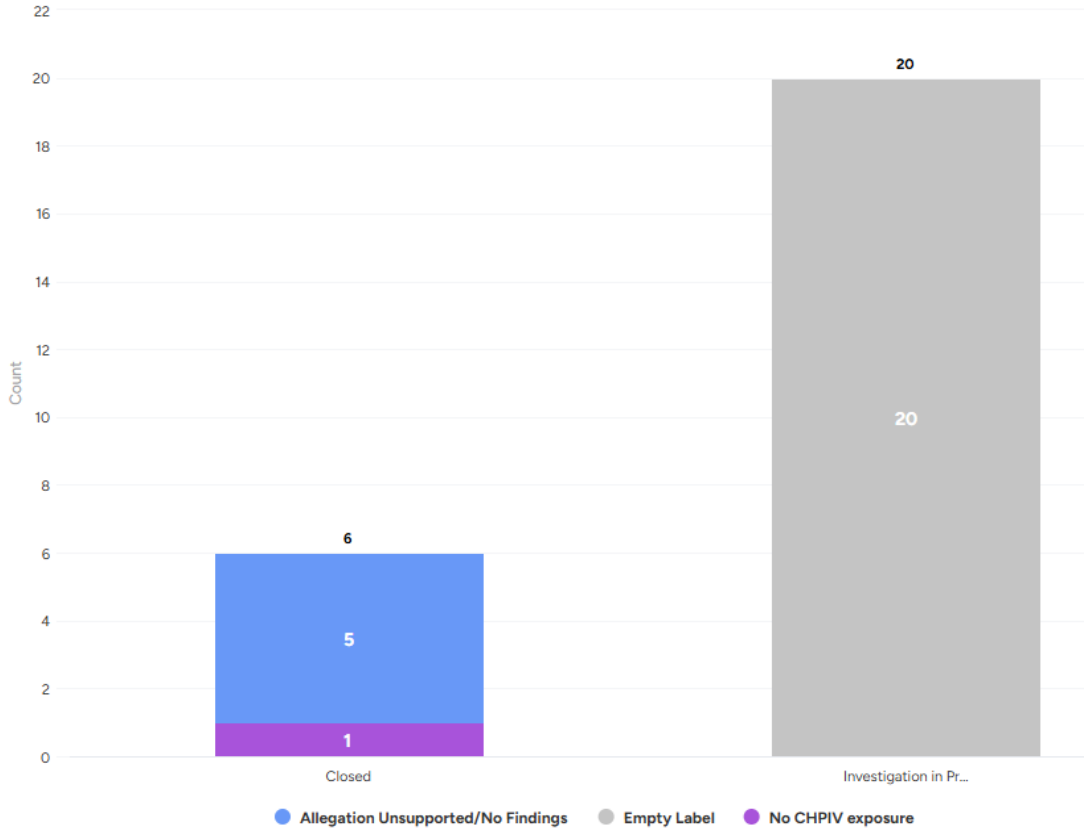


All Plan Letter (APL) Summary



Fraud and Abuse

Potential Fraud and Abuse Cases

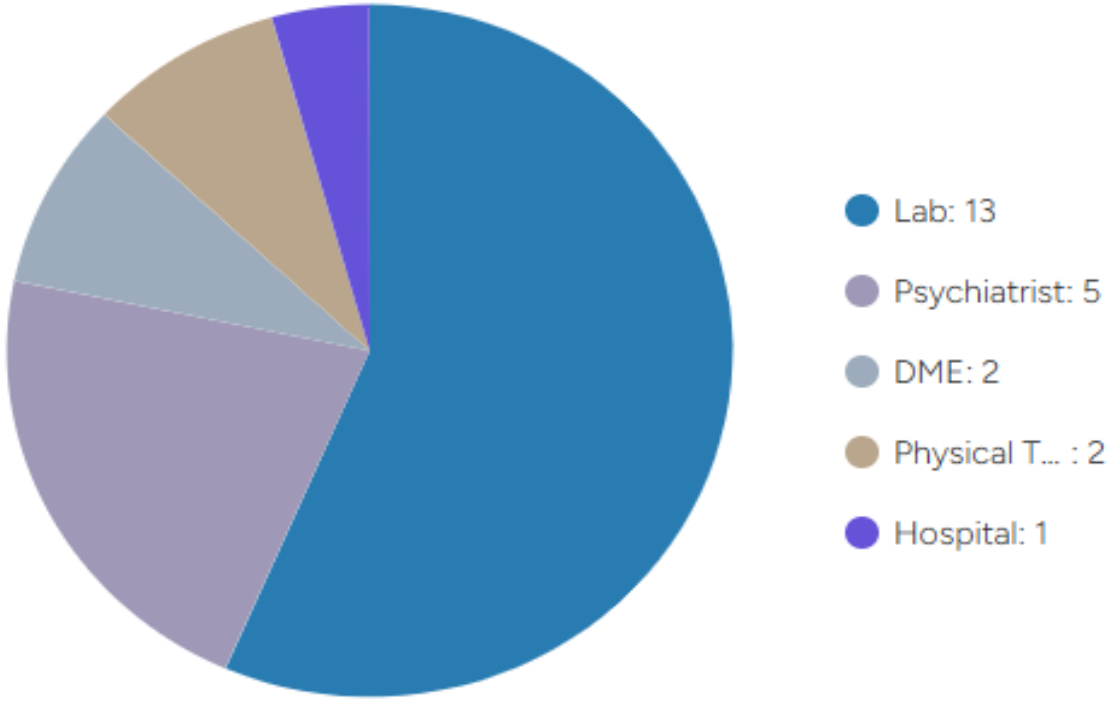


- From 1/1/2024 to date, we have received 26 cases of potential fraud, waste, and abuse.
- 6 investigations have been closed
  - 5 – allegation unsupported/no findings
  - 1 – No CHPIV exposure

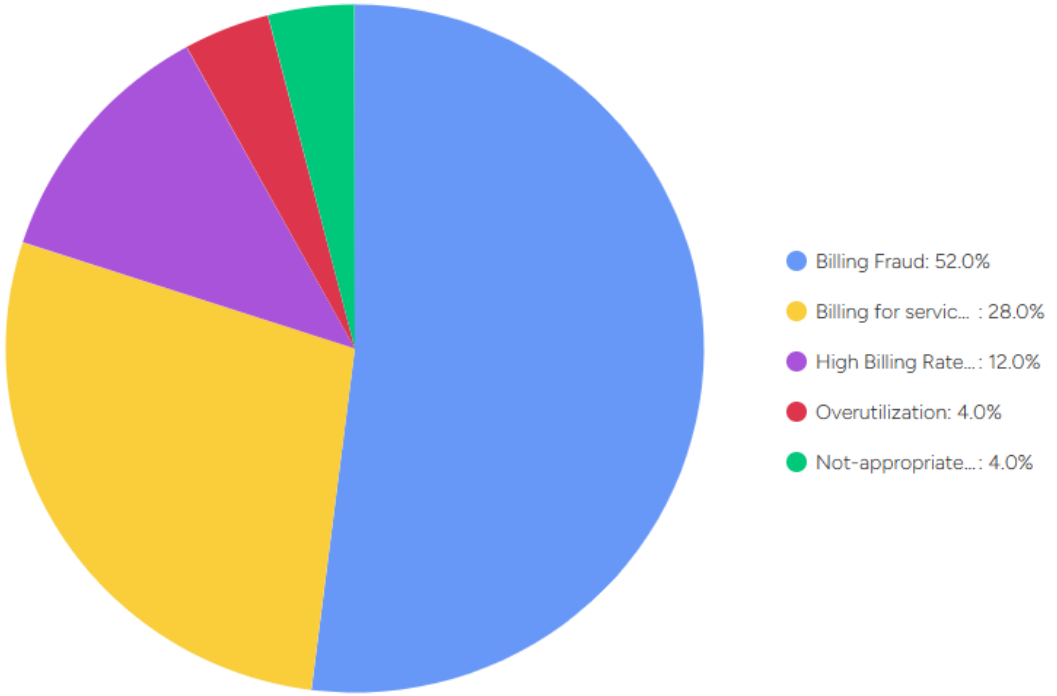
Community Health Plan OF IMPERIAL VALLEY

Potential Fraud and Abuse Case Trends

By Subject Type



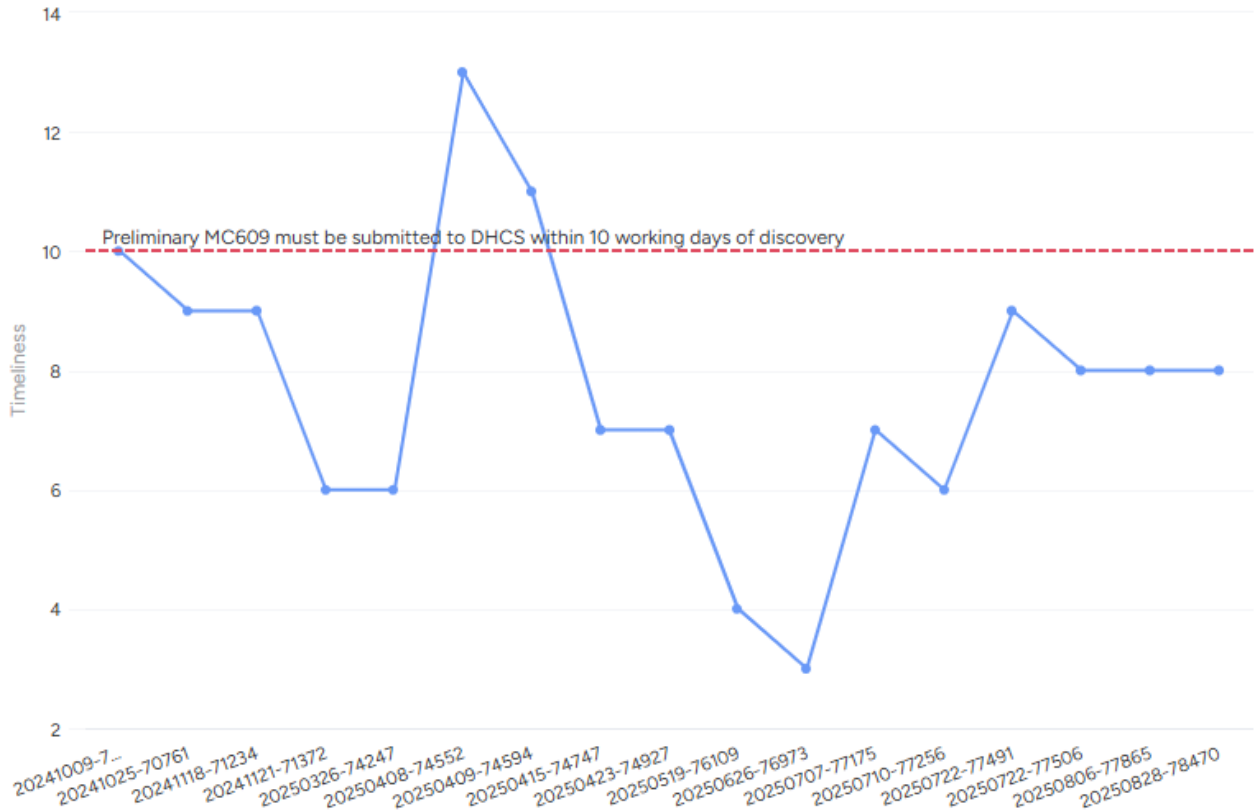
By Case Type



Community Health Plan OF IMPERIAL VALLEY

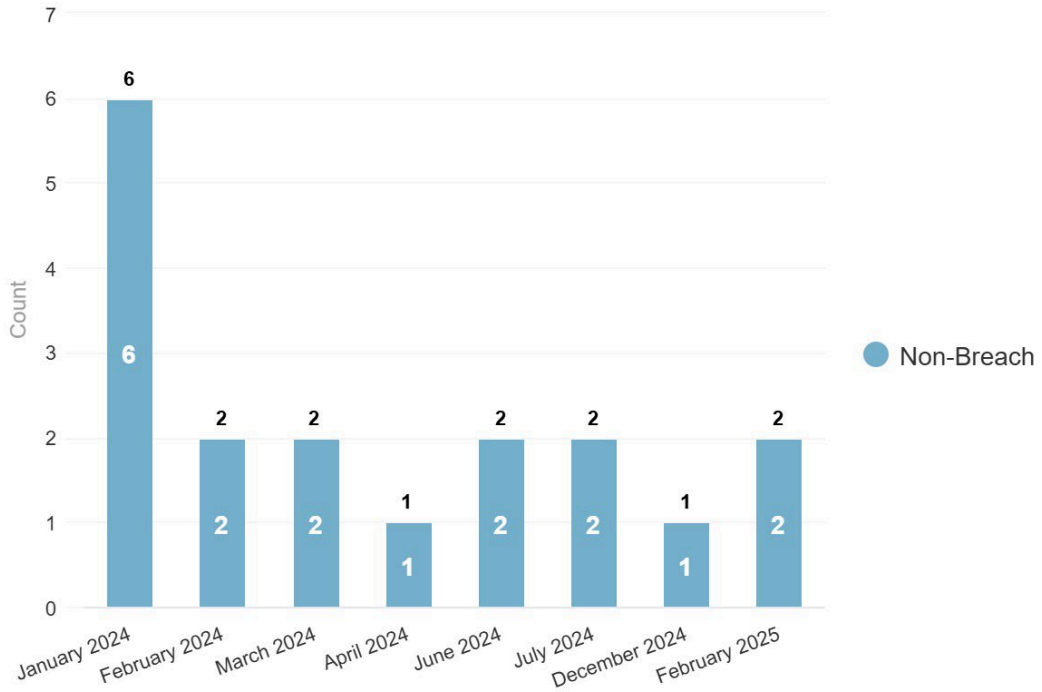
MC609 Submission to DHCS

- MC609 – Required notification to DHCS within 10 working days of initiating or concluding a fraud, waste, or abuse investigation
- Also required when terminating a provider due to FWA concerns
- Ensures DHCS is informed of high-risk providers and supports statewide oversight
- Part of our compliance with FWA reporting and network integrity requirements
- All MC609 cases have been submitted timely for Q2



Privacy Incidents

Privacy Incidents/Breaches



No additional Privacy Incidents since 2025 Quarter 1 2025, no new cases to report.

Questions

Attachments

New All Plan Letters (APLs) Released and Status

Community Health Plan OF IMPERIAL VALLEY

DHCS APLs Released and Status

In-House Function
Delegated Function
In-House & Delegated Function

APL	TITLE	FUNCTIONAL AREA	SUMMARY	STATUS
APL 25-005	**Standards For Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services, And Alternative Formats (Supersedes APL 21-004)**	UM Member Services Provider Network Claims Compliance Marketing & Communications IT	**APL 25-005** updates language access, nondiscrimination, and accessibility standards for MCPs, requiring translated materials, LEP support, and effective communication for members with disabilities—aligning with recent federal Section 1557 updates.	**In-Progress**
APL 25-006	**Timely Access Requirements**	UM Member Services Provider Network Behavioral Health Claims Compliance	**APL 25-006** updates timely access to care requirements for MCPs, including wait time standards, interpreter services, provider survey participation, and new Minimum Performance Levels (MPLs) starting in 2025.	**In-Progress**
APL 25-007	**Enforcement Actions: Corrective Action Plans, Administrative and Monetary Sanctions**	Compliance Provider Network Member Services Claims QI Finance Legal	**APL 25-007** defines DHCS's authority to enforce CAPs, sanctions, and penalties on MCPs for noncompliance, covering areas like network adequacy, timely access, quality, and data accuracy.	**In-Progress**

DHCS APLs Released and Status

In-House Function

Delegated Function

In-House & Delegated Function

APL	TITLE	FUNCTIONAL AREA	SUMMARY	STATUS
APL 25-008	**Hospice Services and Medi-Cal Managed Care**	Compliance DO QI Provider Network Member Services A&G	**APL 25-008** updates CAP requirements for MCPs, introducing a standardized format, timelines, and reporting, with enforcement actions for noncompliance.	**In-Progress**
APL 25-009	**Community Advisory Committee**	Compliance Community Engagement C&L QI	**APL 25-009** expands requirements for Community Advisory Committees, emphasizing diverse membership, structured engagement, and meaningful input into MCP decisions on equity, quality, and service design.	**In-Progress**
APL 25-010	**Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services (Supersedes APL 22-028)**	BH Compliance UM CM Provider Network DO QI	**APL 25-010** requires MCPs to use standardized screening and transition tools to ensure timely, appropriate mental health referrals and coordination with county MHPs, supporting CalAIM's "No Wrong Door" policy.	**In-Progress**

DHCS APLs Released and Status

In-House Function

Delegated Function

In-House & Delegated Function

APL	TITLE	FUNCTIONAL AREA	SUMMARY	STATUS
APL 25-011	**H.R 1-Federal Payments to Prohibited Entities**	Compliance Claims Provider Network Legal	**APL 25-011** Provides guidance on payment restrictions to "Prohibited Entities" under H.R. 1, effective July 4, 2025. Includes exceptions based on court orders (TRO & PI), abortion service carve-outs, and outlines when MCPs must continue or suspend claims. MCPs must ensure network compliance.	**In-Progress**
APL 25-012	**Targeted Provider Rate Increases**	Provider Network Compliance Finance Claims Contracting	**APL 25-012** Provides guidance on Medi-Cal Targeted Rate Increases (TRI), requiring MCPs to reimburse eligible Network and certain out-of-Network Providers at minimum fee schedule rates for qualifying services starting January 1, 2024. It outlines procedures for compliance, payment parity requirements for FQHCs/RHCs, data reporting via Supplemental Data Requests, retroactive adjustments, and enforcement through CAPs and sanctions for non-compliance.	**In-Progress**

DMHC APLs Released and Status

In-House Function

Delegated Function

In-House & Delegated Function

APL	TITLE	FUNCTIONAL AREA	SUMMARY	STATUS
APL 24-022	**Children and Youth Behavioral Health Initiatives, Certified Wellness Coaches**	Behavioral Health, Community Engagement, Provider Network	**APL 24-022** informs health plans about the state's new Certified Wellness Coach program under the Children and Youth Behavioral Health Initiative (CYBHI). It encourages plans to integrate these non-clinical providers into their behavioral health services to support prevention and early intervention for youth up to age 25, reducing reliance on limited clinical resources.	Not Applicable
APL 24-023	**Newly Enacted Statutes Impacting Health Plans (2024 Legislative Session)**	Compliance, Provider Network, Quality Improvement	**APL 24-023** outlines updates to the Timely Access Compliance Report for Measurement Year 2024. It informs health plans of revised requirements and timelines for submitting data on provider appointment availability and call center performance, ensuring compliance with California's timely access standards. The APL includes details on reporting format, calculation methodology, and submission deadlines to support oversight of access to care.	Not Applicable
APL 25-001	**APL 25-001 - Southern California Fires and Enrollees' Continued Access to Health Care Services**	Member Services, Pharmacy, Compliance, Provider Network	**APL 25-001** requires plans to ensure continued access to care for enrollees affected by the Southern California fires and report impacts to DMHC within 48 hours.	**Complete**

DMHC APLs Released and Status

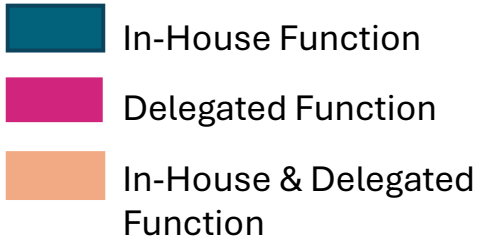
In-House Function

Delegated Function

In-House & Delegated Function

APL	TITLE	FUNCTIONAL AREA	SUMMARY	STATUS
APL 25-002	**Plan Year 2026 QHP, QDP, and Off-Exchange Filing Requirements (1/28/2025)**	Product, Compliance	**APL 25-002** provides filing instructions for Qualified Health Plans (QHPs), Qualified Dental Plans (QDPs), and off-exchange individual/small group products for Plan Year 2026. It outlines regulatory requirements, deadlines, and checklist resources to support timely and compliant submissions.	Not Applicable
APL 25-003	**Large Group Renewal Notice Requirements (2/5/2025)**	Compliance, Sales, Product	**APL 25-003** provides guidance on required content and timing for large group renewal notices. It ensures plans notify contract holders of rate or coverage changes at least 120 days in advance and include rate comparison data and DMHC review rights.	Not Applicable
APL 25-004	**AB 118: Part 1 – Compliance with Large Group Standardized Evidence of Coverage/Disclosure Form (3/10/2025)**	Compliance, Product, Legal,	**APL 25-004** outlines filing requirements for commercial full-service plans to implement Part 1 of the standardized Evidence of Coverage/Disclosure Form (EOC/DF) for large group products, as required under AB 118. Plans must adopt DMHC-issued template language for exclusions, member rights, and definitions by January 1, 2026, and submit amendment filings to demonstrate compliance.	Not Applicable

DMHC APLs Released and Status



APL	TITLE	FUNCTIONAL AREA	SUMMARY	STATUS
APL 25-005	**Southern California Fires and Flexibilities to Impacted Providers (3/19/2025)**	Provider Network, Claims, Compliance	**APL 25-005** directs health plans to implement temporary flexibilities for providers displaced by the Southern California fires, including extending prior authorizations, claims deadlines, and allowing alternative care settings.	**Complete**
APL 25-006	**Health Plan Coverage of Mobile Crisis Services (3/21/2025)**	Behavioral Health, Claims, Compliance, Provider Network	**APL 25-006** clarifies that health plans must cover mobile crisis and 988 center services for behavioral health without prior authorization, even out-of-network, through stabilization. It outlines provider claim requirements, billing codes, and eligible provider types to ensure timely reimbursement.	N/A
APL 25-007	**Assembly Bill 3275 Guidance (Claim Reimbursement) (4/1/2025)**	Claims, Compliance, Provider Relations, Legal	**APL 25-007** provides guidance on implementing Assembly Bill 3275, requiring plans to reimburse complete claims within 30 days starting January 1, 2026. It outlines new interest and penalty requirements, dispute resolution timeframes, and mandates that enrollee complaints about claim delays be treated as grievances.	**In-Progress**

DMHC APLs Released and Status

In-House Function

Delegated Function

In-House & Delegated Function

APL	TITLE	FUNCTIONAL AREA	SUMMARY	STATUS
APL 25-008	**Provider Directory Annual Filing Requirements (4/8/2025)**	Provider Network, Compliance, IT	**APL 25-008** reminds health plans of the requirement to submit annual provider directory policies and procedures, including updates required by SB 923.	**In-Progress**
APL 25-009	**2025 Health Plan Annual Assessments (4/15/2025)**	Finance, Compliance	**APL 25-009** provides instructions for submitting the 2025 Health Plan Annual Assessment via DMHC's eFiling portal.	**Complete**
APL 25-010	**Sections 1357.503 and 1357.505 MEWA Registration and Annual Compliance Requirements (5/20/2025)**	Legal, Compliance	**APL 25-010** outlines registration and annual compliance requirements for health plans and MEWAs under Sections 1357.503 and 1357.505. It implements new standards from AB 2072 and AB 2434, requiring MEWAs to register with DMHC, and plans to file annual compliance documentation.	N/A

DMHC APLs Released and Status

In-House Function

Delegated Function

In-House & Delegated Function

APL	TITLE	FUNCTIONAL AREA	SUMMARY	STATUS
APL 25-011	**Health Plan Coverage of HIV Preexposure Prophylaxis (PrEP) (5/23/2025)**	Pharmacy, Compliance, Claims, Member Services	**APL 25-011** reaffirms that health plans must cover all FDA-approved HIV preexposure prophylaxis (PrEP) drugs and related preventive services without prior authorization or cost-sharing. It also provides billing guidance to ensure consistent claims processing and avoid incorrect member charges.	No action required
APL 25-012	**Closure of Rite Aid Pharmacies (6/9/2025)**	Pharmacy, Member Services, Compliance, Provider Network	**APL 25-012** requires health plans to ensure uninterrupted prescription drug access following Rite Aid pharmacy closures and submit a filing to DMHC outlining impacts, affected enrollees, and steps taken to maintain access.	**Complete**
APL 25-013	**Amendment to Rules 1300.51, 1300.52, 1300.52.4, 1300.67.2.2 and the Incorporated Annual Network Submission Instruction Manual and Annual Network Report Forms**	Compliance, Network Legal Product	**APL 25-013** outlines updated requirements for the Annual Network Report for RY 2026 and beyond, including new network definitions, forms, and filing rules.	In-Progress

DMHC APLs Released and Status

In-House Function

Delegated Function

In-House & Delegated Function

APL	TITLE	FUNCTIONAL AREA	SUMMARY	STATUS
APL 25-014	**Provider Appointment Availability Survey Manual and Report Form Amendments**	Compliance Product Quality	**APL 25-014** provides updates to the PAAS Manual, Report Forms, and TA Instruction Manual beginning MY 2026. It outlines revised reporting standards for timely access compliance due May 1, 2027 and annually thereafter.	In-Progress

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

DATES			
Policy Effective Date	10/9/2023	**Reviewed/Revised Date**	03/25/2025
Next Annual Review Due	03/25/2026	**Regulator Approval**	NA

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

ATTACHMENTS

- None

AUTHORITIES/REFERENCES

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

HISTORY

Revision Date	Description of Revision
10/9/2023	Policy Creation
03/25/2025	Annual Review
	Update for Community Investments APL 25-004

	Community Donations and Support	ADM-001

I. OVERVIEW

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

II. POLICY

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

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

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

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

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

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

~~1. The financial PARTICIPATION will be used by the external entity to provide a service that complements, or enhances, one that CHPIV provides; or~~

~~2. There is an identifiable benefit to CHPIV and/or its members.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

K. There may be circumstances where **FINANCIAL PARTICIPATION for external entities**, such as charitable organizations, or activities (*e.g.,* United Way, etc.), may be **permitted based on a**

finding by the CHPIV Commission that the request for financial PARTICIPATION falls within CHPIV's authority and purpose, and meets one (1) of the following criteria:

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

~~K.~~L.

III. PROCEDURE

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

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

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

1. Review and analyze the request to ensure each policy criteria is met;
2. Complete the Event PARTICIPATION Request Form and place the completed form and all supporting documentation in a folder within five (5) business days of the date of receipt of completed request;

3. Submit the request to the CEO, his/her designee for consideration. If the request is denied, the requestor shall be notified.

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

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

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

1. Requests shall be submitted to the CEO's Office, in writing, at least thirty (30) calendar days in advance of the date for which an entity wishes to distribute items branded with the CHPIV master logo.
2. Upon receipt of a completed request to distribute items branded with the CHPIV's master logo, the CEO's office shall review and analyze the request with input from appropriate internal departments within five (5) business days.
3. CEO shall approve donations of items valued at five dollars ($5) or less, and up to and including a cumulative total of five hundred dollars ($500) worth of goods. Requests to distribute items that exceed a cumulative total of five hundred dollars ($500) shall require the prior approval of the CHPIV Commission.
4. The CEO's office shall notify the requesting entity, in writing, after CHPIV's determination is made.
5. The CEO's Office shall process an approved request to distribute items branded with the CHPIV's master logo within three (3) business days of approval.
6. The requesting entity shall agree to return any items that it does not distribute at the conclusion of the event for which the item was used.

IV. DEFINITIONS

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

TERM	DEFINITION
Chief Executive Officer (CEO)	CHPIV staff member who serves as the focal point for compliance activities as well as manages the Compliance Department of CHPIV. The CCO reports directly to the Chief Executive Officer and the Commission. The CCO is responsible for developing, operating, and monitoring the compliance program. This includes establishing an auditing and monitoring plan, overseeing compliance audit functions, continuously reviewing organizational risk areas to identify necessary auditing, and monitoring activities, assisting in the formulation of correction action plans, and overseeing and/or verifying implementation of corrective action.

	Community Donations and Support	ADM-001

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

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

DATES			
Policy Effective Date	10/9/2023	**Reviewed/Revised Date**	03/25/2025
Next Annual Review Due	03/25/2026	**Regulator Approval**	NA

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

ATTACHMENTS

- None

AUTHORITIES/REFERENCES

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

HISTORY

Revision Date	Description of Revision
10/9/2023	Policy Creation
03/25/2025	Annual Review
	Update for Community Investments APL 25-004

I. OVERVIEW

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

II. POLICY

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

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

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

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

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

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

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

1. Requests for Participation, **other than financial contributions**, such as hosting booths at health fairs, conducting education programs and presentations, or organizing community/town hall meetings:
    a. Requests for non-financial PARTICIPATION from external entities shall be submitted no less than fourteen (14) calendar days in advance of the date of the event.

b. The CHIEF EXECUTIVE OFFICER (CEO) or his/her designee is authorized to approve non-financial requests from external entities for community/member-oriented events that meet the eligibility requirements as provided in this Policy.
c. Non-financial PARTICIPATION requests from external entities for community/member-oriented events such as health fairs, educational events, and/or community/town hall forums shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:
    i. Member interaction/enrollment – The activity shall include PARTICIPATION from CHPIV members and/or potential members that could be enrolled in any of CHPIV's programs, or be in furtherance of CHPIV's mission, vision & values, programs, and/or purpose; and
    ii. Inclusion of Details of the Event – Information about the organization and event, including name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator's contact information, expected number of attendees, primary demographics of people served, purpose and outcome of the proposed event, and description of CHPIV's PARTICIPATION in the event.

2. Requests for **financial Participation**, up to and including, a cumulative **value of one thousand dollars ($1,000) per organization per fiscal year**, which shall include all materials and supplies:
    a. Requests for financial PARTICIPATION in an amount up to and including one thousand dollars ($1,000) per organization per fiscal year, inclusive of all materials and supplies, shall be submitted no less than twenty-one (21) calendar days in advance of the date of the event, or if in a shorter amount of time, at the discretion of the CEO, or his/her designee, so long as such request is submitted to the CEO, or his/her designee, in a reasonable and sufficient amount of time so that CHPIV can complete a meaningful review and evaluation of the request.
    b. The CEO or his/her designee is authorized to approve requests for financial PARTICIPATION for qualifying external entities and events for a cumulative amount of up to and including one thousand dollars ($1,000) per organization per fiscal year, subject to availability of budgeted funds.
    c. All requests for financial PARTICIPATION sent to CHPIV from external entities shall meet the standards set forth above in Sections II. A. through F. along with the following criteria:
        i. Member interaction/enrollment – The activity shall include PARTICIPATION from CHPIV members and/or potential members that could be enrolled in any of CHPIV's programs or be in furtherance of CHPIV's mission, vision & values, programs, and/or purpose; and
        ii. Inclusion of Details of the Event – Information about the organization and event, including the name of the organization hosting the event, the name of the event itself, day/date, start and end time, location,

event coordinator's contact information, expected number of attendees, primary demographics of people served, purpose and outcome of the proposed event, description of CHPIV's PARTICIPATION in the event, and/or how CHPIV's financial PARTICIPATION will be used, etc.

d. The CEO or his/her designee is authorized to purchase and use in-kind contributions of items branded with CHPIV's logo for the purpose of outreach and promoting CHPIV's role and services in the community.
e. The CEO or his/her designee will report all approved PARTICIPATION in events involving financial PARTICIPATION in an amount up to and including one thousand dollars ($1,000) per organization per fiscal year to the CHPIV Commission in the CEO's regular CEO Report to the Commission.
f. The use of CHPIV staff time (*e.g.,* in their capacity as a CHPIV employee) to attend events such as health fairs, educational or community events;
g. The use of CHPIV resources (*e.g.,* CHPIV facilities);
h. The use of current, or future, CHPIV eligible funds; and
i. The value of items donated with the CHPIV master brand/logo.

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

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

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

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

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

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

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

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

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

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

b. Financial contributions should be for sustainable operations/services

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

L.

III. PROCEDURE

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

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

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

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

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

1. Notify the requesting entity of CHPIV's determination; and

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

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

1. Requests shall be submitted to the CEO's Office, in writing, at least thirty (30) calendar days in advance of the date for which an entity wishes to distribute items branded with the CHPIV master logo.
2. Upon receipt of a completed request to distribute items branded with the CHPIV's master logo, the CEO's office shall review and analyze the request with input from appropriate internal departments within five (5) business days.
3. CEO shall approve donations of items valued at five dollars ($5) or less, and up to and including a cumulative total of five hundred dollars ($500) worth of goods. Requests to distribute items that exceed a cumulative total of five hundred dollars ($500) shall require the prior approval of the CHPIV Commission.
4. The CEO's office shall notify the requesting entity, in writing, after CHPIV's determination is made.
5. The CEO's Office shall process an approved request to distribute items branded with the CHPIV's master logo within three (3) business days of approval.
6. The requesting entity shall agree to return any items that it does not distribute at the conclusion of the event for which the item was used.

IV. DEFINITIONS

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

TERM	DEFINITION
Chief Executive Officer (CEO)	CHPIV staff member who serves as the focal point for compliance activities as well as manages the Compliance Department of CHPIV. The CCO reports directly to the Chief Executive Officer and the Commission. The CCO is responsible for developing, operating, and monitoring the compliance program. This includes establishing an auditing and monitoring plan, overseeing compliance audit functions, continuously reviewing organizational risk areas to identify necessary auditing, and monitoring activities, assisting in the formulation of correction action plans, and overseeing and/or verifying implementation of corrective action.
Participation	Financial, Goods & Services, Staff, or other CHPIV resources provided to an external entity.

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

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

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

ATTACHMENTS

- None

AUTHORITIES/REFERENCES

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

HISTORY

Revision Date	Description of Revision

I. OVERVIEW

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

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

II. POLICY

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

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

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

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

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

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

G. **Implementation** timeline

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

H. Reporting and compliance

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

III. PROCEDURE

A. Annual determination of funding obligations

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

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

B. Planning & community engagement

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

C. Community Reinvestment Plan (CRP) submission

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

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

D. Implementation of activities

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

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

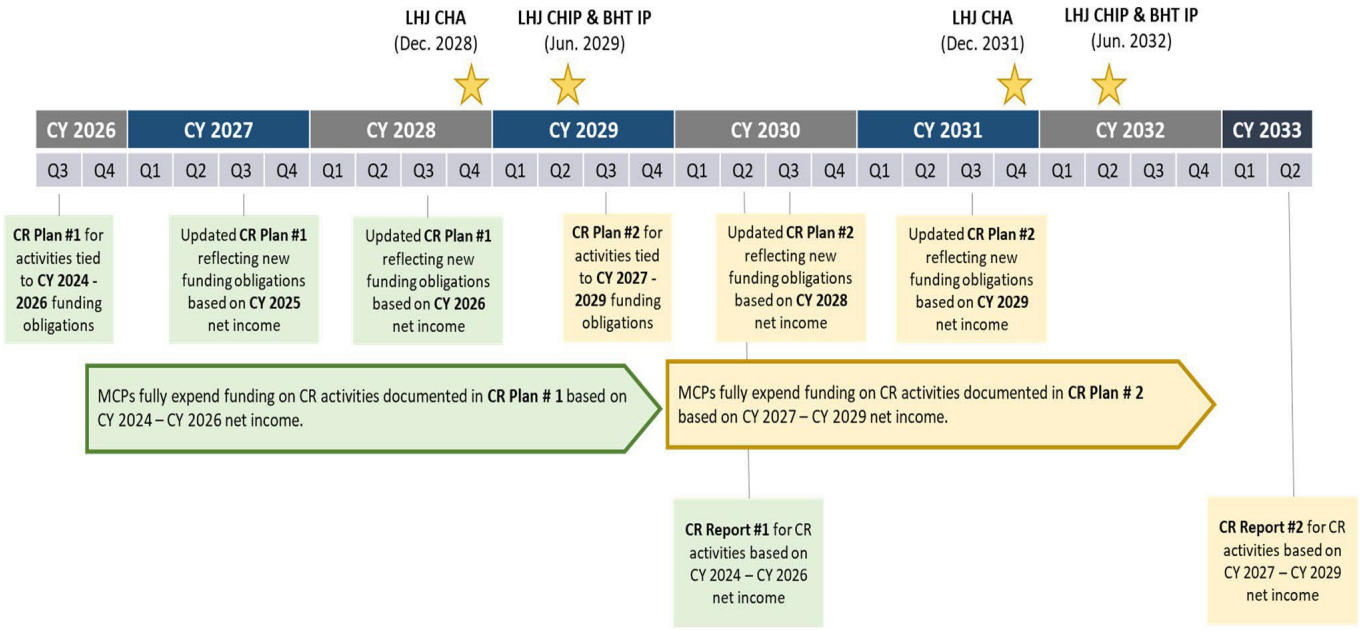
E. Non-compliance may trigger corrective action plans or sanctions.

IV. DEFINITIONS

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

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

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



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

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

APPROVALS		
Internal		**Regulator**
Name	Julia Hutchins	☐ DHCS ☐ NA ☒ DMHC
Title	Chief Operating Officer	

ATTACHMENTS

NA

AUTHORITIES/REFERENCES

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

HISTORY

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

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

I. OVERVIEW

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

II. POLICY

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

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

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

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

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

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

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

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

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

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

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

III. PROCEDURE

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

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

C. Delegation Oversight

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

IV. DEFINITIONS

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

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

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

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

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

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

APPROVALS		
Internal		**Regulator**
Name	Julia Hutchins	☐ DHCS ☐ NA ☒ DMHC
Title	Chief Operating Officer	

ATTACHMENTS

NA

AUTHORITIES/REFERENCES

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

HISTORY

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

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

I. OVERVIEW

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

II. POLICY

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

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

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

C.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

III. PROCEDURE

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

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

C. Delegation Oversight

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

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

IV. DEFINITIONS

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

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

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

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

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

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

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

ATTACHMENTS

N/A

AUTHORITIES/REFERENCES

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

HISTORY

Revision Date	Description of Revision

	Grievance Process	GA-001

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

I. OVERVIEW

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

II. POLICY

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

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

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

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

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

d. Who has authority to require corrective action.

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

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

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

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

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

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

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

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

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

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

O. CHPIV will ensure written communications to MEMBERSs are provided in the threshold languages defined by the DHCS [RR3. A.5] [DHCS APL 21-011]. Written communications shall also be provided in alternative formats (including Braille, large-size print font no smaller than 20-point, or audio format) and through auxiliary aids upon request and in a timely fashion appropriate for the format being requested and taking into consideration the special needs of MEMBERS with disabilities or LEP [Titles II and III of the Americans with Disabilities Act of 1990, section 1557 of the Affordable Care Act of 2010, sections 504 and 508 of the Rehabilitation Act of 1973, Government Code sections 11135 and 7405]. Written notices to MEMBERS also enclose information regarding The Plan's Notice of Nondiscrimination, Notice of Language Assistance, and DMHC Independent Medical Review/ COMPLAINT application form and process.

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

4. Written communications to MEMBERS s are provided in the threshold languages as defined by the DHCS [RR3. A.5]. Written communications shall also be provided in alternative formats (including Braille, large-size print font no smaller than 20-point, or audio format) and through auxiliary aids upon request and in a timely fashion appropriate for the format being requested and taking into consideration the special needs of MEMBERS with disabilities or LEP [Titles II and III of the Americans with Disabilities Act of 1990, section 1557 of the Affordable Care Act of 2010, sections 504 and 508 of the Rehabilitation Act of 1973, Government Code sections 11135 and 7405].
5. The case is then assigned to a CASE COORDINATOR for handling.
6. The CASE COORDINATOR determines the appropriate GRIEVANCE Type Code for entry into the on-line system according to requirements for tracking and reporting purposes. (See Attachment 2) The CASE COORDINATOR'S logging includes:
    a. A description of the MEMBER'S issue (MEMBER Issue)
    b. A description of the actions taken by the plan or provider to investigate the GRIEVANCE. (Action Taken).
    c. The proposed RESOLUTION by the plan or provider, (RESOLUTION Notes)
    d. The name of the person responsible for resolving the GRIEVANCE, and
    e. The date of the notification to the MEMBER.
7. The CASE COORDINATOR uses a Provider Information Request (PIR) to obtain the response, and any other pertinent information required for review, including medical records. The CASE COORDINATOR then creates a summary of the GRIEVANCE that provides specific information on the Provider(s), date of service and information needed with the PPG's written response. The CASE COORDINATOR sends the PIR to the appropriate PPG/Provider or hospital contact.
8. The PPG/Provider has seven (7) calendar days to respond to the request for information. If no response has been received, the CASE COORDINATOR contacts his/her manager for assistance. The plan may send a copy service for medical records.
9. Upon receipt of medical records, information and responses from the PPG, the CASE COORDINATOR forwards the case to the A&G CLIINICAL SPECIALIST II.
10. The A&G CLIINICAL SPECIALIST II verifies that all information has been received. The A& Clinical Specialist II summarizes the COMPLAINT and forwards all cases to the plan MEDICAL DIRECTOR for review. The summary includes the MEMBER'S perception with pertinent information along with the PPG's response and records, if applicable.
11. A determination is made as to the specialty required to review the case.
12. If needed the practitioner in a similar specialty that would typically treat the medical condition, performs the procedure or provides the treatment at issue, will be consulted and documentation of the consult will be included with the GRIEVANCE file.
13. The MEDICAL DIRECTOR may request that the case be referred to the plan's contracted third-party review organization for a similar specialty review. Refer to desktop protocol: A&G Department Protocol Consultation Review.
14. The plan MEDICAL DIRECTOR Review:
    a. The Plan's MEDICAL DIRECTOR conducts a peer review assessment of the care provided. The MEDICAL DIRECTOR conducting the review for the proposed RESOLUTION of the GRIEVANCE will not have participated in any prior decisions related to the GRIEVANCE. The MEDICAL DIRECTOR will code the peer review form with an appropriate severity outcome level code.

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

15. A final RESOLUTION letter is sent to the MEMBER that clearly and concisely describes any administrative or service outcome information [1368(a)(5)]. The RESOLUTION letter is sent within 30 calendar days of receipt of the GRIEVANCE [Health & Safety Code, Section 1368.01(a); Title 28, CCR, Sections 1300.68(a) and (d)(3)]. Additionally, the RESOLUTION letter describes the MEMBER'S options if the MEMBER is not satisfied with the GRIEVANCE outcome. The final letter advises the MEMBER of The Plans determination without releasing peer-protected information. Information is included informing the MEMBER of his or her right to APPEAL to the DHCS or DMHC [Title 22 CCR Section 53858(e)(5), RR3. A.3].
16. MEMBERS have the right to APPEAL an adverse decision. If CHPIV makes an adverse decision as part of resolving a COMPLAINT, it notifies MEMBERS s of the decision and of their right to APPEAL. If the organization cannot resolve a COMPLAINT within the time frame stated in its policies or cannot notify the MEMBER of the final decision for legal or statutory reasons, at a minimum, it must notify the MEMBER that the COMPLAINT was received and investigated.
17. Written communications to the MEMBER are provided in the threshold languages defined by the DHCS [RR3. A.5]. Written communications shall also be provided in alternative formats (including Braille, large-size print font no smaller than 20-point, or audio format) and through auxiliary aids upon request and in a timely fashion appropriate for the format being requested and taking into consideration the special needs of MEMBERS with disabilities or LEP [Titles II and III of the Americans with Disabilities Act of 1990, section 1557 of the Affordable Care Act of 2010, sections 504 and 508 of the Rehabilitation Act of 1973, Government Code sections 11135 and 7405]. Written notices to MEMBERS also enclose information regarding The Plan's Notice of Nondiscrimination, Notice of Language Assistance, and DMHC Independent Medical Review/ COMPLAINT application form and process.
18. The PPG/Provider receives a copy of the final MEMBER letter.
19. When applicable, final letters should contain specific information for referrals generated during the GRIEVANCE process, such as the name of the specialist and for what timeframe the MEMBER has been referred.
20. The CASE COORDINATOR documents in the file and the online system after review has been conducted and proposed RESOLUTIONS have been determined:
    a. The date the case was sent to the A&G CLIINICAL SPECIALIST II for review.
    b. The date of the A&G CLIINICAL SPECIALIST II review
    c. The date the case was sent to the plan MEDICAL DIRECTOR for review.
    d. The date of the plan MEDICAL DIRECTOR Review
    e. The date of notification to the MEMBER of the RESOLUTION
    f. A description of the MEMBER'S issue (MEMBER Issue)

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

III. PROCEDURE

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

IV. DEFINITIONS

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

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

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

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

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

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

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

ATTACHMENTS

N/A

AUTHORITIES/REFERENCES

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

HISTORY

Revision Date	Description of Revision

	Grievance Process	GA-001

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

I. OVERVIEW

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

II. POLICY

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

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

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

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

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

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

d. Who has authority to require corrective action.

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

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

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

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

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

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

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

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

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

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

O. CHPIV will ensure written communications to MEMBERSs are provided in the threshold languages defined by the DHCS [RR3. A.5] [DHCS APL 21-011]. Written communications shall also be provided in alternative formats (including Braille, large-size print font no smaller than 20-point, or audio format) and through auxiliary aids upon request and in a timely fashion appropriate for the format being requested and taking into consideration the special needs of MEMBERS with disabilities or LEP [Titles II and III of the Americans with Disabilities Act of 1990, section 1557 of the Affordable Care Act of 2010, sections 504 and 508 of the Rehabilitation Act of 1973, Government Code sections 11135 and 7405]. Written notices to MEMBERS also enclose information regarding The Plan's Notice of Nondiscrimination, Notice of Language Assistance, and DMHC Independent Medical Review/ COMPLAINT application form and process.

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

4. Written communications to MEMBERS s are provided in the threshold languages as defined by the DHCS [RR3. A.5]. Written communications shall also be provided in alternative formats (including Braille, large-size print font no smaller than 20-point, or audio format) and through auxiliary aids upon request and in a timely fashion appropriate for the format being requested and taking into consideration the special needs of MEMBERS with disabilities or LEP [Titles II and III of the Americans with Disabilities Act of 1990, section 1557 of the Affordable Care Act of 2010, sections 504 and 508 of the Rehabilitation Act of 1973, Government Code sections 11135 and 7405].
5. The case is then assigned to a CASE COORDINATOR for handling.
6. The CASE COORDINATOR determines the appropriate GRIEVANCE Type Code for entry into the on-line system according to requirements for tracking and reporting purposes. (See Attachment 2) The CASE COORDINATOR'S logging includes:
    a. A description of the MEMBER'S issue (MEMBER Issue)
    b. A description of the actions taken by the plan or provider to investigate the GRIEVANCE. (Action Taken).
    c. The proposed RESOLUTION by the plan or provider, (RESOLUTION Notes)
    d. The name of the person responsible for resolving the GRIEVANCE, and
    e. The date of the notification to the MEMBER.
7. The CASE COORDINATOR uses a Provider Information Request (PIR) to obtain the response, and any other pertinent information required for review, including medical records. The CASE COORDINATOR then creates a summary of the GRIEVANCE that provides specific information on the Provider(s), date of service and information needed with the PPG's written response. The CASE COORDINATOR sends the PIR to the appropriate PPG/Provider or hospital contact.
8. The PPG/Provider has seven (7) calendar days to respond to the request for information. If no response has been received, the CASE COORDINATOR contacts his/her manager for assistance. The plan may send a copy service for medical records.
9. Upon receipt of medical records, information and responses from the PPG, the CASE COORDINATOR forwards the case to the A&G CLIINICAL SPECIALIST II.
10. The A&G CLIINICAL SPECIALIST II verifies that all information has been received. The A& Clinical Specialist II summarizes the COMPLAINT and forwards all cases to the plan MEDICAL DIRECTOR for review. The summary includes the MEMBER'S perception with pertinent information along with the PPG's response and records, if applicable.
11. A determination is made as to the specialty required to review the case.
12. If needed the practitioner in a similar specialty that would typically treat the medical condition, performs the procedure or provides the treatment at issue, will be consulted and documentation of the consult will be included with the GRIEVANCE file.
13. The MEDICAL DIRECTOR may request that the case be referred to the plan's contracted third-party review organization for a similar specialty review. Refer to desktop protocol: A&G Department Protocol Consultation Review.
14. The plan MEDICAL DIRECTOR Review:
    a. The Plan's MEDICAL DIRECTOR conducts a peer review assessment of the care provided. The MEDICAL DIRECTOR conducting the review for the proposed RESOLUTION of the GRIEVANCE will not have participated in any prior decisions related to the GRIEVANCE. The MEDICAL DIRECTOR will code the peer review form with an appropriate severity outcome level code.

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

15. A final RESOLUTION letter is sent to the MEMBER that clearly and concisely describes any administrative or service outcome information [1368(a)(5)]. The RESOLUTION letter is sent within 30 calendar days of receipt of the GRIEVANCE [Health & Safety Code, Section 1368.01(a); Title 28, CCR, Sections 1300.68(a) and (d)(3)]. Additionally, the RESOLUTION letter describes the MEMBER'S options if the MEMBER is not satisfied with the GRIEVANCE outcome. The final letter advises the MEMBER of The Plans determination without releasing peer-protected information. Information is included informing the MEMBER of his or her right to APPEAL to the DHCS or DMHC [Title 22 CCR Section 53858(e)(5), RR3. A.3].
16. MEMBERS have the right to APPEAL an adverse decision. If CHPIV makes an adverse decision as part of resolving a COMPLAINT, it notifies MEMBERS s of the decision and of their right to APPEAL. If the organization cannot resolve a COMPLAINT within the time frame stated in its policies or cannot notify the MEMBER of the final decision for legal or statutory reasons, at a minimum, it must notify the MEMBER that the COMPLAINT was received and investigated.
17. Written communications to the MEMBER are provided in the threshold languages defined by the DHCS [RR3. A.5]. Written communications shall also be provided in alternative formats (including Braille, large-size print font no smaller than 20-point, or audio format) and through auxiliary aids upon request and in a timely fashion appropriate for the format being requested and taking into consideration the special needs of MEMBERS with disabilities or LEP [Titles II and III of the Americans with Disabilities Act of 1990, section 1557 of the Affordable Care Act of 2010, sections 504 and 508 of the Rehabilitation Act of 1973, Government Code sections 11135 and 7405]. Written notices to MEMBERS also enclose information regarding The Plan's Notice of Nondiscrimination, Notice of Language Assistance, and DMHC Independent Medical Review/ COMPLAINT application form and process.
18. The PPG/Provider receives a copy of the final MEMBER letter.
19. When applicable, final letters should contain specific information for referrals generated during the GRIEVANCE process, such as the name of the specialist and for what timeframe the MEMBER has been referred.
20. The CASE COORDINATOR documents in the file and the online system after review has been conducted and proposed RESOLUTIONS have been determined:
    a. The date the case was sent to the A&G CLIINICAL SPECIALIST II for review.
    b. The date of the A&G CLIINICAL SPECIALIST II review
    c. The date the case was sent to the plan MEDICAL DIRECTOR for review.
    d. The date of the plan MEDICAL DIRECTOR Review
    e. The date of notification to the MEMBER of the RESOLUTION
    f. A description of the MEMBER'S issue (MEMBER Issue)

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

III. PROCEDURE

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

IV. DEFINITIONS

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

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

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

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

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

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

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

ATTACHMENTS
• NA

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

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

I. OVERVIEW

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

1. To ensure access to needed drugs for:

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

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

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

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

II. POLICY

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

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

3. This policy applies to the following CHPIV MEMBERS:

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

    b. newly eligible beneficiaries transitioned from other coverage;

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

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

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

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

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

Commented [FO1]: Attestation 7.

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

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

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

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

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

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

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

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

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

    The notice will include the following elements:

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

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

Commented [FO2]: Attestation 11.

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

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

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

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

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

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

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

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

III. PROCEDURE

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

2. Delegation Oversight

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

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

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

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

4. Notification will happen in two ways:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IV. DEFINITIONS

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

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

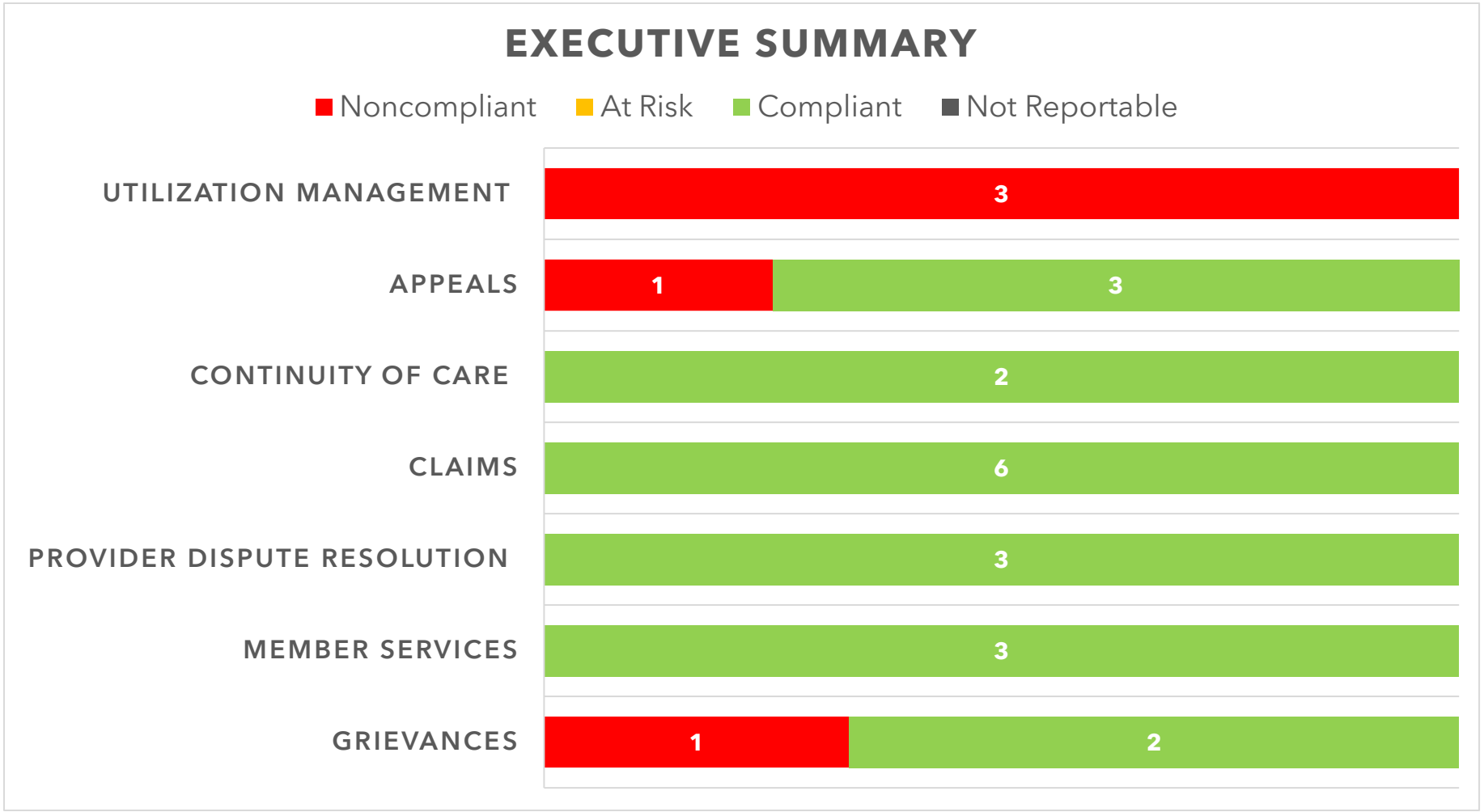
	EPSDT. Services that maintain or improve the child's current health condition are also covered under EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they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

DELEGATION OVERSIGHT

Health Net 2025 Quarter 1 Final Scorecard

Report Issued: July 1, 2025

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



DELEGATION OVERSIGHT

Health Net 2025 Quarter 1 Final Scorecard

Report Issued: July 1, 2025

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

HIGH PERFORMING AREAS

- ✓ 100% APPEAL Acknowledgement, Decision, Effectuation of Overturned Appeals
- ✓ 100% CoC Processing Timeliness, and Notification Timeliness
- ✓ 97% MS Calls Answered within 30 seconds, 0.64% Call Center Abandonment Rate Level, 99% Timely Issuance of Member ID Cards
- ✓ 100% GRV Acknowledgement Letter Timeliness, Resolution Timeliness
- ✓ 98% PDR Acknowledgement Timeliness, 100% Written Determination Timeliness, 100% Interest Payment on Late PDRs Timeliness
- ✓ 99% CLM 30 C- Days, 99% 45 W-Days and 100% 90 C- Days Claims Payment Timeliness
- ✓ 100% CLM Acknowledgment Timeliness, 99% Misdirected Claims Timeliness, 100% Timeliness of Interest Payment on Late Claims

NON-COMPLIANT AREAS

- ☒ UM001 Decision Timeliness
- ☒ UM002 Member Notification Timeliness
- ☒ UM003 Provider Notification Timeliness
- ☒ APP004 Member Notification Timeliness
- ☒ GRV003 Member Notification Timeliness

ACTIONS REQUIRED

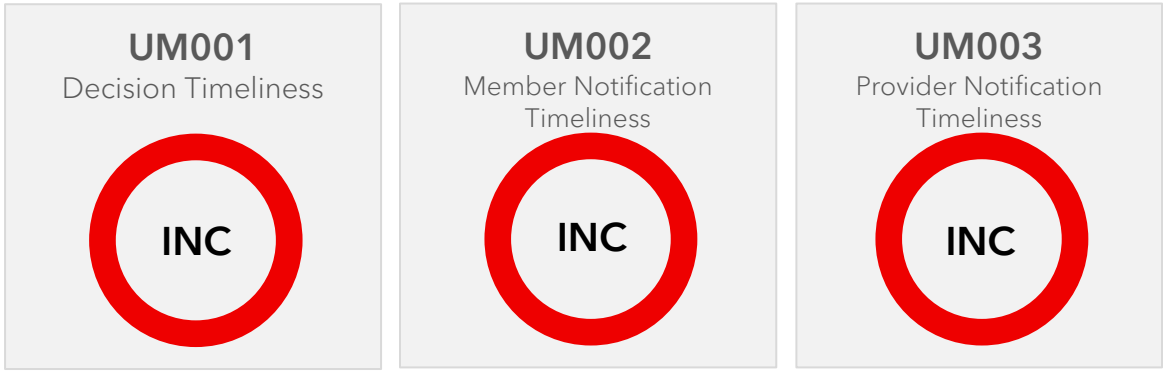
FUNCTIONAL AREA	ACTION	DUE DATE
UTILIZATION MANAGEMENT	Corrective Action Plan (CAP)	TBD
APPEALS	None	N/A
CONTINUITY OF CARE	None	N/A
CLAIMS	None	N/A
PROVIDER DISPUTE RESOLUTION	None	N/A
MEMBER SERVICES	None	N/A
GRIEVANCES	None	N/A

DELEGATION OVERSIGHT

Health Net 2025 Quarter 1 Final Scorecard

Report Issued: July 1, 2025

UTILIZATION MANAGEMENT



KPI #	KPI	Quarter 1	Quarter 2	Quarter 3	Quarter 4
UM001	**Decision Timeliness**	**Incomplete**			
UM001SP	▸ Standard Preservice	**Incomplete**			
UM001EP	▸ Expedited Preservice	**Incomplete**			
UM001C	▸ Concurrent	**Incomplete**			
UM001R	▸ Retrospective	**Incomplete**			
UM001PS	▸ Post Stabilization	**Incomplete**			
UM002	**Member Notification Timeliness**	**Incomplete**			
UM002SP	▸ Standard Preservice	**Incomplete**			
UM002EP	▸ Expedited Preservice	**Incomplete**			
UM002C	▸ Concurrent	**Incomplete**			
UM002R	▸ Retrospective	**Incomplete**			
UM003	**Provider Notification Timeliness**	**Incomplete**			
UM003SP	▸ Standard Preservice	**Incomplete**			
UM003EP	▸ Expedited Preservice	**Incomplete**			
UM003C	▸ Concurrent	**Incomplete**			
UM003R	▸ Retrospective	**Incomplete**			

**Failed 2025 Q1 Data Validation, in the process of resubmission. **

DELEGATION OVERSIGHT

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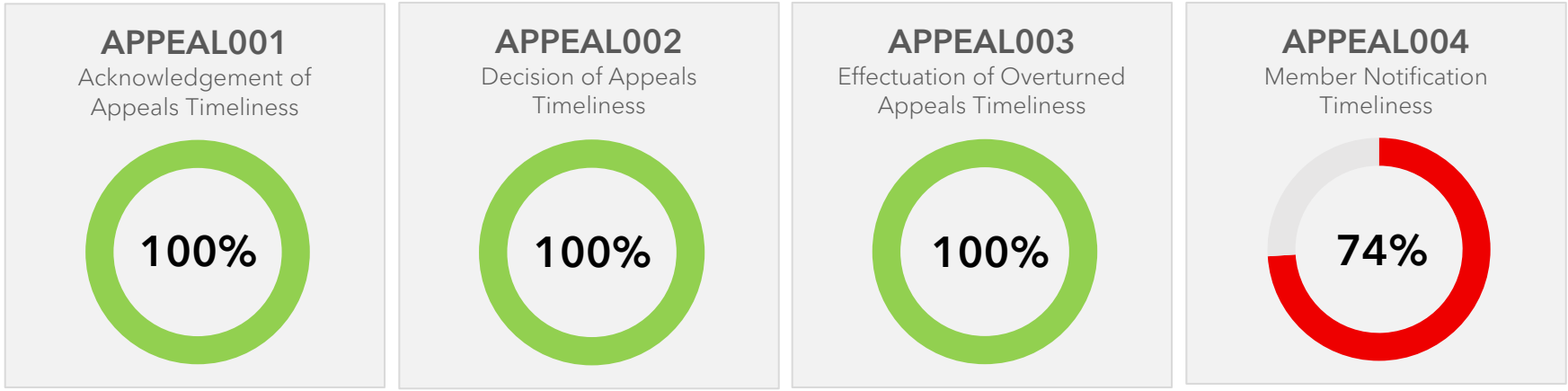
APPEALS



KPI #	KPI	Quarter 1	Quarter 2	Quarter 3	Quarter 4
APPEAL001	**Acknowledgement of Appeals Timeliness**	**100%**			
APPEAL002	**Decision of Appeals Timeliness**	**100%**			
APPEAL002S	▸ Standard	100%			
APPEAL002E	▸ Expedited	100%			
APPEAL003	**Effectuation of Overturned Appeals Timeliness**	**100%**			
APPEAL004	**Member Notification Timeliness**	**74%**			
APPEAL004S	▸ Standard	73%			
APPEAL004E	▸ Expedited	100%			

Community Health Plan OF IMPERIAL VALLEY

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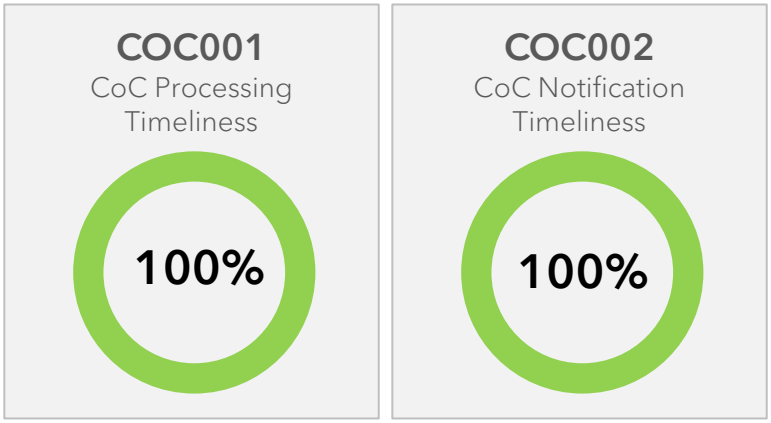
CONTINUITY OF CARE



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

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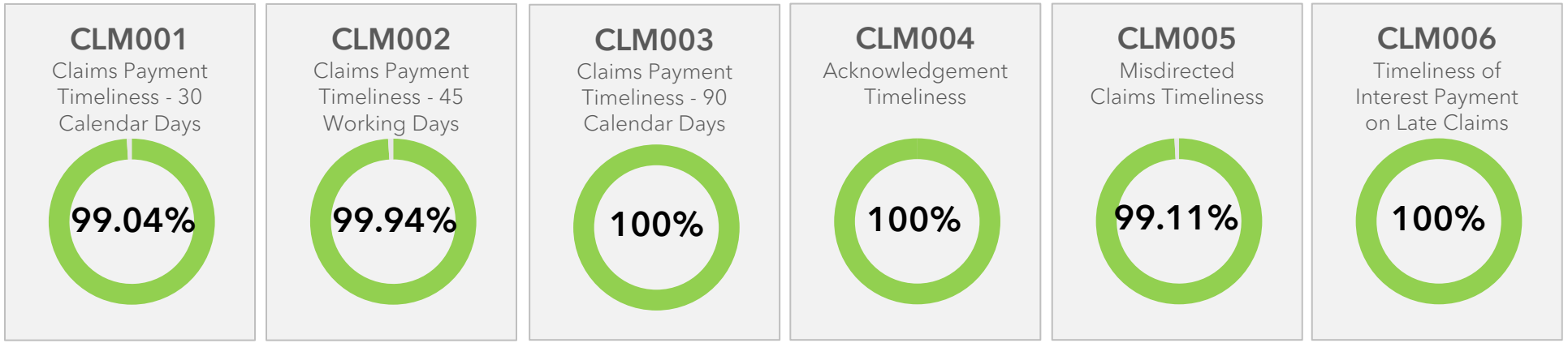
CLAIMS



KPI #	KPI	Quarter 1	Quarter 2	Quarter 3	Quarter 4
CLM001	**Claims Payment Timeliness - 30 Calendar Days**	**99.04%**			
CLM002	**Claims Payment Timeliness - 45 Working Days**	**99.94%**			
CLM003	**Claims Payment Timeliness - 90 Calendar Days**	**100%**			
CLM004	**Acknowledgement Timeliness**	**100%**			
CLM004E	▸ Acknowledgement Timeliness - Electronic	100%			
CLM004P	▸ Acknowledgement Timeliness - Paper	99.92%			
CLM005	**Misdirected Claims Timeliness**	**99.11%**			
CLM006	**Timeliness of Interest Payment on Late Claims**	**100%**			

DELEGATION OVERSIGHT

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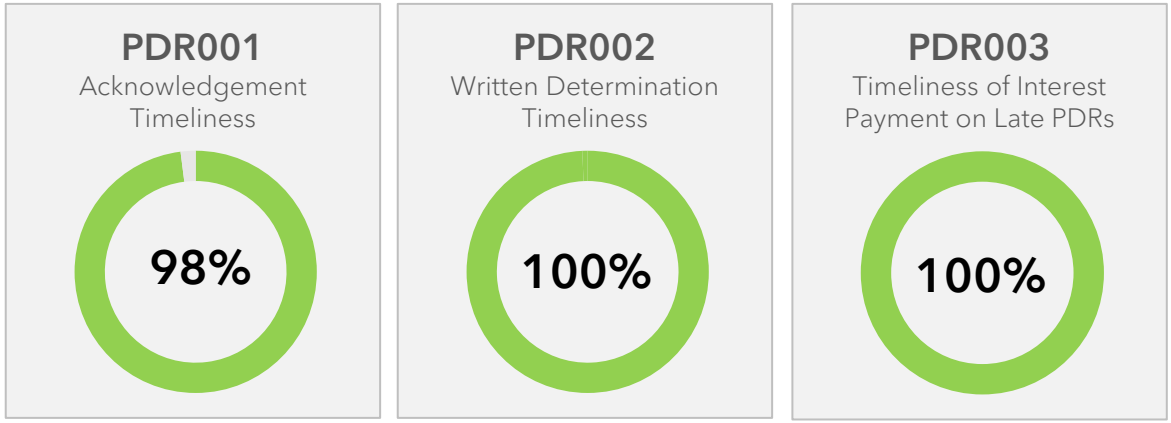
PROVIDER DISPUTE RESOLUTION



KPI #	KPI	Quarter 1	Quarter 2	Quarter 3	Quarter 4
PDR001	**Acknowledgement Timeliness**	**98.00%**			
PDR001E	▸ Acknowledgement Timeliness - Electronic	No Cases			
PDR001P	▸ Acknowledgement Timeliness - Paper	98.00%			
PDR002	**Written Determination Timeliness**	**100%**			
PDR003	**Timeliness of Interest Payment on Late PDRs**	**100%**			

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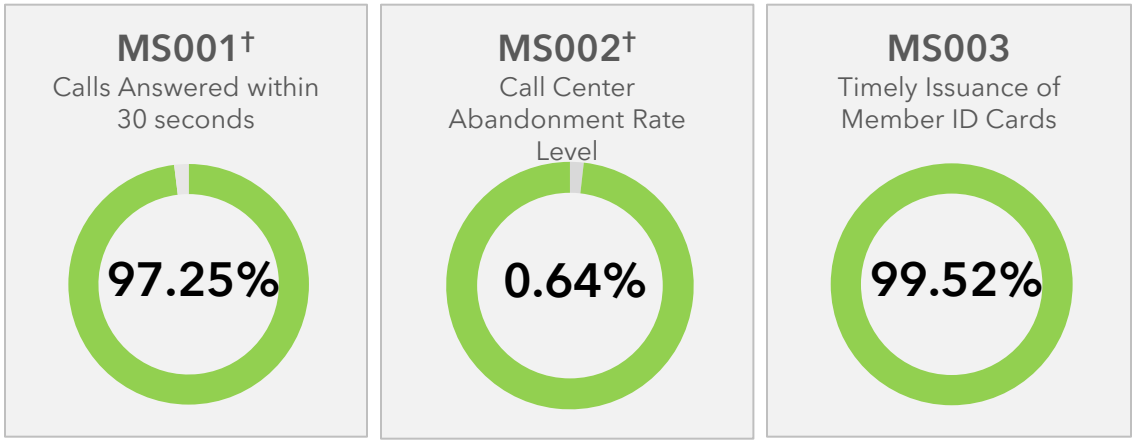
MEMBER SERVICES



KPI #	KPI	Quarter 1	Quarter 2	Quarter 3	Quarter 4
MS001	**Calls Answered within 30 seconds**	**97.25%†**			
MS002	**Call Center Abandonment Rate Level**	**0.64%†**			
MS003	**Timely Issuance of Member ID Cards**	**99.52%**			

† Self-reported compliance rate

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GRIEVANCES

KPI #	KPI	Quarter 1	Quarter 2	Quarter 3	Quarter 4
GRV001	**Acknowledgement Letter Timeliness**	**100%**			
GRV002	**Grievance Resolution Timeliness**	**100%**			
GRV002S	▸ Standard	100%			
GRV002E	▸ Expedited	100%			
GRV003	**Member Notification Timeliness**	**70.8%**			
GRV003S	▸ Standard	72.1%			
GRV003E	▸ Expedited	33.3%			

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Appendix 1 – KPI Details

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

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

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Functional Area	KPI Type	KPI #	KPI	Thresholds			Log
				Green	Yellow	Red	
Provider Dispute Resolution (PDR)	Quantitative	PDR001	PDR Acknowledgement Timeliness	>96%	95-96%	<95%	PDR Log
Provider Dispute Resolution (PDR)	Quantitative	PDR002	PDR Written Determination Timeliness	>96%	95-96%	<95%	PDR Log
Provider Dispute Resolution (PDR)	Quantitative	PDR003	Timeliness of Interest Payment on Late PDRs	>96%	95-96%	<95%	PDR Log
Member Services	Quantitative	MS001	Calls Answered within 30 seconds	>90%	80%-90%	<80%	Call Center SLA Log
Member Services	Quantitative	MS002	Call Center Abandonment Rate Level	less than 5%	5%	>5%	Call Center SLA Log
Member Services	Quantitative	MS003	Timely Issuance of Member ID cards	>98%	95-98%	<95%	Member ID Cards Log
Grievances	Quantitative	GRV001	Timely Acknowledgement Letter	>96%	95-96%	<95%	Grievance Log
Grievances	Quantitative	GRV002	Timely Grievance Resolution	>96%	95-96%	<95%	Grievance Log Call Log
Grievances	Quantitative	GRV003	Member Notification Timeliness	>96%	95-96%	<95%	Grievance Log