COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

AGENDA

Executive Committee

March 4, 2026

12:00 p.m.

512 W. Aten Rd., Imperial, CA 92251

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

Microsoft Teams
Join the meeting now
Meeting ID: 259 514 478 66
Passcode: vULVTd

Committee Role	Member	Representing
Committee Chair	Lee Hindman	Joint Chamber of Commerce (Public Representative)
Committee Co-Chair	Yvonne Bell	CEO, Innercare & CCIPA
Member	Dr. Carlos Ramirez	CEO/Senior Consultant, DCRC
Member	Dr. Unnati Sampat	President of Imperial County Medical Society
Member	Dr. Allan Wu	CMO, Innercare and President of CCIPA

1. CALL TO ORDER *Lee Hindman, Chair*

A. Roll Call *Donna Ponce, Commission Clerk*

B. Approval of Agenda

1. Items to be pulled or added from the Information/Action/Closed Session Calendar

2. Approval of the order of the agenda

2. PUBLIC COMMENT *Lee Hindman, Chair*

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

3. CONSENT CALENDAR

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

A. Approval of Minutes from 1/7/2026 and 2/4/2026...pg. 5-11

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

1. Executive Summary...pg. 12-14
2. Enrollment Report...pg. 15
3. Statement of Revenues, Expenses, and Changes in Net Position... pg. 16
4. Product Profit & Loss Statement...pg. 17
5. Statement of Net Position...pg. 18
6. Summarized TNE Calculation...pg. 19
7. Cash Transaction Report...pg. 20-21

4. ACTION

A. Motion to recommend to the full commission the appointment of Xochitl Fausto as the Chair of the Community Advisory Committee *(Lee Hindman, Chair)* ...pg. 23

B. Motion to recommend to the full commission the addition of Daniel Flores representing Imperial County Aging and Disability Resource Center to the CAC Selection Committee as recommended by the CAC Selection Committee *(Dr. Carlos Ramirez, Committee Chair)* ...pg. 24

C. Motion to approve amendments to the CAC Selection Committee Charter as recommended by the CAC Selection Committee *(Dr. Carlos Ramirez, Committee Chair)* ...pg. 25-27

5. COMMITTEE CHAIR REPORTS

A. Quality Improvement Health & Equity Committee-*Quarterly*
(Dr. Gordon Arakawa, CMO) ...pg. 29

B. Finance Committee-*Monthly*
(Dr. Carlos Ramirez, Chair) ...pg. 12-14

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

D. Community Advisory Committee Selection Committee-*Annual (Julia Hutchins, COO)* ...pg. 30

6. INFORMATION

A. Health Services Report *(Dr. Gordon Arakawa, CMO and Jeanette Crenshaw, Executive Director of Health Services)* ...pg. 32-33

B. Compliance Report *(Elysse Tarabola, CCO and Chelsea Hardy, Senior Director of Compliance)* ...pg. 34-92

C. Operations Report *(Julia Hutchins, COO)* ...pg. 93-97

D. Human Resources Report *(Shannon Long, HR Consultant)* ...pg. 98

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

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

7. CLOSED SESSION

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

A. Compliance

8. RECONVENE OPEN SESSION

A. Report on actions taken in closed session.

9. ADJOURNMENT

Next meeting: April 8, 2026

Consent Agenda

COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

MINUTES

Executive Committee

January 7, 2026

12:00 p.m.

512 W. Aten Rd., Imperial, CA 92251

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

Microsoft Teams
Join the meeting now
Meeting ID: 259 514 478 66
Passcode: vULVTd

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

1. **CALL TO ORDER** *Lee Hindman, Chair*
   The meeting was called to order at 12:10 p.m.

A. Roll Call *Donna Ponce, Commission Clerk*
   Roll call taken and quorum confirmed. Attendance is as shown.

B. Approval of Agenda

   1. Items to be pulled or added from the Information/Action/Closed Session Calendar

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

2. PUBLIC COMMENT *Lee Hindman, Chair*

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

3. CONSENT CALENDAR

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

A. Approval of Minutes from 12/3/2025...pg. 5-9

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

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

C. Motion to recommend to the full Commission the acceptance of the 2026 Budget Review as reviewed and accepted by the Finance Committee...pg. 19-26

4. ACTION

A. "At-Risk Compensation" Policy Update...pg. 28-30 *Larry Lewis, CEO*
(Bell/Sampat) Motion to recommend to the full Commission the "At-Risk Compensation" Policy Update. Motion carried.

5. COMMITTEE CHAIR REPORTS

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

B. Finance Committee-*Monthly*
(Dr. Carlos Ramirez, Chair)
Member Ramirez provided updates on the January 7, 2026, Finance Committee meeting.

C. Regulatory Compliance & Oversight Committee-*Quarterly*
(Dr. Allan Wu, Chair) ...pg. 32-34
No report.

D. Community Advisory Committee-*Quarterly*
(Julia Hutchins, COO) ...pg. 35-36
Chief Operations Officer Julia Hutchins provided updates on December 9, 2025, Community Advisory Committee meeting.

6. INFORMATION

A. Officer Elections Process and Candidate recommendations to Full Commission (*Lee Hindman, Chair)*
Chair Hindman asked whether committee members wished to propose any changes to the Officer Elections process. Following discussion, the committee agreed to recommend to the full commission that the voting process be opened.

B. Health Services Report *(Dr. Gordon Arakawa, CMO and Jeanette Crenshaw, Executive Director of Health Services)*
Chief Medical Officer Dr. Gordon Arakawa provided updates on Health Services goals for 2026, including plans to further stratify and segment standard metrics for the Medi-Cal and Medicare lines of business.

Executive Director of Health Services Jeanette Crenshaw provided updates on D-SNP activities, including Care Coordinators conducting Health Risk Assessments in the community.

C. Compliance Report *(Elysse Tarabola, CCO and Chelsea Hardy, Senior Director of Compliance)* ...pg. 38-53
Chief Compliance Officer Elysse Tarabola updated the committee on the following:
- DHCS Medical Audit preliminary findings
- Delegation Oversight-Pre-Delegation D-SNP audits
- Annual audit of Health Net

D. Operations Report *(Julia Hutchins, COO)* ...pg. 54-56
Chief Operations Officer Julia Hutchins updated the committee on the following:
- Community Advantage Plus Go-Live
- Direct Provider Network

E. Human Resources Report *(Shannon Long, HR Consultant)* ...pg. 57

Human Resources Consultant Shannon Long updated the committee on the following:

- Three open positions: Senior Compliance Advisor, Sales Team Member, and Financial Advisor
- Employee benefits open enrollment completed
- Performance Evaluations completed
- Monthly team meetings
- 3.5% pay increases for employees

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

Chief Executive Officer Larry Lewis updated the committee on the following:

- D-SNP Ribbon Cutting event scheduled for January 8th at 5:30 p.m.
- Completion of CHPIV parking lot
- New finance policies are to be presented for approval at the January 12th, 2026, CHPIV Commission meeting.

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

None.

7. CLOSED SESSION

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

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

A. Compliance Report

8. RECONVENE OPEN SESSION

A. Report on actions taken in closed session.

Chair Hindman announced that the committee will reconvene into open session.
Information provided with no action taken.

9. ADJOURNMENT

The meeting was adjourned at 1:28 p.m.
Next meeting: February 4, 2026

COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

MINUTES

Executive Committee

February 4, 2026

12:00 p.m.

512 W. Aten Rd., Imperial, CA 92251

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

Microsoft Teams
Join the meeting now
Meeting ID: 259 514 478 66
Passcode: vULVTd

Committee Role	Member	Representing
Committee Chair	Lee Hindman	Joint Chamber of Commerce (Public Representative)
Committee Co-Chair	Yvonne Bell	CEO, Innercare & CCIPA
Member	Dr. Carlos Ramirez	CEO/Senior Consultant, DCRC
Member	Dr. Unnati Sampat	President of Imperial County Medical Society
Member	Dr. Allan Wu	CMO, Innercare and President of CCIPA

Members present: Lee Hindman, Yvonne Bell, Dr. Carlos Ramirez, Dr. Unnati Sampat, and Dr. Allan Wu
Members absent: None
Others present: Larry Lewis (CEO), David Wilson (CFO), Dr. Gordon Arakawa (CMO) Julia Hutchins (COO), William Smerdon (Attorney), Donna Ponce (Commission Clerk), and Community Health Group (CHG) staff.

1. **CALL TO ORDER** *Lee Hindman, Chair*
   The meeting was called to order at 12:01 p.m.

A. Roll Call *Donna Ponce, Commission Clerk*
   Roll call taken and quorum confirmed. Attendance is as shown.

B. Approval of Agenda

1. Items to be pulled or added from the Information/Action/Closed Session Calendar

2. Approval of the order of the agenda
   (Ramirez/Bell) To approve the order of the agenda. Motion carried.

2. PUBLIC COMMENT *Lee Hindman, Chair*

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

3. CLOSED SESSION

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

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

B. Compliance

4. RECONVENE OPEN SESSION

A. Report on actions taken in closed session.
Chair Hindman announced that the committee will reconvene into open session.
Information provided with no action taken.

5. CONSENT CALENDAR

All items appearing on the consent calendar are recommended for approval and will be acted upon by one motion, without discussion. Should any Commissioner or other person express their preference to consider an item separately, that item will be addressed at a time as determined by the Chair.
Due to time constraints, the committee did not take action on these matters. Items will be scheduled for consideration at a future meeting.

A. Approval of Minutes from 1/7/2026...pg. 5-8

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

1. Executive Summary...pg. 9-10
2. Enrollment Report...pg. 11
3. Statement of Revenues, Expenses, and Changes in Net Position... pg. 12
4. Product Profit & Loss Statement...pg. 13
5. Statement of Net Position...pg. 14

6. Summarized TNE Calculation...pg. 15
7. Cash Transaction Report...pg. 16-17

6. ACTION

No action items.

7. COMMITTEE CHAIR REPORTS

A. Quality Improvement Health & Equity Committee-*Quarterly*
(Dr. Gordon Arakawa, CMO)

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

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

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

8. INFORMATION

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

B. Compliance Report *(Elysse Tarabola, CCO and Chelsea Hardy, Senior Director of Compliance)* ...pg. 20-22

C. Operations Report *(Julia Hutchins, COO)* ...pg. 23-25

D. Human Resources Report *(Shannon Long, HR Consultant)* ...pg. 26

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

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

9. ADJOURNMENT

The meeting was adjourned at 1:28 p.m.
Next meeting: March 4, 2026

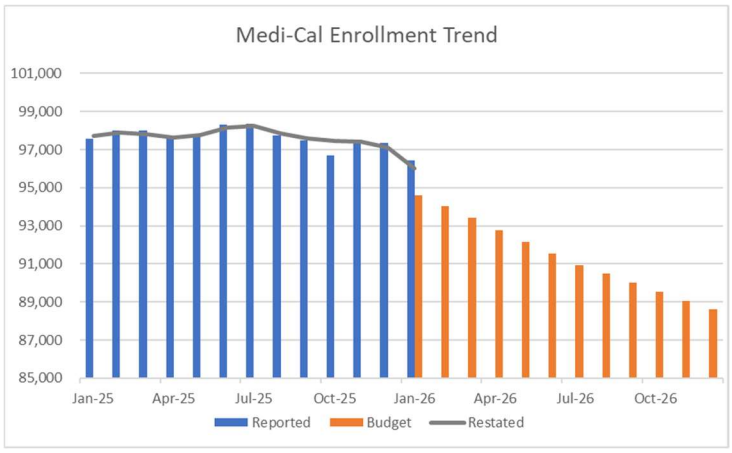
Financial Result

January 2026

Executive Summary

Membership

January Medi-Cal reported membership totaled 96.4K, representing a 951-member decline from the prior month. Despite the decrease, membership remained 1.6K above budget. Membership losses were primarily driven by the SIS population; however, on a percentage basis, declines were consistent with the UIS population.



Medicare membership for January was 169, 26% below forecast, driven by weaker-than-expected sales performance and elevated disenrollment. February enrollment files indicate modest growth; however, membership continues to trend below forecast expectations.

Gross Margin

December gross margin was unfavorable to budget by ($90K), driven by the delayed implementation of the 2026 Medi-Cal rate schedule. The updated rate schedule is expected to be implemented in Q1, inclusive of retroactive payments, and is not anticipated to impact full-year results.

Medi-Cal

Membership Mix & Rate: Current month revenue rate variance was unfavorable to budget by ($2.2M), largely offset by a commensurate reduction in global capitation payments to Health Net. January Medi-Cal payments were based on 2025 rates, whereas the budget assumed 2026 rates.

Volume: Favorable membership contributed $114K in excess revenue relative to the budget. Child and Adult expansion populations favorability offset shortfalls in SPD and LTC.

	Revenue (Current Month Reported)					
Category of Aid (COA)*	**Current**	**Prior Period**	**Budget**	**Variance**	**Vol**	**Rate**
Child	$ 4,493,925	$ 9,159	$ 4,273,299	$ 220,627	$ 99,572	$ 121,055
Adult	$ 3,744,550	$ 13,737	$ 4,466,775	$ (722,225)	$ 76,693	$ (798,918)
Adult Expansion	$ 7,276,273	$ (7,836)	$ 7,899,784	$ (623,512)	$ 250,402	$ (873,914)
SPD-LTC	$ 4,179,310	$ 170,197	$ 4,850,339	$ (671,029)	$ (101,528)	$ (569,501)
SPD-LTC Full Dual	$ 6,419,689	$ 54,501	$ 6,721,802	$ (302,113)	$ (210,995)	$ (91,118)
Total Medicaid	**$ 26,113,747**	**$ 239,757**	**$ 28,211,999**	**$ (2,098,252)**	**$ 114,145**	**$ (2,212,396)**

** Includes SPD Medicaid*

12

Medicare

Medicare Gross Margin was unfavorable by ($10.8K) driven primarily by membership shortfalls. Volume accounted for ($13K) of the margin variance, partially offset by a favorable rate variance of $2.3K.

DSNP average risk score for January membership of 1.548 is favorable to the budget (Bid) risk score of 1.445. An additional Risk Adjustment accrual of 1% was recorded as part of the January close.

As expected, January paid claims were low due to provider billing lag and the product's new market entry. Incurred But Not Reported (IBNR) estimates were established based on budget assumptions.

Consolidated Lag Triangle

		Incurred Month				
		Jan - 2026	**Feb - 2026**	**Mar - 2026**	**Apr - 2026**	**Total**
Paid Month	Jan - 2026	$ 2,716.02				$ 2,716.02
	Feb - 2026	$ 35,120.48	$ 11,133.53			$ 46,254.01
	Mar - 2026	$ -	$ -	$ -		$ -
	Apr - 2026	$ -	$ -	$ -	$ -	$ -
	May - 2026	$ -	$ -	$ -	$ -	$ -
		$ 37,836.50	**$ 11,133.53**	**$ -**	**$ -**	**$ 48,970.03**
						$ -
	IBNR	$197,863.40	TBD			$ 197,863.40
	Total Expense	$235,699.90	TBD	$ -	$ -	$ 235,699.90

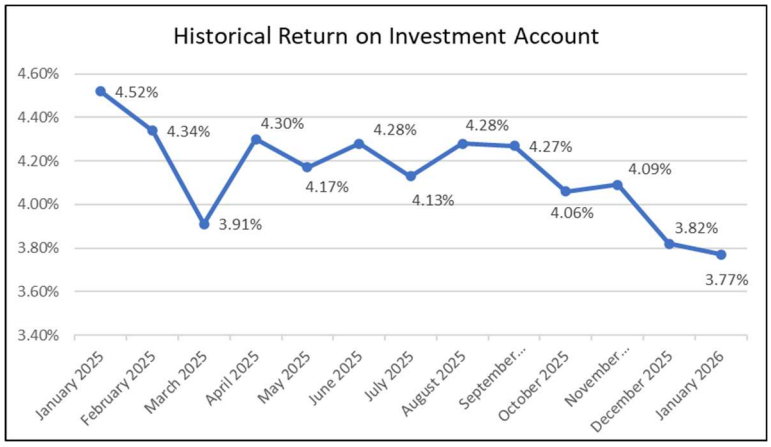
Administrative Expenses

Total administrative expenses were favorable to budget by $69.7K, driven primarily by the timing of professional fees and contingency reserves. Labor costs were unfavorable due to vacation accruals and, to a lesser extent, benefit elections finalized after budget development. These variances are not expected to impact full-year results. There were no new committed expenditures above $50,000.

Other

Investment income was unfavorable by $26K in January due to ongoing interest rate pressure. The average portfolio return declined from a 2025 average of 4.18% to 3.77% in January 2026, reflecting a 75-basis-point decrease from the January 2025 peak.

Month	Return
January 2025	4.52%
February 2025	4.34%
March 2025	3.91%
April 2025	4.30%
May 2025	4.17%
June 2025	4.28%
July 2025	4.13%
August 2025	4.28%
September 2025	4.27%
October 2025	4.06%
November 2025	4.09%
December 2025	3.82%
January 2026	3.77%



Net Income

Overall, Net income/(loss) for the month was ($13.7K), missing the budget by ($20.1K).

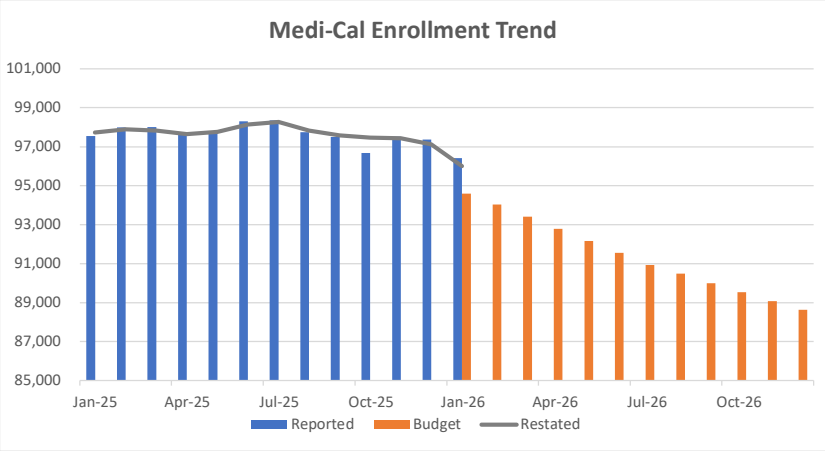
Tangible Net Equity (TNE)

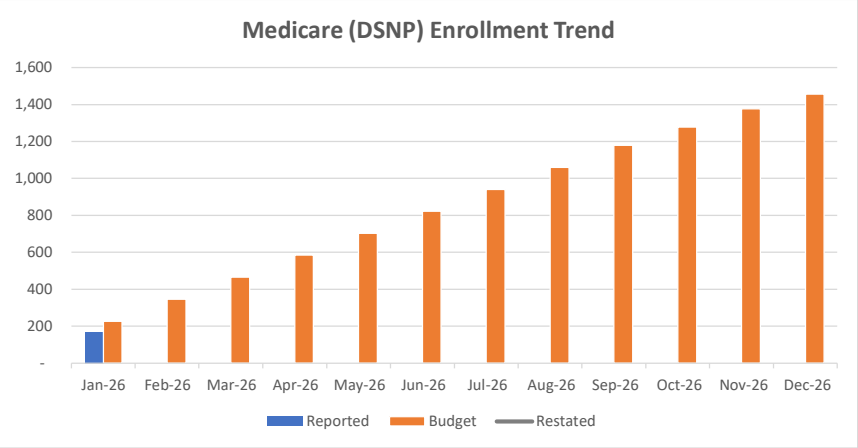
For the month of January, TNE totaled $23.7M, representing 508% of the required $4.7M. On a restated basis, TNE stands at 511% of the required levels.

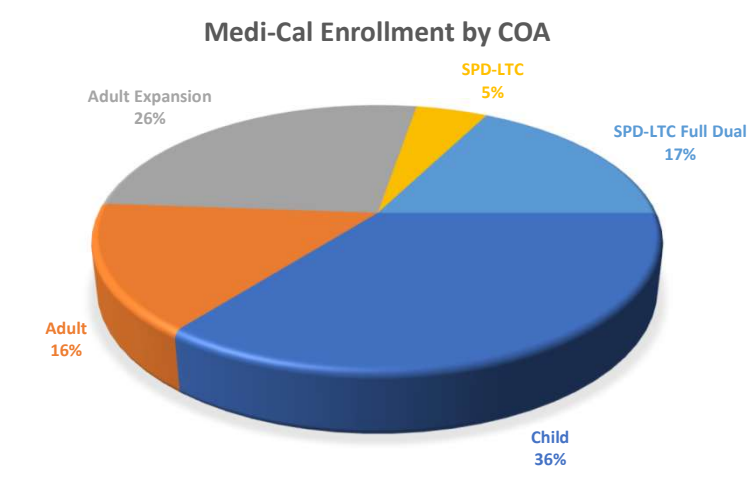
Community Health Plan of Imperial Valley
Enrollment Summary
For January 2026

	2025				2026											
									January				January (YTD)			
											B/(W)				B/(W)	
Category of Aid (COA)*	Q1	Q2	Q3	Q4	January	Q2	Q3	Q4	Actual	Budget	#	%	Actual	Budget	#	%
Child	35,139	35,129	34,728	34,555	34,315				34,315	33,475	840	3%	34,315	33,475	840	3%
Adult	15,801	15,754	15,471	15,306	15,018				15,018	14,677	341	2%	15,018	14,677	341	2%
Adult Expansion	25,995	26,028	25,808	25,988	25,528				25,528	24,797	731	3%	25,528	24,797	731	3%
SPD-LTC	4,693	4,790	4,662	4,684	4,721				4,721	4,634	87	2%	4,721	4,634	87	2%
SPD-LTC Full Dual	16,381	16,614	16,823	16,835	16,835				16,835	17,235	(400)	-2%	16,835	17,235	(400)	-2%
Total Medicaid	98,009	98,315	97,492	97,368	96,417	-	-	-	96,417	94,818	1,599	2%	96,417	94,818	1,599	2%
DSNP	-	-	-	-	169	-	-	-	169	227	(58)	-26%	169	227	(58)	-26%
Monthly/Quarterly Change		*0.3%*	*-0.8%*	*-0.1%*	*-1.0%*				*-1.0%*	*-2.6%*			*-1.0%*	*-2.6%*		

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







Medi-Cal Enrollment Trend (Restated)

	Oct-25	Nov-25	Dec-25	Jan-26	MoM Δ	% Δ
SIS						
Child	34,013	33,952	33,896	33,554	(342)	-1.0%
Adult	14,397	14,331	14,197	13,918	(279)	-2.0%
Adult Expansion	24,433	24,535	24,516	24,151	(365)	-1.5%
SPD-LTC	4,419	4,409	4,366	4,342	(24)	-0.5%
SPD-LTC Full Dual	16,256	16,245	16,205	16,145	(60)	-0.4%
Total SIS	**93,518**	**93,472**	**93,180**	**92,110**	**(1,070)**	**-1.1%**
% of Total	***95.9%***	***95.9%***	***95.9%***	***95.9%***		
UIS						
Child	668	705	684	701	17	2.5%
Adult	1,048	1,032	1,034	1,011	(23)	-2.2%
Adult Expansion	1,490	1,484	1,483	1,432	(51)	-3.4%
SPD-LTC	199	196	199	195	(4)	-2.0%
SPD-LTC Full Dual	555	538	544	549	5	0.9%
Total UIS	**3,960**	**3,955**	**3,944**	**3,888**	**(56)**	**-1.4%**
% of Total	***4.1%***	***4.1%***	***4.1%***	***4.1%***		
Total	**97,478**	**97,427**	**97,124**	**95,998**	**(1,126)**	**-1.2%**

15

Community Health Plan OF IMPERIAL VALLEY

Community Health Plan of Imperial Valley
Statement of Revenues, Expenses, and Changes in Net Position
For January 2026

	January			January (YTD)			
	Actual	Budget	Variance - B/(W)	Actual	Budget	Variance - B/(W)	Current Month Explanations
REVENUE							
Medicaid Revenue	$ 26,353,505	$ 28,211,999	**$ (1,858,495)**	$ 26,353,505	$ 28,211,999	**$ (1,858,495)**	- Medi-Cal unfavorable due to delayed rate adjustment.
Medicare Revenue	$ 388,518	$ 497,583	**$ (109,065)**	$ 388,518	$ 497,583	**$ (109,065)**	- Medicare unfavorable on poor sales performance
Investment & Interest Income	$ 96,310	$ 121,866	**$ (25,556)**	$ 96,310	$ 121,866	**$ (25,556)**	
TOTAL REVENUE	**$ 26,838,332**	**$ 28,831,448**	$ (1,993,115)	**$ 26,838,332**	**$ 28,831,448**	$ (1,993,115)	
HEALTH CARE COSTS							
Global Capitation	$ 25,508,574	$ 27,288,668	**$ 1,780,094**	$ 25,508,574	$ 27,288,668	**$ 1,780,094**	
Shared Risk Capitation	$ 100,035	$ 130,864	**$ 30,829**	$ 100,035	$ 130,864	**$ 30,829**	
FFS Claims	$ 200,579	$ 266,337	**$ 65,758**	$ 200,579	$ 266,337	**$ 65,758**	- Includes $160K for IBNR, PAD, and LAE
Pharmacy (Net)	$ 102,522	$ 127,609	**$ 25,087**	$ 102,522	$ 127,609	**$ 25,087**	(PAD - Provision for Adverse Deviation; LAE - Loss Adjustment Expense)
All Other	$ 29,086	$ 30,385	**$ 1,299**	$ 29,086	$ 30,385	**$ 1,299**	
HEALTH CARE COSTS	**$ 25,940,797**	**$ 27,843,864**	$ 1,903,067	**$ 25,940,797**	**$ 27,843,864**	$ 1,903,067	
Gross Margin	**$ 897,536**	**$ 987,584**	$ (90,049)	**$ 897,536**	**$ 987,584**	$ (90,049)	
ADMINISTRATIVE EXPENSE							
Salaries & Wages	$ 556,201	$ 525,775	**$ (30,426)**	$ 556,201	$ 525,775	**$ (30,426)**	
Benefits Expense	$ 51,575	$ 45,393	**$ (6,182)**	$ 51,575	$ 45,393	**$ (6,182)**	
Other Labor Expense	$ 1,424	$ 1,849	**$ 425**	$ 1,424	$ 1,849	**$ 425**	
Total Labor Costs	$ 609,201	$ 573,018	**$ (36,183)**	$ 609,201	$ 573,018	**$ (36,183)**	- Unfavorable labor due to timing of vacation accruals
Consulting, Legal, & Other Professional	$ 46,731	$ 123,116	**$ 76,386**	$ 46,731	$ 123,116	**$ 76,386**	- Timing of Finance & accouting fees and unused contingency
Outside Services	$ 46,740	$ 48,285	**$ 1,545**	$ 46,740	$ 48,285	**$ 1,545**	
MSO Fees	$ 117,739	$ 131,000	**$ 13,262**	$ 117,739	$ 131,000	**$ 13,262**	- Favorable due to unused contingency
Advertising & Marketing	$ 7,146	$ 14,000	**$ 6,854**	$ 7,146	$ 14,000	**$ 6,854**	
Information Technology	$ 5,268	$ 6,383	**$ 1,114**	$ 5,268	$ 6,383	**$ 1,114**	
Membership and Subscriptions	$ 11,334	$ 13,519	**$ 2,185**	$ 11,334	$ 13,519	**$ 2,185**	
Regulatory Fees	$ 26,021	$ 23,949	**$ (2,072)**	$ 26,021	$ 23,949	**$ (2,072)**	
Travel	$ 4,430	$ 10,100	**$ 5,670**	$ 4,430	$ 10,100	**$ 5,670**	
Occupancy & Facility	$ 3,312	$ 12,008	**$ 8,696**	$ 3,312	$ 12,008	**$ 8,696**	
Office Expense	$ 5,567	$ 4,702	**$ (866)**	$ 5,567	$ 4,702	**$ (866)**	
Other Admin	$ 18,162	$ 11,256	**$ (6,906)**	$ 18,162	$ 11,256	**$ (6,906)**	- Unfavorable driven by sales training
Total Administrative Expense	**$ 901,651**	**$ 971,335**	$ 69,685	**$ 901,651**	**$ 971,335**	$ 69,685	
Non-Operating Income/(Expense)							
Rental Income	$ 1,538	$ 1,494	**$ (45)**	$ 1,538	$ 1,494	**$ (45)**	
Depreciation & Amortization	$ (11,128)	$ (11,350)	$ 222	$ (11,128)	$ (11,350)	$ 222	
Change in Net Position	**$ (13,705)**	**$ 6,392**	$ (20,097)	**$ (13,705)**	**$ 6,392**	$ (20,097)	
Key Metrics							
Enrollment	96,417	94,818	**1,599**	96,417	94,818	**1,599**	
Medicaid Revenue PMPM	$ 273.81	$ 298.25	**$ (24.44)**	$ 273.81	$ 298.25		
Medicare Revenue PMPM	$ 2,298.92	$ 2,191.99	**$ 106.93**	$ 2,298.92	$ 2,191.99	**$ 106.93**	
MLR (Medicaid)	97.1%	97.1%	**(1) bps**	97.1%	97.1%	**(1) bps**	
MLR (Medicare)	91.5%	92.1%	**66 bps**	91.5%	92.1%	**66 bps**	
Admin Ratio	3.4%	3.4%	**1 bps**	3.4%	3.4%	**1 bps**	
FTEs	42	45	**3**	42	45	**3**	
Net Income PMPM	($0.14)	$0.07	**($0.21)**	($0.14)	$0.07	**($0.21)**	
Net Income %	-0.1%	0.0%	**(7) bps**	-0.1%	0.0%	**(7) bps**	

16

Community Health Plan of Imperial Valley

Community Health Plan of Imperial Valley
Product P&L
For January 2026

	January											
	Medi-Cal				Medicare				Consolidated			
	Actual	Budget	Variance B/(W)	% Var	Actual	Budget	Variance B/(W)	% Var	Actual	Budget	Variance B/(W)	% Var
REVENUE												
Medi-Cal												
Premium	$ 25,999,133	$ 27,857,662	**$ (1,858,528)**	-6.7%	$ 64,957	$ 87,602	**$ (22,645)**	-25.8%	$ 26,064,090	$ 27,945,263	**$ (1,881,173)**	-6.7%
Pass-Through	$ 289,415	$ 266,736	**$ 22,678**	8.5%	$ -	$ -	**$ -**	N/A	$ 289,415	$ 266,736	**$ 22,678**	8.5%
Medicare												
Part C Revenue					$ 316,171	$ 399,374	**$ (83,203)**	-20.8%	$ 316,171	$ 399,374	**$ (83,203)**	-20.8%
Part D Revenue					$ 67,846	$ 95,485	**$ (27,639)**	-28.9%	$ 67,846	$ 95,485	**$ (27,639)**	-28.9%
Other Medicare Revenue					$ 4,500	$ 2,724	**$ 1,776**	65.2%	$ 4,500	$ 2,724	**$ 1,776**	65.2%
Other Revenue	$ 94,677	$ 116,866	**$ (22,189)**	-19.0%	$ 1,633	$ 5,000	**$ (3,367)**	-67.3%	$ 96,310	$ 121,866	**$ (25,556)**	-21.0%
TOTAL OPERATING REVENUE	**$ 26,383,225**	**$ 28,241,264**	**$ (1,858,039)**	**-6.6%**	**$ 455,108**	**$ 590,184**	**$ (135,077)**	**-22.9%**	**$ 26,838,332**	**$ 28,831,448**	**$ (1,993,115)**	**-6.9%**
HEALTHCARE COSTS												
Medicaid Capitation	$ 25,219,159	$ 27,021,932	**$ 1,802,772**	6.7%					$ 25,219,159	$ 27,021,932	**$ 1,802,772**	6.7%
Medicaid Pass-Through	$ 289,415	$ 266,736	**$ (22,678)**	-8.5%					$ 289,415	$ 266,736	**$ (22,678)**	-8.5%
Total Medicaid	**$ 25,508,574**	**$ 27,288,668**	**$ 1,780,094**	**6.5%**					**$ 25,508,574**	**$ 27,288,668**	**$ 1,780,094**	**6.5%**
PCP Capitation					$ 100,035	$ 130,864	**$ 30,829**	23.6%	$ 100,035	$ 130,864	**$ 30,829**	23.6%
Inpatient					$ 1,840	$ 88,146	**$ 86,306**	97.9%	$ 1,840	$ 88,146	**$ 86,306**	97.9%
Outpatient					$ 202	$ 32,053	**$ 31,850**	99.4%	$ 202	$ 32,053	**$ 31,850**	99.4%
Other FFS					$ 674	$ 146,139	**$ 145,465**	99.5%	$ 674	$ 146,139	**$ 145,465**	99.5%
IBNR					$ 197,863	$ -	**$ (197,863)**	N/A	$ 197,863	$ -	**$ (197,863)**	N/A
Total FFS					**$ 200,579**	**$ 266,337**	**$ 65,758**	**24.7%**	**$ 200,579**	**$ 266,337**	**$ 65,758**	**24.7%**
Pharmacy (Gross)					$ 156,463	$ -	**$ (156,463)**	N/A	$ 156,463	$ -	**$ (156,463)**	N/A
Federal Reinsurance					$ (10,149)	$ -	**$ 10,149**	N/A	$ (10,149)	$ -	**$ 10,149**	N/A
LICS					$ (42,405)	$ -	**$ 42,405**	N/A	$ (42,405)	$ -	**$ 42,405**	N/A
Other CMS Offsets					$ (4,723)	$ -	**$ 4,723**	N/A	$ (4,723)	$ -	**$ 4,723**	N/A
OTC					$ 757	$ 8,671	**$ 7,914**	91.3%	$ 757	$ 8,671	**$ 7,914**	91.3%
Other Pharmacy					$ 2,580	$ 118,938	**$ 116,358**	97.8%	$ 2,580	$ 118,938	**$ 116,358**	97.8%
Total Pharmacy					**$ 102,522**	**$ 127,609**	**$ 25,087**	**19.7%**	**$ 102,522**	**$ 127,609**	**$ 25,087**	**19.7%**
Other Supplemental					$ 5,921	$ 11,533	**$ 5,611**	48.7%	$ 5,921	$ 11,533	**$ 5,611**	48.7%
Reinsurance (Net)					$ 4,274	$ 2,737	**$ (1,537)**	-56.2%	$ 4,274	$ 2,737	**$ (1,537)**	-56.2%
Community Reinvestment	$ 17,452	$ 16,116	**$ (1,336)**	-8.3%	$ 1,438	$ -	**$ (1,438)**	N/A	$ 18,890	$ 16,116	**$ (2,775)**	-17.2%
TOTAL HEALTHCARE COSTS	**$ 25,526,026**	**$ 27,304,784**	**$ 1,778,758**	**6.5%**	**$ 414,771**	**$ 539,080**	**$ 124,309**	**23.1%**	**$ 25,940,797**	**$ 27,843,864**	**$ 1,903,067**	**6.8%**
Gross Margin	**$ 857,199**	**$ 936,480**	**$ (79,281)**	**-8.5%**	**$ 40,337**	**$ 51,104**	**$ (10,768)**	**-21.1%**	**$ 897,536**	**$ 987,584**	**$ (90,049)**	**-9.1%**
Total Administrative Expense	**$ 516,241**	**$ 596,341**	**$ 80,100**	**13.4%**	**$ 385,410**	**$ 374,995**	**$ (10,416)**	**-2.8%**	**$ 901,651**	**$ 971,335**	**$ 69,685**	**7.2%**
Non-Operating Income/(Expense)												
Rental Income	$ 1,538	$ 1,494	**$ 45**	3.0%	$ -	$ -	**$ -**	N/A	$ 1,538	$ 1,494	**$ 45**	3.0%
Depreciation & Amortization	$ (10,939)	$ (11,323)	**$ 384**	-3.4%	$ (189)	$ (27)	**$ (162)**	594.4%	$ (11,128)	$ (11,350)	**$ 222**	-2.0%
Change in Net Position	**$ 331,558**	**$ 330,310**	**$ 1,248**	**0.4%**	**$ (345,262)**	**$ (323,917)**	**$ (21,345)**	**6.6%**	**$ (13,705)**	**$ 6,392**	**$ (20,097)**	**-314.4%**
Key Metrics												
Enrollment	96,248	94,591	1,657	1.8%	169	227	(58)	-25.6%	96,417	94,818	1,599	1.7%
Revenue PMPM	$274.12	$298.56	($24.44)	-8.2%	$2,692.94	$2,599.93	$93.01	3.6%	$278.36	$304.07	($25.71)	-8.5%
MLR	96.75%	96.68%	-7 bps		91.14%	91.34%	20 bps		96.66%	96.57%	-8 bps	
Admin Ratio	2.0%	2.1%	15 bps		84.7%	63.5%	-2115 bps		3.4%	3.4%	1 bps	
Net Income PMPM	$3.44	$3.49	($0.05)	-1.4%	($2,042.97)	($1,426.95)	($616.02)	43.2%	($0.14)	$0.07	($0.21)	-310.8%
Net Income %	1.3%	1.2%	9 bps		-75.9%	-54.9%	-2098 bps		-0.1%	0.0%	-7 bps	
Gross Margin Vol Variance			$ 16,405				$ (13,058)				$ 16,655	
Gross Margin Rate Variance			$ (95,686)				$ 2,290				$ (106,703)	

Community Health Plan of Imperial Valley
Statement of Net Position
January

	December 2025	January 2025	Change
ASSETS			
Current Assets			
Cash and Investments			
Chase - Checking (Primary & DSNP)	$ 2,762,441	$ 3,449,744	$ 687,303
JPMorgan Securities	$ 17,007,748	$ 17,041,022	$ 33,274
First Foundation Bank	$ 142,177	$ 142,177	$ -
Receivables			
Accounts Receivable	$ (0)	$ 99	$ 99
Dividend & Interest Receivable	$ 126,546	$ 95,963	$ (30,582)
Capitation Receivable	$ 26,998,446	$ 26,064,090	$ (934,356)
Pass-Through Receivable	$ 897,457	$ 289,415	$ (608,042)
Medicare Receivables	$ -	$ 35,105	$ 35,105
Other Current Assets			
Prepaid Admin	$ 277,654	$ 548,003	$ 270,349
Prepaid Commissions	$ -	$ 3,492	$ 3,492
Prepaid Medical	$ 68,250	$ 77,800	$ 9,550
Total Current Assets	**$ 48,280,718**	**$ 47,746,910**	**$ (533,808)**
Noncurrent Assets			
Restricted Deposit			
First Foundation Bank - Restricted	$ 300,000	$ 300,000	$ -
Capital Assets			
Buildings - Net	$ 2,847,895	$ 2,839,066	$ (8,829)
Computer Equipment / Software - Net	$ 5,715	$ 5,546	$ (168)
Improvements - Net	$ 178,499	$ 177,619	$ (880)
Intangible Assets	$ 53,957	$ 52,707	$ (1,250)
Operating ROU Asset (Copier) - Net	$ 10,134	$ 10,134	$ -
Total Noncurrent Assets	**$ 3,396,200**	**$ 3,385,072**	**$ (11,128)**
Total Assets	**$ 51,676,918**	**$ 51,131,982**	**$ (544,936)**
		$ -	
LIABILITIES			
Current Liabilities			
Payables			
Accounts Payable	$ 181,474	$ 243,903	$ 62,430
Capitation Payable	$ 27,085,949	$ 25,508,574	$ (1,577,375)
IBNR	$ -	$ 198,173	$ 198,173
Medicare Payables	$ -	$ 18,960	$ 18,960
Community Reinvestment Reserve	$ -	$ 18,890	
Credit Card Payable	$ 2,415	$ 16,466	$ 14,051
Other Current Liabilities			
Unearned Revenue	$ -	$ 629,893	
Short Term Lease Liability - Copier	$ 3,275	$ 2,984	$ (291)
Bonus Accrual	$ 211,414	$ 230,358	$ 18,944
Salaries Accrual	$ 218,674	$ 275,731	$ 57,058
Vacation Accrual	$ 215,470	$ 243,506	$ 28,036
Total Current Liabilities	**$ 27,918,670**	**$ 27,387,439**	**$ (531,231)**
Total Liabilities	**$ 27,918,670**	**$ 27,387,439**	**$ (531,231)**
NET POSITION			
Net investments in Capital Assets	$ 3,096,200	$ 3,085,072	$ (11,128)
Restricted by Legislative Authority	$ 300,000	$ 300,000	$ -
Unrestricted	$ 16,710,142	$ 20,373,176	$ 3,663,033
YTD Net Revenue	$ 3,651,906	$ (13,705)	$ (3,665,610)
Total Net Position	**$ 23,758,248**	**$ 23,744,543**	**$ (13,705)**
Total Liabilities and Net Position	**$ 51,676,918**	**$ 51,131,982**	**$ (544,936)**

18

Community Health Plan of Imperial Valley
Summarized Tangible Net Equity Calculation
As of January 2026

	Net Equity	$ 23,744,543
	Add: Subordinated Debt and Accrued Subordinated Interest	$ 0
	Less: Report 1, Column B, Line 27 including: Unsecured Receivables from officers, directors, and affiliates; Intangibles	$ 0
	Tangible Net Equity (TNE)	$ 23,744,543
	Required Tangible Net Equity *	$ 4,674,313
	TNE Excess (Deficiency)	$ 19,070,229

	Full Service Plan		* Calculated Required Tangible Net Equity	
		1	$ 26,452,608	- January
A.	Minimum TNE Requirement	$ 1,000,000	$ 317,431,293	- Annualized
B.	REVENUES:			
			$ 150,000,000	
	2% of the first $150 million of		x 2%	
	annualized premium revenues	$ 3,000,000	$ 3,000,000	
	(lines 1, 2, 4, 5, 7, 9 from Income Statement)			
	Plus			
			$ 167,431,293	
	1% of annualized premium revenues		x 1%	
	in excess of $150 million	$ 1,674,313	$ 1,674,313	
	Total	$ 4,674,313	$ 4,674,313	- Required TNE

Community Health Plan of Imperial Valley
January 2026 Cash Transactions

Date	Account	Vendor	Memo/Description	Amount
Chase Primary Checking				
01/01/26	Chase Checking	Rippling	Payroll taxes paid via Rippling for check date 12/31/2025	$ (3,606.57)
01/02/26	Chase Checking	Epstein Becker & Green, P.C.	Multiple inv. (details on stub)	(1,545.00)
01/06/26	Chase Checking	Kaz-Bros Design Shop	Inv 13137-- bill.com Check Number: 80612895	(543.70)
01/06/26	Chase Checking	Shalom Events Professionals	Inv Invoice 01082026-- bill.com Check Number: 80612442	(185.00)
01/06/26	Chase Checking	Quench USA	Inv INV10045696	(129.30)
01/06/26	Chase Checking	CuterEats	Inv 2531-- bill.com Check Number: 80611349	(300.00)
01/06/26	Chase Checking	Imperial Irrigation District	Inv Dec2025-- bill.com Check Number: 80612186	(1,003.33)
01/07/26	Chase Checking	JPMorgan Chase	Dividend Income - December 2025	7,297.46
01/07/26	Chase Checking	Rippling	Employee Reimbursement - E. Montejano, S. Levy, E. Torres and J. Garcia	(587.40)
01/07/26	Chase Checking	Rippling	People Center	(20.00)
01/07/26	Chase Checking	Blue Shield Insurance	Blue Shield Insurance	(35,492.24)
01/07/26	Chase Checking	Rippling	Employee Reimbursement - M. Ramirez & D. Pasillas	(428.45)
01/07/26	Chase Checking	Rippling	Employee Reimbursement - S. Long	(73.87)
01/07/26	Chase Checking	JPMorgan Chase	Service Charges Investment Sweep - December 2025	(550.95)
01/07/26	Chase Checking	UNUM	UNUM Invoice 01/01/26 - 01/31/26	(933.15)
01/08/26	Chase Checking	MAK Solutions	Multiple invoices	(8,125.00)
01/08/26	Chase Checking	Brawley Rotary Club	Inv December Statement-- bill.com Check Number: 80625200	(135.00)
01/08/26	Chase Checking	SLA Paving Inc.	Inv 1869-- bill.com Check Number: 80626371	(95,901.00)
01/08/26	Chase Checking	Inerglo Creative	Inv INV-00671	(3,000.00)
01/08/26	Chase Checking	Health Management Associates, Inc.	Inv 210806 - 0000011	(1,030.00)
01/08/26	Chase Checking	Imperial Desert Landscape	Inv 25-502	(250.00)
01/08/26	Chase Checking	Republic Services	Inv 0467-001767296	(165.48)
01/09/26	Chase Checking	Rick's Roadrunner Lock & Safe	Multiple invoices	(1,165.02)
01/09/26	Chase Checking	Ascend Technologies, LLC	Inv INV049824	(5,787.00)
01/09/26	Chase Checking	State Tax Solutions	Inv STSICLHA001	(250.00)
01/09/26	Chase Checking	Rippling	Employee net pay for check date 01/09/2026	(131,490.45)
01/09/26	Chase Checking	Rippling	Payroll taxes paid via Rippling for check date 01/09/2026	(75,285.68)
01/12/26	Chase Checking	Community Care IPA, Inc.	Inv JAN2025-- bill.com Check Number: 80643328	(33,657.07)
01/12/26	Chase Checking	Imperial County Physicians Medical Group, Inc.	Inv JAN2025-- bill.com Check Number: 80644116	(15,255.85)
01/13/26	Chase Checking	Primary Healthcare Medical Group IPA, Inc.	Inv JAN2026	(7,896.28)
01/13/26	Chase Checking	Premier Patient Care IPA, INC.	Inv JAN2025	(43,226.21)
01/13/26	Chase Checking	Rippling	Employee net pay for check date 01/09/2026	(585.76)
01/13/26	Chase Checking	Rippling	Payroll taxes paid via Rippling for check date 01/09/2026	(413.42)
01/14/26	Chase Checking	Voya	Payroll Date: 01/09/26 Retirement Contribution:	(13,250.48)
01/14/26	Chase Checking	Rippling	Replenishing Rippling Balance	(116.98)
01/16/26	Chase Checking	Kaz-Bros Design Shop	Multiple invoices (details on stub)-- bill.com Check Number: 80664789	(951.48)
01/16/26	Chase Checking	Great America Financial Services	Inv 40830050	(306.01)
01/16/26	Chase Checking	ECG Management Consultants	Inv 4211.001 - 76310	(4,751.25)
01/16/26	Chase Checking	Health Management Associates, Inc.	Inv 206100 - 0000031	(1,332.50)
01/16/26	Chase Checking	Zamosky Communication	Inv 0000056	(8,000.00)
01/16/26	Chase Checking	Shalom Events Professionals	Inv INV 01222026-- bill.com Check Number: 80665177	(116.00)
01/16/26	Chase Checking	Jeffrey Scott Agency	Inv Project 23938	(7,405.00)
01/16/26	Chase Checking	Carlos Ramirez	Inv DECEMBER2025	(400.00)
01/16/26	Chase Checking	Bushra Ahmad	Inv DECEMBER2025	(100.00)
01/16/26	Chase Checking	Allan Wu	Inv DECEMBER2025-- bill.com Check Number: 80665471	(300.00)
01/16/26	Chase Checking	Pablo Velez	Inv DECEMBER2025-- bill.com Check Number: 80665615	(100.00)
01/16/26	Chase Checking	Mayra Widmann	Inv December2025	(100.00)
01/16/26	Chase Checking	Junior's Cafe	Inv 13-19423-- bill.com Check Number: 80667138	(362.32)
01/16/26	Chase Checking	Baker Tilly US, LLP	Inv 102841750-- bill.com Check Number: 80667378	(19,950.00)
01/16/26	Chase Checking	Cambria Imperial Hotel	Inv 001152 2-- bill.com Check Number: 80664925	(830.38)
01/16/26	Chase Checking	360 Business Products	Inv QE-QT-35380-3-- bill.com Check Number: 80666606	(1,169.98)
01/16/26	Chase Checking	Vic's Air Conditioning & Electrical	Inv 103351	(95.00)
01/16/26	Chase Checking	I.V. Termite & Pest Control	Inv 0359679	(120.00)
01/16/26	Chase Checking	City of Imperial	Acct 80683 - Inv 1492833-- bill.com Check Number: 80665960	(244.34)
01/16/26	Chase Checking	Stericycle, Inc.	Inv 8012911969-- bill.com Check Number: 80667146	(113.57)
01/16/26	Chase Checking	Community Health Group	Inv Jan2026	(5,611.68)
01/16/26	Chase Checking	Rippling	Employee net pay for check date 01/16/2026	(2,479.48)
01/16/26	Chase Checking	Rippling	Payroll taxes paid via Rippling for check date 01/16/2026	(1,060.26)
01/16/26	Chase Checking	Rippling	Employee net pay for check date 01/16/2026	(2,653.82)
01/16/26	Chase Checking	Rippling	Payroll taxes paid via Rippling for check date 01/16/2026	(1,412.93)
01/16/26	Chase Checking	Rippling	Employee net pay for check date 01/09/2026	(54.95)
01/16/26	Chase Checking	Rippling	Payroll taxes paid via Rippling for check date 01/09/2026	(25.83)
01/20/26	Chase Checking	American Medical Compliance, Inc.	Inv 011620261089-- bill.com Check Number: 80673278	(3,918.04)
01/21/26	Chase Checking	AM Copiers Inc.	Inv IN8979	(552.11)
01/21/26	Chase Checking	Wealthspire Retirement, LLC	Multiple invoices	(3,750.00)
01/21/26	Chase Checking	Rotary Club of El Centro	Multiple invoices (details on stub)-- bill.com Check Number: 80677553	(247.00)
01/21/26	Chase Checking	Economic Group Pension Services	Multiple invoices (details on stub)-- bill.com Check Number: 80678642	(1,206.25)
01/21/26	Chase Checking	Lee Hindman	Inv December 2025	(200.00)
01/21/26	Chase Checking	Bonde & Associates, LLC	Inv 1007	(6,000.00)
01/21/26	Chase Checking	Rippling	Employee net pay for check date 01/21/2026	(2,701.14)
01/21/26	Chase Checking	Rippling	Payroll taxes paid via Rippling for check date 01/21/2026	(865.55)
01/21/26	Chase Checking	Department of Managed Health Care	Receipt - DHCS (December 2025 Revenue)	26,935,324.17
01/21/26	Chase Checking	Department of Managed Health Care	Receipt - DHCS (December 2025 Revenue)	880,290.22
01/21/26	Chase Checking	Department of Managed Health Care	Receipt - DHCS (December 2025 Revenue)	58,569.47
01/21/26	Chase Checking	Department of Managed Health Care	Receipt - DHCS (December 2025 Revenue)	19,836.92
01/21/26	Chase Checking	Department of Managed Health Care	Receipt - DHCS (December 2025 Revenue)	1,881.87
01/21/26	Chase Checking	State Compensation Insurance Fund	Workers Compensation Payment	(1,424.49)
01/21/26	Chase Checking	Rippling	Account Analysis Settlement Charge	(413.85)
01/21/26	Chase Checking	Rippling	Employee Reimbursement - D. Wilson and J. Hutchins	(2,825.97)
01/21/26	Chase Checking	Rippling	Employee Reimbursement - K. Maldonado	(50.90)
01/21/26	Chase Checking	Rippling	Employee Reimbursement - E. Tarabola, E. Torres, S. Levy, B. Castro and E. Reyes	(705.73)
01/21/26	Chase Checking	Mid Atlantic	Administration Fees	(42.08)
01/21/26	Chase Checking	Rippling	Replenishing FSA	(150.00)
01/22/26	Chase Checking	Nations Benefits, LLC	Inv INV236567	(475.30)
01/22/26	Chase Checking	Nations Benefits, LLC	Inv INV 236594	(1,950.00)
01/22/26	Chase Checking	Alliance Insurance Services LLC	Inv INV JAN2026-- bill.com Check Number: 80681157	(3,492.00)

01/22/26	Chase Checking	Rincon Broadcasting Yuma Operations	Inv 755570-- bill.com Check Number: 80681344		(2,000.00)
01/23/26	Chase Checking	Law Office of William S. Smerdon	Inv 2892		(2,062.50)
01/23/26	Chase Checking	RSC Insurance Brokerage, Inc.	Inv INV 011526		(4,274.01)
01/23/26	Chase Checking	Rippling	Employee garnishments paid via Rippling for check date 01/23/2026		(891.92)
01/23/26	Chase Checking	Rippling	Employee net pay paid by direct deposits for check date 01/23/2026		(136,408.18)
01/23/26	Chase Checking	Rippling	Employee taxes paid via Rippling for check date 01/23/2026		(58,230.35)
01/23/26	Chase Checking	Rippling	Employer taxes paid via Rippling for check date 01/23/2026		(20,419.79)
01/26/26	Chase Checking	FEX Partners Insurance Agency LLC	Inv INV JAN2026		(1,164.00)
01/31/26	Chase Checking	Rippling	Employee Reimbursement - D. Pasillas		(1,234.17)
01/31/26	Chase Checking	Rippling	People Center		(924.00)
01/31/26	Chase Checking	Rippling	Replenish Rippling - FSA		(390.02)
01/31/26	Chase Checking	JPMorgan Chase	Credit Card Payment		(2,414.81)
01/31/26	Chase Checking	Rippling	Replenishing Rippling - FSA		(574.72)
01/31/26	Chase Checking	CMS	Feb 2026 CMS Capitation		629,893.28
01/31/26	Chase Checking	Mid Atlantic	10/01/25 - 12/31/25 - Managed Account Fee		(3,077.47)
01/31/26	Chase Checking	Rippling	Payroll Date: 01/23/26 Retirement Contribution		(14,207.90)
01/31/26	Chase Checking	HealthNet	Rental Income - January 2026		1,538.31
01/31/26	Chase Checking	Voya	Voya Over charge Receivable		(98.91)

Chase Checking - DSNP

01/31/26	Chase Checking - DSNP	JPMorgan Chase	Account Analysis Settlement Charge		(50.00)
01/31/26	Chase Checking - DSNP	Community Health Group	Community Health Group		(10,000.00)
01/31/26	Chase Checking - DSNP	Community Health Group	Community Health Group		(20,371.69)
01/31/26	Chase Checking - DSNP	Community Health Group	Community Health Group		(2,265.85)
01/31/26	Chase Checking - DSNP	JPMorgan Chase	JAN 2026 Interest		346.68

JPMorgan Securities

01/31/26	Chase Securities	Health Net	December Health Net Payment		(27,085,949.28)
01/31/26	Chase Securities	JPMorgan Chase	Accrued Investment Income - December 2025		119,248.16
01/31/26	Chase Securities	JPMorgan Chase	Bank Fee - December 2025 (Portfolio)	$	(25.00)

Action Items

Fact Sheet/Action Items

Action Items

Motions requiring Executive Committee approval

Motion Fact Sheet

Recommendation

Appoint Xochitl Fausto as Chair of the Community Advisory Committee

Background

The Community Advisory Committee serves as the Public Policy Committee of the Commission and is responsible for ensuring that CHPIV is responsive to Members' diverse health care needs. Appointing a Commission member to Chair the committee helps ensure that member's voice is represented in the governance of the plan.

Why Now

The Member representative seat on the Commission was only recently filled and previously had been vacant.

Financial Impact

None.

Risks / Alternatives

CHPIV CAC Coordinator continues to serve as Chair.

Items after the relevant motion to immediately follow

Staff to work with Chair on CAC meeting agenda and reports.

Fact Sheet/Action Items

Action Items

Motions requiring Executive Committee approval

Motion Fact Sheet

Recommendation

Approve addition of Daniel Flores representing Imperial County Aging and Disability Resource Center to CAC Selection Committee.

Background

DHCS D-SNP contract requires inclusion of individuals with knowledge of D-SNP topics.

Why Now

Contract requirement is effective Jan, 1, 2026

Financial Impact

None.

Risks / Alternatives

Appointment of another individual with knowledge of D-SNP topics.

Items after the relevant motion to immediately follow

None.

Fact Sheet/Action Items

Action Items

Motions requiring Executive Committee approval

Motion Fact Sheet

Recommendation

Approve amendments to CAC selection committee charter.

Background

DHCS D-SNP contract requires CHPIV to add 4 seats for members enrolled in Community Advantage Plus.

Why Now

Contract requirement is effective Jan, 1, 2026

Financial Impact

$100 per seat per meeting per additional representative. Annual impact $1,200.

Risks / Alternatives

None

Items after the relevant motion to immediately follow

Recruitment and addition of D-SNP members to CAC.

Community Advisory Committee (CAC)
Selection Committee Charter

Objectives

1. Select the members of the Community Advisory Committee (CAC).
2. Adjust CAC membership to account for changes in CHPIV membership.

Responsibilities

The Committee shall have the following authority and responsibilities, together with any additional authority or responsibility delegated to the Committee by the Commission of the Imperial County Local Health Authority (Commission) from time to time:

1. Ensure the CAC membership reflects the general Medi-Cal Member population in Imperial County, including representatives from Indian Health Service Providers, representatives who receive LTSS and/or individuals representing LTSS recipients, adolescents and/or parents and/or caregivers of children, including foster youth, as appropriate and be modified as the population changes to ensure that CHPIV's communities are represented and engaged;
2. Has at least four (4) Member seats that includes a reasonably representative sample of the population enrolled in D-SNP including Members, Member's family members, consumer advocates, and caregivers that reflect the demographic diversity of the D-SNP population, including individuals with disabilities.
3. Review, at least annually, demographic data, including data on racial, ethnic, and linguistic composition, of residents and members living in Imperial County to ensure CAC recruitment efforts and membership aligns with and reflects the racial, ethnic, and linguistic diversity of their respective Service Area.
4. Make a good faith effort to ensure the CAC membership is composed primarily of CHPIV Members, including representatives from diverse and hard- to-reach populations, with a specific emphasis on persons who are representative of or serving populations that experience health disparities such as individuals with diverse racial and ethnic backgrounds, genders, gender identity, sexual orientation, and physical disabilities.

Committee Membership

The CAC Selection Committee shall consist of such number of directors as the Commission shall from time to time determine, but in no event shall it consist of less than two members. The members of the Committee shall be appointed or replaced by Commission with or without cause.

The CAC Selection Committee must select all CAC members.

The CAC Selection Committee should include representatives from:

1. Persons who sit on the Commission
2. Safety Net Providers including federally qualified health centers (FQHCs), behavioral health, regional centers, local education authorities, dental Providers, IHS Facilities, and home and community-based service Providers; and
3. Persons and community-based organizations who are representatives within Imperial County, adjusting for changes in membership diversity.
4. Individuals who have knowledge and perspective of Exclusively Aligned Enrollment (EAE) D-SNP topics to facilitate a variety of Member perspectives and unique lived experiences, including those using services such as Home and Community Based Services and Long-Term Care.

Frequency

The CAC Selection Committee shall meet annually, or as often as it deems necessary in order to perform its responsibilities. Except as expressly provided in the Bylaws, the Committee shall determine its own rules of procedure.

- CAC Selection Committee members will serve a two-year term and may serve an unlimited number of terms.
- Should a CAC Selection Committee member resign, be asked to resign, or otherwise unable to serve on the CAC Selection Committee, the Committee will exercise best efforts to promptly replace the vacant seat, as needed, within 60 calendar days of the vacancy.

Reviewed and Approved by Commission
Date: 3/9/2026

Committee Chair Reports

Committee Report

Quality Improvement Health & Equity Committee (QIHEC)

Chair: Dr. Gordon Arakawa

Meeting Date: January 14, 2026

1. Appeals & Grievances
2. Care Management
3. CHPIV Credentialing
4. Member Experience
5. GEO Access Report
6. Care Coordination
7. Health Equity
8. QIHEC Q & A

Committee Report

Summary of committee meetings by commissioner chairs

Community Advisory Selection Committee Report

Chair: Dr. Carlos Ramirez

Date: February 24, 2026

Agenda Items Reviewed

- D-SNP required changes:
  - CAC membership additions
  - Charter updates
- Community Advisory Committee (CAC) activities and goals
- CAC demographic report

Key Observations

- CAC currently has 19 members.
- CHPIV is required to add 4 seats for D-SNP members
- Committee agreed to assist Denise Padillas, CHPIV's Community Liaison and CAC Coordinator, in recruiting applicants from underrepresented populations:
  - Former or foster care youth, or parents/caregivers
  - Members of the LGBTQ+ community
  - Members who receive health care through Indian Health Services

Actions Taken

- Motion approved to add 4 seats to the CAC representing D-SNP members.
- Motion approved to recommend to the CHPIV Commission adding Community Advocate Seat filled by Daniel Flores representing Imperial County Aging and Disability Resource Center.
- Motion approved to recommend to the CHPIV commission approval of updates to Committee Charter.

Information Items

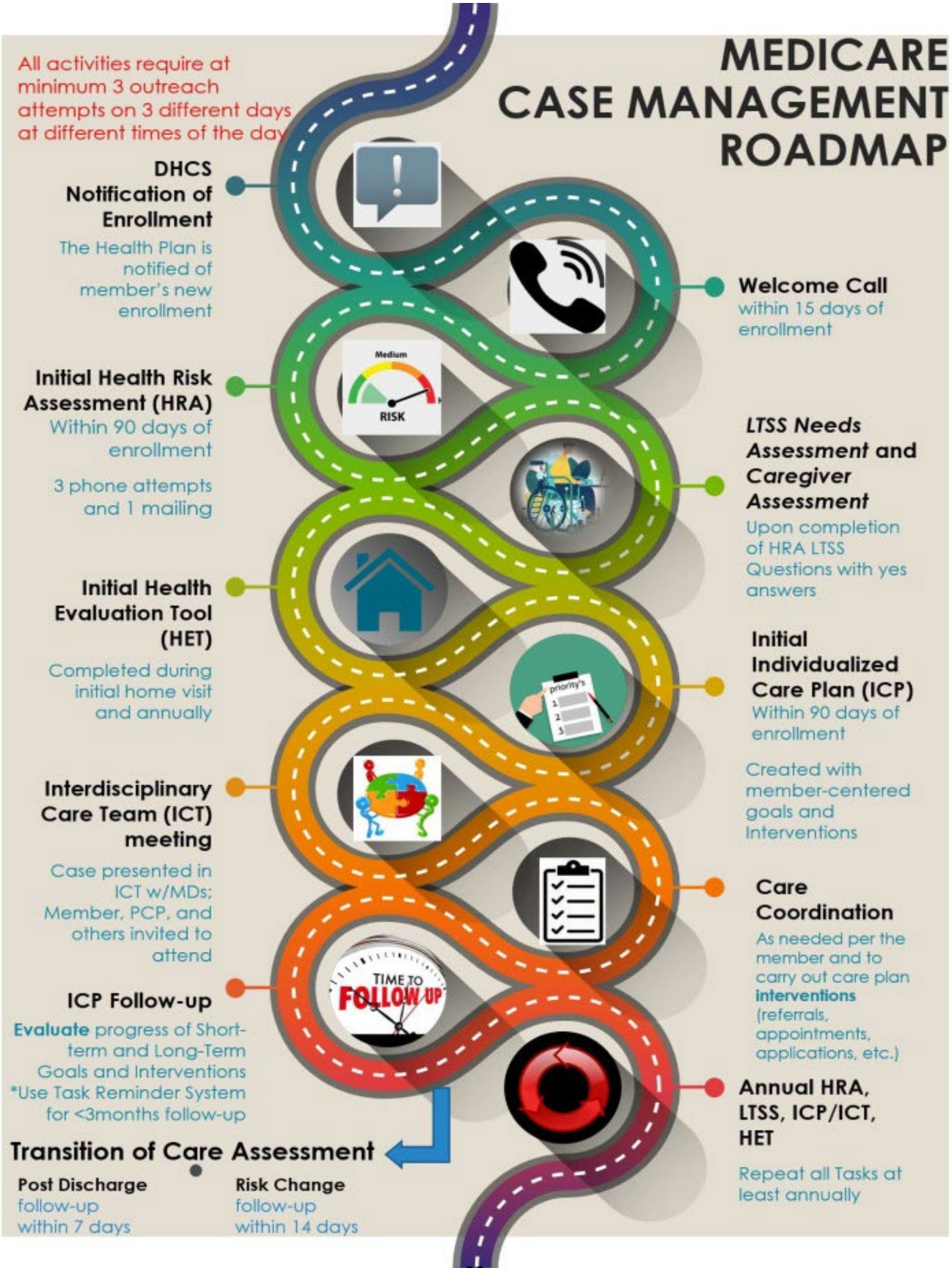
Informational Update

D-SNP Line of Business Care Management

The Health Services department is executing a high impact strategic initiative to operationalize CHPIV's nurse led, in house Care Management model for dual eligible members. This transition represents a deliberate shift toward enhanced clinical oversight, tighter integration of care delivery functions, and strengthened accountability across the care continuum. By internalizing core care management functions, CHPIV is positioning itself to better manage complex medical, behavioral health, and social risk factors inherent to the dual eligible population, while aligning with CMS, DHCS, and D-SNP regulatory expectations.

A foundational component of the initiative is the development of comprehensive care through implementation of member engagement (e.g., Health Risk Assessments, telephonic contact, in-home visits), proactively identifying complex clinical conditions and social determinants of health needs. Additionally, Health Services is strengthening infrastructure to ensure documentation integrity, reporting accuracy, and performance transparency. Enhancements to workflow standardization and data capture are underway to support DHCS ECM and Community Supports reporting requirements, improve internal analytics, and inform continuous quality improvement (CQI) initiatives. Lessons learned from early implementation are being incorporated into refined engagement protocols and documentation practices to optimize both regulatory compliance and member experience.

This initiative demonstrates CHPIV's continued commitment to advancing population health strategies, embedding health equity into service delivery, and strengthening value-based performance outcomes. Through enhanced clinical governance, standardized care coordination processes, and robust performance monitoring, CHPIV is establishing a scalable and sustainable care management infrastructure.


MEDICARE CASE MANAGEMENT ROADMAP
All activities require at minimum 3 outreach attempts on 3 different days at different times of the day
DHCS Notification of Enrollment
The Health Plan is notified of member's new enrollment
Welcome Call
within 15 days of enrollment
Initial Health Risk Assessment (HRA)
Within 90 days of enrollment
3 phone attempts and 1 mailing
Medium
RISK
LTSS Needs Assessment and Caregiver Assessment
Upon completion of HRA LTSS Questions with yes answers
Initial Health Evaluation Tool (HET)
Completed during initial home visit and annually
Initial Individualized Care Plan (ICP)
Within 90 days of enrollment
Created with member-centered goals and Interventions
Interdisciplinary Care Team (ICT) meeting
Case presented in ICT w/MDs; Member, PCP, and others invited to attend
Care Coordination
As needed per the member and to carry out care plan interventions (referrals, appointments, applications, etc.)
ICP Follow-up
Evaluate progress of Short-term and Long-Term Goals and Interventions
*Use Task Reminder System for <3months follow-up
TIME TO FOLLOW UP
Annual HRA, LTSS, ICP/ICT, HET
Repeat all Tasks at least annually
Transition of Care Assessment
Post Discharge
follow-up within 7 days
Risk Change
follow-up within 14 days

Compliance Report

Period Covered: February 2026

Highlights

- DHCS Medical Audit DHCS Medical Audit
- D-SNP – Integrated Organization Determination Extensions
- FY 2024-25 DHCS CFR Scoring Workbook

DHCS Medical Audit – Review Period CY2024

The California Department of Health Care Services (DHCS) conducted a medical audit reviewing CHPIV's performance during its first year of operations. The audit evaluated whether the Plan is meeting Medi-Cal contractual and regulatory requirements across key operational and compliance areas.

Overall Results

This was CHPIV's first DHCS medical audit. The most important theme across the audit was delegation oversight. Because CHPIV operates through a fully delegated subcontractor Health Net, DHCS emphasized that the Plan remains fully responsible for ensuring compliance, monitoring performance, and verifying outcomes — even when another organization performs the daily work. As a first-year plan, DHCS notes that CHPIV has opportunities to mature delegation oversight processes and strengthen monitoring controls.

Finding #	DHCS Finding	Accountable
1.1.1	The Plan did not designate a full-time Chief Health Equity Officer who could collaborate with the Plan's Medical Director to direct the Plan's QIHEC activities.	Health Services
1.5.1	The Plan did not ensure that its fully delegated subcontractor had a mechanism to track and monitor referrals.	Compliance Health Services Health Net
1.5.2	The Plan's monitoring and oversight of its fully delegated subcontractor and downstream subcontractor's functions were deficient.	Compliance Health Services Health Net

Finding #	DHCS Finding	Accountable
2.1.1	The Plan did not ensure that its fully delegated subcontractor consistently conducted care coordination and joint case management between the members' PCP, CCS providers, and the local CCS program once CCS eligibility is established as required.	Compliance Health Services Health Net
2.1.2	The Plan did not ensure that its fully delegated subcontractor consistently performed an IHA within 120 calendar days of enrollment, made reasonable attempts to contact members to schedule an IHA, or document all outreach attempts.	Compliance Health Services Health Net
2.1.3	The Plan did not ensure that its fully delegated subcontractor consistently conducted blood lead screening tests on members at one and two years of age, including up to six years of age as specified in APL 20-016.	Compliance Health Services Health Net
2.1.4	The Plan did not ensure that its fully delegated subcontractor consistently provided oral or written blood lead anticipatory guidance to the parent or guardian of members as specified in APL 20-016.	Compliance Health Services Health Net
2.3.1	The Plan did not ensure that its fully delegated subcontractor consistently fulfilled the requirement that a BHT service provider reviewed, revised, and/or modified the member's treatment plan at least every six months.	Compliance Health Services Health Net
2.4.1	The Plan did not monitor its fully delegated subcontractor to ensure compliance with COC requirements by consistently mailing a written notice of the denial to the member.	Compliance Health Services Health Net
2.5.1	The Plan did not verify that its fully delegated subcontractor had oversight mechanisms, policies, and procedures to ensure the subcontractor consistently provided members with access to needed services, including care coordination, navigation, and referrals for MHSUD needs.	Compliance Health Services Health Net
2.6.1	The Plan did not ensure that the fully delegated subcontractor provided ECM core service components, including the comprehensive assessment, CMP, and Member and Family Supports.	Compliance Health Services Health Net

Finding #	DHCS Finding	Accountable
3.8.1	The Plan did not provide sufficient documentation to demonstrate that its delegate and downstream subcontractor had a process in place to ensure NEMT door-to-door assistance for all members receiving medically necessary NEMT services.	Compliance Operations Health Net
4.1.1	"The Plan did not ensure that its fully delegated subcontractor reported discrimination grievances to the DHCS OCR within ten calendar days of mailing a Discrimination Grievance Resolution letter to a member."	Compliance
4.1.2	The Plan did not ensure that its fully delegated subcontractor consistently sent Transportation Grievance letters and notified members of their rights.	Compliance Operations Health Net

Remediation Summary

CHPIV has already implemented significant corrective actions to address the audit findings and strengthen oversight of delegated activities.

Key remediation steps include:

- **Centralization of Delegation Oversight within Compliance:** Delegation Oversight (DO) activities have been fully centralized under the Compliance department to ensure consistent governance, clearer accountability, and stronger alignment with regulatory requirements.
- **Expanded Oversight Resources:** Dedicated auditors (clinical and non-clinical) have been hired.
- **Completion of Annual Delegation Audit:** The annual delegation audit has been completed to establish a baseline review of delegated performance and identify operational gaps requiring remediation.
- **Integration into Enterprise Risk Assessment:** Applicable findings and delegated risks have been incorporated into CHPIV's risk management process to ensure priority monitoring and leadership visibility.
    - The risk assessment will be presented to Compliance & Policy Committee and Regulatory Compliance & Policy Committee of the Commission for review and approval in Q1 2026 meetings.

- **Enhanced Ongoing Monitoring Program:** CHPIV will increase the frequency and depth of reviews across delegated operational areas through our Monitoring Program based on the risk assessment.

D-SNP – Integrated Organization Determination Extensions

Federal Medicare regulations allow plans to apply extensions for integrated organization determinations (i.e., authorization decisions about whether services are approved or denied under Medicare and Medi-Cal benefits) in limited circumstances (42 CFR § 422.631). Federal rules also permit states to adopt more protective or stricter requirements related to timelines and notice standards (42 CFR § 422.629(c)).

For California EAE D-SNPs, the CY 2026 State Medicaid Agency Contract (SMAC) includes language requiring procedures to ensure integrated organization determination deadlines are not extended (meaning plans may not add extra time to issue authorization decisions).

During the February 2026 DHCS Local Plan D-SNP Readiness and Technical Assistance Meeting, DHCS confirmed that extensions will not be allowed for CY 2026 and stated that extensions are expected to be permitted beginning in CY 2027. DHCS further noted that states have the authority to impose more restrictive standards, and that plans should default to the State regulator for a final determination.

CHG currently allows extensions within its operational model. To clarify alignment between federal and state requirements, CHPIV sought guidance from CMS. CMS indicated that federal regulations allow extensions under specified circumstances but advised the Plan to defer to State guidance.

Risk Assessment Considerations

- Federal guidance permits extensions in limited situations:
    - Member (or their representative) requests the extension
    - The Plan determines an extension is in the member's Interest (e.g., when additional medical information is required that may affect the outcome, not for administrative convenience).
- California's CY 2026 SMAC language and DHCS verbal guidance indicate extensions are not allowed for CY 2026.
- DHCS has communicated that extensions are expected to be permitted beginning in CY 2027.
- Because state requirements may be more restrictive than federal rules, operational and compliance risk assessment is needed to evaluate alignment of processes and timelines

for CY 2026 (including authorization turnaround times) and future implementation planning for CY 2027.

FY 2024-25 DHCS CFR Scoring Workbook

DHCS recently introduced a standardized compliance scoring process required by CMS to measure how Medi-Cal health plans are performing against federal compliance requirements. This is a new statewide scoring methodology intended to give a high-level view of each plan's overall compliance status.

The scoring results provided to CHPIV were completed by DHCS and are based on DHCS's review of activities including the DHCS medical audit, Quality Improvement activities, and Annual Network Certification reviews.

Using this methodology, CHPIV received an overall compliance score of approximately **93%.**

The scoring converts audit findings into a simple "Met" or "Not Met" framework tied to federal regulations. The presence of a finding results in a "Not Met," while areas without findings receive full points.

DHCS has stated that this process is intended to provide a consistent, statewide comparison of compliance performance across managed care plans. Final scores will be submitted to CMS.

DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

LOS ANGELES SECTION

REPORT ON THE MEDICAL AUDIT OF IMPERIAL COUNTY LOCAL HEALTH AUTHORITY DBA COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY FISCAL YEAR 2024-25

Contract Number: 23-30218

Audit Period: January 1, 2024 — December 31, 2024

Dates of Audit: April 29, 2025 — May 13, 2025

Report Issued: February 9, 2026

TABLE OF CONTENTS

I. INTRODUCTION

Imperial County Local Health Authority dba Community Health Plan of Imperial Valley (Plan) was incorporated in 2024 and contracted with the Department of Health Care Services (DHCS) to provide services to Medi-Cal members. The Plan is the local Medi-Cal managed care plan serving Imperial County. The Plan is the local Initiative organized by the Imperial County Local Health Authority. On December 15, 2023, the Plan obtained a Knox Keene license from the California Department of Managed Health Care to serve its Medi-Cal members.

The Plan currently contracts with DHCS to provide services to Medi-Cal members under the Single Plan Model program in Imperial County. The Plan serves the Imperial Valley County population in the following cities: Brawley, Calexico, Calipatria, El Centro, Holtville, Imperial, Westmorland, and eight unincorporated communities (Bombay Beach, Heber, Niland, Ocotillo, Palo Verde, Salton City, Seeley, and Winterhaven).

The Plan is responsible for ensuring that residents receive quality healthcare services through a network of providers. The Plan works closely with the fully delegated subcontractor (Health Net Community Solutions, Inc.) to offer a wide range of medical services and support to the community. The fully delegated subcontractor is responsible for performing all the functions for the Plan, apart from compliance oversight, on behalf of the Plan.

The Plan is not accredited by the National Committee for Quality Assurance.

As of December 2024, the Plan had a total of 97,100 members, which included 80,542 Medi-Cal members and 16,558 members with Dual Benefits.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of January 1, 2024, through December 31, 2024. The audit was conducted from April 29, 2025, through May 13, 2025. It consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on November 20, 2025. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On December 8, 2025, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Utilization Management (UM) Program, Population Health Management and Coordination of Care, Network and Access to Care, Grievances, Appeals, and Member Rights, Quality Improvement and Health Equity Transformation Program, and Plan Administration and Organization.

This is the Plan's first year of operation; consequently, no prior DHCS medical audits have been conducted.

Systemic findings in the audit revealed issues with the monitoring and oversight of the Plan's fully delegated subcontractor. While the subcontractor directly carries out operational duties on behalf of the Plan, it must adhere to the Plan's policies and regulatory requirements and ensure compliance with the State Contract requirements. The Plan maintains ultimate responsibility for fulfilling DHCS contractual obligations.

The summary of the findings by category is as follows:

Category 1 – Utilization Management Program

The Plan must maintain a full-time Chief Health Equity Officer with the necessary qualifications or training. Finding 1.1.1: The Plan did not designate a full-time Chief Health Equity Officer who could collaborate with the Plan's Medical Director in directing the Plan's Quality Improvement Health Equity Committee (QIHEC) activities.

The Plan must have and maintain a management and information system that supports, at a minimum, referrals including tracking of referred services, to follow up with members to ensure that services were rendered. Finding 1.5.1: The Plan did not ensure that its fully delegated subcontractor had a mechanism to track and monitor referrals.

The Plan must monitor and oversee all delegated functions, including those that may flow down to downstream subcontractors. Finding 1.5.2: The Plan's monitoring and oversight of its fully delegated subcontractor and downstream subcontractor's functions were deficient.

Category 2 – Population Health Management and Coordination of Care

The requirement is that once eligibility for the California Children Services (CCS) program is established for a member, the Plan must ensure the coordination of services and joint case management between the member's Primary Care Provider (PCP), CCS providers, and the local CCS program. Finding 2.1.1: The Plan did not ensure that its fully delegated subcontractor consistently conducted care coordination and joint case management between the member's PCP, CCS providers, and the local CCS program once CCS eligibility is established as required.

The Plan must cover and ensure that Initial Health Appointments (IHAs) are performed within 120 calendar days of enrollment with the Plan. Additionally, the Plan must make reasonable attempts to contact a member to schedule an IHA and document all attempts to contact a member. Finding 2.1.2: The Plan did not ensure that its fully delegated subcontractor consistently performed an IHA within 120 calendar days of enrollment, made reasonable attempts to contact members to schedule, or document all outreach attempts.

The Plan must ensure that its network providers order or perform blood lead screening tests on all children in accordance with the All-Plan Letter (APL) 20-016 requirements, *APL 20-016, Blood Lead Screening of Young Children*. Finding 2.1.3: The Plan did not ensure that its fully delegated subcontractor consistently conducted blood lead screening tests on members at one and two years of age, including up to six years of age as specified in APL 20-016.

The Plan is required to provide oral or written anticipatory guidance to the parent(s) or guardian(s) of a child that, at a minimum, includes information that children can be harmed by exposure to lead in accordance with the APL 20-016 requirements, *APL-20-016, Blood Lead Screening of Young Children*. Finding 2.1.4: The Plan did not ensure that its fully delegated subcontractor consistently provided oral or written blood lead anticipatory guidance to the parent or guardian of members as specified in APL 20-016.

A Behavioral Health Treatment (BHT) service provider must review, revise, and/or modify the member's treatment plan at least every six months. Finding 2.3.1: The Plan did not

ensure that its fully delegated subcontractor consistently fulfilled the requirement that a BHT service provider reviewed, revised, and/or modified the member's treatment plan at least every six months.

The Plan must attempt to notify the member of the Continuity of Care (COC) decision via the member's preferred method of communication or by telephone and must send a notice by mail. Finding 2.4.1: The Plan did not monitor its fully delegated subcontractor to ensure compliance with COC requirements by consistently mailing a written notice of the denial to the member.

The Plan must ensure members have access to needed services, including care coordination, navigation, and referrals to services that address members' developmental, physical, mental health, and substance use disorder. Finding 2.5.1: The Plan did not verify that its fully delegated subcontractor had oversight mechanisms, policies, and procedures to ensure the subcontractor consistently provided members with access to needed services, including care coordination, navigation, and referrals for Mental Health and Substance Use Disorder (MHSUD) needs.

The Plan is required to provide the seven Enhanced Care Management (ECM) core service components in accordance with *APL 23-032, Enhanced Care Management Requirements* (12/22/2023). Finding 2.6.1: The Plan did not ensure that the fully delegated subcontractor provided ECM core service components to members, including the Comprehensive Assessment and Care Management Plan (CMP), and Member and Family Supports.

Category 3 – Network and Access to Care

The Plan must have processes in place to ensure door-to-door assistance is provided for all members receiving Non-Emergency Medical Transportation (NEMT) services. Finding 3.8.1: The Plan did not provide sufficient documentation to demonstrate that its delegate and downstream subcontractor had a process in place to ensure NEMT door-to-door assistance for all members receiving medically necessary NEMT services.

Category 4 – Grievances, Appeals, and Member Rights

The Plan must submit information regarding discrimination grievances to the DHCS Office of Civil Rights (OCR) within ten calendar days of mailing a Discrimination Grievance Resolution letter as specified in *APL 21-004*, *Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services* (05/24/2023). Finding 4.1.1: The Plan did not ensure that its fully delegated

subcontractor reported discrimination grievances to the DHCS OCR within ten calendar days of mailing a Discrimination Grievance Resolution letter to a member.

The Plan shall resolve each grievance and provide notice to the member as quickly as the member's health condition requires, within 30 calendar days from the date the Plan receives the grievance. Finding 4.1.2: The Plan did not ensure that its fully delegated subcontractor consistently sent Transportation Grievance letters and notify members of their rights.

Category 5 – Quality Improvement and Health Equity Transformation Program

There were no findings noted for this category during the audit period.

Category 6 – Plan Administration and Organization

There were no findings noted for this category during the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted the audit to ascertain that medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State Contract.

PROCEDURE

DHCS conducted an audit of the Plan from April 29, 2025, through May 13, 2025, for the audit period of January 1, 2024, through December 31, 2024. The audit included a review of the Plan's Contract with DHCS, policies and procedures for providing services, procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with the Plan and delegates' administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management Program

Prior Authorization Requests: A total of 46 delegated medical authorizations, including 14 retrospective, 5 concurrent, 20 routine, and 7 expedited prior authorization requests, were reviewed for timeliness, consistent application of criteria, appropriate review, and communication of results to providers and members.

Appeal Procedures: Eighteen medical appeals (11 routine, 4 expedited, and 3 downgraded from expedited to routine) were reviewed for appropriateness and timeliness of decision-making.

Category 2 – Population Health Management and Coordination of Care

IHA: Twenty files were reviewed for completion and care coordination of services.

CCS: Fifteen files were reviewed for care coordination and compliance.

Complex Case Management: Twenty-nine files were reviewed for care coordination and completeness to evaluate service performance.

BHT: Fifteen files were reviewed for care coordination and completeness to evaluate the performance of services.

COC: Eleven files were reviewed to evaluate timeliness and appropriateness of COC request determination.

MHSUD: Nine files, including three for Non-Specialty Mental Health Services (NSMHS), three for Specialty Mental Health Services (SMHS), and three for both NSMHS and SMHS, were reviewed for care coordination and completeness to evaluate service performance.

ECM: Eight files were reviewed for care coordination and completeness to evaluate service performance.

Category 3 – Network and Access to Care

Family Planning and Emergency Services Claims: Twenty family planning and 20 emergency service claims were reviewed for appropriateness and timeliness.

NEMT: Twenty-three records were reviewed to confirm compliance with transportation requirements and timeliness.

Non-Medical Transportation (NMT): Nineteen records were reviewed to confirm compliance with transportation requirements and timeliness.

NEMT and NMT Grievances: Twenty-three records were reviewed for response to the complainant and submission to the appropriate level of review.

Category 4 – Grievances, Appeals, and Member Rights

Grievance Procedures: Eighteen standard grievances, 12 expedited and 6 exempt grievances were reviewed for timely resolutions, response to complainant, and submission to the appropriate level for review. The 36 grievance cases included 26 quality of care and 10 quality of service.

Category 5 – Quality Improvement and Health Equity Transformation Program

Potential Quality of Care Issues: Fifteen files were reviewed for reporting, investigation, and remediation.

Credentialing and Re-credentialing: A total of 20 files were reviewed for licensing and certification.

New Provider Training: No verification log was provided for this section. The Plan's fully delegated subcontractor stated that no new providers were enrolled during the review period.

Category 6 – Plan Administration and Organization

Fraud, Waste, and Abuse Reporting: There were no fraud, waste, and abuse cases reported by the Plan to DHCS.

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management Program

1.1 – Utilization Management Program

1.1.1 Chief Health Equity Officer

The Plan must maintain a full-time Chief Health Equity Officer who has the necessary qualifications or training at the time of hire or within one year of hire to meet the requirements of the position. *(Contract, Exhibit A, Attachment III, Section 1.1.7)*

The Plan must appoint a physician as Medical Director pursuant to the California Code of Regulations (CCR), Title 22, section 53857, whose responsibilities must include, but should not be limited to, ensuring that medical decisions are rendered by qualified medical personnel. *(Contract, Exhibit A, Attachment III, section 1.1.6)*

The Contract Article 1.0 outlines DHCS' requirements for Plan's organization and administration including key leadership roles and the designation of a Chief Health Equity Officer having the authority to design and implement policies that ensure health equity is prioritized and addressed. (*Contract, Exhibit A, Attachment III, section 1.0)*

QIHEC means a committee facilitated by contractor's Medical Director, or the Medical Director's designee, in collaboration with the Chief Health Equity Officer that meets at least quarterly to direct all Quality Improvement and Health Equity Transformation Program (QIHETP) findings and required actions. *(Contract, Exhibit A, Attachment I, Section 1.0)*

The Plan must maintain a QIHETP which includes the following, at a minimum:

A. Oversight and participation of the Plan's Governing Board.
B. Creation and designation of a QIHEC whose activities are supervised by the Plan's Medical Director or the Medical Director's designee, in collaboration with Plan's Chief Health Equity Officer.
C. Supervision of QIHETP activities by the Plan's Medical Director and the Chief Health Equity Officer.

(Contract, Exhibit A, Attachment III, section 2.2.1)

The Plan must implement and maintain a QIHEC designated and overseen by its Governing Board. The Plan's Medical Director or the Medical Director's designee must

head the QIHEC in collaboration with the contractor's Chief Health Equity Officer. *(Contract, Exhibit A, Attachment III, section 2.2.3)*

Finding: The Plan did not designate a full-time Chief Health Equity Officer who could collaborate with the Plan's Medical Director to direct the Plan's QIHEC activities.

The Plan lacked policies and procedures designating a full-time Chief Health Equity Officer separate from the Chief Medical Officer (CMO)/Medical Director role.

Review of the Plan's organizational chart and job duty statements revealed that the Plan established a hybrid role that assigned the titles of CMO and Chief Health Equity Officer to one person. This role is held by the Plan's CMO, and the job duty for this hybrid role includes the CMO's duties but does not specify the required responsibilities of the Chief Health Equity Officer. Since this hybrid role is filled by one person, the Plan cannot meet the following requirements:

- The Plan must appoint a physician as the Medical Director and appoint a full-time Chief Health Equity Officer.
- Additionally, QIHEC activities must be supervised by the CMO in collaboration with the Chief Health Equity Officer.

During the review, it was noted that the Contract requires the Plan to maintain a full-time Chief Health Equity Officer who has the necessary qualifications or training at the time of hire or within one year of hire to meet the requirements of the position. It is important to note that the audit team is not disputing the individual's qualifications but is specifically citing the Contract's requirement for a separate and distinct individual from the Plan's current structure.

After the exit conference, the Plan stated that they submitted organizational charts to DHCS-Program during the Operation readiness review period that specifically identified a sole resource who acted in a hybrid role as both the Plan's CMO and Chief Health Equity Officer. While the Department acknowledges it did not provide comments or requested modifications to the structure, the responsibility is on the Plan to adhere to the Contract requirements, where it clearly delineates that the Chief Health Equity Officer is a "full-time" position that works in collaboration with the CMO.

When the Plan does not have both a full-time Chief Health Equity Officer and a CMO, it may impact the oversight functions and delivery of services to members.

Recommendation: Develop policies and procedures to ensure that the Plan has a designated full-time Chief Health Equity Officer who can collaborate with the Plan's Chief Medical Director to direct the QIHEC activities.

1.5 Delegation of Utilization Management Activities

1.5.1 Referrals

The Plan must have and maintain a management and information system that supports, at a minimum: A(9) referrals including tracking of referred services to follow up with members to ensure that services were rendered; and A(11) prior authorization requests and specialty referral system as specified in *Exhibit A, Attachment III, Section 2.3. (Utilization Management Program)*. (*Contract, Exhibit A, Attachment III, section 2.1.1, A(9) and (11))*

The Plan must ensure that its UM program has a specialty referral system to track and monitor referrals requiring prior authorization by the Plan. When prior authorization is delegated to delegates and downstream subdelegates, the Plan must ensure that delegates and downstream subdelegates have systems in place to track and monitor referrals requiring prior authorization. The Plan must ensure that all network providers are aware of the specialty referral processes and tracking procedures. *(Contract Exhibit A, Attachment III, section 2.3, H)*

Plans shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the member's condition, consistent with good professional practice. Plans shall establish and maintain provider networks, policies, procedures, quality assurance monitoring systems, and processes sufficient to ensure compliance with this clinical appropriateness standard. Plans shall ensure that all plan and provider processes necessary to obtain covered health care services, including but not limited to prior authorization processes, are completed in a manner that assures the provision of covered health care services to members in a timely manner appropriate for the members condition and in compliance with the requirements of this section. *(CCR, Title 28, section 1300.67.2.2)*

The Plan has the following policies and procedures:

- *CA.UM.40 V Specialty Referral System* (revised 04/02/2024), states the following:
    - The Plan does not require prior authorization for most in-network specialist visits and in-network diagnostic services.
    - For standing referrals issued by the Plan directly, the Plan tracks the standing referral to the specialist in the medical management electronic medical record.
    - The Plan monitors and tracks internal authorizations via the electronic medical management system.

- *CA.UM.HN.27* V8 *Standing Referral to Specialty Care* (revised 02/21/2024), states that the Plan or delegated provider preferred group tracks and monitors referrals requiring prior authorization, including documentation of authorized, denied, deferred, or modified referrals, and the timeliness of the referrals.

Finding: The Plan did not ensure that its fully delegated subcontractor had a mechanism to track and monitor referrals.

During the audit, the Plan was unable to provide the requested prior authorization referral tracking reports as well as reports for open and unused referrals to demonstrate its oversight process.

In the interview, the Plan and its fully delegated subcontractor acknowledged that during the audit period neither entity had a referral tracking system and monitoring process. Additionally, in a written statement, the Plan stated that its fully delegated subcontractor did not track expired or unused prior authorizations.

The Plan has policies and procedures related to tracking and monitoring referrals. However, its fully delegated subcontractor did not follow these procedures to ensure that it had a mechanism to track referrals during the audit period.

When the Plan does not maintain oversight of its fully delegated subcontractor's compliance with the contractual requirements of a referral tracking system, the Plan may not be able to monitor the quality of care provided and its referral system procedures.

Recommendation: Implement oversight mechanisms, policies, and procedures to ensure the fully delegated subcontractor maintains a system to track and monitor referrals in accordance with the contractual requirements.

1.5.2 Oversight of Delegation Functions

The Plan remains fully responsible for the performance of all duties and obligations it delegates to subcontractors and downstream subcontractors. *(Contract, Exhibit A, Attachment III, Section 3.1.1(B)/Delegation Oversight)*

The Plan must monitor and oversee all delegated functions, including those that may flow down to downstream subcontractors. (*Contract, Exhibit A, Attachment III, section 3.1.1(B)(3)/Delegation Oversight)*

The Plan's Delegation Oversight Monitoring program states that the program is an integral component of the Plan's comprehensive risk management and compliance

strategy. The program is specifically tailored to oversee the Plan's delegates through focused and ongoing monitoring activities. The following areas were identified as critical and high risk based on the Plan's Audit and Monitoring program: UM, appeals, COC, claims, provider dispute resolution, member services, and grievance. *(Delegation Oversight Monitoring Protocol)*

The Plan's policy and procedure, *CMP-002 Delegation Oversight* (revised 10/01/2024), states that the Plan shall provide oversight of all delegated entities, including proposed delegated entities. Such oversight shall be conducted using, without limitation, the following actions: periodic reviews and audits, and ongoing monitoring.

Finding: The Plan's monitoring and oversight of its fully delegated subcontractor and downstream subcontractor's functions were deficient.

The Plan demonstrated some elements of delegation monitoring, and oversight of contractual requirements. However, the Plan did not fully oversee its delegated subcontractor's performance of delegated functions, resulting in multiple areas of noncompliance with contractual and regulatory requirements. Specifically in the following areas:

- Written translations of NOAs
- Clear and concise communications
- Clinical criteria for utilization/care management decisions

The Plan did not fully monitor its delegated subcontractor's compliance with delegated responsibilities. Oversight activities such as annual delegation audits, corrective action follow-up, and performance monitoring were either not conducted or inadequately documented. Additionally, it was noted that the Plan made the decision to delay its annual delegate audit to support the Department's audit. However, the Department's expectation is that once approved for operations, the Plan should be compliant with the Contract requirements from the beginning.

The Plan did not ensure that its fully delegated subcontractor consistently translated NOA letters in the member's threshold language. In some instances, a member did not receive a letter, or the letter was not translated, or it was delayed. During the interview, the Plan stated that it did not review the translation of letters into the required threshold language in its oversight review.

The Plan did not ensure that its fully delegated subcontractor consistently used clear and concise language in member letters and communicated the decision on prior authorizations, quality-of-care grievances, and potential quality issues. During the

interview, the Plan stated that its oversight focus was on quantitative data review, and it did not include review of the member letters.

The Plan had a systemic issue related to the use of inconsistent application of criteria and determination of medical necessity for prior authorizations and appeals. The Plan has policies and procedures, *GA-002 Appeal Process*, *CA.UM.03 V5 Clinical Criteria for Utilization/Care Management Decisions*, and *CMP-002 Delegation Oversight*. However, the Plan did not provide oversight to ensure consistent application of criteria and determination of medical necessity in UM decisions. During the interview, the Plan stated that it did not review medical necessity criteria for appeals and prior authorizations in its oversight review.

When the Plan does not fully monitor and oversee its delegated functions, it may result in delayed or inappropriate care for members, potentially leading to adverse health outcomes, including member harm.

Recommendation: Ensure the Plan monitors and oversees its fully delegated subcontractor and downstream subcontractors' functions, including implementing policies and procedures.

COMPLIANCE AUDIT FINDINGS

Category 2 – Population Health Management and Coordination of Care

2.1 California Children Services

2.1.1 California Children's Services Care Coordination

The requirement is that once eligibility for the CCS program is established for a member, the Plan must ensure the coordination of services and joint case management between the member's PCP, CCS providers, and the local CCS program. The Plan must continue to provide case management services to ensure all covered services authorized through the CCS program are provided timely. (*Contract Exhibit A, Attachment III, section 4.3.14 (A)(6))*

For additional Contract criteria, reference Section 1.5.2 on Delegation Oversight *(Contract, Exhibit A, Attachment III, Section 3.1.1(B) Delegation Oversight; Delegation Oversight Monitoring Protocol/Delegation Oversight;* and Plan policy and procedure, *CMP-002 Delegation Oversight).*

The following policies and procedures were submitted as evidence of internal guidance related to CCS care coordination. These documents outline referral protocols, coordination expectations, tracking mechanisms, and requirements specific to CCS-eligible members:

- *CA.CM.02.13 California Children Services (CCS)* (revised 01/26/2024) describes CCS referral and coordination process, including eligibility, provider coordination, and avoidance of service duplication.
- CC.CM.02 *Care Coordination/Care Management* Services (revised 01/15/2025), defines care coordination approach, including risk stratification, ICT involvement, and service tracking.
- Addendum to *CC.CM.02 Care Coordination/Care Management Services* (date of creation or last revision not specified in the document), addresses California-specific CCS requirements using Population Health Management tools to identify and track CCS-eligible members.
- *CA.LTSS.06 V11 California Children's Services* (revised 01/13/2025), details expectations for seamless transitions and coordination across CCS and Medi-Cal providers, including outreach and service tracking.

Finding: The Plan did not ensure that its fully delegated subcontractor consistently conducted care coordination and joint case management between the member's PCP, CCS providers, and the local CCS program once CCS eligibility is established as required.

The Plan has several policies and procedures for CCS care coordination; however, the fully delegated subcontractor staff did not follow these procedures when providing services to CCS members. In the verification study, 4 out of 15 samples revealed that the fully delegated subcontractor exhibited repeated deficiencies in CCS coordination and documentation. The following issues were identified:

- Late service authorization request submissions led to CCS denials for services that had already been rendered.
- Missing baseline diagnostic documentation, essential for determining CCS eligibility.
- Lack of case management involvement or follow-up after CCS denials.
- No internal case notes, tracking logs, or documentation indicating COC or timely access to services.

These findings point to systemic breakdowns in the fully delegated subcontractors' referral workflows, documentation practices, and internal oversight processes related to CCS cases. The absence of documented coordination may have contributed to delays in service delivery and fragmented care for affected members.

During the interview, the Plan stated that during the audit period, it did not monitor or provide oversight of CCS-related delegated functions and file reviews.

The *Delegation Oversight Monitoring Protocol* did not include a review of CCS monitoring activities, and qualitative reviews like file-level validation.

When the Plan and its fully delegated subcontractor do not ensure coordination of services and joint case management between the member's PCP, CCS providers, and the local CCS program, it may lead to delays in access to CCS-authorized services and the provision of other covered services, potentially impacting the timely delivery of care for CCS members.

Recommendation: Implement policies and procedures to ensure care coordination and case management between the member's PCP, CCS providers, and the local CCS program.

2.1 Initial Health Appointment

2.1.2 Initial Health Appointment Timeliness and Outreach

The Plan must cover and ensure that IHAs are performed within 120 calendar days of enrollment with the Plan. (*Contract, Exhibit A, Attachment III, 5.3.4 (A)(1)(2) and 5.3.5 (A)(1))*

The Plan must make reasonable attempts to contact a member to schedule an IHA. The Plan must document all attempts to contact a member. Documented attempts that demonstrate the Plan's efforts to unsuccessfully contact a member and schedule an IHA will be considered evidence in meeting this requirement. *(Contract, Exhibit A, Attachment III, 5.3.3 (C))*

For additional Contract criteria, reference Section 1.5.2 on Delegation Oversight *(Contract, Exhibit A, Attachment III, Section 3.1.1(B) Delegation Oversight; Delegation Oversight Monitoring Protocol/Delegation Oversight;* and Plan policy and procedure, *CMP-002 Delegation Oversight).*

The following documents were submitted by the Plan to outline the Plan's requirements, expectations, provider-facing guidance related to the timely completion of IHAs, member outreach for scheduling IHAs, required outreach activities, documentation standards, and use of support tools:

- *Initial Health Appointment and Dental Assessment* (no policy number (revised 01/2024)*):*
  - Requires completion of the IHA within 120 days of member enrollment.
  - Describes provider expectations, outreach timelines (e.g., follow-up call by day 75), and corrective actions for noncompliance.
  - Requires member outreach to include a welcome packet, automated/live calls, and a follow-up call by day 75 if the IHA has not been completed.
  - Missed IHA cases (beyond 120 days) are identified through provider portal reports and addressed via outreach and health education follow-up.
  - The policy explicitly states that three outreach attempts must be tracked monthly and analyzed annually to demonstrate compliance, confirming that outreach efforts are not only required but must be documented and monitored.
- *CA.CM.01.08 New Member Welcome Call* (revised 04/02/2024), includes:
  - Scripted welcome call content that reminds members to complete their IHA within 120 calendar days of enrollment or within American Academy

of Pediatrics periodicity guidelines for children under age two, whichever is sooner.
    - Outlines monthly outreach activities for new members, including two automated welcome calls using approved scripts that inform members about the IHA requirement and offer the option to speak with a call center agent.
    - For seniors and persons with disabilities, the policy requires a minimum of three outreach attempts within 60 calendar days (or 30 days for high-risk members) using the Proactive Outreach Manager. Outreach staff also offer PCP scheduling assistance and may resend welcome packets.
    - The policy clearly specifies that successful outreach attempts are documented in the member's electronic record (TruCare), and unsuccessful attempts are logged in dialer data-automated system logs that track call attempts and outcomes.
    - Despite two separate requests, the Plan did not submit any documentation from either source (TruCare or dialer data) to demonstrate compliance with these outreach requirements, preventing verification of performance against their own stated protocols.

Finding: The Plan did not ensure that its fully delegated subcontractor consistently performed an IHA within 120 calendar days of enrollment, made reasonable attempts to contact members to schedule an IHA, or document all outreach attempts.

In the verification study, a review of 20 IHA medical records indicated the following:

- Seven out of 20 medical records had IHAs completed beyond the required 120 calendar day timeframe.
- Eight out of 20 did not have any medical records available for review to verify whether an IHA was completed or whether outreach efforts were made to facilitate a timely assessment.

The Plan is required to maintain medical records to support the performance of IHA and document outreach efforts for IHA members. Outreach records were requested twice; however, no supporting documents were provided. This absence of documentation suggests that the Plan did not adequately track or perform member outreach to support the timely completion of IHAs.

During the interview, the Plan stated that it relies on its fully delegated subcontractor to perform all outreach functions related to IHAs and acknowledged that it did not monitor subcontractor IHA activities during the audit period. The Plan further confirmed that it

did not conduct direct oversight, validation, or review of the subcontractor's IHA compliance or medical record review findings related to this section.

This acknowledgment establishes a lack of delegation oversight and demonstrates ongoing noncompliance with contractual requirements for IHA timeliness and monitoring. Although the Plan maintains IHA policies and a *Delegation Oversight Monitoring Protocol*, these were not operationalized. The Plan's absence of monitoring or validating subcontractor performance resulted in no documented assurance that IHAs were completed within 120 calendar days of enrollment.

When the Plan and its fully delegated subcontractor do not ensure that IHAs are performed within 120 calendar days of enrollment and do not conduct and document outreach attempts, it can lead to delays in the identification of health risks and care needs and may impact the quality and COC for new members.

Recommendation: Implement oversight mechanisms, policies, and procedures to ensure that its fully delegated subcontractor consistently completes IHAs within 120 calendar days of member enrollment, makes reasonable attempts to contact members for scheduling, and documents all outreach attempts.

2.1.3 Blood Lead Screening Test

The Plan must comply with all DHCS guidance, including but not limited to APLs, Policy Letters, the California Medicaid State Plan, and the Medi-Cal Provider Manual. (*Contract, Exhibit E, section 1.1.2)*

The Plan must cover and ensure the provision of blood lead screening tests to members at the ages and intervals specified in accordance with *APL 20-016, Blood Lead Screening of Young Children* (11/02/2020). (*Contract, Exhibit A, Attachment III, section 5.3.4 (D)(1))*

The Plan must ensure that its network providers order or perform blood lead screening tests on all children in accordance with the following:

- At 12 months and at 24 months of age.
- When the health care provider performing a Periodic Health Assessment (PHA) becomes aware that a child 12 to 24 months of age has no documented evidence of blood lead screening test taken at 12 months of age or thereafter.
- When the network provider performing a PHA becomes aware that a child member 24 to 72 months of age has no documented evidence of a blood lead screening test taken.

- At any time, a change in circumstances has, in the professional judgement of the network provider, put the child member at risk.
- If requested by the parent or guardian.

(*APL 20-016, Blood Lead Screening of Young Children* (11/02/2020)*)*

For additional Contract criteria, reference Section 1.5.2 on Delegation Oversight *(Contract, Exhibit A, Attachment III, Section 3.1.1(B) Delegation Oversight; Delegation Oversight Monitoring Protocol/Delegation Oversight;* and Plan policy and procedure, *CMP-002 Delegation Oversight).*

The Plan has the following documentation outlining its requirements for Blood Lead Level (BLL) testing in accordance with APL 20-016 and Contract provisions. The documentation reflects expectations for timely screening, catch-up testing, member education, including expectations for provider education as summarized below:

- Policy and procedure, *CA.QI.02 Childhood Blood Lead Screening* (revised 02/18/2025):
  - Requires screening at 12 and 24 months.
  - Catch-up testing allowed up to 72 months.
  - Quarterly compliance monitoring and provider notification.
- Provider Manual (printed 2024):
  - Requires BLL testing at 12 and 24 months.
  - Catch-up testing for children aged 12 to 72 months without prior BLL documented.
  - Refusals must be documented.

Finding: The Plan did not ensure that its fully delegated subcontractor consistently conducted blood lead screening tests on members at one and two years of age, including up to six years of age as specified in APL 20-016.

The Plan and the fully delegated subcontractor did not follow policy and procedure *CA.QI.02 Childhood Blood Lead Screening* and Provider Manual to conduct blood lead screening tests. A review of six out of nine samples lacked documentation for completed blood lead screening tests. Although most of the non-compliant samples involved members ages three to five years beyond the routine testing ages of 12 and 24 months, APL 20-016 requires documentation of prior blood lead screening tests, efforts to obtain historical test results, or a documented test refusal. However, no such documentation was found.

During the interview, the Plan acknowledged that oversight of blood lead screening activities was not conducted during the audit period. The Plan did not assess whether the delegated subcontractor monitored provider-level blood lead screening tests. Furthermore, in a written statement, the Plan confirmed that it did not conduct any care management file reviews related to blood lead screening tests during the audit period. This acknowledgment establishes noncompliance with contractual requirements for delegated oversight and prevents assurance that blood lead screening tests were consistently conducted.

When the Plan and its fully delegated subcontractor do not ensure that blood lead screening tests are conducted at required well-child visits, it may result in missed opportunities for early detection and intervention of lead exposure risks.

Recommendation: Implement oversight mechanisms, policies, and procedures to ensure that the provision of blood lead screening tests are conducted in accordance with APL requirements.

2.1.4 Blood Lead Anticipatory Guidance

The Plan must comply with all DHCS guidance, including but not limited to APLs, Policy Letters, the California Medicaid

State Plan, and the Medi-Cal Provider Manual. (*Contract, Exhibit E, section 1.1.2)*

The Plan is required to provide oral or written anticipatory guidance to the parent(s) or guardian(s) of a child that at a minimum, includes information that children can be harmed by exposure to lead. This anticipatory guidance must be provided to parents or guardians at each PHA, starting at six months of age and continuing until six years of age. (*APL 20-016, Blood Lead Screening of Young Children* (11/02/2020)*)*

For additional Contract criteria, reference Section 1.5.2 on Delegation Oversight *(Contract, Exhibit A, Attachment III, Section 3.1.1(B) Delegation Oversight; Delegation Oversight Monitoring Protocol/Delegation Oversight;* and Plan policy and procedure, *CMP-002 Delegation Oversight).*

The Plan has the following documentation outlining its requirements for providing oral or written anticipatory guidance to the parent(s) or guardian(s) of a child in accordance with APL 20-016 requirements as summarized below:

- Policy and procedure, *CA.QI.02 Childhood Blood Lead Screening* (revised 02/18/2025) states the Plan ensures member education on lead exposure risks and testing through anticipatory guidance starting at 6 months of age.
- Provider Manual (printed 2024) requires providers to offer and document anticipatory guidance on lead exposure risks.

Finding: The Plan did not ensure that its fully delegated subcontractor consistently provided oral or written blood lead anticipatory guidance to the parent or guardian of members as specified in APL 20-016.

The Plan and the fully delegated subcontractor did not follow policy and procedure *CA.QI.02, Childhood Blood Lead Screening* and Provider Manual, related to providing anticipatory guidance. A review of eight out of nine samples demonstrated a lack of any evidence of anticipatory guidance.

During the interview, the Plan acknowledged that oversight of blood lead screening activities was not conducted during the audit period. The Plan did not monitor whether the delegated subcontractor assessed provider-level documentation of blood lead anticipatory guidance during well-child visits. Furthermore, in a written statement, the Plan confirmed that it did not conduct any care management file reviews related to blood lead anticipatory guidance during the audit period.

This acknowledgment establishes noncompliance with contractual requirements for delegated oversight and prevents assurance that oral or written blood lead anticipatory guidance was consistently provided to members.

When the Plan and its fully delegated subcontractor do not provide oral or written blood lead anticipatory guidance at required well-child visits, it may result in missed opportunities to educate families on lead exposure risks, potentially delaying prevention or early detection of lead poisoning in young children.

Recommendation: Implement oversight mechanisms, policies, and procedures to ensure that the provision of blood lead anticipatory guidance is provided in accordance with APL requirements.

2.3 Behavioral Health Treatment

2.3.1 Behavioral Health Treatment Plan

The member's treatment plan must be reviewed, revised, and/or modified at least every six months by a BHT service provider. (*Contract, Exhibit A, Attachment III, 5.3.4 (F)(2))*

For additional Contract criteria, reference Section 1.5.2 on Delegation Oversight *(Contract, Exhibit A, Attachment III, Section 3.1.1(B) Delegation Oversight; Delegation Oversight Monitoring Protocol/Delegation Oversight;* and Plan policy and procedure, *CMP-002 Delegation Oversight).*

The Plan's following policies and procedures, and documentation reflect the requirement for timely reassessment of BHT:

- *CBH.UM.136 Responsibilities for BHT Coverage for Members under the Early and Periodic Screening, Diagnostic, and Treatment Benefit* (revised 12/19/2024) explicitly requires treatment plan reviews every six months and references coordination and corrective actions, reinforcing the Plan's obligation to ensure timely reassessment.
- *CHPIV BH-001 Behavioral Health* (effective 05/13/2024) reiterates the six-month review requirement for treatment plans and emphasizes that BHT services may only be modified or discontinued if no longer medically necessary, in line with Early and Periodic Screening, Diagnostic, and Treatment standards.
- Provider Manual (printed 2024), outlines provider responsibilities and authorization processes, including treatment plan and reassessment procedures under Medi-Cal BHT requirements.

Finding: The Plan did not ensure that its fully delegated subcontractor consistently fulfilled the requirement that a BHT service provider reviewed, revised, and/or modified the member's treatment plan at least every six months.

The Plan and the fully delegated subcontractor did not follow policy and procedure *CBH.UM.136 Responsibilities for BHT Coverage for Members under the Early and Periodic Screening, Diagnostic, and Treatment Benefit, CHPIV BH-00 Behavioral Health,* and Provider Manual. In the verification study, two out of the ten BHT samples revealed that the Plan's fully delegated subcontractor did not complete the required six-month reassessment of the member's treatment plan. For example:

- Sample 1: The initial BHT assessment and treatment plan for this member was completed on January 31, 2024. The six-month reassessment should have been conducted by July 31, 2024, or at the latest by September 30, 2024. However, no documentation for a six-month reassessment was provided.
- Sample 2: The initial BHT assessment and treatment plan were completed on February 2, 2024. Accordingly, the six-month reassessment was due by August 2, 2024, or no later than September 2, 2024. However, no documentation for a six-month reassessment was found for this sample.

In interviews, the Plan stated that oversight of its fully delegated subcontractor was limited to general reporting mechanisms such as utilization reports, dashboards, and webinars. However, the Plan acknowledged that it did not conduct BHT-specific oversight, such as case file reviews or validation of six-month reassessments. The case management team, which should be responsible for monitoring reassessments and ensuring treatment plans are current, did not perform this function. As a result, the Plan could not demonstrate how compliance with reassessment requirements was being monitored.

The subcontractor also stated that it issues automated alerts to notify providers of upcoming treatment plan expirations. Despite having this mechanism in place, the subcontractor did not provide evidence to demonstrate that reassessments were completed on time.

When the Plan and its fully delegated subcontractor do not ensure timely six-month reassessments of BHT plans, members may continue services that are no longer clinically appropriate or miss needed adjustments in care. This may lead to suboptimal treatment outcomes, unnecessary utilization, or gaps in medically necessary services for children with autism spectrum disorder.

Recommendation: Implement oversight mechanisms, policies, and procedures to ensure that the fully delegated subcontractors comply with requirements that treatment plans for BHT services are reviewed, revised, and/or modified at least every six months by a qualified BHT service provider, in accordance with contractual obligations.

2.4 Continuity of Care

2.4.1 Member Notifications for Denied Services

The Plan must allow all members to request COC in accordance with Code of Federal Regulations (CFR), Title 42, section 438.62 and *APL 23-022, Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or After January 1, 2023* (08/15/2023). (*Contract Exhibit A, Attachment III, section 5.2.12 B)*

A COC request is considered complete when the Plan notifies the member of the Plan's decision. The Plan must attempt to notify the member of the COC decision via the member's preferred method of communication or by telephone. The Plan must also send a notice by mail to the member within seven calendar days of the COC decision.

(APL 23-022, Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or After January 1, 2023 (08/15/2023))

For additional Contract criteria, reference Section 1.5.2 on Delegation Oversight *(Contract, Exhibit A, Attachment III, Section 3.1.1(B) Delegation Oversight; Delegation Oversight Monitoring Protocol/Delegation Oversight;* and Plan policy and procedure, *CMP-002 Delegation Oversight).*

Plan policy and procedure, *CA.UM.20, Continuity of Care* (revised 10/30/2024), states as follows:

a. The Plan notifies members and providers of COC decisions as follows: for non-urgent requests, within seven calendar days of the decision.
b. Upon determination of a COC request, the Plan will notify the member using the member's known preferred method of communication, or by using one of these methods: telephone call, text message, e-mail, followed by notification by mail.

Finding: The Plan did not monitor its fully delegated subcontractor to ensure compliance with COC requirements by consistently mailing a written notice of the denial to the member.

The Plan and its fully delegated subcontractor staff did not follow the policy and procedure for *CA.UM.20 Continuity of Care*. In the verification study, a review of 11 verification samples found 6 cases in which the denial of COC services was not mailed to members. The case manager's notes indicated that members were contacted by phone to communicate the decision regarding the denial of services. However, no COC denial decision notices were mailed to the members.

In a written statement and during the interview, the Plan and the fully delegated subcontractor stated that the team reviews the type of services and verifies the type of provider to ensure that it is an eligible COC provider. Members will be informed of the decision via telephone and educated on the other options available to them. In addition, the Plan stated that when the COC criteria are not met, the Plan notifies the member by telephone and then cancels the COC request without mailing the decision to the member. The Plan's practice of canceling COC services without mailing the decision letter indicates the Plan's noncompliance with the COC contractual requirements.

Without COC notification of the Plan and its fully delegated subcontractor's decision, medically necessary services for the member may be delayed, causing a setback in the member's treatment.

Recommendation: Implement policy and procedure to ensure that the fully delegated subcontractor mails notices of denied decisions to the member.

2.5 Mental Health and Substance Use Disorder

2.5.1 Coordination of Concurrent Services

The Plan must ensure members have access to needed services, including care coordination, navigation, and referrals to services that address members' developmental, physical, mental health, substance use disorder, dementia, long term support service, palliative care, and oral health needs. *(Contract, Exhibit A, Attachment III, section 4.3.8(A)(2))*

The Plan must have policies and procedures to ensure medically necessary NSMHS and SMHS provided concurrently are coordinated and non-duplicative. (*Contract, Exhibit A, Attachment III, section 5.6.2(B)(1)(g))*

For additional Contract criteria, reference Section 1.5.2 on Delegation Oversight *(Contract, Exhibit A, Attachment III, Section 3.1.1(B) Delegation Oversight; Delegation Oversight Monitoring Protocol/Delegation Oversight;* and Plan policy and procedure, *CMP-002 Delegation Oversight).*

Any concurrent NSMHS and SMHS for adults, as well as children under 21 years of age, must be coordinated between the Plan and Mental Health Plans (MHPs) to ensure member choice. The Plan must coordinate with MHPs to facilitate care transitions and guide referrals for members receiving NSMHS to transition to a SMHS provider and vice versa, ensuring that the referral loop is closed, and the new provider accepts the care of the member. Such decisions should be made via a patient-centered shared decision-making process. *(APL-22-005, No Wrong Door for Mental Health Services Policy* (03/30/2022)*)*

The memorandum of understanding requires a process for coordinating care for individuals who meet access criteria for and are concurrently receiving NSMHS and SMHS to ensure the care is clinically appropriate and non-duplicative and considers the member's established therapeutic relationships. (*Memorandum of Understanding Between Plan, the Fully Delegated Subcontractor and the County of Imperial Mental Health Plan, section 9(b)(iv)(2))*

The Plan has the following policies and procedures and documents that address screening, referrals, care coordination, and oversight responsibilities related to MHSUD services:

- *CA.CM.02.08 Referrals to Specialty Mental Health, Alcohol, and Substance Abuse Treatment Services* (revised 06/04/2024*),* outlines the referral processes for specialty MHSUD treatment services, affirming the Plan's responsibility to ensure members are referred appropriately to county MHPs or other systems based on clinical need.
- *BH-001 Behavioral Health* (effective 05/13/2024)*, o*utlines the Plan's oversight responsibility MHSUD services and delegates operations to the fully delegated subcontractor.
- *CBH.UM.140 Medi-Cal Screening, Assessment, and Referral Processes* (revised 11/19/2024), details the required processes for screening and referrals for MHSUD services, including coordination with county MHPs.

Finding: The Plan did not verify that its fully delegated subcontractor had oversight mechanisms, policies, and procedures to ensure the subcontractor consistently provided members with access to needed services, including care coordination, navigation, and referrals for MHSUD needs.

A review of three concurrent NSMHS and SMHS samples demonstrated the following:

- Sample 1: Was a cold transfer to the county, showing a lack of close loop coordination and no documentation of an appointment outcome.
- Sample 2: The Plan referred the member to inpatient detox but did not complete a transition of care tool or initiate direct coordination with the county for post-detox services. The burden of follow-up was placed entirely on the member, with no documented referral, warm handoff, or appointment outcome.
- Sample 3: The Plan did not confirm whether the member was linked to services. A missing release of information was noted but not resolved, and there was no documented strategy to ensure care engagement.

All three cases indicated consistent problems with a lack of care coordination, especially in ensuring successful referral completion and confirming member access to services across different delivery systems.

During interviews, the Plan stated that it relied solely on its fully delegated subcontractor for MHSUD service delivery and did not conduct oversight activities.

Policies and procedures, *CA.CM.02.08 Referrals to Specialty Mental Health, Alcohol, and Substance Abuse Treatment Services*, *BH-001 Behavioral Health Policy*, and *CBH.UM.140 Medi-Cal Screening, Assessment, and Referral Process,* require the Plan to monitor

referrals, assess member needs, and ensure care coordination. These provisions were not implemented. Review of submitted documents showed the Plan did not:

- Perform care management case file reviews to confirm referrals were completed.
- Validate whether the subcontractor resolved release of information barriers or facilitated timely referrals.
- Ensure documentation of care coordination between the MHP liaison and subcontractor staff.

As a result, the Plan could not demonstrate compliance with oversight of the fully delegated subcontractor, leading to gaps in member care coordination and referral tracking.

When the Plan does not oversee its fully delegated subcontractor's provision of MHSUD services, members may experience delay in care, missed referrals, and uncoordinated treatment.

Recommendation: Implement oversight mechanisms, policies, and procedures to ensure the fully delegated subcontractor consistently provides the members with access to needed services, including care coordination, navigation, and referrals for MHSUD needs.

2.6 Enhanced Care Management

2.6.1 Enhanced Care Management Core Service Components

The Plan is required to follow all provisions in the ECM Policy Guide, in addition to provisions outlined in the Contract. *(Contract Exhibit A, Attachment III, sections 4.4.1 and 4.4.11)*

The Plan is required to perform oversight of ECM providers, holding them accountable to all ECM requirements contained in the Contract, the DHCS' policies and guidance, APLs, and the Plan's Model of Care. *(Contract, Exhibit A, Attachment III, 4.4.13)*

The Plan is required to provide the following ECM core service components, which include:

- A Comprehensive Assessment and CMP, which must include, but is not limited to: Identifying necessary clinical resources that may be needed to appropriately assess member health status and gaps in care and may be needed to inform the development of an individualized CMP.

- ECM requires Member and Family Supports which includes ensuring that the member and their family members, legal guardians, authorized representatives, caregivers, and authorized support persons, as applicable, have a copy of the member's CMP and information about how to request updates.

(*APL 23-032, Enhanced Care Management Requirements* (12/22/2023)*)*

Plan policy and procedure, *CA.SOC.02 v5 Enhanced Care Management Program Overview and Requirements* (revised 10/04/2023), states as follows*:*

- The section related to ECM core service for Member and Family Supports states the ECM provider is responsible for working with the member's chosen caregiver(s) or family support person, including guardians. This collaboration includes: Ensuring that the member has a copy of his/her care plan and information about how to request updates.
- The section titled Comprehensive Assessment and CMP states the ECM provider/care manager will conduct the comprehensive assessment and care plan in accordance with federal and state regulatory requirements.

Finding: The Plan did not ensure that the fully delegated subcontractor provided ECM core service components, including the comprehensive assessment, CMP, and Member and Family Supports.

The Plan and its fully delegated subcontractor staff did not follow the policy and procedure *Enhanced Care Management Program Overview and Requirements*. In the verification study a review of the eight medical records revealed the following:

- Two out of eight records did not include a CMP.
- Two out of eight records lacked documentation confirming that a copy of the CMP had been provided to the members' authorized support persons, as well as information about how to request updates.

The provider used the eligibility form *(ILS-CA Eligibility Review v3)*, which was filled out by non-clinical staff. A review of two out of eight medical records showed that some of the clinical and non-clinical needs of a member were not addressed, and the following are examples of the review:

- In one case, the member had high blood pressure, needed knee surgery, and had depression. In addition, a member needed food assistance.
- In one case, the member had problems with the nervous system, hip, spinal cord, depression, and anxiety. In addition, a member needed assistance with housing and food.

A comprehensive assessment is necessary to develop an individualized CMP that addresses both clinical and non-clinical care coordination needs. The Plan did not address the clinical and non-clinical needs requiring care coordination.

During the interview, the Plan and its fully delegated subcontractor acknowledged that team members were forgetting to include a CMP in care plans. As a result, the Plan acknowledged an opportunity for improvement in the ECM process.

When the Plan and its fully delegated subcontractor do not provide all ECM core service components, members may not receive coordination of services and comprehensive care management, resulting in adverse health outcomes and the inability to make informed decisions.

Recommendation: Implement policies and procedures to ensure that the fully delegated subcontractor provides all ECM core service components, including a comprehensive assessment, CMP, and Member and Family Supports.

COMPLIANCE AUDIT FINDINGS

Category 3 – Network and Access to Care

3.8 Non-Emergency Medical Transportation and Non-Medical Transportation

3.8.1 Insufficient Documentation

The Plan must cover transportation services as required in the Contract and directed in *APL 22-008, Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses* (05/18/2022), to ensure members have access to all medically necessary services. (*Contract, Exhibit A, Attachment III, section 5.3.4, part I)*

The Plan is required to provide medically necessary NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for obtaining medically necessary services. The Plan is required to provide NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches. The Plan must also have processes in place to ensure door-to-door assistance is being provided for all members receiving NEMT services. (*APL 22-008, Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses* (05/18/2022))

Plan policy and procedure, *CA. LTSS.15 Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT)* (revised 10/10/2024), states that the Plan provides medically necessary NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services. The Plan provides NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches. The Plan ensures door-to-door assistance is provided for all members receiving NEMT services**.**

Finding: The Plan did not provide sufficient documentation to demonstrate that its delegate and downstream subcontractor had a process in place to ensure NEMT door-to-door assistance for all members receiving medically necessary NEMT services.

According to APL 22-008, the Plan must maintain processes to ensure door-to-door assistance is provided for all members receiving Non-Emergency Medical Transportation (NEMT) services when medically necessary.

A review of the Plan's three-phase pre-delegation audit reports indicated that the Plan did not conduct a review of NEMT and NMT services for its fully delegated subcontractor.

Review of the Vendor Oversight Committee (VOC) meeting minutes reflects ongoing discussions held from January through December 2024 between the delegate and the downstream subcontractor. These discussions, however, were limited to establishing a specific complaint category for tracking door-to-door service complaints.

During the review, the Plan did not provide sufficient documentation to demonstrate monitoring of its subdelegated activities related to NEMT door-to-door services.

Although information was requested during the audit, the Plan did not provide adequate evidence that would outline how delegated subcontractor staff verified medical necessity and ensured that NEMT door-to-door assistance was provided in accordance with the member requests.

After the exit conference, the Plan provided a spreadsheet listing its members who received door-to-door services. It was noted that all door-to-door requests were rendered under the Non-Medical Transportation (NMT). While this data reflects completed trips, the documentation did not demonstrate how the delegated subcontractor complied with NEMT door-to-door requirements.

The Plan lacked oversight to verify that subcontractors followed the required processes for providing door-to-door assistance in accordance with medical necessity.

Without adequate documentation and monitoring procedures, the audit could not confirm whether NEMT door-to-door assistance was consistently provided in accordance with the member's medical necessity. This creates a risk of gaps in service delivery for members who need specialized transportation.

Recommendation: Implement oversight mechanisms, policies, and procedures to ensure the Plan's delegate and downstream subcontractors' NEMT door-to-door requests are supported by documentation demonstrating medical necessity.

COMPLIANCE AUDIT FINDINGS

Category 4 – Grievances, Appeals, and Member Rights

4.1 Grievances and Appeals

4.1.1 Discrimination of Grievance

Within ten calendar days of mailing a Discrimination Grievance Resolution letter, the Plan must submit information regarding the discrimination grievance to the DHCS OCR, as specified in *APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services,* (05/24/2023). *(Contract, Exhibit A, Attachment III, section 4.6.3(C))*

For additional Contract criteria, reference Section 1.5.2 on Delegation Oversight *(Contract, Exhibit A, Attachment III, Section 3.1.1(B) Delegation Oversight; Delegation Oversight Monitoring Protocol/Delegation Oversight;* and Plan policy and procedure, *CMP-002 Delegation Oversight).*

The Plan must provide written translations of member information in the threshold and concentration languages identified in the APL in the DHCS Threshold and Concentration Language Requirements section. Within ten calendar days of mailing a Discrimination Grievance Resolution letter to a member. The managed care health plans must submit detailed information regarding the grievance to DHCS OCR's designated discrimination grievance email box. (*APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance* Services (05/24/2023)*)*

The Plan's Appeals and Grievance Department had the following policies and procedures:

- *GA-001 Grievance Process* (revised 11/18/2024), states that the Plan ensures grievances alleging discrimination are forwarded to the DHCS OCR. The procedure section states that the Plan shall provide oversight and continually assess the delegated functions, responsibilities, processes, and performance of the fully delegated subcontractor.
- *CA.AG.35 Medi-Cal Grievance Process* (revised 12/12/2024), states that all grievances reviewed and resolved alleging discrimination against members or eligible beneficiaries because of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability shall be forwarded by the fully delegated subcontractor's

Compliance Department to DHCS OCR for review and appropriate action within ten calendar days of mailing the resolution letter to the member.

Finding: The Plan did not ensure that its fully delegated subcontractor reported discrimination grievances to the DHCS OCR within ten calendar days of mailing a Discrimination Grievance Resolution letter to a member.

The Plan and its fully delegated subcontractor staff did not follow the procedure to report the discrimination grievance to the DHCS OCR. In the verification study a review of four cultural and linguistic grievance files demonstrated the presence of discrimination in the following three files:

- One file had supporting documentation, which included an e-mail to DHCS OCR without a date.
- Two files did not have supporting documentation indicating that these were reported to DHCS OCR.

The Plan's fully delegated subcontractor's Appeals and Grievances Department identified discrimination in complaints filed by members. The member's discrimination grievance was resolved within the required time frame; however, the Plan's fully delegated subcontractor did not report to the DHCS OCR within ten calendar days from the resolution letter.

During the interview, the Plan and its fully delegated subcontractor stated that they did not report these discrimination grievances to the DHCS OCR. The Plan stated that it was the responsibility of the subdelegate's Compliance staff to report to the DHCS OCR in accordance with the Plan's subcontract agreement. Additionally, the Plan did not fully oversee and monitor its fully delegated subcontractor's delegated functions.

Additionally, the Plan policy and procedure, *GA-001 Grievance Process* (revised 11/18/2024), does not include a required reporting timeframe for discrimination grievances.

When the Plan and its fully delegated subcontractor do not report discrimination grievances to DHCS OCR, it may prevent DHCS OCR from addressing members' discriminatory concerns.

Recommendation: Revise and implement policies and procedures to ensure that the fully delegated subcontractor reports discrimination grievances to DHCS OCR within ten calendar days of mailing a Discrimination Grievance Resolution letter to a member.

4.1.2 Notification of Member Rights

For covered services the Plan must have in place a member grievance and appeal system that complies with CFR, Title 42, sections 438.228 and 438.400 - 424, CCR, Title 28, sections 1300.68 and 1300.68.01, and CCR, Title 22, section 53858. *(Contract, Exhibit A, Attachment III, section 4.6.1)*

The Plan shall resolve each grievance and provide notice to the member as quickly as the member's health condition requires, within 30 calendar days from the date the Plan receives the grievance. The Plan is required to notify the member of the grievance resolution in a written member notice. *(CCR, Title 28, section 1300.68 (a) and (d)(3))*

Grievances that are not resolved within 30 calendar days, or grievances referred to the Department's complaint or independent medical review system, shall be reported as "pending" grievances pursuant to subsection (f). Grievances referred to external review processes, such as reviews of Medicare Managed Care determinations pursuant to CFR, Title 42, section 422, or the Medi-Cal Fair Hearing process, shall also be reported pursuant to subsection (f) until the review and any required action by the Plan resulting from the review is completed. *(CCR, Title 28, section 1300.68 4(B))*

For additional Contract criteria, reference Section 1.5.2 on Delegation Oversight *(Contract, Exhibit A, Attachment III, Section 3.1.1(B) Delegation Oversight; Delegation Oversight Monitoring Protocol/Delegation Oversight;* and Plan policy and procedure, *CMP-002 Delegation Oversight).*

The Plan must establish, implement, maintain, and oversee a grievance and appeal system to ensure the receipt, review, and resolution of grievances and appeals. The grievance and appeal system must operate in accordance with all applicable federal and state laws. (*APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Template* (08/31/2022)*)*

Plan policy and procedure, *CA.AG.35 Appeals & Grievances Operations – Business Operations* (revised 12/12/2024), states that 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 DHCS for assistance. You may also be eligible for an independent medical review.

The Plan's process, *AG 001 Grievance Process* (revised 11/18/2024), states that the Plan shall provide oversight and continually assess the delegated functions, responsibilities, processes, and performances of the fully delegated subcontractor. The Plan shall ensure the fully delegated subcontractor complies with regulatory and contractual

requirements through the following activities: ongoing monitoring, performance reviews, data analysis, utilization of benchmarks, and annual desktop and onsite audits.

Finding: The Plan did not ensure that its fully delegated subcontractor consistently sent Transportation Grievance letters and notified members of their rights.

The Plan and its fully delegated and downstream subcontractors did not follow the established policy and procedure *CA.AG.35 Appeals & Grievances Operations – Business Operations*. A review of the 2024 Annual Audit Result Summary dated December 23, 2024, indicated that the fully delegated subcontractor staff conducted an annual audit of the transportation downstream subcontractor. The fully delegated subcontractor audit identified five transportation grievances to be resolved by the close of the next business day (exempt) that were not resolved during the audit period, and no notification was sent to the members to inform them of their rights.

The Plan delegates the grievance process to its fully delegated subcontractor. The subcontractor has a contract with the downstream entity to resolve transportation-exempt grievances within 24 hours. If the exempt grievance is not resolved within 24 hours, the downstream subcontractor is required to forward it to the fully delegated subcontractor for resolution, either as a standard or expedited grievance.

During the interview, the Plan did not respond as to why members were not notified of the unresolved grievances. In a written response, the Plan stated that grievances were six months old and that its fully delegated subcontractor did not notify members to avoid confusion.

Based on the information presented, the Plan did not detect or remediate the issue involving its fully delegated subcontractor through the ongoing monitoring process. This represents a deficiency and constitutes non-compliance with the contractual obligations set forth in the Plan's agreement with the DHCS.

When the Plan and its fully delegated subcontractor do not resolve grievances and notify members of their rights, members may not have all the information they need to make their health care decisions and pursue their rights.

Recommendation: Implement policies and procedures to ensure that its fully delegated subcontractor consistently sends Transportation Grievance letters and notifies members of their rights.

CFR Provisions-438.228 Grievance and Appeal System	Audit Applicability	Available Points	Points Scored	Comments	Additional CFR Provisions
Grievance Systems The State must ensure, through its contracts, that each MCP has in effect a grievance and appeal system that meets the requirements of subpart F of this part.	State Rule/Contract	N/A	N/A		
(b) If the State delegates to the MCP responsibility for notice of action under subpart E of part 431 of this chapter, the State must conduct random reviews of each delegated MCPand its providers and subcontractors to ensure that they are notifying enrollees in a timely manner.	State Rule/Contract	N/A	N/A		
438.402 General requirements. The grievance and appeal system. MCP must have a grievance and appeal system in place for enrollees. Non-emergency medical transportation PAHPs, as defined in § 438.9, are not subject to this subpart F. For grievances and appeals at the plan level, an applicable integrated plan as defined in § 422.561 of this chapter is not subject to this subpart F, and is instead subject to the requirements of § 422.629 through 422.636 of this chapter. For appeals of integrated reconsiderations, applicable integrated plans are subject to § 438.408(f).	Category 6: Member Rights	2	2		
438.402 Authorit	Category 6: Member Rights	2	2		CFR 438.402 - General Requirements. 438.402(c)(iii) written consent requirements.
438.406 Timely	[core bonus]	N/A	N/A		
	Category 1: UM/Appeal Procedures	2	2		
	Category 1: UM/Appeal Procedures	12	12		
	Category 1: UM/Appeal Procedures	12	12		
438.406 Handlin g of Grievanc	Category 6: Member Rights Category 1: UM/Appeal Procedures	N/A	N/A		
	Category 6: Member Rights	4	4		
	Category 1: UM/Appeal Procedures	12	12		
438.408 Resoluti on and	Category 6: Member Rights Category 1: UM/Appeal Procedures	2	2		
	Category 6: Member Rights	2	2		
	Category 1: UM/Appeal Procedures	2	2		
	Category 6: Member Rights	2	2		
	Category 1: UM/Appeal Procedures	2	2		
	Category 6: Member Rights	2	0	6.1.2 Notification of Member Rights. Plan did not ensure that its fully delegated subcontractor consistently sent transportation grievance letters and notified members of their rights.	
	Category 1: UM/Appeal Procedures	2	2		
	Category 1: UM/Appeal Procedures	2	2		
438.410 Expedited resolution of appeals.general (a) Each MCP must establish and maintain an expedited review process for	Category 6: Member Rights Category 1: UM/Appeal Procedures	2	2		
		2	2		
		2	2		
438.414 Information about the grievance	Category 6: Member Rights	2	2		
438.416 (a)Recordkeeping requirements. (a) MCPs are required to maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State's quality strategy.	Category 6: Member Rights Category 1: UM/Appeal Procedures	6	6		
438.420 Continuation of benefits while the	Category 1: UM/Appeal Procedure	2	2		
438.424 Effectuation of reversed appeal resolutions. (a) Services not furnished while the appeal is pending, if the MCP or the State fair hearing officer	Category 1: UM/Appeal Procedure	2	2		
	Total Points	80	78		

A&I Category Crosswalk	Applicable CFRs	CFR	Audit Findings
Category 1-Utilization Management	438.210; 438.230; 438.441 (EPSDT); 438.114; 438.236; 438.228 Subpart F (438.202, 404, 406, 408, 410, 414, 416, 420, 424).	§438.206 - Availability of Services	3.8.1 Insufficient Documentation. Plan did not provide sufficient documentation to demonstrate that its delegate and downstream subcontractor had a process in place to ensure NEMT door-to-door assistance for all members receiving medically necessary NEMT services.
Category 2-Case Management and Coordination of Care	438.114; 438.208; 438.210; 428.441 (EPSDT);	§438.207 - Assurance of Adequate Capacity and Services	
Category 3-Access and Availability	438.206; 438.207; 438.210	§438.208 - Coordination and Continuity of Care	2.1.1 California Children's Services Care Coordination. Plan did not ensure that its fully delegated subcontractor consistently conducted care coordination and joint case management between the member's PCP, CCS providers, and the local CCS Program once CCS eligibility is established as required. 2.1.2 Initial Health Appointment Timeliness and Outreach. Plan did not ensure that its fully delegated subcontractor consistently performed an IHA within 120 calendar days of enrollment, made reasonable attempts to contact members to schedule an IHA, or document all outreach attempts. 2.3.1 Behavioral Health Treatment (BHT) Plan. Plan did not ensure that its fully delegated subcontractor consistently fulfilled the requirement that a BHT service provider reviewed, revised, and/or modified the member's treatment plan at least every six months. 2.4.1 Member Notifications for Denied Services. Plan did not monitor its fully delegated subcontractor to ensure compliance with COC requirements by consistently mailing a written notice of the denial to the member. 2.5.1 Coordination of Concurrent Services. Plan did not verify that its fully delegated subcontractor had oversight
Category 4-Member Rights	438.100; 438.206 (c)(2); 438.208; 438.224; 438.228 Subpart F (438.202, 404, 406, 408, 410, 414, 416, 420, 424).	§438.210 - Coverage and Authorization of Services	1.5.1 Referrals. Plan did not ensure that its fully delegated subcontractor had a mechanism to track and monitor referrals. 2.1.3 Blood Lead Screening Test. Plan did not ensure that its fully delegated subcontractor consistently conducted blood lead screening tests on members at one and two years of age, including up to six years of age as specified in APL 20-016. 2.1.4 Blood Lead Anticipatory Guidance. Plan did not ensure that its fully delegated subcontractor consistently provided oral or written blood lead anticipatory guidance to the parent or guardian of members as specified in APL 20-016.
Category 5-Quality Management	438.214; 438.230; 438.330	§438.214 - Provider Selection	
Category 6-Administrative and Organizational Capacity		§438.224 - Confidentiality	
		§438.228 - Grievance and Appeals Systems	4.1.2 Notification of Member Rights. Plan did not ensure that its fully delegated subcontractor consistently sent transportation grievance letters and notified members of their rights.
		§438.230 - Sub-Contractual Relationships and Delegation	1.5.2 Oversight of Delegation Functions. Plan's monitoring and oversight of its fully delegated subcontractor and downstream subcontractor's functions were deficient.
		§438.236 - Practice Guidelines	
		§438.242 - Health Information Systems	
		§438.330 - QAPI Program	
		§438.56 - Disenrollment: Requirements and Limitations	
		§438.100 - Enrollee Rights	4.1.1 Discrimination of Grievance. Plan did not ensure that its fully delegated subcontractor reported discrimination grievances to the DHCS OCR within ten calendar days of mailing a Discrimination Grievance Resolution letter to a member.
		§438.114 - Emergency and Post-Stabilization Services	
		Unscored Findings - No Applicable CFR	1.1.1 Chief Health Equity Officer. Plan did not designate a full-time Chief Health Equity Officer who could collaborate with the Plan's Medical Director to direct the Plan's QIHEC activities.

CMS Compliance Scoring
SFY 2022-23

Compliance Score %												
Standard Number	**CFR**	**Compliance Review Standard**	**Total Points Available**	**Total Points Scored**	**CHPIV 2025**							
1	§438.206	Availability of Services	30	28	93%							
2	§438.207	Assurance of Adequate Capacity and Services	8	8	100%							
3	§438.208	Coordination and Continuity of Care	36	28	78%							
4	§438.210	Coverage and Authorization of Services	36	32	89%							
5	§438.214	Provider Selection	8	8	100%							
6	§438.224	Confidentiality	12	12	100%							
7	§438.228	Grievance and Appeal Systems	80	78	98%							
8	§438.230	Sub-contractual Relationships and Delegation	20	18	90%							
9	§438.236	Practice Guidelines	12	12	100%							
10	§438.242	Health Information Systems	22	22	100%							
11	§438.330	QAPI Program	30	30	100%							
12	§438.56	Disenrollment: Requirements and Limitations	2	2	100%							
13	§438.100	Enrollee Rights	18	14	78%							
14	§438.114	Emergency and Post-stabilization Services	16	16	100%							
Total Points			**330**	**308**	**93%**							

CFR 438.206 Provisions: Availability of Services	Audit Applicability	Available Points	Points Scored
(a) Basic rule. Each State must ensure that all services covered under the State plan are available and accessible to enrollees of MCP in a timely manner. The State must also ensure that MCO, PIHP and PAHP provider networks for services covered under the contract meet the standards developed by the State in accordance with § 438.68 (Network Adequacy Standards).	State Role/Contract	NA	NA
(b)Delivery network. The state must ensure through its contracts, that each MCP, consistent with the scope of its contracted services, meets the following requirements:	State Role/Contract	NA	NA
(b)(1) Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities.	Annual Network Certification Process	2	2
(b)(2) Provides female enrollees with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.	Category 3: Access and Availability of Care	2	2
(b)(3) Provides for a second opinion from a network provider, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.	Category 3: Access and Availability of Care	2	2
(b)(4) If the provider network is unable to provide necessary services, covered under the contract, to a particular enrollee, the MCP must adequately and timely cover these services out of network for the enrollee, for as long as the MCP's provider network is unable to provide them.	Category 3: Access and Availability of Care	2	2
(b)(5) Requires out-of-network providers to coordinate with the MCP for payment and ensures the cost to the enrollee is no greater than it would be if the services were furnished within the network.	State Role/Contract	NA	NA
(b)(6) Demonstrates that its network providers are credentialed as required by § 438.214.	Category 3: Access and Availability of Care	2	2
(b)(7) Demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services.	Annual Network Certification Process	2	2
Furnishing of Services, Timely Access (c)(1)(i) Meet and require its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services.	Category 3: Access and Availability of Care	2	2
(c)(1)(ii) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid FFS, if the provider serves only Medicaid enrollees.	Category 3: Access and Availability of Care	2	2
(c)(1)(iii) Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.	Category 3: Access and Availability of Care	2	2
(c)(1)(iv) Establish mechanisms to ensure compliance by network providers.	Category 3: Access and Availability of Care	2	0
(c)(1)(v) Monitor network providers regularly to determine compliance.	Category 3: Access and Availability of Care	2	2
(c)(1)(vi) Take corrective action if there is a failure to comply by a network provider.	Category 3: Access and Availability of Care	2	2
(c)(2) Access and cultural considerations. Each MCP participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex.	Category 4: Member Rights Category 5: Quality Improvement System	2	2
(c)(3) Accessibility considerations. Each MCP must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.	Category 2: Basic Case Management	2	2
438.10 (h) Provider Directory. Each MCP must make available in paper form upon request and electronic form, information about its network providers	Category 3: Access and Availability of Care	2	2
	Total Points	**30**	**28**

438.207 CFR Provisions Assurance of Adequate Capacity and Services	Audit Applicability	Available Points	Points Scored	Comments
(a) *Basic rule.* The State must ensure, through its contracts, that each MCP gives assurances to the State and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care under this part, including the standards at § 438.68 and § 438.206(c)(1).	Annual Network Certification	NA	NA	
(b) Nature of supporting documentation. Each MCP must submit documentation to the State, in a format specified by the State, to demonstrate that it complies with the following requirements:	Annual Network Certification	N/A	N/A	
(b)(1) Offers an appropriate range of preventive, primary care, specialty services, and LTSS that is adequate for the anticipated number of enrollees for the service area.	Annual Network Certification	2	2	
(b)(2) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.	Annual Network Certification	2	2	
(c) Timing of documentation. Each MCP must submit the documentation described in paragraph (b) of this section as specified by the State, but no less frequently than the following:	Annual Network Certification	N/A	NA	
(c)(1) At the time it enters into a contract with the State.	Annual Network Certification	N/A	N/A	
(c)(2) On an annual basis.		2	2	
(c)(3) At any time there has been a significant change (as defined by the State) in the MCP's operations that would affect the adequacy of capacity and services, including -		N/A	N/A	
(c)(3)(i) Changes in MCP services, benefits, geographic service area, composition of or payments to its provider network; or		N/A	N/A	
(c)(3)(ii) Enrollment of a new population in the MCP.		2	2	
(d) State review and certification to CMS. After the State reviews the documentation submitted by the MCP, the State must submit an assurance of compliance to CMS that the MCP meets the State's requirements for availability of services, as set forth in § 438.68 and § 438.206. The submission to CMS must include documentation of an analysis that supports the assurance of the adequacy of the network for each contracted MCP related to its provider network.	State Role/Contract	NA	NA	
(e) CMS' right to inspect documentation. The State must make available to CMS, upon request, all documentation collected by the State from the MCP.	State Role/Contract	NA	NA	
(f) *Applicability date.* This section applies to the rating period for contracts with MCOs, PIHPs, and PAHPs beginning on or after July 1, 2018. Until that applicability date, states are required to continue to comply with § 438.207 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.	State Role/Contract	NA	NA	

438.208 CFR Provisions: Coordination and Continuity of Care	Audit Applicability	Available Points	Points Scored
(a) Basic requirement (1) General rule. Except as specified in paragraphs (a)(2) and (3) of this section, the State must ensure through its contracts, that each MCP complies with the requirements of this section.	State Role/Contract	NA	NA
(a)(2) PIHP and PAHP exception. For PIHPs and PAHPs, the State determines, based on the scope of the entity's services, and on the way the State has organized the delivery of managed care services, whether a particular PIHP or PAHP is required to implement mechanisms	State Role/Contract	NA	NA
(a)(3) Exception for MCPs that serve dually eligible enrollees. (i) For each MCO that serves enrollees who are also enrolled in and receive Medicare benefits from a Medicare Advantage Organization (as defined in § 422.2 of this chapter), the State determines to what extent the MCO must meet the identification, assessment, and treatment planning provisions of paragraph (c) of this section for dually eligible individuals.	CMC MCPs: Category 2 -Case Management and Coordination of Care	2	2
(a)(3)(ii) The State bases its determination on the needs of the population it requires the MCO to serve.	State Role/Contract	NA	NA
(b) Care and coordination of services for all MCP enrollees. Each MCP must implement procedures to deliver care to and coordinate services for all MCP enrollees. These procedures must meet State requirements and must do the following: (1) Ensure that each enrollee has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee. The enrollee must be provided information on how to contact their designated person or entity;	Category 2-Case Management and Coordination of Care	2	0
(b)(2) Coordinate the services the MCP furnishes to the enrollee: (i) Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays; (ii) With the services the enrollee receives from any other MCO, PIHP, or PAHP; (iii) With the services the enrollee receives in FFS Medicaid; and (iv) With the services the enrollee receives from community and social support providers.	Category 2-Case Management and Coordination of Care	8	6
(b)(3) Provide that the MCP makes a best effort to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the enrollee is unsuccessful;	Category 2-Case Management and Coordination of Care	2	0
(b)(4) Share with the State or other MCPs, PIHPs, and PAHPs serving the enrollee the results of any identification and assessment of that enrollee's needs to prevent duplication of those activities;	Category 2-Case Management and Coordination of Care	2	2
(b)(5) Ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards; and	Category 2-Case Management and Coordination of Care	2	2
(b)(6) Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.	Category 4-Member Rights	2	2
(c) Additional services for enrollees with special health care needs or who need LTSS -	State Role/Contract	NA	NA
(c)(1) Identification. The State must implement mechanisms to identify persons who need LTSS or persons with special health care needs to MCPs, as those persons are defined by the State. These identification mechanisms -	State Role/Contract	NA	NA
(c)(1)(i) Must be specified in the State's quality strategy under § 438.340.	State Role/Contract	NA	NA
(c)(1)(ii) May use State staff, the State's enrollment broker, or the State's MCOs, PIHPs and PAHPs.	State Role/Contract	NA	NA
(c)(2) Assessment. Each MCP must implement mechanisms to comprehensively assess each Medicaid enrollee identified by the State (through the mechanism specified in paragraph (c)(1) of this section) and identified to the MCP by the State as needing LTSS or having special health care needs to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate providers or individuals meeting LTSS service coordination requirements of the State or the MCP as	Category 2-Case Management and Coordination of Care	2	2
(c)(3) Treatment/service plans. MCPs must produce a treatment or service plan meeting the criteria in paragraphs (c)(3)(i) through (v) of this section for enrollees who require LTSS and, if the State requires, must produce a treatment or service plan meeting the criteria in paragraphs (c)(3)(iii) through (v) of this section for enrollees with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The treatment or service plan must be:	Category 2-Case Management and Coordination of Care	2	2
(c)(3)(i) Developed by an individual meeting LTSS service coordination requirements with enrollee participation, and in consultation with any providers caring for the enrollee;	Category 2-Case Management and Coordination of Care	2	2
(c)(3)(ii) Developed by a person trained in person-centered planning using a person-centered process and plan as defined in § 441.301(c)(1) and (2) of this chapter for LTSS treatment or service plans;	Category 2-Case Management and Coordination of Care	2	2
(c)(3)(iii) Approved by the MCP, if this approval is required by the MCP	Category 2-Case Management and Coordination of Care	2	2
(c)(3)(iv) In accordance with any applicable State quality assurance and utilization review standards; and	Category 2-Case Management and Coordination of Care	2	2
(c)(3)(v) Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly, or at the request of the enrollee per § 441.301(c)(3) of this chapter.	Category 2-Case Management and Coordination of Care	2	0
(c)(4) Direct access to specialists. For enrollees with special health care needs determined through an assessment (consistent with paragraph (c)(2) of this section) to need a course of treatment or regular care monitoring, each MCP must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.	Category 1: Utilization Management Category 3: Access and Availability of Care	2	2
(d) Applicability date. This section applies to the rating period for contracts with MCPs beginning on or after July 1, 2017. Until that applicability date, states are required to continue to comply with § 438.208 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.	State Role/Contract	NA	NA

CFR Provisions 438.210 Coverage and Authorization of Services	Audit Applicability	Available Points	Points Scored	Comments
(a) Coverage. Each contract between a State and an MCP must do the following: (1) Identify, define, and specify the amount, duration, and scope of each service that the MCP is required to offer.	State Role/Contract	NA	NA	
(2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid, as set forth in § 440.230 of this chapter, and for enrollees under the age of 21, as set forth in subpart B of part 441 of this chapter.	State Role/Contract	NA	NA	
(3) Provide that the MCP - (i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.	Category 1: Utilization Management	2	2	
(ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.	Category 1: Utilization Management	2	2	
(4) Permit an MCP to place appropriate limits on a service - (i) On the basis of criteria applied under the State plan, such as medical necessity; or (ii) For the purpose of utilization control, provided that - (A) The services furnished can reasonably achieve their purpose, as required in paragraph (a)(3)(i) of this section; (B) The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the enrollee's ongoing need for such services and supports; and (C) Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with § 441.20 of this chapter.	Category 1: Utilization Management	4	4	
(5) Specify what constitutes "medically necessary services" in a manner that -	State Role/Contract	NA	NA	
(i) Is no more restrictive than that used in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and	State Role/Contract	NA	NA	
(ii) Addresses the extent to which the MCP is responsible for covering services that address:	State Role/Contract	NA	NA	
(A) The prevention, diagnosis, and treatment of an enrollee's disease, condition, and/or disorder that results in health impairments and/or disability.	Category 2-Case Management and Coordination of Care	2	0	2.1.3 Blood Lead Screening Test. Plan did not ensure that its fully delegated subcontractor consistently conducted blood lead screening tests on members at one and two years of age, including up to six years of age as specified in APL 20-016.
(B) The ability for an enrollee to achieve age-appropriate growth and development.	Category 2-Case Management and Coordination of Care	2	2	
(C) The ability for an enrollee to attain, maintain, or regain functional capacity.	Category 2-Case Management and Coordination of Care	2	2	
(D) The opportunity for an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.	Category 2-Case Management and Coordination of Care	2	2	
(b) Authorization of services. For the processing of requests for initial and continuing authorizations of services, each contract must require -	State Role/Contract	NA	NA	
(1) That the MCP and its subcontractors have in place, and follow, written policies and procedures.	Category 1-Utilization Management	2	0	1.5.1 Timeliness of Referrals. Plan did not ensure that its fully delegated subcontractor had a mechanism to track and monitor referrals.
(2) That the MCP- (i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.	Category 1-Utilization Management	2	2	
(ii) Consult with the requesting provider for medical services when appropriate.	Category 1-Utilization Management	2	2	
(iii) Authorize LTSS based on an enrollee's current needs assessment and consistent with the person-centered service plan.	Category 2-Case Management and Coordination of Care	2	2	
(3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs.	Category 1-Utilization Management	2	2	
(c) Notice of adverse benefit determination. Each contract must provide for the MCP to notify the requesting provider, and give the enrollee written notice of any decision by the MCP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For MCPs, the enrollee's notice must meet the requirements of § 438.404. For Medicaid contracts with an applicable integrated plan, as defined in § 422.561 of this chapter, in lieu of the provisions in this paragraph governing notices of adverse benefit determinations, the provisions set forth in §§ 422.629 through 422.634 of this chapter apply to determinations affecting dually eligible individuals who are also enrolled in a dual eligible special needs plan with exclusively aligned enrollment, as defined in § 422.2 of this chapter.	Category 1-Utilization Management	2	2	
(d) Timeframe for decisions. Each MCP contract must provide for the following decisions and notices:	State Role/Contract	NA	NA	
(1) Standard authorization decisions. For standard authorization decisions, provide notice as expeditiously as the enrollee's condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if -	Category 1-Utilization Management	2	2	
(i) The enrollee, or the provider, requests extension; or				
(ii) The MCP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.				
(2) Expedited authorization decisions.				
(i) For cases in which a provider indicates, or the MCP determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service.	Category 1-Utilization Management	2	2	
(ii) The MCP may extend the 72 hour time period by up to 14 calendar days if the enrollee requests an extension, or if the MCP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.				
(3) Covered outpatient drug decisions. For all covered outpatient drug authorization decisions, provide notice as described in section 1927(d)(5)(A) of the Act.	Category 1: Utilization Management	2	2	
(4) For Medicaid contracts with an applicable integrated plan, as defined in § 422.561 of this chapter, timelines for decisions and notices must be compliant with the provisions set forth in §§ 422.629 through 422.634 of this chapter in lieu of §§ 438.404 through 438.424.	State Role/Contract	NA	NA	
(e) Compensation for utilization management activities. Each contract between a State and MCP must provide that, consistent with §§ 438.3(i), and 422.208 of this chapter, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.	Category 1: Utilization Management	2	2	
(f) Applicability date. (1) Subject to paragraph (f)(2) of this section, this section applies to the rating period for contracts with MCOs, PIHPs, and PAHPs beginning on or after July 1, 2017. Until that applicability date, States are required to continue to comply with § 438.210 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015. (2) Provisions in this section affecting applicable integrated plans, as defined in § 422.561 of this chapter, are applicable no later than January 1, 2021.	N/A	NA	NA	
	Total Points	36	32	

CFR Provisions 438.214 Provider Selection	Audit Applicability	Available Points	Points Scored	Comments
(a) General rules. The State must ensure, through its contracts, that each MCP implements written policies and procedures for selection and retention of network providers and that those policies and procedures, at a minimum, meet the requirements of this section.	State Role/Contract	**NA**		
Credentialing and recredentialing requirements. (b)(1) Each State must establish a uniform credentialing and recredentialing policy that addresses acute, primary, behavioral, substance use disorders, and LTSS providers, as appropriate, and requires each MCP to follow those policies.	State Role/Contract	**NA**		
(2) Each MCP must follow a documented process for credentialing and recredentialing of network providers.	Category 5: Quality Improvement Category 1: Utilization Management	2	2	
(c) Nondiscrimination. MCP network provider selection policies and procedures, consistent with § 438.12, must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	Category 5: Quality Improvement	2	2	
(d)(1) MCPs may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.	Category 5: Quality Improvement	2	2	
(e) State requirements. Each MCP must comply with any additional requirements established by the State.	Category 5: Quality Improvement	2	2	
	Total Points	**8**	**8**	

438.224 CFR Provisions: Confidentiality	Audit Applicability	Available Points	Points Scored	Comments
The State must ensure, through its contracts, that (consistent with subpart F of part 431 of this chapter), for medical records and any other health and enrollment information that identifies a particular enrollee, each MCP uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable.	Category 4: Member Rights Exhibit G Health Insurance Portability and Accessibility Act (HIPAA)	2	2	
45 CFR 164.308 Administrative Safeguards. MCP has effective administrative safeguards in place to prevent, detect, contain, and correct security violations	Category 4: Member Rights Exhibit G Health Insurance Portability and Accessibility Act (HIPAA)	2	2	
45 CFR 164.310 Physical safeguards. MCP has effective physical safeguards in place to ensure appropriate access to its electronic information system and facilities in order to maintain enrollee information safe and secure from unauthorized access.	Category 4: Member Rights Exhibit G Health Insurance Portability and Accessibility Act (HIPAA)	2	2	
45 CFR 164.312 Technical safeguards. MCP has in place effective technical policies and procedures for electronic information systems that maintain electronic protected health information to allow access only to those persons or software programs that have been granted access rights as specified in § 164.308(a)(4).	Category 4: Member Rights Exhibit G Health Insurance Portability and Accessibility Act (HIPAA)	2	2	
45 CFR 164.316 Policies and procedures and documentation requirements. MCP maintains and retains appropriate policies and procedures in accordance with the law.	Category 4: Member Rights Exhibit G Health Insurance Portability and Accessibility Act (HIPAA)	2	2	
45 CFR 164.400 Notification in the Case of Breach of Unsecured Protected Health Information. MCP adheres to all notification requirements with respect to the acquisition, access, use, or disclosure of protected health information in a manner not permitted under CFR 45 subpart E which compromises the security or privacy of the protected health information	Category 4: Member Rights Exhibit G Health Insurance Portability and Accessibility Act (HIPAA)	2	2	
	Total Points	**12**	**12**	

CFR Provisions 438.230 Subcontractual Relationships and Delegation	Audit Applicability	Available Points	Points Scored	Comments
(a) *Applicability.* The requirements of this section apply to any contract or written arrangement that an MCP entity has with any subcontractor.	State Role/Contract	**NA**	**NA**	
(b) *General rule.* The State must ensure, through its contracts with MCPs entities that - (b)(1) Notwithstanding any relationship(s) that the MCP entity may have with any subcontractor, the MCP entity maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State; and	Category 5: Quality Improvement	2	2	
(b)(2) All contracts or written arrangements between the MCP entity and any subcontractor must meet the requirements of paragraph (c) of this section.	State Role/Contract	**NA**	**NA**	
(c) Each contract or written arrangement described in paragraph (b)(2) of this section must specify that: (c)(1) If any of the MCP entity's activities or obligations under its contract with the State are delegated to a subcontractor -	Category 5: Quality Improvement Category 1: UM/Delegation of UM	2	2	
(c)(1)(i) The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement.	Category 5: Quality Improvement Category 1: UM/Delegation of UM	2	2	
(c)(1)(ii) The subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCP's entity's contract obligations.	Category 5: Quality Improvement Category 1: UM/Delegation of UM	2	0	1.5.2 Oversight of Delegation Functions. Plan did not monitor and oversee its fully delegated subcontractor and downstream subcontractors' functions.
(c)(1)(iii) The contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the MCP entity determine that the subcontractor has not performed satisfactorily.	Category 5: Quality Improvement Category 1: UM/Delegation of UM	2	2	
(c)(2) The subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions;	Category 5: Quality Improvement Category 1: UM/Delegation of UM	2	2	
(c)(3) The subcontractor agrees that - (i) The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCO's, PIHP's, or PAHP's contract with the State.	Category 5: Quality Improvement Category 1: UM/Delegation of UM	2	2	
(c)(3)(ii) The subcontractor will make available, for purposes of an audit, evaluation, or inspection under paragraph (c)(3)(i) of this section, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid enrollees.	Category 5: Quality Improvement Category 1: UM/Delegation of UM	2	2	
(c)(3)(iii) The right to audit under paragraph (c)(3)(i) of this section will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.	Category 5: Quality Improvement Category 1: UM/Delegation of UM	2	2	
(c)(3)(iv) If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.	Category 5: Quality Improvement Category 1: UM/Delegation of UM	2	2	
(d) Applicability date. This section applies to the rating period for contracts with MCOs, PIHPs, PAHPs, and PCCM entities beginning on or after July 1, 2017. Until that applicability date, states are required to continue to comply with § 438.230 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.	NA	**NA**	**NA**	
	Total Points	**20**	**18**	

CFR Provisions 438.236 Practice Guidelines	Audit Applicability	Available Points	Points Scored	Comments
(a) Basic rule. The State must ensure, through its contracts, that each MCP meets the requirements of this section.	State Role/Contract	**NA**	**NA**	
(b) Adoption of practice guidelines. Each MCP adopts practice guidelines that meet the following requirements:	Category 1: Utilization Management	**NA**	**NA**	Practice guidelines: dissemination and application (42 C.F.R. §§ 438.236(c) and 457.1233(c))...5. **What steps are taken to ensure that decision-making in the areas of utilization management or coverage determinations and other functional areas are consistent with the adopted practice guidelines?**
(1) Are based on valid and reliable clinical evidence or a consensus of providers in the particular field.	Category 1: Utilization Management	2	2	
(2) Consider the needs of the MCPs enrollees.		2	2	
(3) Are adopted in consultation with network providers.		2	2	
(4) Are reviewed and updated periodically as appropriate.		2	2	
(c) Dissemination of guidelines. Each MCP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.	Category 1: Utilization Management	2	2	
(d) Application of guidelines. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.	Category 1: Utilization Management	2	2	
	Total Points	**12**	**12**	

CFR Provisions 438.242 Health Information Systems	Audit Applicability	Available Points	Points Scored	Comments
(a) General rule. The State must ensure, through its contracts that each MCP maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this part. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.	General Assessment	2	2	
(b) Basic elements of a health information system. The State must require, at a minimum, that each MCP comply with the following:	State Role/Contract	NA	NA	
(1) Section 6504(a) of the Affordable Care Act, which requires that State claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of section 1903(r)(1)(F) of the Act.	State Role/Contract	NA	NA	
(2) Collect data on enrollee and provider characteristics as specified by the State, and on all services furnished to enrollees through an encounter data system or other methods as may be specified by the State.	Encounter Data Validation (EDV) Process	2	2	
(3) Ensure that data received from providers is accurate and complete by - (i) Verifying the accuracy and timeliness of reported data, including data from network providers the MCP is compensating on the basis of capitation payments.	EDV/DHCS Stop Light Reports	2	2	
(b)(3)(ii) Screening the data for completeness, logic, and consistency.	EDV Process	2	2	
(b)(3)(iii) Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts.	EDV Process	2	2	
(4) Make all collected data available to the State and upon request to CMS.	State Role/Contract	NA	NA	
(5) Implement an Application Programming Interface (API) as specified in § 431.60 of this chapter as if such requirements applied directly to the MCO, PIHP, or PAHP and include - (i) All encounter data, including encounter data from any network providers the MCP is compensating on the basis of capitation payments and adjudicated claims and encounter data from any subcontractors.	API/Member Portal	2	2	
(5)(ii) [Reserved]	NA	NA	NA	
(6) Implement, by January 1, 2021, and maintain a publicly accessible standards-based API described in § 431.70, which must include all information specified in § 438.10(h)(1) and (2) of this chapter.	Online Provider Directory	2	2	
(c) Enrollee encounter data. Contracts between a State and a MCP must provide for: (1) Collection and maintenance of sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees.	EDV Process	2	2	
(c)(2) Submission of enrollee encounter data to the State at a frequency and level of detail to be specified by CMS and the State, based on program administration, oversight, and program integrity needs.		2	2	
(c)(3) Submission of all enrollee encounter data, including allowed amount and paid amount, that the State is required to report to CMS under § 438.818.		2	2	
(c)(4) Specifications for submitting encounter data to the State in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate.		2	2	
(d) State review and validation of encounter data. The State must review and validate that the encounter data collected, maintained, and submitted to the State by the MCP, meets the requirements of this section. The State must have procedures and quality assurance protocols to ensure that enrollee encounter data submitted under paragraph (c) of this section is a complete and accurate representation of the services provided to the enrollees under the contract between the State and the MCO, PIHP, or PAHP.	State Role/Contract	NA	NA	
(e) Applicability date. This section applies to the rating period for contracts with MCOs, PIHPs, PAHPs, and PCCM entities beginning on or after July 1, 2017. Until that applicability date, states are required to continue to comply with § 438.242 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.	N/A	NA	NA	
	Total Points	**22**	**22**	

CFR Provisions 438.330 QAPI Program	Audit Applicability	Available Points	Points Scored	Comments
(a)General rules. (1) The State must require, through its contracts, that each MCP establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees that includes the elements identified in paragraph (b) of this section	State Role/Contract	2	2	
(b)Basic elements of quality assessment and performance improvement programs. The comprehensive quality assessment and performance improvement program described in paragraph (a) of this section must include at least the following elements:	State Role/Contract	NA	NA	
(1) Performance improvement projects in accordance with paragraph (d) of this section.	QI Process	2	2	
(2) Collection and submission of performance measurement data in accordance with paragraph (c) of this section.	QI Process	2	2	
(3) Mechanisms to detect both underutilization and overutilization of services.	QI Process	2	2	
(4) Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs, as defined by the State in the quality strategy under § 438.340.	QI Process	2	2	
For MCPs providing long-term services and supports: (5)(i) Mechanisms to assess the quality and appropriateness of care furnished to enrollees using long-term services and supports, including assessment of care between care settings and a comparison of services and supports received with those set forth in the enrollee's treatment/service plan, if applicable; and	Category 5: Quality Improvement	NA	NA	
(5) (ii) Participate in efforts by the State to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare per §§ 441.302 and 441.730(a) of this chapter) that are based, at a minimum, on the requirements on the State for home and community-based waiver programs per § 441.302(h) of this chapter	Category 5: Quality Improvement	NA	NA	
(c)Performance measurement. The State must - (1)(i) Identify standard performance measures, including those performance measures that may be specified by CMS under paragraph (a)(2) of this section, relating to the performance of MCOs, PIHPs, and PAHPs; and	Annual HEDIS Data and Rate Submission Process (MCAS)	NA	NA	
(ii) In addition to the measures specified in paragraph (c)(1)(i) of this section, in the case of an MCP providing long-term services and supports, identify standard performance measures relating to quality of life, rebalancing, and community integration activities for individuals receiving long-term services and supports.		NA	NA	
(c)Require that each MCP annually - (2)(i) Measure and report to the State on its performance, using the standard measures required by the State in paragraph (c)(1) of this section		2	2	
(2)(ii) Submit to the State data, specified by the State, which enables the State to calculate the MCO's, PIHP's, or PAHP's performance using the standard measures identified by the State under paragraph (c)(1) of this section; or		2	2	
(2)(iii) Perform a combination of the activities described in paragraphs (c)(2)(i) and (ii) of this section.				
(d)Performance improvement projects. (1) The State must require that MCOs, PIHPs, and PAHPs conduct performance improvement projects, including any performance improvement projects required by CMS in accordance with paragraph (a)(2) of this section, that focus on both clinical and nonclinical areas	PIPs/QI Process	NA	NA	
(2) Each performance improvement project must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction, and must include the following elements:		2	2	
(i) Measurement of performance using objective quality indicators.		2	2	
(ii) Implementation of interventions to achieve improvement in the access to and quality of care.		2	2	
(iii) Evaluation of the effectiveness of the interventions based on the performance measures in paragraph (d)(2)(i) of this section.		2	2	
(iv) Planning and initiation of activities for increasing or sustaining improvement.		2	2	
(3) The State must require each MCO, PIHP, and PAHP to report the status and results of each project conducted per paragraph (d)(1) of this section to the State as requested, but not less than once per year		2	2	
(4) The State may permit an MCO, PIHP, or PAHP exclusively serving dual eligible to substitute an MA Organization quality improvement project conducted under § 422.152(d) of this chapter for one or more of the performance improvement projects otherwise required under this section.		2	2	
(e)Program review by the State. (1) The State must review, at least annually, the impact and effectiveness of the quality assessment and performance improvement program of each MCP entity described in § 438.310(c)(2). The review must include -	State Role/Contract	NA	NA	
(1)(i) The MCP entity's performance on the measures on which it is required to report.				
(ii) The outcomes and trended results of each MCP's performance improvement projects				
(iii) The results of any efforts by the MCP to support community integration for enrollees using long-term services and supports.				
QAPI evaluation review (e)(2) The State may require that an MCP entity described in §438.310(c)(2) develop a process to evaluate the impact and effectiveness of its own quality assessment and performance improvement program.	QI Process	2	2	
	Total Points	**30**	**30**	

CFR Provisions 438.56 Disenrollment: Requirements and Limitations	Audit Applicability	Available Points	Points Scored	Comments
(a) Applicability. The provisions of this section apply to all managed care programs whether enrollment is mandatory or voluntary and whether the contract is with an MCO, PIHP, PAHP, PCCM, or PCCM entity.	State Role/Contract	**NA**	**NA**	
(b)Disenrollment requested by the MCP (1) Specify the reasons for which the MCP entity may request disenrollment of an enrollee.	State Role/Contract	**NA**	**NA**	
(2) Provide that the MCP entity may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCP entity seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees).	Category 2.1: Basic Case Management	2	2	
(3)Specify the methods by which the MCP entity assures the agency that it does not request disenrollment for reasons other than those permitted under the contract.	State Role/Contract	**NA**	**NA**	
(c) Disenrollment requested by the enrollee. *If the State chooses to limit disenrollment, its MCP entity contracts must provide that a beneficiary may request disenrollment as follows…*	***Section C-NOT APPLICABLE TO CA MEDICAID***	**NA**	**NA**	
	Total Points	**2**	**2**	

CFR Provisions 438.100 Enrollee Rights	Audit Applicability	Available Points	Points Scored	Comments	Additional CFR Requirements
(a) *General rule.* The State must ensure that: (1) Each MCP entity has written policies regarding the enrollee rights specified in this section.	State Role/Contract	NA	NA		
(2) Each MCP entity complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its employees and contracted providers observe and protect those rights.	Category 4: Member Rights (Exhibit A, Attachment 13 MEMBER SERVICES)	2	0	4.1.1 Discrimination of Grievance. Plan did not ensure that its fully delegated subcontractor reported discrimination grievances to the DHCS Office of Civil Rights within ten (10) calendar days of mailing a discrimination grievance resolution letter to a member.	
(b) *Specific rights* - (1) Basic requirement. The State must ensure that each managed care enrollee is guaranteed the rights as specified in paragraphs (b)(2) and (3) of this section.	State Role/Contract	NA	NA		
2) An enrollee of an MCP entity has the following rights: The right to- Information requirement for all enrollees:	State Role/Contract	NA	NA		
(i) Receive information in accordance with 438.10	Category 4: Member Rights (Exhibit A, Attachment 13 MEMBER SERVICES)	2	2		CFR 438.10 - Information Requirements. Plans are required to provide information in a manner and format that is easily understood and accessible, including limited English proficient members
(ii) Be treated with respect and with due consideration for his or her dignity and privacy.	Category 4: Member Rights (Exhibit A, Attachment 13 MEMBER SERVICES)	2	2		
(iii) Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. (The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in § 438.10(g)(2)(ii)(A) and (B).)	Category 4: Member Rights (Exhibit A, Attachment 13 MEMBER SERVICES)	2	0	2.1.4 Blood Lead Anticipatory Guidance. Plan did not ensure that its fully delegated subcontractor consistently provided oral or written blood lead anticipatory guidance to the parent or guardian of members as specified in APL 20-016.	
(iv) Participate in decisions regarding his or her health care, including the right to refuse treatment.	Category 4: Member Rights (Exhibit A, Attachment 13 MEMBER SERVICES)	2	2		
(v) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.	Category 4: Member Rights (Exhibit A, Attachment 13 MEMBER SERVICES)	2	2		
(vi) If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526.	Category 4: Member Rights (Exhibit A, Attachment 13 MEMBER SERVICES)	2	2		
(3) An enrollee of an MCP has the right to be furnished health care services in accordance with §438.206 through 438.210.	*Captured in Other Areas (438.206)*	NA	NA		
(c) *Free exercise of rights.* The State must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCP entity and its network providers or the State agency treat the enrollee.	Category 4: Member Rights (Exhibit A, Attachment 13 MEMBER SERVICES)	2	2		
(d) *Compliance with other Federal and State laws.* The State must ensure that each MCP entity complies with any other applicable Federal and State laws (including: Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.	*Applicability Varies*	2	2		
	Total Points	**18**	**14**		

CFR Provisions 438.114 Emergency and Poststabilization Services	Audit Applicability	Available Points	Points Scored	Comments
(a) Definitions. As used in this section - Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:	State Role/Contract	NA		
(i) Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. (ii) Serious impairment to bodily functions. (iii) Serious dysfunction of any bodily organ or part.				
Emergency services means covered inpatient and outpatient services that are as follows:				
(i) Furnished by a provider that is qualified to furnish these services under this Title.				
(ii) Needed to evaluate or stabilize an emergency medical condition.				
Poststabilization care services means covered services, related to an emergency medical condition that are provided after an enrollee is stabilized to maintain the stabilized condition, or, under the circumstances described in paragraph (e) of this section, to improve or resolve the enrollee's condition.				
(b) Coverage and payment: General rule. The following entities are responsible for coverage and payment of emergency services and poststabilization care services. (1) The MCO, PIHP, or PAHP. (2) The State, for managed care programs that contract with PCCMs or PCCM entities				
(c) Coverage and payment: Emergency services. (1) The entities identified in paragraph (b) of this section whether the provider that furnishes the services has a contract with the MCP entity;	Category 3: Access and Availability of Care	2	2	
(ii) May not deny payment for treatment obtained under either of the following circumstances:	Category 3: Access and Availability of Care	NA	NA	
(A) An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in paragraphs (1), (2), and (3) of the definition of emergency medical condition in paragraph (a) of this section.	Category 3: Access and Availability of Care	2	2	
(B) A representative of the MCP entity instructs the enrollee to seek emergency services.		2	2	
(2) A PCCM or PCCM entity must allow enrollees to obtain emergency services outside the primary care case management system regardless of whether the case manager referred the enrollee to the provider that furnishes the services.	NA	NA	NA	
(d) Additional rules for emergency services. (1) The entities specified in paragraph (b) of this section may not-	NA	NA	NA	
(i) Limit what constitutes an emergency medical condition with reference to paragraph (a) of this section, on the basis of lists of diagnoses or symptoms; and	Category 3: Access and Availability of Care	2	2	
(ii) Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider, MCO, PIHP, PAHP or applicable State entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services.		2	2	
(2) An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.		2	2	
(3) The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in paragraph (b) of this section as responsible for coverage and payment.	Category 3: Access and Availability of Care	2	2	
(e) Coverage and payment: Poststabilization care services. Poststabilization care services are covered and paid for in accordance with provisions set forth at § 422.113(c) of this chapter. In applying those provisions, reference to "MA organization" and "financially responsible" must be read as reference to the entities responsible for Medicaid payment, as specified in paragraph (b) of this section, and payment rules governed by Title XIX of the Act and the States.	Category 3: Access and Availability of Care	2	2	
(f) Applicability to PIHPs and PAHPs. To the extent that services required to treat an emergency medical condition fall within the scope of the services for which the PIHP or PAHP is responsible, the rules under this section apply.	State Role/Contract	NA	NA	
	Total Points	**16**	**16**	

Information Items

Operations report for review

Operations Report

Period Covered: Feb 2025

Highlights

Medi-Cal

Our first Community Advisory Committee meeting of the year is scheduled for 3/17 from noon-2pm at the CHPIV offices. Based on prior year committee input and results from CHPIV's Health Equity Scorecard, staff is proposing the following areas of focus for the year:

- Referral and authorization grievances
- Resources to support children with autism spectrum disorder
- Literacy level of grievance and denial letters
- Equitable health outcomes for hypertension
- D-SNP member experience

Community Advantage Plus

Operations is focused on improving the first 90-days of the member experience. The team has mapped out the member journey from enrollment through active coverage, identifying friction points and implementing process improvements to make transitions smoother.

- **Retention specialist position:** Veronica Arroyo was promoted from Member Experience Representative to Retention Specialist. This new position is responsible for bridging the gap between sales and care coordination by proactively reaching out to members to identify and mitigate any potential service or access problems and answer questions. Sales and member services teams continue working closely with care coordinators and provider offices to resolve issues quickly and restore trust where needed.
- **Office administrator luncheon:** CHPIV's is hosting a luncheon on March 25 at 12pm for office administrators to provide feedback to staff on Community Advantage Plus operations and identify opportunities for improvement.
- **Nurse Practitioners as PCPs:** Many members have long-standing relationships with Nurse Practitioners (NPs), and are confused when their ID card arrives with the name of a physician they have never seen. We are currently evaluating the feasibility and implications of allowing patients to be assigned directly to NPs.

CHPIV in the Community

This month, our team was active in the community, participating in local events and meeting with providers to build relationships and answer questions face to face.

Heart Health Month: Heart of the Valley Cardiology Physicians

In recognition of National Heart Month, Denise Padissas and Michelle launched a February awareness campaign to highlight heart health in our community. As part of the effort, Heart of the Valley created a short educational video to help raise awareness and encourage prevention.

Dr. Steven Rough, a cardiologist specializing in general and interventional cardiology

Watch the video:

- English: https://drive.google.com/file/d/1OpBrxGEnzjK0Ag0nl90u4EunxetG4Q2M/view?usp=sharing
- Spanish: https://drive.google.com/file/d/1MUs26Twdu-adC_wL1TphZUBaHoa1ayxu/view?usp=sharing

Senior Wellness & Health Fair at the Imperial Valley Mall

Our sales team participated in the Senior Wellness & Health Fair, engaging directly with community members and sharing information about Community Advantage Plus and CHPIV services.

CHPIV's Liz Torres and Steve Levy, Sales Representatives

Read more about the event in the Calexico Chronicle.

First Five Health Fair

CHPIV was proud to participate in the First Five Community Resource & Family Health Fairs held throughout the Valley at Lincoln Elementary, Dogwood Elementary, Main Elementary and Jefferson Elementary Schools. These family-focused events provided important safety and health resources to families with children.

A key highlight of the events was the free car seat inspection and replacement program, ensuring children are safely and properly secured. Families also had the opportunity to connect with multiple community agencies offering valuable information, services and support programs.

CHPIV remains committed to supporting the health, safety and well-being of families in our community and values the opportunity to collaborate with partners who share this mission.

CHPIV's Denise Padillas, Community Liaison

Key Metrics – Community Advantage Plus

Status	Category	Goal	Current Month Performance (as of 1/29/26)
	Provider Network	100% of direct provider contracts are executed	62% of provider contracts are fully executed
	Member Issues	Minimize and resolve escalated issues quickly	109 in Jan; 31 in Feb 94% same-day resolution
	Enrollment	346 Total 89 per month	231 on Feb 1 61 new
	Disenrollment	5%	18% in Jan; 7% in Feb

- **Direct Provider Network:** 20 physicians and 50 mid-levels have been pre-credentialed and can see Community Advantage Plus members. These providers cannot be assigned patients as a PCP and will not appear in the Provider Directory until they pass full credentialing and are approved by the CHPIV credentialing committee.
    - Pending one IPA contract. UCSD rate agreement only.
    - 55 of 84 direct provider contracts are fully executed; remaining contracts are pending final signature and processing. This includes 19 new LOAs that were executed this month.
- **Member Issues:** Escalated member issues have declined significantly since Jan. Primary issues this month have been PCP changes, ID cards, and authorization/continuity of care requests.
- **Enrollment:** While we are expecting fewer enrollments than projected again for March, numbers should start to improve in April through the rest of the year. In addition to continued outreach and support to providers, we are adding another inside sales reps (for a total of 3 FTEs), initiating direct mail campaigns, and increasing advertising through billboards and TV.
- **Disenrollment:** Rates have declined significantly since Jan, as we continue to educate providers, enhance provider data quality, and improve our internal onboarding processes. Top disenrollment reasons to date are: member didn't want to change plans, access to care, and provider not in network. Almost 50% of new members were previously with Original Medicare, so sales reps and care coordinators are increasing member education about referrals and network limitations associated with being in an HMO/IPA.

Issues / Risks

- IPA coordination and encounter data exchange
- Continuity of care for members transitioning from Original Medicare
- Ongoing provider awareness and support

Next 30 Days

- Develop implementation plans for risk adjustment coding accuracy
- Establishing relationships with IPA management services organizations (MSO) to ensure smooth hand-offs and data exchange. Staff are in the process of scheduling in-person visits to MSO corporate offices in March.

Period Covered: February 10, 2026- March 9, 2026

Highlights

- No new hires
- 3 open positions: Financial Analyst, Sales and Marketing Representative, Member Experience Coordinator
- Completed several individual check-ins with Imperial employees
- Managers discussed the February topic with their employees and reported their answers to the Leadership team. The question was: **Do you see a path for career advancement at CHPIV?**
- Had the initial meeting of an employee workgroup that is solutioning on issues that were discovered when managers asked the January question: **When you think about your day-to-day work, in what ways do you feel supported by your manager and the organization — and in what ways could we improve our support?**

Key Metrics

There were no new hires over this period.

Total number of employees	42
Local	29
Remote	13
Number of exits in 2026	0 new. 2 YTD: One for career growth opportunities, one for performance reasons

Issues / Risks

- Employee ideas that are generated as a part of the work group need to be considered and balanced with business objectives and bandwidth. This is a unique leadership development opportunity.
- Any issues that are revealed during one-on-one sessions must be confidentially managed, while ensuring alignment.

Next 30 Days

- 1st quarter check-ins will be conducted via Rippling to track progress on assigned goals.