IMPERIAL COUNTY
Local Health Authority Commission

Regulatory Compliance Oversight Committee of the Commission

AGENDA

Date/Time: April 29, 2026, 12:00 PM
Location: Community Health Plan of Imperial Valley, 512 West Aten Road, Imperial, CA 92251

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

Click here to join the meeting
Meeting ID: 260 262 365 221 28
Passcode: N6ee9Mc3

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

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

IMPERIAL COUNTY
Local Health Authority Commission
Regulatory Compliance Oversight Committee of the Commission

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

    This is an opportunity for members of the public to address the Commission on any subject matter within the Commission's jurisdiction. Any action taken as a result of public comment shall be limited to the direction to staff. When addressing the Commission, state your name for the record prior to providing your comments. Please address the Commission as a whole, through the Chairman. Individuals will be given 3 minutes to address the Commission; groups or topics will be given a maximum of 15 minutes. Public comments will be limited to a maximum of 30 minutes. If additional time is required for public comments, they will be heard at the end of the meeting.
5. Approval of Minutes from December 11, 2025 — *Chair*
6. Chairperson's Report
7. Chief Compliance Officer Report — Elysse Tarabola, *Chief Compliance Officer*
    a. Approve New a*nd* Updated Policies & Procedures *(Exhibit A)* — Chelsea Hardy, *Executive Director of Compliance*
    b. Risk Management Program & Audit Monitoring Program *(Exhibit B and C)* — Elysse Tarabola, *Chief Compliance Officer*
    c. 2025 Risk Assessment *(Exhibit D)* — Elysse Tarabola, *Chief Compliance Officer*
    d. Discrimination Grievances — Alfredo Flores, Compliance Manager

e. Fraud and Abuse Q4 2025 – Q1 2026 — Alfredo Flores, *Compliance Manager*
   i. Fraud Waste and Abuse Cases
   ii. Case Trends

f. Corrective Action Plan Update — Chelsea Hardy, *Executive Director of Compliance*; Cynthia Mesa, *Senior Director, Internal and Delegation Oversight*
   i. DHCS Audit
   ii. DO CAP Summary

g. Monitoring Results *(Exhibit E)* — Cynthia Mesa, *Senior Director, Internal and Delegation Oversight*
   i. Medi-Cal

h. Monitoring Results
   i. D-SNP
   ii. Data Validation Results

8. Reconvene in Open Session — *Chair*

9. Adjournment — *Chair*

IMPERIAL COUNTY
Local Health Authority Commission

Regulatory Compliance Oversight Committee of the Commission

MEETING MINUTES

Date/Time: December 11th, 2025, 12:00 PM – 1:01 PM

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

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

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

CHPIV Staff	Job Title	Present
Lawrence Lewis	Chief Executive Officer	☒
Elysse Tarabola	Chief Compliance Officer	☒
Dr. Gordon Arakawa	Chief Medical Officer	☒
David Wilson	Chief Financial Officer	☒
Julia Hutchins	Chief Operating Officer	☐
Chelsea Hardy	Senior Director of Compliance	☒
Cynthia Mesa	Director of Internal and Delegation Oversight	☒
Alfredo Flores	Compliance Manager	☐
Kristi Wilkerson	Internal and Delegation Oversight Manager	☒
Joe Escobar	Compliance Auditor	☒
Ricki Collins	Clinical Compliance Auditor	☒
Lulu Gallegos	Clinical Compliance Auditor	☒
Miriam Botello	Compliance Advisor	☒
Eduardo Ron-Lopez	Compliance Coordinator	☒
Jeanette Crenshaw	Executive Director of Healthcare Services	☒
Fernanda Ortega	Project Supervisor, Healthcare Services	☒
Donna Ponce	Executive Assistant/Commission Clerk	☐

AGENDA ITEM/ PRESENTER	MOTION/MAJOR DISCUSSIONS	ACTIONS TAKEN
Call to Order Dr. Allan Wu, Chair	Dr. Allan Wu called meeting to order at 12:00 PM	
Approval of the Agenda Dr. Allan Wu, Chair	A. Items to be pulled or added from the Consent/Information/Action/Closed Session Calendar	
	B. Approval of the order of the agenda	Motion to Approve by Dr. Carlos Ramirez Second by Lee Hindman
Public Comment Dr. Allan Wu, Chair		**No Public Comment**
Chairperson Dr. Allan Wu, Chair	A. Approval of Minutes from September 22nd, 2025	Motion to approve by Dr. Ramirez Second by Mr. Hindman
Chairperson's Report Dr. Allan Wu, Chair	No recent meeting was held but a set of amendments were provided. Fraud, waste, and abuse policies were approved.	
Chief Compliance Officer Report Elysse Tarabola, Chief Compliance Officer		
a. Approve New and Updated Policies & Procedures Chelsea Hardy, Senior Director of Compliance	a. Approve New and Updated Policies & Procedures Chelsea Hardy presented forty-eight new and existing policies and procedures. The policy template was revised to include line of business and delegated entities; this resulted in a large volume update.	Motion to approve by Mr. Hindman Second by Dr. Ramirez

AGENDA ITEM/ PRESENTER	MOTION/MAJOR DISCUSSIONS	ACTIONS TAKEN
	Six new policies are included: five related to sales for D-SNP and one new HR policy for the retirement plan. These have been reviewed and approved by internal Compliance and Policy Committee. Mrs. Tarabola asked for a motion to approve the following policies: • **CMP-002** – Delegation Oversight • **CMP-003** – Corrective Action Plans • **CMP-005** – Confidentiality and Member Privacy • **CMP-007** – Escalation of Noncompliance Issues • **CMP-008** – Selecting a Chief Compliance Officer • **CMP-010** – Effective Lines of Communication • **CMP-011** – Breach Notification • **CMP-012** – Notice of Privacy Practices • **UM-001** – Utilization Management • **UM-002** – Referrals • **UM-003** – Continuity of Care • **UM-004** – Appropriate Professionals and Use of Board-Certified Physician Consultants in UM Decision Making • **UM-005** – Medical Necessity Criteria, Technology Assessment and Hierarchy of Resources • **UM-006** – Utilization Management System Controls • **UM-007** – Collection of Ethnicity & Diversity Data • **BH-001** – Behavioral Health • **QM-001** – Quality Management and Improvement • **GA-001** – Grievances Process • **GA-002** – Appeals Process • **GA-003** – Independent Medical Review (IMR) • **CM-001** – Care Management Programs • **CM-002** – Complex Case Management • **CM-003** – Complex Case Management Program Oversight and Model • **CM-004** – Multipurpose Senior Services Program General Provisions • **CM-006** – IHSS Personal Care Attendant Services • **CM-007** – Staff Training on CBAS and Other LTSS • **CM-008** – Personal Care (Case) Coordination • **CM-009** – Interdisciplinary Care Team (ICT) • **CM-010** – Medical Case Management • **CM-011** – D-SNP Individualized Care Plan (ICP) • **CM-012** – Health Risk Assessment and Case Management • **CM-014** – Risk Stratification Process • **PS-001** – Pharmacy Services • **PS-002** – Transitional Care Services • **PNM-001** – Standards of Network Accessibility and Timely Access to Care • **PNM-002** – Provider Directory • **CR-001** – Credentialing and Recredentialing • **CR-002** – Credentialing Appeals Process • **MS-001** – Language Assistance Program • **MS-002** – Member Services • **CLM-001** – Claims & Provider Dispute Resolution • **BC-001** – States of Emergency • **SR-001** – Agent Licensing Training • **SR-002** – Marketing Materials • **SR-003** – Sales Activities • **SR-004** – Enrollment Intake • **SR-005** – Sales Complaints • **HR-011** – Retirement Plan	
b. Notices of Noncompliance i. Health Net: Post Stabilization ii. Health Net: Undisclosed Physician Provider Groups (PPGs) Elysse Tarabola, Chief Compliance Officer	Elysse Tarabola presented updates to the two Notices of Noncompliance issued to Health Net. i. Health Net: Post-Stabilization Updates were provided to the full commission, however more detail will be given within this committee. The first step involved asking Health Net to conduct an impact analysis and retrospective review of all potential post stabilization claims cases that may have been potentially misclassified and inappropriately denied. Health Net confirmed the review was completed and they found that there were no adjustments to authorizations required. CHPIV DO is planning on reviewing a sample of those cases to validate their statement.	

AGENDA ITEM/ PRESENTER	MOTION/MAJOR DISCUSSIONS	ACTIONS TAKEN
	Health Net did also make changes to their phone line, making it exclusive for post stabilization requests. This change has not been fully implemented but will be completed by Q1 2026. Health Net will be submitting monthly hospital admission logs to CHPIV, and they have also updated their training to reinforce post stabilization requirements with their staff. The communications Health Net has prepared for the provider community will be brought to the provider advisory committee for feedback. Dr. Ramirez asked a question regarding whether the denials were for the patient or the facility and he also inquired about the denial categories and trends. Dr. Ramirez looked for further information on the major issues, since Health Net stated there were no non-compliance issues. Mrs. Tarabola responded that the main issue is that the guidelines surrounding post stabilization are strict. There is a short thirty-minute window where the providers call, and Health Net must approve or deny. There were denials in the ER that could've been addressed as post stabilization. Member impact was low, but provider impact was high due to the number of denials. Dr. Ramirez asked if the patient receives a bill after this process. Cynthia Mesa confirmed they did not and expanded on the process. She stated that the member is stabilized in the emergency room, and the hospital contacts the plan. However, the person contacting the plan likely does not know the difference between post stabilization and direct admission, creating a disconnect. The plan will end up receiving the fax and processing as a concurrent review, which has different guidelines than post stabilization. This gives Health Net more time than if they were to do post stabilization. Health Net reported zero post stabilization cases for the entire year of business. When we reviewed the post stabilization line, they had two different phone lines and people were faxing the sheets. If Health Net were to follow the post stabilization timeframes, they would need more staff to be on call 24/7, including holidays. Lee Hindman inquired if Health Net currently has staff on call 24/7 and Mrs. Mesa confirmed. Pablo Velez stated that this is a frequent issue from the provider side, as the health plans frequently deny claims, which leads to appeals. This has been an issue at the entire state level. Lee asked if the issues were more frequent at night. Mrs. Mesa clarified that the timing does not matter, as this is more so an opportunity for education. Informing the hospitals of this right would lead to a lesser burden on the provider, as they would not have to dispute certain denials. Mrs. Tarabola added that there are proactive measures to ensure that the phone line is clear and that the providers and internal staff are being trained appropriately. CHPIV is working closely with Health Net to close out any action and ongoing monitoring will occur to ensure this does not continue to be an issue. Dr. Ramirez asked who would benefit the most from the training: the hospital admissions department or the authorization department. Mrs. Mesa stated that the training should be done for the case management department, as well as the admissions, and the ED physicians. Dr. Wu asked if we should establish a meeting between the ED case managers, CHPIV, and Health Net to understand the subtleties of the process. This would prevent the longer appeals process for the hospitals as it is very expensive. Larry Lewis stated this is the intent behind the corrective action plan to ensure that Health Net does that as it is their responsibility. Dr. Wu inquired if we could ask Health Net to provide a tracking board, however Mrs. Mesa clarified that since they are not calling the number, there would be nothing to track as Health Net is stating it is zero. However, a breakdown of admissions could be provided, btu they would all be concurrent, which defeats the purpose of the review. Dr. Ramirez added that this is a process failure. Mrs. Mesa clarified that if Health Net does not respond within thirty minutes, it is an automatic approval, and this puts a burden on the staff and resources. Mr. Hindman asked when the thirty-minute timeframe begins, and Mrs. Mesa responded that the clock starts as soon as they make the call and we answer. Mrs. Tarabola circled back to Dr. Wu's request and clarified that the intention behind the hospital admission logs is to delineate the types of hospital admissions, as it will have an indicator of emergency room admissions. This will allow us to review and monitor to ensure the reported number is accurate. Dr. Wu inquired if there is a way to preemptively get the information near real time, so the local plan can access and keep the LHA informed. Mrs. Tarabola stated that we	

AGENDA ITEM/ PRESENTER	MOTION/MAJOR DISCUSSIONS	ACTIONS TAKEN
	could monitor call recordings to ensure those calls are being handled appropriately. We have already requested post stabilization logs, ii. Undisclosed IPAs – closed effective November 17th Health Net has either transferred all members that were in the out of area IPAs or they have performed outreach and identified that the members were no longer CHPIV members. The only IPAs remaining are Alpha Care and LaSalle. Those two will continue to be assigned and accept CHPIV membership. We have reviewed their DO audits from Health Net as they were contracted with them for other lines of business. There were issues regarding claims and provider dispute resolutions that have since been closed. Moving forward, we will continue to ensure that Health Net does proper onboarding implementation to identify CHPIV members and that they maintain proper oversight of LaSalle and Alpha Care. CHPIV has been receiving enrollment reports monthly, and they are reviewed to make sure there are not out of area member assignments. Dr. Ramirez asked about the services provided by the non-contracted IPAs and if they got paid for said services. Mrs. Tarabola stated that since the members were assigned to the IPAs, they did get paid for the services. The primary issue is that CHPIV did not have a line of sight to how the IPAs were performing.	
c. Regulatory Audits i. DMHC Routine Survey: Themes ii. DHCS Medical Audits: Status iii. DHCS Medical Audit - Response to Prelim Report iv. DMHC Routine Financial Chelsea Hardy, Senior Director of Compliance	Mrs. Hardy presented updates on regulatory audits. i. Mrs. Hardy provided key themes on the 2025 DMHC Routine Survey. Through the onsite interviews, we were able to identify the following themes. - Sub-delegation: DMHC had a lack of clarity around the delegation model. CHPIV delegates directly to Health Net, but Health Net has subcontractors that provide services to our members. There was a lot of discussion on how the oversight of Centene is handled. This was addressed in the DO annual audit and the NONC around undisclosed delegates. - Post Stabilization: This was related to the NONC discussed earlier and was addressed through the corrective action plan. - Delegation Oversight: There was a lack of oversight during the audit period. As discussed with DMHC, we were in the middle of our audit activity when they were on site. DMHC did acknowledge that there was oversight conducted. Our DO monitoring program did demonstrate our strengths, especially our quarterly oversight. ii. Mrs. Tarabola covered the status of the DHCS Medical Audit CHPIV received the preliminary report from DHCS and there were no unexpected findings. iii. CHPIV did respond to all their findings, indicating whether we agreed or disagreed. After their review of our responses, the corrective action plan process will be initiated. This will include a formal writing of corrective action plans with submission to DHCS. ii. Mrs. Hardy provided information on the DMHC Routine Financial Examination: The engagement began in November. We are currently in the pre-audit deliverable phase. The interview portion of the audit will be conducted in February. The audit scope involves finance, claims, and provider dispute resolution. Mr. Hindman asked if this includes David and his team. Mrs. Hardy confirmed that Health Net and our internal finance team are collecting the information for the audit.	
d. Delegation Oversight Audits i. Pre Delegation Audits – Status Report ii. CHG Pre Delegation Final Report iii. Annual Audit of Health Net Cynthia Mesa, Director of Internal and Delegation Oversight	Mrs. Mesa provided an introduction, outlining the process of a pre-delegation audit. Policy and procedures, along with organization status and financials, are reviewed to enter business with them. Policy review is done to make sure that all CMS rules are included. i. CHG is currently in the CAP portion of their audit. Community Care IPA and Imperial County Physician's Medical Group are in the draft report phase, as well as Premier Patient Care IPA and Primary Healthcare Medical Group. The submissions of additional documentation are due this Friday, 12/12/2025. Mr. Hindman asked if this will be completed by 1/1/2026, and Mrs. Mesa clarified there is no threat to their starting date on 1/1 ii. Mrs. Mesa presented the final report of CHG. Their final score was 76%. When we first started the pre-delegation audit, their score was in the 60s. Since they identified they	

AGENDA ITEM/ PRESENTER	MOTION/MAJOR DISCUSSIONS	ACTIONS TAKEN
	needed to do updates, they presented their draft policies and once they take it to their committee, the respective CAP will be closed. The audit cycle starts from when the audit is kicked off and we have 13 months to perform an annual audit. Ramirez inquired about whether we are appropriately staffed to conduct these many audits. Mrs. Mesa stated that we are appropriately staffed as of right now. Mr. Hindman requested additional information as to what is reviewed during the financial portion. David Wilson stated that we are looking for solvency, that they can pay claims if they are delegated to do so, and that they can support themselves operationally. Ultimately, we are financially responsible for all claims payment even if that function is delegated through the contract. Mr. Hindman asked what cadence this is being reviewed on. Mr. Wilson clarified that this is an ongoing process. iii. Health Net was issued the preliminary report of their annual audit. They prepared responses and submitted additional deliverables this Monday. This is currently under review. Most of the file review results will stand, especially in UM. Letters were part of the themes identified, as they struggled with member notification and appropriate translation.	
e. Delegation Oversight Monitoring Program i. Quarter 3 Preliminary Results: Highlights ii. Utilization Management Ongoing Data Issues Kristi Wilkerson, Manager of Internal and Delegation Oversight Cynthia Mesa, Director of Internal and Delegation Oversight	Mrs. Mesa presented updates around the Delegation Oversight Monitoring Program. i. KPI metrics are reviewed on a quarterly basis. Appeals is staying stagnant in terms of member notification timeliness. Claims dropped 1%, but they are still passing. There was previously a data issue when they reported 0%, but it was 100%. Grievance department is currently under a CAP for timeliness of translated letters. In a standard grievance, there are 30 days total to complete the investigation and issue the result. Health Net is issuing partially translated letters to meet the timeframe and stating that they will follow up later with the fully translated letter. ii. Utilization management failed their data validation and is also under a cap for their decision timeliness. This indicates that there may be staffing issues. While they have improved, they are not at the 95% threshold. The reason they are failing data validation is that they have a unique system, where they use the same authorization number for an entire year, and a new line is added when a provider requests a new authorization. Since the logs extract information from the original authorization number, this leads to issues with dates syncing up between their system and the log. A meeting did occur with them on November 17, but this has been an ongoing issue throughout the year.	
f. Fraud and Abuse i. Fraud and Abuse Cases ii. Case Trends Chelsea Hardy, Senior Director of Compliance	i. Mrs. Hardy stated we received six potential fraud, waste, and abuse cases in Quarter 3, and all six are currently under investigation. All MC609 forms, required by DHCS, were submitted timely in Q3. Mr. Hindman asked if CHPIV staff are responsible for completing the investigation, and Mrs. Hardy stated Health Net staff does the investigation and CHPIV is responsible for reviewing and submitting it to the regulator. Dr. Ramirez inquired about the categorization of fraud, waste, and abuse cases and if they are investigated the same regardless of severity. Mrs. Tarabola stated that it is considered when implementing corrective actions or any kind of mitigation. It does matter throughout the investigation as determination needs to be made whether it was intentional or not. Dr. Ramirez asked if only the potential fraud cases need to be reported to the state and Mrs. Tarabola stated that all potential fraud, waste, and abuse cases are reported to the plan and the state. ii. Mrs. Hardy presented a breakdown of the six potential cases; three of them are related to providers while the other three were related to labs. 85.7% of the case types were related to billing for services not rendered and the remaining 14.3% were for not appropriate billing.	
g. Privacy Incidents Chelsea Hardy, Senior Director of Compliance	Mrs. Hardy reported there were three non-breaches identified from CY 2025 to Q3 2025. In Q3, one privacy incident was determined to be a non-breach, and it was reported timely. The root cause of this issue was human error and that sole individual was provided coaching and privacy training.	
2025 All Plan Letter (APL) Summary Chelsea Hardy, Senior Director of Compliance	All plan letters are received from DHCS and DMHC throughout the year. The summary provided an overview of the number received in 2025 and the status. CHPIV is on track for the APLs requiring deliverables.	
Adjourn to Closed Session	The Committee adjourned to closed session at 1:03 pm to discuss preliminary results from a DHCS audit.	

AGENDA ITEM/ PRESENTER	MOTION/MAJOR DISCUSSIONS	ACTIONS TAKEN
Dr. Allan Wu, Chair		
Reconvene in Open Session Dr. Allan Wu, Chair	The Committee reconvened in open session at 1:11 pm. No reportable action was taken in closed session.	
Adjournment Dr. Allan Wu, Chair	Meeting was adjourned at 1:14 pm.	

Community Health Plan
OF IMPERIAL VALLEY

Regulatory Compliance & Oversight Committee

Quarter 1 2026

April 29, 2026

Agenda

ACTION ITEMS – Review and request approval of the following:

- Quarter 4 RCOC Minutes
- Updated and New Policies and Procedures
- Risk Management Program & Audit Monitoring Program
- 2025 Risk Assessment

INFORMATIONAL

- Discrimination Grievances
- Fraud and Abuse
- Corrective Action Plans
- Monitoring Results – Medi-Cal
- Monitoring Results - D-SNP

ATTACHMENTS

- New All Plan Letters (APLs) Released and Status
- Privacy Incidents

Community Health Plan OF IMPERIAL VALLEY

ACTION ITEMS

Updated and New Policies and Procedures

Updated P&Ps

See Exhibit A – Policy Packet

Policy Name	Department	Functional Area	Summary of Changes
CMP-004 Implementation of Regulatory Notifications	Compliance	Compliance	Annual Review
CMP-005 Confidentiality and Member Privacy	Compliance	Compliance	Ad-hoc Updates
CMP-006 Compliance Training	Compliance	Compliance	Annual Review
CMP-014 Compliance Program	Compliance	Compliance	Annual Review
EXC-001 Conflict of Interest Avoidance	Executive Services	Executive Services	Annual Review
EXC-002 Delegation of Authority	Executive Services	Executive Services	Annual Review
GA-001 Grievance Process	Health Services	Grievance & Appeals	The policy was updated to revise language related to discrimination grievances in response to DHCS findings.
HR-005 New Positions	Human Resources	Human Resources	Annual Review
HR-006 Diversity, Equity, & Inclusion	Human Resources	Human Resources	Annual Review

Community Health Plan OF IMPERIAL VALLEY

Updated P&Ps

See Exhibit A – Policy Packet

Policy Name	Department	Functional Area	Summary of Changes
HR-007 EEO Affirmative Action	Human Resources	Human Resources	Annual Review
HR-008 Organizational Readiness	Human Resources	Human Resources	Annual Review
HR-009 Remote Work	Human Resources	Human Resources	Annual Review
HR-010 Promotions	Human Resources	Human Resources	Annual Review
HR-0012 Employee Recognition	Human Resources	Human Resources	New Policy
HR-004 After Hours Communication	Human Resources	Human Resources	Retire -The policy is being retired because it was a short-term trial and limiting after-hours communication could hinder operations and delay critical issue escalation, potentially impacting members and regulatory compliance.
FIN-001 Delegated Provider Financial Solvency Oversight Process	Finance & Informatics	Finance	Annual Review

Updated P&Ps

See Exhibit A – Policy Packet

Policy Name	Department	Functional Area	Summary of Changes
FIN-002 Delegated Provider Financial Solvency Corrective Action Plan Process	Finance & Informatics	Finance	Annual Review
FIN-003 Medical Loss Requirements for Subcontractors	Finance & Informatics	Finance	Annual Review
FIN-006 Investment Policy	Finance & Informatics	Investment Management	Annual Review

Risk Management Program and Audit & Monitoring Program

2 New Foundational Compliance Programs – effective 2026

Risk management program

- Establishes how CHPIV identifies, scores, and tracks compliance risks
- Drives a Risk Repository — the organization's record of all compliance risk
- Produces an Annual Risk Assessment that sets oversight priorities for the year ahead
- Governs how risks are formally accepted, remediated, and retired

Audit & monitoring Program

- Defines what and how CHPIV audits & monitors
- Frequency of reviews based on risk
  - High/Critical – monthly/quarterly monitoring
  - Med/Low – annual audits
- Specifications on data/reporting, KPI list, case file audit tools

Community Health Plan OF IMPERIAL VALLEY

How the Programs Connect

Every risk is scored, tracked, and linked to prior records. Closure requires validated correction.

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See Exhibit B – Risk Management Program

Risk Management Program

Component	What It Does	Role in Program
Risk Repository	Living inventory of every compliance risk — open, active, and retired. Updated continuously as risks are identified, remediated, and validated.	**Foundation**
Risk Scoring	Three factors scored 1–3: Member/Provider Impact + Regulatory Focus + Deficiency/Recurrence. Composite score (3–9) assigns a tier: Critical, High, or Medium/Low.	**Drives oversight intensity**
Annual Risk Assessment	All risks scored, tiered by line of business. Output sets the Monitoring Program for the year ahead. Delivered to Compliance & Policy Committee (CPC) and Regulatory Compliance Oversight Committee (RCOC) of the Commission before program year starts.	**Sets priorities for the year**
Validation & Retirement	A risk is not closed because a CAP was implemented. It is closed because correction is validated — two consecutive GREEN quarters, or no repeat at next audit.	**Ensures correction**

Community Health Plan OF IMPERIAL VALLEY

See Exhibit B – Risk Management Program

Risk Scoring Methodology

Every risk scored on three factors — composite score sets the tier

Factor 1 Member / Provider Impact	Factor 2 Regulatory Focus	Factor 3 Deficiency / Recurrence
3 — High Lack of access to care, denial of medically necessary care, or immediate threat to health/safety	**3 — High** Active enforcement action subject to monetary penalties	**3 — Major** Systemic noncompliance; regulatory NONC; pattern of recurrence across multiple audit cycles
2 — Med Adverse effects on well-being; not an immediate threat to health, safety, or access	**2 — Med** Active NONC or targeted in a focus audit, recent APL/HPMS memo, or active regulatory inquiry	**2 — Moderate** Substantive gap in process or controls; repeat finding after prior risk was validated and closed
1 — Low Administrative or process-oriented; indirect impact on member/provider experience	**1 — Low** In routine audit scope; no targeted scrutiny or active inquiry in this domain	**1 — Minor** Isolated, first-occurrence finding. Non-systemic; immediately correctable

Composite Score 3–9 | **7–9: CRITICAL** | **5–6: HIGH** | **3–4: MEDIUM / LOW** — *Tier determines monitoring frequency and audit intensity*

Community Health Plan OF IMPERIAL VALLEY

See Exhibit C – Audit & Monitoring Program

Audit & Monitoring Program

One framework, three element types — frequency driven by risk tier

Quantitative KPIs

Quarterly — All Areas

- Data-driven metrics calculated from internal and delegate-submitted logs
- GREEN / YELLOW / RED thresholds applied to each KPI
- 1 YELLOW: warning letter issued
- 2 consecutive YELLOWs: CAP required
- RED: CAP required; risk logged in repository
- Covers: Claims, Member Services, Grievances, PDR, CoC, Appeals acknowledgement, and more

Qualitative KPIs (Case File Review)

Quarterly (High/Critical) | Annual (Med/Low)

- Structured review using CHPIV audit tools
- NCQA 8/30 sample logic: start with 8 cases; expand to 30 if compliance < 95%
- Each case scored compliant/noncompliant against predefined criteria
- Covers: UM decisions, appeals resolution, grievances, BHT, ECM/CCM, IHA, BLL, CCS, transportation

Policy Reviews

Annual — All Areas

- Evaluates whether written P&Ps comply with CHPIV standards and regulatory requirements
- Conducted annually regardless of risk tier
- Finding = policy absent, materially deficient, or noncompliant → CAP required

Community Health Plan OF IMPERIAL VALLEY

Key Points

Oversight is Risk Driven

The Annual Risk Assessment determines where we focus — not administrative schedules. High and Critical areas get quarterly attention. Medium/Low areas receive annual review.

Risk acceptance is formal

When full remediation isn't immediately feasible, leadership can formally accept a risk — documented, reasoned, and reviewed annually.

Closure requires evidence

A CAP that has been implemented but not validated stays open. Closure requires demonstrated correction.

Quarterly Escalation

Performance scores and CAP Statuses will come to the Compliance & Policy Committee and RCOC every quarter.

The Annual Risk Assessment and Audit Report are presented before each new program year.

Institutional memory is preserved.

Every finding is linked to prior records. If a risk recurs after being validated and closed, the history of prior remediation — what was done, when it was validated, how long the correction held — is on record.

Community Health Plan OF IMPERIAL VALLEY

2025 Risk Assessment

See Exhibit D

2026 New Monitoring KPIs

Based on the risk assessment, we've added 32 new KPIs to review on a quarterly basis

Functional Area	KPI Type	KPI #	KPI Name
Appeals	Qualitative	**APPEAL-004**	RESOLUTION LETTER CONTENT
Blood Lead Level	Qualitative	**BLL-001**	BLL SCREENING – INITIAL REQUIREMENTS RM-20
Blood Lead Level	Qualitative	**BLL-003**	ELEVATED BLL FOLLOW-UP PROTOCOLS
Blood Lead Level	Qualitative	**BLL-002**	ANTICIPATORY GUIDANCE RM-13
CCS	Qualitative	**CS-001**	CCS AUTHORIZATION & SERVICE TYPE
CCS	Qualitative	**CS-002**	CCS REFERRAL & CLOSED-LOOP REFERRAL (CLR)
CCS	Qualitative	**CS-003**	CCS SERVICE DELIVERY
CCS	Qualitative	**CS-004**	CCS OUTCOME & COORDINATION (CLR CLOSURE)
CCS	Qualitative	**CS-005**	CCS DELEGATION & QI

Community Health Plan OF IMPERIAL VALLEY

2026 New Monitoring KPIs

Based on the risk assessment, we've added 32 new KPIs to review on a quarterly basis

Functional Area	KPI Type	KPI #	KPI Name
Delegation Oversight	Qualitative	**DO-009**	TRANSPORTATION — MOVICARE
Enhanced Care Management	Qualitative	**ECM-010**	AUDIT UNIVERSE & DELEGATION
Enhanced Care Management	Qualitative	**ECM-001**	MEMBER IDENTIFICATION & OUTREACH
Enhanced Care Management	Qualitative	**ECM-001**	CARE ELEMENT 1: MEMBER ID & OUTREACH
Enhanced Care Management	Qualitative	**ECM-002**	CARE ELEMENT 2: COMPREHENSIVE ASSESSMENT
Enhanced Care Management	Qualitative	**ECM-003**	CARE ELEMENT 3: CARE PLAN
Enhanced Care Management	Qualitative	**ECM-004**	CARE ELEMENT 4: CARE COORDINATION

Community Health Plan OF IMPERIAL VALLEY

2026 New Monitoring KPIs

Based on the risk assessment, we've added 32 new KPIs to review on a quarterly basis

Functional Area	KPI Type	KPI #	KPI Name
Exempt Grievances	Qualitative	**EXG-004**	CORRECT CLASSIFICATION OF EXEMPT GRIEVANCE
Exempt Grievances	Qualitative	**EXG-005**	EXEMPT GRIEVANCE HANDLING AND RESOLUTION
Grievances	Qualitative	**GRV-004**	RESOLUTION LETTER CONTENT
Grievances	Qualitative	**GRV-006**	TRANSPORTATION GRIEVANCES
Grievances	Qualitative	**GRV-007**	DISCRIMINATION GRIEVANCES
Initial Health Appointment	Qualitative	**IHA-001**	IHA COMPLETION & TIMELINESS
Initial Health Appointment	Qualitative	**IHA-006**	OUTREACH & DOCUMENTATION
Initial Health Appointment	Qualitative	**IHA-005**	FOLLOW-UP & REFERRALS

Community Health Plan OF IMPERIAL VALLEY

2026 New Monitoring KPIs

Based on the risk assessment, we've added 32 new KPIs to review on a quarterly basis

Functional Area	KPI Type	KPI #	KPI Name
MHSUD-BHT	Qualitative	**BHT-001**	LEVEL OF CARE (LOC) ASSESSMENT
MHSUD-BHT	Qualitative	**BHT-002**	BH TREATMENT PLAN RM-12
MHSUD-BHT	Qualitative	**BHT-004**	TRANSITIONS OF CARE – BH DISCHARGE
MHSUD-BHT	Qualitative	**BHT-006**	OVERSIGHT & DELEGATION RM-34
Utilization Management	Qualitative	**UM-010**	POST-STABILIZATION
Utilization Management	Qualitative	**UM-001**	PHYSICIAN REVIEWER QUALIFICATIONS & ACCESSIBILITY
Utilization Management	Qualitative	**UM-008**	DENIAL LETTER CONTENT
Utilization Management	Qualitative	**UM-009**	UM CRITERIA APPLICATION & MN RATIONALE

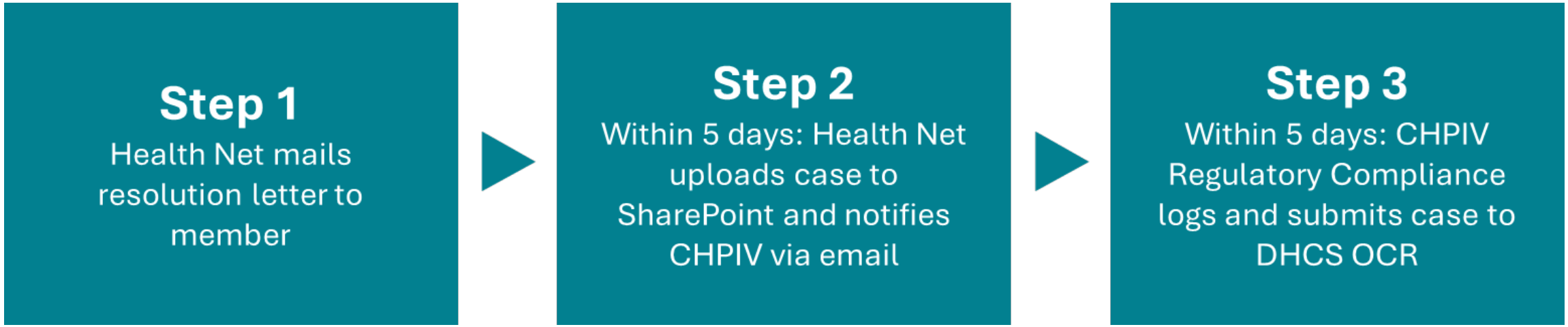
Community Health Plan OF IMPERIAL VALLEY

INFORMATIONAL

Discrimination Grievances

Discrimination Grievances
Improved Submission Process to DHCS Office of Civil Rights (OCR)

- Coordinated with Health Net to enhance the end-to-end submission process for discrimination grievances to the DHCS Office of Civil Rights (OCR), with CHPIV Regulatory Compliance now owning the OCR submission step.
- Implemented a dedicated Monday.com tracker to monitor and ensure timeliness of each case across all stages of the submission process.

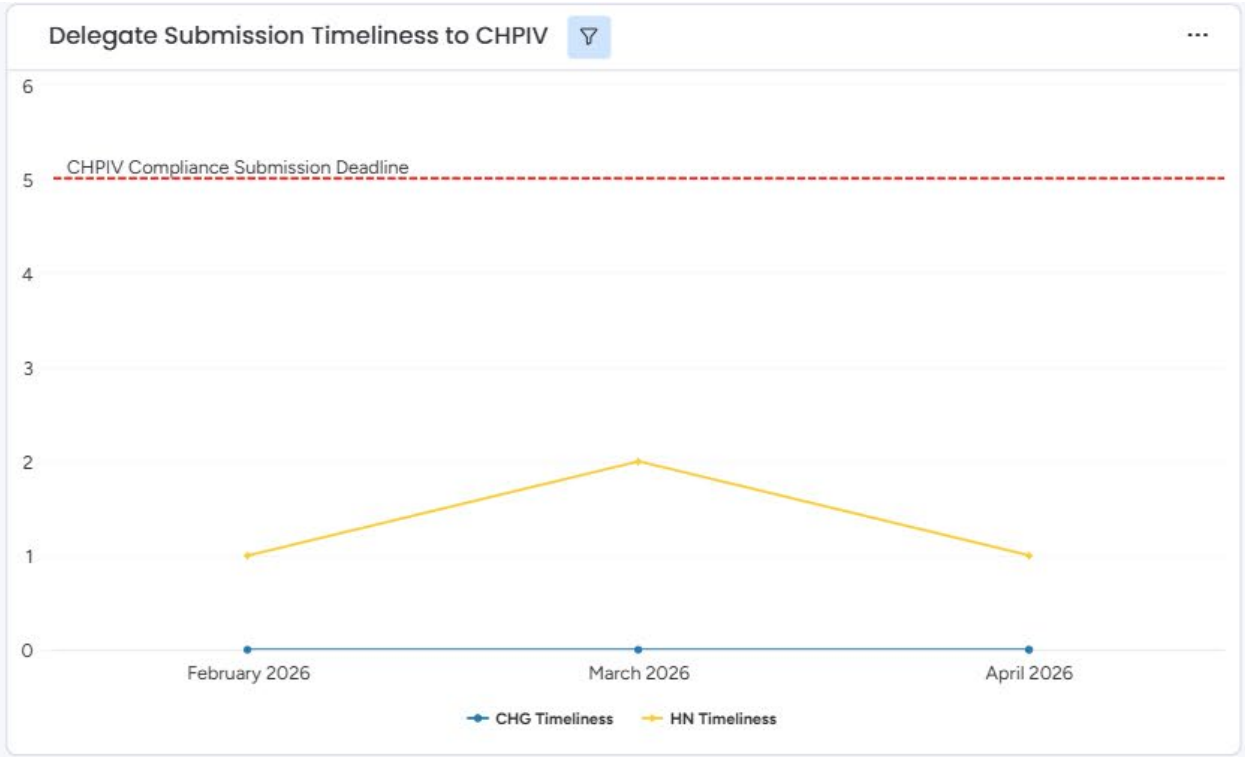


Community Health Plan OF IMPERIAL VALLEY

Discrimination Grievances Quarter 1 2026

Community Health Plan OF IMPERIAL VALLEY

Discrimination Grievances Quarter 1 2026 Timeliness

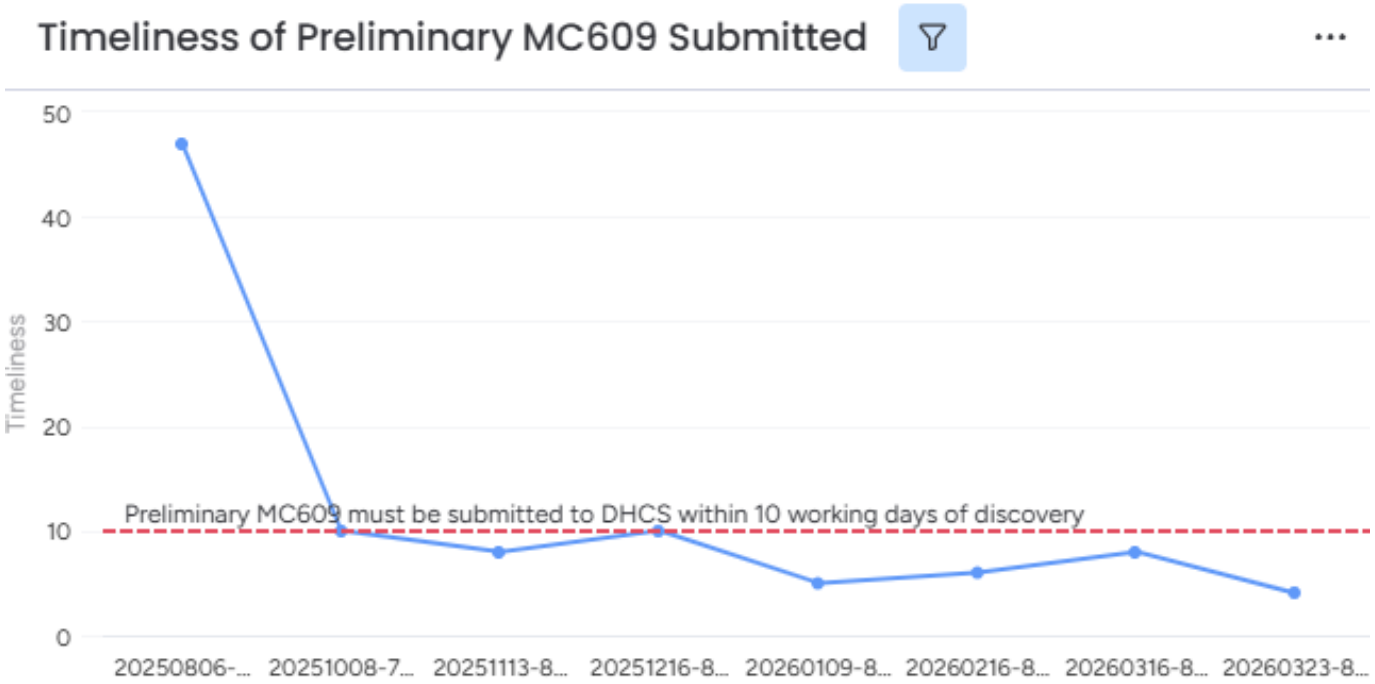


Community Health Plan OF IMPERIAL VALLEY

Fraud and Abuse

Potential Fraud Waste and Abuse Cases

- MC609 – Required notification to DHCS within 10 working days of initiating or concluding a fraud, waste, or abuse investigation and when terminating a provider due to FWA concerns.



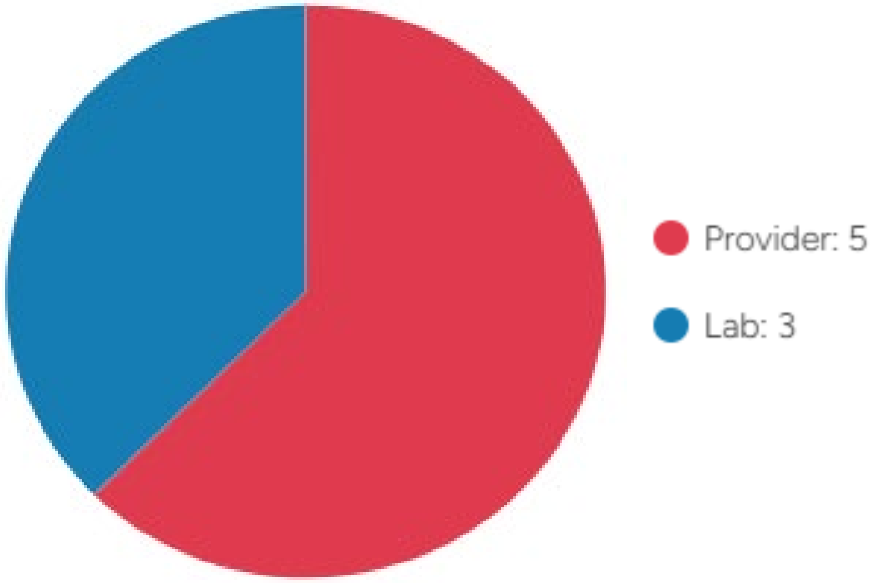
- For **Q4 2025 - Q1 2026**, we received 8 cases of potential fraud, waste, and abuse.
- All 8 cases remain under investigation.
- 7 MC609 cases were submitted timely;
  1 did not meet timeliness requirements for Q4.

Community Health Plan OF IMPERIAL VALLEY

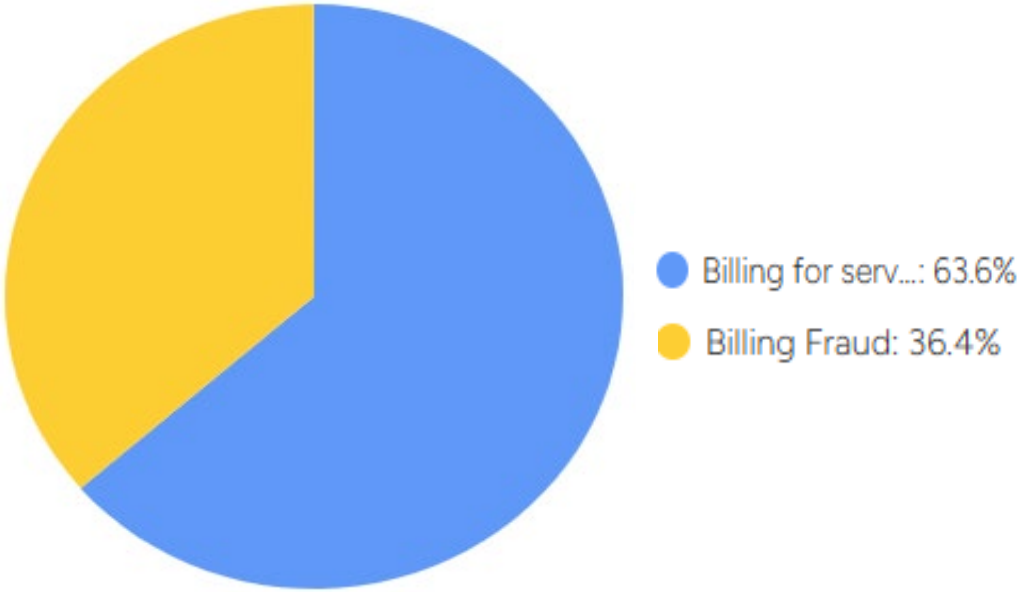
Potential Fraud and Abuse Case Trends

- For **Q4 2025 – Q1 2026**, we received a total of 8 cases: 3 cases related to laboratories and 5 involving individual providers.
- The primary trend identified this quarter was “Billing for Services Not Rendered.”

By Subject Type



By Case Type



Community Health Plan OF IMPERIAL VALLEY

Corrective Action Plans

2024 DHCS Audit CAP Status Summary

- **Review Period:** 1/1/2024 – 12/31/2024
- **CAP Request Date:** 2/18/2026
- **Initial CAP Submission:** 3/20/2026
- **DHCS Feedback Received:** Post–3/20/2026
- **Next Submission Due:** 5/1/2026 (Revised CAP narratives and documentation are currently in progress)

Community Health Plan OF IMPERIAL VALLEY

DHCS Audit CAP Feedback Highlights

- Health Equity Officer – urging CHPIV to hire by 9/1/2026 (currently aiming for 4/1/2027)
- Long term solution for referral tracking is reporting to QIHEC by 9/30/2026. DHCS is suggesting an interim process (short term solution)
- Seeking clarity on Audit and Monitoring Program, audit tools, and when the next scorecard will be available with new KPIs

Community Health Plan OF IMPERIAL VALLEY

Delegation Oversight – CAP Summary

Medi-Cal

- **Health Net Annual Audit 2025**
  - **14** CAPs are **open and in progress**
    - Missing policy updates, training, and evidence submissions
  - **6** CAPs are **closed**.
  - Auditors are actively following up with HN
  - **Next submission due:** 4/28/2026

D-SNP

- **Pre-Delegation Audits (2026)**
  - **CHG**
    - CAPs remediated; no further action
  - **PPCIPA | ICPMG | CCIPA | PHCMG**
    - Second-round CAP responses submitted
    - Auditors currently reviewing responses
    - **Next reviewer deadline:** 4/28/2026

Community Health Plan OF IMPERIAL VALLEY

Monitoring Results

Medi-Cal

See Exhibit E

2025 Results – Utilization Management

KPI #	KPI Name	Q1	Q2	Q3	Q4
UM001	**Decision Timeliness**	82%	64.25%	73%	95%
UM002	**Member Notification Timeliness**	99%	94.76%	95%	92%
UM003	**Provider Notification Timeliness**	88%	76.79%	94%	56%

- Ongoing data issues make the data unreliable.
- Shifting to case file reviews to test timeliness for UM

Community Health Plan OF IMPERIAL VALLEY

See Exhibit E

2025 Results – Appeals

KPI #	KPI Name	Q1	Q2	Q3	Q4
APPEAL 001	**Acknowledgement Timeliness**	🟢 100%	🟢 100%	🟢 100%	🟢 100%
APPEAL 002	**Decision Timeliness**	🟢 100%	🟢 100%	🟢 100%	🟢 100%
APPEAL 003	**Effectuation Timeliness**	🟢 100%	🟢 100%	🟢 100%	🔴 85%
APPEAL 004	**Member Notification Timeliness**	🔴 74%	🔴 95.45%	🔴 95.45 %	🟢 100%

- Appeals is strong
- Emerging risk in Effectuation Timeliness
  - *Note: Q4 result of 85% is based on 11 of 13 compliant files.*
- Member notification timeliness shows clear improvement

Community Health Plan OF IMPERIAL VALLEY

See Exhibit E

2025 Results – Continuity of Care

KPI #	KPI Name	Q1	Q2	Q3	Q4
COC001	**Processing Timeliness**	🟢 100%	🟢 100%	🟢 100%	🟢 100%
COC002	**Notification Timeliness**	🟢 100%	🟢 100%	🔴 50%	🔴 0%

- COC Processing is fully compliant and stable
- COC002 Notification Timeliness critical issue by Q4
  - CAP Issued
  - *Note: Q3 and Q4 results based on review of relatively small sample sizes.*
    - ➢ *Q3, two files reviewed.*
    - ➢ *Q4, one file reviewed.*

Community Health Plan OF IMPERIAL VALLEY

2025 Results – Claims

See Exhibit E

KPI #	KPI Name	Q1	Q2	Q3	Q4
CLM001	**30-Day Payment Timeliness**	99.04%	96.49%	98.92%	99.20%
CLM002	**45-Day Payment Timeliness**	99.94%	99.80%	99.64%	99.65%
CLM003	**90-Day Payment Timeliness**	100%	100%	100%	100%
CLM004	**Acknowledgement Timeliness**	100%	99.66%	99.68%	99.31%
CLM005	**Misdirected Claims Timeliness**	99.11%	99.13%	99.61%	97.25%
CLM006	**Interest Payment Timeliness**	100%	0%	100%	100%

- Claims is consistently high-performing
- One isolated failure in interest payment but recovered
- Overall: low risk / stable

Community Health Plan OF IMPERIAL VALLEY

2025 Results – PDR

See Exhibit E

KPI #	KPI Name	Q1	Q2	Q3	Q4
PDR001	**Acknowledgement Timeliness**	98%	97.85%	100%	96.53 %
PDR002	**Written Determination Timeliness**	99%	99.30%	99%	97.27 %
PDR003	**Interest Payment Timeliness**	100%	100%	100%	99.84 %

- PDR is consistently compliant across all quarters
- Minor variation but no meaningful risk

Community Health Plan OF IMPERIAL VALLEY

2025 Results – Member Services

See Exhibit E

KPI #	KPI Name	Q1	Q2	Q3	Q4
MS001	**Calls Answered <30 sec**	97.25%	97.09%	97.07 %	96.28 %
MS002	**Call Abandonment Rate**	0.64%	1.04%	1.32%	0.89%
MS003	**Member ID Timeliness**	99.52%	99.73%	99.29 %	99.45 %

- Member Services is consistently high-performing
- Stable across all quarters → no risk

Community Health Plan OF IMPERIAL VALLEY

2025 Results – Grievances

See Exhibit E

KPI #	KPI Name	Q1	Q2	Q3	Q4
GRV001	**Acknowledgement Timeliness**	100%	96.43%	97.09 %	98.00 %
GRV002	**Resolution Timeliness**	100%	100%	100%	100%
GRV003	**Member Notification Timeliness**	70.80 %	64.70%	36.36 %	67.00 %

- Member notification continued to be an issue because letters were not translated, as appropriate.
- HN is implementing CAP which involves a new process to fully translate grievance resolution letters

2026 Medi-Cal Monitoring: Current State

- Auditors are collecting new logs (blood lead level screening, California Children Services, etc.)
- Select samples
- Collect case files
- Conduct file reviews
- Q1 scorecard will include new KPIs tied to **qualitative** measures

Community Health Plan OF IMPERIAL VALLEY

D-SNP

2026 D-SNP Monitoring: Current State

- IPAs are submitting monthly universes to CHPIV
  - CHG has only agreed to submit quarterly
- CHPIV is in the process of conducting data validation audits to ensure reports match delegate systems (data integrity)
- CHG just submitted universes on 4/15. Currently reviewing
- Q1 scorecard set to be disseminated by May 2026.

Community Health Plan OF IMPERIAL VALLEY

Quarter 1 Data Validation: Dual Eligible Special Needs Plan (D-SNP)

CMS Universe	Community Care IPA	Imperial County Physicians Medical Group	Primary Healthcare Medical Group	Premier Patient Care IPA
Table 1: Standard and Expedited Pre-service OD (Authorizations)	**FAIL** – resubmission required	**FAIL** – resubmission required	**FAIL** – resubmission required	**PASS**
Table 3 - Payment OD and RECON (Claims and PDRs)	PASS	Scheduling in Progress	**FAIL** – resubmission required	**PASS**

Community Health Plan OF IMPERIAL VALLEY

Questions

Attachments

	REGULATORY COMPLIANCE NOTICE
	[Insert name & link of regulatory document (ex. APL 23-XXX)]

Date	
Attachments/References	
Functional Area(s)	
Functional Owners	☐ CHPIV ☐ Health Net
Delegation Oversight	☐ Audits ☐ Monitoring ☐ NA

The summary below is intended to highlight key elements of the APL. Please review the entire APL for full details and requirements.

REGULATORY DELIVERABLES				
Deliverable Description		**Owner**	**Internal/CHPIV Due Date**	**Regulator Due Date**
1				

SUMMARY OF SIGNIFICANT UPDATES
▸

PURPOSE & SCOPE
Clearly state the overall purpose of the APL; keep it brief.

KEY REQUIREMENTS/ CHANGES
▸ *Emphasize the most significant requirements. This is usually the primary reason the APL is important. Don't go into the detail; keep it high level.*

IMPACT
Summarize the impact very briefly. Since the full APL is included, detailed impact analysis can be referred to in the document.

Delegation Oversight

The information below summarizes the impact on CHPIV delegation oversight processes.

DELEGATION OVERSIGHT PROGRAM	
Annual Audit Element	**Change Summary**
TBD	
Monitoring KPIs	**Change Summary**
TBD	

Implementation Plan Form

Regulatory Compliance Notice/Operational function			
Requirements Summary			
Regulatory Agency	☐ DMHC ☐ DHCS	Business Owner(s)	

NEEDS ASSESSMENT					
Staffing	☐ New ☐ Reclassification	Systems	☐ New ☐ Enhancements	Funding	☐ Yes
Training	☐ Provider ☐ Subcontractor ☐ Staff	Provider/ member materials	☐ Provider: new ☐ Provider: revised ☐ Member: new ☐ Member: revised	Delegation Oversight	☐ Audits ☐ Monitoring
Vendors	☐ New ☐ Existing	Contracts	☐ New ☐ Amendments	Policies and procedures (P&Ps)	☐ New ☐ Revised
Other	Documents				

IMPLEMENTATION PLAN Action item(s) to address all implementation needs (as noted above).				
Need	Implementation Action	Task Owner (Staff Name, Department)	Supporting Documentation	Implementation Date
Example: Training	*Example:* *1. Develop required Compliance Training material.*	*Example:*	*Example: Training material*	*Example: 4/1/2023*
P&Ps	*2. Develop a Compliance Training P&P outlining requirements to complete training within 90 days of onboarding and annually thereafter.*		*P&P CMP-001 Compliance Training*	*4/15/2023*
Training	*3. Deploy Compliance Training to organization on 5/1/2023.*		*Sign in sheets Completion reports*	*5/1/2023*

	Implementation of Regulatory Notifications	CMP-004
	Department	Compliance
	Functional Area	Compliance
	Line of Business	☒ Medi-Cal ☒ D-SNP

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

DATES			
Policy Effective Date	10/09/2023	**Reviewed/Revised Date**	03/25/2025
Next Annual Review Due	03/25/2026	**Regulator Approval**	8/25/2023

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

ATTACHMENTS

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

AUTHORITIES/REFERENCES

- NA

HISTORY

Revision Date	Description of Revision
10/09/2023	Policy Creation
03/25/2025	Annual Review
	Annual Review

I. OVERVIEW

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

II. POLICY

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

III. PROCEDURE

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

B. Final REGULATORY NOTIFICATIONS

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

IV. DEFINITIONS

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

TERM	DEFINITION
Commission	The governing body of the Local Health Authority (LHA). It is comprised of thirteen voting members that represent different sectors of the health system, the public, Medi-Cal beneficiaries, and businesses as outlined in LHA Establishing Ordinance.
Delegated Entities (Delegate)	A contracted entity which CHPIV authorizes to perform certain functions on its behalf. Although, CHPIV can delegate the authority to perform a function, it cannot delegate the responsibility for ensuring that the function is performed according to CHPIV and National Committee on Quality Assurance (NCQA) standards.
Department of Health Care Services (DHCS)	The State agency responsible for administration of the federal Medicaid (referred to Medi-Cal in California) Program, California Children's Services (CCS) Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP) and other health related programs.
Department of	The state agency responsible for administering the "Knox-Keene Health

TERM	DEFINITION
Managed Health Care (DMHC)	Care Service Plan Act of 1975.
Disciplinary Action	A formal action taken in response to unacceptable performance or misconduct.
Compliance and Policy Committee (CPC)	An internal committee of CHPIV management staff that monitors compliance activities and makes recommendations for action to CHPIV staff, including CHPIV's executive staff, and the Commission
Regulatory Agencies	State and federal governing bodies overseeing consumer rights to quality health care. This includes, but is not limited to, the Department of Managed Health Care (DMHC), the California Department of Health Care Services (DHCS), and the Centers for Medicare and Medicaid Services (CMS).
Regulatory Notification	Notices released by the Department of Health Care Services and Centers for Medicare and Medicaid Services (All Plan Letter (APL), Policy Letter (PL), Duals Plan Letter (DPL) and Health Plan Management System (HPMS) Memos), to aid health plans in implementing programmatic and policy changes.
Subcontractor	An individual or entity that has a subcontract with the MCP that relates directly or indirectly to the performance of the MCP's obligations under the contract with DHCS. A network provider is not a subcontractor by virtue of the network provider agreement, as per 42 CFR § 438.2.

	Confidentiality and Member Privacy	CMP-005
Department	Compliance	
Functional Area	Compliance	
Line of Business	☒ Medi-Cal ☒ D-SNP	

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

DATES			
Policy Effective Date	06/12/2023	**Reviewed/Revised Date**	12/11/2025
Next Annual Review Due	12/11/2026	**Regulator Approval**	07/02/2024

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

ATTACHMENTS
NA

AUTHORITIES/REFERENCES

- **Internal**
  - CHPIV, Delegation Oversight Policy and Procedure, CMP-002
  - CHPIV, Notice of Privacy Practices, CMP-012
  - CHPIV, IT Policy and Procedure, IT-001
- **Federal**
  - 45 Code of Federal Regulations ("CFR") Parts 160, 162, and 164
- **State**
  - California Assembly Bill 1184: The Confidentiality of Medical Information Act (CMIA)
  - California Assembly Bill 254: Confidentiality of Medical Information Act: Reproductive or Sexual Health Application Information
  - California Civil Code Sections 56.05 & 56.10 et seq., 56.108, 56.109, 56.110 56.107, 56.111, 1798 et seq.
  - California Code of Civil Procedure ("CCP") Sections 3421, 3424, 3427, 3428
  - Health and Safety Code Sections ("H&S Code") 1280.1, 1280.3, 1280.15, 1364.5, 123100 – 123149, 1364.5
  - California Code of Regulations ("CCR") Title 22 § 51009
  - DMHC All Plan Letter ("APL") 22-010 (OPL): Guidance Regarding AB 1184;
  - 2024 DHCS Contract Exhibit A, Attachment III 5.1.1(B)
  - California Senate Bill 497 (SB 497): Gender-Affirming Health Care; Civil Code Section 56.111

- **Accreditation**
  - NCQA: Member Experience (ME) 3, Element B, Medicaid (MED) 4, Elements A-C

HISTORY	
Revision Date	**Description of Revision**
6/12/2023	Policy creation
5/17/2024	Annual review- revisions to align with AB 254 & AB 352 updated requirement & NCQA requirements
11/12/2024	Policy revision to align with NCQA requirements
12/11/2025	Updated procedure section
	Ad-Hoc Updates

I. OVERVIEW

A. This policy addresses Community Health Plan of Imperial Valley's ("CHPIV" or the "Plan") Confidentiality and Member Privacy requirements, policies, and procedures. The purpose of this policy is to establish a process to protect the confidentiality of CHPIV's subscribers' and enrollee's PHI, PII, and data regarding race, ethnicity, language, gender identity, and sexual orientation.

II. POLICY

A. CHPIV ensures there are processes to protect the confidentiality of a subscriber's or enrollee's PHI, PII, and data regarding a Member's race, ethnicity, language, gender identity, and sexual orientation. This includes:
   1. Not requiring a protected individual to obtain the primary subscriber or other enrollee's authorization to receive sensitive services or to submit a claim for sensitive senses if the protected individual has the right to consent to care.
   2. Directing communications regarding a protected individual's receipt of sensitive senses as follows:
      a. Directly to the protected individual's designated alternative mailing address, email address, or telephone number OR
      b. In the absence of a designated alternative mailing address, email address or telephone number: to the address or telephone number on file in the name of the protected individual.
      c. Communications (written, verbal or electronic communications) regarding a protected individual's receipt of sensitive services shall include:
         i. Bills and attempts to collect payment.
         ii. A notice of adverse benefits determinations.
         iii. An explanation of benefits notice.
         iv. A plan's request for additional information regarding a claim.
         v. Notice of a contested claim.
         vi. The name and address of a provider, description of services provided, and other information related to a visit.
         vii. Any written, oral, or electronic communication from a plan that contains PROTECTED HEALTH INFORMATION.

3. As outlined in IT-001, managing the use of PHI, PII, and data regarding a Member's race, ethnicity, language, gender identity, and sexual orientation through:
    a. Managing and limiting employee access to physical and electronic data sources, such as media, devices, and data storage, and
    b. Delineating permissible and impermissible uses and disclosures of the data. In accordance with 45 C.F.R. §§ 164.502(a), 164.506(a)-(b), CHPIV may make the following permissible disclosure types:
        i. To the individual.
        ii. To the individual's PERSONAL REPRESENTATIVE.
        iii. With the individual's authorization.
        iv. By CHPIV for purposes of treatment, payment or health care operations in compliance with 45 C.F.R. § 164.502.
        v. To business associates of CHPIV.
        vi. To a plan sponsor.
        vii. To research organizations.
        viii. Additional uses and disclosures consistent with the Notice of Privacy Practices (see CMP-012) that are permitted or required by law.
        ix. CHPIV may not use race, ethnicity, language, gender identity, and sexual orientation data for underwriting, or to deny services, coverage and benefits.

B. CHPIV will not cooperate with any inquiry or investigation by or provide PHI, PII, or data regarding a Member's race, ethnicity, language, gender identity, and sexual orientation to any individual, agency, or department from another state or, to the extent permitted by federal law, to a federal law enforcement agency that would identify protected individual and that is related to the protected individual seeking or obtaining an abortion or abortion-related services that are lawful under the laws of California & Civil Code Section 56.108, or related to an individual seeking or obtaining gender-affirming health care or gender-affirming mental health care that is lawful under the laws of California, pursuant to Civil Code Section 56.111, unless the request for PHI, PII, or data regarding a Member's race, ethnicity, language, gender identity, and sexual orientation is authorized under Civil Code Section 56.110.This prohibition does not apply to an inquiry or investigation of activity that is punishable as a crime under California law, an audit or investigation of activity that is unlawful under California or federal law, or an audit, review, or investigation conducted for purposes of licensure, registration, accreditation, or certification under California or federal law or pursuant to an accrediting organization recognized by the State Department of Public Health or the federal Centers for Medicare and Medicaid Services.

C. CHPIV will not disclose, transmit, transfer, share or grant access to PHI, PII, or data regarding a Member's race, ethnicity, language, gender identity, and sexual orientation, or related sensitive health care services provided to a protected individual to the primary subscriber or any plan enrollees other than the protected individual receiving care, absent an express authorization of the protected individual. This includes PHI or PII in an electronic health records system or through a health information exchange that would identify the protected individual and that is related to the protected individual seeking, obtaining, providing, supporting, or aiding in the performance of an abortion that is lawful under the laws of California to any individual from another state, unless the disclosure, transmittal, transfer, sharing, or granting is authorized under any of the conditions listed in Civil Code Sections 56.110.This prohibition also applies to

PHI or PII related to an individual seeking or obtaining gender-affirming health care or gender-affirming mental health care, or to a person or entity allowing a child to receive gender-affirming health care or gender-affirming mental health care, to the extent such information is being sought by a person or entity from another state whose law authorizes a civil or criminal action against a person or entity that provides, seeks, obtains, or receives gender-affirming health care or gender-affirming mental health care, or who allows a child to receive such care, pursuant to Civil Code Section 56.111.

D. Prohibition on Release of Gender-Affirming Health Care Information in Response to Out-of-State Subpoenas (SB 497 / Civil Code Section 56.111): CHPIV will not release medical information related to a person seeking or obtaining gender-affirming health care or gender-affirming mental health care, or related to a person or entity allowing a child to receive gender-affirming health care or gender-affirming mental health care, in response to any subpoena or request, including a foreign subpoena as defined in California Code of Civil Procedure Section 2029.200, where such subpoena or request is based on another state's law that: (1) interferes with an individual's right to seek or obtain gender-affirming health care or gender-affirming mental health care; or (2) authorizes a person to bring a civil or criminal action against a person or entity that allows a child to receive gender-affirming health care or gender-affirming mental health care. CHPIV will also not release such information to persons or entities who are otherwise authorized to receive medical information under Civil Code Section 56.10(c) if the request is made pursuant to another state's law that authorizes civil or criminal action against a person or entity that provides, seeks, obtains, or receives gender-affirming health care or gender-affirming mental health care, or who allows a child to receive such care.
E. CHPIV will disclose the content of health records containing PHI and/or PII in accordance with Civil Code Section 56.110:
    1. A protected individual, or their PERSONAL REPRESENTATIVE, consistent with the Patient Access to Health Records Act.
    2. In response to an order of a California or federal court, but only to the extent clearly stated in the order and consistent with Penal Code Section 1543 (if applicable) and only if all information pertaining to the protected individual's identity and records are protected from public scrutiny through mechanisms, including but not limited to, a sealed proceeding or court record.
    3. When expressly required by federal law that preempts California law, but only to the extent expressly required.
F. CHPIV permits and accommodate requests from subscribers or enrollees for confidential communication in the form and format requested, if readily producible in the requested form and format, or at alternative locations.
G. CHPIV will deem any entity that offers a Reproductive or Sexual Health Digital Service to the protected individual for the purpose of allowing the protected individual to manage their individual information, or for the diagnosis, treatment, or management of a medical condition of the individual, to be a health care provider subject to the requirements of the California Assembly Bill 254 and Civil Code Section 56.05. CHPIV will enable the entity offering Reproductive or Sexual Health Digital Service to the protected individual to the following in accordance with Civil Code Section 56.101:

1. limit user access privileges to information systems that contain PHI and/or PII related to sensitive services only to those persons who are authorized to access specified PHI and/or PII.
2. Prevent the disclosure, access, transfer, transmission, or processing of Medical Information related to sensitive services to persons and entities outside of California.
3. Segregate Medical Information related to sensitive services from the rest of the protected individual's record.
4. Provide the ability to automatically disable access to segregated Medical Information related to sensitive services by individuals and entities in another state.

H. CHPIV ensures implementation of confidential communications requests within 7 calendar days of receipt of an electronic or telephonic request or within 14 calendar days of receipt by first-class mail. In addition, CHPIV ensures there is acknowledgment of receipt of confidential communications requests and advising the subscribers or enrollees of the status of implementation of the requests if the subscribers or enrollees contact the plan.

I. CHPIV ensures subscribers and enrollees are notified that they may request a confidential communication, how to make the request, and providing this information to subscribers and enrollees at initial enrollment and annually thereafter on renewal as follows:
   1. In a conspicuously visible location in the evidence of coverage.
   2. On the plan's internet website, accessible through a hyperlink on the internet website's home page in a manner allowing subscribers, enrollees, prospective subscribers, prospective enrollees and members of the public to easily locate the information.

J. CHPIV ensures that enrollment or coverage is not conditional based on the waiver of the confidentiality rights provided in Civil Code section 56.107.

K. CHPIV maintains implementation of a means of directing all electronic communications, including online portal communications, regarding a protected individual's receipt of sensitive services as required by Civil Code section 56.107, subdivisions (a)(3)(A), (B) and (C)(vii).

L. CHPIV ensures there are policies and procedures in place to ensure Members' Rights to confidentiality of PHI, PI, and data regarding a Member's race, ethnicity, language, gender identity, and sexual orientation in accordance with 45 CFR Parts 160 and 164, and in accordance with Civil Code section 1798 et seq.
   1. CHPIV ensures its Subcontractors, DOWNSTREAM SUBCONTRACTORS, and NETWORK PROVIDERS have policies and procedures in place to guard against unlawful disclosure of PHI, PI, data regarding a Member's race, ethnicity, language, gender identity, and sexual orientation, and any other CONFIDENTIAL INFORMATION to any unauthorized persons or entities.
   2. CHPIV ensures its Subcontractor shall inform and advise Members on the right to confidentiality of their PHI, PI, and data regarding a Member's race, ethnicity, language, gender identity, and sexual orientation. Contractor shall obtain the Member's prior written authorization to release CONFIDENTIAL INFORMATION, unless such prior written authorization is not required by 22 CCR section 51009.

III. PROCEDURE

A. Delegation of Functions

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

B. Delegation Oversight

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

IV. DEFINITIONS

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

TERM	DEFINITION
Confidential Information	Means any non-public information including but not limited to business plans, products, technical data, specifications, documentation, rules and procedures, contracts, presentations, know-how, product plans, business methods, product functionality, services, data, customers, markets, competitive analysis, databases, formats, methodologies, applications, developments, processes, payment, delivery and inspection procedures, algorithms, formulas, or information related to marketing, or finance.
Downstream Subcontractor	Means an individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.
Network Provider	Means any Provider or entity that has a Network Provider Agreement with Contractor, Contractor's Subcontractor, or Contractor's Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under this Contract. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement.
Personal Representative	Means any person who has the right and authority under state law to make health care decisions on behalf of the individual, including surrogates such as a court-appointed guardian, persons with power of attorney, and others acting on behalf of an adult or emancipated minor, and parents, guardians and persons acting in loco parentis for a minor. An executor, administrator or other person who has authority under state law to act on behalf of a deceased individual or the individual's estate is also a personal representative.

TERM	DEFINITION
Protected Health Information (PHI)	Means information that identifies the individual or it is reasonably believed could identify the individual and is transmitted or maintained in any form or medium and: i. Is created or received by a health care provider, plan, or clearinghouse; and ii. Relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to the individual; or the past, present or future payment for the provision of health care to the individual.
Personally Identifiable Information (PII)	Means any personal information about an individual including, but not limited to, education, financial transactions, medical history and criminal or employment history, and information which can be used to distinguish or trace an individual's identity, such as their name, Social Security number, date and place of birth, mother's maiden name, biometric records and any other personal information, which is linked or linkable to an individual.
Reproductive or Sexual Health Application Information	Means information about a consumer's reproductive health, menstrual cycle, fertility, pregnancy, pregnancy outcome, plans to conceive, or type of sexual activity collected by a reproductive or sexual health digital service, including, but not limited to, information from which one can infer someone's pregnancy status, menstrual cycle, fertility, hormone levels, birth control use, sexual activity, or gender identity.
Reproductive or Sexual Health Digital Service	Means a mobile-based application or internet website that collects reproductive or sexual health application information from a consumer, markets itself as facilitating reproductive or sexual health services to a consumer, and uses the information to facilitate reproductive or sexual health services to a consumer.
Subcontractor	Means an individual or entity that has a Subcontractor Agreement with Contractor that relates directly or indirectly to the performance of Contractor's obligations under this Contract.

	Compliance Training	CMP-006
Department	Compliance	
Functional Area	Compliance	
Line of Business	☒ Medi-Cal ☒ D-SNP	

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

DATES			
Policy Effective Date	10/09/2023	**Reviewed/Revised Date**	03/25/2025
Next Annual Review Due	03/25/2026	**Regulator Approval**	08/25/2023

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

ATTACHMENTS
NA

AUTHORITIES/REFERENCES

• **State**
  ○ 2024 DHCS Contract Exhibit A Attachment III Section 1.3.1(G)
  ○ 2024 DHCS Contract Exhibit A Attachment III Section 1.3.1(H)(1)
  ○ CMP-002 Delegation Oversight

HISTORY	
Revision Date	**Description of Revision**
10/09/2023	Policy creation
03/25/2025	Annual Review
	Annual Review

I. OVERVIEW

A. This policy describes the Community Health Plan of Imperial Valley's (CHPIV) Compliance Training Program requirements for its CHPIV Employees, SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS.

II. POLICY

A. CHPIV will establish a system for training and educating the Compliance Officer, Senior Management, Employees, and Commissioners on federal and State standards and requirements of the DHCS contract.

B. CHPIV compliance training will include standards of conduct, compliance plan, fraud, waste, and abuse, and compliance policies and procedures.

C. CHPIV will ensure compliance trainings are verified through a certification or attestation upon training completion and review of the standard of conduct, compliance program, fraud, waste, and abuse, and compliance policies and procedures.

D. CHPIV will ensure that training for the Compliance Officer, Senior Management, Employees, and Commisioners on the compliance program is completed within ninety (90) days of employment and annually thereafter.

III. PROCEDURE

A. Training Content

1. When reviewing and establishing the content of the Compliance Training Program, the Compliance Officer may consider applicable statutes, regulations, regulatory contractual requirements, and regulatory guidance. The following are examples of topics the Compliance Training Program shall communicate:
    a. A description of the Compliance Program, including a review of compliance policies and procedures, the Code of Conduct, fraud, waste, and abuse, and CHPIV's commitment to business ethics;
    b. An overview of how to ask compliance questions, request compliance clarification, or report suspected, or detected, non-compliance. Training should emphasize Confidentiality, anonymity, and non-Retaliation for reporting compliance related questions, or reports of suspected, or detected, non-compliance;
    c. The requirement to report to CHPIV actual or suspected program non-compliance;
    d. Scenarios of reportable non-compliance that an Employee might observe;
    e. A review of the disciplinary guidelines for non-compliant behavior. The guidelines will communicate how such behavior can result in mandatory retraining and may result in disciplinary action, including possible termination when such behavior is serious or repeated, or when knowledge of a possible violation is not reported;
    f. Discussion of attendance and participation in the Compliance Training Program as a condition of continued employment and a criterion to be included in Employee evaluations;
    g. A review of policies related to contracting with the government, such as the

laws addressing gifts and gratuities for government Employees;

h. A review of potential conflicts of interest and CHPIV's system for disclosure of conflicts of interest;
i. An overview of HIPAA/Health Information Technology for Economic and Clinical Health Act (HITECH), the CMS Data Use Agreement (if applicable), and the importance of maintaining the Confidentiality of Protected Health Information;
j. An overview of the Monitoring and Auditing process; and
k. A review of the laws that govern Employee conduct in CHPIV programs.

B. Distributing Training for Existing CHPIV Employees

1. On an annual basis, the Compliance Department shall communicate to all Employees that an updated Compliance training is available and must be successfully completed within sixty (60) calendar days.
2. Upon completion, Employees can access a learner certificate confirming successful completion. The certificate will include the training title and completion date. The Compliance Department is responsible for retaining evidence of an Employee's successful completion of all Compliance training modules.

C. Distributing Training for New Employees

1. Upon hire, the Compliance Department shall provide each new Employee with instructions to complete the Compliance Training within ninety (90) days of employment.
2. The Compliance Department shall create a system generated report that identifies those who fail to comply within the mandated time frames. Non-compliance will result in revoking system access.

D. Distributing Training to Subcontractors and Downstream Subcontractors

1. The Compliance Department conducts oversight to ensure SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS complete compliance training related to federal and State standards and requirements of the DHCS contract.
2. The Compliance Department will require the Subcontractor to disseminate to the DOWNSTREAM SUBCONTRACTORS the compliance documents and complete Compliance Training. The Subcontractor and DOWNSTREAM SUBCONTRACTORS are required to attest the Compliance Training is completed by their employees within ninety (90) calendar days of hire and at least annually thereafter.
3. Annually, the Compliance Department shall distribute and monitor receipt of updated attestation to all SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS for execution.
4. When there are updates to compliance training materials and/or related policies and procedures, the Compliance Department shall communicate updates to all Subcontractors and DOWNSTREAM SUBCONTRACTORS.

E. Documentation of Compliance with Training

1. All CHPIV Employees and SUBCONTRACTORS/DOWNSTREAM SUBCONTRACTORS must complete the Compliance Training Program with a score of eighty percent (80%) or greater.
2. Failure to successfully complete all required Compliance training modules may lead to disciplinary action (up to and including termination). The Compliance Department will have a systematic indicator that identifies those who fail to comply within the mandated timeframes; non-compliance will result in revoking CHPIV system access.

3. SUBCONTRACTORS/DOWNSTREAM SUBCONTRACTORS shall provide annual attestations confirming completion of all Compliance training as stated in this policy. Failure to provide timely attestation will lead to further CORRECTIVE ACTION.
4. The Compliance Department is responsible for monitoring and auditing the compliance of Employees and SUBCONTRACTORS/DOWNSTREAM SUBCONTRACTORS with the Compliance training and education requirements.
5. CHPIV shall maintain all evidence of Compliance-related training completion for at least ten (10) years. Such materials include, but are not limited to:
    a. Attendance;
    b. Topic;
    c. Certificates of Completion;
    d. Subcontractor/Downstream Subcontractor Attestations;
    e. Test scores; and
    f. Tests administered to Employees.

IV. DEFINITIONS

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

TERM	DEFINITION
Corrective Action	Means specific identifiable activities or undertakings of Contractor which address Contract deficiencies or noncompliance.
Downstream Subcontractor	Means an individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.
Subcontractor	An individual or entity that has a subcontract with the MCP that relates directly or indirectly to the performance of the MCP's obligations under the contract with DHCS. A network provider is not a subcontractor by virtue of the network provider agreement, as per 42 CFR § 438.2.

	Compliance Program	CMP-014
Department	Compliance	
Functional Area	Compliance	
Line of Business	☒ Medi-Cal ☒ D-SNP	

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

DATES			
Policy Effective Date	03/25/2025	**Last Revised Date**	
Next Annual Review Due	03/25/2026	**Regulator Approval**	

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

ATTACHMENTS
N/A

AUTHORITIES/REFERENCES
• 42 CFR § 423.504(b)(4)(vi)
• Medicare Managed Care Manual
• CHPIV Code of Conduct
• CHPIV Compliance Program

HISTORY	
Revision Date	**Description of Revision**
03/25/2025	Policy Creation
	Annual Review

I. OVERVIEW

A. The purpose of this policy is to establish and maintain a comprehensive Compliance Program for CHPIV, ensuring adherence to all federal and state regulatory requirements, including those outlined in **42 CFR § 423.504(b)(4)(vi)** for Medicare Part D, Medicare Part C, Medi-Cal, and other applicable programs. This policy is designed to promote a culture of compliance, ethical conduct, and accountability throughout the organization. This policy applies to all employees, contractors, governing body members, and other stakeholders involved in the operations of CHPIV, across all lines of business, including Medi-Cal and Dual Eligible Special Needs Plans (D-SNPs) operating under Medicare Part C and Part D.

II. POLICY

A. CHPIV is Compliance Program incorporates the following elements to ensure program effectiveness and compliance with regulatory requirements:

1. **Written Policies, Procedures, and Code of Conduct**
   a. CHPIV maintains comprehensive compliance policies and procedures that outline expectations for regulatory compliance, fraud prevention, and ethical behavior.
   b. The Code of Conduct establishes the foundation for ethical decision-making, emphasizing integrity, accountability, and adherence to laws and regulations.
2. **Compliance Officer, Compliance Committee, and Governing Body Oversight**
   a. CHPIV has designated a Chief Compliance Officer (CCO) responsible for overseeing the Compliance Program and ensuring its implementation.
   b. The Compliance & Policy Committee (CPC) and Regulatory Compliance Oversight Committee (RCOC) of the Commission support the CCO in addressing compliance risks.
   c. The Full Commission (Governing Body) provides high-level oversight and accountability for the program's success.
3. **Effective Training and Education**
   a. All employees, contractors, and Commissioners must participate in annual compliance training.
   b. Training covers key topics such as fraud, waste, and abuse prevention, privacy regulations, and compliance expectations related to State and Federal requirements, including Medicare Part D and Part C.
4. **Effective Lines of Communication**
   a. CHPIV ensures open and accessible communication channels, including a confidential compliance hotline and direct access to the CCO.
   b. Employees are encouraged to report compliance concerns without fear of retaliation, in alignment with CMP-007 Escalation of Noncompliance Issues and CMP-010 Effective Lines of Communication.
5. **Effective Systems for Routine Monitoring and Auditing**
   a. CHPIV conducts regular monitoring and auditing activities to identify and mitigate compliance risks.
   b. Monitoring efforts focus on high-risk areas such as authorization and claims processing, provider disputes, and member grievances.
   c. Findings from audits are documented, and corrective actions are implemented promptly.

6. **Procedures and Systems for Promptly Responding to Compliance Issues**
   a. CHPIV has established processes for investigating, resolving, and reporting compliance issues.
   b. Corrective actions include policy updates, training enhancements, and disciplinary measures where necessary.
   c. Compliance issues are reported to CMS or other regulatory authorities as required.
7. **Accountability for Delegation Oversight**
   a. CHPIV maintains accountability for ensuring that delegated entities comply with all applicable laws and contractual requirements.
   b. Delegation oversight includes regular monitoring, audits, and corrective action plans to address deficiencies.
   c. CHPIV ensures that its delegated entities meet all applicable regulatory requirements, including Medicare Part D standards.

B. Roles and Responsibilities

1. Chief Compliance Officer: Oversees the implementation and operation of the Compliance Program and serves as the primary point of contact for compliance issues and reports directly to the Commission (governing body).
2. Governing Body: Provides oversight and ensures the Compliance Program's effectiveness. Reviews and approves the annual compliance work plan.
3. Employees and Contractors: Adhere to the Code of Conduct and report any suspected compliance issues. Participate in mandatory compliance training.
4. Compliance Committees: Monitors compliance activities and ensures alignment with regulatory requirements.

C. Reporting Violations

1. All employees, contractors, and governing body members are required to report any suspected compliance violations in accordance with CMP-007 Escalation of Noncompliance Issues and CMP-010 Effective Lines of Communication.

D. Corrective Actions

1. When a compliance issue is identified, CHPIV investigate the issue promptly, implements corrective actions, including training, process changes, or disciplinary measures as needed, and monitors the effectiveness of corrective actions to prevent recurrence in accordance with CMP-003 Corrective Action Plans.

III. DEFINITIONS

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

TERM	DEFINITION

Chief Compliance Officer (CCO)	CHPIV staff member who serves as the focal point for compliance activities as well as manages the Compliance Department of CHPIV. The CCO reports directly to the Chief Executive Officer and the COMMISSION. The CCO is responsible for developing, operating, and monitoring the compliance program. This includes establishing an auditing and monitoring plan, overseeing compliance audit functions, continuously reviewing organizational risk areas to identify necessary auditing and monitoring activities, assisting in the formulation of correction action plans, and overseeing and/or verifying implementation of corrective action.
Commission	The governing body of the Local Health Authority (LHA). It is comprised of thirteen voting members that represent different sectors of the health system, the public, Medi-Cal beneficiaries, and businesses as outlined in LHA Establishing Ordinance.
Regulatory Compliance Oversight Committee (RCOC)	The Regulatory Compliance Oversight Committee of the Commission is a subcommittee of the Commission that is focused on ensuring the effectiveness of the Compliance Program.
Compliance & Policy Committee (CPC)	The Compliance & Policy Committee (CPC) offers valuable oversight, advice, and general guidance to CHPIV's senior management on all matters related to compliance. This committee is specifically focused on ensuring that CHPIV and its subcontractors adhere fully to both mandated and non-mandated performance standards.
The Centers for Medicare & Medicaid Services (CMS)	The federal agency within the Department of Health and Human Services that is responsible for the administration of the Medicare and Medicaid programs as well as overseeing other Federal Healthcare Programs such as the Children's Health Insurance Program (CHIP)

ATTACHMENT A

CONFLICT OF INTEREST CODE

1. DISCLOSURE CATEGORIES DEFINED:

Categories are established that coincide with the reporting schedules included in FPPC Form 700. Employees and members may be required to make disclosures in multiple categories as specified in Section 2 of this Code.

Employees and Commissioner required to provide disclosures pursuant to the Community Health Plan of Imperial Valley Conflict of Interest Code shall provide disclosures upon entering office/employment, on an annual basis and upon leaving office/employment.

Disclosure Categories:

Category A-1: Investments - Those required to make disclosures pursuant to Category A-1 must report any and all ownership interest of or investment in (including but not limited to stocks, bonds, warrants, and options and managed investment funds) any business entity wherein the employee or member or the employee or member's spouse, registered domestic partner, or dependent children have a direct, indirect, or beneficial interest owns an interest equal to or lesser than ten percent (10%) of said business entity totally $2,000 or more at any time during the reporting period.

Category A-2: Investments -Those required to make disclosures pursuant to Category A-2 must report any and all ownership interest of or investment in (including but not limited to stocks, bonds, warrants, and options and managed investment funds) any business entity wherein the employee or member or the employee or member's *spouse, registered domestic partner, or dependent children had a* direct, indirect, or beneficial interest owns an interest in excess of ten percent (10%) of said business entity.

Category B Real Property Interest – Those required to make disclosures pursuant to Category B must report all their interest in real property located in the County of Imperial. "Real property interest" means a direct, indirect or beneficial interest totally $2,000.00 or more any time during the reporting period in which the employee or member, or the employee or member's spouse, registered domestic partner, or dependent children had a direct, indirect, or beneficial interest in located in the County of Imperial. The principal residence of an employee or member is NOT subject to disclosure as a Real Property Interest.

REGULATORY COMPLIANCE NOTICE

Category C — Income – Those required to make disclosures pursuant to Category C must report the source and amount of gross income of $500 or more received during the reporting period. "Gross income" is the total amount of income before deducting expenses, losses, or taxes and includes loans other than loans from a commercial lending institution. Those required to make disclosures must also report income received by their spouse. A source of income must be reported only if the source is doing business in, planning to do business in, or has does business in the County of Imperial during the previous two years.

Category D — Gifts – Those required to make disclosures in pursuant to Category D must report gifts received that have a fair market value in excess of $50.00. In addition, multiple gifts received from the same source that total $50.00 or more during the reporting period must be reported.

Category E — Travel Payments, Advances and Reimbursements – Those required to make disclosures pursuant to Category E must report the source of some travel payments, advances and reimbursements. Please see the instructions for Schedule E of Form 700 for more detail.

2. DESIGNATED POSITIONS:

Designated Positions	Disclosure Categories
Commissioners	A-1, A-2, B, C, D, E
Legal Counsel	A-1, A-2, B, C, D, E
Chief Executive Officer	A-1, A-2, B, C, D, E
Chief Financial Officer	A-1, A-2, B, C, D, E
Chief Compliance Officer	A-1, A-2, B, C, D, E

	Conflict of Interest Avoidance	EXC-001
Department	Executive Services	
Functional Area	Executive Services	
Line of Business	☒ Medi-Cal ☒ D-SNP	

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

DATES			
Policy Effective Date	09/06/2023	**Reviewed/Revised Date**	03/25/2025
Next Annual Review Due	03/25/2026	**Regulator Approval**	NA

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

ATTACHMENTS

- Attachment A – Conflict of Interest Code
- Attachment B – Conflict of Interest and Non-Discrimination Attestation (CPRC)
- Attachment C – Conflict of Interest Disclosure Form
- Attachment D – Conflict of Interest/Attestation

AUTHORITIES/REFERENCES

- DHCS Contract Section 1.1.3 Conflict of Interest – Current and Former State Employees, Exhibit H – Conflict of Interest Avoidance Requirements
- Health and Safety Code §1367(g)
- Title 42, Code of Federal Regulations (C.F.R.), §422.205, 438.3(f)(2), 438.58
- Title 28, California Code of Regulations (CCR) §1300.67.3
- Title 22, California Code of Regulations (CCR) sections 53874 and 53600

HISTORY

Revision Date	Description of Revision
09/06/2023	Policy Creation
03/25/2025	Annual Review. three grammar changes I.A. ; “II. E.”; III.A.1.c.
03/25/2025	Attachment A Expanded List of Leadership
	Annual Review

I. OVERVIEW

A. This policy addresses the Community Health Plan of Imperial Valley (CHPIV) requirements that all individuals in an appointed, volunteer, or employed position for CHPIV including all committees and subcommittees who make decisions regarding CHPIV operations, fully disclose any actual, perceived, or potential conflict of interest(s) that arise in the course and scope of serving in such a capacity. This policy provides guidance regarding identification, disclosure, and evaluation of conflicts of interest so that such conflicts are resolved and/or avoided in compliance with legal and ethical standards, statutes, and regulations. The policy stated herein is applicable in addition to and does not supplant the provisions of Cal. Wel. & Inst. Code § 14087.38, and the Fair Political Practices Act.

II. POLICY

A. It is the policy of CHPIV to promote the best interests of its members. All decisions concerning safe care, quality of care, and services provided to CHPIV's members are to meet the needs of members without any actual, or perceived conflicts of interest. No one making decisions about the services and operations of CHPIV will place their own financial interests above that of CHPIV and its members.

B. CHPIV will not utilize any State officer, employee in State civil service, other appointed State official, or intermittent State employee, or contracting consultant for DHCS, unless the employment, activity, or enterprise is required as a condition of the officer's or employee's regular State employment.

C. All individuals will carry out their responsibilities, avoiding conflicts of interest, and must appropriately disclose when conflicts of interest arise.

D. All individuals have a continuous obligation to disclose the existence of any actual, perceived, or potential conflict of interest to CHPIV in accordance with this policy.

E. CPHIV's CHIEF EXECUTIVE OFFICER and CHIEF COMPLIANCE OFFICER shall evaluate all conflicts of interest and adjust this policy as needed.

F. DELEGATED ENTITY shall have policies and procedures consistent with this policy to identify, avoid, and/or manage conflicts of interest as needed.

G. If required by the Department of Healthcare Services (DHCS), a third-party monitor must certify CHPIV's compliance with the conflict avoidance plan.

H. CHPIV periodically reviews and may amend the conflict avoidance plan to address material changes impacting the conflict of interest.

III. PROCEDURE

A. Conflict of Interest

1. A conflict of interest depends on the situation and not on the individual. The conflict of interest may arise where an individual, including a related party directly controlled by them:
    a. Receives material compensation (gifts, grants, stipends, amenities) from any individual and/or their employer, or entity that is conducting business or services with CHPIV.
    b. Has an ownership interest in any entity that is conducting business with CHPIV.
    c. Has a past- or present personal relationship with an entity with or individual conducting business or providing services to CHPIV.
    d. Has a financial interest in any consultant that is engaged and/or contracted with CHPIV.

2. The following are examples of Conflicts of Interest:
    a. An individual who makes decisions with another entity or individual (outside of CHPIV) that is a direct competitor of CHPIV, or where there had been a past personal, employment or financial relationship.
    b. An individual has an ownership or financial interest in the consulting firm engaged by CHPIV.
    c. An individual receives monetary or non-monetary compensation from a pharmaceutical manufacturer whose drug is reviewed for listing on the CHPIV or related downstream delegate's formulary.
    d. An individual leases property to CHPIV and is a member of the COMMISSION or employed by CHPIV.

B. Conflict of Interest Disclosure Process

1. On an annual basis, an individual who is involved in CHPIV a governance or leadership role, shall sign a "Conflict of Interest Attestation", and complete a "Conflict of Interest Disclosure Form" identifying any activities, interests, relationships, or financial interests that create of have the potential to create a Conflict of Interest for the individual.
2. Upon appointment and prior to serving on the COMMISSION, any Committee of the COMMISSION, or senior leadership role shall sign a Conflict-of-Interest Attestation and complete a Conflict-of-Interest Disclosure Form, identifying any activities, interests, relationships, or financial holdings that create or have the potential to create a Conflict of Interest for the individual.
3. If an individual believes that he/she may have a potential, perceived, or actual Conflict of Interest prior to a committee, or subcommittee, meeting, they will provide written notice to the committee, or subcommittee, chairperson disclosing the potential, perceived, or actual Conflict of Interest.
4. Whenever a Participant believes that he/she may have a potential, perceived, or actual Conflict of Interest during a committee, or subcommittee, meeting, they will immediately alert the committee, or subcommittee, chairperson that they may have a potential, perceived, or actual Conflict of Interest. Before leaving the meeting, the Participant may be asked, and may answer, any questions concerning the Conflict of Interest.
5. In all other situations, whenever a Participant realizes that they may have a potential or actual Conflict of Interest, they will provide written notice to the CHIEF EXECUTIVE OFFICER disclosing the potential, perceived, or actual Conflict of Interest.
6. To the extent CHPIV engages an external reviewer or expert consultant, that external reviewer or expert consultant shall be required to sign a Conflict-of-Interest Statement and complete a Conflict-of-Interest Disclosure Form prior to performing any services for CHPIV.
7. In addition, all persons holding the offices listed in the Conflict-of-Interest Code which is attached hereto as Appendix One shall file a FPPC Form 700 with the Clerk of the COMMISSION upon assuming office, annually thereafter, and upon vacating the office in question as provided in the Fair Political Practices Act.

C. Management and Resolution of the Conflicts of Interest

1. The CHIEF EXECUTIVE OFFICER, the COMMISSION Chairperson, or the COMMISSION committee chairperson will review and evaluate all written disclosures thoroughly for conflicts.

For any decision involving a CHPIV employee, the CHIEF EXECUTIVE OFFICER shall involve Legal Counsel before taking any action.

2. The applicable committee or subcommittee chairperson shall resolve any issue over the existence of a Conflict of Interest involving an individual who is a COMMISSION or member of a committee of the COMMISSION. All other Conflict of Interest issues shall be resolved by the CHIEF EXECUTIVE OFFICER. CHPIV shall verify that no unresolved Conflicts of Interest exist prior to retaining an external reviewer or expert consultant.
3. If it is determined that there is no conflict, then the individual can continue to be involved in the matter, subject to any limitations imposed by the CHIEF EXECUTIVE OFFICER, or COMMISSION or committee of the COMMISSION, chairperson.
4. If it is determined that there is a Conflict of Interest, the individual may be excluded from participation in the matter that gave rise to the Conflict of Interest.
5. The committee chairperson and/or CHIEF EXECUTIVE OFFICER may resolve the conflict when appropriate, by imposing limitations where there is a determination that a Conflict of Interest does not prohibit the individual's continued involvement in the matter. These limitations may include, but are not limited to, requiring that the Participant abstain from voting regarding the matter, or prohibiting the individual from participating in any investigation of the matter.
6. If a Participant disagrees with a COMMISSION or committee of the COMMISSION chairperson's decision regarding a Conflict of Interest, he/she can request that the CHIEF EXECUTIVE OFFICER review the Conflict of Interest.

D. Record Retention

1. The CEO's office shall keep copies of all Conflict-of-Interest Disclosure Forms and any written information disclosing a Conflict of Interest in accordance with applicable regulatory record retention requirements, and no less than ten years.
2. COMMISSION and committees of the COMMISSION minutes shall reflect the disclosure of Conflicts of Interest and any abstentions and exclusions from participation from voting on actions.

E. Non-Compliance with Conflicts of Interest.

1. Suspected violations of this Policy should be reported to the CHIEF EXECUTIVE OFFICER or CHIEF COMPLIANCE OFFICER. Such reports may be made confidentially.
2. The failure of an individual to disclose a Conflict of Interest when it is known or reasonably should be known to the individual may result in actions against the individual, including, but not limited to disciplinary action, sanctions, removal, dismissal, and/or termination from a committee or subcommittee. The matter may also be referred to the CHPIV's CEO's office, CHIEF COMPLIANCE OFFICER's office, and/or Human Resources for further action, as appropriate.

IV. DEFINITIONS

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

TERM	DEFINITION
Chief Compliance Officer (CCO)	CHPIV staff member who serves as the focal point for compliance activities as well as manages the Compliance Department of CHPIV. The CCO reports directly to the Chief Executive Officer and the Commission. The CCO is

	responsible for developing, operating, and monitoring the compliance program. This includes establishing an auditing and monitoring plan, overseeing compliance audit functions, continuously reviewing organizational risk areas to identify necessary auditing, and monitoring activities, assisting in the formulation of correction action plans, and overseeing and/or verifying implementation of corrective action.
Chief Executive Officer	The Chief Executive Officer (CEO) of a Managed Care Plan is the highest-ranking executive, responsible for implementing organizational strategies, ensuring the achievement of overall objectives, and maintaining operational, legal, and financial integrity, all while being accountable to the Commission.
Commission	The governing body of the Local Health Authority (LHA). It is comprised of thirteen voting members that represent different sectors of the health system, the public, Medi-Cal beneficiaries, and businesses as outlined in LHA Establishing Ordinance.
Delegated Entity	A contracted entity which CHPIV authorizes to perform certain functions on its behalf. Although, CHPIV can delegate the authority to perform a function, it cannot delegate the responsibility for ensuring that the function is performed according to CHPIV and National Committee on Quality Assurance (NCQA) standards.

	Delegation of Authority	EXC-002
Department	Executive Services	
Functional Area	Executive Services	
Line of Business	☒ Medi-Cal ☒ D-SNP	

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

DATES			
Policy Effective Date	10/09/2023	**Reviewed/Revised Date**	03/25/2025
Next Annual Review Due	03/25/2026	**Regulator Approval**	

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

ATTACHMENTS

- None

AUTHORITIES/REFERENCES

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

HISTORY

Revision Date	Description of Revision
10/09/2023	Policy creation
03/25/2025	Annual Review
	Annual Review

I. OVERVIEW

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

II. POLICY

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

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

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

III. PROCEDURE

A. Delegation of Authority to AUTHORIZED REPRESENTATIVES

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

B. Designation and Notification Process

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

DHCS Address:
California Department of Health Care Services
Managed Care Operations Division
Attn: DHCS Contract Manager
MS 4407
P.O. Box 997413

Sacramento, CA 95899-7413

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

C. By implementing this Delegation of Authority Policy, DHCS and CHPIV ensure effective contract management throughout the duration of the DHCS Contract agreement.

IV. DEFINITIONS

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

TERM	DEFINITION
Authorized Representative	Means any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member.
Department of Health Care Services (DHCS)	The State agency responsible for administration of the federal Medicaid (referred to as Medi-Cal in California) Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP) and other health related programs.

	Delegated Entity Financial Solvency Oversight Process	FIN-001
	Department	Finance & Informatics
	Functional Area	Finance
	Line of Business	☒ Medi-Cal ☒ D-SNP

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

DATES			
Policy Effective Date	10/09/2023	**Reviewed/Revised Date**	
Next Annual Review Due	03/25/2026	**Regulator Approval**	06/02/2023

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

ATTACHMENTS
• None

AUTHORITIES/REFERENCES

• **State**
  ○ California Health and Safety Code Sections
  ○ 1300.75.4-1300.75.4.8 and 1300.76 of Title 28 of the California Code of Regulations (These regulations were promulgated pursuant to authority in sections 1344 and 1375.4 of the California Health and Safety Code)
• **Related Policices**
  ○ FIN-002 Delegated Provider Financial Solvency CAP Process
  ○ Pre-Contractual Due Diligence

HISTORY	
Revision Date	**Description of Revision**
10/09/2023	Policy creation
03/25/2025	Annual review
	Annual Review

I. OVERVIEW

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

II. POLICY

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

III. PROCEDURE

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

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

C. Financial Solvency Review Process

1. Delegated entities are required to submit quarterly and/or annual audited FINANCIAL STATEMENTS to CHPIV. If a delegated entity is not meeting the financial solvency requirements, they may be asked to also provide monthly FINANCIAL STATEMENTS to CHPIV.
    a. Quarterly and annual audited FINANCIAL STATEMENTS are due to CHPIV as follows:
        i. Quarterly FINANCIAL STATEMENTS are due within 45 days of the end of each calendar quarter.
        ii. Audited annual FINANCIAL STATEMENTS are due within 150 days of the end of each fiscal year.
    b. Prior to each due date, CHPIV requests delegated entities to submit the applicable FINANCIAL STATEMENTS.
        i. Reminders are sent to delegated entities who have not responded.
        ii. Non-responsive delegated entities will be reviewed to determine if additional actions are required (i.e., escalate to the appropriate oversight committee).
    c. CHPIV assesses the financial solvency of each delegated provider based on CHPIV's established criteria and the DMHC required grading criteria. Delegated providers must

meet the minimum acceptable liquidity, profitability, efficiency, and stop-loss protection levels.

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

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

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

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

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

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

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

D. DMHC RBO Non-Filer Process

1. Following the end of a reporting period, the DMHC will provide a list of RBO non-filers to CHPIV, as appropriate. The non-filers are RBOs who failed to file quarterly or annual audited financial surveys to the DMHC within the required timeframe.

a. Upon receipt of the notification from the DMHC, CHPIV informs applicable department contacts regarding the RBO identified by DMHC as a "Non-Filer." CHPIV notifies the RBO directly to advise the RBO to comply within the required time frame. The notice to the RBO shall include a punitive statement such as,"... failure by RBO to comply within the required time frame shall result in an administrative action against the health plan by DMHC's Office of Enforcement, including freeze of membership assignment and other possible sanctions, up to and including termination of contract."

b. CHPIV will respond to the DMHC regarding CHPIV's policies and procedures to make sure it complies with the requirements.
c. CHPIV communicates the RBO's status to the applicable oversight committees, as needed, until the delegated entity completes the required filing
d. If an RBO does not comply with DMHC requirements, CHPIV may be sanctioned by the DMHC. For these situations, CHPIV keeps the applicable oversight committees and/or departments in the loop on the progress or non-progress of the RBO. The applicable oversight committee is responsible for determining final decisions to remediate RBO noncompliance up to and including termination that is based on a decision-making criteria process.

E. Financial Solvency Reporting Process

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

F. Pre-contractual Due Diligence Financial Solvency Review Process

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

IV. DEFINITIONS:

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

TERM	DEFINITION
Cash-to-Claims Ratio (CCR)	Provider's cash, readily available marketable securities, and receivables, excluding all risk pool, risk- sharing, incentive payment program and pay -for- performance receivables, reasonably anticipated to be collected within sixty (60) days divided by Provider 's unpaid claims liability.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CHPIV, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care

TERM	DEFINITION
	Services (DHCS), or designated representatives. FDRs and/or CHPIV departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CHPIV and its regulators.
Department of Managed Health Care (DMHC)	The State agency responsible for administering the "Knox-Keene Health Care Service Plan Act of 1975."
Downstream Subcontractor	An individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.
Financial Statements	A balance sheet, an income statement, a statement of cash flows, and footnote disclosures.
Generally Accepted Accounting Principles (GAAP)	GAAP is the adopted accounting framework of the U.S. Securities and Exchange Commission and the Internal Revenue Service for healthcare accounting
Hospital	Refers to delegated or risk-bearing hospitals only
Medical Cost Ratio (MCR)	Metric used in managed health care and health insurance to measure medical costs as a percentage of premium revenues
Network Provider	Provider or entity that has a Network Provider Agreement with Contractor, Contractor's Subcontractor, or Contractor's Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under this Contract. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement.
Risk Bearing Organization (RBO)	A risk bearing organization (RBO) is either a professional medical corporation, other form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempt from licensure pursuant to subdivision (l) of Section 1206 of the Health and Safety Code, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services. An RBO does not include an individual or a health care service plan. An RBO does all of the following
Sponsoring Organization	A sponsoring organization is one that has a tangible net equity of a level to be established by the director that is in excess of all amounts that it has guaranteed to any person or entity.
Subcontractor	An individual or entity that has a subcontract with the MCP that relates directly or indirectly to the performance of the MCP's obligations under the contract with DHCS. A network provider is not a subcontractor by

TERM	DEFINITION
	virtue of the network provider agreement, as per 42 CFR § 438.2.
Tangible Net Equity (TNE)	Net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; obligations of officers, directors, owners, or affiliates which are not fully secured, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with nonaffiliates and which are not more than sixty (60) days past due; long term prepayments of deferred charges, and nonreturnable deposits.
Working Capital (WC)	The difference between current assets and current liabilities

	Delegated Entity Financial Solvency Corrective Action Plan Process	**FIN-002**
Department	Finance & Informatics	
Functional Area	Finance	
Line of Business	☒ Medi-Cal ☐ D-SNP	

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

DATES			
Policy Effective Date	10/09/2023	**Reviewed/Revised Date**	
Next Annual Review Due	03/25/2026	**Regulator Approval**	06/02/2023

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

ATTACHMENTS

- None

AUTHORITIES/REFERENCES

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

HISTORY

Revision Date	Description of Revision
10/09/2023	Policy creation
03/25/2025	Annual Review
	Annual Review

I. OVERVIEW

A. This policy applies to any SUBCONTRATCOR (including any Plan-to-Plan, or P2P, SUBCONTRACTORS), DOWNSTREAM SUBCONTRACTOR, or NETWROK PROVIDER who has accepted and been delegated financial risk for the provision of Covered Services for one or more lines of business. For purposes of this policy only, they shall collectively be referred to as "delegated entities".

The purpose of this policy is to outline the Community Health Plan of Imperial County's ("CHPIV" or "Plan") process to request, review and monitor CORRECTIVE ACTION PLANS (CAPs) required by delegated providers who are not in compliance with the CHPIV's financial solvency standard benchmarks, contracts, and the legal requirements set forth in the California Health & Safety Code.

II. POLICY

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

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

III. PROCEDURE

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

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

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

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

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

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

i. Timeframes for correcting WORKING CAPITAL deficiencies shall not exceed 12 months.
ii. Timeframes for correcting TNE deficiencies shall not exceed 12 months.
iii. Timeframes for IBNR deficiencies shall not exceed three months.
iv. Timeframes for correcting claims timeliness deficiencies shall not exceed six months.
v. Timeframes for correcting cash-to-claims ratio deficiencies shall not exceed 12 months.

f. Identify the name, title, telephone and facsimile numbers, and postal and email addresses for the person responsible at the delegated entity or RBO for ensuring compliance with the final CAP.
g. An RBO may avoid submitting a self-initiated CAP proposal if it demonstrates to the DMHC that necessary and prudent capital investments have caused or may cause a temporary deficiency in its TNE, working capital, or cash-to-claims ratios and that the RBO has implemented an appropriate business plan that will correct the deficiency within a reasonable time period without causing a deficiency in the RBO's claims processing timeliness. The RBO shall seek and receive written approval from the DMHC to avoid submitting a self-initiated CAP proposal.

2. To the extent possible, the self-initiated CAP proposal shall be set forth in a single document that addresses the concerns of all plans with which the RBO maintains a contract that includes a risk arrangement.
3. The DMHC will notify CHPIV when a delegated entity or RBO has submitted a self-initiated proposed CAP. Upon receipt of this notification, CHPIV shall log onto the DMHC secured web portal to access the latest message and instruction pertaining to the CAP from the DMHC and RBO. CHPIV also downloads a copy of the delegated entity's or RBO's proposed CAP or on-going CAP update from the portal. CHPIV is responsible for tracking and monitoring CAP status.
    a. Applicable committees and/or departments are notified when the CAP is available for review to determine if the CAP adequately addresses the identified deficiencies and provide a recommendation to accept or object/suggest changes back to the RBO and the DMHC.
    b. In an event the initial or on-going CAP submitted has inadequate financial projection, i.e., less than three (3) quarter projections required by the DMHC and by recommendation from CHPIV, CHPIV will automatically request from the RBO additional projections. This action will be done without filing an objection by the health plan to the DMHC. The DMHC will take similar action by requesting the same information from the RBO before proceeding with its review and determination.
    c. Per ICE guidelines, health plans can object to CAP and require the delegated entity or RBO to submit two or more additional projections as it deemed necessary based on the CAP review results.
    d. All CAPs are saved in the secure Financial Oversight network drive. Each delegated provider has a separate folder where current and archived copies are stored.
        i. If the CAP is related to claims timeliness, it's forwarded to the oversight department.

ii. CHPIV is responsible for filing the health plan response to the DMHC via the web portal. CHPIV response is either to Accept or Object to the CAP as determined by CHPIV.

e. Within 15 calendar days of receipt of the RBO's self-initiated CAP proposal, CHPIV will provide written notice to the DMHC (filed electronically through the DMHC Web portal) accepting the CAP or stating the reason for its objections and recommendations for revisions. If CHPIV does not respond within this timeline, the self-initiated CAP shall be considered a final CAP; however, it is CHPIV's intent and process to always provide a response within this timeline.

4. In the event that CHPIV files a written objection with the DMHC and a delegated entity or RBO, the DMHC shall, within 10 calendar days, review the objections and inform the delegated entity or RBO if revisions to the CAP proposal are needed or if the objections can be resolved. If the objections can be resolved, the self-initiated CAP proposal shall be considered the final CAP subject to approval by the DMHC. If revisions to the CAP proposal are required, the delegated entity or RBO will have 10 calendar days to do the following:
    a. Implement all corrective action strategies contained in its self-initiated CAP proposal that were not objected to by CHPIV or another contracted plan; and,
    b. Submit to the DMHC a revised CAP proposal that addresses the concerns raised by the objecting contracting health plan including CHPIV. To the extent possible, the revised CAP proposal shall be prepared as a single document that addresses the concerns of all plans including CHPIV with which the subcontracted entity or RBO maintains a contract that includes a risk arrangement. Upon receipt of the auto notification from DMHC, CHPIV will access and download a copy of the revised CAP from the DMHC web portal.
5. Within seven calendar days of receipt of the revised self-initiated CAP proposal, CHPIV will provide to the delegated entity or RBO and the DMHC its acceptance or objections and recommended revisions, in an electronic format prepared by the DMHC, to the self-initiated revised CAP proposal. If there are no objections, the self-initiated revised CAP proposal shall become the final CAP subject to approval by the DMHC.
    a. CHPIV performs the review of the revised CAP proposal to determine if the revised CAP adequately addresses the identified deficiencies and provide a recommendation to accept or object/suggest changes back to the delegated entity or RBO and the DMHC.
    b. If CHPIV needs clarification or additional documentation regarding the revised CAP, CHPIV may arrange a meeting or conference call with the delegated entity or RBO representatives. CHPIV may require the delegated entity or RBO to submit supporting documentation to any new CAP relevant information discussed prior to or during the meeting.
    c. CHPIV is responsible for notifying the DMHC regarding its recommendations.
6. Within seven calendar days of receipt of any contracting health plans' including CHPIV's objections and recommended revisions to the revised CAP proposal, the DMHC shall schedule a meeting ("CAP Settlement Conference") with the delegated entity or RBO and all of its contracting health plans including CHPIV to discuss and reconcile the differences.

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

D. CAP Reporting

1. Each periodic progress report prepared pursuant to a final CAP shall be submitted to the DMHC and CHPIV and shall include a written verification stating that the periodic progress report is true and correct to the best knowledge and belief of a principal officer of the RBO.
2. In addition to the quarterly progress reports specified in a CAP, every contract involving a risk arrangement between CHPIV and a RBO shall require that:
    a. The delegated entity or RBO shall advise CHPIV and the DMHC within five calendar days if the delegated entity or RBO experiences an event that materially alters the delegated entity's or RBO's ability to remain compliant with the requirements of a final CAP, and
    b. The RBO, upon DMHC's request, will provide additional documentation to the DMHC and CHPIV to demonstrate the delegated entity's or RBO's progress towards fulfilling the requirements of a CAP.
3. Non-disclosure of CAP documentation and supporting work papers:
    a. All draft, preliminary and final CAPs and all CAP compliance reports required by a final CAP, including supporting documentation and supplemental financial information, submitted to the DMHC shall be received and maintained on a confidential basis and shall not be disclosed, except for the information outlined in section 1300.75.4.4(c)(3) to any party other than the RBO and, as necessary, to its contracting health plans including CHPIV that are participating in the CAP.
4. CHPIV communicates delegated entity or RBO CAP status to the applicable committees and/or departments on a monthly or quarterly basis, as defined.

E. Plan Obligation

1. CHPIV shall advise the DMHC and the RBO in writing within five days of becoming aware that (H&S Code 1300.75.4.5.(a)(5)):

a. A delegated entity or RBO is not in compliance with the requirements of a final CAP; or when,
b. A delegated entity's or RBO's conduct may cause CHPIV to be subject to disciplinary action pursuant to Health and Safety Code section 1386.

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

F. Delegated Entity or RBO Obligation

1. The delegated entity or RBO will advise CHPIV and the DMHC within five business days after discovering that the RBO experienced any event that materially alters the RBO's financial situation or threatens the RBO's solvency (H&S Code 1300.75.4.2.(f)).
2. CHPIV will advise the DMHC and the delegated entity or RBO within five business days from discovering that any of its RBOs experienced any event which materially alters the organization's financial situation or threatens its solvency (H&S Code 1300.75.4.3.(e)).
3. If the subcontracted delegated entity is a Knox-Keene licensed health plan with a Plan-to-Plan contract with CHPIV, then the subcontracted P2P will report to CHPIV all of its outstanding CORRECTIVE ACTION PLANS (CAPs) to CHPIV no less than on a quarterly basis.

IV. DEFINITIONS

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

TERM	DEFINITION
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CHPIV, the Centers for Medicare & Medicaid Services (CMS), Department of

TERM	DEFINITION
	Health Care Services (DHCS), or designated representatives. FDRs and/or CHPIV departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CHPIV and its regulators.
Department of Managed Health Care (DMHC)	The State agency responsible for administering the "Knox-Keene Health Care Service Plan Act of 1975."
Financial Statements	A balance sheet, an income statement, a statement of cash flows, and footnote disclosures (footnote disclosure required when submitting CPA-reviewed and audited financial statements).
Incurred But Not Reported (IBNR)	The amount owed by an insurer to all valid claimants who have had a covered loss but have yet reported it.
Risk Bearing Organization (RBO)	A risk bearing organization (RBO) is either a professional medical corporation, other form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempts from licensure pursuant to subdivision (l) of Section 1206 of the Health and Safety Code, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services. An RBO does not include an individual or a health care service plan.
Subcontractor	An individual or entity that has a subcontract with the MCP that relates directly or indirectly to the performance of the MCP's obligations under the contract with DHCS. A network provider is not a subcontractor by virtue of the network provider agreement, as per 42 CFR § 438.2.
Tangible Net Equity (TNE)	Net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; obligations of officers, directors, owners, or affiliates which are not fully secured, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with nonaffiliates and which are not more than sixty (60) days past due; long term prepayments of deferred charges, and nonreturnable deposits.

	Medical Loss Requirements for Subcontractors	**FIN-003**
Department	Finance & Informatics	
Functional Area	Finance	
Line of Business	☒ Medi-Cal ☒ D-SNP	

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

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

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

ATTACHMENTS
NA

AUTHORITIES/REFERENCES

- **Federal**
  - 42 Code of Federal Regulations ("CFR") 438.8(j)
  - Welfare and Institutions Code (W&I) section 14197 .2
- **State**
  - CalAIM Section 1915(b), STC A11
  - DHCS All Plan Letter 24-018 Medical Loss Ratio Requirements for Subcontractors and Downstream Subcontractors

HISTORY	
Revision Date	**Description of Revision**
03/25/2025	Policy creation
	Annual Review

I. OVERVIEW

A. In December 2021, CMS approved California's CalAIM Section 1915(b) waiver including new MLR reporting and remittance requirements which increases DHCS' oversight of MLR reporting in the context of Subcontractor arrangements. Pursuant to this requirement and as outlined in APL 24-018, CHPIV must oversee the imposition of MLR reporting and remittance requirements on applicable downstream entities.

II. POLICY

A. CHPIV must impose MLR reporting and remittance requirements equivalent to the requirements in 42 CFR section 438.8(k) on their applicable Subcontractors and Downstream Subcontractors.
B. CHPIV will utilize a materiality threshold established by DHCS for determining whether a Subcontractor or Downstream Subcontractor Agreement is subject to the STC A 11 reporting and remittance requirements.

III. PROCEDURE

C. CHPIV will utilize a materiality threshold established by DHCS for determining whether a Subcontractor or Downstream Subcontractor Agreement is subject to the STC A 11 reporting and remittance requirements.
    1. For the CY 2023 MLR reporting year, and until modified by DHCS, applicable Subcontractors that receive $30,000,000 or more in Medi-Cal capitation annually from CHPIV as payment for services rendered in a single county or rating region, for which they assume risk and are not directly providing will be subject to MLR reporting requirements. Subcontractors and Downstream Subcontractors that fall below the annual threshold dollar will not be subject to reporting for the given MLR reporting year, except as required by DHCS on a case-by-case basis.
D. CHPIV, at its discretion, may use a four-part test, consistent with MLR calculations described in CFR section 438.8 and the 2012 CCIIO guidance. Under the 4-part test, payments to a clinical risk bearing entity are considered incurred claims if the following four factors are met:
    1. The entity contracts with an issuer to deliver, provide, or arrange for the delivery and provision of clinical services to the issuer's enrollees but the entity is not the issuer with respect to those services;
    2. The entity contractually bears financial and utilization risk for the delivery, provision, or arrangement of specific clinical services to enrollees;
    3. The entity delivers, provides, or arranges for the delivery and provision of clinical services through a system of integrated care delivery that, as appropriate, provides for the coordination of care and sharing of clinical information, and which includes programs such as Provider performance reviews, tracking clinical outcomes, communicating evidence-based guidelines to the entity's clinical Providers, and other, similar care delivery efforts; and
    4. Functions other than clinical services that are included in the payment (capitated or fee-for-service) must be reasonably related or incidental to the clinical services and must be performed on behalf of the entity or the entity's Providers.
E. Administrative functions performed on behalf of its Providers would be included in incurred claims. Conversely, to the extent that administrative functions are performed on behalf of the CHPIV, such as processing claims in order to issue explanations of benefits (EOBs) to enrollees and handling

enrollee appeals and grievances, that portion of CHPIV's payment that is attributable to these administrative functions may not be included in incurred claims.

F. CHPIV may exempt a newly contracted Subcontractor or Downstream Subcontractor from the MLR reporting requirements in the Subcontractor's or Downstream Subcontractor's first year of operation. Exemptions only apply to the first MLR reporting year that overlaps with the newly contracted Subcontractor's or Downstream Subcontractor's first year of operation regardless of whether the overlap is less than 12 months. Beginning with the CY 2023 MLR reporting year, CHPIV will report any exempted Subcontractors and Downstream Subcontractors to DHCS by the end of the third quarter of each MLR reporting year utilizing DHCS' reporting form.

G. CHPIV will identify all Subcontractors and Downstream Subcontractors in its MLR submission whether or not the Subcontractors and Downstream Subcontractors are required to submit an MLR report.

H. CHPIV requires its Subcontractors and Downstream Subcontractors to report an MLR at the Subcontractor Agreement and Downstream Subcontractor Agreement level, respectively, by county or rating region, to their upstream entity.

I. CHPIV will ensure that Subcontractors and Downstream Subcontractors that report an MLR include within their MLR the revenues, expenses, and membership specific to the services for which they are at risk, and which are not directly provided by them. CHPIV requires Subcontractors and Downstream Subcontractors providing claims adjudication activities to provide all underlying data associated with MLR reporting within 180 days of the end of the MLR reporting year or within 30 days of being requested by CHPIV, whichever comes sooner. For each MLR reporting year, CHPIV set the paid-through dates for all levels of delegation to ensure consistency of the data received.

J. Commencing with the CY 2025 MLR reporting year, CHPIV will impose remittance requirements equivalent to 42 CFR section 438.8(j) on its Subcontractors and Downstream Subcontractors. If the MLR for a Subcontractor Agreement or Downstream Subcontractor Agreement, by county or rating region, does not meet the established minimum standard of 85 percent or higher for the respective MLR reporting year, CHPIV will require the Subcontractor or Downstream Subcontractor to pay a remittance to their upstream entity. The upstream entity must account for this remittance in their own MLR report as a reduction to expenditures.

K. Consistent with 42 CFR sections 438.8(h) and (k)(1)(viii), and the July 31, 2017, CIB entitled Medical Loss Ratio (MLR) Credibility Adjustments, Subcontractors and Downstream Subcontractors may apply credibility adjustment factors within their MLR reporting. CHPIV requires Subcontractors and Downstream Subcontractors that are non-credible but meet the materiality threshold to submit an MLR report.

L. CHPIV will impose requirements on Subcontractors to ensure that Subcontractors and Downstream Subcontractors perform delegated activities or obligations, and related reporting responsibilities, relating to Members, in accordance with 42 CFR section 438.230(c)(1). Subcontractors must comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions, in accordance with 42 CFR section 438.230(c)(2).

M. CHPIV will ensure MLR reports submitted by Subcontractors and Downstream Subcontractors are consistent with the information required in 42 CFR section 438.8(k). CHPIV will review and provide oversight of their downstream entity MLR submissions and will attest to performing this review as part of the MLR submission. Specific expectations may include, but are not limited to:

1. Review each Subcontractor's and Downstream Subcontractor's MLR and reported medical cost PMPM to identify and investigate outliers.
2. Review reported expenses to ensure medical and non-medical expenses are appropriately accounted for in the MLR calculation.
3. Review that reported expenses align with service volume reported in encounters.
4. Review that the Subcontractor's or Downstream Subcontractor's reported revenues align with the payments reported by the upstream entity.
5. For Subcontractor Agreements or Downstream Subcontractor Agreements covering multiple lines of business, review the methodologies for allocation of expenditures to ensure reasonableness.
6. Reviewing IBNR for reasonableness.

N. In accordance with 42 CFR section 438.8(k)(2), CHPIV will submit MLR reports to DHCS within 12 months of the end of the MLR reporting year, which is before the timeframe for State Directed Payments (SDP) are calculated and paid. Therefore, SDPs will not be included in the initial MLR report submitted by Subcontractors and Downstream Subcontractors. When the remittance requirement is imposed beginning with the CY 2025 MLR period, a proxy remittance amount will be calculated, which will exclude these SDPs. The remittance of payments from Subcontractors and Downstream Subcontractors to their upstream entities, and from CHPIV to DHCS, will be delayed until SDPs have been finalized and paid. After SDPs are calculated and paid, the MLR will be recalculated and resubmitted. Subcontractors and Downstream Subcontractors will only need to re-report their MLR if those SOP amounts flow to them from their upstream entity. The final remittance amounts will be calculated and collected following receipt of the restated MLRs.

O. CHPIV will review its contractually required P&Ps to determine if amendments are needed to comply with APL 2024-018. If the requirements, including any updates or revisions, necessitate a change in this P&Ps, will submit its updated P&Ps to the Managed Care Operations Division (MCOD)-MCP Submission Portal 14 within 90 days of the release of APL 24-018. If no changes are necessary, CHPIV will attach an attestation to the Portal within 90 days of the release of APL 24-018 stating that P&Ps have been reviewed and no changes were necessary. The attestation will include the title of this APL as well as the applicable APL release date in the subject line.

P. CHPIV will be responsible for ensuring that its Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters. CHPIV will ensure its Subcontractors have reviewed and updated their P&Ps. CHPIV will submit an attestation validating that Subcontractors subject to this APL have compliant P&Ps within 120 days of the release of this APL. CHPIV will review their Provider and/or Subcontractor Agreements, including Division of Financial Responsibility provisions as appropriate to ensure compliance with this APL 24-018.

IV. Key Dates and Activities

Date	Activity
No later than 12/31/2025	Receipt of CY 2024 MLRs – CHPIV to submit their CY 2024 MLR report to DHCS accounting for their applicable Subcontractors' MLRs.

Date	Activity
1/1/2026 – 9/30/2026	DHCS' MLR Review - DHCS reviews compliance with CY 2024 MLR reporting requirements, including consideration of Subcontractor reporting, and calculates, but does not collect, draft remittance in accordance with State law.
No later than 3/31/2027	Receipt of Restated CY 2024 MLRs – CHPIV will submit restated CY 2024 MLR reports including final SOP revenues and expenditures.
4/1/2027 – 9/30/2027	DHCS' MLR Review - DHCS calculates CY 2024 remittances in accordance with State law.
No later than 13/31/2027	Remittance Collection – CHPIV will remit any owed amounts for CY 2024.

	Investment Policy	FIN-006
Department	Finance & Informatics	
Functional Area	Investment Management	
Impacted Delegate	☒ Medi-Cal ☐ D-SNP	

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

DATES			
Policy Effective Date	11/13/2023	**Reviewed/Revised Date**	
Next Annual Review Due	11/13/2024	**Regulator Approval**	N/A

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

ATTACHMENTS
• None

AUTHORITIES/REFERENCES
• California Government Code, Section 16340, 16429.1, 27133, 53601, 53601.6, 53601.8, 53630 et seq., 53635, 53635.8, and 57603.

HISTORY	
Revision Date	**Description of Revision**
11/13/2023	Policy Creation
	Annual Review

I. OVERVIEW

A. This policy sets forth the investment guidelines for all Operating Funds and Commission-Designated Reserve Funds of CHPIV invested on or after January 10, 2006, to ensure CHPIV's funds are prudently invested according to the LHA Commission' objectives and the California Government Code to

preserve Capital, provide necessary Liquidity, and achieve a market-average Rate of Return through Economic Cycles. Each annual review takes effect upon its adoption by the LHA Commission.

II. POLICY

A. CHPIV investments may only be made as authorized by this Policy.

1. This Policy shall conform to California Government Code, Section 53600 et seq. (hereinafter, the Code) as well as customary standards of prudent investment management. Should the provisions of the Code be, or become, more restrictive than those contained herein, such provisions shall be considered immediately incorporated into this Policy and adhered to.
2. Safety of Principal: Safety of Principal is the primary objective of CHPIV and, as such, each investment transaction shall seek to ensure that large Capital losses are avoided from securities or Broker-Dealer default.
    a. CHPIV shall seek to ensure that Capital losses are minimized from the erosion of market value and preserve principal by mitigating the two (2) types of Risk: Credit Risk and Market Risk.
        i. Credit Risk shall be mitigated by investing in only permitted investments and by diversifying the Investment Portfolio, in accordance with this Policy.
        ii. Market Risk shall be mitigated by matching Maturity Dates, to the extent possible, with CHPIV's expected cash flow needs and other factors.
    b. It is explicitly recognized herein, however, that in a diversified portfolio, occasional losses are inevitable and must be considered within the context of the overall investment return.
3. Liquidity: Liquidity is the second most important objective of CHPIV. It is important that each portfolio contain investments for which there is a secondary market and which offer the flexibility to be easily sold at any time with minimal Risk of loss of either the principal or interest based upon then prevailing rates.
4. Total Return: CHPIV's Investment Portfolios shall be designed to attain a market-average Rate of Return through Economic Cycles given an acceptable level of Risk, established by the LHA Commission' and the CHPIV Treasurer's objectives.
    a. The performance Benchmark for each Investment Portfolio shall be based upon published Market Indices as primary Benchmark, and Custom Peer Group Reports, as necessary, for short-term investments of comparable Risk and duration.
        i. These performance Benchmarks shall be reviewed monthly by CHPIV staff, and quarterly by CHPIV's Treasurer and the Investment Advisory Committee members and shall be reported to the LHA Commission.

B. The investments purchased by an Investment Manager shall be held by the Custodian Bank acting as the agent of CHPIV under the terms of a custody agreement in compliance with California Government Code, Section 53608.

C. Investment Managers must certify that they will purchase securities from Broker-Dealers (other than themselves) or financial institutions in compliance with California Government Code, Section 53601.5 and this Policy.

D. The LHA Commission, or persons authorized to make investment decisions on behalf of CHPIV (e.g., Chief Officers), are trustees and fiduciaries subject to the Prudent Person Standard, as defined in the Code, which shall be applied in the context of managing an overall portfolio.

E. CHPIV's Officers, employees, Commission members, and Investment Advisory Committee members involved in the investment process shall refrain from personal and professional business activities that could conflict with the proper execution of the investment program, or which could impair their ability to fulfill their roles in the investment process.

1. CHPIV's Officers and employees involved in the investment process are not permitted to have any material financial interests in financial institutions, including state or federal credit unions, that conduct business with CHPIV, and are not permitted to have any personal financial, or investment holdings, that could be materially related to the performance of CHPIV's investments.

F. On an annual basis, CHPIV's Treasurer shall provide the LHA Commission with this Policy for review and adoption by the Commission, to ensure that all investments made are following this Policy.

1. This Policy shall be reviewed annually by the LHA Commission at a public meeting pursuant to California Government Code, Section 53646, Subdivision (a).
2. This policy may only be changed by the LHA Commission.

III. PROCEDURE

A. Delegation of Authority
   1. Authority to manage CHPIV's investment program is derived from an order of the LHA Commission.
   2. Management responsibility for the investment program shall be delegated to CHPIV's Treasurer, as appointed by the LHA Commission, for a one (1)-year period following the approval of this Policy.
      a. The LHA Commission may renew the delegation of authority annually.
   3. No person may engage in investment transactions except as provided under the terms of this Policy and the procedures established by CHPIV's Treasurer.

B. CHPIV Treasurer Responsibilities
   1. The Treasurer shall be responsible for:
      a. All actions undertaken and shall establish a system of controls to regulate the activities of subordinate officials and Commission-approved Investment Managers;
      b. The oversight of CHPIV's Investment Portfolio;
      c. Directing CHPIV's investment program and for compliance with this Policy pursuant to the delegation of authority to invest funds or to sell or exchange securities; and
      d. Providing a quarterly report to the LHA Commission in accordance with California Government Code, Section 53646, Subdivision (b).
   2. The Treasurer shall also be responsible for ensuring that:
      a. The Operating Funds and Commission-Designated Reserve Funds targeted average maturities are established and reviewed monthly.
      b. All Investment Managers are provided a copy of this Policy, which shall be appended to an Investment Manager's investment contract.

i. Any investments made by an Investment Manager outside this Policy may subject the Investment Manager to termination for cause or other appropriate remedies or sanctions, as determined by the LHA Commission.

3. Investment diversification and portfolio performance is reviewed monthly to ensure that Risk levels and returns are reasonable and that investments are diversified in accordance with this Policy.
4. All Investment Managers are selected and evaluated for review by the Chief Executive Officer and the LHA Commission.

C. Investment Advisory Committee

1. The Investment Advisory Committee shall not make, or direct, CHPIV staff to make any particular investment, purchase any particular investment product, or conduct business with any particular investment companies, or brokers.
    a. It shall not be the purpose of the Investment Advisory Committee to advise on particular investment decisions of CHPIV.
2. The Investment Advisory Committee shall be responsible for the following functions:
    a. Annual review of this Policy before its consideration by the LHA Commission and revision recommendations, as necessary, to the Finance and Audit Committee of the LHA Commission.
    b. Quarterly review of CHPIV's Investment Portfolio for conformance with this Policy's diversification and maturity guidelines, and recommendations to the Finance and Audit Committee of the LHA Commission, as appropriate.
    c. Provision of comments to CHPIV's staff regarding potential investments and potential investment strategies.
    d. Performance of such additional duties and responsibilities pertaining to CHPIV's investment program as may be required from time to time by specific action and direction of the LHA Commission.

D. Permitted Investments

1. CHPIV shall invest only in Instruments as permitted by the Code (see Figure 1), subject to the limitations of this Policy.
    a. Permitted investments under the Operating Funds, unless otherwise specified, are subject to a maximum stated term of up to five (5) years.
    b. Permitted investments under the Commission-Designated Reserve Funds, unless otherwise specified, are subject to a maximum stated term of five (5) years.
    c. The LHA Commission must grant express written authority to make an investment, or to establish an investment program, of a longer term.

Figure 1 - Fund Type Term Assigned Term Allowed by the Code

INVESTMENT TYPE	MAXIMUM MATURITY[C]	MAXIMUM SPECIFIED % OF PORTFOLIO[D]	MINIMUM QUALITY REQUIREMENTS	GOV'T CODE SECTIONS
Local Agency Bonds	5 years	None	None	53601(a)
U.S. Treasury Obligations	5 years	None	None	53601(b)
State Obligations— CA And Others	5 years	None	None	53601(c) 53601(d)
CA Local Agency Obligations	5 years	None	None	53601(e)
U.S Agency Obligations	5 years	None	None	53601(f)
Bankers' Acceptances	180 days	40%[E]	None	53601(g)

Commercial Paper—Non-Pooled Funds[F] (under $100,000,000 of investments)	270 days or less	25% of the agency's money[G]	Highest letter and number rating by an NRSRO[H]	53601(h)(2)(c)
Commercial Paper—Non-Pooled Funds (min. $100,000,000 of investments)	270 days or less	40% of the agency's money[G]	Highest letter and number rating by an NRSRO[H]	53601(h)(2)(c)
Commercial Paper— Pooled Funds[I]	270 days or less	40% of the agency's money[G]	Highest letter and number rating by an NRSRO[H]	53635(a)(1)
Negotiable Certificates of Deposit	5 years	30%[J]	None	53601(i)
Non-negotiable Certificates of Deposit	5 years	None	None	53630 et seq.
Placement Service Deposits	5 years	50%[K]	None	53601.8 and 53635.8
Placement Service Certificates of Deposit	5 years	50%[K]	None	53601.8 and 53635.8
Repurchase Agreements	1 year	None	None	53601(j)
Reverse Repurchase Agreements and Securities Lending Agreements	92 days[L]	20% of the base value of the portfolio	None[M]	53601(j)
Medium-Term Notes[N]	5 years or less	30%	"A" rating category or its equivalent or better	53601(k)
Mutual Funds And Money Market Mutual Funds	N/A	20%	Multiple[P,Q]	53601(l) and 53601.6(b)
Collateralized Bank Deposits[R]	5 years	None	None	53630 et seq. and 53601(n)
Mortgage Pass–Through and Asset–Backed Securities	5 years or less	20%	"AA" rating category or its equivalent or better	53601(o)
County Pooled Investment Funds	N/A	None	None	27133
Joint Powers Authority Pool	N/A	None	Multiple[S]	53601(p)
Local Agency Investment Fund (LAIF)	N/A	None	None	16429.1
Voluntary Investment Program Fund[T]	N/A	None	None	16340
Supranational Obligations[U]	5 years or less	30%	"AA" rating category or its equivalent or better	53601(q)
Public Bank Obligations	5 years	None	None	53601(r), 53635(c)

Notes for Figure 1

A. *Sources: Sections 16340, 16429.1, 27133, 53601, 53601.6, 53601.8, 53630 et seq., 53635, 53635.8, and 57603.*

B. Municipal Utilities Districts have the authority under the Public Utilities Code Section 12871 to invest in certain securities not addressed here.

C. Section 53601 provides that the maximum term of any investment authorized under this section, unless otherwise stated, is five years from the settlement date. However, the legislative body may grant express authority to make investments either specifically or as a part of an investment program approved by the legislative body that exceeds this five year remaining maturity limit. Such approval must be issued no less than three months prior to the purchase of any security exceeding the five-year maturity limit.

D. Percentages apply to all portfolio investments regardless of source of funds. For instance, cash from a reverse repurchase agreement would be subject to the restrictions.

E. No more than 30 percent of the agency's money may be in bankers' acceptances of any one commercial bank.

F. Includes agencies defined as a city, a district, or other local agency that do not pool money in deposits or investment with other local agencies, other than local agencies that have the same governing body.

G. Local agencies, other than counties or a city and county, may purchase no more than 10 percent of the outstanding commercial paper and medium-term notes of any single issuer.

H. Issuing corporation must be organized and operating within the U.S., have assets in excess of $500 million, and debt other than commercial paper must be in a rating category of "A" or its equivalent or higher by a nationally recognized statistical rating organization, or the issuing corporation must be organized within the U.S. as a special purpose corporation, trust, or LLC, have program wide credit enhancements, and have commercial paper that is rated "A-1" or higher, or the equivalent, by a nationally recognized statistical rating agency.

I. Includes agencies defined as a county, a city and county, or other local agency that pools money in deposits or investments with other local agencies, including local agencies that have the same governing body. Local agencies that pool exclusively with other local agencies that have the same governing body must adhere to the limits set forth in Section 53601(h)(2)(C).

J. No more than 30 percent of the agency's money may be in negotiable certificates of deposit that are authorized under Section 53601(i).

K. Effective January 1, 2020, no more than 50 percent of the agency's money may be invested in deposits, including certificates of deposit, through a placement service as authorized under 53601.8 (excludes negotiable certificates of deposit authorized under Section 53601(i)). On January 1, 2026, the maximum percentage of the portfolio reverts back to 30 percent. Investments made pursuant to 53635.8 remain subject to a maximum of 30 percent of the portfolio.
Reverse repurchase agreements or securities lending agreements may exceed the 92-day term if the agreement includes a written codicil guaranteeing a minimum earning or spread for the entire period between the sale of a security using a reverse repurchase agreement or securities lending agreement and the final maturity dates of the same security.

M. Reverse repurchase agreements must be made with primary dealers of the Federal Reserve Bank of New York or with a nationally or state chartered bank that has a significant relationship with the local agency. The local agency must have held the securities used for the agreements for at least 30 days.

N. "Medium-term notes" are defined in Section 53601 as "all corporate and depository institution debt securities with a maximum remaining maturity of five years or less, issued by corporations organized and operating within the United States or by depository institutions licensed by the United States or any state and operating within the United States."
O. No more than 10 percent invested in any one mutual fund. This limitation does not apply to money market mutual funds.
P. A mutual fund must receive the highest ranking by not less than two nationally recognized rating agencies or the fund must retain an investment advisor who is registered with the SEC (or exempt from registration), has assets under management in excess of $500 million, and has at least five years' experience investing in instruments authorized by Sections 53601 and 53635.
Q. A money market mutual fund must receive the highest ranking by not less than two nationally recognized statistical rating organizations or retain an investment advisor registered with the SEC or exempt from registration and who has not less than five years' experience investing in money market instruments with assets under management in excess of $500 million.
R. Investments in notes, bonds, or other obligations under Section 53601(n) require that collateral be placed into the custody of a trust company or the trust department of a bank that is not affiliated with the issuer of the secured obligation, among other specific collateral requirements.
S. A joint powers authority pool must retain an investment advisor who is registered with the SEC (or exempt from registration), has assets under management in excess of $500 million, and has at least five years' experience investing in instruments authorized by Section 53601, subdivisions (a) to (o).
T. Local entities can deposit between $200 million and $10 billion into the Voluntary Investment Program Fund, upon approval by their governing bodies. Deposits in the fund will be invested in the Pooled Money Investment Account.
U. Only those obligations issued or unconditionally guaranteed by the International Bank for Reconstruction and Development (IBRD), International Finance Corporation (IFC), and Inter-American Development Bank (IADB), with a maximum remaining maturity of five years or less.

IV. DEFINITIONS

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

TERM	DEFINITION
Banker's Acceptance (BA)	Time drafts which a bank "accepts" as its financial responsibility as part of a trade finance process. These short-term notes are sold at a discount, and are obligations of the drawer (i.e., the bank's trade finance client) as well as the bank. Once accepted, the bank is irrevocably obligated to pay the banker's acceptance (BA) upon maturity, if the drawer does not. Eligible banker's acceptances: • Are eligible for purchase by the Federal Reserve System, and are drawn on and accepted by a bank rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency; and • May not exceed the five percent (5%) limit of any one (1) commercial bank and may not exceed the five percent (5%) limit for any security of any bank.
Benchmark	Benchmarks are usually constructed using unmanaged indices, exchange-traded Funds or mutual fund categories to represent each asset class. Benchmarks are often used as a tool to assess the allocation, Risk and return of a portfolio.
Commission-Designated Reserve Funds	Funds established to address unexpected agency needs and not intended for use in the normal course of business. The amount of Commission-Designated Reserve Funds should be offset by any working Capital or net current asset deficits. The desired level for these funds is a minimum of 1.4 and maximum of 2.0 months of capitation revenues
Bonds	A debt security, under which the issuer owes the holders a debt and, depending on the terms of the bond, is obliged to pay them interest (the coupon) and/or to repay the principal at a later date, termed the maturity date.

Broker-Dealer	In financial services, a Broker-Dealer is a natural person, a company or other organization that engages in the business of trading securities for its own account or on behalf of its customers.
CHPIV Treasurer	Appointed by CHPIV's LHA Commission, the treasurer is a person responsible for overseeing CHPIV's investment funds.
Capital	Capital refers to financial assets or the financial value of assets, in the form of money or other assets owned by an organization.
Cash Flow Draws	Amount of cash needs to support CHPIV business operation.
Chief Officers	For the purposes of this policy, may include, but is not limited to, the Chief Executive Officer (CEO), Chief Financial Officer (CFO), and/or Chief Counsel.
Collateral Securities	A security given in addition to the direct security, and subordinate to it, intended to guarantee its validity or convertibility or insure its performance; so that, if the direct security fails, the creditor may fall back upon the collateral security.
Commercial Paper (CP)	Unsecured promissory notes issued by companies and government entities at a discount.
Consumer Price Index (CPI)	The Consumer Price Indexes (CPI) program produces monthly data on changes in the prices paid by urban consumers for a representative basket of goods and services.
Corporate Securities	Notes issued by corporations organized and operating within the U.S. or by depository institutions licensed by the U.S. or any state, and operating within the U.S.
Credit Risk	The Risk of loss due to failure of the issuer of a security.
Custodian Bank	A specialized financial institution responsible for safeguarding a firm's or individual's financial assets and is not engaged in "traditional" commercial or consumer/retail banking such as mortgage or personal lending, branch banking, personal accounts, automated teller machines (ATMs) and so forth.
Custom Peer Group Report	Developed based on a small peer universe with similar investment guidelines. The Purpose of the report is to provide more accurate performance comparison.
Designee	For purposes of this policy, a person who has been designated to act on behalf of the CHPIV Treasurer.
Economic Cycles	The natural fluctuation of the economy between periods of expansion (growth) and contraction (recession).
Finance and Audit Committee (FAC)	A standing committee of the LHA Commission with oversight responsibilities for all financial matters of CHPIV including but not limited to: budget development and approval, financial reporting, investment practices and policies, purchasing and procurement practices and policies, insurance issues, and capitation and claims. The Committee serves as the primary level of Commission review for any finance-related issues or policies affecting the CHPIV program.
Inflation	Inflation is the rate at which the general level of prices for goods and services is rising and, consequently, the purchasing power of currency is falling.
Instrument	Refers to a financial Instrument or asset that can be traded. These assets can be cash, Bonds, or shares in a company

Investment Advisor(s)	Registered or non-registered person or group that makes investment recommendations or conducts securities analysis in return for a fee.
Investment Advisory Committee (IAC)	A standing committee of the LHA Commission who provide advice and recommendations regarding CHPIV's Investment Policies, Procedures and Practices.
Investment Manager(s)	A person or organization that makes investments in portfolios of securities on behalf of clients, in accordance with the investment objectives and parameters defined by these clients.
Investment Portfolio	A grouping of financial assets such as stocks, Bonds and cash equivalents, as well as their funds counterparts, including mutual, exchange-traded and closed funds. Portfolios are held directly by investors and/or managed by financial professionals.
Joint Powers Authority Pool	Shares of beneficial interest issued by a joint powers authority organized pursuant to California Government Code, Section 6509.7; each share represents an equal proportional interest in the Underlying Pool of Securities owned by the joint powers authority.
Lien	A legal right granted by the owner of property, by a law or otherwise acquired by a creditor
Liquidity	Liquidity describes the degree to which an asset or security can be quickly bought or sold in the market without affecting the asset's price.
Market Indices	Measurements of the value of a section of the stock market. It is computed from the prices of selected stocks (typically a weighted average).
Market Risk	The Risk of market value fluctuations due to overall changes in the general level of interest rates.
Maturity Dates	The date on which the principal amount of a note, draft, acceptance bond or another debt Instrument becomes due and is repaid to the investor and interest payments stop. It is also the termination or due date on which an installment loan must be paid in full.
Medium Term Notes (MTN)	A debt note that usually matures (is paid back) in five (5) – ten (10) years, but the term may be less than one (1) year or as long as one hundred (100) years. They can be issued on a fixed or floating coupon basis.
Nationally Recognized Statistical Ratings Organization (NRSRO)	A credit rating agency that the Securities and Exchange Commission in the United States registers and uses for regulatory purposes. Current NRSROs listed at www.sec.gov/ocr/ocr-current-nrsros.html.
Negotiable Certificates of Deposit	A negotiable (i.e., marketable or transferable) receipt for a time deposit at a bank or other financial institution, for a fixed time and interest rate.
Operating Funds	Funds intended to serve as a money market account for CHPIV to meet daily operating requirements. Deposits to this fund are comprised of State warrants that represent CHPIV's monthly capitation revenues from its State contracts. Disbursements from this fund to CHPIV's operating cash accounts are intended to meet operating expenses, payments to providers and other payments required in day-to-day operations.
Prudent Person Standard	When investing, reinvesting, purchasing, acquiring, exchanging, selling, or managing public funds, a trustee shall act with care, skill, prudence, and

	diligence under the circumstances then prevailing, including but not limited to, the general economic conditions and the anticipated needs of the agency, that a prudent person acting in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and maintain the Liquidity needs of the agency (California Government Code, Section 53600.3)
Rate of Return	The gain or loss on an investment over a specified time period, expressed as a percentage of the investment's cost. Gains on investments are defined as income received plus any Capital gains realized on the sale of the investment.
Rating Category	With respect to any long-term category, all ratings designated by a particular letter or combination of letters, without regard to any numerical modifier, plus or minus sign or other modifier.
Repurchase Agreements	A purchase of securities under a simultaneous agreement to sell these securities back at a fixed price on some future date.
Risk	Investment Risk can be defined as the probability or likelihood of occurrence of losses relative to the expected return on any particular investment. Description: Stating simply, it is a measure of the level of uncertainty of achieving the returns as per the expectations of the investor.
State and California Local Agency Obligations	Registered warrants, notes or Bonds of any of the fifty (50) U.S. states, including Bonds payable solely out of the revenues from a revenue producing property owned, controlled, or operated by a state or by a department, board, agency, or authority of any of the fifty (50) U.S. states. Additionally, Bonds, notes, warrants, or other evidences of indebtedness of any local agency within the State of California, including Bonds payable solely out of revenues from a revenue producing property owned, controlled, or operated by the state or local agency, or by a department, board, agency or authority of the State or local agency.
Supranational Institutions	International institutions formed by two (2) or more governments that transcend boundaries to pursue mutually beneficial economic or social goals.
Surplus	Assets beyond liabilities.
Underlying Pool of Securities	Those securities and obligations that are eligible for direct investment by local public agencies.
Valuation	An estimation of the worth of a financial Instrument or asset. CHPIV's asset managers provide CHPIV with reporting that shows the Valuation of each financial Instrument that they own on behalf of CHPIV. Each asset manager uses a variety of market sources to determine individual Valuations.

	Grievance Process	GA-001
Department	Health Services	
Functional Area	Grievances & Appeals	
Line of Business	☒ Medi-Cal ☒ D-SNP	

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

DATES			
Policy Effective Date	06/12/2023	**Reviewed/Revised Date**	
Next Annual Review Due		**Regulator Approval**	12/15/2023

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

ATTACHMENTS
N/A

AUTHORITIES/REFERENCES

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

HISTORY

Revision Date	Description of Revision
06/12/2023	Policy creation
07/10/2023	Added the requirements related to expedited grievances

10/01/2024	Annual review- no changes
11/12/2024	Updated to align with NCQA standards
11/18/2024	Updated to align with NCQA standards
12/11/2025	Updated to comply with DMHC APL 25-007
12/11/2025	Annual Review - Updates for APLs and/or applicable regulations. Revisions to P&P formatting.
	Added additional language on discrimination grievances

I. OVERVIEW

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

II. POLICY

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

1. CHPIV ensures MEMBERS are allowed to file a GRIEVANCE at any time to express dissatisfaction about any matter other than a notice of ABD:
    a. GRIEVANCES may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the MEMBER's right to dispute an extension of time proposed by the MCP to make an authorization decision.
    b. A COMPLAINT is the same as a GRIEVANCE. If the MCP is unable to distinguish between a GRIEVANCE and an INQUIRY, it must be considered a GRIEVANCE.
    c. An INQUIRY is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other MCP processes.
    d. A COMPLAINT made by an MEMBER to a plan about a delay or denial of a payment of a claim will be treated by the plan as a GRIEVANCE, regardless of whether the MEMBER uses the term "grievance" as part of the COMPLAINT.
2. CHPIV ensures MEMBERS are allowed to file a GRIEVANCE to contest the unilateral decision to extend the timeframe for RESOLUTION of an APPEAL or expedited APPEAL.
3. CHPIV will ensure to maintain an integrated process for the timely resolution of grievances, organization determinations, and reconsiderations to ensure a streamlined MEMBER experience. This integrated process applies to all entities and individuals through which the Plan provides covered items and services. *This requirement applies specifically to the Dual Eligible Special Needs Plan (D-SNP) line of business.*
4. CHPIV will ensure to maintain its integrated appeals and grievances processes apply to all covered benefits, including optional supplemental benefits offered under this D-SNP contract. This includes access to both grievance and appeals procedures for any adverse benefit determination related to optional supplemental benefits. *This requirement applies specifically to the Dual Eligible Special Needs Plan (D-SNP) line of business.*

5. CHPIV ensures every GRIEVANCE involving clinical issues is reported to qualified medical professionals with appropriate clinical expertise and is escalated to the MEDICAL DIRECTOR as needed, to ensure the GRIEVANCE is properly handled.
6. CHPIV ensures GRIEVANCES are monitored to identify issues that require Corrective Action. GRIEVANCES related to medical Quality of Care issues must be referred to qualified medical professionals with appropriate clinical expertise and is escalated to the MEDICAL DIRECTOR as needed.
7. CHPIV ensures written acknowledgement is provided within five (5) calendar days of receipt of the GRIEVANCE. The acknowledgement letter must advise the MEMBER that the GRIEVANCE has been received, provide the date of the receipt, and provide the name, telephone number, and address of the representative who the MEMBER or their Provider or AUTHORIZED REPRESENTATIVE may contact about the GRIEVANCE.
8. The GRIEVANCES Process shall address the receipt, handling, and disposition of MEMBER GRIEVANCES and APPEALS, in accordance with the Department of Health Care Services (DHCS) Contract and applicable state and federal statutes, regulations and DHCS All Plan Letters.
9. CHPIV will ensure The Plan's GRIEVANCE system is established in writing (approved by the Department of Health Care Services (DHCS) Title 22 CCR Section 53858(a)(1)) and provides for procedures that receive, review and resolve GRIEVANCES as quickly as MEMBER'S health condition requires, not to exceed 30 calendar days of receipt by the plan, or any provider or entity with delegated authority to administer and resolve the plan's GRIEVANCE system [Title 28, CCR1300.68(a), §438.408(b)(1), RR3.A.4]. The Plan's internal GRIEVANCE process includes only one level of review [Title 28, CCR 1300.68(a) (4)(A)].
10. The GRIEVANCE and APPEAL process ensures that MEMBERS s are given a reasonable opportunity to present evidence and testimony, and make legal or factual arguments, in person, by telephone or in writing, in support of their GRIEVANCE or APPEAL. The Plan will inform MEMBERS that they must submit additional evidence for Contractor to consider within the 30-calendar day review timeframe for an APPEAL and within 72 hours timeframe for resolving an expedited APPEAL. In the case of a GRIEVANCE subject to expedited review, MEMBER Services informs the MEMBER of the limited time available to present evidence. Specific to APPEALS, the process provides the MEMBER and his or her representative opportunity, before and during APPEALS process, to examine the MEMBER'S case file, including medical records, and any other documents and records considered during the APPEALS process or within 30 calendar days for an APPEAL and within 72 hours for an expedited APPEAL. [§ 438.406(b)(3), DHCS Contract Exhibit A, Attachment 14, 2H, DHCS Contract Exhibit A, Attachment 14, 4C].
11. Medi-Cal MEMBERS are notified within 7 days of enrollment and annually thereafter about The Plan's GRIEVANCE process, including information on the plan's procedures for filing and resolving an issue, and the toll-free telephone number and address for obtaining forms, requesting information or presenting an issue [Title 28, CCR 1300.68(b)(2), 1300.68(b)(4), Title 22 CCR Section 53858(a)(2)(A)]. Notices additionally include:
    a. A statement that GRIEVANCE forms are available in the office of each primary care provider, or in each MEMBER services department of the plan [Title 22 CCR Section 53858(a)(2)(B)].
    b. A statement that GRIEVANCES may be filed in writing (by mail, facsimile, email, or The Plan's website) or verbally (by telephone) or in person directly at The Plan's

local office or with the plan in which the MEMBER is enrolled or at any office or facility of the contracted plan's providers [Title 22 CCR Section 53858(a)(2)(C)].

c. An explanation of the state's Medi-Cal Managed Care Ombudsman program and the program's voice number [Title 22 CCR Section 53858(a)(2)(F)].

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

d. Who has authority to require corrective action.

18. Although, existing state regulations [Title 28, CCR, Section 1300.68(b)(9)] limits the timeframe for filing GRIEVANCES of at least 180 calendar days from the date of the incident subject to the enrollee's dissatisfaction, The Plan shall allow enrollees to file GRIEVANCES anytime and according to the current federal regulations [Title 42, CFR, Section 438.402(c)(2)(i)]. The GRIEVANCE process is a 30-calendar-day maximum process, from the date the initial request was received by The Plan, until written response is sent to the COMPLAINANT [Title 28, CCR 1300.68(d)(3), 1368.01(a), Title 22 CCR Section 53858(g)(1), DHCS Contract Exhibit A, Attachment 14,
    a. If the case exceeds the 30-calendar daytime requirement, it is considered out of compliance and the MEMBER is sent a letter notifying them of the reason for delay and is given an expected timeframe for RESOLUTION.
    b. The delay notice includes a statement notifying the MEMBERS that they may exercise their right to request a DSS hearing [Title 22 CCR Section 53858(g) (3)].
19. CHPIV will ensure the GRIEVANCE process addresses the linguistic and cultural needs of the MEMBER, as well as the needs of MEMBERS with disabilities, including but not limited to any described in contracts between The Plan and DHCS [Title 22 CCR Section 53858(e)(6)] but more specifically, The Plan provides assistance, including but not limited to, translation of APPEAL and GRIEVANCE procedures, forms, and plan responses to issues, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate [Title 28, CCR 1300.68(b)(3), § 438.406(a)(1), DHCS Contract Exhibit A, Attachment 14, 2B].
20. CHPIV will ensure GRIEVANCE processing varies based on whether the MEMBER'S GRIEVANCE is an Administrative GRIEVANCE or Clinical GRIEVANCE. The Plan investigates the substance of all GRIEVANCES, including any clinical aspects [RR3. A.2]. PQI issues are internally investigated using the plan's GRIEVANCE investigation protocols.
21. Although there may be multiple reasons for a GRIEVANCE within one COMPLAINT (such as interpersonal, wait time and administrative issues), a primary reason should be identified. The following methodology can be used to select the primary reason. If there is a perceived quality of care failure, the case should be filed as a quality-of-care issue even though administrative or interpersonal issues may be associated. However, all concerns are to be noted in the file documentation and RESOLVED with the provider and/or PPG, as appropriate. Multiple cases may be generated from one COMPLAINT to address all issues raised by the MEMBER.
22. CHPIV will ensure Timeframes for resolving GRIEVANCES and sending written RESOLUTION to the beneficiary are delineated in both federal [Title 42, CFR, Section 438.408(b)(1)] and state [HSC Section 1368.01(a); Title 28, CCR, Sections 1300.68(a) and (d)(3)] regulations. Federal regulations, which remain unchanged, allow the State to establish a timeframe for GRIEVANCE RESOLUTION that does not exceed 90 calendar days from the date of receipt of the GRIEVANCE. The State's established timeframe is 30 calendar days. The Plan shall continue to comply with the State's established timeframe of 30 calendar days for GRIEVANCE RESOLUTION [DHCS APL 21-011].
    a. "RESOLVED" means that the GRIEVANCE has reached a final conclusion with respect to the beneficiary's submitted GRIEVANCE as delineated in existing state regulations [Title 28, CCR, Section 1300.68(a)(4)]

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

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

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

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

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

E. CHPIV ensures prompt review and investigation of MEMBER GRIEVANCES are conducted by the appropriate department and/or staff delegated the responsibility to handle CHPIV's internal GRIEVANCE operations.

F. CHPIV will ensure its MEMBERS have the right to file a written complaint with the Quality Improvement Organization (QIO) regarding the quality of Medicare-covered services.

1. CHPIV will ensure to provide its MEMBERS with information on how to file a complaint with the QIO upon the MEMBERS request. *This requirement applies specifically to the Dual Eligible Special Needs Plan (D-SNP) line of business.*

2. CHPIV will ensure to cooperate with Quality Improvement Organizations (QIOs) in resolving complaints submitted to them regarding the quality of Medicare-covered services. Upon notice of a QIO complaint, the Plan will respond timely to QIO inquiries, provide requested information, and coordinate resolution activities as required. *This requirement applies specifically to the Dual Eligible Special Needs Plan (D-SNP) line of business.*

G. CHPIV ensures that every GRIEVANCE submitted by a MEMBER, or a provider or AUTHORIZED REPRESENTATIVE acting on behalf of a MEMBER and with the MEMBER's written consent, is reported to an appropriate level within its network (i.e., quality of care versus quality of service).

H. CHPIV ensures the immediate referral of all medical quality of care issues to a MEDICAL DIRECTOR or Designee for review.

I. CHPIV ensures MEMBERS, MEMBER's AUTHORIZED REPRESENTATIVES, or providers are not discriminated against or retaliated against on grounds that he or she filed a GRIEVANCE as required by federal and State nondiscrimination law.

J. CHPIV ensures GRIEVANCES alleging discrimination are forwarded to the Department of Health Care Services (DHCS) Office of Civil Rights (OCR).

K. CHPIV GRIEVANCES processed for pharmacy services rendered or requested before implementation of Medi-Cal Rx.

L. CHPIV ensures the maintenance and availability for DHCS review, GRIEVANCE logs, including GRIEVANCE logs delineated by Subcontractor and Downstream Subcontractor. The record of each GRIEVANCE must contain, at a minimum, all the following information and must be accurately maintained in a manner accessible to the state and available upon request to CMS:

1. A general description of the reason for the GRIEVANCE.
2. The date received.
3. The date of each review or, if applicable, review meeting.
4. A description of the action taken by the plan or provider to investigate and resolve the GRIEVANCE.
5. RESOLUTION at each level of the GRIEVANCE, if applicable.
6. The name of the plan provider or staff person responsible for resolving the GRIEVANCE
7. Date of RESOLUTION at each level, if applicable.
8. Name of the covered person for whom the GRIEVANCE was filed.

M. CHPIV will ensure that The Plan has established a system that provides for the prompt receipt of DMHC contacts regarding urgent GRIEVANCESs and APPEALS twenty-four (24) hours a day, seven (7) days a week. During normal business hours, the system provides for The Plan to contact the DMHC within 30 minutes following the DMHC contact regarding an urgent issue [Title 28, CCR 1300.68.01(b)]. After normal business hours, on weekends or holidays, the system provides for The Plan to contact the DMHC within one (1) hour following the DMHC contact regarding an urgent issue. This system provides for the availability of The Plan's representative with authority on the plan's behalf to resolve urgent GRIEVANCES and authorize the provision of health care services covered under the MEMBER'S contract in a medically appropriate and timely manner. Such authority includes

making financial decisions for expenditure of funds on behalf of The Plan without first having to obtain approval from supervisors or other superiors within the plan. Refer to compliance filing: Title 28, CCR Section 1300.68.01(b)(1).

N. CHPIV will ensure after either completing the GRIEVANCE process or participating in the process for at least 30 days, a subscriber or enrollee may submit the GRIEVANCE to the DMHC for review. In any case determined by DMHC to be a case involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, cancellations, rescissions, or the nonrenewal of a health care service plan contract, or in any other case where the department determines that an earlier review is warranted, a subscriber or enrollee shall not be required to complete the GRIEVANCE process or to participate in the process for at least 30 days before submitting a GRIEVANCE to the DMHC for review [1368(b)(1)(A)].

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

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

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

plan representative who may be contacted about the GRIEVANCE [Title 28, CCR 1300.68(d)(1), 1368(a)(4)(A)]. Information is included informing the MEMBER of his or her right to request a DSS hearing or APPEAL to the DHCS or DMHC [Title 22 CCR Section 53858(e)(5)].

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

The MEDICAL DIRECTOR will code the peer review form with an appropriate severity outcome level code.

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

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

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

R. CHPIV will ensure to maintain adherence to mandated notice and timing requirements for an integrated organization determination or integrated reconsideration will constitute an adverse determination for the enrollee. In such instances, CHPIV will proceed as required for an adverse determination. *This requirement applies specifically to the Dual Eligible Special Needs Plan (D-SNP) line of business*.

S. CHPIV will ensure to provide all contracted providers and subcontractors with comprehensive information regarding the integrated grievance and integrated appeal system, including procedures and timeframes for grievances, reconsiderations, fair hearings, and Independent Medical Reviews, at the time of contract execution. CHPIV ensures to provide this information as part of the contracting process. *This requirement applies specifically to the Dual Eligible Special Needs Plan (D-SNP) line of business*.

T. CHPIV will ensure to provide its MEMBERS with information regarding integrated grievance and integrated reconsideration rights:
1. The right to file an integrated grievance and integrated reconsideration.
2. The requirements and timeframes for filing an integrated grievance or integrated reconsideration.
3. The availability of assistance in the filing process upon the MEMBERs request.

U. CHPIV will ensure to provide reasonable assistance to MEMBERS in completing forms and navigating procedural steps for all integrated grievances and appeals, including those related to carved-out benefits. This assistance will extend to grievances and appeals concerning Medi-Cal Dental benefits. Upon request, assistance will be made available in a manner that is timely, culturally and linguistically appropriate, and accessible to individuals with disabilities. *This requirement applies specifically to the Dual Eligible Special Needs Plan (D-SNP) line of business*.

V. CHPIV will ensure to provide assistance to its MEMBERS in obtaining Medi-Cal covered services and navigating Medi-Cal appeals and grievances related to their Medi-Cal coverage, including Medi-Cal fee-for-service and separate Medi-Cal Dental Managed Care Plans. This includes support in filing grievances or complaints related to access, quality, coordination of care, or dissatisfaction with services under any Medi-Cal delivery system. *This requirement applies specifically to the Dual Eligible Special Needs Plan (D-SNP) line of business*.

W. CHPIV will ensure to provide assistance upon a MEMBER request with Medi-Cal fee-for-service needs, including identifying and reaching out to appropriate Medi-Cal fee-for-service points of contact, providing assistance in filing an appeal or grievance, helping the Member obtain supporting documentation, and assisting with completing paperwork related to the grievance or appeal process. *This requirement applies specifically to the Dual Eligible Special Needs Plan (D-SNP) line of business*.

X. CHPIV will ensure the following for D-SNP related grievances:
1. Respond to a grievance within 24 hours regarding an extension of an integrated organization determination or reconsideration, or the refusal of a request for an expedited integrated organization determination or reconsideration.
2. The grievance resolution timeframe may be extended by 14 calendar days upon a MEMBER request or if the integrated plan justifies the need for additional information, documenting how the delay is in the enrollee's best interest. Such extensions will be documented in the grievance file.
3. Resolve expedited Integrated Grievances within 24 hours.

4. Respond to integrated grievances in writing or orally upon being submitted orally; however, upon request from the enrollee, a written response will be provided.
5. When extending a grievance timeframe, the Plan ensures to make reasonable efforts to promptly notify the enrollee orally of both the delay and the reason for the extension.
6. CHPIV will ensure to provide written acknowledgement to the enrollee upon receipt of an integrated grievance or integrated reconsideration request. Such acknowledgement will be sent within 5 business days of receipt.
7. CHPIV will ensure to provide a written response to all integrated grievances received in writing. This written response requirement applies regardless of resolution timeframe and supersedes any exemptions outlined for non-integrated grievances.
8. CHPIV will ensure to provide a written response for all integrated grievances related to quality of care, regardless of the method of submission.
9. CHPIV will ensure to issue a written resolution to the Member for any Integrated Grievance when the Member submits the grievance in writing or requests a written response, unless the grievance is resolved by the next business day. This written resolution requirement applies regardless of how the Integrated Grievance is filed, the type of Integrated Grievance, or whether the grievance concerns quality of care, coverage dispute, or a disputed health care service.
10. CHPIV will ensure to process all discrimination grievances in compliance with federal nondiscrimination requirements.
11. CHPIV will ensure to designate a discrimination grievance coordinator responsible for ensuring compliance with federal and State nondiscrimination requirements. The coordinator will investigate discrimination grievances related to actions prohibited by, or noncompliant with, federal or State nondiscrimination law.
    a. CHPIV will ensure to establish and maintain internal procedures for the prompt and equitable resolution of all discrimination grievances prior to forwarding to the DHCS Office of Civil Rights.
    b. CHPIV will ensure MEMBERS are not required to file a discrimination grievance prior to filing a complaint with the DHCS Office of Civil Rights or the U.S. Health and Human Services Office for Civil Rights. The Plan will forward discrimination grievances to the DHCS Office of Civil Rights.
12. CHPIV will ensure to mail all discrimination grievance resolution letter(s) within 10 calendar days and submit all required documentation regarding the resolved discrimination grievance to the DHCS Office of Civil Rights in a secure format. This documentation includes the original grievance, accused party's response, contact information for involved parties, all related correspondence, and investigation results with corrective actions. This requirement applies specifically to the Dual Eligible Special Needs Plan (D-SNP) line of business.

Y. CHPIV shall ensure Discrimination Grievances are processed in accordance with federal and State nondiscrimination laws and Department of Health Care Services (DHCS) policy, including but not limited to 45 CFR §84.7, 34 CFR §106.8, 28 CFR §35.107, Welfare and Institutions Code §14029.91(e)(4), and DHCS All Plan Letter (APL) 21-004.
1. CHPIV shall ensure there is a designated Discrimination Grievance Coordinator responsible for overseeing compliance with federal and State nondiscrimination requirements and for coordinating the investigation and resolution of Discrimination Grievances. The Coordinator is responsible for investigating grievances alleging discrimination related to any action that would be prohibited by, or out of compliance with, applicable federal or State nondiscrimination laws.
2. CHPIV shall ensure the prompt and equitable resolution of Discrimination Grievances. Members or Potential Members shall not be required to file a Discrimination Grievance with CHPIV prior to

filing a complaint with the DHCS Office of Civil Rights or the U.S. Department of Health and Human Services Office for Civil Rights.

3. Reporting to DHCS Office of Civil Rights: Within ten (10) calendar days of mailing the Discrimination Grievance resolution letter, CHPIV shall submit the required information regarding the Discrimination Grievance to the DHCS Office of Civil Rights in accordance with APL 21-004. Submissions shall be sent to DHCS.DiscriminationGrievances@dhcs.ca.gov and include all information required by DHCS policy.
4. Member Notification and Website Disclosure: CHPIV shall inform Members on its public website that Discrimination Grievances may be filed directly with the DHCS Office of Civil Rights. The website shall include the contact information for the DHCS Office of Civil Rights, consistent with the requirements in DHCS Contract Exhibit A, Attachment III, Subsection 5.1.3 (Member Information).

III. PROCEDURE

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

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

IV. DEFINITIONS

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

TERM	DEFINITION
Member	A beneficiary enrolled in a CHPIV program.
Adverse Benefit Determination ("ABD")	Means any of the following actions taken by Contractor: • The denial or limited authorization of a requested service, including determinations based on the type or level of a Covered Service, Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service.

	• The reduction, suspension, or termination of a previously authorized Covered Service. • The denial, in whole or in part, of payment for a Covered Service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of Clean Claim is not an Adverse Benefit Determination. • The failure to provide Covered Services in a timely manner. • The failure to act within the required timeframes for standard resolution of Grievances and Appeals. • The denial of the Member's request to obtain services out of Network when a Member is in an area with only one Medi-Cal managed care health plan; or The denial of a Member's request to dispute financial liability.
Authorized Representative	Means any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews, and in any other capacity, as specified by the Member or Potential Member.
Grievance	Means an oral or written expression of dissatisfaction about any matter other than an ABD, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or Contractor's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by Contractor to make an authorization decision.
Inquiry	An inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CHPIV processes.
Resolution	Means that the Grievance has reached a conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the grievance system, including entities with delegated authority.
State Fair Hearing (SFH)	Means a hearing with a State Administrative Law Judge to resolve a member's dispute about an action taken by Contractor, its Network Providers, Subcontractors, or Downstream Subcontractors.
Appeal	Is federally defined as a review by The Plan of an adverse benefit determination [42 CFR 438.400(b)]. While California regulations do not explicitly define the term "appeal," they do delineate specific requirements for certain types of grievances that would fall under the federal definition of appeal be-cause they involve the delay, modification, or denial of services based on medical necessity or a determination that the requested service is not a covered benefit [28 CCR 1300.68(d)(4)-(5)]. The Plan shall treat these grievances as appeals under federal regulations.
Notice Of Appeal Resolution (NAR)	A formal letter from The Plan informing a member of the outcome of the appeal of an adverse benefit determination [42 CFR 438.408(d)(2)]. The NAR

	informs the member whether The Plan has overturned or upheld its decision on the adverse benefit determination. The contents of the NAR shall meet all the language and accessibility standards including translation, font, and format requirements as set forth in DHCS APL 21-004 [Title 42 CFR section 438.10, 438.402(c)(1)(i)(A), 438.404, and 438.408(c)(3) and (i); WIC 14029.91 and 10951(b)(1)(A); and Title 45 CFR, Part 92].
A&G Clinical Specialist II	A Registered Nurse who provides clinical expertise in Clinical Grievance resolution and coordinates case as appropriate with the Medical/Dental Director, PPG/Provider and Third-Party Reviewer Organization.
Case Coordinator	A non-clinician knowledgeable associate involved in grievance resolution.
Complaint	is the same as "grievance."
Complainant	is the same as "grievant," and means the person who filed the grievance including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee.
Medical Director	A physician reviewer who is involved in grievance review and resolution.
Resolved	Means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the plan's grievance system, including entities with delegated authority.

	After-Hours Communication	HR-004
	Department	Human Resources
	Functional Area	Human Resources
	Line of Business	☒ Medi-Cal ☒ D-SNP

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

DATES			
Policy Effective Date	10/01/2024	**Last Revised Date**	
Next Annual Review Due	10/02/2024	**Regulator Approval**	

APPROVALS			
Internal		**Regulator**	
Name	Shannon Long	☐ DHCS ☐ DMHC	☒ NA
Title	HR Consultant		

ATTACHMENTS
NA

AUTHORITIES/REFERENCES
NA

HISTORY	
Revision Date	**Description of Revision**
10/01/2024	Policy creation

I. OVERVIEW

A. The purpose of this policy is to promote work-life balance and respect employees' personal time by establishing guidelines for after-hours communication.

B. While we encourage flexible practices, it is essential to recognize that certain situations may require contacting employees outside of regular working hours.

C. Examples of business-critical or time-sensitive situations include security breaches, equipment breakdowns affecting operations, health and safety emergencies, and cybersecurity threats

D. This policy will protect all employees under management. Management will be able to work after-hours on a case by case basis, under emergency situations.

II. POLICY

A. Expectation
1. Reasonable expectation: We expect work -related communication after hours to be reasonable and necessary
2. Supervisors' Responsibility: Supervisors should be mindful when communicating with employees after stipulated working hours, regardless of the platform (phone calls, SMS, messaging apps).
3. Employee Leave: Employees on leave should not be contacted unless it is urgent, and no other options exist. Which should be extremely rare.

B. Guidelines for Communication
1. Urgent Matters: Only urgent matters warrant after-hours communication.
2. Respect Personal Time: Employees are entitled to uninterrupted personal time outside of work hours.
3. Setting Boundaries: Employees should set clear boundaries and communicate their availability to colleagues and supervisors.
4. Emergency Contacts: Maintain an emergency contact list for critical situations. This includes Larry Lewis (CEO) and Dr. Gordon Arakawa (CMO)

C. Human Resources Director's Responsibility
1. Education: HR managers should educate employees about this policy during onboarding.
2. Enforcement: Monitor compliance and address any violations promptly.
3. Feedback: Encourage feedback from employees regarding the effectiveness of the policy.

D. Pilot Period -Implementation
1. We will implement this policy on a trial basis for three months.
2. Gather feedback from employees and supervisors during this period.
3. Adjust the policy as needed based on feedback

III. PROCEDURE

A. Working Hours
1. All personnel are mandated to confine work-related requests to the designated business hours, specifically from 8:00 AM to 5:00 PM.

B. Reporting Violations
1. In the event of a perceived policy violation, the concerned employee is required to submit a formal report to the Human Resources (HR) department via email. This report should encompass:
    a. Incident Specifics: A comprehensive account of the incident, detailing the date, time, and nature of the perceived violation

b. Supporting Evidence: Any corroborative evidence that substantiates the claim, such as copies of email correspondence, text messages, or other relevant communication.

C. Non-Compliance
1. Any personnel found to be non-compliant with this policy will be subject to disciplinary proceedings initiated by the Human Resources (HR) department.
   a. Initial Violation: The first instance of non-compliance will result in a verbal warning to the personnel involved, followed by an official email documenting the violation.
   b. Recurring Violations: In the event of subsequent non-compliance by the same personnel, a formal notice of disciplinary action will be issued.

D. Reporting Employees
1. Personnel who report violations of this policy will be safeguarded against any form of punitive action or retaliation. It is strictly prohibited for managers to harbor any prejudice against the reporting personnel.

E. Enforcement
1. This policy will be enforced by the HR department. All personnel are urged to report any perceived violations to HR.

IV. DEFINITIONS

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

TERM	DEFINITION
None	

	New Positions	HR-005
Department	Human Resources	
Functional Area	Human Resources	
Line of Business	☒ Medi-Cal ☒ D-SNP	

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

DATES			
Policy Effective Date	10/01/2024	**Last Revised Date**	03/25/2025
Next Annual Review Due	03/25/2026	**Regulator Approval**	

APPROVALS			
Internal		**Regulator**	
Name	Shannon Long	☐ DHCS	☒ NA
Title	Human Resources Advisor	☐ DMHC	

ATTACHMENTS
NA

AUTHORITIES/REFERENCES
NA

HISTORY	
Revision Date	**Description of Revision**
10/01/2024	Policy creation
03/25/2025	Ad Hoc update
	Annual review

I. OVERVIEW

A. This policy applies to all departments and positions at all levels, including full-time regular, part-time regular and temporary positions.

II. POLICY

A. It is the policy of CHPIV to place a high priority on the recruitment and hiring of local staff.
B. Planning for new positions begins with the annual budget development wherever possible.
C. A needs justification is required for each new position requested.

III. PROCEDURE

A. Approval Process

1. 1. In the case of a new position, the hiring manager downloads the job description template from the HR folder and completes all applicable sections based on the requirements of the position. In the case of an existing position, the hiring manager should make any modifications to the existing job description. The job description should be forwarded to HR for review and any requested modifications should be made prior to HR initiating the recruiting process.
2. HR market prices the position by identifying the midpoint and calculating the minimum and maximum point.
3. HR creates a requisition within the applicant tracking system. The requisition is electronically sent to the CFO followed by the CEO for approval.
4. Once approved, HR creates the job posting and posts the position.
5. As resumes are received, HR screens the resumes and sends qualified applicants to the hiring manager.
6. The hiring manager identifies candidates to formally engage in the recruiting process.
7. HR conducts a phone interview and screens for basic qualifications.
8. Any candidates that are assessed by HR to be qualified are scheduled with the hiring manager for interview.
9. The default location for all positions is the Imperial office. In exceptional cases, the CEO may approve simultaneous recruiting at the default location, as well as remotely in California. The criteria that the CEO uses to decide to make an exception is the following:
   a. The position requires such technical skills that it is unlikely that skills can be found in the Imperial area; AND
   b. The position can work remotely without any impact to productivity or collaboration
10. In the case that an exception is made, the position must remain open for 30 days to allow time for local candidates to apply. Every local candidate that is minimally qualified must be interviewed by the hiring manager.

IV. DEFINITIONS

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

TERM	DEFINITION
None	

	Diversity Equity & Inclusion	HR-006
Department	Human Resources	
Functional Area	Human Resources	
Line of Business	☒ Medi-Cal ☒ D-SNP	

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

DATES			
Policy Effective Date	11/12/2024	**Last Revised Date**	
Next Annual Review Due	11/13/2025	**Regulator Approval**	

APPROVALS			
Internal		**Regulator**	
Name	Shannon Long	☐ DHCS ☐ DMHC	☒ NA
Title	Human Resources Advisor		

ATTACHMENTS
NA

AUTHORITIES/REFERENCES
NA

HISTORY	
Revision Date	**Description of Revision**
11/12/2024	Policy Creation
	Annual review

I. OVERVIEW

A. Community Health Plan of Imperial Valley is committed to fostering, cultivating, and preserving a culture of DIVERSITY, EQUITY, and INCLUSION.
B. Our human capital is the most valuable asset we have. The collective sum of the individual differences, life experiences, knowledge, inventiveness, innovation, self-expression, unique capabilities, and talent that our employees invest in their work represents a significant part of not only our culture, but our reputation and company's achievement as well.
C. We embrace and encourage our employees' differences in age, color, disability, ethnicity, family or marital status, gender identity or expression, language, national origin, physical and mental ability, political affiliation, race, religion, sexual orientation, socio-economic status, veteran status, and other characteristics that make our employees unique.
D. To ensure a work environment that provides commitment to equal employment opportunities for all CHPIV employees and applicants. All employment decisions, including recruiting, hiring, training opportunities, promotions, discipline, termination, are made on the basis of qualifications and merit.

II. POLICY

A. All employees of Community Health Plan of Imperial Valley have a responsibility to treat others with dignity and respect at all times. All employees are expected to exhibit conduct that reflects INCLUSION during work, at work functions on or off the work site, and at all other company-sponsored and participative events. All employees are also required to attend and complete annual DIVERSITY awareness training to enhance their knowledge to fulfill this responsibility.
B. Any employee found to have exhibited any inappropriate conduct or behavior against others may be subject to disciplinary action.
C. Employees who believe they have been subjected to any kind of discrimination that conflicts with the company's DIVERSITY policy and initiatives should seek assistance from a supervisor or an HR representative.

III. PROCEDURE

A. All CHPIV Staff will take part in training in DIVERSITY, EQUITY & INCLUSION to ensure we have a staff properly educated on the boundaries that should be respected at work.
B. Ensuring a diverse, equitable, and inclusive (DEI) hiring process involves several key steps. Here is a comprehensive procedure to guide Human Resources:
   1. Job Description and Requisition
      a. Review and Revise: Ensure job descriptions are free from biased language and focus on essential qualifications. Use gender-neutral language and consider competencies and transferable skills.
      b. Commitment to DEI: Include a statement about the organization's commitment to DIVERSITY, EQUITY, and INCLUSION in all job postings.
   2. Recruitment Strategy
      a. Diverse Outreach: Develop a strategic recruitment plan that includes outreach to diverse groups. Utilize platforms and networks that cater to underrepresented communities.
      b. Inclusive Advertising: Allocate budget for advertising in channels that reach diverse candidates.
   3. Training and Education

a. Bias Training: Provide training for hiring managers and interviewers on unconscious bias and inclusive hiring practices.
b. Interview Preparation: Train interviewers on legal and appropriate interview questions, focusing on assessing candidates' commitment to DEI.

4. Candidate Sourcing
   a. Broad Networks: Partner with organizations that support underrepresented groups and attend DIVERSITY-focused job fairs.
   b. Employee Resource Groups: Leverage internal employee resource groups to share job postings within their networks.
5. Interview Process
   a. Structured Interviews: Use structured interview questions and evaluation rubrics to ensure fairness.
   b. Diverse Panels: Include diverse members in the interview panel to provide varied perspectives.
6. Selection and Hiring
   a. Holistic Evaluation: Assess candidates holistically, considering their skills, experiences, and potential contributions to DEI.
   b. Fair Policies: Implement fair hiring policies that do not automatically disqualify candidates with non-traditional backgrounds.
7. Committees and Governing Bodies
   a. CHPIV utilizes its QIHEC committee to ensure appropriate processes are followed for recruiting and hiring personnel with diverse backgrounds.
   b. At a minimum CHPIV will.
      i. Assess committee membership composition and ensure alignment with its membership composition.
      ii. Include practitioners/providers and members of the community in the committee.
      iii. Complete process improvement measures as outlined in section E. Performance Measures, Analysis and Reporting.
8. Continuous Improvement
   a. Feedback and Review: Regularly review and assess hiring practices for inclusivity and effectiveness. Seek feedback from candidates and employees to identify areas for improvement.
9. Performance Measures, Analysis and Reporting
   a. To monitor its hiring and recruiting processes, and create opportunities for improvement in recruiting and hiring diverse staff, CHPIV will assess the performance of these measures utilizing the following;
   b. To identify opportunities, CHPIV will;
      i. Annually gather (through surveys or other engagement activities) and report on staff feedback on and satisfaction with the organization's promotion of DIVERSITY, EQUITY, INCLUSION, and cultural humility.
      ii. Survey staff to identify the primary barriers to maintain employment, to reduce turnover rates for traditionally marginalized, disenfranchised, or disempowered groups.
      iii. Compare the DIVERSITY of the organization's workforce with groups or subgroups of the community or population that the organization serves (e.g., racial/ethnic, preferred language, gender identity, sexual orientation) and with the available pool of candidates in the labor market where the organization operates.

c. To act on opportunities, CHPIV will:
   i. Annually share the data with the QIHEC committee to vote on opportunities to improve recruitment and hiring of diverse staff and annually share with the committee how performance in this area has improved or declined.
   ii. Build DIVERSITY, EQUITY, INCLUSION and cultural humility performance metrics into all management and leadership job descriptions and goals.
   iii. Suggest staff share pronouns in introductions and/or email signatures.
   iv. Design workspaces to better accommodate staff of differing mobility.
   v. Host, offer or promote events (e.g., webinars, speaker series, brown bag sessions) that foster DIVERSITY, EQUITY, INCLUSION, and cultural humility and highlight traditionally marginalized, disenfranchised, or disempowered groups.
   vi. Create temporary or permanent positions, departments, councils, or committees focused on highlighting underrepresented groups.

C. By following these steps, HR can create a more inclusive hiring process that attracts and retains a diverse workforce.

IV. DEFINITIONS

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

TERM	DEFINITION
Diversity	The practice or quality of including or involving people from a range of different social and ethnic backgrounds and of different genders, sexual orientations, etc.
Equity	The quality of being fair and impartial.
Inclusion	The practice or policy of providing equal access to opportunities and resources for people who might otherwise be excluded or marginalized, such as those who have physical or intellectual disabilities and members of other minority groups.

	Equal Employment Opportunity & Affirmative Action	**HR-007**

Department	Human Resources
Functional Area	Human Resources
Line of Business	☒ Medi-Cal ☒ D-SNP

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

DATES			
Policy Effective Date	11/12/2024	**Reviewed/Revised Date**	
Next Annual Review Due	11/13/2025	**Regulator Approval**	

APPROVALS			
Internal		**Regulator**	
Name	Shannon Long	☐ DHCS	☒ NA
Title	Human Resources Advisor	☐ DMHC	

ATTACHMENTS
N/A

AUTHORITIES/REFERENCES

- **Accreditation**
  - NCQA HE.1.A – Organizational Readiness

HISTORY	
Revision Date	**Description of Revision**
11/12/2024	Policy Creation
	Annual review

I. OVERVIEW

A. Community Health Plan of Imperial Valley (CHPIV) is an equal opportunity employer and conforms to the spirit as well as to the letter of all applicable laws and regulations.

II. POLICY

A. CHPIV prohibits discrimination and harassment of any type and affords equal employment opportunities to employees and applicants without regard to race, color, religion, sex, sexual orientation, gender identity or expression, pregnancy, age, national origin, disability status, genetic information, protected veteran status, or any other characteristic protected by law.
   1. CHPIV maintains an affirmative action plan to promote equal opportunities for marginalized or disadvantaged groups.

B. CHPIV prohibits retaliation against any employee who reports discrimination or harassment or participates in an investigation of such reports. Retaliation is a serious violation of this policy and will be subject to disciplinary action.

III. PROCEDURE

A. Recruitment and Hiring
   1. All job postings and advertisements will include a statement of CHPIV's commitment to equal employment opportunities.
      a. Selection will be based on job-related qualifications and abilities.

B. Training and Development
   1. All employees will be required annually to complete training on EEO principles and the importance of respect in the workplace.

C. Complaint Resolution
   1. Employees who believe they have been subjected to discrimination or harassment should report the incident to their supervisor or Human Resources.
      a. All complaints will be investigated promptly and thoroughly, and appropriate corrective action will be taken if necessary.

IV. DEFINITIONS

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

TERM	DEFINITION
None	

	Organizational Readiness	HR-008
Department	Human Resources	
Functional Area	Human Resources	
Line of Business	☒ Medi-Cal ☒ D-SNP	

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

DATES			
Policy Effective Date	11/12/2024	**Reviewed/Revised Date**	
Next Annual Review Due	11/13/2025	**Regulator Approval**	

APPROVALS			
Internal		**Regulator**	
Name	Shannon Long	☐ DHCS	☒ NA
Title	Human Resources Advisor	☐ DMHC	

ATTACHMENTS
• N/A

AUTHORITIES/REFERENCES
• **Accreditation**   ○ NCQA: Health Equity (HE) standards and guidelines: HE 1, Element A

HISTORY	
Revision Date	**Description of Revision**
11/12/2024	Policy creation
	Annual review

I. OVERVIEW

A. The Community Health Plan of Imperial Valley (CHPIV) ensures that it advances its health equity strategy by building a diverse and inclusive staff while supporting health equity goals that are aimed at reducing bias and improving diversity, equity, and inclusion within the workplace, its committees, and governing bodies.

II. POLICY

A. CHPIV will ensure that its hiring and recruitment practices promote diversity, including for internal and external positions, promotions and reclassifications and temporary and permanent positions.
B. CHPIV will ensure that its hiring and recruitment practices consider, at a minimum, the following:
   1. How the organization's workforce reflects the diversity of the population served.
   2. Groups that are inadequately represented in the workforce.
   3. Whether particular groups are marginalized, disenfranchised or disempowered by the organization's recruitment and hiring practices.
C. CHPIV will ensure that its hiring and recruitment process explicitly addresses how the organization promotes diversity for:
   1. Staff.
   2. Leadership (individuals with managerial authority and executive roles such as managers, directors, vice presidents or chief officers).
   3. Committees (individuals internal or external to the organization, appointed for a specific function).
   4. Governance bodies, including, but not limited to, the organization's board of directors.
   5. CHPIV will ensure analysis is conducted at least annually to identify opportunities to improve diversity, equity, inclusion or cultural humility for staff, leadership, governance bodies, and committees.
D. CHPIV will ensure that interventions are implemented to address identified opportunities to improve diversity, equity, inclusion and cultural humility for at least one of the groups (staff, leadership, committees or governance bodies).

III. PROCEDURE

A. Hiring and Recruiting
   1. Staff and Leadership
      a. New positions will be presented to Department Leadership for approval.
      b. Once approved, hiring manager will submit the job description to human resources (HR).
      c. HR will evaluate job description, title, and compensation.
      d. To refill existing positions, the hiring manager will complete a requisition form and provide the job description.
      e. HR will evaluate the position and will work with the hiring manager to complete the process.
      f. To promote diversity and inclusion, CHPIV will develop and maintain all job descriptions to include the following:
         i. Gender-neutral language,
         ii. Salary range for each position,

iii. Mobility requirements,
iv. List of all the "must-have" requirements for the position, and
v. CHPIV's commitment to diversity and inclusion.
vi. Use blind- review resumes when hiring new staff.

g. Hold hiring decision makers and leadership responsible for representation growth within teams and organization.
h. Dedicate resources to recruiting underrepresented groups such as individuals with disabilities, on governing bodies.
i. Deploy technology that screens for biased language in job descriptions and postings.
j. Require interview panels to include interviewers from underrepresented populations, genders or diverse position levels.
k. Broaden recruitment sources, for example.
   i. Schools with diverse student bodies or alumni networks.
   ii. National associations or groups that advocate for marginalized, disenfranchised, or disempowered groups.
   iii. Recruitment firms that specialize in job placement for diverse groups of executives.
l. Require QIHEC committees to reflect the diversity of the organization.
m. Base the salaries offered to internal and external candidates on factors that support salary equity for traditionally marginalized, disenfranchised, or disempowered groups, such as:
   i. Salaries for similar positions at other organizations.
   ii. Salaries for the same position level and experience within the organization.

2. Committees and Governing Bodies
   a. CHPIV utilizes its QIHEC committee to ensure appropriate processes are followed for recruiting and hiring personnel with diverse backgrounds.
   b. At a minimum CHPIV will;
      i. Assess committee membership composition and ensure alignment with its membership composition.
      ii. Include practitioners/providers and members of the community in the committee.
      iii. Complete process improvement measures as outlined in section E. Performance Measures, Analysis and Reporting.

B. Job Postings and Application Selection:
   1. To ensure diversity and equal opportunity for all skilled applicants, all positions will be posted on CHPIV's internal and external sites as well as National External Job Posting Websites.
   2. HR will work directly with the Hiring Manager to create a job posting if there is not one on file.
   3. HR will work with the Hiring Manager to choose specific external sites for posting positions that require specific qualifications or credentials.
   4. The position may remain open for an undetermined amount of time depending on applicant pool and qualification necessary for the position.
   5. When a position has been open for 90 days without a successful applicant pool, HR will remove the posting-evaluate the position with the Hiring Manager, and repost, if necessary, to create a fresh appeal on social media.

6. Applicants will be reviewed and evaluated for the position based on the knowledge, skills and abilities required in the job description. Consideration will also be given to results of analysis of data collection and reporting described within Section D below.
7. HR will send the most qualified applicants to the Hiring Manager for review.
8. HR may strip away resumes from identifiable characteristics that are not related to the job or experiences needed for success. Information that may be stripped from resumes are:
    i. Names
    ii. Gender
    iii. Age
    iv. Education history
    v. Years of job experience
9. Internal applicants will be evaluated based on the qualifications in the job description. If the employee is qualified and in good standing per the performance management policy, they will be interviewed for the position. Applicant must have been in the current role for a minimum of six (6) months, with minimal exception.
10. External applicants will be evaluated based on the qualification in the job description. If the applicant is qualified, not on an exclusion list for Medicare/Medicaid, and licensed in the area necessary, the most qualified 3-5 applicants will be selected to interview.

C. Interview Process and Candidate Selection:
    1. Phone screens and interviews may be scheduled within a day of the job posting.
    2. If appropriate, HR will check licensure of licensed applicants prior to scheduling interviews.
    3. To reduce bias, CHPIV HR will use standard behavioral questions for each position, will share them with hiring managers, and will calculate a score based on applicants' responses.
    4. All job offers for internal and external applicants will be reviewed by the hiring manager and the executive leader of the department prior to being presented to the candidate.
    5. HR will make all job offers contingent upon pre-hire checks (including but not limited to; background, drug-screen, SAM, OIG, references and other licensure requirement verifications).

D. Performance Measures, Analysis and Reporting
    1. To monitor its hiring and recruiting processes, and create opportunities for improvement in recruiting and hiring diverse staff, CHPIV will assess the performance of these measures utilizing the following;
    2. To identify opportunities, CHPIV will:
        a. Annually gather (through surveys or other engagement activities) and report on staff feedback on and satisfaction with the organization's promotion of diversity, equity, inclusion and cultural humility.
        b. Survey staff to identify the primary barriers to maintain employment, to reduce turnover rates for traditionally marginalized, disenfranchised or disempowered groups.
        c. Compare the diversity of the organization's workforce with groups or subgroups of the community or population that the organization serves (e.g., racial/ethnic, preferred language, gender identity, sexual orientation) and with the available pool of candidates in the labor market where the organization operates.
    3. To act on opportunities, CHPIV will:

a. Annually share the data with the QIHEC committee to vote on opportunities to improve recruitment and hiring of diverse staff and annually share with the committee how performance in this area has improved or declined.
b. Build diversity, equity, inclusion and cultural humility performance metrics into all management and leadership job descriptions and goals.
c. Suggest staff share pronouns in introductions and/or email signatures.
d. Design workspaces to better accommodate staff of differing mobility.
e. Host, offer or promote events (e.g., webinars, speaker series, brown bag sessions) that foster diversity, equity, inclusion and cultural humility and highlight traditionally marginalized, disenfranchised or disempowered groups.
f. Create temporary or permanent positions, departments, councils or committees focused on highlighting underrepresented groups.

IV. DEFINITIONS

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

TERM	DEFINITION
Diversity	Diversity in recruiting and hiring describes the presence of differences (e.g., race/ ethnicity, preferred language, gender identity, sexual orientation, age, mobility) in the pool of candidates for employment opportunities that reflects the population served.
Equity	Means developing, strengthening and supporting procedural and outcome fairness in systems, procedures and resource distribution mechanisms to create fair opportunities for all individuals. Equity and "equitable" are distinct from equality or "equal," which refers to everyone having the same treatment but does not account for different needs or circumstances. Equity focuses on eliminating barriers that have prevented the full participation of historically and currently oppressed groups.
Inclusion	Means intentionally designed, active and ongoing engagement with individuals that ensures opportunities and pathways for participation in all aspects of a group, organization or community, including decision-making processes. Inclusion refers to how groups show that individuals are valued as respected members of the group, team, organization or community and is often created through progressive, consistent actions to expand, include and share.
Cultural Humility	Means the ability of organizations, systems and health care professionals to value, respect and respond to diverse cultural health beliefs, behaviors and needs (e.g., social, cultural, linguistic) when providing health care services.

	Remote Work	HR-009
	Department	Human Resources
	Functional Area	Human Resources
	Line of Business	☒ Medi-Cal ☒ D-SNP

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

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

APPROVALS			
Internal		**Regulator**	
Name	Shannon Long	☐ DHCS	☒ NA
Title	Human Resources Advisor	☐ DMHC	

ATTACHMENTS
HR-009 Attach A_Work From Home Agreement_Draft

AUTHORITIES/REFERENCES
N/A

HISTORY	
Revision Date	**Description of Revision**
3/25/2025	Policy creation
	Annual Review

I. OVERVIEW

A. Certain positions at Community Health Plan of Imperial Valley may work in a Hybrid or Remote work arrangement. The goal of such arrangement is to ensure the continued productivity, collaboration, and security of information regardless of work location.

II. POLICY

A. CHPIV provides the opportunity to work remotely, either on a full-time or a part-time basis, for certain positions/functions.

B. The organization may hire a position remotely because the skills needed for the position cannot be found locally. In every case, preference will be given to local candidates. However, in the case that a local candidate cannot be found, or an individual that is located remotely is determined to have more advanced skills than local candidates, the remote candidate may be hired with the approval of the Chief Executive Officer (CEO).

1. A local recruitment effort will be conducted for the first 30 days and applications shared with the hiring manager PRIOR to expanding a search. In certain circumstances, the CEO may approve recruiting both locally and remotely within California at the same time. In these instances, the CEO's decision for concurrent recruiting is based on the following factors:
   a. A belief based on both qualitative and quantitative data, when available, that the technical skill needed to be successful in the position doesn't exist locally.
   b. An assessment that Hybrid or remote work will not affect the productivity or collaboration required to be successful in the position.
2. Any remote or Hybrid work candidate that is minimally qualified must be interviewed by the hiring manager. In the event that the hiring manager wishes to proceed with hiring a non-local candidate, the rationale for recommending a non-local candidate must be approved by the CEO.

III. PROCEDURE

A. Approval

1. A current office-based employee who wishes to engage in a Remote or Hybrid work arrangement must make the request to their direct manager. The request must be in writing and address the following:
   a. The reason for the request
   b. The proposed Remote or Hybrid schedule
   c. How childcare, eldercare, and other personal commitments will be met through the day while working
   d. A commitment to be available during the organization's core hours of 8:00-5:00 PT, Monday-Friday and to attend meetings in-person, as required.
   e. How sensitive information will be secured when working offsite
   f. Proof an internet bandwidth test (several free resources exist for this test). A minimum bandwidth speed of 10 Mbps is required for optimal work-at-home productivity

g. How productivity will be maintained through periods of internet disruption. This may include coming into the Imperial office, if the employee lives within commuting distance, or temporarily relocating to a new offsite work location such as a co-working space. Any associated cost with this location is strictly the responsibility of the employee.

h. Adherence to the CHPIV dress code, which can be found in the employee handbook.

i. An agreement to abide ty the rules governing the use of laptop cameras. This includes having cameras on for all meetings with both internal and external

j.

k. A secure organization-issued computer will be sent to the home of any Remote employee

l. Hybrid employees will be issued a secure, organization-issued laptop that will be utilized for any work-related processes.

m. Home office furnishings will be at the expense of the employee

B. If the direct manager approves the Remote or Hybrid arrangement, the department head and CEO must also approve the arrangement. Only after all approvals have been granted, may the arrangement begin.

C. The arrangement is not guaranteed for any period of time, and either the employee or the organization may revoke the agreement at any time, for any reason, including convenience.

D. Once approved, the employee and manager must execute the Remote Work Agreement.

IV. DEFINITIONS

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

TERM	DEFINITION
Chief Executive Officer	The Chief Executive Officer (CEO) of a Managed Care Plan is the highest-ranking executive, responsible for implementing organizational strategies, ensuring the achievement of overall objectives, and maintaining operational, legal, and financial integrity, all while being accountable to the Commission.
Remote	A working arrangement where the employee works from home 100% of the time
Hybrid	A working arrangement where the employee works from home on a set schedule, with some days per week spent in the office.

COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

This Work from Home Agreement (WFHA) outlines the expectations for an employee with an approved remote or hybrid work arrangement.

By signing this agreement, the employee attests to maintaining the requirements in their home environment that will lead to optimal efficiency, productivity, and collaboration.

The employee further understands that the arrangement may be revoked at any time by the Organization for any lawful reason, including reasons of convenience.

I understand and agree that I will abide by the following requirements in my approved remote or hybrid work arrangement:

This work-from-home agreement is effective from **[Start Date]** to **[End Date]**. At the end date, a new WFHA must be completed by me.

1. The operational hours of CHPIV are 8:00 am – 5:00 pm, Monday-Friday. Except for two 10-minute breaks and a lunch break during the day, I agree to be available for meetings and collaboration through email, Teams messaging, and other agreed communication methods during this time.
2. Participation in meetings and other collaboration activities is required.
3. As directed, in-person attendance at meetings and events may be required.
4. An internet connection with a minimum speed of 10 Mbps must be maintained.
5. In the event of internet disruption, I will find an alternative way to access the internet. This may include coming into the Imperial office, if I live within commuting distance, or temporarily relocating to a new offsite work location such as a co-working space. Any associated cost with this location is strictly my responsibility.
6. I will adhere to the CHPIV dress code, which can be found in the employee handbook.
7. I will abide by the rules governing the use of laptop cameras. This includes having cameras on for all meetings with both internal and external stakeholders.
8. Confidential information, including PHI, must be maintained in strict privacy. I agree to adhere to the Organization's data security and confidentiality policies.
9. Private and confidential information must be stored in a locked office that only the employee has access to, or in a locked desk/ file cabinet when left unattended.
10. Loss of Organization-owned technology or information must be immediately reported to my manager or another member of the leadership team.
11. Working remotely is not a substitute for child or elder care. My work environment must be kept quiet and free from regular interruptions.
12. I must maintain the same level of productivity and performance as if I were working in the office.

13. Regular check-ins with my manager will be conducted to monitor performance and address any issues.
14. I will ensure that my home office environment complies with health and safety regulations. The company is not responsible for any injuries or accidents that occur in the remote work environment.
15. Pre-approval is required before any equipment or supplies are purchased.
16. I will give at least 2 weeks' notice of my intent to end my remote arrangement to ensure the opportunity for adequate in-office space planning.
17. This agreement only covers work from my primary residence. Work from another location, such as while on vacation or due to a move more than 50 miles from my current primary residence, requires advanced approval.

Employee Signature: _____ Date: _____

Manager Signature: _____ Date: _____

	Promotions	HR-010
Department	Human Resources	
Functional Area	Administration	
Line of Business	☒ Medi-Cal ☒ D-SNP	

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

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

APPROVALS			
Internal		**Regulator**	
Name	Shannon Long	☐ DHCS ☐ DMHC	☒ NA
Title	Human Resources Advisor		

ATTACHMENTS
N/A

AUTHORITIES/REFERENCES

HISTORY	
Revision Date	**Description of Revision**
03/25/2025	Policy creation
	Annual review

I. OVERVIEW

The purpose of this promotion policy is to provide clear guidelines for employee promotions within Community Health Plan of Imperial Valley. This policy aims to ensure a fair and transparent process that recognizes and rewards employee performance, skills, and potential.

II. POLICY

A. Promotions will be based on the following criteria:

a. Performance: Consistently high performance as reflected in performance appraisals, feedback from supervisors, and measurable outcomes.

b. Skills and Competencies: Possession of required skills, competencies, and qualifications for the new role.
c. Experience: Relevant experience and time spent in the current position.
d. Potential: Demonstrated potential for growth and ability to take on additional responsibilities.
e. Behavior and Attitude: Alignment with organizational values, teamwork, and a positive attitude

III. PROCEDURE

A. Identification: Managers can initiate a promotion request based on the criteria listed above.

B. Request for consideration: To formally request promotion consideration, managers should send an email to their department head with a cc to the CEO and Human Resources. The email should contain the following information:
1. The nominated employee's total length of service and time in their current position
2. The employee's total year of experience, including time employed in the function outside of CHPIV
3. A narrative that addresses the employee's possession of skills, competencies, and qualifications for the new role.
4. Attachments to substantiate the narrative, including past performance evaluations or commendations.

C. Review: The department head will review the information and ask for any clarifying information or additional documentation.

D. Recommendation: The department head will make a recommendation to the CEO to either approve or deny the promotion request.

E. Review of recommendation: The CEO will review the initial email and the department head's recommendation and make a final decision to either approve or deny the promotion.
1. Any decision to deny the promotion at either the department head or CEO level will be specific and include areas for development or improvement for the employee before the employee will be reconsidered.

F. Compensation benchmarking: Once a promotion is approved, HR will conduct a salary study to determine the salary range of the new position.

G. Compensation recommendation: HR will make a salary recommendation to the department head and CEO.
1. In most cases, the promoted employee will receive at least a 10% salary increase
2. It is expected that salary will be below the midpoint of the new salary range, as to represent that the employee is new in the level

H. Notification: The employee will be formally notified of the promotion decision, new salary, and effective date

IV. DEFINITIONS

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

TERM	DEFINITION

Salary range	A range of salaries that is comprised of a minimum, midpoint, and maximum
Midpoint	The average salary that the market is paying for a position considering the size of the organization and location of the position.

	Employee Recognition	HR-012
	Department	Human Resources
	Functional Area	Human Resources
	Line of Business	☒ Medi-Cal ☒ D-SNP

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

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

APPROVALS			
Internal		**Regulator**	
Name	Shannon Long	☐ DHCS	☒ NA
Title	Human Resources Advisor	☐ DMHC	

ATTACHMENTS
•

AUTHORITIES/REFERENCES
• N/A

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

I. OVERVIEW

A. CHPIV rewards and recognizes employees who demonstrate exceptional performance, embody company values, or contribute meaningfully to team and organizational success.

Employee rewards and recognition initiatives aim to foster a culture of appreciation, motivation, and engagement.

I. POLICY

A. Employees who exceed expectations, complete critical projects, innovate solutions, or demonstrate leadership may be considered for a once per year employee recognition award.

1. The total value of rewards received over the calendar year may not exceed $50 per employee.
2. Rewards may be given as gift cards or other small gifts such as flowers.
3. Rewards within the $50 per employee budget are not taxable. No employee should receive rewards greater than $50 per calendar year.

II. PROCEDURE

A. Approval

1. The nominating manager should send an email request to Human Resources and the department head with the following information:
   a. Employee name
   b. Brief Description of why the employee is being recognized. Possible reasons for recognition include:
      i. Delivering exceptional results or exceeding goals
      ii. Demonstrating company values in action
      iii. Going above and beyond during high-pressure periods
      iv. Contributing to team morale or collaboration
      v. Innovation or improving processes
   c. Proposed award and value
2. The request will be reviewed based on alignment with policy and budget. Any employee that is on any type of performance improvement plan is not eligible for an employee reward. If approved, the manager will be notified and is responsible for purchasing the reward.
3. The cost of the reward is reimbursable to the manager. Proper documentation of the purchase must be entered into Rippling to receive reimbursement.

B. Administration

1. HR is responsible for maintaining records, monitoring fairness and frequency, and reporting on program effectiveness.
2. Human Resources will track the type and amount of the reward to ensure that no single employee receives more than $50 total for the calendar year. Human Resources will also track fairness and equity of administration across the organization.
3.

C. Managers are encouraged to recognize employees regularly and equitably.

III. DEFINITIONS

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

TERM	DEFINITION

RISK MANAGEMENT PROGRAM

Community Health Plan of Imperial Valley (CHPIV)

Compliance Department

Effective Date	[DATE]
Version	1.0
Date Approved by CCO	03/20/2026
Date Approved by Compliance & Policy Committee	[DATE]
Date Approved by Regulatory Compliance Oversight Committee of the Commission	[DATE]
Review Cycle	Annual
Related Documents	Audit & Monitoring Program; Risk Repository; Risk Assessment

I. Purpose

The purpose of this Risk Management Program is to establish a structured, enterprise-wide framework for identifying, assessing, prioritizing, managing, and monitoring compliance risks across all of CHPIV's lines of business and delegated functions. The program ensures that CHPIV's oversight activities — including monitoring, auditing, and corrective action — are driven by actual organizational risk rather than uniform schedules or administrative convention.

The Delegation Oversight Audit and Monitoring Program, the CAP process, and related compliance tools are downstream outputs of this program's risk assessment and prioritization work.

II. Scope

This program applies to all lines of business operated by CHPIV, including Medi-Cal, Medicare, Commercial, and Dual Eligible programs. It encompasses all internal business units and all first-tier, downstream, and related entities (FDRs) operating under delegation agreements with the plan.

All identified compliance risks — regardless of source — are subject to this program's identification, scoring, tracking, and validation requirements. No risk identified within CHPIV's operations or delegation network is exempt from the requirements of this program.

III. Program Objectives

- Maintain a dynamic, comprehensive inventory of all known compliance risks facing the organization through the risk repository.
- Ensure that compliance oversight resources — monitoring, auditing, and corrective action — are allocated based on risk level rather than uniformly across all areas.
- Produce an annual risk assessment that objectively scores and prioritizes risks by line of business using a defined, repeatable methodology.
- Establish a consistent standard for how risks are validated and retired, ensuring that closure requires demonstrated correction, not just implementation of a corrective action.
- Create institutional memory through risk linkage — connecting current findings to prior findings to detect recurrence, evaluate the durability of prior remediation, and identify systemic patterns.
- Enable transparent, data-driven reporting to leadership and governance bodies on the organization's risk posture over time.
- Provide a formal mechanism for leadership to accept risk when full remediation is not feasible, with appropriate documentation and accountability.

IV. Program Structure

The Risk Management Program operates through four integrated components. Each component has a defined purpose and a defined relationship to the others. Together, they form a continuous cycle of risk identification, assessment, remediation, and validation.

Component	Purpose	Relationship to Program
Risk Repository	Centralized, living inventory of all identified compliance risks	Foundation of the program — all other components draw from it or feed into it
Annual Risk Assessment	Objective scoring and prioritization of risks by line of business	Output drives the following year's monitoring and audit focus areas
Monitoring Protocol	The monitoring protocol is shaped by risk assessment priorities and regularly updated based on the annual risk assessment	Governed by the DO Audit & Monitoring Program; informed by the risk assessment
Corrective Action & Validation	Remediation tracking and validation-gated closure for each risk	Governed by the CAP Policy; closure linked back to risk repository

The risk repository is the connective tissue. Every finding that enters the organization — from a regulatory audit, a Monitoring Protocol KPI Noncompliance, an internal audit, a notice of noncompliance, or any other source — is logged in the repository. The repository then informs the annual risk assessment, which shapes the Monitoring Protocol. When risks are remediated and validated, the repository is updated to reflect closure. When risks recur, the linkage to prior records is preserved.

V. Risk Repository

A. Overview

The risk repository is a continuously maintained record of all compliance risks identified across CHPIV's operations and delegation network. It is not a point-in-time document — it is updated throughout the year as new risks are identified, as existing risks move through remediation, and as validation is completed or confirmed. The repository is the organization's authoritative source of truth for its current and historical risk posture.

The repository is distinct from the CAP module. The repository tracks what the risk is, where it came from, how it scores, and whether it has been validated. The CAP module tracks what is being done about it. The two are linked by reference so that risk status and remediation status are always visible together, but they are governed and maintained separately.

B. Risk Input Sources

Risks enter the repository from any of the following source categories. All sources are treated equally — a risk identified through internal monitoring carries the same documentation and scoring requirements as one identified through a regulatory audit.

Source Category	Description
Regulatory Audit Findings	Findings from DHCS, DMHC, CMS, DOI, or other regulatory audits, desk reviews, or focused examinations directed at the plan
Delegation Oversight Annual Audit Findings	Findings from CHPIV's annual or focused audits of delegated entities and FDRs
Internal Audit Findings	Findings from CHPIV's internal audit function across any operational domain
Notices of Noncompliance — Received	NOCs received from state or federal regulators identifying noncompliance by the plan
Notices of Noncompliance — Issued	NOCs issued by CHPIV to delegated entities identifying noncompliance with contractual or regulatory obligations
Monitoring Protocol KPI Noncompliance	Quantitative or qualitative KPI threshold breaches identified through the ongoing monitoring protocol
Escalated Operational Risk	Compliance concerns surfaced and escalated by internal CHPIV business units through formal or informal channels
Escalated Delegate Risk	Compliance concerns escalated by or about delegated entities outside of the formal audit or monitoring cycle
Accreditation Findings	Findings from NCQA, URAC, AAAHC, or other accreditation bodies
Regulatory or Policy Changes	Delayed implementation of new or amended APLs, HPMS memos, regulations, or guidance that create compliance obligations requiring operational response
Proactive Identification	Risks identified through industry enforcement trends, peer plan actions, self-assessments, or compliance analysis prior to any external identification
Privacy Incidents	Privacy incidents (e.g., systemic access failure, inadequate safeguards); breach-reportable events are tracked separately under the breach notification process.
FWA — Confirmed Compliance Failure	Compliance failures identified as an outcome of a fraud, waste, and abuse (FWA) referral — specifically, oversight gaps, delegation failures, or process breakdowns confirmed by the SIU or legal review. The repository record does not reference investigation details, allegations, or findings about specific individuals.

C. Risk Linkage

The repository is designed to preserve and surface connections between risks over time. When a new risk is entered, it is evaluated against existing records — both open and retired — to determine whether a relationship exists. Rather than creating standalone records for every identified risk, CHPIV uses the following linkage types to document how risks relate to one another:

Linkage Type	Definition	Why It Matters
Repeat Finding	The identical noncompliance recurs after a prior risk was validated and retired	The most significant signal in the program — indicates that prior remediation did not achieve durable correction. Automatically increases the Deficiency/Recurrence score and triggers leadership notification.
Related Finding	A new risk shares a root cause, regulatory citation, functional domain, or delegate with an existing open or closed record — but is not the exact same finding	Signals potential systemic or structural failure rather than an isolated incident. May indicate that the scope of a prior CAP was insufficient.
Expansion of Existing Risk	A new source (e.g., a regulatory audit) identifies the same noncompliance already documented in the repository from a different source (e.g., a prior Delegation Oversight Annual Audit finding)	Rather than creating a duplicate record, the new source is added to the existing risk. Prevents fragmentation of related risk information.
Downstream Risk	A plan-level risk has a corresponding risk identified at the delegate level, or vice versa	Helps distinguish between isolated delegate-level failures and broader systemic risk that may implicate plan-level oversight obligations.

Linkage is proposed at intake and confirmed by a compliance reviewer. All linkages — including linkages to retired records — are permanent. A retired risk that resurfaces as a new finding does not lose its history; the link to the prior closed record tells the complete story of how the noncompliance was previously remediated, when it was validated, and how long the correction held.

D. Risk Repository Schema

Each risk record contains the following fields. Full definitions and permissible values for each field are maintained in the CHPIV Risk Repository.

Block	Fields
Identification	Risk ID | Risk Date | Entry Source Type | Source Reference | Regulatory Citation | Business Line | Risk Status
Classification	Function | Category | Internal Owners | Delegate(s) Affected
Linkage	Linked Risk ID(s) | Linkage Type | Repeat Finding Indicator
Risk Description	Risk Description | Root Cause Category | Root Cause Narrative
Risk Scoring	Member/Provider Impact Score (1–3) | Regulatory Focus Score (1–3) | Deficiency/Recurrence Score (1–3) | Composite Score | Risk Tier
Status	Risk Status | Risk Status Notes
CAP Reference	CAP Issued Date | CAP Status | CAP Status Notes | CAP ID Reference
Validation & Closure	Validation Method | Validation Due Date | Validation Outcome | Validation Date | Closure Approved By | Residual Risk Rating
Risk Acceptance	Risk Acceptance Indicator | Risk Acceptance Rationale | Acceptance Approved By | Acceptance Date

E. Risk Acceptance

In circumstances where full remediation is not immediately feasible — due to regulatory ambiguity, resource constraints, pending regulatory guidance, or a leadership determination that the cost of remediation is disproportionate to the risk level — CHPIV leadership may formally accept a risk rather than opening a corrective action plan.

Risk acceptance is not the same as ignoring a risk. It is a deliberate, documented decision that requires the following:

- Written rationale documenting why remediation is not being pursued at this time
- Identification of the specific leader accepting the risk on behalf of the organization
- Documented date of acceptance and expected review date
- Entry in the risk repository with Risk Acceptance Indicator set to Yes

Accepted risks remain active in the repository. They are included in the annual risk assessment and scored accordingly — acceptance does not reduce the risk score. Accepted risks are reviewed at each annual assessment cycle to determine whether the circumstances that led to acceptance have changed. If conditions change (new regulatory guidance, enforcement action at a peer plan, internal capacity shift), the acceptance is revisited, and a CAP may be opened.

VI. Risk Scoring Methodology

A. Overview

Each risk in the repository is scored using three factors that together produce a composite risk score. The composite score determines the risk tier, which in turn determines the intensity and frequency of oversight applied to that risk area. Scoring is applied at intake and updated at each annual risk assessment. Scores are stored per assessment period to enable year-over-year trending.

The three factors are: Member and Provider Impact, Regulatory Focus, and Deficiency/Recurrence. Each is scored on a 1–3 scale. The composite score is the sum of all three factors, producing a range of 3–9.

B. Scoring Factors

Factor 1: Member / Provider Impact — Assesses the potential downstream harm to members or providers if the noncompliance is not remediated.

Score	Criteria
1 — Low	Non-compliance may indirectly impact member or provider experience but does not directly affect access to care, safety, or financial rights. The risk is primarily administrative or process-oriented.
2 — Medium	Non-compliance may cause adverse effects on member or provider well-being but is not of such a severe nature that immediate health, safety, or access to care is affected.
3 — High	Non-compliance may result in a member's lack of access to medications or services, denial of medically necessary care, a violation of member rights, or an immediate threat to an enrollee's health and safety.

Factor 2: Regulatory Focus — Evaluates the degree to which this risk domain is under active or heightened regulatory scrutiny, drawing from CHPIV's existing regulatory tracking infrastructure (APL/HPMS memo log, regulatory inquiry tracker, audit protocol monitoring).

Score	Criteria
1 — Low	Regulators have included this area in routine audit scope or ongoing reporting requirements, but have not specifically targeted it or issued focused guidance. No active regulatory inquiry or enforcement in this domain.
2 — Medium	The area has been specifically targeted in a DHCS or DMHC focus audit scope, highlighted in recent APLs, policy guides, or HPMS memos, or is the subject of a regulatory inquiry or data request received by the plan.
3 — High	Regulators have designated this area a top priority, issued an NONC or enforcement action against the plan in this domain, or the area is subject to monetary penalties or sanctions. Applies when an active consent agreement or corrective action requirement from a regulator exists.

Factor 3: Deficiency / Recurrence — Evaluates the severity of the existing deficiency and whether the noncompliance has been previously identified. This factor is directly informed by the risk linkage architecture in the repository.	
Score	**Criteria**
1 — Minor	An isolated, first-occurrence finding. Non-systemic; can be corrected immediately. No prior linkage to a closed or open record for this noncompliance.
2 — Moderate	A substantive gap in process, controls, or compliance. Identified as a repeat finding after a prior risk was validated and closed, or linked to a related finding that suggests a shared root cause that was not fully addressed in prior remediation.
3 — Major	A significant, systemic non-compliance. Tied to a regulatory NONC or subject to monetary penalties or sanctions; or linked to multiple prior closed risks demonstrating a pattern of recurrence despite repeated remediation; or a finding that has remained open across multiple audit cycles without successful resolution.

C. Composite Score and Risk Tier

Composite Score	Risk Tier	Oversight Implication
7–9	**CRITICAL**	Mandatory inclusion in the monitoring protocol for the following year. Priority focus for targeted or enhanced audit scope. Escalation to Compliance & Policy Committee and senior leadership.
5–6	**HIGH**	Strong candidate for inclusion in the monitoring protocol. Enhanced focus in annual audit scope. Leadership visibility required.
3–4	**MEDIUM / LOW**	Addressed through the standard annual audit cycle. Routine oversight applies. May qualify for auto-score if already covered by monitoring.

VII. Annual Risk Assessment

A. Purpose and Timing

The annual risk assessment is the formal process by which CHPIV evaluates its total risk posture for the year just completed and uses that evaluation to shape the Monitoring Protocol for the following year. It is conducted in the fourth quarter of each calendar year, with output delivered to the Compliance & Policy Committee before the start of the new program year.

The risk assessment is a structured analysis of the risk repository — pulling every open risk, every newly identified risk from the assessment period, and every recently closed risk — and applying the scoring methodology in Section VI to produce a ranked, tiered inventory of risk by line of business. The result tells CHPIV where to focus its oversight resources in the year ahead.

B. What the Risk Assessment Produces

- A risk-tiered inventory of all open risks, organized by line of business and functional domain
- Year-over-year score trending for each risk area, showing whether risk is improving, stable, or escalating
- Identification of repeat findings — areas where prior remediation did not hold — flagged for leadership attention
- A recommended monitoring and audit focus for the following year, organized by risk tier
- Documentation of any accepted risks, with the rationale and accountable leader on record
- Input to the Monitoring Protocol

C. Line-of-Business Risk Assessment

The risk assessment is conducted at the line-of-business level, not at the delegate level or the individual business unit level. This is a deliberate design choice. Conducting the assessment by line of business produces a meaningful picture of where the regulatory, clinical, and operational risk is concentrated for each product — Medi-Cal, Medicare, Commercial, Dual Eligible — without creating an unmanageable number of parallel assessment tracks.

Within each line of business, risks are grouped by functional domain (e.g., UM, A&G, Care Management, Claims) and scored. The resulting tier for each domain drives monitoring prioritization for that line of business in the coming year.

D. Assessment Cycle

1. **Risk Repository Pull:** All risks active or newly identified during the assessment year are extracted from the repository. Retired risks closed during the year are included for trending purposes.
2. **Scoring Review:** Each risk is scored or re-scored using the three-factor methodology. Scores are reviewed against prior year scores to identify trends.
3. **Tier Assignment:** Composite scores are mapped to risk tiers (Critical, High, Medium/Low) by line of business and functional domain.
4. **Repeat Finding Identification:** Risks linked to prior closed records are flagged. Recurrence patterns across domains or delegates are surfaced for leadership review.
5. **Draft Assessment Report:** A draft risk assessment report is prepared, including the tiered risk inventory, trend analysis, repeat finding summary, and recommended Monitoring Protocol priorities.

6. **Leadership Review:** The draft is reviewed by compliance leadership and any weighting adjustments are documented and approved by the Compliance Officer.
7. **Committee and Commission Presentation:** The final risk assessment and Audit & Monitoring Program are presented to the Compliance & Policy Committee and Regulatory Compliance Oversight Committee (RCOC) of the Commission for approval before the start of the new program year.

IX. Risk Validation and Retirement

A. The Validation Principle

A risk is not closed because a corrective action plan has been implemented. A risk is closed because the corrective action has been validated — meaning there is objective evidence that the noncompliance has been corrected and that the correction is durable. Implementation and validation are two distinct events. A CAP that has been implemented but not validated remains open, and the associated risk remains active in the repository.

B. Validation Standards by Risk Source

The required validation standard depends on the source of the risk. Each standard is designed to match the nature and scope of the noncompliance:

Risk Source	Validation Standard	CAP Closure Trigger
Monitoring **Protocol** KPI Noncompliance	Two consecutive compliant (GREEN) quarters on the applicable KPI following CAP implementation	Second consecutive GREEN quarter confirmed on the monitoring scorecard
Delegation Oversight Annual Audit Finding	The finding domain is evaluated at the next annual Delegation Oversight Annual Audit and the finding is not repeated	Next Delegation Oversight Annual Audit report documents no repeat finding in that domain
Regulatory Audit Finding (DHCS, DMHC, CMS)	The finding domain is evaluated at the next regulatory audit, and the finding is not repeated	Next regulatory audit report documents no repeat finding; or regulator issues written confirmation of closure
Notice of Noncompliance — Received	Regulator written confirmation of closure; OR no repeat at next regulatory audit; OR a CHPIV-conducted focused validation audit demonstrates correction	Applicable validation mechanism is satisfied and documented in the repository
Notice of Noncompliance — Issued to Delegate	CHPIV-conducted focused validation audit or documentation review confirms correction; OR no repeat finding at next annual Delegation Oversight Annual Audit	Plan-conducted validation is complete and documented; compliance reviewer concurs
Escalated Operational or Delegate Risk	Ad hoc review, focused audit, monitoring data, or evidenced attestation by the accountable owner — reviewed and concurred by compliance	Compliance team documents validation and approves closure

C. Retirement and Linkage Preservation

When a risk is validated and closed, its status is updated to Retired in the repository. The record is not deleted. All fields — including scoring history, linkage data, CAP references, and validation documentation — are preserved permanently.

This permanence is foundational to the program's institutional memory function. If a retired risk resurfaces in a future audit, monitoring period, or regulatory examination, the new finding is linked back to the retired record. The linkage tells the full story: when the prior noncompliance was identified, what the corrective action was, when it was validated, and how long the correction held before the finding recurred. This history directly informs the Deficiency/Recurrence score for the new risk and, over time, supports escalation of oversight intensity for areas with repeated recurrence patterns.

XI. Reporting

The following reports are produced from the risk repository and distributed to governance stakeholders on a defined schedule. All reports are generated from live repository data to ensure they reflect current risk posture.

Report	Frequency	Primary Audience
Risk Repository Status Report — Summary of open risks, CAP aging, and newly identified risks	Quarterly	Compliance leadership; Compliance & Policy Committee; Regulatory Compliance & Oversight Committee of the Commission
Annual Risk Assessment Report — Scored risk inventory by line of business; trends; Monitoring Protocol recommendations	Annual	Compliance leadership, Compliance & Policy Committee; Regulatory Compliance Oversight Committee (RCOC) of the Commission
Monitoring Protocol —Priorities for the coming year derived from the risk assessment	Annual	Senior leadership; Compliance Committee; Regulatory Compliance Oversight Committee (RCOC) of the Commission

XII. Program Review and Maintenance

This program document is reviewed and updated annually in conjunction with the annual risk assessment cycle. The review evaluates whether the program's scope, scoring methodology, validation standards, and governance structure remain appropriate given the organization's current regulatory environment and risk posture.

Updates may also be triggered at any point by material regulatory changes, significant enforcement actions or consent agreements, findings from an external review of the compliance program itself, accreditation requirements, or a leadership determination that the program's structure requires revision.

Community Health Plan OF IMPERIAL VALLEY

AUDIT & MONITORING PROGRAM

Community Health Plan of Imperial Valley (CHPIV)

Compliance Department

Effective Date	[DATE]
Version	1.0
Date Approved by CCO	03/20/2026
Date Approved by Compliance & Policy Committee	[DATE]
Date Approved by Regulatory Compliance Oversight Committee (RCOC) of the Commission	[DATE]
Review Cycle	Annual — aligned with Annual Risk Assessment
Related Documents	Risk Management Program; Risk Repository; Risk Assessment; Log Templates; File Review Tools; KPI Master List

I. Purpose

The Audit & Monitoring Program (AMP) is the primary oversight instrument through which CHPIV evaluates compliance performance across its internal business units and delegation network. It operationalizes the outputs of the Risk Management Program by defining what is reviewed, how it is reviewed, and how often.

The AMP is a single unified framework. One set of oversight elements, derived from CHPIV's audit tools, governs all oversight activity. Two rules determine frequency:

- All quantitative KPIs are monitored quarterly — for every functional area, regardless of risk tier. The underlying log data is available monthly and continuous performance tracking is both feasible and necessary.
- All qualitative KPIs (case file reviews) are conducted quarterly for High and Critical risk areas, and annually for Medium/Low risk areas. Risk tier, set by the Annual Risk Assessment, is the determining factor.
- All policy reviews are conducted annually, regardless of risk tier.

Log templates — including field-level specifications, data validation rules, and file naming conventions — are maintained as standalone reference documents. This program governs the oversight process; the log templates govern the submission format.

II. Scope

This program applies to all CHPIV internal business units responsible for regulated functions, all delegated entities under delegation agreements with CHPIV, and all lines of business: Medi-Cal and D-SNP.

The oversight elements in the Master Oversight Element Table (Section VI) are derived from CHPIV's audit and monitoring tools. When new tools are developed or existing tools revised, the Master Table is updated accordingly per the maintenance provisions in Section XIII.

III. Relationship to the Risk Management Program

The AMP is a downstream output of the Risk Management Program. The Annual Risk Assessment scores and tiers all open compliance risks by functional area. That output feeds the AMP in two ways: it sets the qualitative review frequency for each area, and it determines the intensity and scope of oversight applied within each cycle.

Element Type	Frequency Rule	Frequency	What Risk Tier Affects
Quantitative KPI	Always quarterly	Quarterly	Depth of data validation applied
Qualitative KPI / Case File Review	Tier-driven	Quarterly (High/Critical) Annual (Medium/Low)	Directly sets frequency. Also affects whether a focused review is added mid-year, and priority in audit scope.
Policy Review	Always annual	Annual	Not affected — policy reviews are always annual regardless of tier.

Findings from all AMP activities feed back into the Risk Repository. Every finding meeting the logging threshold is entered as a risk record and — where applicable — triggers a Corrective Action Plan that stays open until validation is complete.

IV. Oversight Element Types

A. Quantitative KPIs — Quarterly (All Areas)

Quantitative KPIs are data-driven performance measures calculated from delegate-submitted logs. Results are expressed as a percentage of compliant transactions and evaluated against a three-band threshold:

Band	Level	Consequence
GREEN	At or above threshold	No action required. Result documented in quarterly monitoring scorecard.
YELLOW	Within warning band	Warning letter issued. No CAP for first occurrence. Second consecutive YELLOW triggers CAP.
RED	Below threshold	CAP required. Risk logged in Risk Repository. Validation requires two consecutive GREEN quarters.

B. Qualitative KPIs / Case File Review — Quarterly (High/Critical) or Annual (Medium/Low)

Qualitative KPIs are assessed through structured case file review using CHPIV's audit tools. CHPIV selects a representative sample of cases from validated logs and evaluates each case against predefined criteria to determine whether applicable regulatory, contractual, and internal requirements were met. Results are aggregated to produce an overall compliance rate for each qualitative KPI.

Sample methodology follows NCQA 8/30 logic: an initial sample of 8 cases is reviewed; if compliance falls below 95%, the sample is expanded to 30 cases. Case files are selected randomly, with approximately 2–4 cases reviewed per month within each quarter.

Case file document requirements for each functional area are defined in Appendix A of this program.

C. Policy Review — Annual (All Areas)

Policy reviews evaluate whether a delegate's or business unit's written policies and procedures comply with CHPIV's standards and applicable regulatory requirements. Policy reviews are always conducted annually regardless of risk tier. A finding — a policy that is absent, materially deficient, or noncompliant — is logged in the Risk Repository and triggers a CAP.

V. Oversight Intensity by Risk Tier

Risk tier determines the frequency and scope of oversight within each review cycle — not whether something is reviewed. The table below summarizes what each tier means in practice.

Tier	Score	Quant KPIs	Qualitative KPIs	Scope
CRITICAL	7–9	Quarterly	Quarterly	Mandatory quarterly monitoring. Priority scope for annual audit. CCO and Compliance & Policy Committee notification. Enhanced CAP tracking.
HIGH	5–6	Quarterly	Quarterly	Quarterly monitoring. Enhanced focus in annual audit. Leadership visibility required. Standard CAP process applies.
MED/LOW	3–4	Quarterly	Annual	Quantitative KPIs monitored quarterly. Case file reviews and policy reviews conducted annually. Standard audit scope.

VI. KPI List – Quarterly Monitoring

CHPIV Maser KPI List is inclusive of all elements subject to oversight.

The table below is the authoritative list of all KPIs subject to quarterly monitoring, organized by functional area. Frequency is derived from element type and risk tiers, which reflect the most recent Annual Risk Assessment.

Note: UM005 and UM006 have been converted to qualitative KPIs assessed through case file sample review due to data validation limitations; this is consistent with DHCS and DMHC audit methodology.

Functional Area	Oversight Element	KPI #	Type	Green	Yellow	Red	Log
Utilization Management (UM)	Decision Timeliness	UM005	Qualitative	>96%	95-96%	<95%	UM Authorizations Log
Utilization Management (UM)	Notification Timeliness	UM006	Qualitative	>96%	95-96%	<95%	UM Authorizations Log
Utilization Management (UM)	Physician Reviewer Qualifications & Accessibility	UM001	Qualitative	>96%	95-96%	<95%	UM Authorizations Log
Utilization Management (UM)	Denial Letter Content & Compliance	UM008	Qualitative	>96%	95-96%	<95%	UM Authorizations Log
Utilization Management (UM)	UM Criteria Application & MN Rationale	UM009	Qualitative	>96%	95-96%	<95%	UM Authorizations Log
Utilization Management (UM)	Post Stabilization	UM010	Qualitative	>96%	95-96%	<95%	UM Authorizations Log
Appeals	Acknowledgement Letter	APPEAL-001	Quantitative	>96%	95-96%	<95%	Appeal Log
Appeals	Resolution Timeliness	APPEAL002	Qualitative	>96%	95-96%	<95%	Appeal Log
Appeals	Resolution Letter Content	APPEAL-003	Qualitative	>96%	95-96%	<95%	Appeal Log
Blood Lead Level	BLL Screening – Initial Requirements	BLL-001	Qualitative	>96%	95-96%	<95%	BLS Log
Blood Lead Level	Anticipatory Guidance	BLL-002	Qualitative	>96%	95-96%	<95%	BLS Log
Blood Lead Level	Elevated BLL Follow-Up Protocols	BLL-003	Qualitative	>96%	95-96%	<95%	BLS Log
California Children's Services	CCS Authorization & Service Type	CS-001	Qualitative	>96%	95-96%	<95%	CCS Log
California Children's Services	CCS Referral & Closed-Loop Referral (CLR)	CS-002	Qualitative	>96%	95-96%	<95%	CCS Log
California Children's Services	CCS Service Delivery	CS-003	Qualitative	>96%	95-96%	<95%	CCS Log
California Children's Services	CCS Outcome & Coordination (CLR Closure)	CS-004	Qualitative	>96%	95-96%	<95%	CCS Log
California Children's Services	CCS Delegation & QI	CS-005	Qualitative	>96%	95-96%	<95%	CCS Log
Enhanced Care Management	Care Element 1: Member ID & Outreach	ECM-001	Qualitative	>96%	95-96%	<95%	ECM Log
Enhanced Care Management	Care Element 2: Comprehensive Assessment	ECM-002	Qualitative	>96%	95-96%	<95%	ECM Log
Enhanced Care Management	Care Element 3: Care Plan	ECM-003	Qualitative	>96%	95-96%	<95%	ECM Log

Functional Area	Oversight Element	KPI #	Type	Green	Yellow	Red	Log
Enhanced Care Management	Care Element 4: Care Coordination	ECM-004	Qualitative	>96%	95-96%	<95%	ECM Log
Enhanced Care Management	Audit Universe & Delegation	ECM-010	Qualitative	>96%	95-96%	<95%	ECM Log
Enhanced Care Management	ECM Eligibility & Identification	ECM-001	Qualitative	>96%	95-96%	<95%	ECM Log
Initial Health Appointments	IHA Completion & Timeliness	IHA-001	Qualitative	>96%	95-96%	<95%	IHA Log
Initial Health Appointments	Follow-Up & Referrals	IHA-005	Qualitative	>96%	95-96%	<95%	IHA Log
Initial Health Appointments	Outreach & Documentation	IHA-006	Qualitative	>96%	95-96%	<95%	IHA Log
Continuity of Care	CoC Processing Timeliness	COC-001	Quantitative	>96%	95-96%	<95%	CoC Log
Continuity of Care	CoC Notification Timeliness	COC-002	Quantitative	>96%	95-96%	<95%	CoC Log
Claims	Claims Payment Timeliness — 30 Calendar Days	CLM-001	Quantitative	>91%	90-91%	<90%	Claims Log
Claims	Claims Payment Timeliness — 45 Working Days	CLM-002	Quantitative	>96%	95-96%	<95%	Claims Log
Claims	Claims Payment Timeliness — 90 Calendar Days	CLM-003	Quantitative	>99%	99%	<99%	Claims Log
Claims	Claims Acknowledgement Timeliness	CLM-004	Quantitative	>96%	95-96%	<95%	Claims Log
Claims	Misdirected Claims Timeliness	CLM-005	Quantitative	>96%	95-96%	<95%	Claims Log
Claims	Timely Interest Payment on Late Claims	CLM-006	Quantitative	>96%	95-96%	<95%	Claims Log
MHSUD-BHT	Level of Care (LOC) Assessment	BHT-001	Qualitative	>96%	95-96%	<95%	BHT Log
MHSUD-BHT	BH Treatment Plan	BHT-002	Qualitative	>96%	95-96%	<95%	BHT Log
MHSUD-BHT	Transitions of Care — BH Discharge	BHT-003	Qualitative	>96%	95-96%	<95%	MHSUD Log
MHSUD-BHT	Oversight & Delegation	BHT-006	Qualitative	>96%	95-96%	<95%	MHSUD Log
Member Services	Calls Answered Within 30 Seconds	MS-001	Quantitative	>90%	80-90%	<80%	Call Log
Member Services	Call Center Abandonment Rate	MS002	Quantitative	<5%	5%	>5%	SLA Log
Member Services	Timely Issuance of Member ID Cards	MS003	Quantitative	>96%	95-96%	<95%	Member ID Log
Provider Dispute Resolution (PDR)	PDR Acknowledgement Timeliness	PDR-001	Quantitative	>96%	95-96%	<95%	PDR Log
Provider Dispute Resolution (PDR)	PDR Written Determination Timeliness	PDR-002	Quantitative	>96%	95-96%	<95%	PDR Log
Provider Dispute Resolution (PDR)	Timeliness of Interest Payment on Late PDRs	PDR-003	Quantitative	>96%	95-96%	<95%	PDR Log
Grievances	Acknowledgment Letter	GRV-001	Quantitative	>96%	95-96%	<95%	Grievance Log
Grievances	Grievance Resolution Timeliness	GRV-003	Quantitative	>96%	95-96%	<95%	Grievance Log

Functional Area	Oversight Element	KPI #	Type	Green	Yellow	Red	Log
Grievances	Resolution Letter Content	GRV-004	Qualitative	>96%	95-96%	<95%	Grievance Log
Grievances	Transportation Grievances	GRV-006	Qualitative	>96%	95-96%	<95%	Grievance Log
Grievances	Discrimination Grievances	GRV-007	Qualitative	>96%	95-96%	<95%	Grievance Log
Exempt Grievances	Correct Classification of Exempt Grievance	EXG-004	Qualitative	>96%	95-96%	<95%	Exempt Grievance Log
Exempt Grievances	Exempt Grievance Handling and Resolution	EXG-005	Qualitative	>96%	95-96%	<95%	Exempt Grievance Log
Delegation Oversight	Transportation — ModivCare	DO-009	Qualitative	>96%	95-96%	<95%	Transportation Log

VII. Log Submission Requirements

For delegated entities, quantitative and qualitative KPI monitoring depends on accurate, timely log submissions. Logs must be submitted monthly by the 20th of the following month using the file naming conventions below. The Exempt Grievance Log and ModivCare Transportation Log are submitted quarterly. Log field specifications, data validation rules, and universe inclusion/exclusion criteria are defined in the individual log templates, which are incorporated into this program by reference.

Log Name	File Naming Convention	Submission Frequency
UM Authorizations Log	UMAuth_MMYYYY	Monthly
Appeal Log	Appeal_MMYYYY	Monthly
Blood Lead Level (BLL) Log *	BLL_MMYYYY	Monthly
California Children's Services (CCS) Log *	CCS_MMYYYY	Monthly
Enhanced Care Management (ECM) Log *	ECM_MMYYYY	Monthly
Continuity of Care (CoC) Log	CoC_MMYYYY	Monthly
Claims Log	Claims_MMYYYY	Monthly
Initial Health Appointment (IHA) Log	IHA_MMYYYY	Monthly
Behavioral Health Treatment (BHT) Log *	BHT_MMYYYY	Monthly
Mental Health & Substance Use Disorder (MHSUD) Log *	MHSUD_MMYYYY	Monthly
Member Services — Call Log	CallLog_MMYYYY	Monthly
Member Services — Call Center SLA Log	CallCenterSLA_MMYYYY	Monthly
Member Services — Member ID Log	MemberID_MMYYYY	Monthly
Provider Dispute Resolution (PDR) Log	PDR_MMYYYY	Monthly
Grievance Log	Grievance_MMYYYY	Monthly
Exempt Grievance Log *	ExemptGrv_QQYYYY	Quarterly
ModivCare Transportation Log *	Transport_QQYYYY	Quarterly

** Logs identified with an asterisk were added or revised in 2026.*

VIII. Data Validation Process

Prior to calculating KPI results, CHPIV validates all submitted logs for data accuracy and integrity. The data validation process applies to all quantitative KPI logs and proceeds as follows:

- Data Validation Webinars: CHPIV schedules a separate webinar per functional area within 5 business days of log receipt to evaluate and confirm quantitative KPI metric scores.
- System Verification: CHPIV reviews the delegate's live system to verify data points and may request screenshots for additional confirmation.
- Sample Case Selection: CHPIV selects 5 cases from quarterly logs and provides the sample selections to the delegate approximately one hour prior to the scheduled webinar.
- Log Integrity Standard: A passing score of 95% or higher is required for log integrity. If data points are incomplete, mismatched, or cannot be verified, the log fails integrity review. CHPIV requests corrections and a new log upload. A follow-up data validation webinar is scheduled for each corrected log.
- Allowable Attempts: Delegates have a maximum of 3 attempts to submit a complete and accurate log. If all 3 attempts fail to meet the passing score, further corrective action is taken per Section X.
- Results Issuance: Once data quality is confirmed, CHPIV calculates KPI results and develops the quarterly monitoring scorecard.

IX. Quarterly Monitoring Process

Quarterly monitoring applies to: (1) all quantitative KPIs across every functional area, and (2) all qualitative KPIs for functional areas rated High or Critical. The monitoring cycle runs on a calendar quarter basis.

A. Quantitative KPI Measurement

CHPIV calculates quantitative KPIs directly from validated logs submitted by the delegate. KPIs are extracted using predefined algorithms and analysis methodologies aligned with state regulatory and contractual requirements.

B. Qualitative KPI Case File Review

CHPIV conducts case file reviews for all qualitative KPIs in High/Critical risk areas on a quarterly basis. The process includes:

- Sample selection from validated logs using NCQA 8/30 methodology: initial review of 8 cases per quarter; expanded to 30 cases if compliance falls below 95%.
- Case files are selected randomly, with approximately 2–4 cases reviewed per month within the quarter.
- Each case is evaluated using a standardized audit tool. Each KPI element is scored compliant or noncompliant against predefined criteria.
- Results are aggregated to produce an overall compliance rate for each qualitative KPI. See Section VI for thresholds.
- Case file document requirements for each functional area are defined in **Appendix B** of this program.

C. Quarterly Monitoring Scorecard

Following data validation and case file review, CHPIV compiles and disseminates a Quarterly Monitoring Scorecard to the delegate. The scorecard includes:

- Calculated KPI results for all quantitative and qualitative KPIs in scope for the quarter, organized by functional area
- Data validation findings, including any log integrity issues identified during the validation process
- An executive summary highlighting strengths, areas for improvement, operational deficiencies, log inaccuracy, and oversight discrepancies
- Visual performance indicators (GREEN / YELLOW / RED) for each KPI

Scorecard delivery: CHPIV Internal and Delegation Oversight sends the scorecard to the delegate via email and presents results at the next scheduled Joint Operations Committee (JOC) to allow real-time discussion and immediate response.

X. Corrective Action & Risk Repository Connection

A. CAP Process and Timeline

In the event of noncompliance, CHPIV enforces the following corrective action process:

Trigger	Action
1 quarter noncompliant	Warning Letter issued. Delegate must initiate remediation activities to address noncompliance. No CAP required at this stage.
2 consecutive quarters noncompliant	Corrective Action Plan (CAP) issued. Delegate has 10 business days to respond with a remediation plan. CHPIV monitors CAP implementation and completion.
3 consecutive quarters noncompliant	Focused review or audit in the area of noncompliance, potentially conducted as part of or in addition to the annual audit. Risk escalated in Risk Repository.
Log integrity failure (3 failed attempts)	CAP issued within 10 business days. Delegate must outline plan to address data quality issues and prevent future occurrences.

B. Risk Repository Logging Threshold

The following findings are logged in the Risk Repository:

- Any quantitative KPI result in the RED band
- Any second consecutive YELLOW result on any KPI
- Any qualitative KPI case file review finding of noncompliance that is not isolated and immediately correctable
- Any policy review finding identifying a policy that is absent, materially deficient, or noncompliant
- Any log integrity failure resulting in a CAP
- Any finding that represents a repeat of a previously retired risk

C. Validation Standards

A CAP remains open until the underlying noncompliance is validated — not just until the corrective action is implemented. For quantitative KPI findings, validation requires two consecutive GREEN quarters following CAP implementation. For qualitative and policy review findings, validation is confirmed at the next review cycle showing no recurrence.

XI. Annual Audit Process

The annual audit applies to all functional areas regardless of risk tier. For Medium/Low areas it is the primary mechanism for qualitative KPI and policy reviews. For High/Critical areas subject to quarterly monitoring, the annual audit provides a comprehensive point-in-time review that complements ongoing monitoring.

A. Annual Audit Scope

The Compliance Department prepares an annual audit work plan based on the Annual Risk Assessment output. The work plan identifies areas in scope, the review period, oversight elements to be evaluated, methodology, and — for delegation oversight — which delegates are in scope and any expanded scope driven by prior findings. The work plan is approved by the CCO and presented to the Compliance & Policy Committee before the audit cycle begins.

B. Annual Audit Timeline

Phase	Activity
Scope & Planning	Risk assessment output received; work plan finalized; auditees notified
Data Collection	Document and data requests issued; submission deadline set
Fieldwork	KPI calculations, case file reviews, policy reviews conducted
Findings Development	Draft findings prepared; internal review completed
Draft Report	Draft report issued to auditee; response period opens
Final Report	Auditee responses incorporated; final report issued
CAP & Repository	Findings logged in Risk Repository; CAPs issued
Follow-Up	CAP milestone tracking; validation monitoring begins

XII. Reporting & Governance

Report	Frequency	Content	Audience
Quarterly Monitoring Scorecard	Quarterly	KPI results by functional area; Yellow/Red findings; data validation results; CAPs issued	CCO; Compliance & Policy Committee; RCOC; Delegates
Annual Audit Report	Annual	Audit findings; policy review results; CAPs issued; year-over-year comparison	CCO; Compliance & Policy Committee; RCOC; Delegates
CAP Status Report	Quarterly	Open CAPs, milestone status, overdue items, approaching validations	CCO; Compliance & Policy Committee; RCOC
Annual Risk Assessment Input	Annual	AMP findings summary as input to the annual risk assessment and tier-setting process	Compliance & Policy Committee; RCOC

Appendix A — Case File Specifications

The tables below identify the specific documents delegates must submit for each qualitative KPI case file review. Each document list is derived from CHPIV's audit tools and the CHPIV Master Compliance Oversight Repository evidence requirements. Missing or incomplete documentation will result in a Not Met (N) score for the corresponding sub-element.

UM Authorizations KPIs: UM001, UM002, UM003, UM004, UM005, UM006 *Audit Tool: UM File Tool*
• Authorization case file with case tracking number
• Member eligibility confirmation (CIN, DOB, line of business)
• Original authorization request with date and time stamp
• Reviewer credentials — name, title, specialty, and license type
• Reviewer direct phone number (validated)
• P2P consultation offer documentation in case notes or denial letter
• P2P call log — date, participants, clinical discussion, and final decision (if P2P occurred)
• Decision date and time stamps (request received, clock start, decision rendered)
• Written NOA/denial letter — member copy and provider copy
• NOA template — current CHPIV/HN-approved version confirmed
• Clinical criteria cited — tool name, version, and specific section
• Member-specific MN rationale linking criteria to member's clinical data
• Provider phone/fax notification record (date and time)
• Member written notification letter (2 business days from decision)
• Your Rights attachment
• State Fair Hearing instructions (Medi-Cal members)
• Non-discrimination tagline in threshold languages
• Post-stabilization: live call log with timestamps (30 minutes response)

- Post-stabilization: Plan financial responsibility notation in case notes
- UM Authorizations Log entry confirming case is in submitted universe

Appeals

KPIs: APPEAL001, APPEAL002, APPEAL003

Audit Tool: Appeals File Review Tool

- Appeal case file with case tracking number
- Member eligibility confirmation (CIN, DOB, preferred language)
- Original denial or adverse determination being appealed
- Date and time appeal was received
- Acknowledgment letter (standard: 5 calendar days; N/A for Expedited)
- Written appeal determination/resolution letter
- Resolution letter — current CHPIV/HN-approved template and version
- Reviewer name, credentials, title, and specialty documented in file
- Clinical rationale linking criteria to member's specific case (MN appeals)
- Criteria name, edition, and relevant section cited
- All 4 required contact items: Plan phone, DMHC 1-888-466-2219, TDD, DMHC website
- IRO/IMR rights language (Knox-Keene) or State Fair Hearing rights (Medi-Cal) per LOB
- Rights language in 12-point boldface type
- Notice of Appeal Resolution (NAR) — date sent to member
- Effectuation documentation if appeal was overturned
- Appeal Log entry confirming case is in submitted universe

Grievances

KPIs: GRV001, GRV002, GRV003, GRV004, GRV005

Audit Tool: Grievance File Review Tool

- Grievance case file with case tracking number
- Member eligibility confirmation (CIN, DOB, preferred language)

Grievances

KPIs: GRV001, GRV002, GRV003, GRV004, GRV005

Audit Tool: Grievance File Review Tool

- Date and time grievance was received
- Acknowledgment letter (Standard: 5 calendar days)
- Grievance classification in tracking system (QOS / QOC / Discrimination / Transportation)
- Written resolution letter — current CHPIV/HN-approved template
- Plain language decision explanation in resolution letter
- Reviewer credentials on file (licensed clinician for QOC; trained staff for QOS)
- All required contact items: Plan phone, DMHC phone, TDD, DMHC website
- State Fair Hearing instructions and DHCS Ombudsman number (Medi-Cal)
- Rights language in 12-point boldface type
- GRV-006: Transportation grievance — MODIVCARE vendor oversight tracking entry
- GRV-006: Transportation resolution letter with required member rights block
- GRV-007: CHPIV Compliance notification — 5 calendar days from receipt
- GRV-007: DHCS OCR report or notification documentation with submission date
- Grievance Log entry confirming case is in submitted universe

Exempt Grievances

KPIs: EXG001, EXG002

Audit Tool: Exempt Grievances File Review Tool

- Call record with File ID / Case Number
- Member identification: name, ID/CIN, DOB, county, preferred language
- Call date and time stamp (starts 24-hour resolution clock)
- Resolution date and time stamp (verifies 24-hour compliance)
- Staff identification: name, title, and organization at call opening
- Exempt classification rationale with reason code in tracking system
- Confirmation issue does not involve medical necessity or coverage dispute

- Approved script/talking points used — confirmed in call notes or quality review
- Interpreter service name and ID (if interpreter used; NA if not)
- If NOT resolved in 24 hours: formal transfer to HN — date, time, HN case number
- If discrimination identified: CHPIV Compliance notification date: 5 calendar days
- CM referral notation if repeated access complaints warranted CM follow-up
- Exempt Grievance Log entry confirming case is in submitted universe

Blood Lead Level

KPIs: BLL001, BLL002, BLL003

Audit Tool: BLL File Review Tool

- Member case record with DOB confirming age eligibility (0–72 months)
- Lab report — BLL result with exact date and numerical value in ug/dL
- CPT code 83655 on lab order or claims record
- Refusal documentation with date and counseling note (if screening refused)
- Catch-up screening documentation for children ages 1–6 with no prior BLL test
- Anticipatory guidance record — date, method (oral/handout), and language used
- Language-appropriate guidance materials or interpreter service record
- BLL 3.5–9.9 ug/dL: nutrition counseling note + environmental guidance + repeat test order
- BLL 10–19 ug/dL: CM referral date and receiving CM documented
- BLL 20 ug/dL: DHCS/LHD notification + intensive CM case opening record
- Environmental assessment or LHD referral documentation (elevated BLL cases)
- Follow-up BLL test order and subsequent lab result with date
- BLS Log entry confirming case is in submitted universe

California Children's Services (CCS)

KPIs: CS001, CS002, CS003, CS004, CS005

Audit Tool: CCS File Review Tool

- Member CCS case file with CCS case number and SAR number

- Member eligibility confirmation and CCS-eligible diagnosis (full description)
- CCS service type — specific type from DHCS-authorized CalAIM CS service list
- CCS authorization — service type, start date, and authorized duration
- CS provider name and NPI (validated in DHCS provider directory)
- Referral source documentation — who initiated (ECM/CCM/PCP/self), name, and date
- CLR system entry — referral submission date and confirmation to referring practitioner
- CLR status history — full lifecycle from referral through closure with outcome
- SDOH domain that triggered CCS referral — linked to assessment finding
- Service delivery records — actual dates services were delivered
- CS provider progress notes showing service activities and member engagement
- Referral outcome — goals achieved, modified, or discontinued with reason
- Warm handoff record to ECM/CCM after CCS completion
- Delegate flag — if delegate: delegate name/ID and CHPIV standards confirmed
- CCS Log entry confirming case is in submitted universe

Initial Health Appointments

KPIs: IHA001, IHA002, IHA003

Audit Tool: IHA File Review Tool

- Member enrollment date (to verify 120-day IHA deadline)
- Completed IHA form — signed and dated by provider
- IHA completion date (actual visit date, not system entry date)
- IHA form with all four sections: history, physical exam, assessment, and plan
- IHEBA (Staying Healthy Assessment) completed and in member's medical record
- IHA and IHEBA in EHR or medical record (not plan system only)
- For members <18 months: IHA aligned with AAP periodicity or 120 days
- IHA findings — risk factors and conditions identified (not left blank)
- Follow-up referrals or orders from IHA findings — each with date and recipient
- Referral tracking — appointment confirmed or kept for each IHA-generated referral

- Positive SDOH screen — linked CS/community referral and CLR status
- Outreach attempt log — 3 attempts with date, method, and outcome (if IHA not completed)
- Good-faith outreach compliance notation per APL 23-014 (if IHA not completed after attempts)
- ECM/CCM members: comprehensive 6-domain assessment within 45 days of enrollment in addition to IHA
- IHA Log entry confirming case is in submitted universe

Enhanced Care Management / CCM

KPIs: ECM001, ECM002, ECM003, ECM004, ECM005, CCM001

Audit Tool: ECM/CCM File Review Tool

- ECM/CCM enrollment universe report — member ID confirmed in universe for audit period
- CalAIM program type documented as ECM or CCM (not blank or mislabeled)
- CCM only: confirmation member is NOT concurrently enrolled in ECM for same period
- ECM/CCM eligibility criterion with supporting data — specific trigger named
- Member enrollment date
- Lead Care Coordinator / Case Manager name and credentials
- Outreach attempt log — each attempt with date, method, and outcome; minimum 3 entries
- Initial engagement — first successful contact date, method, and summary
- Member/caregiver consent — signed, dated, covers enrollment and data sharing
- SB 1009 right-to-refuse documentation (if member declined to sign)
- Comprehensive assessment — completed within 45 calendar days of enrollment
- Assessment tool name documented (CPSP, 5P, or DHCS-approved equivalent)
- All 6 assessment domains completed: medical, BH, SDOH, housing, functional, trauma
- Person-centered care plan — dated, individualized, member-specific goals
- Care plan signed within 30 days of enrollment OR SB 1009 right-to-refuse noted
- Care plan addresses all 5 required domains: medical, BH, SDOH, housing, functional
- Care plan review date — 6 months since last review; updated at significant change
- Care plan distribution log — sent to member AND PCP with date and method
- Positive SDOH screen results in care plan with CCS referrals and CLR status

- Complete care team list — all treating providers with name, specialty, role, and contact
- PCP coordination documentation — at least one documented PCP contact
- Referral tracking — each referral traceable to assessment, appointment confirmed, outcome noted
- Medication list — reviewed date; discrepancies communicated to PCP
- Case contact notes — frequency consistent with care plan and ECM requirements
- CLR system entry for any practitioner-initiated ECM/CCM referral
- Delegate flag — if delegate: delegate name/org and CHPIV standards confirmed
- ECM Log / CCM records confirming case is in submitted universe

MHSUD & Behavioral Health Treatment (BHT)

KPIs: BHT001, BHT002, MHSUD001, MHSUD002

Audit Tool: MHSUD-BHT File Review Tool

- BHT case file with case tracking number
- Member identification and BH program type (BHT / MHSUD / ECM-BH) documented
- LOC assessment — tool name (ASAM, CALOCUS, or LOCUS), date, and specific level
- LOC determination linked to service authorization
- LOC reassessment when member's condition changes
- LOC reassessment at required frequency (6 months)
- Individualized BH treatment plan — member-specific, signed, dated
- Treatment plan includes all 5 elements: diagnoses, goals, medications, SDOH, crisis/safety plan
- BH provider signature and credentials on treatment plan or review note
- Treatment plan review documentation — 6 months between reviews (RM-12)
- Member/caregiver participation in treatment plan documented in case notes
- Consent for BH-PCP data sharing (42 CFR Part 2 for SUD cases)
- BH inpatient or residential discharge date
- 72-hour post-discharge follow-up — date, method, and outcome
- Same-day or next-day outpatient BH appointment confirmation (BHIN-25-011)
- Outpatient BH appointment outcome — kept, rescheduled, or canceled with reason

- Provider notification of discharge — date, method, and confirmation of receipt
- Post-discharge care plan reassessment — date and updated content in file
- HN/CHPIV oversight documentation for delegated MHSUD subcontractor (RM-34)
- Delegate flag — CHPIV MHSUD standards confirmed in case record
- BHT Log entry confirming case is in submitted universe

Continuity of Care

KPIs: COC001, COC002

Audit Tool: CoC File Review Tool

- Member care file with case tracking number
- Documentation of continuity of care request (date received)
- Evidence of eligibility for continuity of care (e.g., active treatment, qualifying condition)
- Provider information (requesting/continuing provider)
- Determination outcome (approved/denied)
- Date of determination
- Evidence of member notification (approval or denial letter)
- If approved, duration of continuity of care period documented
- If denied, reason for denial documented
- Evidence of coordination with provider (if applicable)
- Case notes documenting review and decision-making process

Claims

KPIs: CLM001, CLM002, CLM003, CLM004, CLM005, CLM006

Audit Tool: Claims File Review Tool

- Claim record with claim number
- Date claim received
- Date claim adjudicated (paid or denied)
- Claim type (clean vs. complex, if applicable)

- Evidence of timeliness compliance (within required timeframe)
- Payment amount and adjudication outcome (paid/denied)
- Explanation of Benefits (EOB) or Remittance Advice
- If denied: reason for denial documented
- If adjusted/reprocessed: evidence of adjustment and updated adjudication
- Provider information (billing provider)
- Member information
- Evidence of interest payment, if applicable (for late claims)
- Documentation of claim processing workflow/system notes (if available)

Provider Dispute Resolution

KPIs: PDR001, PDR002, PDR003

Audit Tool: PDR File Review Tool

- PDR request record with tracking number
- Date request received
- Description of information requested
- Requesting entity (e.g., DHCS, CMS, internal)
- Date response submitted
- Evidence of response (submitted documents or correspondence)
- Documentation demonstrating completeness of response
- Evidence of timeliness compliance (within required timeframe)
- Case notes or documentation of request handling process

Transportation — ModivCare

KPIs: DO001

Audit Tool: DO File Tool

- HN completed ModivCare transportation audit tool for the review period
- Evidence HN verified ModivCare sends Transportation Grievance Resolution Letters

- Sample transportation grievance resolution letters with member rights block
- NEMT/NMT performance reports reviewed by HN — on-time, no-show, complaint rates
- Documentation that HN escalated below-threshold ModivCare performance
- Door-to-door assistance requested vs. delivered data from ModivCare
- Transportation Log confirming HN verification was completed for the period

CHPIV — 2025 Risk Assessment

IDENTIFICATION				RISK DESCRIPTION	RISK SCORING					OVERSIGHT ELEMENT MAPPING
Risk ID	Risk Date	Entry Source Type	Source Reference	Risk Description	Member/ Provider Impact	Regulatory Focus (1–3)	Deficiency/Recurrence (1–3)	Composite Score (Auto)	Risk Tier	Oversight Element (Master List Reference)
2025-005	8/21/2025	Notice of Noncompliance — Sent	NONC — Undisclosed PPGs	Undisclosed delegated entities (out-of-area PPGs) processing claims for CHPIV members without plan awareness or approval.	1	2	2	5	MEDIUM	N/A
2025-009	12/26/2025	Delegation Oversight Annual Audit Finding	2025 DO Annual Audit	Appeal acknowledgements not consistently sent within 5 calendar days and/or missing required elements (receipt confirmation/date; contact name/phone/address) and required language assistance taglines/notices.	2	2	1	5	MEDIUM	N/A
2025-014	12/26/2025	Delegation Oversight Annual Audit Finding	2025 DO Annual Audit	0% compliance/evidence of forwarding misdirected claims (or issuing denial with instructions) within 10 working days increases provider abrasion/payment delay and regulatory noncompliance risk.	2	2	1	5	MEDIUM	N/A
2025-015	12/26/2025	Delegation Oversight Annual Audit Finding	2025 DO Annual Audit	Deficiencies in system controls/security & privacy, annual compliance training evidence, UM/BH/Pharmacy oversight controls, and credentialing governance evidence increase enterprise compliance and delegation risk.	2	2	1	5	MEDIUM	N/A
2025-018	12/26/2025	Delegation Oversight Annual Audit Finding	2025 DO Annual Audit	Claims-to-encounter reconciliation key field mismatches (POS/CPT/status) plus 'not all adjudicated claims had corresponding encounters' (0% for that measure) risk DHCS encounter integrity issues and downstream financial/quality impacts.	2	2	1	5	MEDIUM	N/A
2025-019	12/26/2025	Delegation Oversight Annual Audit Finding	2025 DO Annual Audit	Rendering provider documentation often did not match encounter NPI (40%) and some ICD	2	2	1	5	MEDIUM	N/A
2025-021	12/26/2025	Delegation Oversight Annual Audit Finding	2025 DO Annual Audit	Member Services did not consistently document follow-up/referrals (including to Case Management) when needs identified, risking missed care coordination and access/navigation obligations.	2	2	1	5	MEDIUM	N/A
2025-024	12/26/2025	Delegation Oversight Annual Audit Finding	2025 DO Annual Audit	Adverse determination communications did not consistently include clear reviewer identification and direct contact/availability, increasing provider escalation friction and compliance risk.	2	2	1	5	MEDIUM	N/A
2025-037	2/9/2026	Regulatory Audit Finding	2024 DHCS Medical Audit	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.	1	2	1	4	MEDIUM	N/A

Oversight elements added to or modified in the CHPIV Delegation Oversight Monitoring

Functional Area	KPI Type	KPI #
Appeals	Qualitative	**APPEAL-004**
Blood Lead Level	Qualitative	**BLL-001**
Blood Lead Level	Qualitative	**BLL-003**
Blood Lead Level	Qualitative	**BLL-002**
CCS	Qualitative	**CS-001**
CCS	Qualitative	**CS-002**
CCS	Qualitative	**CS-003**
CCS	Qualitative	**CS-004**
CCS	Qualitative	**CS-005**
Delegation Oversight	Qualitative	**DO-009**
Enhanced Care Management	Qualitative	**ECM-010**
Enhanced Care Management	Qualitative	**ECM-001**
Enhanced Care Management	Qualitative	**ECM-001**
Enhanced Care Management	Qualitative	**ECM-002**
Enhanced Care Management	Qualitative	**ECM-003**
Enhanced Care Management	Qualitative	**ECM-004**
Exempt Grievances	Qualitative	**EXG-004**
Exempt Grievances	Qualitative	**EXG-005**
Grievances	Qualitative	**GRV-004**
Grievances	Qualitative	**GRV-006**
Grievances	Qualitative	**GRV-007**
Initial Health Appointment	Qualitative	**IHA-001**
Initial Health Appointment	Qualitative	**IHA-006**
Initial Health Appointment	Qualitative	**IHA-005**
MHSUD-BHT	Qualitative	**BHT-001**
MHSUD-BHT	Qualitative	**BHT-002**
MHSUD-BHT	Qualitative	**BHT-004**
MHSUD-BHT	Qualitative	**BHT-006**
Utilization Management	Qualitative	**UM-010**
Utilization Management	Qualitative	**UM-001**
Utilization Management	Qualitative	**UM-008**
Utilization Management	Qualitative	**UM-009**

CHPIV — 2026 Monitoring Program Crosswalk to 2026 Risk Assessm

Program for 2026, based on risk assessment findings and 2024 DHCS Medical Audit results. Reflects program ev

KPI Name	Change Type
RESOLUTION LETTER CONTENT	New — 2026
BLL SCREENING – INITIAL REQUIREMENTS RM-20	New — 2026
ELEVATED BLL FOLLOW-UP PROTOCOLS	New — 2026
ANTICIPATORY GUIDANCE RM-13	New — 2026
CCS AUTHORIZATION & SERVICE TYPE	New — 2026
CCS REFERRAL & CLOSED-LOOP REFERRAL (CLR)	New — 2026
CCS SERVICE DELIVERY	New — 2026
CCS OUTCOME & COORDINATION (CLR CLOSURE)	New — 2026
CCS DELEGATION & QI	New — 2026
TRANSPORTATION — MOVICARE	New — 2026
AUDIT UNIVERSE & DELEGATION	New — 2026
MEMBER IDENTIFICATION & OUTREACH	New — 2026
CARE ELEMENT 1: MEMBER ID & OUTREACH	New — 2026
CARE ELEMENT 2: COMPREHENSIVE ASSESSMENT	New — 2026
CARE ELEMENT 3: CARE PLAN	New — 2026
CARE ELEMENT 4: CARE COORDINATION	New — 2026
CORRECT CLASSIFICATION OF EXEMPT GRIEVANCE	New — 2026
EXEMPT GRIEVANCE HANDLING AND RESOLUTION	New — 2026
RESOLUTION LETTER CONTENT	New — 2026
TRANSPORTATION GRIEVANCES	New — 2026
DISCRIMINATION GRIEVANCES	New — 2026
IHA COMPLETION & TIMELINESS	New — 2026
OUTREACH & DOCUMENTATION	New — 2026
FOLLOW-UP & REFERRALS	New — 2026
LEVEL OF CARE (LOC) ASSESSMENT	New — 2026
BH TREATMENT PLAN RM-12	New — 2026
TRANSITIONS OF CARE – BH DISCHARGE	New — 2026
OVERSIGHT & DELEGATION RM-34	New — 2026
POST-STABILIZATION	New — 2026
PHYSICIAN REVIEWER QUALIFICATIONS & ACCESSIBILITY	New — 2026
DENIAL LETTER CONTENT	New — 2026
UM CRITERIA APPLICATION & MN RATIONALE	New — 2026

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olution to a risk-based, dynamic oversight model incorporating both quantitative and qualitative elements.

Risk ID	Threshold — Green	Threshold — Yellow	Threshold — Red
2025-008	Pass	—	Fail
2025-029	Pass	—	Fail
2025-029	Pass	—	Fail
2025-030	Pass	—	Fail
2025-011; 2025-027	Pass	—	Fail
2025-011	Pass	—	Fail
2025-011; 2025-027	Pass	—	Fail
2025-011	Pass	—	Fail
2025-027	Pass	—	Fail
2025-025	Pass	—	Fail
2025-012	Pass	—	Fail
2025-012	Pass	—	Fail
2025-033	Pass	—	Fail
2025-033	Pass	—	Fail
2025-033	Pass	—	Fail
2025-033; 2025-038	Pass	—	Fail
2025-035	Pass	—	Fail
2025-035	Pass	—	Fail
2025-020	Pass	—	Fail
2025-026	Pass	—	Fail
2025-035	Pass	—	Fail
2025-013; 2025-028	TBD	TBD	TBD
2025-013; 2025-028	TBD	TBD	TBD
2025-038	Pass	—	Fail
2025-031	Pass	—	Fail
2025-031	Pass	—	Fail
2025-031	Pass	—	Fail
2025-032	Pass	—	Fail
2025-007	Pass	—	Fail
2025-017	Pass	—	Fail
2025-022	Pass	—	Fail
2025-022	Pass	—	Fail

CHPIV — Risk Scoring Guide

FACTOR 1: Member / Provider Impact

Score	Level	Criteria
1 — Low	Low	Areas in which non-compliance may indirectly impact member safety or well-being.
2 — Medium	Medium	Areas in which non-compliance may cause adverse effects on member safety or well-being but are not of such a severe nature that members' immediate health and safety is affected.
3 — High	High	Areas in which noncompliance may result in a member's lack of access to medications and/or services or posed an immediate threat to an enrollee's health and safety.

FACTOR 2: Regulatory Focus

Score	Level	Criteria
1 — Low	Low	Regulators have indicated some attention to the area by including it in routine audit scope and ongoing reporting.
2 — Medium	Medium	Area has been specifically targeted in a DHCS or DMHC focus audit scope, highlighted in recent communications (APLs, policy guides), or included in specific guidance or requirements issued by regulators.
3 — High	High	Regulators have specifically highlighted the area as a top priority, dedicated substantial resources, or targeted this area for scrutiny — or an NONC, enforcement action, or consent agreement exists in this domain.

FACTOR 3: Deficiency / Recurrence		
Score	**Level**	**Criteria**
1 — Minor	**Minor**	An isolated incident or minor deviation from established policies or procedures. The deficiency is non-systemic and can be rectified immediately. No prior linkage in the risk repository.
2 — Moderate	**Moderate**	Non-compliance or gap in processes; identified as a repeat audit finding or linked to one prior closed risk where prior CAP did not achieve durable correction.
3 — Major	**Major**	Significant non-compliance or gap in processes; tied to regulatory NOCs and subject to monetary penalties or sanctions; or linked to multiple prior closed risks / persistent open risk across multiple audit cycles.

COMPOSITE SCORE → RISK TIER		
Score	**Tier**	**Action**
8–9	**CRITICAL**	Continuous monitoring required; priority focus for targeted audit in the following program year.
6–7	**HIGH**	Ongoing monitoring and enhanced audit focus.
4–5	**MEDIUM/LOW**	Standard annual audit cycle; routine monitoring applies.

3 and below	**LOW**	Standard annual audit cycle; routine monitoring applies.

DELEGATION OVERSIGHT

Health Net 2025 Quarter 4 Final Scorecard

Report Issued: March 31st, 2026

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

DELEGATION OVERSIGHT

Health Net 2025 Quarter 4 Final Scorecard

Report Issued: March 31st, 2026

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

HIGH PERFORMING AREAS

- ✓ APPEAL001 Acknowledgement of Appeals Timeliness
- ✓ APPEAL002 Decision of Appeals Timeliness
- ✓ APPEAL004 Member Notification Timeliness
- ✓ COC001 CoC Processing Timeliness
- ✓ CLM001 Claims Payment Timeliness - 30 Calendar Days
- ✓ CLM002 Claims Payment Timeliness - 45 Working Days
- ✓ CLM002 Claims Payment Timeliness - 45 Working Days
- ✓ CLM003 Claims Payment Timeliness - 90 Calendar Days
- ✓ CLM004 Acknowledgement Timeliness
- ✓ CLM005 Misdirected Claims Timeliness
- ✓ CLM006 Timeliness of Interest Payment on Late Claims
- ✓ PDR001 Acknowledgement Timeliness
- ✓ PDR002 Written Determination Timeliness
- ✓ PDR003 Timeliness of Interest Payment on Late PDRs
- ✓ MS001 Calls Answered within 30 seconds
- ✓ MS002 Call Center Abandonment Rate Level
- ✓ MS003 Timely Issuance of Member ID Cards
- ✓ GRV001 Acknowledgement Letter Timeliness
- ✓ GRV002 Grievance Resolution Timeliness

NON-COMPLIANT AREAS

- ☒ UM002 Member Notification Timeliness
- ☒ UM003 Provider Notification Timeliness
- ☒ APPEAL003 Effectuation of Overturned Appeals Timeliness
- ☒ COC002 CoC Notification Timeliness
- ☒ GRV003 Member Notification Timeliness

ACTIONS REQUIRED

FUNCTIONAL AREA	ACTION	DUE DATE
UTILIZATION MANAGEMENT	Corrective Action Plan (CAP)	Submitted
APPEALS	None	N/A
CONTINUITY OF CARE	Corrective Action Plan (CAP)	4/28/2026
CLAIMS	None	N/A
PROVIDER DISPUTE RESOLUTION	None	N/A
MEMBER SERVICES	None	N/A
GRIEVANCES	Corrective Action Plan (CAP)	Submitted

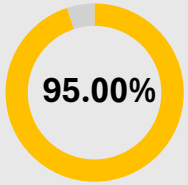
DELEGATION OVERSIGHT

Health Net 2025 Quarter 4 Final Scorecard

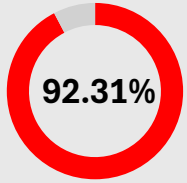
Report Issued: March 31st, 2026

UTILIZATION MANAGEMENT

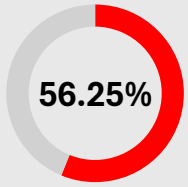
UM001
Decision Timeliness



UM002
Member Notification Timeliness



UM003
Provider Notification Timeliness



KPI #	KPI	Q1	Q2	Q3	Q4
UM001	**Decision Timeliness**	**82%**	**64.25%**	**73%**	**95%**
UM001SP	• Standard Preservice	62%	23.57%	41%	100%
UM001EP	• Expedited Preservice	100%	95.65%	83%	100%
UM001C	• Concurrent	100%	99.88%	99%	75%
UM001R	• Retrospective	100%	100.00%	100%	100%
UM001PS	• Post-Stabilization	NA	NA	NA	NA
UM002	**Member Notification Timeliness**	**99%**	**94.76%**	**95%**	**92%**
UM002SP	• Standard Preservice	100%	98.41%	100%	100%
UM002EP	• Expedited Preservice	0%	0.00%		100%
UM002C	• Concurrent	99%	96.24%	96%	75%
UM002R	• Retrospective	100%	100.00%	95%	100%
UM003	**Provider Notification Timeliness**	**88%**	**76.79%**	**94%**	**56%**
UM003SP	• Standard Preservice	95%	88.25%	97%	20%
UM003EP	• Expedited Preservice	5%	5.00%	79%	50%
UM003C	• Concurrent	86%	69.17%	92%	50%
UM003R	• Retrospective	100%	100.00%	95%	100%

DELEGATION OVERSIGHT

Health Net 2025 Quarter 4 Final Scorecard

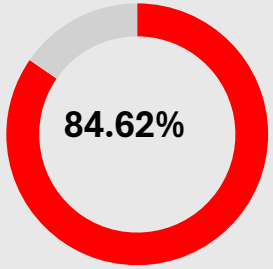
Report Issued: March 31st, 2026

APPEALS

APPEAL001
Acknowledgement of Appeals Timeliness

APPEAL002
Decision of Appeals Timeliness

APPEAL003
Effectuation of Overturned Appeals Timeliness



APPEAL004
Member Notification Timeliness

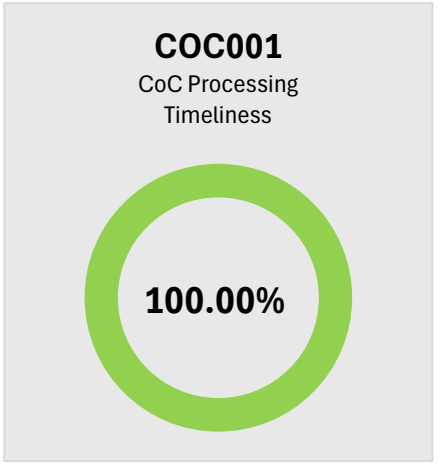
KPI #	KPI	Q1	Q2	Q3	Q4
APPEAL001	**Acknowledgement of Appeals Timeliness**	**100%**	**100.00%**	**100%**	**100%**
APPEAL002	**Decision of Appeals Timeliness**	**100%**	**100.00%**	**100%**	**100%**
APPEAL002S	• Standard	100%	100.00%	100%	100%
APPEAL002E	• Expedited	100%	100.00%	100%	100%
APPEAL003	**Effectuation of Overturned Appeals Timeliness**	**100%**	**100.00%**	**100%**	**85%**
APPEAL004	**Member Notification Timeliness**	**74%**	**95.45%**	**95.45%**	**100%**
APPEAL004S	• Standard	73%	94.74%	100%	100%
APPEAL004E	• Expedited	100%	100.00%	67%	100%

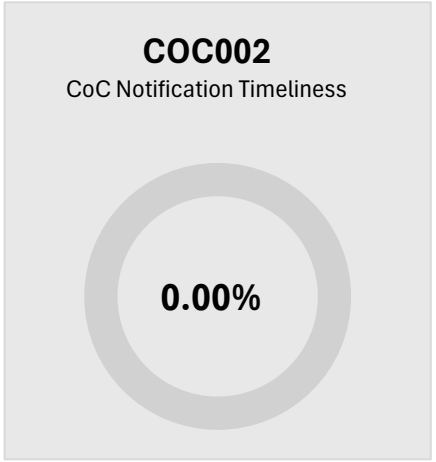
DELEGATION OVERSIGHT

Health Net 2025 Quarter 4 Final Scorecard

Report Issued: March 31st, 2026

CONTINUITY OF CARE





KPI #	KPI	Q1	Q2	Q3	Q4
COC001	**CoC Processing Timeliness**	**100%**	**100.00%**	**100%**	**100%**
COC001N	• Non-Urgent	100%	N/A	100%	100%
COC001I	• Immediate	NA	NA	NA	NA
COC001U	• Urgent	NA	100.00%	NA	NA
COC002	**CoC Notification Timeliness**	**100%**	**100.00%**	**50%**	**0%**
COC002N	• Non-Urgent	100%	#DIV/0!	50%	0%
COC002I	• Immediate	NA	NA	NA	NA
COC002U	• Urgent	NA	100.00%	NA	NA

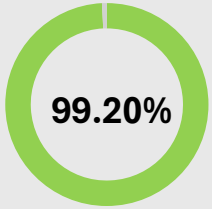
DELEGATION OVERSIGHT

Health Net 2025 Quarter 4 Final Scorecard

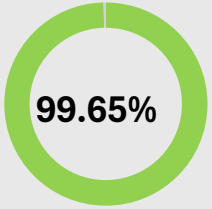
Report Issued: March 31st, 2026

CLAIMS

CLM001
Claims Payment Timeliness - 30 Calendar Days

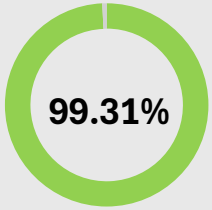


CLM002
Claims Payment Timeliness - 45 Working Days

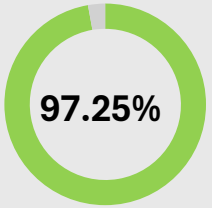


CLM003
Claims Payment Timeliness - 90 Calendar Days

CLM004
Acknowledgement Timeliness



CLM005
Misdirected Claims Timeliness



CLM006
Timeliness of Interest Payment on Late Claims

KPI #	KPI	Q1	Q2	Q3	Q4
CLM001	**Claims Payment Timeliness - 30 Calendar Days**	**99.04%**	**96.49%**	**98.92%**	**99.20%**
CLM002	**Claims Payment Timeliness - 45 Calendar Days**	**99.94%**	**99.80%**	**99.64%**	**99.65%**
CLM003	**Claims Payment Timeliness - 90 Calendar Days**	**100%**	**100.00%**	**100%**	**100%**
CLM004	**Acknowledgement Timeframes**	**100%**	**99.66%**	**99.68%**	**99.31%**
CLM004E	• Acknowledgement Timeliness - Electronic	100%	100%	100%	100%
CLM004P	• Acknowledgement Timeliness - Paper	99.92%	83.62%	85.97%	77.27%
CLM005	**Misdirected Claims Timeliness**	**99.11%**	**99.13%**	**99.61%**	**97.25%**
CLM006	**Timeliness of Interest Payment on Late Claims**	**100%**	**0.00%**	**100%**	**100%**

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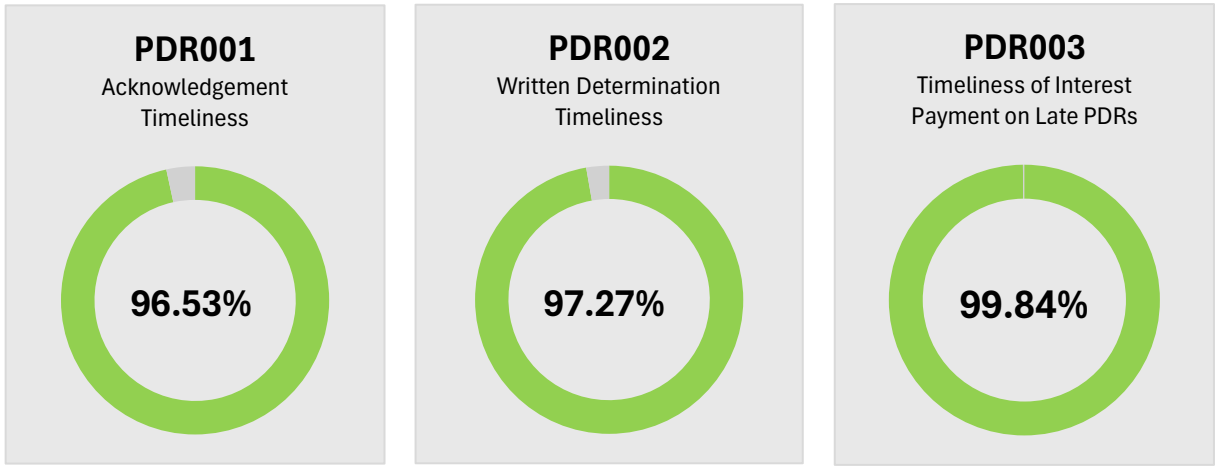
PROVIDER DISPUTE RESOLUTION



KPI #	KPI	Q1	Q2	Q3	Q4
PDR001	**Acknowledgement Timeliness**	**98%**	**97.85%**	**100%**	**96.53%**
PDR001E	• Acknowledgement Timeliness - Electronic	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
PDR001P	• Acknowledgement Timeliness - Paper	98%	97.85%	100%	96.53%
PDR002	**Written Determination Timeliness**	**99%**	**99.30%**	**99%**	**97.27%**
PDR003	**Timeliness of Interest Payment on Late PDRs**	**100%**	**100.00%**	**100%**	**99.84%**

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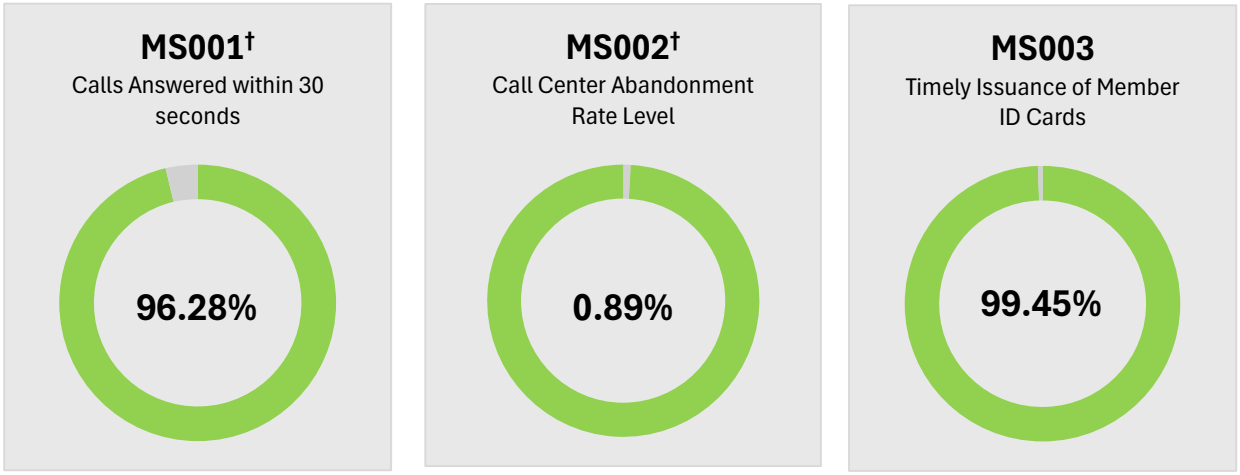
MEMBER SERVICES



KPI #	KPI	Q1	Q2	Q3	Q4
MS001	Calls Answered within 30 seconds	97.25%	97.09%	97.07%	96.28%
MS002	Call Center Abandonment Rate Level	0.64%	1.04%	1.32%	0.89%
MS003	Timely Issuance of Member ID Cards	99.52%	99.73%	99.29%	99.45%

†Self-reported compliance rate

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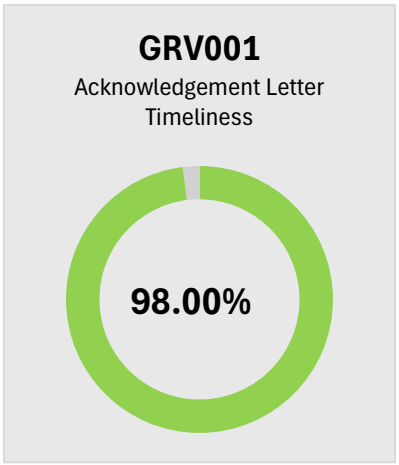
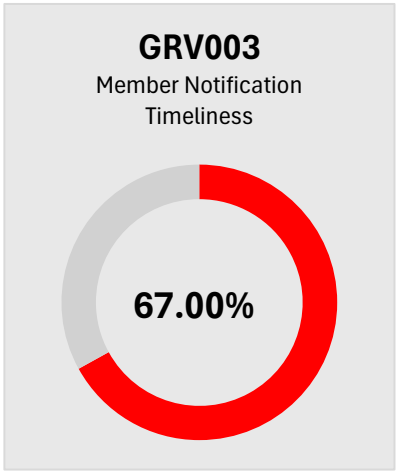
GRIEVANCES





KPI #	KPI	Q1	Q2	Q3	Q4
GRV001	**Acknowledgement Letter Timeliness**	**100%**	**96.43%**	**97.09%**	**98.00%**
GRV002	**Grievance Resolution Timeliness**	**100%**	**100.00%**	**100%**	**100%**
GRV002S	• Standard	100%	100.00%	100%	100%
GRV002E	• Expedited	100%	100.00%	100%	100%
GRV003	**Member Notification Timeliness**	**70.80%**	**64.70%**	**36.36%**	**67.00%**
GRV003S	• Standard	72.10%	65.20%	34.95%	100%
GRV003E	• Expedited	33.30%	50.00%	57.14%	33.00%

Appendix 1 - KPI Details

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

Functional Area	KPI Type	KPI	Thresholds			Log
			Green	Yellow	Red	
Utilization Management (UM)	Quantitative	UM001 Decision Timeliness	>96%	95-96%	<95%	UM Authorizations Log
Utilization Management (UM)	Quantitative	UM002 Member Notification Timeliness	>96%	95-96%	<95%	UM Authorizations Log
Utilization Management (UM)	Quantitative	UM003 Provider Notification Timeliness	>96%	95-96%	<95%	UM Authorizations Log
Appeals	Quantitative	APPEAL001 Timely Acknowledgement of Appeals	>96%	95-96%	<95%	Appeal Log
Appeals	Quantitative	APPEAL002 Timely Decision of Appeals	>96%	95-96%	<95%	Appeal Log
Appeals	Quantitative	APPEAL003 Timely Effectuation of Overturned Appeals	>96%	95-96%	<95%	Appeal Log
Appeals	Quantitative	APPEAL004 Member Notification Timeliness	>96%	95-96%	<95%	Appeal Log
Continuity of Care	Quantitative	COC001 CoC Processing Timeliness	>96%	95-96%	<95%	CoC Log
Continuity of Care	Quantitative	COC002 CoC Notification Timeliness	>96%	95-96%	<95%	CoC Log
Claims	Quantitative	CLM001 Claims Payment Timeliness - 30 Calendar Days	>91%	90-91%	<90%	Claims Log
Claims	Quantitative	CLM002 Claims Payment Timeliness - 45 Working Days	>96%	95-96%	<95%	Claims Log
Claims	Quantitative	CLM003 Claims Payment Timeliness - 90 Calendar Days	>99%	99%	>99%	Claims Log
Claims	Quantitative	CLM004 Claims Acknowledgement Timeliness	>96%	95-96%	<95%	Claims Log

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Functional Area	KPI Type	KPI	Thresholds			Log
			Green	Yellow	Red	
Claims	Quantitative	CLM005 Misdirected Claims Timeliness	>96%	95-96%	<95%	Claims Log
Claims	Quantitative	CLM006 Timely Interest Payment on Late Claims	>96%	95-96%	<95%	Claims Log
Provider Dispute Resolution (PDR)	Quantitative	PDR001 PDR Acknowledgement Timeliness	>96%	95-96%	<95%	PDR Log
Provider Dispute Resolution (PDR)	Quantitative	PDR002 PDR Written Determination Timeliness	>96%	95-96%	<95%	PDR Log
Provider Dispute Resolution (PDR)	Quantitative	PDR003 Timeliness of Interest Payment on Late PDRs	>96%	95-96%	<95%	PDR Log
Member Services	Quantitative	MS001 Calls Answered within 30 seconds	>90%	80-90%	<80%	Call Center SLA Log
Member Services	Quantitative	MS002 Call Center Abandonment Rate Level	less than 5%	5%	>5%	Call Center SLA Log
Member Services	Quantitative	MS003 Timely Issuance of Member ID cards	>98%	95-98%	<95%	Call Center SLA Log
Grievances	Quantitative	GRV001 Timely Acknowledgement Letter	>96%	95-96%	<95%	Grievance Log
Grievances	Quantitative	GRV002 Timely Grievance Resolution	>96%	95-96%	<95%	Grievance Call Log
Grievances	Quantitative	GRV003 Member Notification Timeliness	>96%	95-96%	<95%	Grievance Log