IMPERIAL COUNTY
Local Health Authority Commission

Regulatory Compliance Oversight Committee of the Commission

AGENDA

Date/Time: August 12, 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	
Cynthia Mesa	Interim Chief Compliance Officer	
Dr. Gordon Arakawa	Chief Medical Officer	
David Wilson	Chief Financial Officer	
Julia Hutchins	Chief Operating Officer	
Alfredo Flores	Interim Director of Compliance	
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 April 29, 2026 — *Chair*
6. Chairperson's Report
7. Chief Compliance Officer Report — Cynthia Mesa, *Interim Chief Compliance Officer*
    a. Approve New a*nd* Updated Policies & Procedures *(Exhibit A)* — Cynthia Mesa, *Interim Chief Compliance Officer*
    b. Approval Public and Policy Advisory *(Exhibit B)* — Cynthia Mesa, *Interim Chief Compliance Officer*
    c. Approval New Compliance Program *(Exhibit C)* — Cynthia Mesa, *Interim Chief Compliance Officer*
    d. Fraud and Abuse Q2 Summary — Alfredo Flores, *Interim Director of Compliance*
        i. Fraud Waste and Abuse Cases
        ii. Case Trends
        iii. Aging
        iv. FPO
    e. Privacy Incidents — Alfredo Flores, *Interim Director of Compliance*
        i. Medi-Cal

f. Discrimination Grievances	Alfredo Flores, *Interim Director of Compliance*
g. Corrective Action Plan i. DMHC (Grievance) ii. DHCS 2024	Krisit Wilkerson, *Internal and Delegation Oversight Manager*
h. Medi-Cal Quarterly Activity *(Exhibit D and E)*	Krisit Wilkerson, *Internal and Delegation Oversight Manager*
i. D-SNP Quarterly Activity *(Exhibit F through J)*	Krisit Wilkerson, *Internal and Delegation Oversight Manager*
j. Delegate Open CAPs	Krisit Wilkerson, *Internal and Delegation Oversight Manager*

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: April 29th, 2026, 12:00 PM – 1:00 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	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	☒
Ricki Collins	Clinical Compliance Auditor	☒
Lulu Gallegos	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	☒
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 Palo Velez Second by Dr. Carlos Ramirez
Public Comment Dr. Allan Wu, Chair	A public request was made for background information on the Salton Sea to support the development of a video on related issues.	Dr. Allan Wu volunteered to provide additional information following the committee meeting. Lawrence Lewis also offered to assist with questions and help direct the requestor to the appropriate point of contact.
Chairperson Dr. Allan Wu, Chair	A. Approval of Minutes from December 11th, 2025.	Motion to approve by Pablo Velez Second by Lee Hindman
Chairperson's Report Dr. Allan Wu, Chair	No report given.	
Chief Compliance Officer Report Elysse Tarabola, Chief Compliance Officer	Elysse Tarabola stated that several items were being presented to the committee for approval. The first item included a batch of policies that had been previously reviewed and approved by the internal Compliance and Policy Committee. These policies were brought forward to the RCOC for final approval.	

AGENDA ITEM/ PRESENTER	MOTION/MAJOR DISCUSSIONS	ACTIONS TAKEN
a. Approve New and Updated Policies & Procedures Chelsea Hardy, Executive Director of Compliance	a. Approve New and Updated Policies & Procedures Chelsea Hardy presented a total of 17 policies and procedures for committee approval and one policy for retirement, the majority of which were submitted as part of the annual review process. Most policies reviewed did not include substantive changes. Policy GA-001 (Grievance Process) was updated to strengthen and clarify procedures related to discrimination grievances, including reporting requirements and timelines to the Department of Health Care Services (DHCS). These revisions were made in response to findings identified during a recent DHCS audit. One Human Resources policy, HR-004 (After Hours Communication), was proposed for retirement. This policy was originally implemented as part of a short-term trial and is no longer needed. All policies presented have been previously reviewed and approved by the internal Compliance and Policy Committee. Mrs. Hardy requested for a motion to approve the following policies: • **CMP-004** – Implementation of Regulatory Notifications • **CMP-005** – Confidentiality and Member Privacy • **CMP-006** – Compliance Training • **EXC-001**– Conflict of Interest Avoidance • **EXC-002** – Delegation Authority • **GA-001** – Grievance Process • **HR-005** – New Positions • **HR-006** – Diversity, Equity, & Inclusion • **HR-007** – EEO Affirmative Action • **HR-008** – Organizational Readiness • **HR-009** – Remote Work • **HR-010** – Promotions • **HR-012** – Employee Recognition • **HR-004** – After Hours Communication *(Retire)* • **FIN-001**- Delegated Provider Financial Solvency Oversight Process • **FIN-002** – Delegated Provider Financial Solvency Corrective Action Plan Process • **FIN-003** – Medical Loss Requirements for Subcontractors • **FIN-006** – Investment Policy	Motion to approve by Pablo Velez Second by Dr. Carlos Ramirez
b. Risk Management Program & Audit Monitoring Program Elysse Tarabola, Chief Compliance Officer	Mrs. Tarabola stated that two new programs were being presented to the committee for review and approval: the Risk Management Program and the Audit and Monitoring Program. While ongoing oversight activities such as monthly and quarterly monitoring and annual audits have already been in place, these efforts are now being formalized into a comprehensive Audit and Monitoring Program. This program standardizes the approach across all lines of business, including defining what is audited, audit frequency, and ensuring alignment with risk levels. High and critical risks are monitored more frequently, while medium and low risks are reviewed at least annually. In addition, the Risk Management Program was introduced as a formal framework to identify, assess, and track organizational risks. The program outlines processes for risk identification, scoring, and tracking. A centralized risk repository has also been established to consolidate all risks into a single, live tracking system. This repository supports oversight by ensuring risks are actively managed, corrective action plans (CAPs) are tracked, and effectiveness is evaluated through to resolution. Mrs. Tarabola presented a visual overview of the risk management process. She explained that once a risk is identified, it is entered into the centralized risk repository and scored based on established criteria. These risk scores feed into the annual risk assessment, providing a snapshot of low-, medium-, and high-risk areas across the organization. The annual risk assessment is then used to inform and drive the following year's Audit and Monitoring Program, including prioritization of focus areas and allocation of resources. Higher-risk areas are monitored more frequently to ensure appropriate oversight. CAPs are integrated into the process, ensuring that identified deficiencies are tracked through resolution and formally closed. Additionally, the Risk Management Program and repository generate ongoing reports and metrics. These will be shared with the committee on a regular basis to provide visibility into risk trends, monitoring activities, and overall program effectiveness.	Motion to approve by Lee Hindman Second by Dr. Carlos Ramirez
c. 2025 Risk Assessment Elysse Tarabola, Chief Compliance Officer	Mrs. Tarabola presented the starting point of the risk scoring methodology, explaining that it is designed to prioritize areas of focus and determine which risks require more frequent monitoring. She outlined three key factors used in the scoring process: (1) impact to members or providers, (2) level of regulatory focus, and (3) the presence of an existing or recurring deficiency. She noted that, collectively, these factors help identify which risks	Motion to approve by Lee Hindman Second by Dr. Carlos Ramirez

AGENDA ITEM/ PRESENTER	MOTION/MAJOR DISCUSSIONS	ACTIONS TAKEN
	should be monitored more frequently. There were extensive internal discussions regarding the selection of these factors. The proposed methodology is being presented to the RCOC for review, and the team welcomes feedback and is open to refining the factors as needed. Pablo Velez inquired whether the approach includes both ongoing monitoring and audits. Mrs. Tarabola clarified that the program incorporates ongoing monitoring in addition to annual audits. While all requirements are reviewed at least annually, the risk scoring methodology helps determine which areas should be monitored on a monthly or quarterly basis to support a risk-based oversight strategy and ensure focus on the most critical areas. Cynthia Mesa added that the risk-based approach enhances visibility into areas under review and ensures oversight efforts are focused where they are most needed. She explained that the annual audit serves as the baseline for all delegates. When a new delegate is onboarded, an initial annual audit is conducted, and subsequent monitoring is informed by prior performance and identified risks. This approach allows the organization to allocate resources more effectively by increasing oversight in higher-risk areas, particularly those that may pose regulatory risk. Ms. Mesa emphasized that transitioning to a risk-based program ensures monitoring activities are purposeful and targeted, rather than conducting audits solely for compliance purposes, ultimately making the process more meaningful and effective. Mrs. Tarabola explained that, as part of the Audit and Monitoring Program, a comprehensive master list of all oversight elements was developed using regulatory and contractual requirements. She acknowledged and thanked Mrs. Mesa's team for their efforts in compiling and crosswalking all requirements, ensuring completeness and eliminating duplication. The master list includes quantitative reviews, such as data analysis to assess timeliness and performance metrics, as well as case file reviews, including member records, call logs, and grievance resolution letters. She also highlighted that policy reviews are conducted to ensure alignment with all regulatory requirements. She further explained that this oversight matrix is now aligned with the risk management framework, allowing identified risks to be directly tied to specific monitoring activities. This integration supports the development of a structured, risk-based annual monitoring plan that can be clearly presented and tracked. Mrs. Tarabola emphasized that the program is risk-driven and focuses on areas identified as high or critical through the annual risk assessment. She also noted that the program includes a methodology for formally accepting and documenting risk when appropriate. The high and critical risks identified for 2025 have been incorporated into the 2026 monitoring program. As part of this effort, two new Key Performance Indicators (KPIs) have been introduced, many of which involve case file reviews to be conducted by nurse auditors on a monthly and quarterly basis. Mrs. Tarabola requested a motion from the committee to approve the new two programs and the KPIs for 2026.	
d. Discrimination Grievances Alfredo Flores, Compliance Manger	Alfredo Flores shared that a recent DHCS audit identified a finding related to untimely submission of discrimination grievances to the Office of Civil Rights. To address this, a new process has been implemented in coordination with Health Net, assigning the internal compliance team responsibility for submitting cases to DHCS within the required 10 calendar days. The updated workflow includes: Health Net resolving the case and sending the resolution letter to the member, compiling and uploading the case within 5 days while notifying compliance, and the compliance team reviewing and submitting to DHCS. A tracking system has also been implemented to monitor timeliness. For Q1 2026, there were 4 discrimination grievance cases; 3 were submitted on time and 1 was late due to a communication breakdown when Health Net failed to notify the compliance team after uploading the case. The case was identified on day 15 and submitted immediately. To prevent recurrence, Health Net will now directly notify the team upon upload, and the compliance team will conduct daily folder checks. In response to questions, Mr. Flores stated there have been no repercussions for late submissions. He also confirmed that procedures are in place to ensure continuity, including a documented desktop procedure, daily monitoring by a compliance advisor, weekly oversight by a compliance manager, and executive director review. Ms. Mesa added that additional tracking measures through file reviews of appeals and grievances are used to cross-reference and ensure submissions are completed.	

AGENDA ITEM/ PRESENTER	MOTION/MAJOR DISCUSSIONS	ACTIONS TAKEN
e. Fraud and Abuse Q4 2025 -Q1 2026 Summary i. Fraud Waste and Abuse Cases ii. Case Trends Alfredo Flores, Compliance Manager	Mr. Flores reported that CHPIV received a total of eight cases from Q4 2025 through Q1 2026, all of which remain under investigation. One case was submitted untimely due to the initial submission being sent to an incorrect email group, resulting in a delay. The cases are broken down by: Subject Type: • 3 cases related to provider offices • 5 cases related to lab Case Type: • 63.3% Billing for services not rendered • 36.4% Billing fraud	
f. Corrective Actions i. DHCS Audit ii. DO CAP Summary Chelsea Hardy, Executive Director of Compliance	Mrs. Hardy stated that following the 2024 audit by the Department of Health Care Services, the findings report and formal Corrective Action Plan (CAP) request were received. The team collaborated with Health Net and internal staff to develop CAPs, which were submitted on March 20. Ongoing coordination continues to ensure implementation, with the next CAP update due this Friday. DHCS will maintain monthly follow-ups, and updates will be provided as required. Regarding key CAP items, DHCS requested an accelerated hiring timeline for the Health Equity Officer, expressing concern with the original April 1, 2027 target. DHCS now requires a revised timeline with the position to be filled by September 1, 2026. DHCS also requested a short-term solution for referral tracking to ensure immediate action while long-term fixes are developed. Additionally, clarification was requested on the audit and monitoring program, along with updates on the timeline for the next KPI scorecard reflecting audit findings.	
g. Monitoring Results i. Medi-Cal Cynthia Messa, Senior Director of Internal and Delegation Oversight Eduardo Ron-Lopez, Compliance Auditor	Mrs. Mesa reported on delegation oversight CAP activities, noting multiple ongoing audits within the monitoring program and 14 open CAPs currently in progress. Six CAPs have been closed, confirming compliance with state and federal requirements, while the remaining CAPs are being actively addressed with appropriate corrective actions. The team continues close follow-up, with the next submission upcoming, and both clinical and non-clinical auditors reviewing for accuracy and completeness. Eduardo Ron-Lopez shared that for Medi-Cal utilization management, ongoing data issues with logs have made them unreliable, requiring a shift to case file reviews. While there has been improvement in decision timeliness, performance appears inconsistent across areas. Mrs. Mesa added that notification timeliness reflects initial decisions (fax or phone), and teams have been focusing on meeting required turnaround times (5 days standard, 72 hours urgent), though this may mask underlying issues given smaller volume compared to the overall health plan. Mr. Velez inquired about performance goals, and Mrs. Mesa clarified that the standard is 100% compliance. Mr. Ron-Lopez further noted that appeals effectuation timeliness is at 85%, based on a small sample (11 of 13 compliant cases), and member notification timeliness is improving. For Continuity of Care, notification timeliness failures over two consecutive quarters triggered a CAP, largely due to small sample size. Claims, PDR, and Member Services remain high-performing areas, while grievance member notification continues to be a risk area. Overall, new logs are being implemented, and there will be a shift toward more qualitative, case file-based review measures beginning in the next quarter.	
g. Monitoring Results i. D-SNP ii. DV Results Cynthia Mesa, Senior Director of Internal and Delegation Oversight Eduardo Ron-Lopez, Compliance Auditor	Community Health Group's pre-delegation audit identified deficiencies in policies; however, CHG has since remediated the issues and no further action is required, as all CAPs have been closed. Some open items remain with PPCIPA, ICPMG, CCIPA, and PHCMG, and meetings were held this week to review CAPs. These items are low risk and mainly require clarification or documentation. A post-implementation audit will be conducted in a few months, with annual audits planned thereafter. CHG will submit monitoring universes quarterly, while other IPAs will submit monthly. Data validation with delegates is currently underway; CHG has submitted its universes, which are under review. The Q1 2026 scorecard for this line of business will be issued by the end of May. CCIPA and ICPMG failed one metric related to authorizations and were required to submit revised logs, with a second round of data validation scheduled for the following week.	

	Mrs. Tarabola acknowledged and applauded Mrs. Mesa and her team for their efforts in implementing these processes. She inquired on feedback for improving future RCOC committee reporting. Dr. Carlos Ramirez commented that the meeting and presentation were clear and well done.	
Adjourn to Closed Session Dr. Allan Wu, Chair	The Committee did not convene in closed session. No items were discussed.	
Reconvene in Open Session Dr. Allan Wu, Chair	No closed session was held; therefore, there is nothing to report.	
Adjournment Dr. Allan Wu, Chair	Meeting was adjourned at 01:00 pm.	

Community Health Plan
OF IMPERIAL VALLEY

Regulatory Compliance & Oversight Committee

Quarter 3, 2026

August 12, 2026

Agenda

ACTION ITEMS – Review and request approval of the following:

- Quarter 1 CPC Minutes
- Updated and New Policies and Procedures
- Public Provider Advisory Committee
- New Compliance Program

INFORMATIONAL

- Fraud and Abuse
- Privacy Incidents
- Discrimination Grievances
- Corrective Action Plans
- Medi-Cal Quarterly Activity
- D-SNP Quarterly Activity
- Delegate Open CAPs

ACTION ITEMS

Updated and New Policies and Procedures

Updated P&Ps

See Exhibit A – Policy Packet

Policy Name	Department	Functional Area	Summary of Changes
EXC-001 Conflict of Interest Avoidance	Executive Services	Executive Services	Ad-hoc Updates
IT-002 After-Hours Computer Shutdown	Information Technology	Information Technology	Annual Review
QM-002 Quality Improvement Health Equity Committee	Health Services	Quality Management	Annual Review

Community Health Plan OF IMPERIAL VALLEY

Public Policy Advisory Committee

See Exhibit B – Policy Packet

New Compliance Program

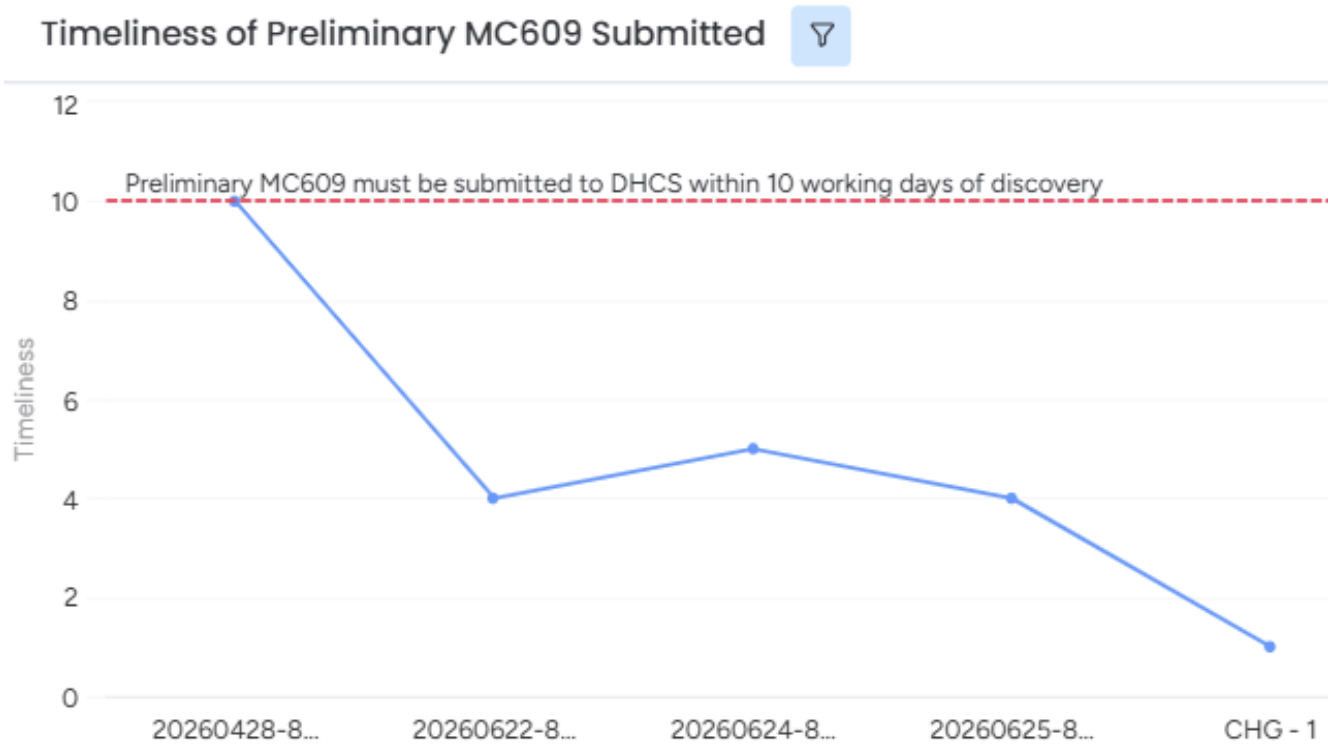
See Exhibit C – Policy Packet

INFORMATIONAL

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.



5 cases received in Q2 2026

Health Net

4 cases

4 remain under investigation

CHG

1 case

1 case closed

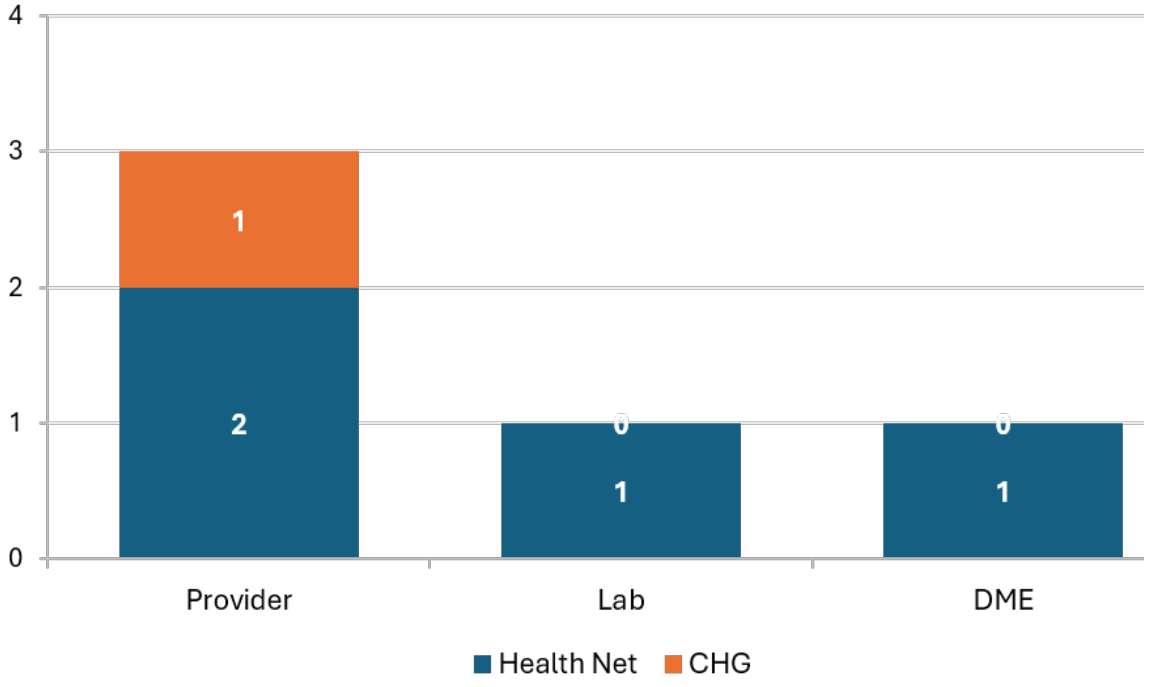
✓ **All MC609 cases were submitted timely**

Community Health Plan OF IMPERIAL VALLEY

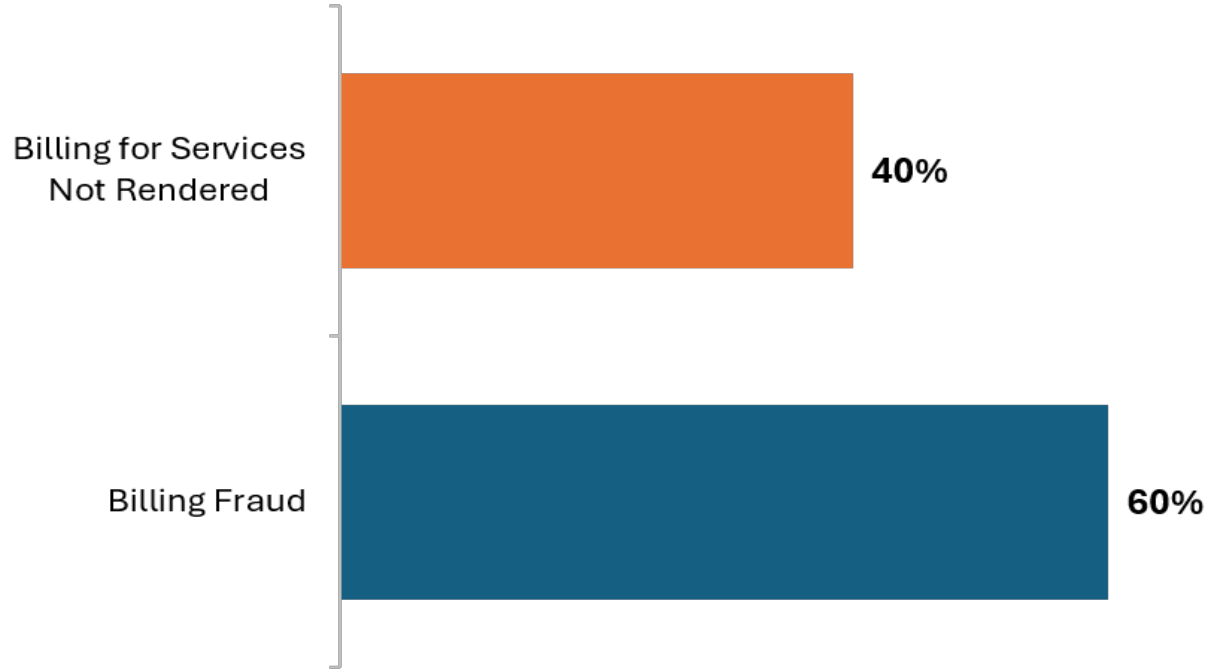
Potential Fraud and Abuse Case Trends

Q2 2026: 5 total cases received - 1 for Laboratory, 3 for provider, and 1 DME.
Primary trend: **Billing Fraud**

By Subject Type



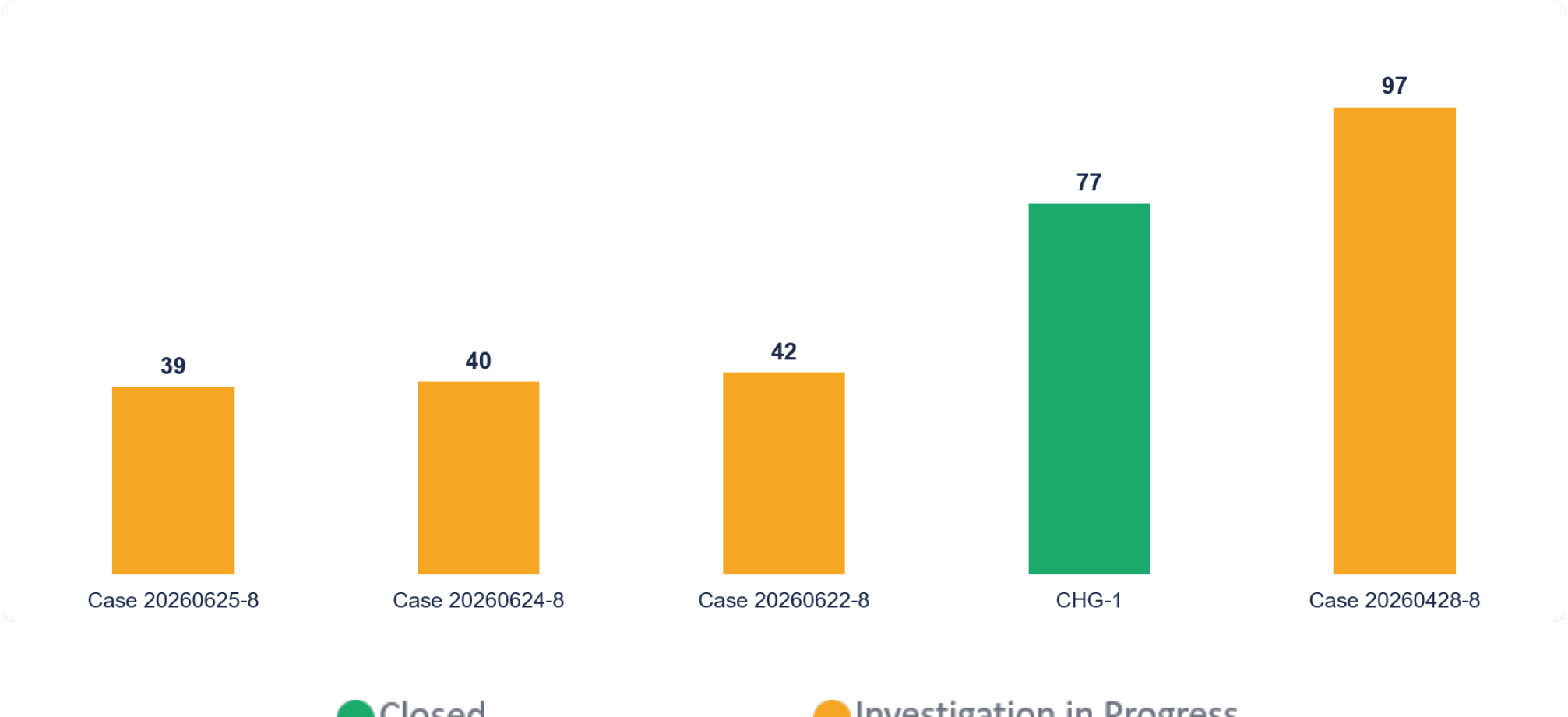
By Case Type



Community Health Plan of Imperial Valley

Potential Fraud and Abuse Case Aging

Oldest open case has been under investigation for **97 days**

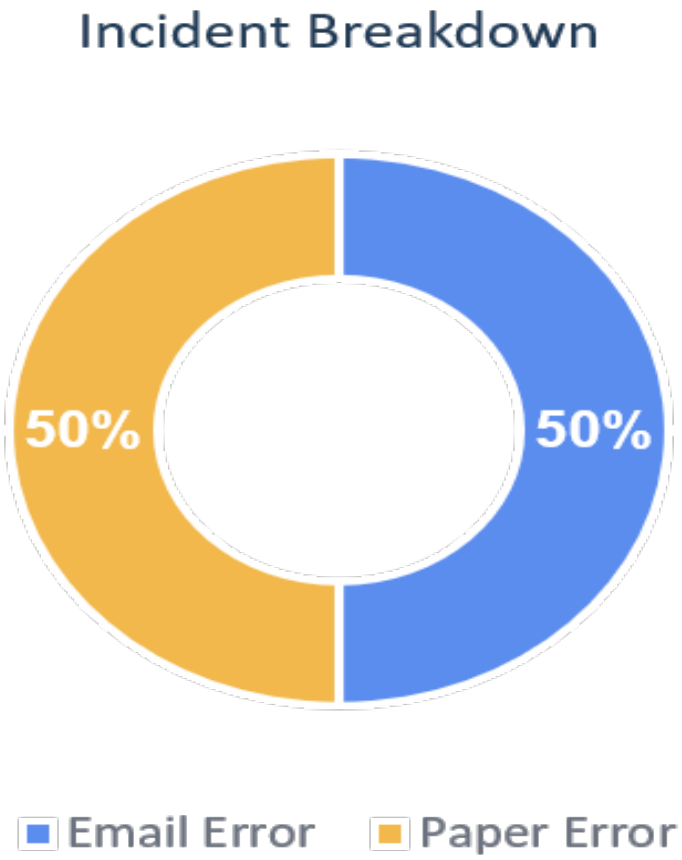


Community Health Plan OF IMPERIAL VALLEY

Privacy Incidents

Privacy Incidents/Breaches

PIR is a required notification to DHCS when we become aware of a potential privacy or security incident involving member data.



Q2 2026 Summary

- 2 privacy incident cases received
- 0 confirmed breaches

Incident Breakdown:

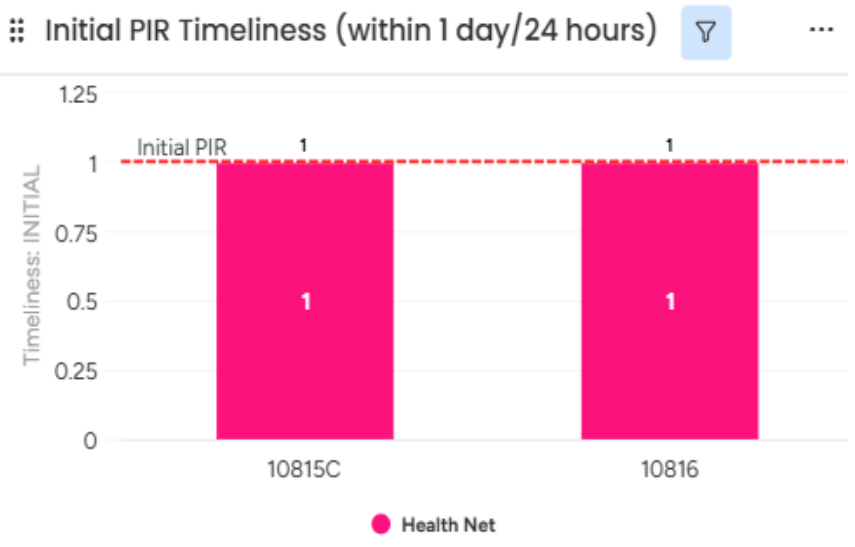
- Email errors – 1 case (50%)
- Paper errors – 1 case (50%)

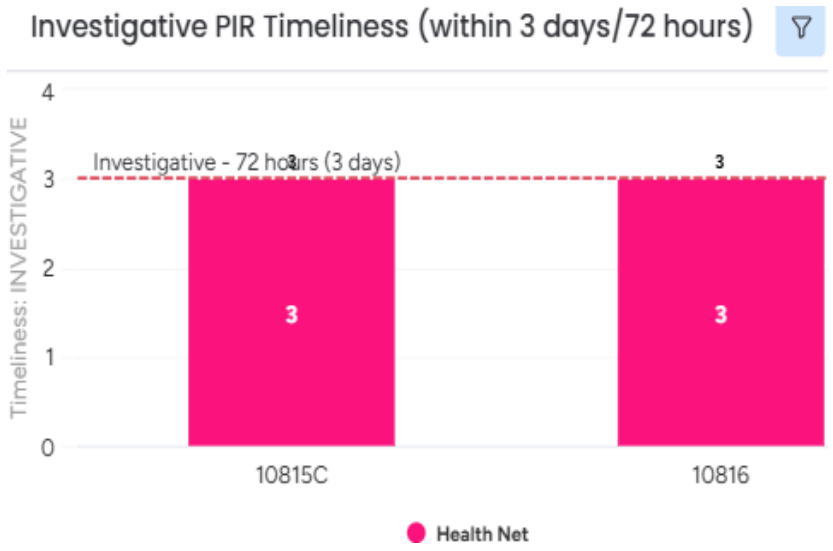
Community Health Plan OF IMPERIAL VALLEY

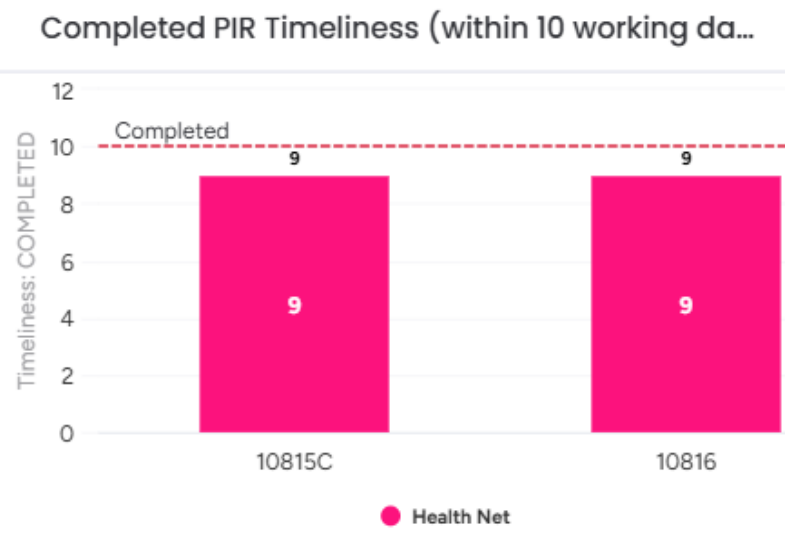
Timely Reporting to DHCS Q2 2026

Q2 2026 • Initial PIR (24 hrs) • Investigative PIR (72 hrs) • Completed PIR (10 working days)

All cases have been submitted timely for Q2 2026



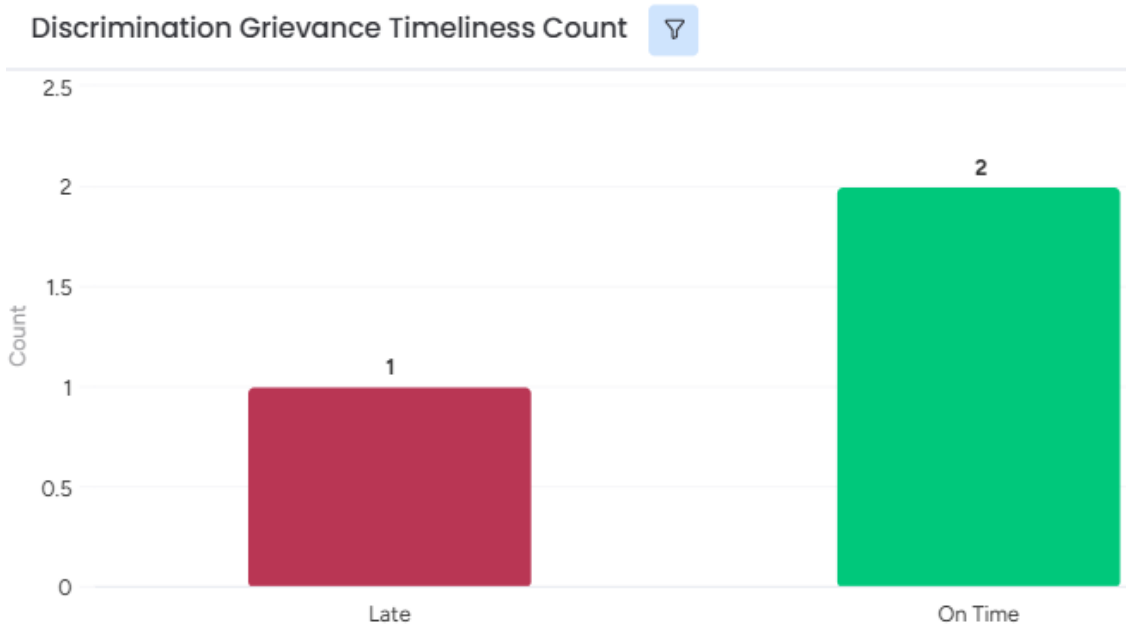




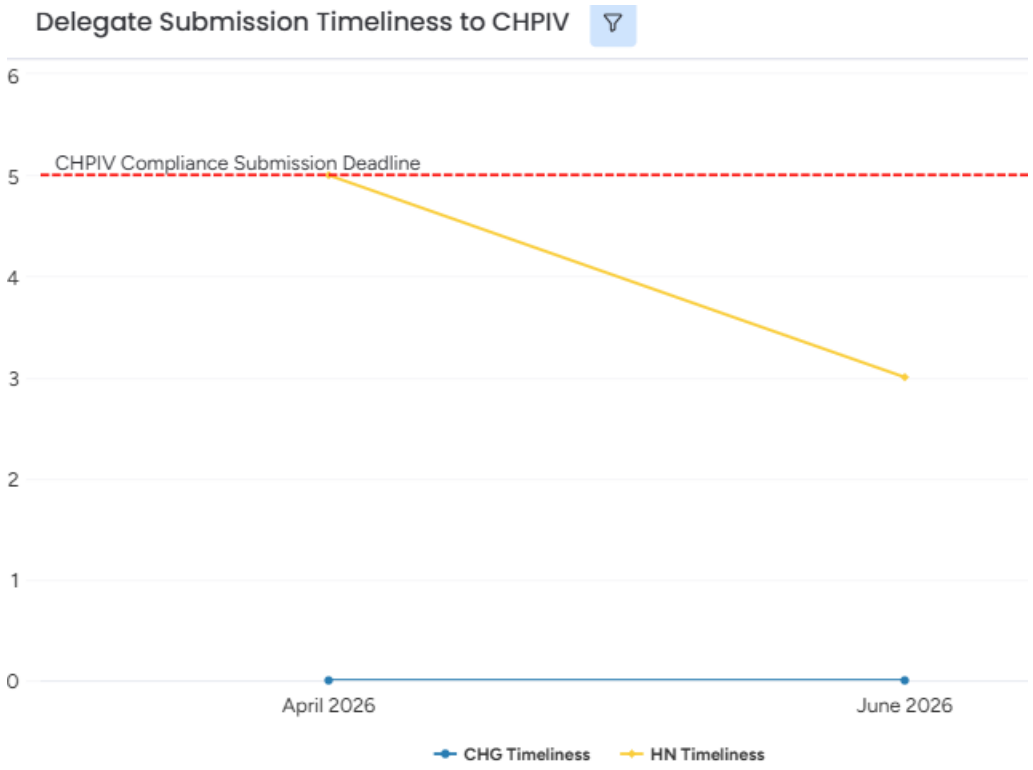
Community Health Plan OF IMPERIAL VALLEY

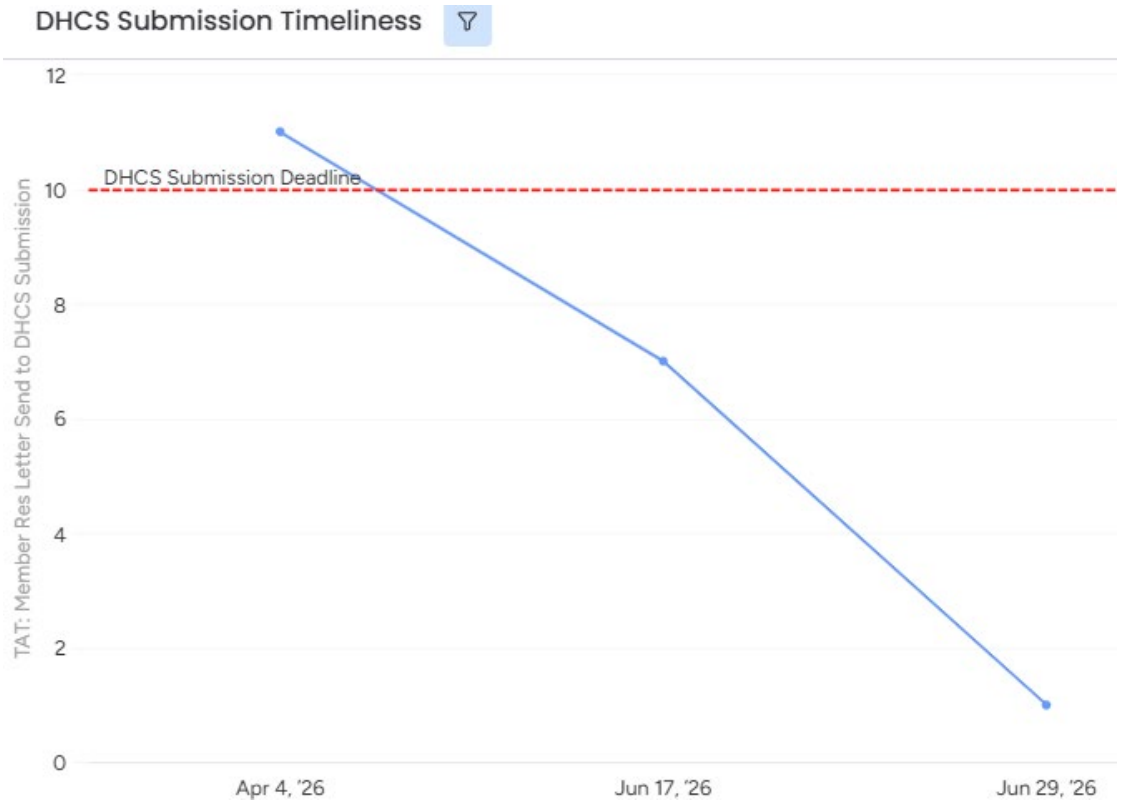
Discrimination Grievances

Discrimination Grievances Quarter 2 2026



Discrimination Grievances Quarter 2 2026 Timeliness





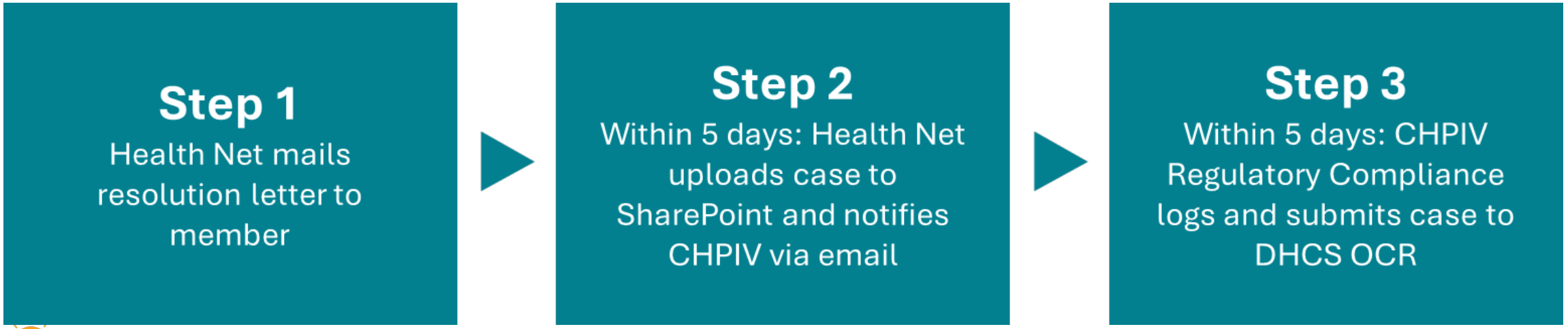
Community Health Plan OF IMPERIAL VALLEY

Corrective Action Plans

DMHC Grievance

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

DHCS 2024

ID	Name	Status
2.6.1	ECM	Pending completion of evidence
IHA	Initial Health Assessment	The pilot program is in the implementation phase, with provider onboarding, gift card allocation, and monitoring activities underway
1.5.1	Referral Tracking Mechanism	Have not received sufficient documentation to validate the processes. Status update due 14 Aug

Community Health Plan OF IMPERIAL VALLEY

Medi-Cal
Quarterly Activity

See Exhibit D – Medi-Cal Activity

Review Type Methodology

Each audit item follows one of three review paths based on its requirements

Review Type	Process	What It Certifies
Data Validation	Receive incoming log, select samples, conduct system review of selected samples	Certifies calculations through the log
File Review	Receive incoming log, select samples, conduct file review of selected samples	Certifies results through file review
Both	Receive incoming log, select samples, conduct file review of selected samples	Certifies applicable metrics from the log and validates remaining elements through file review

See Exhibit D – Medi-Cal Activity

Utilization Management

KPI #	KPI Name	File Review Only	Q1 2026 Result
UM001	Physician Reviewer Qualifications & Accessibility	✓ **File Review**	100%
UM005	Decision Timeliness	✓ **File Review**	99.15%
UM006	Notification Timeliness	✓ **File Review**	98.31%
UM008	Denial Letter Content & Compliance	✓ **File Review**	95.93%
UM009	UM Criteria Application & Medical Necessity Rationale	✓ **File Review**	98.89%
UM010	Post-Stabilization	✓ **File Review**	N/A

See Exhibit D – Medi-Cal Activity

Appeals

KPI #	KPI Name	DV Only	File Review Only	BOTH	Q1 2026 Result
APPEAL-001	Acknowledgement Letter Timeliness	✓ **DV**			100%
APPEAL-002	Resolution Timeliness			✓ **BOTH**	100%
APPEAL-003	Resolution Letter Content		✓ **File Review**		91.09%

See Exhibit D – Medi-Cal Activity

Grievances

KPI #	KPI Name	DV Only	File Review Only	BOTH	Q1 2026 Result
GRV-001	Acknowledgment Letter Timeliness	✓ **DV**			100.0%
GRV-003	Grievance Resolution Timeliness			✓ **BOTH**	96.6%
GRV-004	Resolution Letter Content		✓ **File Review**		91.1%
GRV-006	Transportation Grievances		✓ **File Review**		80.0.%
GRV-007	Discrimination Grievances		✓ **File Review**		40.0%

GRV-007: Of the 5 cases reviewed, 3 were found to be non-compliant, resulting in a 40% compliance rate (2/5 compliant).

Exempt Grievances

See Exhibit D – Medi-Cal Activity

KPI #	KPI Name	DV Only	File Review Only	BOTH	Q1 2026 Result
EXG-004	Correct Classification of Exempt Grievance		✓ **File Review**		100%
EXG-005	Exempt Grievance Handling and Resolution			✓ **BOTH**	100%

See Exhibit D – Medi-Cal Activity

Behavioral Health Treatment / MHSUD (BHT)

KPI #	KPI Name	File Review Only	Q1 2026 Result
BHT-001	Level of Care (LOC) Assessment	✓ **File Review**	98.39%
BHT-002	BH Treatment Plan	✓ **File Review**	94.81%
BHT-003	Transitions of Care – BH Discharge	✓ **File Review**	94.34%
BHT-006	Oversight & Delegation	✓ **File Review**	94.96%

See Exhibit D – Medi-Cal Activity

Continuity of Care (CoC)

KPI #	KPI Name	DV Only	Q1 2026 Result
COC-001	CoC Processing Timeliness	✓ **DV**	100%
COC-002	CoC Notification Timeliness	✓ **DV**	100%

Community Health Plan OF IMPERIAL VALLEY

Claims

See Exhibit D – Medi-Cal Activity

KPI #	KPI Name	DV Only	Q1 2026 Result
CLM-001	Claims Payment Timeliness – 30 Calendar Days	✓ **DV**	100%
CLM-002	Claims Payment Timeliness – 45 Working Days	✓ **DV**	100%
CLM-003	Claims Payment Timeliness – 90 Calendar Days	✓ **DV**	100%
CLM-004	Claims Acknowledgement Timeliness	✓ **DV**	100%
CLM-005	Misdirected Claims Timeliness	✓ **DV**	100%
CLM-006	Timely Interest Payment on Late Claims	✓ **DV**	100%

See Exhibit D – Medi-Cal Activity

Member Services

KPI #	KPI Name	DV Only	Q1 2026 Result
MS-001	Calls Answered Within 30 Seconds	✓ **DV**	94.43%
MS-002	Call Center Abandonment Rate	✓ **DV**	0.99%
MS-003	Timely Issuance of Member ID Cards	✓ **DV**	99.87%

See Exhibit D – Medi-Cal Activity

Provider Dispute Resolution (PDR)

KPI #	KPI Name	DV Only	Q1 2026 Result
PDR-001	PDR Acknowledgement Timeliness	✓ **DV**	99.73%
PDR-002	PDR Written Determination Timeliness	✓ **DV**	99.18%
PDR-003	Timeliness of Interest Payment on Late PDRs	✓ **DV**	99.18%

See Exhibit D – Medi-Cal Activity

Delegation Oversight — Transportation (ModivCare)

KPI #	KPI Name	File Review Only	Q1 2026 Result
DO-009	Transportation — ModivCare (Health Net oversight evidence)	✓ **File Review**	100%

IHA, BLL, CCS & ECM

See Exhibit D – Medi-Cal Activity

All four functional areas are currently undergoing file review; Q1 2026 results remain pending completion.

Functional Area	# of KPIs	Review Type	Q1 2026 Status	Notes / Next Step
Initial Health Appointments (IHA)	3	File Review	**Under Review**	Meeting held 08/03/2026
Blood Lead Level (BLL)	3	File Review	**Under Review**	Meeting held 08/03/2026
California Children's Services (CCS)	5	File Review	**Under Review**	Extension requested until 08/07/2026
Enhanced Care Management (ECM)	5	File Review	**Under Review**	Meeting held 08/04/2026

See Exhibit E – Medi-Cal Activity

Sub-Delegate Timeliness Reporting – **Q1 2026**

Timeliness data for CHPIV's sub-delegates — from Health Net's quarterly MOM reports

PPG

Capitated Groups & Network Vendors

MOM 25 — Health Net's quarterly claims/PDR/settlement compliance tracking across delegated entities

QUARTERLY

NEMT

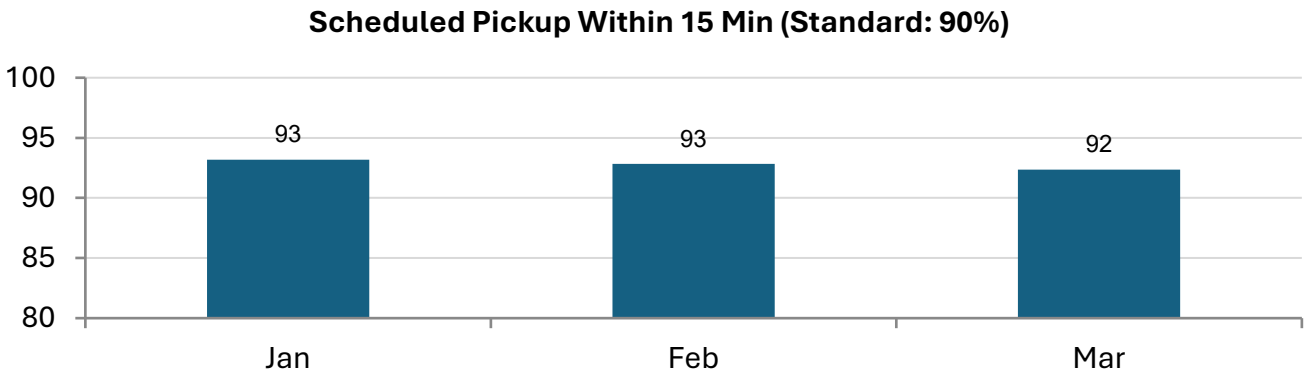
Transportation (ModivCare)

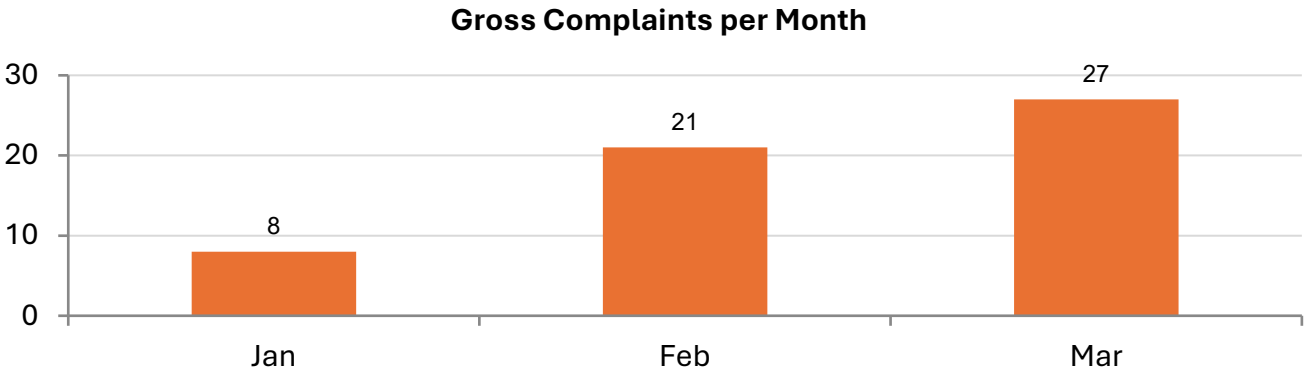
MOM 27 — ModivCare's own response-time standards and complaint volume

QUARTERLY

NEMT — Transportation Timeliness (ModivCare)

MOM 27 · Quarterly Transportation Standards Report





What the data shows

Standards met all quarter: ASAP response (90% within 4 hrs) hit 100% every month; scheduled pickup (90% within 15 min) stayed compliant at 93.2% → 92.8% → 92.4%, though the trend is drifting down.

Call center: Average speed of answer was 6–13 seconds (goal: ≤30 sec); call abandonment was under 0.3% (goal: <5%) — both well within standard.

See Exhibit E – Medi-Cal Activity

PPG & Network Vendors — Claims/PDR/Settlement Compliance

MOM 25 · Health Net's Q1 2026 Tracking

N = Sample Size

Entity	MTR Q1 result	PDR Q1 result	Claims Settlement	Status
Alpha Care Medical Group	100% (n=261)	75% (n=4)	1 deficiency (Feb)	Monitoring — PDR & claims settlement CAPs, both remediated; ongoing monitoring through Q3 2026.
Community Care IPA	99.4% (n=25,112)	100% (n=269)	None	Compliant
La Salle Medical Associates	70.8% (n=24)	No disputes (n=0)	None	Non-compliant (MTR) — low volume, growth outpaced staffing; new hires trained 4/17. Target: sustained compliance by 6/30/26.
American Specialty Health	100% (n=98)	No disputes (n=0)	None	Compliant
ModivCare	100% (n=41,167)	No disputes (n=0)	None	Compliant

See Exhibit E – Medi-Cal Activity

D-SNP
Quarterly Activity

See Exhibit F – D-SNP Activity

CHG — ODAG and CDAG **Q1 2026**

KPI #	KPI Name	Q1 2026 Result
ODAG 1: 1.1	Standard Pre Service OD Notification Timeliness	98%
ODAG 1: 1.2	Part B Drug OD Notification Timeliness	100%
ODAG 1: 1.3	Expedited Pre-Service OD Notification Timeliness	81.82%
ODAG 3: 1.9	Payment OD Timeliness	100%
ODAG 5: 1.18	Standard Grievance Timeliness	100%
ODAG-6	NR	NR
ODAG-7	NR	NR

KPI #	Q1 2026 Result
CDAG-1	NR
CDAG-2	NR
CDAG-3	NR
CDAG-4	NR
CDAG-5	NR
CDAG-6	NR
CDAG-7	NR

Community Health Plan OF IMPERIAL VALLEY

See Exhibit G – D-SNP Activity

CCIPA— ODAG **Q1 2026**

KPI #	KPI Name	Type	Q1 2026 Result
ODAG-1: 1.1	Standard Pre-Service OD Notification Timeliness	ODAG	27.84%
ODAG-1: 1.2	Part B Drug OD Notification Timeliness	ODAG	0%
ODAG-1: 1.3	Expedited Pre-Service OD Notification Timeliness	ODAG	17.95%
ODAG-1: 1.4	Expedited Part B Drug Pre-Service OD Notification Timeliness	ODAG	0%
ODAG-3: 1.9	Payment OD Timeliness	ODAG	100%

- **1.1 – Standard Pre-Service OD Notification:** Jan 0%, Feb 2.78%, Mar 78.79% (Q1: 27.84%)
- **1.2 – Part B Drug OD Notification:** Jan 0% (1 failing case), Feb 0% (2 failing cases), Mar not reported (Q1: 0%)
- **1.3 – Expedited Pre-Service OD Notification:** Jan 0% (6 failing cases), Feb 0% (13 failing cases), Mar 35% (Q1: 17.95%)
- **1.4 – Expedited Part B Drug Pre-Service OD Notification:** Jan 0% (1 failing case), Feb/Mar not reported (Q1: 0%)

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See Exhibit H – D-SNP Activity

ICPMG— ODAG **Q1 2026**

KPI #	KPI Name	Type	Q1 2026 Result
ODAG-1: 1.1	Standard Pre-Service OD Notification Timeliness	ODAG	11.11%
ODAG-1: 1.3	Expedited Pre-Service OD Notification Timeliness	ODAG	0%
ODAG-3: 1.9	Payment OD Timeliness	ODAG	100%

- **1.1 – Standard Pre-Service OD Notification:** Jan 0%, Feb 0%, Mar 66.67% (Q1: 11.11%)
- **1.3 – Expedited Pre-Service OD Notification:** Jan 0% (5 failing cases), Feb/Mar not reported (Q1: 0%)

See Exhibit I – D-SNP Activity

PPCIPA — ODAG **Q1 2026**

KPI #	KPI Name	Type	Q1 2026 Result
ODAG-1: 1.1	Standard Pre-Service OD Notification Timeliness	ODAG	100%
ODAG-1: 1.2	Part B Drug OD Notification Timeliness	ODAG	85.71%
ODAG-1: 1.3	Expedited Pre-Service OD Notification Timeliness	ODAG	100%
ODAG-1: 1.4	Expedited Part B Drug Pre-Service OD Notification Timeliness	ODAG	100%
ODAG-3: 1.9	Payment OD Timeliness	ODAG	100%

- **1.2 – Part B Drug OD Notification:** Jan 66.67%, Feb 75%, Mar 100% (Q1: 85.71%)

Community Health Plan OF IMPERIAL VALLEY

See Exhibit J – D-SNP Activity

PHCMG — ODAG **Q1 2026**

KPI #	KPI Name	Type	Q1 2026 Result
ODAG-1: 1.1	Standard Pre-Service OD Notification Timeliness	ODAG	12.24%
ODAG-1: 1.3	Expedited Pre-Service OD Notification Timeliness	ODAG	0%
ODAG-3: 1.9	Payment OD Timeliness	ODAG	100%

- **1.1 – Standard Pre-Service OD Notification:** Jan 0%, Feb 0%, Mar 24.49% (Q1: 12.24%)
- **1.3 - Expedited Pre-Service OD Notification:** Jan/Feb not reported, Mar 0% (12 failing cases)

Delegate Open CAPs

CAPs

Pre-del

CCIPA & ICPMG - website accessibility

Premier - website accessibility

Data Validation

PHCMG - data integrity

Medi-Cal

DOMP/AMP - post stabilization

UM003, CoC - timeliness

Annual audit - Initial health assessment - gift card allocation

Community Health Plan OF IMPERIAL VALLEY

Questions

Attachments

Exhibit A

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.

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

REGULATORY COMPLIANCE NOTICE

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 and Non-Discrimination Attestation

Community Health Plan of Imperial Valley

I, _____, agree and attest as follows:

1. I am a member of the following of the Community Health Plan of Imperial Valley (CHPIV) Commission and/or Committee(s)]: _____.

2. I understand CHPIV requires that all individuals who serve on _____ (Commission or Committee (s) ["Participant"], or who otherwise makes decisions on CHPIV and activities, timely and fully disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity.

3. I understand that a conflict of interest occurs whenever an individual who is in a position to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision including:

   a. when there is a divergence between the Participant's private interests and his/her professional obligations, such that an independent observer might reasonably question whether the Participant's professional actions or other decisions are determined by considerations of personal gain, financial or otherwise;

   b. when a decision may have an effect on the financial interests of the Participant, any member of the Participant's immediate family (spouse, domestic partner, civil union partner, natural or adoptive parents, step-parents, children, stepchildren, siblings, step-siblings, nieces/nephews, aunts/uncles, grandparents, grandchildren, in-laws, son-in-law, daughter-in-law, brother-in-law, sister-in, law, or the spouse of a grandparent), or the Participant's employers, partners, or other business associates; and

   c. when medical decisions are unduly influenced by fiscal and administrative management.

4. I understand all decisions concerning the best interests of CHPIV, safe care, quality of treatment, and services provided to CHPIV's members must be made solely with the intent to meet the needs of those members and without any actual, perceived, or potential conflicts of interest.

5. That, under no circumstances, may I place my own financial interests above the welfare of CHPIV's patients.

6. In my role as a Participant, I will conduct myself so as to avoid or minimize conflicts of interest, and I will appropriately disclose all potential or actual conflicts of interest in accordance with CHPIV's policies and procedures.

7. I will refrain from participation, including voting, discussing, or in any way trying to influence the outcome of the decision, in any matter in which I have a conflict of interest.

8. I will comply with all CHPIV's decisions regarding the resolution of conflicts and/or CHPIV's imposition of safeguards (*e.g.,* abstention from voting, non-participation in reviews) deemed necessary and appropriate to manage conflicts of interest.

9. I acknowledge that Federal law prohibits CHPIV from discriminating, in terms of participation, against any health care professional who acts within the scope of his or her license or certification under State law, solely on the basis of the license or certification category but that this prohibition does not preclude actions designed to maintain quality of care.

10. I acknowledge and understand that I may not base recommendations or on race, ethnic/national identity, gender, age, sexual orientation or patient type (e.g., Medicaid) and I agree that I will not discriminate against person or entity in making such recommendations or decisions as a Participant of any CHPIV Commission or Committee.

_____

Signature

_____

Printed Name

_____

Date

CALIFORNIA FORM 700
FAIR POLITICAL PRACTICES COMMISSION

STATEMENT OF ECONOMIC INTERESTS
COVER PAGE
A PUBLIC DOCUMENT

Date Initial Filing Received
Filing Official Use Only

Please type or print in ink.

NAME OF FILER (LAST) **(FIRST)** **(MIDDLE)**

1. Office, Agency, or Court

Agency Name *(Do not use acronyms)*

Division, Board, Department, District, if applicable

Your Position

► If filing for multiple positions, list below or on an attachment. *(Do not use acronyms)*

Agency: _____ Position: _____

2. Jurisdiction of Office *(Check at least one box)*

☐ State

☐ Judge (Supreme, Appellate, Superior Court), Retired Judge, Pro Tem Judge, or Court Commissioner (Statewide Jurisdiction)

☐ Multi-County _____

☐ County of _____

☐ City of _____

☐ Other _____

3. Type of Statement *(Check at least one box)*

☐ **Annual:** The period covered is January 1, 20254, through December 31, 20254.

-or-

The period covered is _____/_____/_____, through December 31, 20254.

☐ **Assuming Office:** Date assumed _____/_____/_____

☐ **Leaving Office:** Date Left _____/_____/_____
(Check one circle below.)

○ The period covered is January 1, 20254, through the date of leaving office.

-or-

○ The period covered is _____/_____/_____, through the date of leaving office.

☐ **Candidate:** Date of Election _____ and office sought, if different than Part 1: _____

4. Schedule Summary (required)

► ***Total number of pages including this cover page:*** _____

Schedules attached

☐ **Schedule A-1 -** *Investments* – schedule attached
☐ **Schedule A-2 -** *Investments* – schedule attached
☐ **Schedule B -** *Real Property* – schedule attached
☐ **Schedule C -** *Income, Loans, & Business Positions* – schedule attached
☐ **Schedule D -** *Income – Gifts* – schedule attached
☐ **Schedule E -** *Income – Gifts – Travel Payments* – schedule attached

☐ **Attachment 700-P -** *Prospective Employment (87200 Filers Only)* – schedule attached

-or- ☐ ***None*** **-** *No reportable interests on any schedule*

5. Verification

MAILING ADDRESS STREET CITY STATE ZIP CODE
(Business or Agency Address Recommended - Public Document)

DAYTIME TELEPHONE NUMBER
( )

EMAIL ADDRESS

I have used all reasonable diligence in preparing this statement. I have reviewed this statement and to the best of my knowledge the information contained herein and in any attached schedules is true and complete. I acknowledge this is a public document.

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date Signed _____
(month, day, year)

Signature _____
(File the originally signed paper statement with your filing official.)

	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**	
Next Annual Review Due		**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 –FPPC Form 700 Statement of Economic Interests

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
09/29/2026	Annual Review
05/15/2026	Ad-hoc Updates

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 " FPPC Form 700 Statement of Economic Interests" relationships, or financial interests that create or 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 FPPC Form 700 Statement of Economic Interests", identifying 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 an FPPC Form 700 Statement of Economic Interests prior to performing any services for CHPIV.
7. 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.

	Computer Update Policy	IT-002
	Department	Information Technology
	Functional Area	Information Technology
	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		**Regulator Approval**	Not Applicable

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

ATTACHMENTS

- NA

AUTHORITIES/REFERENCES

- NA

HISTORY

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

I. OVERVIEW

II. This policy addresses Community Health Plan of Imperial Valley's ("CHPIV" or the "Plan") procedures for securing and maintaining company-issued devices at the end of the workday. The purpose of this policy is to ensure data security, system stability, operational efficiency, and the timely application of software updates and security controls.POLICY

A. This policy outlines the procedures for securing company-issued devices, including desktops, laptops, tablets, and any other devices used for work purposes. Proper end-of-day device management is essential for:

Data Integrity: Preventing data loss and corruption.

System Stability: Supporting the reliable operation of devices through routine maintenance and updates.

Security: Ensuring devices receive security updates, monitoring, and protection against vulnerabilities.

Operational Efficiency: Allowing Information Technology (IT) to perform software deployments, maintenance, troubleshooting, backups, and support activities outside normal business hours.

III. PROCEDURE

1. Daily End-of-Day Procedures Save all work and documents before leaving for the day.
2. Close all applications, including web browsers, email clients, and any other software not required to remain running.
3. Sign out of applications as appropriate and lock the workstation before leaving the work area.
4. For laptop users, connect the device to a power source whenever possible to ensure availability for scheduled maintenance and updates.
5. Verify that the device remains powered on and connected to the network, either directly or through an approved remote connection method, if applicable.
6. Do not force shutdowns by unplugging devices or pressing and holding the power button, except when directed by the IT Department or in the event of a system failure.

B. After-Hours Device Availability

1. Employees are expected to leave company-issued computers powered on and connected to the network at the end of each workday unless otherwise directed by the IT Department.
2. Devices may automatically lock after a period of inactivity in accordance with CHPIV security requirements.
3. The IT Department may perform software deployments, operating system updates, security patching, antivirus and endpoint security updates, backups, monitoring, troubleshooting, and other maintenance activities during non-business hours.

4. Employees should not disable, interrupt, or otherwise interfere with scheduled maintenance activities unless authorized by the IT Department.
5. Employees who must power off their device for travel, maintenance, or other business reasons should ensure the device is powered on and connected to the network during their next scheduled work period.

C. Exceptions

1. Exceptions to this policy may be necessary in certain situations, including:
    1. Scheduled maintenance requiring a device restart or shutdown.
    2. Emergency situations or critical system maintenance.
    3. Device replacement, repair, or hardware upgrades.
    4. Business travel or remote work circumstances where network connectivity or power is unavailable.
    5. Other situations approved by the IT Department.

D. Policy Updates

1. This policy may be updated from time to time. Employees will be notified of any changes to the policy.

E. Contact

1. For questions or concerns regarding this policy, please contact the IT Department.

IV. DEFINITIONS

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

TERM	DEFINITION
System Updates	Software enhancements released by the manufacturer of the device and/or Operating System
Operating System	Fundamental software that manages a computer's hardware and software resources.
Software	Set of instructions, data, or programs that a computer executes to perform specific tasks.
Hardware	Physical components of a computer or any electronic device.
Applications	Computer programs designed to perform specific tasks for users.
Network	CHPIV's wired, wireless, virtual private network (VPN), or other approved connectivity methods used to access organizational resources.
Device Availability	The condition in which a company-issued device remains powered on, connected to the network, and capable of receiving updates, maintenance, monitoring, and remote support.

	Quality Improvement Health Equity Committee (QIHEC)	QM-002
Department	Health Services	
Functional Area	Quality Management	
Line of Business	☒ Medi-Cal ☒ D-SNP	

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

DATES			
Policy Effective Date	10/9/2023	**Reviewed/Revised Date**	7/24/2026
Next Annual Review Due	7/20/2027	**Regulator Approval**	

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

ATTACHMENTS

- N/A

AUTHORITIES/REFERENCES

- DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III, 2.2.2 and 2.2.3 QIHEC
- NCQA Health Plan Accreditation Standard QI 1: Program Structure and Operations

HISTORY

Revision Date	Description of Revision
10/9/2023	Policy creation
3/25/2025	Annual Review - Updates for APLs and/or applicable regulations. Revisions to P&P formatting.
7/24/2026	Annual Review - Updates for APLs and/or applicable regulations. Revisions to P&P formatting.

I. OVERVIEW

The QUALITY IMPROVEMENT AND HEALTH EQUITY COMMITTEE (QIHEC) is responsible for oversight of CHPIV's QUALITY IMPROVEMENT and HEALTH EQUITY efforts (QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM). The purpose of this policy is to specify the role, structure, and function of Community Health Plan of Imperial Valley's (CHPIV) QUALITY IMPROVEMENT AND HEALTH EQUITY COMMITTEE (QIHEC).

II. POLICY

A. CHPIV implements and maintains a QIHEC designated and overseen by its Board of Directors.

B. CHPIV's Commission appoints the QIHEC as an accountable entity responsible for the oversight of CHPIV's QUALITY IMPROVEMENT and HEALTH EQUITY initiatives.

C. The QIHEC is responsible for oversight of the QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM (QIHETP). The program description clearly defines the distinct role, function, and reporting relationships for the QIHEC and each of its subcommittees, including those associated with oversight of delegated activities.

D. CHPIV's Commission appoints a liaison to the QIHEC to ensure effective oversight of the QIHETP and facilitate communication between the Commission and QIHEC.

E. The QIHEC's activities are supervised by CHPIV's Chief Medical Officer, or the Chief Medical Officer's designee, in collaboration with CHPIV's Chief Health Equity Officer. The QIHEC is responsible for the annual development, approval, and oversight of the Quality Improvement and Health Equity Program annual work plan, ensuring its alignment with the organization's quality improvement and health equity goals and regulatory requirements.

III. PROCEDURE

A. CHPIV's Chief Medical Officer serves as the Chief Health Equity Officer

B. CHPIV's Chief Health Equity Officer chairs the QIHEC.

C. CHPIV ensures a broad range of NETWORK PROVIDERS, including but not limited to hospitals, clinics, county partners, physicians, SUBCONTRACTORS, DOWNSTREAM SUBCONTRACTORS, NETWORK PROVIDERS, and members, actively participate in the QIHEC or in any sub-committee that reports to the QIHEC.

1. The QIHEC will include seats for individuals who have knowledge and perspective of Dual Eligible Special Needs Plan (D-SNP) topics, including those using services such as Home and Community Based Services (HCBS) and Long-Term Care (LTC), to facilitate a variety of member perspectives and unique lived experiences.

D. Participating SUBCONTRACTORS, DOWNSTREAM SUBCONTRACTORS, and NETWORK PROVIDERS must be representative of the composition of CHPIV's NETWORK PROVIDERS and include, at a minimum, NETWORK PROVIDERS who provide health care services to:

1. Members affected by Health Disparities;
2. Limited English Proficiency (LEP) members;
3. Children with Special Health Care Needs (CSHCN);
4. Seniors and Persons with Disabilities (SPDs); and

5. Persons with chronic conditions.

E. CHPIV's QIHEC includes representatives from fully delegated entity.

F. The QIHEC's responsibilities include, but are not limited to, the following:

2. 1. Analyze and evaluate the results of QUAILITY IMPROVEMENT and HEALTH EQUITY activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, delegation oversight reports and activities, and the findings and activities of other CHPIV committees such as the Community Advisory Committee (CAC) and Provider Advisory Committee (PAC). Institute actions to address performance deficiencies, including policy recommendations. When monitoring identifies non-compliance, the Committee(s) will ensure necessary corrective actions are taken and documented.
3. Ensure appropriate follow-up and remediation of identified performance deficiencies.

G. CHPIV ensures member confidentiality is maintained in QI discussions and ensures avoidance of conflict of interest among QIHEC members.

H. The QIHEC meets at least quarterly, and more frequently if needed.

I. A written summary of QIHEC activities, as well as QIHEC activities of its FULLY DELEGATED SUBCONTRACTOR and DOWNSTREAM FULLY DELEGATED SUBCONTRACTOR findings, recommendations, and actions, is prepared after each meeting.

1. CHPIV submits the written summary of QIHEC activities to the Board of Directors.
2. CHPIV makes the written summary of QIHEC activities publicly available on CHPIV's website at least quarterly.
3. Upon request, CHPIV submits written summaries of QIHEC proceedings to DHCS.

J. CHPIV ensures that its FULLY DELEGATED SUBCONTRACTOR and DOWNSTREAM FULLY DELEGATED SUBCONTRACTOR maintains a QIHEC that meets the requirements set forth above.

K. CHPIV ensures its FULLY DELEGATED SUBCONTRACTOR and DOWNSTREAM FULLY DELEGATED SUBCONTRACTOR report to CHPIV's QIHEC quarterly, at a minimum.

IV. DEFINITIONS

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

TERM	DEFINITION
Downstream Fully Delegated Subcontractor	A Downstream Subcontractor that contractually assumes all duties and obligations of Contractor under the Contract, through the Subcontractor, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A managed care plan can operate as a Downstream Fully Delegated Subcontractor.
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.
Fully Delegated Subcontractor	A subcontractor that contractually assumes all duties and obligations of Contractor under the Contract, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A

TERM	DEFINITION
	managed care plan can operate as a Fully Delegated Subcontractor.
Health Equity	The reduction or elimination of Health Disparities, Health Inequities, or other disparities in health that adversely affect vulnerable populations.
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.
Quality Improvement (QI)	Means a systematic and continuous actions that lead to measurable improvements in the way health care is delivered and outcomes for Members.
Quality Improvement and Health Equity Committee (QIHEC)	Means a committee facilitated by CHPIV's medical director, or the medical director's designee, in collaboration with the Health Equity officer, to meet at least quarterly to direct all QIHETP findings and required actions.
Quality Improvement and Health Equity Transformation Program (QIHETP)	The systematic and continuous activities to monitor, evaluate, and improve upon the Health Equity and health care delivered to Members in accordance with the standards set forth in applicable laws, regulations, and the DHCS Medi-Cal Managed Care 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.

Exhibit B

COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

Community Advisory Committee (CAC) Charter

Purpose

The Community Advisory Committee (CAC) is a standing committee of the CHPIV Commission, the plan's governing board. The Committee's purpose is to ensure that members of CHPIV have meaningful opportunities to shape the plan's public policy and to ~~appointed by the Community Advisory Committee Selection Committee to advocate for CHPIV enrollees (members) by ensuring that~~ enable CHPIV ~~is~~ to be responsive to Members' diverse health care needs. The CAC empowers members to bring their voices to the table to ensure CHPIV is actively driving interventions and solutions to build more equitable care.

Objectives.

1. Obtain local level feedback, insights, and perspectives to inform and address CHPIV policy, operations, including quality and health equity strategy.
2. Maintain a stable local presence and forum to engage and collaborate with local community partners and resources to ensure community needs are met.
3. Provide perspectives on health equity and disparities, population health, children's services, - and relevant plan operations and programs.
4. Inform CHPIV's cultural and linguistic services program.
5. Maximize member participation and involvement to solicit meaningful insights and perspectives to improve how CHPIV delivers services through ongoing training as well as effective meeting facilitation.
6. Inform and advise CHPIV how to utilize Health Equity Improvement zones based on identified health disparities to ensure talent, resources and partnerships are aligned to improve health equity performance outcomes for members and residents of the Imperial Valley County
7. Provide forum for bidirectional communication between committee members and CHPIV leadership to inform use of community reinvestment funds; and
8. Assess the need for and establish Community Impact Council(s) using data, insights, and considering community and CHPIV priorities, who will collaborate with diverse community stakeholders to further drive community impact and create sustainable forums for continued work.

CAC Responsibilities.

The Committee shall have the following authority and responsibilities, together with any additional authority or responsibility delegated to the Committee by the Commission from time to time:

1. Make policy recommendations and provide quarterly reports to the CHPIV Commission.
2. ~~1.~~ Identify and advocate for preventive care practices.
3. ~~2.~~ Advise on necessary Member or Provider targeted services, programs, and training.
4. ~~3.~~ Gather feedback, develop, and update cultural and linguistic policy and procedure decisions including those related to Quality Improvement (QI), education, and operational and cultural competency issues affecting groups who speak a primary language other than English.
    a. Make recommendations to CHPIV regarding the cultural appropriateness of communications, partnerships, program design and services.
    b. Provide input on the selection of targeted health education, cultural and linguistic, and QI strategies, including prioritizing the same.
5. ~~4.~~ Review Population Needs Assessment (PNA) and/or the annual Population Health Management Strategy results, discuss and provide input into opportunities to improve performance with an emphasis on Health Equity and Social Drivers of Health. These reviews will be annually depending on the reports received. PNA to be reviewed every 3 Years, however the PMH strategy due yearly to be reviewed.
6. ~~5.~~ Ensure findings, recommendations, and actions to/from the CHPIV Quality Improvement and Health Equity Committee (QIHEC) connect to holistic decisions and programming.
7. ~~6.~~ Recommend strategies to effectively engage members, including but not limited to consumer listening sessions, focus groups, and/or surveys; and
8. ~~7.~~ Provide input and advice, including, but not limited to, the following:
    a. Member satisfaction survey results.
    b. Plan marketing materials and campaigns.
    c. Communication of needs for Network development and assessment.
    d. Community resources and information.
    e. Population Health Management.
    f. Quality.
    g. Health Delivery Systems Reforms to improve health outcomes.
    h. Carved Out Services.
    i. Coordination of Care;

j. Health Equity; and
k. Access to Services

~~8.~~9. CHPIV will ensure that CAC meetings are accessible to CAC members, and that CAC feedback is meaningfully incorporated in CHPIV operations and governance.

~~9.~~10. Review and approve meeting minutes from previous session.

~~10.~~11. Review and reassess the adequacy of this Charter annually and recommend any proposed changes to the Commission for approval. The Committee shall annually review its own performance.

Committee Membership.

The Committee shall consist of at least 51% CHPIV members and include ~~several directors as the~~ at least one member of the Commission and at least one provider representative ~~shall review from time to time~~. The members of the Committee shall be appointed or replaced by the Commission upon the recommendation of the CAC Selection Committee of the Commission, with or without cause.

Unless the Commission appoints a Chair of the Committee, a designated CHPIV staff member shall assume the role of CAC Coordinator and Chairperson. The Chair of the CAC is responsible for:

1. Providing advice and guidance to the CHPIV Quality Improvement and Health Equity Committee and CHPIV ~~Leadership~~ Commission regarding the direction, approach and response of Community Health Plan of Imperial Valley regional and cultural issues that have implications on member satisfaction, new product lines, health promotion and education efforts, marketing, and outreach.
2. Ensuring a local presence for the Community Advisory Committee Membership
3. Oversight of the Community Advisory Committee administration.
4. Organizing all CAC Meetings

The compensation of the Committee members shall be as determined by the Commission.

Reporting Structure.

1. CAC will submit regular reports of activities, findings, and formal recommendations to the Commission and QIHEC to advance the CAC purpose and objectives. CAC recommendations shall include needed interventions where applicable. The inclusion of needed interventions in their recommendations is a proactive step to

address any issues identified during their activities. This process not only helps in advancing the CAC's purpose and objectives but also supports the organization's broader mission to implement changes that lead to improvements in policy or practice.

2. The CAC Coordinator to perform defined responsibilities such as scheduling meetings, developing agendas under the direction of the CAC Chair, CAC Selection Committee, ~~QIIEC~~ and CHPIV, ensuring accessibility and active participation, compliance with public meeting requirements as applicable, meeting minutes and updating the CAC and Commission. The CAC Coordinator will also be responsible for managing the operations of the CAC in compliance with all statutory, regulatory, and contract requirements.

Frequency & Structure of Meetings.

The Community Advisory Committee shall meet at least quarterly, or as often as it deems necessary to perform its responsibilities.

Reviewed and Approved by Commission
Date: 7/13/2026

Community Advisory Committee (CAC)
Selection Committee Charter

Objectives

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

Responsibilities

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

1. Ensure the CAC membership includes at least 51% CHPIV members, at least one Commissioner, and at least one provider representative.

~~1.~~2. Ensure the CAC membership reflects the general Medi-Cal Member population in Imperial County, including representatives from Indian Health Service Providers, representatives who receive LTSS and/or individuals representing LTSS recipients, adolescents and/or parents and/or caregivers of children, including foster youth, as appropriate and be modified as the population changes to ensure that CHPIV's communities are represented and engaged;

~~2.~~3. Review, at least annually, demographic data, including data on racial, ethnic, and linguistic composition, of residents and members living in Imperial County to ensure CAC recruitment efforts and membership aligns with and reflects the racial, ethnic, and linguistic diversity of their respective Service Area.

~~3.~~4. Make a good faith effort to ensure the CAC membership is composed primarily of CHPIV Members, including representatives from diverse and hard- to-reach populations, with a specific emphasis on persons who are representative of or serving populations that experience health disparities such as individuals with diverse racial and ethnic backgrounds, genders, gender identity, sexual orientation, and physical disabilities.

Committee Membership

The CAC Selection Committee shall consist of such number of directors as the Commission shall from time to time determine, but in no event shall it consist of less than

two members. The members of the Committee shall be appointed or replaced by Commission with or without cause.

The CAC Selection Committee must select all CAC members.

The CAC Selection Committee should include representatives from:

1. Persons who sit on the Commission
2. Safety Net Providers including federally qualified health centers (FQHCs), behavioral health, regional centers, local education authorities, dental Providers, IHS Facilities, and home and community-based service Providers; and
3. Persons and community-based organizations who are representatives within Imperial County, adjusting for changes in membership diversity.

Frequency

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

Length of Appointments

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

Reviewed and Approved by Commission
Date: 7/13~~4~~/2026~~5~~

Fact Sheet/Action Items

Action Items - Motions requiring Commission approval

Motion Fact Sheet

Recommendation

Motion to formally designate the Community Advisory Committee (CAC) as the Public Policy Committee of the Commission and to update the charters of the CAC and CAC Selection Committee to reflect this designation, composition requirements, and responsibilities.

Background

The Knox-Keene Act, 28 CCR §1300.69(e), requires that the plan operate a Public Policy to Committee to ensure that members have meaningful opportunities to participating in shaping the plan's public policy. The committee must be a standing committee of the governing body and include:

Must establish a standing committee of the governing body or executive committee:

- At least **51%** of members must be subscribers and/or enrollees
- At least **one** member must also be on the governing body/executive committee
- At least **one** member must be a provider

Recommendations and reports must be regularly and timely reported to the governing body/executive committee, which must act on them and record the action in minutes.

Why Now

This resolution is to formalize this requirement. The CAC is currently comprised of 51% CHPIV members and is chaired by a Commissioner, Xochitl Fausto. Committee reports are reported to the Commission on a quarter basis, and considered in strategic planning of the Commission.

Financial Impact

None

Risks / Alternatives

The regulation allows the Commission to serve as the Public Policy Committee, but current composition does not satisfy the Public Policy Committee requirements.

Items after the relevant motion to immediately follow

The CAC Selection Committee will meet to recommend appointment of a Provider Representative to the CAC to satisfy Public Policy Committee composition requirements.

Exhibit C

COMPLIANCE PROGRAM

Community Health Plan of Imperial Valley (CHPIV)

Compliance Department

Effective Date	[DATE]
Date Approved by Compliance & Policy Committee	[DATE]
Date Approved by Regulatory Compliance Oversight Committee of the Commission	[DATE]
Review Cycle	Annual
Related Documents	Risk Management Program; Audit & Monitoring Program; Delegation Oversight Plan; Code of Conduct; CHPIV Policies & Procedures

I. Purpose

The Compliance Program is the foundational framework through which Community Health Plan of Imperial Valley ("CHPIV") ensures that its business operations adhere to ethical standards, contractual obligations, and all applicable federal and state laws, regulations, and rules — including those of the State of California, the Department of Health Care Services (DHCS), the Department of Managed Health Care (DMHC), and the Medicare program.

This Program defines the organizational structure, authority, and operating disciplines through which CHPIV prevents, detects, and corrects noncompliance across its own operations and across its delegation network. The Risk Management Program, the Audit & Monitoring Program, and the supporting Compliance policies and procedures are downstream instruments of this Program; together they translate the Program's commitments into routine operating practice.

II. Scope

This Program applies to all CHPIV lines of business — Medi-Cal and Medicare D-SNP — and to all stakeholders responsible for or affected by CHPIV's regulated activities, including:

- The Commission (governing body), CHPIV employees, officers, and contractors;
- All first-tier, downstream, and related entities (FDRs); including Subcontractors, IPAs, and other downstream entities under contract;
- Knox-Keene-licensed health plan operations conducted by CHPIV or on its behalf.

No CHPIV activity or contracted relationship is exempt from this Program. Where operational functions are performed by delegated entities, this Program governs the oversight CHPIV applies to those entities. A copy of this Program is available on CHPIV's website.

III. Operating Model

CHPIV retains accountability for Compliance, Delegation Oversight, and Internal Audit functions. Operational functions — including claims, member services, utilization management, appeals, grievances, care management, provider operations, are performed by internal departments and delegated entities under their respective delegation agreements.

The Compliance Program is structured accordingly: oversight is centralized, standardized, and driven by risk, with the Risk Management Program setting priorities and the Audit & Monitoring Program executing against them.

IV. Seven Elements of an Effective Compliance Program

The Compliance Program incorporates the seven fundamental elements of an effective compliance program required under 42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi) and aligns with DHCS and DMHC expectations. The table below identifies each element, where it is operationalized in this Program, and the supporting policies and instruments that govern its execution.

Element	Operationalized in	Supporting Policies & Instruments
1. Written Policies, Procedures, and Standards of Conduct	Section XI	CMP-001; CMP-005; Code of Conduct
2. Compliance Officer, Compliance Committee, and Governing Body Oversight	Sections V and VI	CMP-008; CMP-013
3. Effective Training and Education	Section X	CMP-006
4. Effective Lines of Communication	Section XII	CMP-010
5. Well-Publicized Disciplinary Standards	Section XII.C	CMP-007; Employee Handbook
6. Effective System for Routine Monitoring, Auditing, and Identification of Compliance Risks	Section VII	Risk Management Program; Audit & Monitoring Program; CMP-002
7. Procedures for Prompt Response to Compliance Issues	Section VIII	CMP-003; CMP-007; CMP-011

V. Compliance Organizational Structure

A. Chief Compliance Officer

The Chief Compliance Officer (CCO) serves as the focal point for all compliance activities and is responsible for developing, operating, and monitoring the Compliance Program. The CCO is a CHPIV employee and is not employed by any first-tier, downstream, or related entity.

The CCO reports administratively to the Chief Executive Officer and has direct access to, and reports periodically to, the CHPIV Commission and the Regulatory Compliance Oversight Committee (RCOC) of the Commission on the activities and status of the Compliance Program, including issues identified, investigated, and resolved.

B. Centralization of Delegation Oversight and Internal Audit

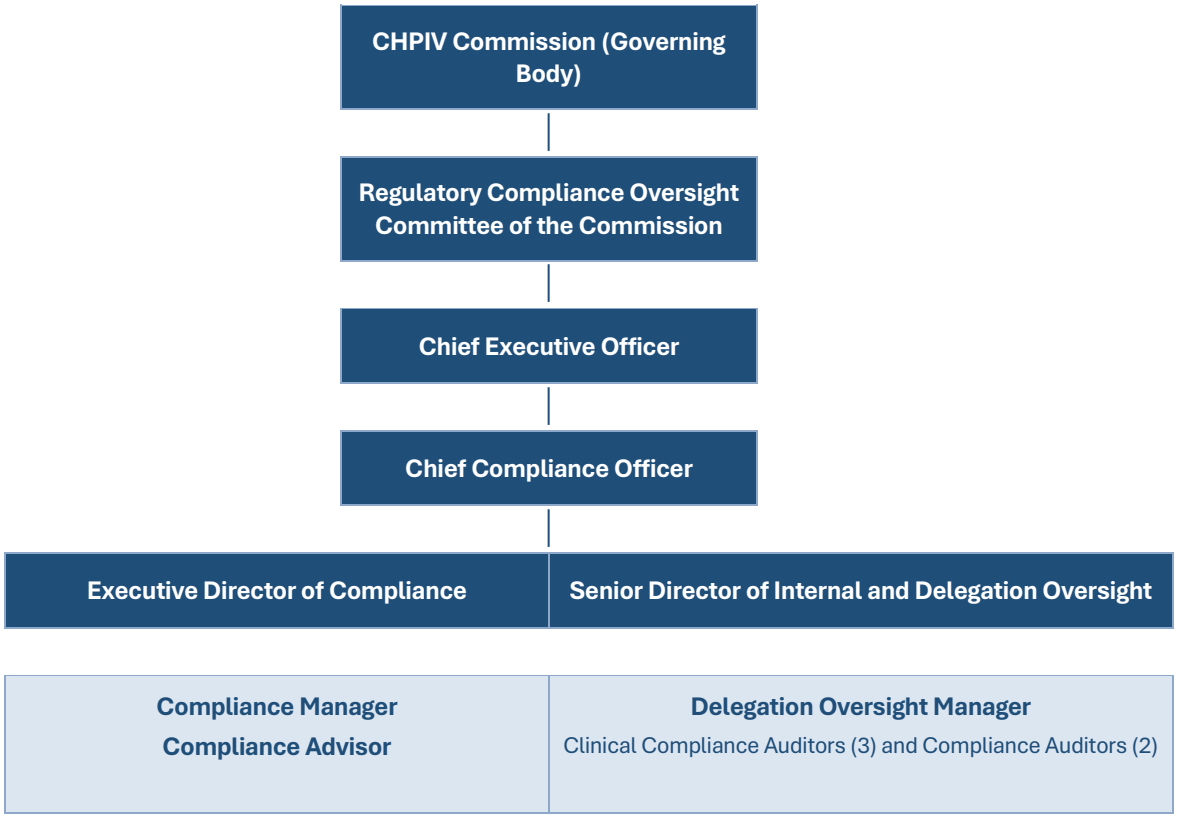
The Internal and Delegation Oversight function is fully centralized under the Compliance Department. The Senior Director of Internal and Delegation Oversight reports to the CCO and is the strategic leader and final authority on audit outcomes across all delegated functions and any internal CHPIV functions subject to audit.

This consolidation reflects the Operating Model described in Section III and produces four enterprise outcomes:

- **Clear ownership.** Compliance owns audit strategy, execution, and prioritization end-to-end.
- **Standardized methodology.** A single risk-based audit approach is applied consistently across all delegated functions and is extensible to any function CHPIV may in-source in the future.
- **Higher cadence and coverage.** Dedicated audit staff enable broader scopes and more frequent monitoring than a shared-services model permits.
- **Strategic engagement by business leaders.** Operational leaders consume audit results and lead remediation with delegates rather than performing the audits themselves.

C. Organizational Chart

The chart below depicts CHPIV's governance and reporting lines:



Note: The Compliance & Policy Committee reviews all delegation oversight and internal audit plans and reports.

D. Roles & Responsibilities

Role	Primary Responsibilities
Chief Compliance Officer	Owns the Compliance Program end-to-end. Sets strategy, ensures regulatory alignment, reports to the CEO and Commission, and has authority to escalate independently to the governing body.
Executive Director of Compliance	Leads day-to-day Corporate Compliance: policies and procedures, regulatory implementation, FWA, privacy and security, training, and CAP management. Serves as the Privacy Officer.
Senior Director of Internal and Delegation Oversight	Strategic leader and final authority on audit outcomes. Owns the audit and monitoring plan, approves audit tools and findings, and ensures alignment with DHCS, DMHC, CMS, and NCQA standards.
Delegation Oversight Manager	Execution lead and people manager. Drives day-to-day operations, assigns scopes, manages workload, develops staff, and partners with the Director on findings, escalations, and regulatory readiness.
Compliance Manager	Manages compliance operations, regulatory tracking and implementation, CAP intake and monitoring, and supports the CCO on enterprise compliance initiatives.
Compliance Advisor	Provides regulatory interpretation and advisory support to business areas, including review of materials, member communications, policy questions, and responses to regulatory inquiries.
Clinical Compliance Auditor	• Reviews member grievances, quality of care cases, and appeals for clinical appropriateness, timely resolution, and policy adherence. • Oversees prior authorization, concurrent review, post-stabilization, retroactive authorizations, and denial notice compliance, including medical necessity, turnaround times, and readability standards. • Audits behavioral health access (including parity), Complex Care Management, Enhanced Care Management, EPSDT, continuity of care, and prescription drug compliance.
Compliance Auditor	Audits non-clinical delegated functions, including claims, encounters, credentialing, provider network, language assistance, and compliance program effectiveness.

VI. Governance and Authority

A. CHPIV Commission

The CHPIV Commission serves as the organization's governing body and actively oversees compliance efforts. The Commission is knowledgeable about the content and operation of the Compliance Program and exercises reasonable oversight of its implementation and effectiveness. The Commission regularly evaluates CHPIV's overall performance, reviews compliance reports, and provides direction in response to instances of noncompliance.

B. Regulatory Compliance Oversight Committee of the Commission

The Regulatory Compliance Oversight Committee (RCOC) is a subcommittee of the Commission. It supports the Commission's oversight by reviewing the effectiveness of the Compliance Program, approving annual program documents and audit plans, monitoring significant compliance matters, and addressing issues as they arise.

C. Compliance & Policy Committee

The internal Compliance & Policy Committee (CPC) provides operational oversight, advice, and guidance to CHPIV senior leadership on all compliance matters. The CPC reviews and approves the Compliance Program and its downstream instruments — including the Risk Management Program, the Audit & Monitoring Program, and the annual audit and monitoring plans — and oversees implementation of policies that require compliance with applicable laws, regulations, contractual requirements, and internal policy.

VII. Risk Management and the Audit & Monitoring Program

Routine monitoring, auditing, and identification of compliance risks are operationalized through two integrated downstream programs: the Risk Management Program and the Audit & Monitoring Program. These programs are governed by, and operate in service of, this Compliance Program.

A. Risk Management Program

The Risk Management Program establishes a structured, enterprise-wide framework for identifying, assessing, prioritizing, managing, and monitoring compliance risks across all CHPIV lines of business and delegated functions. It ensures that CHPIV's oversight activities are driven by actual organizational risk rather than uniform schedules or administrative convention.

The Risk Management Program operates through four integrated components: a continuously maintained Risk Repository; an Annual Risk Assessment that scores and tiers risks by line of business; a Monitoring Protocol shaped by the risk assessment; and a Corrective Action and Validation cycle that closes risks only after correction is objectively confirmed. Each risk is scored using a three-factor methodology — Member/Provider Impact, Regulatory Focus, and Deficiency/Recurrence — producing a composite score

that maps to a risk tier (Critical, High, Medium/Low). Details are documented in the Risk Management Program.

B. Audit & Monitoring Program

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. Quantitative KPIs are monitored quarterly for every functional area regardless of risk tier. Qualitative case file reviews are conducted quarterly for High and Critical risk areas and annually for Medium/Low risk areas. Policy reviews are conducted annually. Findings from all AMP activities feed back into the Risk Repository, and CAPs remain open until validation is complete. Details are documented in the Audit & Monitoring Program.

C. Relationship Between Programs

The relationship among the three programs is sequential and self-reinforcing:

Program	Function
Compliance Program	Sets the framework: governance, authority, scope, the seven elements, and the operating model under which all oversight occurs.
Risk Management Program	Identifies, scores, and prioritizes compliance risks; produces the Annual Risk Assessment that drives oversight focus for the following year.
Audit & Monitoring Program	Executes oversight: quarterly quantitative KPIs, tier-driven qualitative case file reviews, and annual policy reviews. Findings flow back to the Risk Repository.

VIII. Responding to Compliance Issues

CHPIV maintains a structured approach for identifying, investigating, and resolving compliance concerns. Issues are detected through audits, monitoring, hotline and email reports, regulatory communications, and self-disclosure by employees, contractors, or delegates. Each report is logged, triaged, and assigned for investigation under standardized protocols designed to ensure thorough, impartial, and consistent handling. High-risk or complex issues are escalated to leadership and, when required, to regulators.

Corrective Action Plans (CAPs) are issued, developed, and executed to address noncompliance, with a focus on root cause and prevention of recurrence. CAPs are governed by CMP-003 and managed under the validation discipline established in the Risk Management Program: a CAP that has been implemented

but not validated remains open, and the associated risk remains active in the Risk Repository. Noncompliance involving delegated entities is managed in accordance with CMP-002 Delegation Oversight.

Where employee conduct is implicated, CHPIV applies progressive disciplinary action consistent with Section XII.C.

IX. Privacy and Fraud, Waste, and Abuse

A. Privacy

CHPIV is committed to compliance with federal and state privacy and security requirements and continuously monitors regulatory developments to update privacy and security policies. CHPIV provides clear guidelines for the handling and protection of Protected Health Information (PHI) and Personally Identifiable Information (PII), conducts regular HIPAA training, and maintains established procedures for reporting and managing breaches or unauthorized disclosures. Privacy incidents are tracked in accordance with CMP-005, CMP-011, and CMP-012, and systemic privacy risks are logged in the Risk Repository.

B. Fraud, Waste, and Abuse

CHPIV's Fraud, Waste, and Abuse (FWA) program is designed to prevent, detect, and correct fraudulent activity. The program includes investigation of suspected FWA, accessible reporting channels, training and education for employees and contractors, and corrective action where issues are identified. CHPIV cooperates with regulator-led fraud prevention initiatives, including CMS pre-payment integrity activities, and refers matters to regulators or law enforcement as required. Compliance failures confirmed through FWA referrals — specifically, oversight gaps, delegation failures, or process breakdowns — are logged in the Risk Repository in accordance with the Risk Management Program.

X. Training and Education

CHPIV's Training and Education Program, governed by CMP-006, provides comprehensive compliance training for employees, delegated entities, the Chief Executive Officer, senior administrators, and Commissioners. Training addresses legal and ethical obligations under applicable laws, regulations, and federal health program requirements; is conducted at least annually; and is incorporated into the orientation of new employees, senior administrators, and governing body members. Completion is tracked and reported through the Compliance Department.

XI. Policies, Procedures, and Code of Conduct

A. Policies and Procedures

Policies and procedures are the operational foundation of the Compliance Program. The Compliance Department oversees the review and approval process under CMP-001 and maintains a centralized repository of approved policies. Each policy is reviewed at least annually, with stakeholder collaboration for development and updates, and updates are communicated to affected stakeholders. Current policies and procedures are accessible to staff in the CHPIV Policies & Procedures Repository.

The Compliance policies listed below provide detailed guidance for implementing the Compliance Program:

Policy #	Title	Description
CMP-001	**Writing and Processing Policies and Procedures**	Outlines the process for managing CHPIV policies to ensure compliance with regulations, contracts, and accreditation, with the Compliance Department as the responsible unit.
CMP-002	**Delegation Oversight**	Sets standards for overseeing delegated entities to ensure compliance with regulations, contracts, and CHPIV policies, with ongoing audits and monitoring under the Audit & Monitoring Program.
CMP-003	**Corrective Action Plans**	Establishes the process for developing and implementing CAPs to address noncompliance, including root cause analysis, corrective measures, and validation of effectiveness.
CMP-004	**Implementation of Regulatory Notifications**	Outlines the process for organization-wide implementation of regulatory notifications issued by regulatory agencies.
CMP-005	**Confidentiality and Member Privacy**	Outlines CHPIV requirements for maintaining confidentiality and protecting member privacy, including safeguarding PHI, PII, and demographic data.
CMP-006	**Compliance Training**	Outlines requirements for CHPIV's Compliance Training Program, applicable to all employees, subcontractors, and downstream subcontractors.
CMP-007	**Escalation of Noncompliance Issues**	Establishes a framework for identifying, communicating, investigating, and resolving compliance concerns, including self-disclosure to regulators where required.

Policy #	Title	Description
CMP-008	**Selecting a Chief Compliance Officer**	Establishes a standardized process for the selection of a CCO who will ensure adherence to contractual requirements.
CMP-009	**Fraud, Waste, and Abuse**	Establishes CHPIV's Fraud Prevention Program to prevent, detect, and address FWA, with responsibilities for training, monitoring, reporting, and compliance.
CMP-010	**Effective Lines of Communication**	Ensures open, accessible, and confidential channels for reporting compliance concerns and promoting ethical business practices, with non-retaliation protections.
CMP-011	**Breach Notification**	Ensures compliance with state and federal laws regarding notification of affected individuals in the event of a breach of member privacy.
CMP-012	**Notice of Privacy Practices**	Outlines content and distribution of CHPIV's Notice of Privacy Practices and supporting privacy compliance monitoring.
CMP-013	**Key Personnel Change**	Establishes a process for disclosing changes in executive-level personnel to DHCS and DMHC.

B. Code of Conduct

The Code of Conduct establishes the standards of ethical behavior and compliance expected throughout the organization. It emphasizes adherence to applicable laws, regulations, and industry best practices; safeguards sensitive information; requires identification and management of potential conflicts of interest; prohibits workplace discrimination and harassment; and protects whistleblowers. All employees acknowledge the Code annually, and training reinforces its principles. The Code of Conduct is available on CHPIV's website.

XII. Lines of Communication, Self-Disclosure, and Discipline

A. Reporting Compliance Issues

CHPIV maintains multiple reporting channels, including a confidential Compliance Hotline, a designated Compliance email address, and direct contact with the Chief Compliance Officer. These channels are regularly communicated to staff and stakeholders through training and are available for confidential and anonymous reporting of:

- Incidents of fraud, waste, and abuse;
- Criminal activity (fraud, kickbacks, embezzlement, theft, and similar);
- Conflict of interest concerns;
- Code of Conduct violations;
- Privacy and information security incidents.

Verbal and written communications to the Compliance Hotline or the Compliance Department are treated confidentially within the bounds of applicable law. Anonymity is respected; reporters are not required to provide their names. Retaliation against any person for reporting in good faith is prohibited.

Channel	Contact
Compliance Hotline	800-919-4947 (confidential and anonymous)
Chief Compliance Officer	Direct line and email available on CHPIV's website and internal directory
Compliance Department	Compliance@chpiv.org
Human Resources	Contact information available on CHPIV's internal directory
Online Reporting Form	Committed to Compliance — available on the CHPIV website

B. Voluntary Self-Reporting of Noncompliance

CHPIV voluntarily self-reports noncompliance — including potential fraud, waste, abuse, and misconduct — to regulatory agencies including CMS, DMHC, and DHCS as required by law, contract, or regulator request. The Compliance Department assesses each issue, determines whether self-reporting is required, and documents the investigation, findings, and corrective actions in the Risk Repository.

Criteria for self-reporting. CHPIV self-reports when (1) there is evidence of intentional fraud, misconduct, or systemic noncompliance; (2) the issue results in improper payments, regulatory violations, or potential harm to members; or (3) reporting is required by law, contract, or at the request of a regulator.

Self-disclosure mechanics. When an issue meets self-reporting criteria, CHPIV prepares and submits a Self-Disclosure Report through the designated method (e.g., CMS HPMS, DMHC online portal, or direct submission to the DHCS Contract Manager), including a summary of the issue, parties involved, and potential impact; root cause and corrective actions taken or planned; and supporting documentation. CHPIV cooperates fully with regulator follow-up and implements additional corrective action as needed.

C. Disciplinary Standards

CHPIV maintains disciplinary standards and enforcement procedures that promote compliance, accountability, and ethical conduct. These standards encourage good-faith participation in the

Compliance Program by setting clear expectations, defining consequences for noncompliance, and ensuring consistent enforcement.

Progressive disciplinary actions for employees may include additional training, verbal and written warnings for minor violations, probationary periods with close monitoring for serious or repeated noncompliance, temporary suspension for significant violations, and termination for severe or repeated offenses. These standards are publicized through compliance policies, the employee handbook, training, and ongoing communications.

XIII. Program Review and Maintenance

This Compliance Program is reviewed and updated at least annually by the Chief Compliance Officer, the Compliance & Policy Committee, and the Regulatory Compliance Oversight Committee of the Commission. The review evaluates whether the Program's scope, organizational structure, governance, and operating model remain appropriate given CHPIV's regulatory environment, contractual obligations, and risk posture.

Updates may also be triggered between annual cycles by material regulatory changes; significant enforcement actions or consent agreements; findings from regulatory audits, accreditation reviews, or internal reviews of the Compliance Program itself; or a leadership determination that the Program's structure requires revision. Updates are coordinated with the annual review cycles of the Risk Management Program and the Audit & Monitoring Program to keep the three documents aligned.

Exhibit D

DELEGATION OVERSIGHT

Health Net of CA — Q1 2026 Appeals Scorecard

Report date: Quarter 1 2026

APPEALS

APPEAL-001	APPEAL-002	APPEAL-003
Acknowledgement Letter	Resolution Timeliness	Resolution Letter Content
Quantitative	*Qualitative*	*Qualitative*
100.00%	**100.00%**	**100.00%**

KPI #	KPI / Sub-measure	Type	Source	Q1	Q2	Q3	Q4
APPEAL-001	**Acknowledgement Letter**	Quantitative	Universe	**100.0%**			
APPEAL-002	**Resolution Timeliness**	Qualitative	File Review	**100.0%**			
APPEAL002S	↳ *Timely Decision of Appeals — Standard (≤30 cal days)*	Qualitative	File Review	100.0%			
APPEAL002	↳ *Timely Decision of Appeals — Expedited (≤72 hrs)*	Qualitative	File Review	100.0%			
APPEAL-00	**Resolution Letter Content**	Qualitative	File Review	**100.0%**			
APPEAL003	↳ *Timely Effectuation of Overturned Appeals (≤72 hrs)*	Qualitative	File Review	100.0%			
APPEAL-004	**Member Notification Timeliness**	Qualitative	File Review	**100.0%**			
APPEAL004	↳ *Member Notification — Standard (≤30 cal days)*	Qualitative	File Review	100.0%			
APPEAL004	↳ *Member Notification — Expedited (≤72 hrs)*	Qualitative	File Review	100.0%			

Only APPEAL-001 Acknowledgement is quantitative, validated on the full appeal-log universe. Every other measure is qualitative and File Review-sourced — computed from the nurse-verified dates on the Sample Log (NCQA 8/30: scored on 8, opens to 30 if below 95%). Band: > 96% Green · 95%–96% Yellow · < 95% Red.

OLUME & MIX — Oversight Talking Points (full appeal-log universe

Metric	Count	% of total
Total appeals received	**34**	
• Determination by the Plan	24	70.6%
• Determination by a delegate	10	29.4%
• Processed as Standard	33	97.1%
• Processed as Expedited	1	2.9%
• Overturned	17	50.0%
• Upheld	0	0.0%
• SPD appeals	10	29.4%
• Referred to quality review	0	0.0%

AVERAGE TURNAROUND · receipt → resolution		
• All appeals (universe)	22.3 days	
• Spanish-language appeals	22.3 days	

Counts and averages read from the full appeal log (TAT Review). Plan/delegate reflects who made the initial UR determination on medical-necessity appeals.

APPEALS BY NATURE / CATEGORY

Category (auto-detected)	Count	% of total
Not Medically Necessary-Diagnostic - CAT Scan	2	5.9%
Not Medically Necessary-Diagnostic - Ultrasound	1	2.9%
ILOS Related-Recuperative Care (Medical Respite)	8	23.5%
Not Medically Necessary-Diagnostic - MRI	6	17.6%
Pharmacy Denial-RX - Does Not Meet Exception Guidelines	1	2.9%
Not Medically Necessary-Surgical - Arthroscopy	2	5.9%
ILOS Related-Meals/Medically Tailored Meals	1	2.9%
Not Medically Necessary-Other - Anesthesia Service	1	2.9%
Not Medically Necessary-Diagnostic - MUGA/PET Scan	2	5.9%
Pharmacy Denial-RX - Does Not Meet Prior Auth Guidelines	1	2.9%
ILOS Related-Community Transition Services	1	2.9%
Not Medically Necessary-DME - Other	3	8.8%

DELEGATION OVERSIGHT

Health Net of CA — Q1 2026 MHSUD / BHT Scorecard

Report date: August 5, 2026

MENTAL HEALTH & SUBSTANCE USE DISORDER · BEHAVIORAL HEALTH TREATMENT

BHT-001	BHT-002	BHT-003
Level of Care (LOC) Assessment	BH Treatment Plan	County BH Coordination
Qualitative	*Qualitative*	*Qualitative*
98.39%	**94.81%**	**94.34%**

BHT-004	BHT-005	BHT-006
Transitions of Care — BH Discharge	MAT Access (SUD only)	Oversight & Delegation
Qualitative	*Qualitative*	*Qualitative*
no cases	**no cases**	**94.96%**

KPI #	KPI / Sub-measure	Type	Source	Q1	Q2	Q3	Q4
BHT-001	Level of Care (LOC) Assessment	Qualitative	File Review	98.39%			
BHT-002	BH Treatment Plan	Qualitative	File Review	94.81%			
BHT-003	County BH Coordination	Qualitative	File Review	94.34%			
BHT-004	Transitions of Care — BH Discharge	Qualitative	File Review	no cases			
BHT-005	MAT Access (SUD only)	Qualitative	File Review	no cases			
BHT-006	Oversight & Delegation	Qualitative	File Review	94.96%			
	Overall compliance (all blocks)	Qualitative	File Review	95.63%			

All six MHSUD-BHT KPIs are qualitative and File Review-sourced, scored 1 / 0 / N-A against the case file (NCQA 8/30: scored on 8, opens to 30 if below 95%). N/A is excluded from every rate. Band: > 96% Green · 95%–96% Yellow, warning letter · < 95% Red, CAP required. KPI numbers follow the CHPIV Master KPI List — AMP Section VI numbers Transitions of Care as BHT-003 and omits BHT-004 and BHT-005.

OVERSIGHT TRENDS — where the failures concentrate

Signal	Count	Rate
• Criteria scoring below the 95% floor	12	44.4%
• Lowest-scoring single criterion	75.00%	
• Consent & information sharing (BHT-FR-002.8 and 003.1)	34	79.1%
• RM-12 treatment plan review ≤ 6 months (BHT-FR-002.4 and 002.5)	22	84.6%
• Cases with at least one recorded failure	8	26.7%
• KPIs with no applicable cases in this sample	6	
• Cases flagged as a pattern worth escalating	0	0.0%
• Member identifiers populated (name / ID / DOB / county / language)	150	100.0%

Rates exclude N/A. A blank is a missing determination, not an N/A — the Unscored column on the File Review tab must read zero before sign-off.

LOG VALIDATION — does the delegate log agree with the case files?

Check	Log says	File review says	Agreement
• LOC assessment date recorded		100.0%	
• BH treatment plan date recorded		100.0%	
• Treatment plan reviewed within the RM-12 interval		84.6%	
• 72-hour post-discharge follow-up completed			
• Same/next-day outpatient BH appointment confirmed			
• Members with a BH discharge in the period (universe → sample)	0	0	

The delegate log and the case files answer some of the same questions independently. Where they agree, the log is evidence. Where they disagree, the log is wrong — a data-integrity finding under AMP Section VIII, separate from the delegate's performance, with its own CAP path after three failed submissions.

DELEGATION OVERSIGHT

Health Net Claims Scorecard

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CLAIMS TIMELINESS & PAYMENT INTEGRITY

CLM001	CLM002	CLM003
Payment ≤ 30 calendar days	Payment ≤ 45 working days	Payment ≤ 90 calendar days
Timeliness	*Timeliness*	*Timeliness*
100.0%	**100.0%**	**100.0%**

CLM004	CLM005	CLM006
Acknowledgement timeliness	Misdirected claims redirect	Interest on late claims
Timeliness	*Timeliness*	*Timeliness*
100.0%	**100.0%**	**100.0%**

COMPLIANCE DETAIL — timeliness measures (rate = compliant ÷ compliant+non-compliant)

Measure	Description	Numerator	Denominator	Compliance Rate	Result
PAYMENT TIMELINESS					
CLM001	Payment timeliness — within 30 calendar days	252817	252817	**100.0%**	**PASS**
CLM002	Payment timeliness — within 45 working days	252817	252817	**100.0%**	**PASS**
CLM003	Payment timeliness — within 90 calendar days	252817	252817	**100.0%**	**PASS**
ACKNOWLEDGEMENT					
CLM004	Acknowledgement timeliness — overall	251479	251479	**100.0%**	**PASS**
CLM004-E	Acknowledgement — electronic	247832	247832	**100.0%**	**PASS**
CLM004-P	Acknowledgement — paper	3647	3647	**100.0%**	**PASS**
MISDIRECTED & INTEREST					
CLM005	Misdirected claims timeliness	10157	10157	**100.0%**	**PASS**
CLM006	Interest payment on late claims	1437	1437	**100.0%**	**PASS**

Band: ≥ 96% Green · 95%–96% Yellow · < 95% Red. Rates read every row of the Claims Log.

VOLUME & MIX — Oversight Talking Points (full claims universe)

Metric	Count	% of total	Contracted (C)	Non-Contr. (NC)
Total claims received	**252817**		**177221**	**75596**
• Electronic (E)	247832	98.0%	174667	73165
• Paper (P)	4985	2.0%	2554	2431
• Paid / approved	194987	77.1%	138845	56142
• Denied	38793	15.3%	29027	9766
• Overpayments flagged (Y)	4	0.0%	4	0
• Interest due (Y)	1437	0.6%	1241	196

• Redirected / misdirected (Y)	10157	4.0%	3852	6305

CLAIM DOLLARS

Dollar metric	Amount		Contracted (C)	Non-Contr. (NC)
Total billed amount	**$408,378,445**		$345,530,335	$62,848,110
Total net paid (less interest)	**$33,536,512**		$29,736,379	$3,800,133
Total overpayment recovered	**$51**		$51	$0
Largest single billed claim	**$999,728**		$998,060	$999,728

UTILIZATION — cost & service intensity (over / under)

Utilization measure	Value	Context	Contracted (C)	Non-Contr. (NC)
Average billed per claim	**$1,615**		$1,950	$831
High-cost claims (≥ $10,000) ▲ over	**4486**	1.8%	3854	632
High-cost billed $	**$254,315,289**		$232,761,924	$21,553,364
Denial rate ▼ under / access	**38793**	15.3%	29027	9766

BY TYPE OF SERVICE (service-line utilization)

Type of service	Claims	Billed $	Denied	% claims	C	NC
↓ auto-detected; claims, billed $, denials & the contracted (C) / non-contracted (NC) split span every claim						
12	22852	$9,328,748	2691	9.0%	18296	4556
10	3245	$918,566	210	1.3%	2879	366
11	79557	$29,906,424	5941	31.5%	63343	16214
20	6635	$2,323,599	265	2.6%	6511	124
23	22734	$17,424,355	1377	9.0%	5768	16966
81	25206	$22,572,912	16521	10.0%	20445	4761
21	10903	$139,634,254	1600	4.3%	5278	5625
2	6861	$1,572,591	804	2.7%	6111	750
22	57327	$119,495,971	6961	22.7%	33537	23790
99	11496	$48,541,729	1683	4.5%	11113	383
24	661	$2,294,627	87	0.3%	367	294
72	289	$91,383	5	0.1%	289	0
31	1313	$7,659,502	198	0.5%	951	362
19	47	$8,985	8	0.0%	5	42
61	48	$17,657	29	0.0%	9	39

PAPER vs ELECTRONIC (submission mix)

Submission type	Count	% of total	Contracted (C)	Non-Contr. (NC)
Electronic (E)	247832	98.0%	174667	73165
Paper (P)	4985	2.0%	2554	2431

BY CONTRACT STATUS (contracted vs non-contracted)

Contract status	Claims	Billed $	Denied	% of claims
↓ auto-detected — scans the first 10,000 rows for contract-status values; claims, billed $ & denials span every claim				
C	177221	$345,530,335	29027	70.1%
NC	75596	$62,848,110	9766	29.9%

BY CLAIM DISPOSITION (highly approved / denied)

Disposition	Count	% of total	Contracted (C)	Non-Contr. (NC)
Paid	194987	77.1%	138845	56142
Approved	0	0.0%	0	0
Denied	38793	15.3%	29027	9766
Contested / pended	19107	7.6%	9383	9724
Adjusted / reversed	0	0.0%	0	0

REDIRECTS — misdirected claims & where sent

Claims redirected (Redirected = Y)	10157	4.0%	3852	6305
Where redirected	**Count**	**% of redir.**	**Contracted (C)**	**Non-Contr. (NC)**

↳ auto-detected across every redirected claim, C / NC split included. "NA" = redirected but NO destination recorded — an auditor finding to send back to the delegate

OVERPAYMENT — recovery trend

Claims flagged (Overpayment = Y)	4	0.0%
Total overpayment recovered	$51	
Average recovery per overpayment	$13	

Overpayment reason — list values	Count	$ recovered	C	NC

↳ auto-detected across every overpayment, C / NC split included. "NA" = flagged but NO reason recorded — an auditor finding to correct

Rec: Provider reduced billed charges	1	$51	1	0
Unslctd refund -provider billing error	3	$0	3	0

BY CPT / HCPCS CODE (ranked by billed $ — top codes)

CPT / HCPCS	Claims	Billed $	% of claims	C	NC

↳ top 25 codes by billed $ (auto-detected & ranked); claims, billed $ & the C / NC split span every claim

CPT: 99214, REV:	10017	$2,743,675	4.0%	7883	2134
CPT: 99213, REV:	10111	$2,138,006	4.0%	8147	1964
CPT: 74177, REV:	1143	$434,168	0.5%	200	943

CPT: 99223, REV:	602	$408,397	0.2%	344	258
CPT: 99204, REV:	959	$380,201	0.4%	704	255
CPT: 87804, 99214, REV:	927	$356,625	0.4%	917	10
CPT: 90837, REV:	1443	$311,435	0.6%	1360	83
CPT: 99203, REV:	770	$218,361	0.3%	502	268
CPT: 99212, REV:	1690	$178,001	0.7%	815	875
CPT: 71045, REV:	3326	$131,775	1.3%	729	2597
CPT: 71275, REV:	299	$118,174	0.1%	51	248
CPT: 59400, REV:	21	$91,918	0.0%	20	1
CPT: 87804, 99204, REV:	201	$77,318	0.1%	200	1
CPT: 71046, REV:	1476	$71,695	0.6%	448	1028
CPT: 96372, 99214, J1100, J18	156	$68,293	0.1%	153	3
CPT: 81003, 99214, REV:	168	$52,287	0.1%	134	34
CPT: K0001, REV:	426	$48,460	0.2%	178	248
CPT: 96372, 99213, J1100, J18	95	$34,917	0.0%	95	0
CPT: 93971, REV:	188	$31,809	0.1%	68	120
CPT: 87086, REV:	523	$30,417	0.2%	407	116
CPT: E0465, REV:	13	$26,763	0.0%	13	0
CPT: 74018, REV:	551	$26,155	0.2%	224	327
CPT: 76815, 76817, REV:	101	$22,722	0.0%	10	91
CPT: 87804, 96372, 99214, J11	46	$22,520	0.0%	46	0
CPT: 80053, 80061, 83036, 850	89	$19,388	0.0%	30	59

BY PROVIDER (ALL providers — paste the full list)

Provider — paste ALL	Claims	Billed $	Denied	Approved / paid	Denial %	C	NC	Mixed C/NC?
↓ paste EVERY provider in column B (Data tab ▸ copy the Provider column ▸ Data ▸ Remove Duplicates ▸ paste here), then press F9. Sort by Billed $ to rank. ⚠ both = provider marked BOTH contracted and non-contracted (data inc								
EL CENTRO REGIONAL MEDICAL	18599	$57,804,610	4242	13685	22.8%	18587	12	⚠ both
PIONEERS MEMORIAL HOSPITAL	9698	$9,438,360	556	8500	5.7%	192	9506	⚠ both
DOUGLAS JUAREZ, M.D.	7187	$2,771,809	249	6001	3.5%	0	7187	
AMEEN ALSHAREEF, M.D.	6275	$1,930,653	581	5668	9.3%	6275	0	
OMALI DIAGNOSTICS, LLC	5232	$8,540,234	5232	0	100.0%	5230	2	⚠ both
SERENE HEALTH GROUP LLC	4630	$540,555	214	4404	4.6%	4630	0	
PIONEERS MEMORIAL HEALTHCARE D	4433	$23,717,322	743	3487	16.8%	4351	82	⚠ both
PRIME DX LABS, LLC	4320	$4,625,301	4201	94	97.2%	4319	1	⚠ both
JOHN STRONG, M.D.	4255	$686,279	328	3639	7.7%	4253	2	⚠ both
ALEGRIA ADULT DAY HEALTH CARE	4146	$316,314	114	4032	2.7%	4146	0	
BRIAN KAY, D.O.	3802	$992,943	146	3467	3.8%	0	3802	
LABCORP SAN DIEGO	3340	$2,163,081	159	1989	4.8%	3340	0	
ECRMC - EL CENTRO OUTPATIENT	3252	$768,236	458	2788	14.1%	3252	0	
QUEST DIAGNOSTICS WEST HILLS	2703	$1,270,521	357	2229	13.2%	2703	0	
VACHASPATH PALAKODETI, M.D.	2599	$888,962	66	2419	2.5%	2599	0	
JUAN VELAZQUEZ, M.D.	2449	$385,596	176	2160	7.2%	2449	0	
ANTHONY HUYNH, M.D.	2431	$774,779	58	2348	2.4%	2431	0	
ECRMC - CALEXICO OUTPATIENT	2355	$525,035	333	2016	14.1%	2354	1	⚠ both
SOHAIB TARIQ, M.D.	2118	$1,437,172	78	2006	3.7%	0	2118	
LABORATORY CORPORATION OF AMER	2094	$1,097,681	1762	182	84.1%	0	2094	
JOHN SANICO, M.D.	2019	$187,552	122	1363	6.0%	0	2019	

BYRAM HEALTHCARE CENTERS, INC.	2018	$520,592	45	1851	2.2%	2018	0	
MOHSEN ELRAMAH, M.D.	1940	$769,694	73	1825	3.8%	1940	0	
QUI JEFF VO, M.D.	1930	$186,505	156	1260	8.1%	0	1930	
CLINICAS DE SALUD DEL PUEBLO	1917	$770,379	35	1860	1.8%	3	1914	⚠ both
MOHSEN EL RAMAH, M.D.	1909	$310,131	771	1111	40.4%	1909	0	
AMILCAR DIAZ, M.D.	1902	$199,313	97	1403	5.1%	0	1902	
PATRICK WOLCOTT, M.D.	1880	$629,754	54	1794	2.9%	1875	5	⚠ both
ACTIVE LIFE MEDICAL PRODUCTS	1865	$551,054	131	1652	7.0%	1865	0	
VISHWA KAPOOR, M.D.	1853	$698,015	22	1809	1.2%	1853	0	
ALIDAD ZADEH, D.O.	1738	$402,200	374	1342	21.5%	1738	0	
RADY CHILDRENS HOSP SD	1668	$6,241,412	48	1572	2.9%	1668	0	
UNNATI SAMPAT, M.D.	1572	$750,441	29	1511	1.8%	1570	2	⚠ both
LORENZO SUAREZ, M.D.	1561	$391,264	48	1488	3.1%	1561	0	
NATIONAL HEALTH CARE AND	1519	$344,063	34	1483	2.2%	1519	0	
THEODORE AFFUE, M.D.	1500	$581,359	18	1468	1.2%	1500	0	
MEDZED PHYSICIAN SERVICES, INC	1470	$543,714	29	1440	2.0%	1470	0	
JAIME ESTRADA, M.D.	1419	$348,725	90	1308	6.3%	1419	0	
UCSD MEDICAL CENTER	1408	$34,629,327	182	1021	12.9%	1394	14	⚠ both
IMPERIAL VALLEY HEALTHCARE DIS	1407	$5,747,934	86	1226	6.1%	0	1407	
BETTERNIGHT	1327	$209,720	192	1036	14.5%	1326	1	⚠ both
BHARATH SURAPANENI, M.D.	1299	$101,677	84	905	6.5%	0	1299	
WILLIAM CREIGHTON, M.D.	1281	$78,646	19	1150	1.5%	0	1281	
ATHAR ANSARI, M.D., INC.	1270	$781,458	40	1194	3.1%	1270	0	
SUNRISE RESPIRATORY CARE, INC.	1245	$191,596	65	1106	5.2%	0	1245	
RAY LOO, M.D	1234	$737,512	44	1189	3.6%	1234	0	
APRIA HEALTHCARE LLC - EL CENT	1209	$733,921	68	1063	5.6%	1145	64	⚠ both
BRIAN TYSON, M.D.	1192	$453,454	61	1075	5.1%	1187	5	⚠ both
VIJAYKANTH MAHENDRAKAR, M.D	1188	$370,103	127	1037	10.7%	1188	0	
IMPERIAL VALLEY FAMILY CARE	1101	$198,176	931	119	84.6%	102	999	⚠ both
UCSD EMERGENCY PHYSICIANS	1075	$614,419	68	980	6.3%	0	1075	
MAN DUONG, M.D.	1062	$425,434	23	1019	2.2%	1062	0	
DAYOUT ADHC - EL CENTRO	1054	$398,144	94	960	8.9%	1054	0	
RESOLUTIONCARE, PC	994	$150,171	209	781	21.0%	994	0	
LIN KYAUNG	908	$107,983	25	883	2.8%	908	0	
ALFREDO NEGRETE, M.D.	905	$219,141	53	834	5.9%	905	0	
COLLIN FLEECS, P.T.	903	$310,051	17	853	1.9%	903	0	
JOHANNA MURILLO, B.C.B.A.	889	$110,360	24	865	2.7%	889	0	
JACLYN PERAKIS, P.T.	856	$295,659	43	789	5.0%	856	0	
ANDRES MALDONADO, F.N.P.	848	$303,964	20	786	2.4%	847	1	⚠ both
DAVID JOSE RODRIGUEZ, F.N.P.	823	$298,979	27	745	3.3%	823	0	
SAYED MONIS, M.D.	823	$757,865	25	763	3.0%	0	823	
UNILAB CORPORATION	820	$301,382	728	29	88.8%	820	0	
JOEL ROMO, F.N.P.	808	$299,495	5	767	0.6%	802	6	⚠ both
BRIAN BIGONI, M.D.	805	$398,181	131	665	16.3%	805	0	
TAYSON DELENGOCKY, D.O.	785	$605,590	33	736	4.2%	0	785	
MASOUD AFSHAR, M.D.	755	$207,824	28	707	3.7%	751	4	⚠ both
MERVAT KELADA, M.D.	736	$82,305	58	660	7.9%	0	736	

LISA ROSA-RE, M.D.	733	$176,035	111	425	15.1%	0	733	
LABCORP - PHOENIX	730	$514,209	51	558	7.0%	0	730	
VINCENT SOUN, M.D.	728	$206,346	30	658	4.1%	728	0	
AKASHDEEP DHALIWAL, D.O.	707	$143,750	73	425	10.3%	0	707	
PACIFIC HEALTH GROUP	707	$109,092	384	323	54.3%	707	0	
HAMID ZADEH, M.D.	698	$429,504	39	652	5.6%	698	0	
ISSADORA LARA, M.D.	683	$159,058	89	422	13.0%	0	683	
RICARDO VILLALBA LOPEZ, M.D.	663	$197,851	28	426	4.2%	0	663	
IV FAMILY CARE MED GROUP CORP	636	$138,199	11	604	1.7%	0	636	
MICHELLE MELENDEZ, M.D.	626	$155,517	86	367	13.7%	0	626	
ELIJAH BISHOP III, P.T.	625	$210,022	1	602	0.2%	625	0	
EMILIANO HIGUERA, M.D.	625	$162,970	50	404	8.0%	625	0	
LESSLY NEGRETE-TUY, B.C.B.A	618	$63,270	8	610	1.3%	618	0	
PAUL JAFFRAY, M.D.	607	$163,207	35	436	5.8%	0	607	
JAY KENNET BUENAFLOR, M.D.	603	$195,695	5	591	0.8%	603	0	
REGENTS OF THE UNIVERSITY OF C	588	$12,852,724	227	336	38.6%	583	5	⚠ both
YUJI SEO, M.D.	584	$1,059,530	46	474	7.9%	584	0	
NEREIDA MELCHOR	572	$58,651	15	556	2.6%	572	0	
DAWN KELLEY-LEWIS, N.P.	571	$224,702	17	524	3.0%	571	0	
STEVEN ROUGH, M.D.	550	$555,621	112	427	20.4%	550	0	
KEVIN SULLIVAN, D.O.	530	$661,419	10	380	1.9%	530	0	
AMANDA CUELLAR, N.P.	529	$116,907	79	406	14.9%	37	492	⚠ both
LETICIA PERALTA	514	$61,230	16	498	3.1%	514	0	
CANCER RESOURCE CENTER OF THE	511	$56,146	7	490	1.4%	511	0	
DANIEL MANJARREZ, M.D.	510	$129,439	18	476	3.5%	510	0	
GABRIEL LAM, L.C.S.W.	510	$78,699	7	479	1.4%	510	0	
SANJAY VASWANI, M.D.	501	$115,748	14	464	2.8%	501	0	
GEORGE RAPP, M.D.	485	$67,121	65	293	13.4%	66	419	⚠ both
ASHLEY HERRIN, D.O.	480	$604,537	11	374	2.3%	0	480	
ALI GHOLAMREZANEZHAD, M.D.	473	$120,408	48	291	10.1%	330	143	⚠ both
MAJID MANI, M.D.	472	$400,425	6	459	1.3%	268	204	⚠ both
LENA VAN	471	$60,618	9	462	1.9%	471	0	
ELANA GODEBU, M.D.	466	$268,915	7	459	1.5%	466	0	
CARESSE VUONG, M.D.	465	$572,616	10	349	2.2%	465	0	
JORGE ROBLES, M.D.	462	$136,104	21	429	4.5%	462	0	
YONG TAN, M.D.	459	$155,230	20	430	4.4%	459	0	
MEHBOOB GHULAM, D.O.	458	$106,833	22	418	4.8%	458	0	
HEATHER BOYNTON, M.D.	455	$571,804	7	349	1.5%	455	0	
BLANCA CASTELLANOS	451	$64,772	7	387	1.6%	451	0	
ABRAHAM SALCIDO, B.C.B.A.	444	$49,309	10	434	2.3%	444	0	
MARIO CEJA, M.D.	440	$110,017	12	418	2.7%	440	0	
MARCELA PERDOMO	437	$540,154	15	418	3.4%	437	0	
VANESSA HERNANDEZ, D.O.	431	$137,790	14	345	3.2%	50	381	⚠ both
AMERICAN MEDICAL RESPONSE	428	$2,541,973	24	57	5.6%	0	428	
MAURICIO PONS, M.D.	425	$284,015	18	402	4.2%	425	0	
DAVID HUERTA, B.C.B.A.	424	$539,595	0	424	0.0%	424	0	
OLGA DIAZ, M.D.	410	$525,947	4	303	1.0%	409	1	⚠ both

AUSTINA CHO, M.D.	405	$94,823	42	357	10.4%	405	0	
DIANA DANG, M.D.	404	$123,518	17	383	4.2%	404	0	
MICHAEL KOSOFSKY, M.D.	399	$536,544	10	280	2.5%	399	0	
EDWARD SMITAMAN, M.D.	398	$48,551	48	294	12.1%	274	124	⚠ both
SLEEP DATA HOLDINGS, LLC	392	$130,683	9	352	2.3%	392	0	
KARINA ALCOCER, B.C.B.A.	390	$50,827	10	380	2.6%	390	0	
ANOOSHIRVA BOZORGMEHR, D.O.	388	$150,382	2	376	0.5%	385	3	⚠ both
DAYOUT ADHC - BRAWLEY	384	$138,290	36	348	9.4%	384	0	
JOHN GUERRERO, N.P.	381	$113,411	60	295	15.7%	381	0	
CITY OF CALEXICO FIRE DEPT.	379	$501,066	17	24	4.5%	0	379	
SARA BENITEZ, B.C.B.A.	374	$182,200	15	351	4.0%	374	0	
WALID ABDALLAH, M.D.	369	$357,295	16	346	4.3%	369	0	
ANGELA LASHINSKI	367	$397,188	13	347	3.5%	367	0	
VIVIANA MORALES, P.T.	360	$128,984	11	340	3.1%	0	360	
VAHE ESMAEILI	351	$45,001	7	344	2.0%	351	0	
POSITIVE BEHAVIOR SUPPORTS	349	$40,981	2	347	0.6%	349	0	
CHARLES STEVENS, M.D.,APC	346	$108,486	4	340	1.2%	346	0	
JAMES PEAIRS, M.D.	344	$277,950	12	323	3.5%	344	0	
JOEL SOLANO, M.D.	341	$194,802	77	257	22.6%	341	0	
IOANA MOLDOVAN, M.D.	332	$80,718	15	315	4.5%	332	0	
JAMES NELSON, M.D.	317	$388,172	10	240	3.2%	317	0	
SOUTHERN C PATHOLOGY ASSOC LABOR/	317	$251,191	306	0	96.5%	317	0	
VICTOR RIVERA BATIZ, B.C.B.A.	314	$41,595	7	307	2.2%	314	0	
ELANA GODEBU	313	$213,420	30	275	9.6%	0	313	
MOBIN MALIK, M.D.	313	$87,383	30	281	9.6%	0	313	
ROSARIO ARAGUAS , D.P.M.	313	$57,789	26	282	8.3%	313	0	
JULIE AN, M.D.	307	$77,148	10	267	3.3%	0	307	
KESTUTIS KURAITIS, M.D.	302	$306,764	6	216	2.0%	302	0	
ATHENIE GALVEZ, P.T.	300	$108,085	7	290	2.3%	300	0	
JESUS EQUIHUA, P.T.	300	$92,768	4	283	1.3%	300	0	
GEORGIOS PAPASTERGIOU, M.D.	298	$210,720	2	293	0.7%	285	13	⚠ both
DACARE INC	292	$21,322	18	274	6.2%	292	0	
ARNETT CARRABY, M.D.	286	$218,680	7	271	2.4%	286	0	
GUSTAVO MARTINEZ, N.P.	285	$358,299	1	212	0.4%	285	0	
KAROON CLINICAL LABORATORY	285	$225,950	285	0	100.0%	285	0	
ANGELA MACIS, B.C.B.A.	282	$40,975	7	275	2.5%	282	0	
ROOTS FOOD GROUP MANAGEMENT LL	278	$34,873	43	235	15.5%	273	5	⚠ both
LAB CORP OF AMERICA - LITTLE	277	$118,010	242	7	87.4%	277	0	
RAUL OVIEDO-LINARES, M.D. A MED COR	276	$186,092	11	260	4.0%	276	0	
UNI CARE HOME CARE INC	276	$243,995	272	0	98.6%	6	270	⚠ both
REBECCA BAJKOWSKI, M.D.	275	$351,567	5	203	1.8%	0	275	
MARIO MORENO, M.D.	274	$57,083	40	205	14.6%	204	70	⚠ both
YUMA REGIONAL MEDICAL CENTER	273	$2,906,255	56	178	20.5%	0	273	
ERIC MENDOZA, PSY.D.	266	$51,771	4	191	1.5%	266	0	
DND PHARMACY INC	263	$41,976	20	202	7.6%	0	263	
SMA MEDICAL INC	263	$60,793	257	0	97.7%	263	0	
GAYLE KOOKOOTSEDES, M.D.	260	$65,650	8	228	3.1%	0	260	

HUSSEIN EL-NEWIHI, M.D.	259	$153,867	17	234	6.6%	259	0	
JOY LIAU, M.D.	258	$75,373	26	208	10.1%	185	73	⚠ both
AILEEN CONEJO	257	$31,782	7	250	2.7%	257	0	
KAREN CHENG, M.D.	257	$35,625	83	152	32.3%	183	74	⚠ both
K & K HOME HEALTH CARE INC	251	$119,052	251	0	100.0%	0	251	
N YOUR HOME HEALTH CARE	249	$67,406	22	220	8.8%	248	1	⚠ both
WOMENS HEALTH CENTER	242	$146,721	46	191	19.0%	242	0	
COLIN IP, M.D.	241	$136,910	16	216	6.6%	241	0	
JONATHAN CIRIELLO, M.D.	238	$25,501	3	201	1.3%	0	238	
CYNTHIA SANTILLAN, M.D.	231	$62,929	35	176	15.2%	183	48	⚠ both
MICHAEL SAMUEL, M.D.	230	$122,634	44	181	19.1%	230	0	
PIONEERS MEMORIAL SKILLED NURS	229	$2,292,706	1	227	0.4%	229	0	
EL CENTRO REGIONAL MEDICAL CEN	228	$52,239	129	79	56.6%	227	1	⚠ both
VITALIY ZAK, M.D.	228	$166,469	78	145	34.2%	65	163	⚠ both
ARGO HOME HEALTH, INC.	227	$168,751	227	0	100.0%	0	227	
SAQIB RAZZAQUE, M.D.	227	$45,183	5	218	2.2%	227	0	
IMPERIAL VALLEY FAMILY CARE ME	226	$124,300	127	48	56.2%	0	226	
SYED AHMED, M.D.	225	$39,532	0	220	0.0%	225	0	
ALLAN WU, M.D.	223	$34,579	33	5	14.8%	222	1	⚠ both
ETHAN GERDTS, M.D.	223	$293,227	3	180	1.3%	223	0	
COLIN BACORN, M.D.	220	$109,660	1	213	0.5%	220	0	
EDWIN RUIZ, P.T.	220	$74,498	2	217	0.9%	220	0	
EL CENTRO POST ACUTE - CARE	220	$1,427,974	37	179	16.8%	220	0	
KATHRYN DELGADO, P.T.	219	$75,454	2	217	0.9%	0	219	
OSCAR AGUILAR, L.C.S.W.	218	$45,908	0	206	0.0%	218	0	
SAYED SADAT, D.O.	218	$52,152	21	136	9.6%	144	74	⚠ both
LISA BEAN, M.D.	210	$62,003	9	162	4.3%	0	210	
MARIANA MAGANA, L.C.S.W.	208	$38,592	1	198	0.5%	208	0	
EMMANUEL MUNOZ, F.N.P.	206	$82,683	12	182	5.8%	205	1	⚠ both
ALTON SKAGGS, M.D.	200	$48,920	32	113	16.0%	143	57	⚠ both
LESLIE J ACERO, B.C.B.A.	197	$114,525	10	187	5.1%	197	0	
JOSE NAVARRO, N.P.	192	$72,279	7	176	3.6%	179	13	⚠ both
YUSEINNY VALLE PENA	191	$32,555	4	187	2.1%	191	0	
SHAHID HUSSAIN, M.D.	190	$87,853	7	171	3.7%	190	0	
CHRISTOPHE KANE, M.D.	189	$10,029	166	15	87.8%	153	36	⚠ both
I.V. FAMILY PHARMACY, INC.	187	$7,603	7	148	3.7%	0	187	
THOMAS LOEHFELM, M.D.	185	$53,554	4	167	2.2%	0	185	
DENISE CACCARILE	183	$27,689	3	180	1.6%	183	0	
NATHANAEL SMITH, D.P.M.	182	$50,077	10	98	5.5%	0	182	
JAMES CREEK, M.D.	181	$39,622	21	157	11.6%	181	0	
MICHELLE PONCE MORALES PHUNG, B.C.E	178	$22,059	0	178	0.0%	178	0	
VALLEY ENDOSCOPY CENTER	176	$414,600	20	146	11.4%	174	2	⚠ both
LOURDES GONZALEZ, B.C.B.A.	175	$330,246	1	171	0.6%	174	1	⚠ both
MOHAMMED AL-JASIM, M.D.	175	$49,776	3	167	1.7%	175	0	
SELEAINA THOMAS, F.N.P.	175	$55,322	2	173	1.1%	175	0	
BENJAMIN REISIN, M.F.T.	174	$34,278	4	163	2.3%	174	0	
CAIRINE MCNAMEE, M.D.	174	$48,202	10	143	5.7%	111	63	⚠ both

ALICIA KURTZ, M.D.	173	$216,110	1	138	0.6%	173	0	
RODOLFO MERCADO, L.C.S.W.	173	$33,944	1	141	0.6%	173	0	
BRIAN HURT, M.D.	172	$26,018	23	118	13.4%	116	56	⚠ both
RAFID ASFAR, M.D.	172	$31,615	13	159	7.6%	172	0	
TAILUN ZHAO, M.D.	170	$105,409	48	120	28.2%	170	0	
BLANCA TELLEZ, B.C.B.A.	169	$19,305	3	166	1.8%	169	0	
VERONICA LANDEROS, L.C.S.W.	169	$34,483	3	158	1.8%	169	0	
PAUL MURPHY, M.D.	168	$58,546	38	104	22.6%	111	57	⚠ both
BRADY HUANG, M.D.	167	$20,982	23	125	13.8%	110	57	⚠ both
BERNARD LICHTENSTEIN, M.D.	166	$26,235	2	158	1.2%	0	166	
ADAM SEARLEMAN, M.D.	165	$50,694	10	137	6.1%	0	165	
DUC NGUYEN, D.P.M.	160	$28,518	6	144	3.8%	160	0	
ELIAS MOUKARZEL, M.D.	158	$54,626	79	67	50.0%	0	158	
GENE2GENOME LLC	158	$252,878	156	0	98.7%	158	0	
CODY COOPER, P.T.	157	$50,884	27	123	17.2%	0	157	
DORATHY TAMAYO MURILLO, M.D.	154	$41,608	33	108	21.4%	104	50	⚠ both
SHARP MEMORIAL HOSPITAL	154	$2,849,461	43	91	27.9%	92	62	⚠ both
ANH VO, D.O.	153	$83,428	4	86	2.6%	0	153	
MINH NGUYEN, M.D.	153	$92,189	46	74	30.1%	153	0	
GENENTOX LABORATORIES LLC	151	$80,635	151	0	100.0%	26	125	⚠ both
ODAY SAEED, M.D.	151	$55,764	7	140	4.6%	151	0	
MICHAEL HOROWITZ, M.D.	150	$17,109	17	107	11.3%	101	49	⚠ both
PETER SU, M.D.	148	$80,929	39	74	26.4%	148	0	
OMEGA DIAGNOSTIC LABORATORIES	145	$233,415	145	0	100.0%	145	0	
PURFOODS, LLC	145	$29,005	1	144	0.7%	145	0	
JOHN FRIEDLINE, M.D.	144	$49,061	6	135	4.2%	0	144	
ANDRES GUTIERREZ	143	$277,719	0	137	0.0%	143	0	
FRESENIUS MEDICAL CARE	143	$13,445,487	0	110	0.0%	143	0	
THOMAS AUBUCHON, M.D.	143	$180,949	2	109	1.4%	143	0	
TRISA JESSAMY	142	$15,965	3	139	2.1%	142	0	
ARTHUR MABAQUIAO, M.D.	141	$67,712	2	139	1.4%	141	0	
SCRIPPS HEALTH	140	$3,005,619	103	33	73.6%	110	30	⚠ both
NILKANTH AMS, INC	139	$15,926	11	113	7.9%	0	139	
GARFIELD BEACH CVS LLC - CALEX	138	$15,026	3	122	2.2%	0	138	
SAMUEL IRONS, D.P.M.	138	$40,079	4	94	2.9%	0	138	
QUEST DIAGNOSTICS - NICHOLS	137	$53,536	60	68	43.8%	137	0	
SHARON BROUHA, M.D.	135	$15,224	11	95	8.1%	87	48	⚠ both
DIAMED LABORATORY SERVICES INC	134	$51,516	129	0	96.3%	134	0	
ALTERNATIVE BEHAVIOR	133	$71,400	7	124	5.3%	133	0	
ENRIQUE AGUILAR-COTA	133	$286,310	0	131	0.0%	133	0	
GARFIELD BEACH CVS, LLC	133	$24,218	7	115	5.3%	0	133	
PATRICIA ROMERO, F.N.P.	133	$27,000	43	58	32.3%	54	79	⚠ both
JFK MEMORIAL HOSPITAL, INC.	130	$4,904,258	20	106	15.4%	130	0	
MEGAN DEMOTT, M.D.	130	$162,710	6	104	4.6%	130	0	
REAL DIAGNOSTICS, LLC	130	$155,591	129	1	99.2%	130	0	
KOOROSH KOOROS, M.D.	129	$57,930	17	111	13.2%	129	0	
MORGAN NOWLIN, D.O.	128	$31,306	1	69	0.8%	0	128	

LABORATORY CORPORATION OF	127	$61,796	120	5	94.5%	127	0	
SURGERY CENTER OF CALIFORNIA,	127	$456,396	56	21	44.1%	80	47	⚠ both
WELIM AZINGE, M.D.	127	$38,697	2	116	1.6%	125	2	⚠ both
STEPHEN GOCKE, M.D.	126	$66,269	1	107	0.8%	0	126	

By Provider lists every provider you paste (all rows read the full Claims Log). By CPT is ranked to the top codes by billed $. Other trend tables auto-detect their values from a sample window while all counts, dollars & rates read every row. A PivotTable on the Data tab (Provider in Rows, Contract status in Columns, Claim ID in Values) also lists all providers and flags any marked both.

DELEGATION OVERSIGHT

Health Net of CA — Continuity of Care Scorecard

Reporting period ending March 31, 2026 · Report date: August 5, 2026

CONTINUITY OF CARE

COC001	COC002
Processing Timeliness	Notification Timeliness
Quantitative	*Quantitative*
100.00%	**100.00%**

KPI #	KPI / Sub-measure	Type	Source	Q1	Q2	Q3	Q4
COC001	**Processing Timeliness**	Quantitative	CoC Log	**100.00%**			
COC001-N	↳ Non-Urgent	Quantitative	CoC Log	100.00%			
COC001-I	↳ Immediate	Quantitative	CoC Log	no cases			
COC001-U	↳ Urgent	Quantitative	CoC Log	100.00%			
COC001-S	↳ Special Populations	Quantitative	CoC Log	no cases			
COC002	**Notification Timeliness**	Quantitative	CoC Log	**100.00%**			
COC002-N	↳ Non-Urgent	Quantitative	CoC Log	100.00%			
COC002-I	↳ Immediate	Quantitative	CoC Log	no cases			
COC002-U	↳ Urgent	Quantitative	CoC Log	100.00%			
COC002-S	↳ Special Populations	Quantitative	CoC Log	no cases			

Both CoC KPIs are quantitative and calculated from the full CoC log — there is no case file review in this area, so every figure comes from the delegate submission. Rates count decided cases only: COMPLIANT ÷ (COMPLIANT + NON-COMPLIANT). Cancelled and pending requests are excluded, and open or overdue cases are reported separately below rather than being dropped. Band: > 96% Green · 95%–96% Yellow, warning letter · < 95% Red, CAP required.

LOG INTEGRITY — AMP Section VIII · must be clear before results are issued

Signal	7	Rate
• Duplicate case numbers	**0**	0.0%
• Missing case number — duplicates cannot be detected	**0**	0.0%
• Missing urgency tier — cannot be measured against a limit	**0**	0.0%
• Missing request date	**0**	0.0%
• Values not on the approved CoC Log list	**0**	0.0%
• Missing member ID — AMP Appendix A requires member identification	**0**	0.0%
• Cases excluded from every rate (cancelled or pending)	**0**	0.0%

A log that cannot be verified fails integrity review under AMP Section VIII. Three failed submissions trigger a CAP under Section X.A. Excluded cases are shown so the gap between the universe and the measured denominator is visible rather than silent.

OPEN & OVERDUE — still running against the clock

Signal	Count	Rate
• Determinations still open (within limit)	**0**	
• Determinations overdue	**0**	
• Notifications still open (within limit)	**0**	
• Notifications overdue	**0**	

Open and overdue cases sit outside the compliance rates because they have no outcome yet. An overdue case has already breached its limit and will land as non-compliant once decided — it is a leading indicator, not a neutral one.

OVERSIGHT TRENDS — where the failures concentrate

Signal	Count	Rate
• Denial rate	**7**	100.0%
• Urgent requests — the tightest limit, highest exposure	**3**	42.9%
• Processed at the limit or one day inside it (processing)	**0**	0.0%
• Notified on the same day as the determination	**7**	100.0%
• Requests with a non-English preferred language	**0**	0.0%
• Requested more than 90 days after enrollment	**7**	100.0%

Rates exclude cancelled and pending requests. Near-limit counts move before the KPI does — they give warning while the measure still reads compliant.

DENIAL ANALYSIS — reasons as recorded on the CoC Log

Reason	Count	% of denials
• CoC eligibility — no continuity to protect	**4**	**57.1%**
· No relationship between member and provider	0	0.0%
· Provider is in MCP network	4	57.1%
• Provider-driven — contracting and terms	**1**	**14.3%**
· Provider refused to work with managed care plan	1	14.3%
· Provider and plan did not agree to a rate	0	0.0%
• Provider qualification — regulatory	**0**	**0.0%**
· Provider not State approved	0	0.0%
• Quality of care	**0**	**0.0%**
· Quality of Care Issues	0	0.0%
• Other — uncategorised	**0**	**0.0%**
· Other	0	0.0%
Denials with a reason not on the approved list	0	0.0%

Reasons are the seven values on the CoC Log dropdown, grouped by what drives the denial. Percentages are of denied and modified requests. "No relationship between member and provider" and "Provider is in MCP network" both mean no continuity of care arises — a high share there suggests requests are reaching the CoC process that do not belong in it, rather than members being turned away from care they were receiving. A reason typed outside the list cannot be counted and is flagged.

DELEGATION OVERSIGHT — SUB-DELEGATE REVIEW

Health Net oversight of ModivCare (Transportation + Exempt Grievance)

Review period: Quarter 1 2026

Auditor: Joe Escobar Report date: —

DO-009	EXG-004	EXG-005
Transportation — ModivCare	Correct Classification	Handling & Resolution
100.0%	100.0%	100.0%
PASS · Green	*PASS · Green*	*PASS · Green*

SCORE DETAIL — BY SECTION & SUB-SECTION

#	Element	Score	Status				
OVERALL	Overall compliance — all sub-elements	100.0%	PASS				
DO-009	Transportation — forward to Plan, resolve, letter	100.0%	PASS				
DO-FR-009.1	*Forwarded over-24-hr exempt grievances to the Plan*	100.0%	PASS				
DO-FR-009.2	*Member received their resolution letter*	100.0%	PASS				
DO-FR-009.3	*NEMT/NMT performance thresholds met*	100.0%	PASS				
EXG-004	Correct classification of exempt grievance	100.0%	PASS				
EXG-FR-004.1	*Correctly classified exempt (≤24 hrs)*	100.0%	PASS				
EXG-FR-004.2	*Documented with reason code*	100.0%	PASS				
EXG-005	Exempt grievance handling & resolution	100.0%	PASS				
EXG-FR-005.1	*Handled and resolved well per notes*	100.0%	PASS				

Exhibit E

Community Health Plan OF IMPERIAL VALLEY

Claims Monthly/Quarterly Timeliness Report Track

PPG/ Hosp #	PPG/Hospital Name	MSO	RBO #	LOB	Auditor Initials:	Reporting Month	Initials of Person Entering Data	Date Report was Received	Paid	Contested
	Alpha Care Medical Group	Astrana Health Management Inc	10022	MCL	LR	Jan	PT	04/30/26	52	13
	Alpha Care Medical Group	Astrana Health Management Inc	10022	MCL	LR	Feb	PT	04/30/26	91	28
	Alpha Care Medical Group	Astrana Health Management Inc	10022	MCL	LR	Mar	PT	04/30/26	61	16
									204	57
IM22	Community Care IPA	Medpoint Management	10756	MCL	DL	Jan	PT	04/30/26	5,494	843
IM22	Community Care IPA	Medpoint Management	10756	MCL	DL	Feb	PT	04/30/26	8,961	736
IM22	Community Care IPA	Medpoint Management	10756	MCL	DL	Mar	PT	04/30/26	8,166	912
									22,621	2,491
	La Salle Medical Associates	Altura Management Services	10208	MCL	CLT	Jan	PT	04/30/26	11	1
	La Salle Medical Associates	Altura Management Services	10208	MCL	CLT	Feb	PT	04/30/26	6	0
	La Salle Medical Associates	Altura Management Services	10208	MCL	CLT	Mar	PT	04/30/26	5	1
									22	2
	American Specialty Health			MCL		Jan	RO	04/15/26	19	1
	American Specialty Health			MCL		Feb	RO	04/15/26	38	1
	American Specialty Health			MCL		Mar	RO	04/15/26	39	0
									96	2
	Centene Vision			MCL		Jan	RO			
	Centene Vision			MCL		Feb	RO			
	Centene Vision			MCL		Mar	RO			
									0	0
	ModivCare			MCL		Jan	RO	02/10/26	14,694	64

	ModivCare			MCL		Feb	RO	03/10/26	13037	39
	ModivCare			MCL		Mar	RO	04/10/26	13,229	104
									40,960	207

cing System

First Quarter 2026

Member Denied	TOTAL	Number in 30 C Days (Timely)	Number in 45 W Days (2025)	Number Processed W/in 45 W Days	Result: % 30 C Days (=> 95%)	Result: % 45 W Days (=> 95%)	DROH	Paid carried down from above	Number Paid w/ in 30 C-days	Number Paid w/ 45 W-days	Number paid beyond the TAT w/ interest/penalty	Total # of claims received FFS only/encounters
0	**65**	65	51	51	**100%**	**100%**	0	52	52	51	0	NA
0	**119**	119	0	0	**100%**	**NA**	0	91	91	0	0	NA
0	**77**	77	0	0	**100%**	**NA**	0	61	61	0	0	NA
0	261	261	51	51	**100%**	**100%**	0	204	204	51	0	0
0	**6,337**	6,304	3,739	3,740	**99%**	**100%**	0	5,494	5,461	3,738	2	NA
0	**9,697**	9,680	5	5	**100%**	**100%**	0	8,961	8,946	5	0	NA
0	**9,078**	8,979	1	1	**99%**	**100%**	0	8,166	8,079	0	1	NA
0	25,112	24,963	3,745	3,746	**99%**	**100%**	0	22,621	22,486	3,743	3	0
0	**12**	9	5	5	**75%**	**100%**	0	11	8	5	2	NA
0	**6**	4	0	0	**67%**	**NA**	0	6	4	0	0	NA
0	**6**	4	0	0	**67%**	**NA**	0	5	4	0	0	NA
0	24	17	5	5	**71%**	**100%**	0	22	16	5	2	0
0	**20**	20	0	0	**100%**	**#DIV/0!**	0	19	19	0	0	24
0	**39**	39	0	0	**100%**	**NA**	0	38	38	0	0	39
0	**39**	39	0	0	**100%**	**NA**	0	39	39	0	0	52
0	98	98	0	0	**100%**	**NA**	0	96	96	0	0	115
	0						0	0				
	0						0	0				
	0						0	0				
0	0	0	0	0	**#DIV/0!**	**NA**	0	0	0	0	0	0
0	**14,758**	14,758	0	0	**100%**	**NA**	0	14,694	14,694	0	0	14,758

0	**13,076**	13,076	0	0	**100%**	**NA**	0	13,037	13,037	0	0	13,076
0	**13,333**	13,333	0	0	**100%**	**NA**	0	13,229	13,229	0	0	13,333
0	41,167	41,167	0	0	**100%**	**NA**	0	40,960	40,960	0	0	41,167

		Corrective Action Plan (CAP): Please indicate below any corrective action the PLAI																
		Check boxes for: *- Cap Request - check anytime we have requested a CAP for the non-compliant MTR* *- Plan Monitoring - check when we are performing more frequent monitoring or audits, i,e, monthly or quarterl* *- Plan Performed - check when we already performed the focus audit*																
Total # ER clms-paid, contested, denied (mbr & Prov)	Total # ER claims pd on time	CAP Requested	Plan Monitor	Plan Performed	Weekly reporting	Bi-weekly reporting	Required additional	Required Training	Contracted with payors	Breach Notice	De-delegated Claims	Enrollment Freeze	Notice to terminate contract	Plan terminated	No Action Taken	Other	OTHER: How the Plan is Monitoring	Summary of deficiency
9	9																	
24	24																	
18	18																	
51	51																	
1,265	1,265																	
2,422	2,422																	
2,736	2,736																	
6,423	6,423																	
5	5																	
3	3																	
2	2																	
10	10																	
0	0																	
0	0																	
0	0																	
0	0																	
0	0																	
0	0																	

N has instituted based on Delegation Oversight Dept.'s DO-003 Corrective Action Plan (CAP) Program

y audits, not meant for monitoring MTR.

Summary of CAP	Expected Date of Completion/Compliance	Note Section
LaSalle experienced siignificant gowth in Q4 2025 - Q1 2026 that exceeded the forecast. As a result, there was a need for additional examiners. A large number of new hires will complete their training as of 4/17/2026. Once they reach production we expect to achieve and exceed timeliness standards by 6/30/2026.	6/30/2026	
		Centene Vision Services in working on the development of reports specific to CHPIV membership. Current ETA is June 15, 2026 for May reporting.

ModivCare - Community Health Plan Imperial Valley - Standard 1
Quarter 1 2026
Due Date: May 28, 2026 Submitted: June 01, 2026
Member Satisfaction Survey

Community Health Plan Imperial Valley Member's Survey Results Quarter 1 2026

	January					February					March			
Questions	Yes	No	Total Responses	% of Callers Satisfied		Yes	No	Total Responses	% of Callers Satisfied		Yes	No	Total Responses	% of Callers Satisfied
Would you ride with this driver again?	75	7	82	91.46%		73	5	78	93.59%		58	5	63	92.06%
Was the driver friendly?	76	4	80	95.00%		69	6	75	92.00%		60	1	61	98.36%
Did you have a safe trip?	78	4	82	95.12%		72	4	76	94.74%		60	3	63	95.24%
Did you arrive to your appointment?	75	6	81	92.59%		72	6	78	92.31%		58	6	64	90.63%
¿Llegaste a tu cita?	136	7	143	95.10%		128	6	134	95.52%		168	9	177	94.92%
¿Tuviste un viaje seguro?	136	6	142	95.77%		124	8	132	93.94%		170	9	179	94.97%
¿El conductor fue amable?	135	6	141	95.74%		127	5	132	96.21%		165	12	177	93.22%
¿Volverías a viajar con este conductor?	134	7	141	95.04%		124	8	132	93.94%		167	12	179	93.30%

Exhibit F

Compliance Scorecard

Delegate	Community Health Group
Period	February 2026
KPIs measured	0
Overall compliance	NR
Generated	Aug 4, 2026, 4:48 PM

KPI Compliance

KPI Compliance

No KPIs with testable cases for this period.

Compliance by Universe & KPI

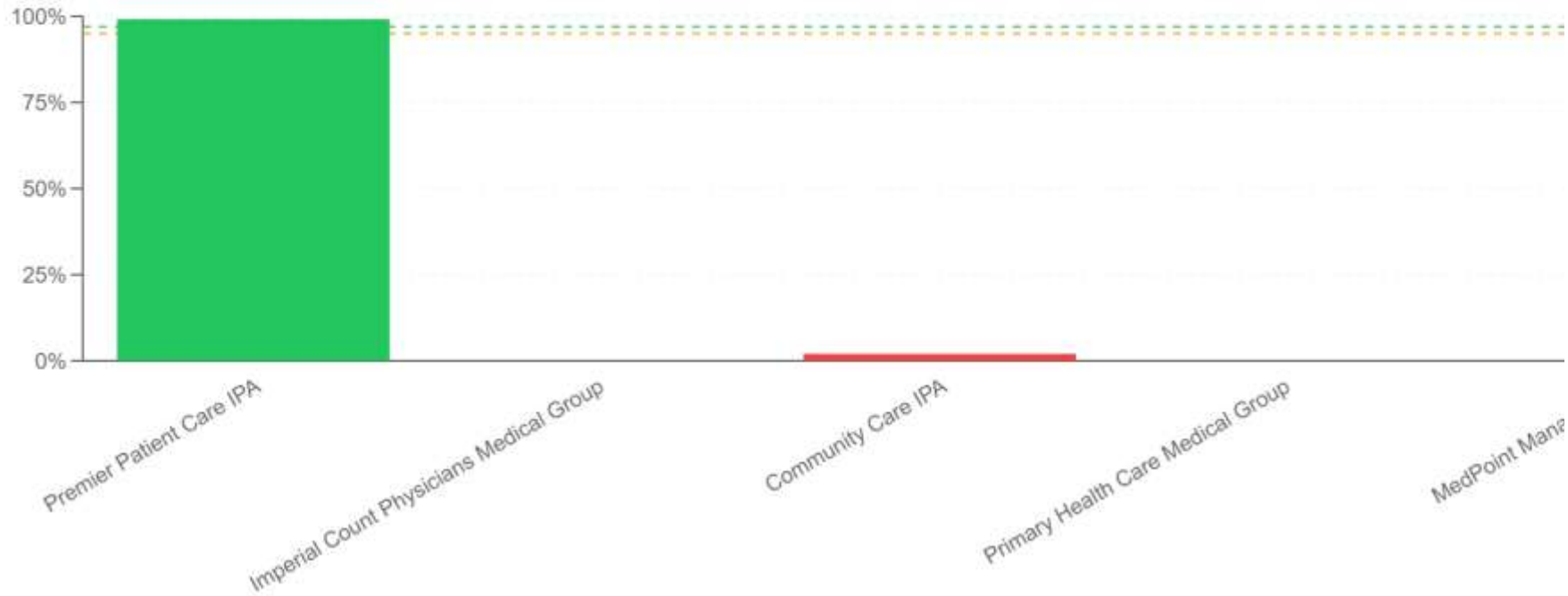
KPI #	Name	Jan	Feb	Mar	Q1
CDAG: 3 PYMT_D	**All KPIs**	—	—	—	—
1.17	Auto-Forwarding to IRE	—	—	—	—
1.5	Payment CD and Notification Timeliness	—	—	—	—
1.7	Payment Redeterminations Timeliness	—	—	—	—
CDAG: 4 RD	**All KPIs**	—	—	—	—
1.17	Auto-Forwarding to IRE	—	—	—	—
1.8	Standard Redetermination Notification Timeliness	—	—	—	—
1.9	Expedited Redetermination Notification Timelines	—	—	—	—
CDAG: 5 EFF_D	**All KPIs**	—	—	—	—
1.10	Timely Effectuation of Pre-Benefit Standard Overt	—	—	—	—
1.11	Timely Effectuation of Standard At-Risk Determina	—	—	—	—

1.12	Timely Effectuation of Post-Service/Payment Over	—	—	—	—
1.13	Timely Effectuation of Pre-Benefit Expedited Over	—	—	—	—
1.14	Timely Effectuation of Expedited At-Risk Determir	—	—	—	—
CDAG: 6 GRV_D	**All KPIs**	—	—	—	—
1.15	Standard Grievance Resolution Timeliness	—	—	—	—
1.16	Expedited Grievance Resolution Timeliness	—	—	—	—
ODAG: 1 OD	**All KPIs**	—	—	**95.16%**	**95.16%**
1.1	Standard Pre-Service OD Notification Timeliness	—	—	98.00%	98.00%
1.2	Part B Drug OD Notification Timeliness	—	—	100.00%	100.00%
1.3	Expedited Pre-Service OD Notification Timeliness	—	—	81.82%	81.82%
1.4	Expedited Part B Drug Pre-Service OD Notification	—	—	—	—
ODAG: 2 RECON	**All KPIs**	—	—	—	—
1.5	Standard Pre-Service Reconsiderations Notificatio	—	—	—	—
1.6	Standard Part B Drug Reconsiderations Notificatio	—	—	—	—
1.7	Expedited Reconsiderations Notification Timelines	—	—	—	—
1.8	Expedited Part B Drug Reconsiderations Notificati	—	—	—	—
ODAG: 3 PYMT_C	**All KPIs**	—	—	**100.00%**	**100.00%**
1.10	Payment Reconsiderations Timeliness	—	—	—	—
1.9	Payment OD Timeliness	—	—	100.00%	100.00%
ODAG: 4 EFF_C	**All KPIs**	—	—	—	—
1.11	Standard Pre-Service IRE Overturn Effectuation Ti	—	—	—	—
1.12	Standard Part B Drug IRE Overturn Effectuation Ti	—	—	—	—
1.13	Expedited Pre-Service IRE Overturn Effectuation T	—	—	—	—
1.14	Expedited Part B Drug IRE Overturn Effectuation T	—	—	—	—
1.15	Payment IRE Overturn Effectuation Timeliness	—	—	—	—
1.16	ALJ/MAC Overturn Effectuation Timeliness	—	—	—	—
1.17	ALJ/MAC Part B Drug Overturn Effectuation Timeli	—	—	—	—
ODAG: 5 GRV_C	**All KPIs**	**100.00%**	—	—	**100.00%**
1.18	Standard Grievance Timeliness	100.00%	—	—	100.00%
1.19	Expedited Grievance Timeliness	—	—	—	—

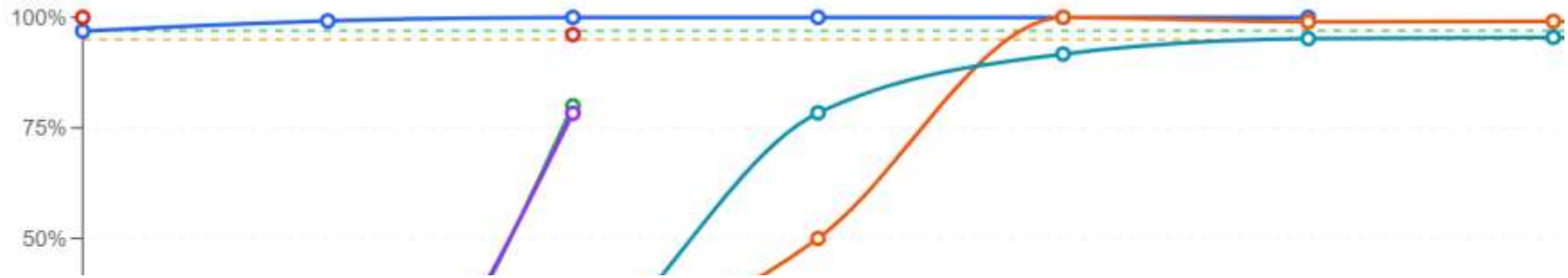
Trends

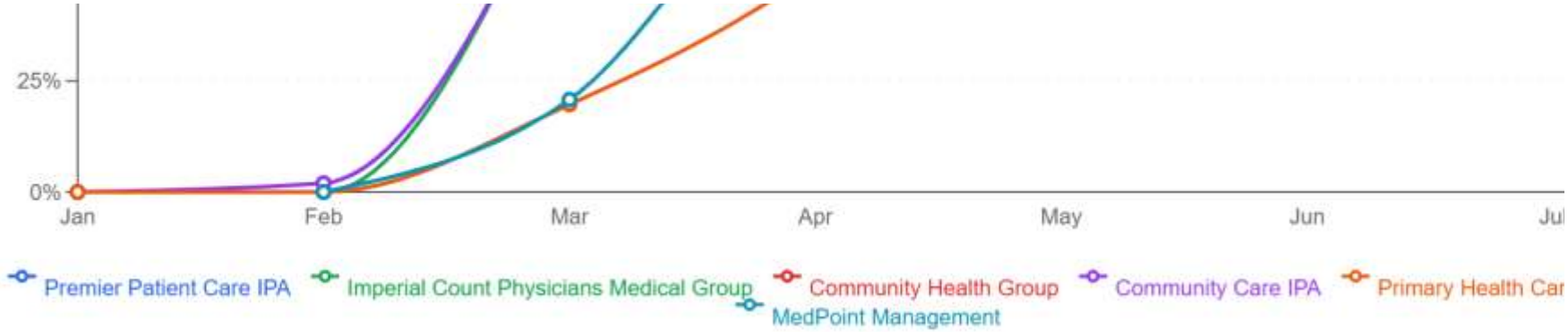
Trends

Delegate Comparison · Feb 2026



Delegate Compliance Over Time




25%
0%
Jan
Feb
Mar
Apr
May
Jun
Premier Patient Care IPA
Imperial Count Physicians Medical Group
Community Health Group
Community Care IPA
Primary Health Car
MedPoint Management

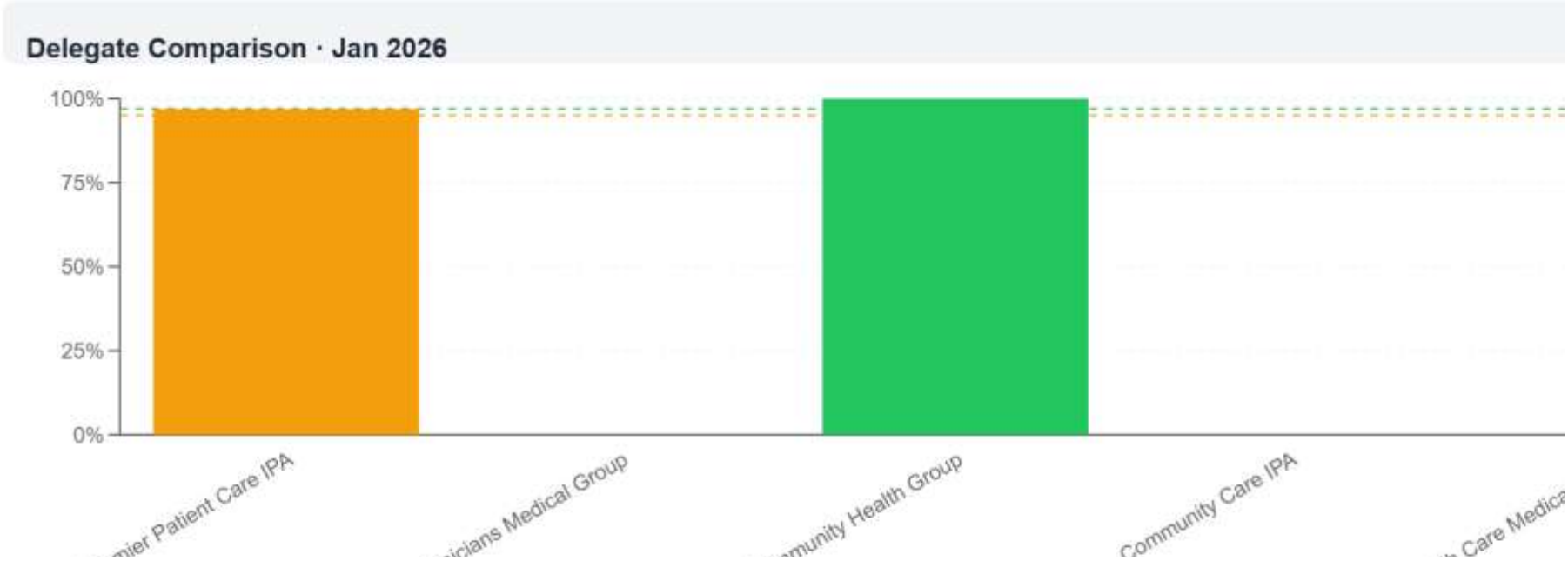
Compliance by Universe & KPI

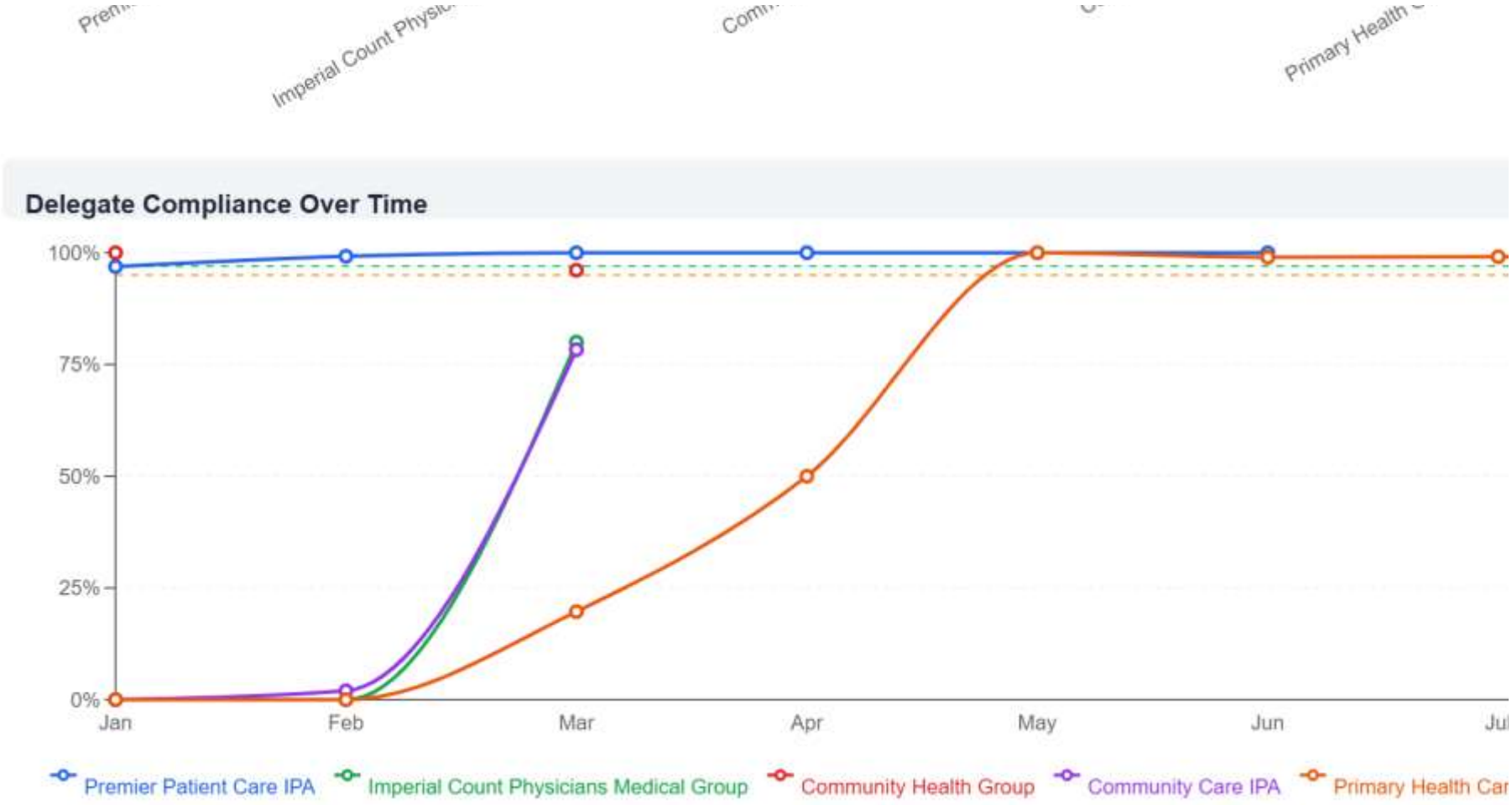
KPI #	Name	Jan	Feb	Mar	Q1
CDAG: 3 PYMT_D	**All KPIs**	—	—	—	—
1.17	Auto-Forwarding to IRE	—	—	—	—
1.5	Payment CD and Notification Timeliness	—	—	—	—
1.7	Payment Redeterminations Timeliness	—	—	—	—
CDAG: 4 RD	**All KPIs**	—	—	—	—
1.17	Auto-Forwarding to IRE	—	—	—	—
1.8	Standard Redetermination Notification Timeliness	—	—	—	—
1.9	Expedited Redetermination Notification Timelines	—	—	—	—
CDAG: 5 EFF_D	**All KPIs**	—	—	—	—
1.10	Timely Effectuation of Pre-Benefit Standard Overt	—	—	—	—
1.11	Timely Effectuation of Standard At-Risk Determina	—	—	—	—
1.12	Timely Effectuation of Post-Service/Payment Over	—	—	—	—
1.13	Timely Effectuation of Pre-Benefit Expedited Over	—	—	—	—
1.14	Timely Effectuation of Expedited At-Risk Determir	—	—	—	—
CDAG: 6 GRV_D	**All KPIs**	—	—	—	—
1.15	Standard Grievance Resolution Timeliness	—	—	—	—
1.16	Expedited Grievance Resolution Timeliness	—	—	—	—
ODAG: 1 OD	**All KPIs**	—	—	**95.16%**	**95.16%**
1.1	Standard Pre-Service OD Notification Timeliness	—	—	98.00%	98.00%
1.2	Part B Drug OD Notification Timeliness	—	—	100.00%	100.00%
1.3	Expedited Pre-Service OD Notification Timeliness	—	—	81.82%	81.82%
1.4	Expedited Part B Drug Pre-Service OD Notification	—	—	—	—
ODAG: 2 RECON	**All KPIs**	—	—	—	—
1.5	Standard Pre-Service Reconsiderations Notificatio	—	—	—	—
1.6	Standard Part B Drug Reconsiderations Notificatio	—	—	—	—
1.7	Expedited Reconsiderations Notification Timelines	—	—	—	—
1.8	Expedited Part B Drug Reconsiderations Notificati	—	—	—	—
ODAG: 3 PYMT_C	**All KPIs**	—	—	**100.00%**	**100.00%**
1.10	Payment Reconsiderations Timeliness	—	—	—	—
1.9	Payment OD Timeliness	—	—	100.00%	100.00%

ODAG: 4 EFF_C	**All KPIs**	—	—	—	—
1.11	Standard Pre-Service IRE Overturn Effectuation Ti	—	—	—	—
1.12	Standard Part B Drug IRE Overturn Effectuation Ti	—	—	—	—
1.13	Expedited Pre-Service IRE Overturn Effectuation T	—	—	—	—
1.14	Expedited Part B Drug IRE Overturn Effectuation T	—	—	—	—
1.15	Payment IRE Overturn Effectuation Timeliness	—	—	—	—
1.16	ALJ/MAC Overturn Effectuation Timeliness	—	—	—	—
1.17	ALJ/MAC Part B Drug Overturn Effectuation Timeli	—	—	—	—
ODAG: 5 GRV_C	**All KPIs**	**100.00%**	—	—	**100.00%**
1.18	Standard Grievance Timeliness	100.00%	—	—	100.00%
1.19	Expedited Grievance Timeliness	—	—	—	—

Trends

Trends

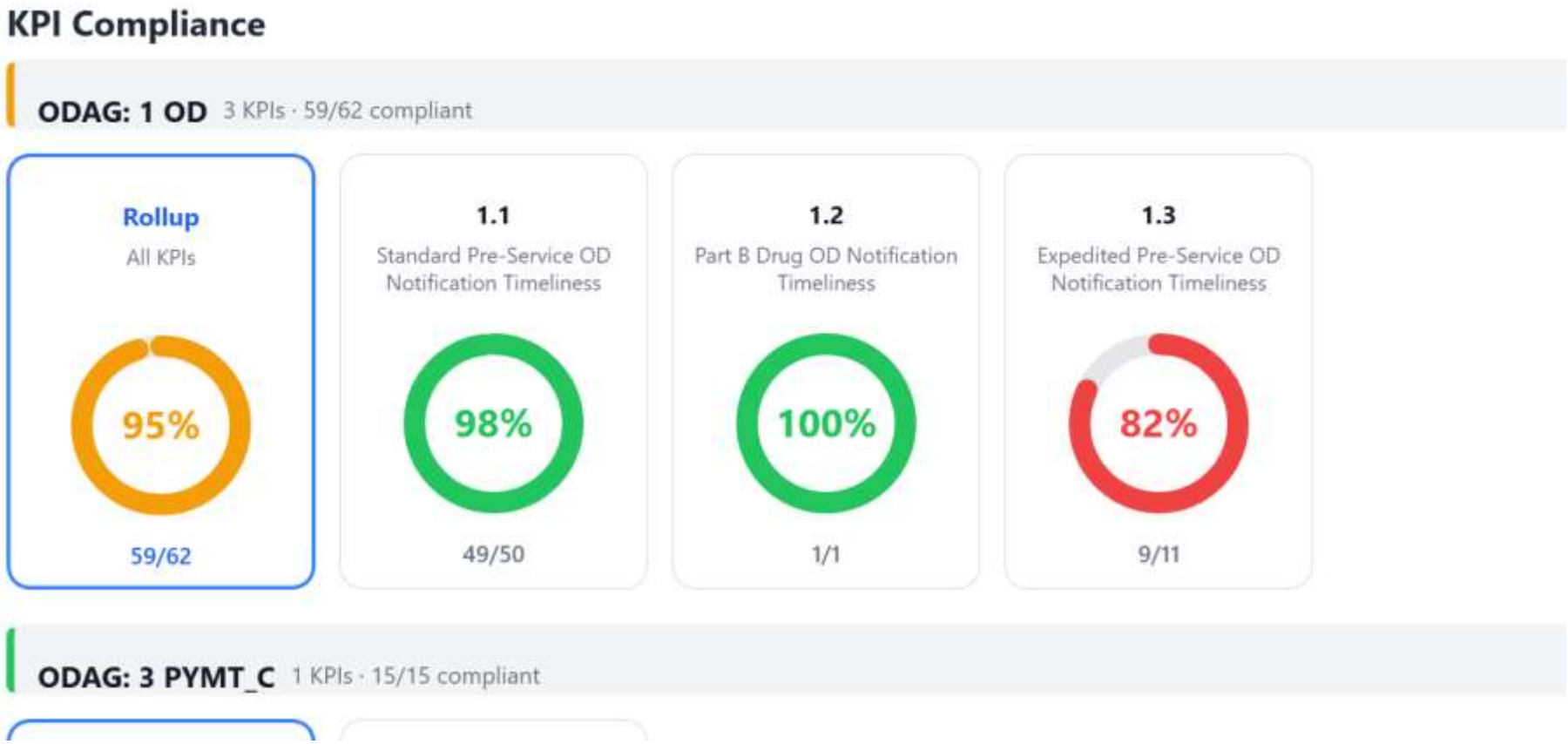


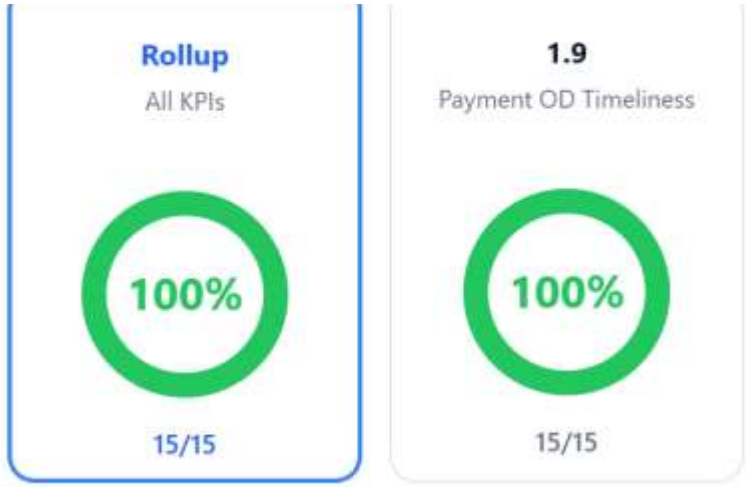

Delegate Compliance Over Time
100%
75%
50%
25%
0%
Jan
Feb
Mar
Apr
May
Jun
Premier Patient Care IPA
Imperial Count Physicians Medical Group
Community Health Group
Community Care IPA
Primary Health Car

Compliance Scorecard

Delegate	Community Health Group
Period	March 2026
KPIs measured	4
Overall compliance	96.1% (74/77)
Generated	Aug 4, 2026, 4:48 PM

KPI Compliance





Compliance by Universe & KPI

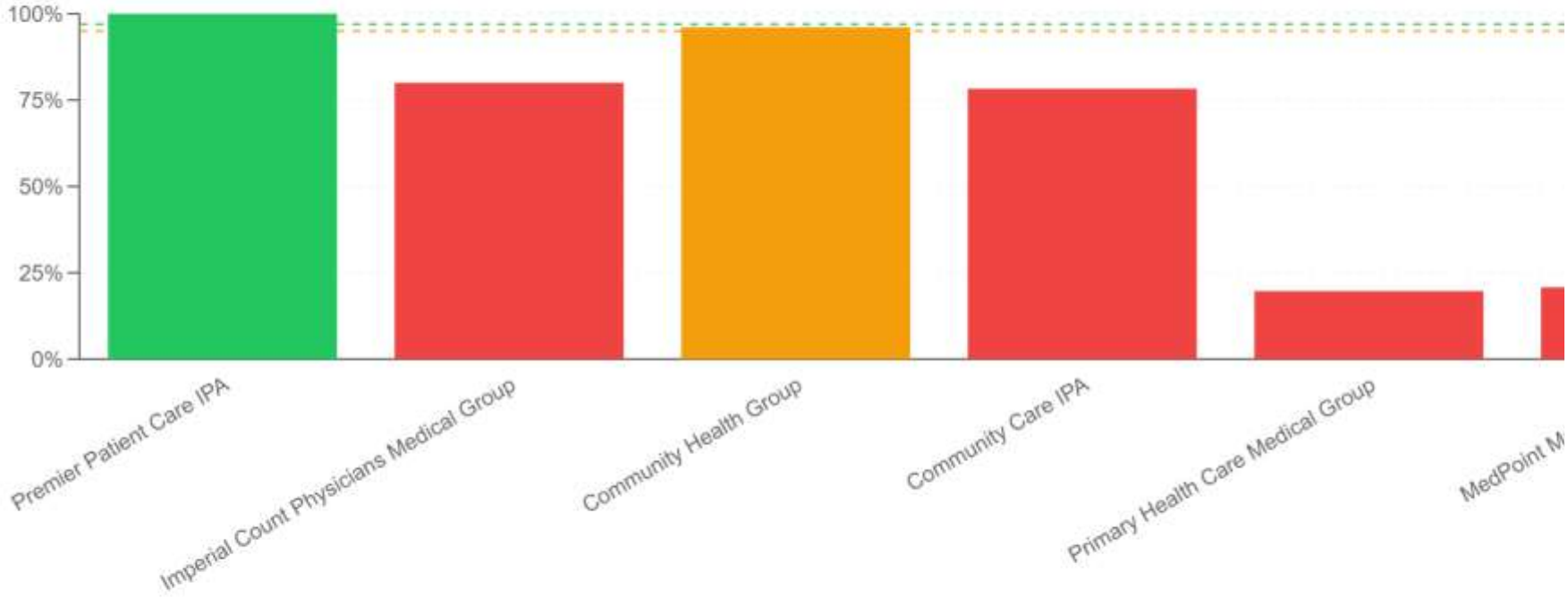
KPI #	Name	Jan	Feb	Mar	Q1
CDAG: 3 PYMT_D	**All KPIs**	—	—	—	—
1.17	Auto-Forwarding to IRE	—	—	—	—
1.5	Payment CD and Notification Timeliness	—	—	—	—
1.7	Payment Redeterminations Timeliness	—	—	—	—
CDAG: 4 RD	**All KPIs**	—	—	—	—
1.17	Auto-Forwarding to IRE	—	—	—	—
1.8	Standard Redetermination Notification Timeliness	—	—	—	—
1.9	Expedited Redetermination Notification Timelines	—	—	—	—
CDAG: 5 EFF_D	**All KPIs**	—	—	—	—
1.10	Timely Effectuation of Pre-Benefit Standard Overt	—	—	—	—
1.11	Timely Effectuation of Standard At-Risk Determina	—	—	—	—
1.12	Timely Effectuation of Post-Service/Payment Over	—	—	—	—
1.13	Timely Effectuation of Pre-Benefit Expedited Over	—	—	—	—
1.14	Timely Effectuation of Expedited At-Risk Determir	—	—	—	—

CDAG: 6 GRV_D	**All KPIs**	—	—	—	—
1.15	Standard Grievance Resolution Timeliness	—	—	—	—
1.16	Expedited Grievance Resolution Timeliness	—	—	—	—
ODAG: 1 OD	**All KPIs**	—	—	**95.16%**	**95.16%**
1.1	Standard Pre-Service OD Notification Timeliness	—	—	98.00%	98.00%
1.2	Part B Drug OD Notification Timeliness	—	—	100.00%	100.00%
1.3	Expedited Pre-Service OD Notification Timeliness	—	—	81.82%	81.82%
1.4	Expedited Part B Drug Pre-Service OD Notification	—	—	—	—
ODAG: 2 RECON	**All KPIs**	—	—	—	—
1.5	Standard Pre-Service Reconsiderations Notificatio	—	—	—	—
1.6	Standard Part B Drug Reconsiderations Notificatio	—	—	—	—
1.7	Expedited Reconsiderations Notification Timelines	—	—	—	—
1.8	Expedited Part B Drug Reconsiderations Notificati	—	—	—	—
ODAG: 3 PYMT_C	**All KPIs**	—	—	**100.00%**	**100.00%**
1.10	Payment Reconsiderations Timeliness	—	—	—	—
1.9	Payment OD Timeliness	—	—	100.00%	100.00%
ODAG: 4 EFF_C	**All KPIs**	—	—	—	—
1.11	Standard Pre-Service IRE Overturn Effectuation Ti	—	—	—	—
1.12	Standard Part B Drug IRE Overturn Effectuation Ti	—	—	—	—
1.13	Expedited Pre-Service IRE Overturn Effectuation T	—	—	—	—
1.14	Expedited Part B Drug IRE Overturn Effectuation T	—	—	—	—
1.15	Payment IRE Overturn Effectuation Timeliness	—	—	—	—
1.16	ALJ/MAC Overturn Effectuation Timeliness	—	—	—	—
1.17	ALJ/MAC Part B Drug Overturn Effectuation Timeli	—	—	—	—
ODAG: 5 GRV_C	**All KPIs**	**100.00%**	—	—	**100.00%**
1.18	Standard Grievance Timeliness	100.00%	—	—	100.00%
1.19	Expedited Grievance Timeliness	—	—	—	—

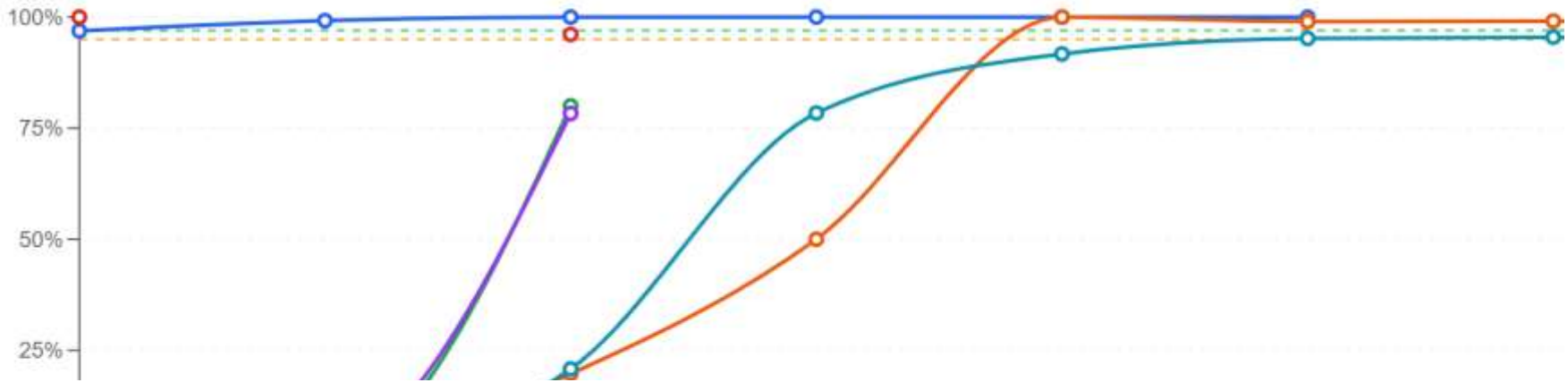
Trends

Trends

Delegate Comparison · Mar 2026



Delegate Compliance Over Time




0%
Jan
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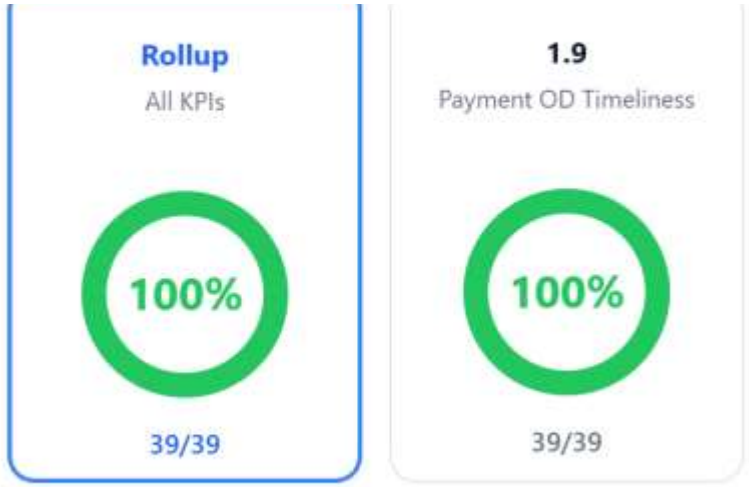
May
Jun
Premier Patient Care IPA
Imperial Count Physicians Medical Group
Community Health Group
Community Care IPA
Primary Health Car
MedPoint Management

Exhibit G

Compliance Scorecard

Delegate	Community Care IPA
Period	March 2026
KPIs measured	3
Overall compliance	78.26% (72/92)
Generated	Aug 4, 2026, 4:55 PM

KPI Compliance



Compliance by Universe & KPI

KPI #	Name	Jan	Feb	Mar	Q1
ODAG: 1 OD	**All KPIs**	**0.00%**	**1.96%**	**62.26%**	**24.29%**
1.1	Standard Pre-Service OD Notification Timeliness	0.00%	2.78%	78.79%	27.84%
1.2	Part B Drug OD Notification Timeliness	0.00%	0.00%	—	0.00%
1.3	Expedited Pre-Service OD Notification Timeliness	0.00%	0.00%	35.00%	17.95%
1.4	Expedited Part B Drug Pre-Service OD Notification	0.00%	—	—	0.00%
ODAG: 3 PYMT_C	**All KPIs**	—	—	**100.00%**	**100.00%**
1.10	Payment Reconsiderations Timeliness	—	—	—	—
1.9	Payment OD Timeliness	—	—	100.00%	100.00%

Trends

Trends

Delegate Comparison · Mar 2026

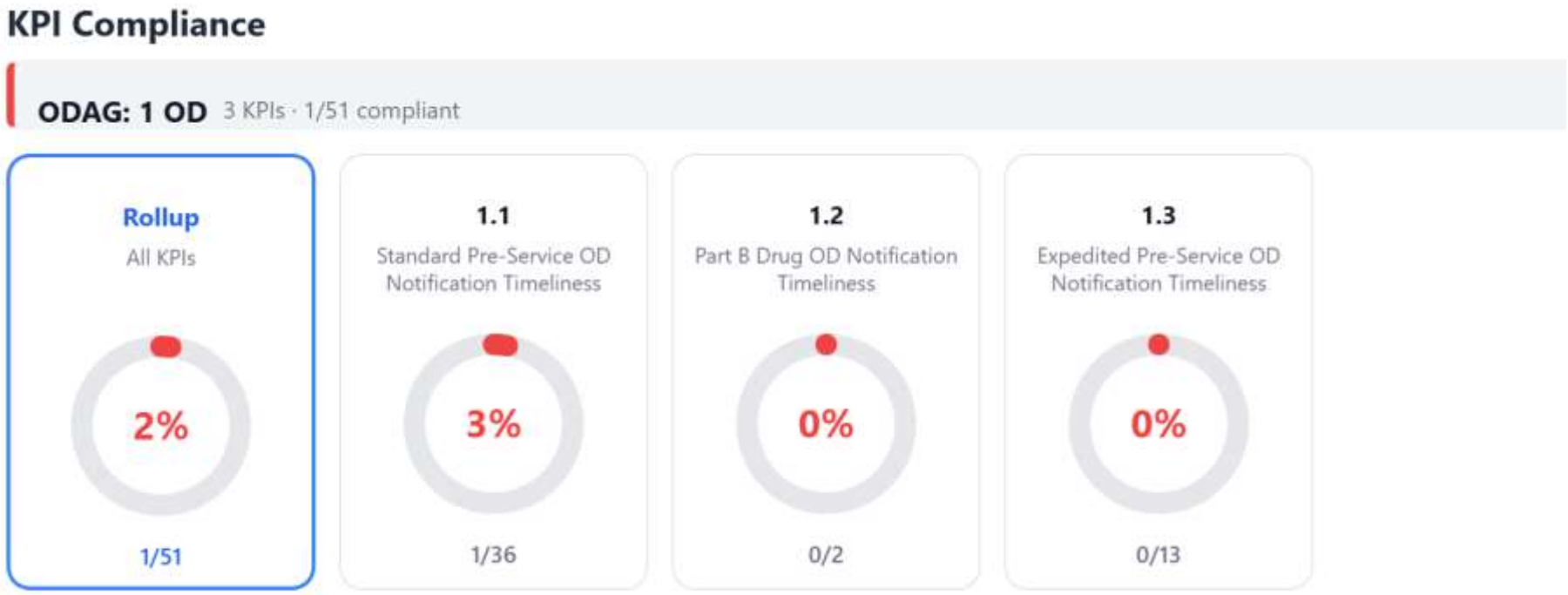
Delegate Compliance Over Time


25%
0%
Jan
Feb
Community Care IPA

Compliance Scorecard

Delegate	Community Care IPA
Period	February 2026
KPIs measured	3
Overall compliance	1.96% (1/51)
Generated	Aug 4, 2026, 4:48 PM

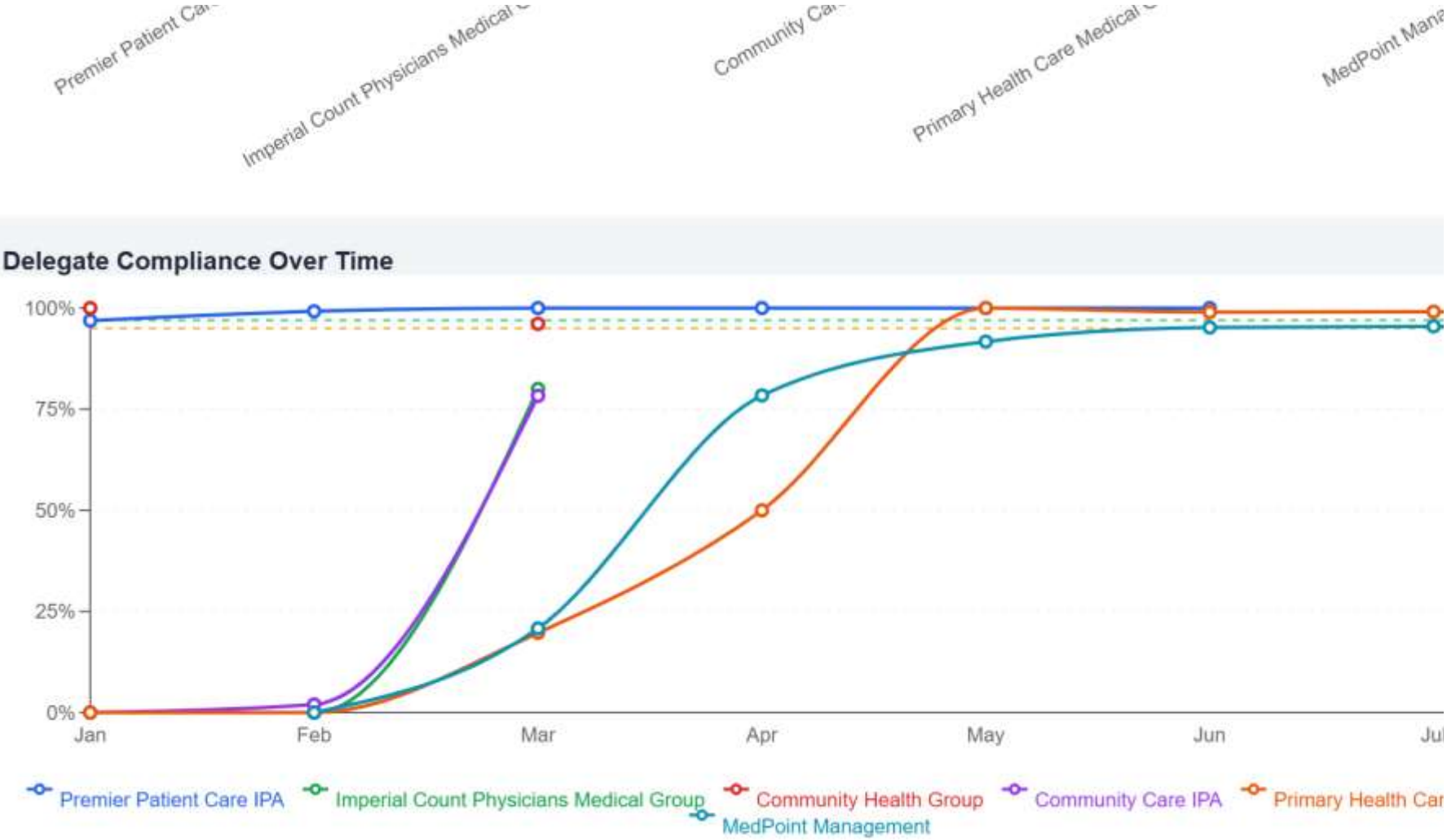
KPI Compliance



Compliance by Universe & KPI

KPI #	Name	Jan	Feb	Mar	Q1
ODAG: 1 OD	**All KPIs**	**0.00%**	**1.96%**	**62.26%**	**24.29%**
1.1	Standard Pre-Service OD Notification Timeliness	0.00%	2.78%	78.79%	27.84%
1.2	Part B Drug OD Notification Timeliness	0.00%	0.00%	—	0.00%
1.3	Expedited Pre-Service OD Notification Timeliness	0.00%	0.00%	35.00%	17.95%
1.4	Expedited Part B Drug Pre-Service OD Notification	0.00%	—	—	0.00%
ODAG: 3 PYMT_C	**All KPIs**	—	—	**100.00%**	**100.00%**
1.10	Payment Reconsiderations Timeliness	—	—	—	—
1.9	Payment OD Timeliness	—	—	100.00%	100.00%

Trends


Premier Patient Ca
Imperial Count Physicians Medical G
Community Ca
Primary Health Care Medical G
MedPoint Mana
Delegate Compliance Over Time
100%
75%
50%
25%
0%
Jan
Feb
Mar
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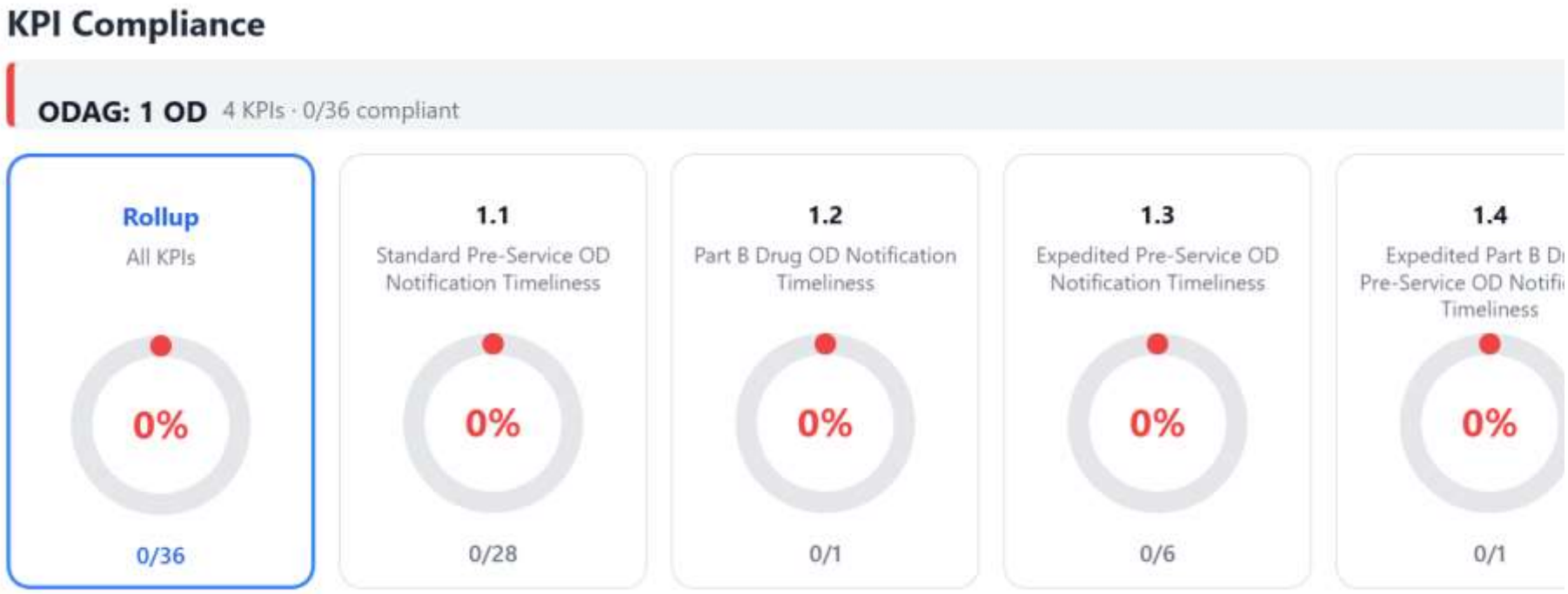
Jun
Jul
Premier Patient Care IPA
Imperial Count Physicians Medical Group
Community Health Group
Community Care IPA
Primary Health Car
MedPoint Management

Compliance Scorecard

Delegate	Community Care IPA
Period	January 2026
KPIs measured	4
Overall compliance	0% (0/36)
Generated	Aug 4, 2026, 4:47 PM

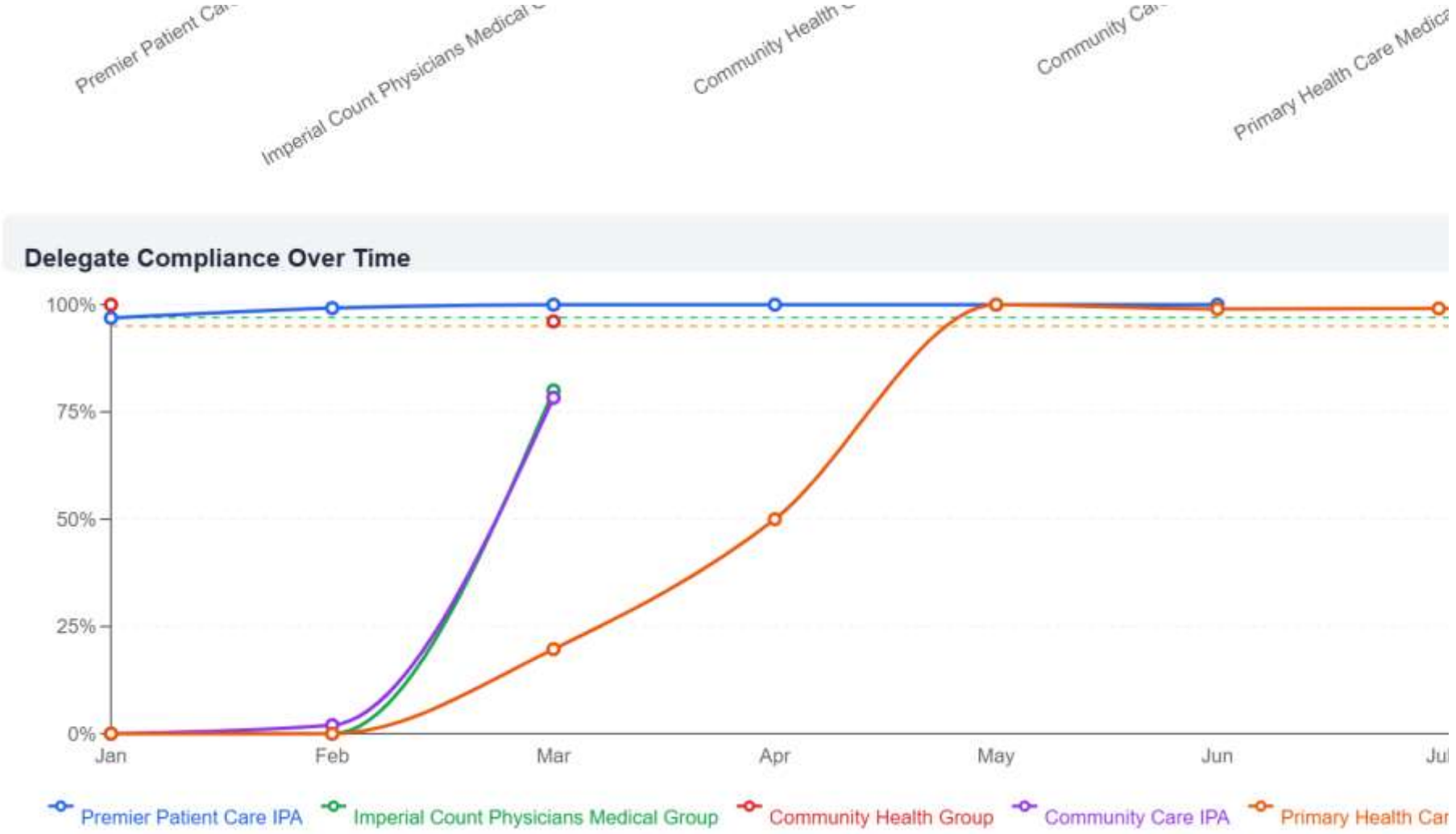
KPI Compliance



Compliance by Universe & KPI

KPI #	Name	Jan	Feb	Mar	Q1
ODAG: 1 OD	**All KPIs**	**0.00%**	**1.96%**	**62.26%**	**24.29%**
1.1	Standard Pre-Service OD Notification Timeliness	0.00%	2.78%	78.79%	27.84%
1.2	Part B Drug OD Notification Timeliness	0.00%	0.00%	—	0.00%
1.3	Expedited Pre-Service OD Notification Timeliness	0.00%	0.00%	35.00%	17.95%
1.4	Expedited Part B Drug Pre-Service OD Notification	0.00%	—	—	0.00%
ODAG: 3 PYMT_C	**All KPIs**	—	—	**100.00%**	**100.00%**
1.10	Payment Reconsiderations Timeliness	—	—	—	—
1.9	Payment OD Timeliness	—	—	100.00%	100.00%

Trends


Premier Patient Ca
Imperial Count Physicians Medical
Community Health
Community Ca
Primary Health Care Medica
Delegate Compliance Over Time
100%
75%
50%
25%
0%
Jan
Feb
Mar
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May
Jun
Premier Patient Care IPA
Imperial Count Physicians Medical Group
Community Health Group
Community Care IPA
Primary Health Car

Compliance Scorecard

Delegate	Premier Patient Care IPA
Period	January 2026
KPIs measured	3
Overall compliance	96.88% (31/32)
Generated	Aug 4, 2026, 4:47 PM

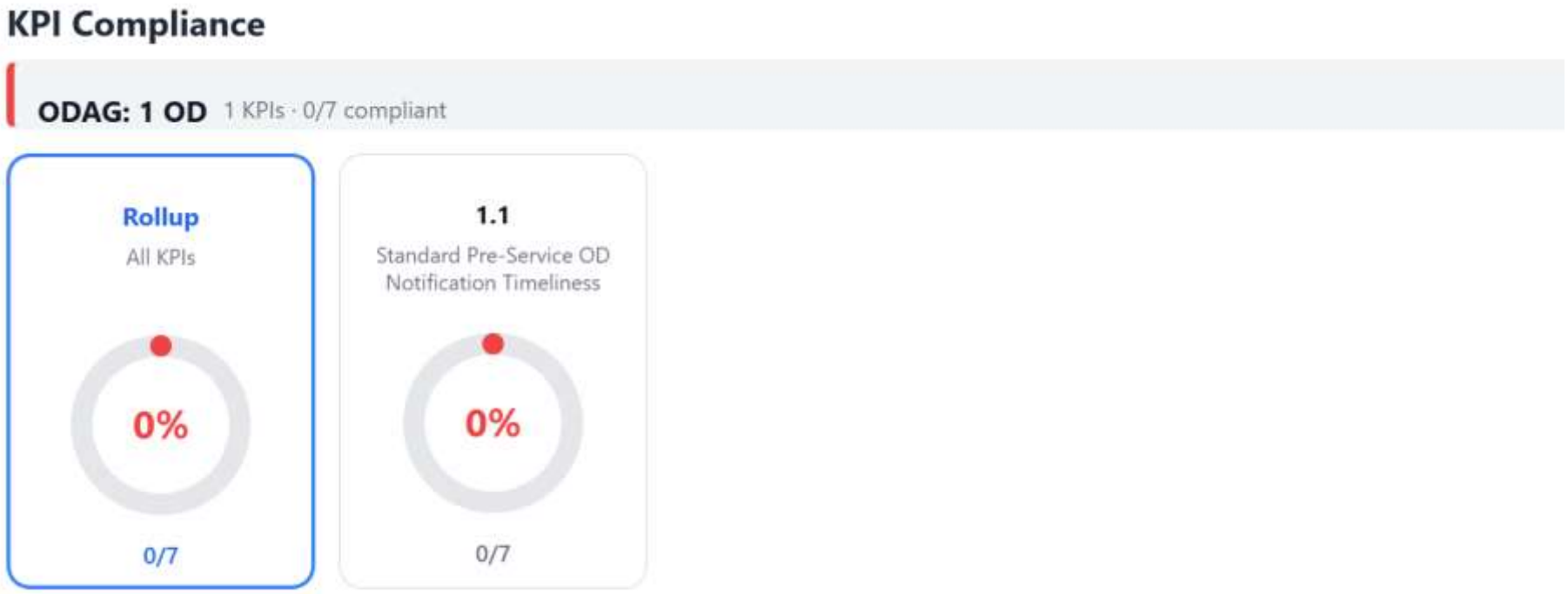
KPI Compliance

Exhibit H

Compliance Scorecard

Delegate	Imperial Count Physicians Medical Group
Period	February 2026
KPIs measured	1
Overall compliance	0% (0/7)
Generated	Aug 4, 2026, 4:48 PM

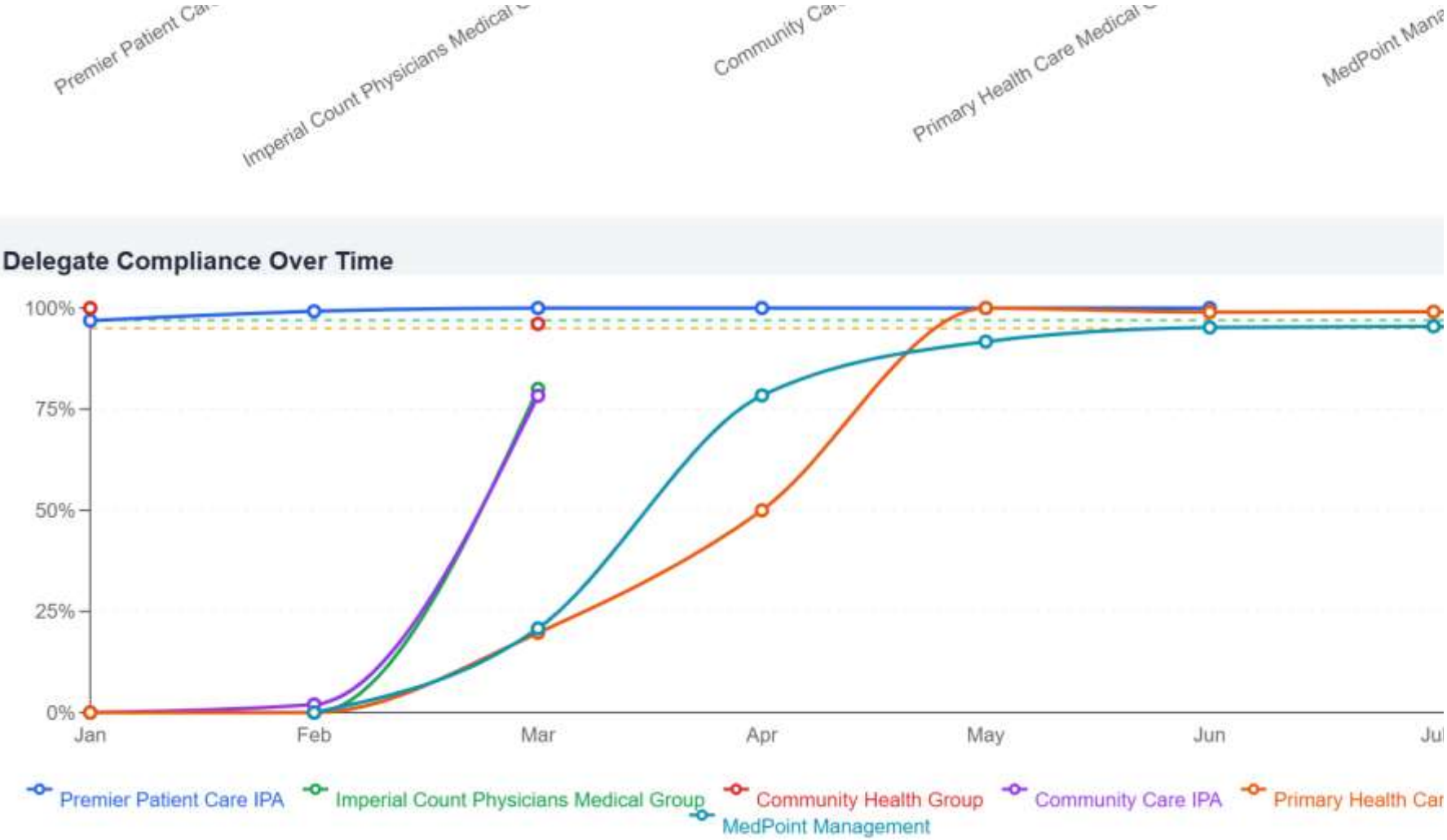
KPI Compliance



Compliance by Universe & KPI

KPI #	Name	Jan	Feb	Mar	Q1
ODAG: 1 OD	**All KPIs**	**0.00%**	**0.00%**	**66.67%**	**8.70%**
1.1	Standard Pre-Service OD Notification Timeliness	0.00%	0.00%	66.67%	11.11%
1.2	Part B Drug OD Notification Timeliness	—	—	—	—
1.3	Expedited Pre-Service OD Notification Timeliness	0.00%	—	—	0.00%
1.4	Expedited Part B Drug Pre-Service OD Notification	—	—	—	—
ODAG: 3 PYMT_C	**All KPIs**	—	—	**100.00%**	**100.00%**
1.10	Payment Reconsiderations Timeliness	—	—	—	—
1.9	Payment OD Timeliness	—	—	100.00%	100.00%

Trends


Premier Patient Ca
Imperial Count Physicians Medical G
Community Ca
Primary Health Care Medical G
MedPoint Mana
Delegate Compliance Over Time
100%
75%
50%
25%
0%
Jan
Feb
Mar
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May
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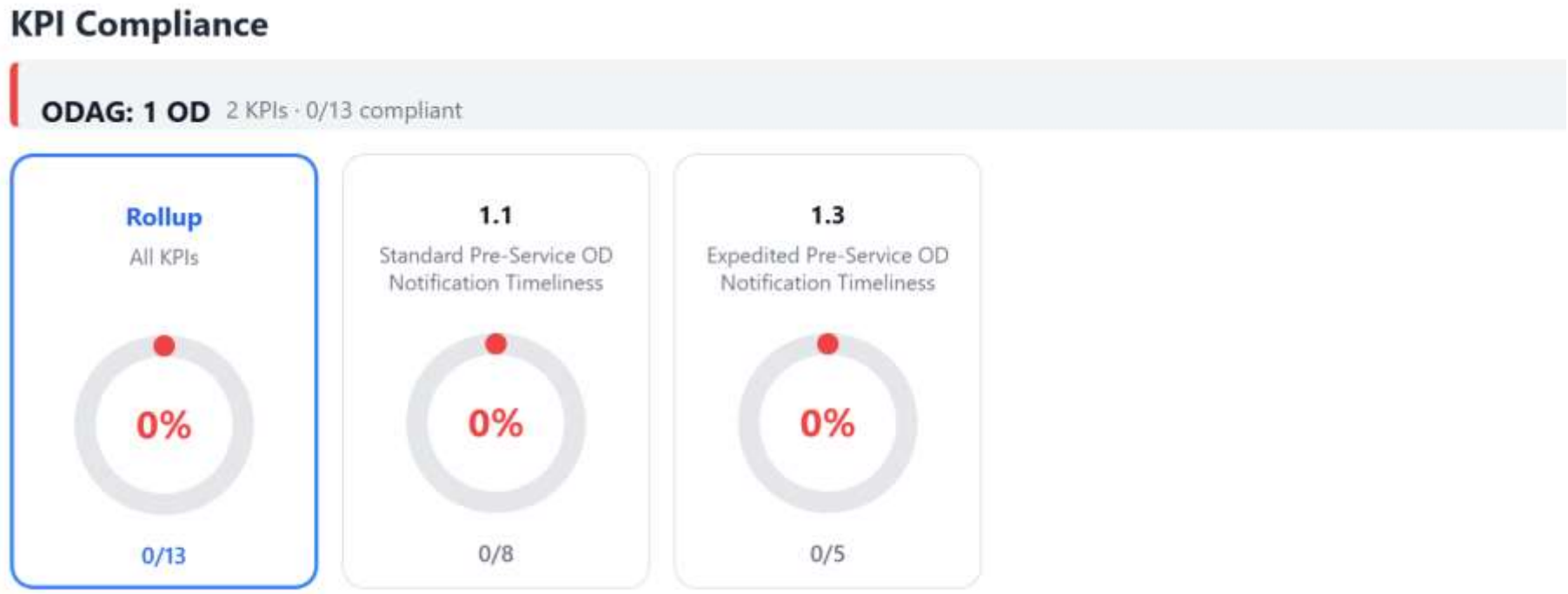
Premier Patient Care IPA
Imperial Count Physicians Medical Group
Community Health Group
Community Care IPA
Primary Health Car
MedPoint Management

Compliance Scorecard

Delegate	Imperial Count Physicians Medical Group
Period	January 2026
KPIs measured	2
Overall compliance	0% (0/13)
Generated	Aug 4, 2026, 4:47 PM

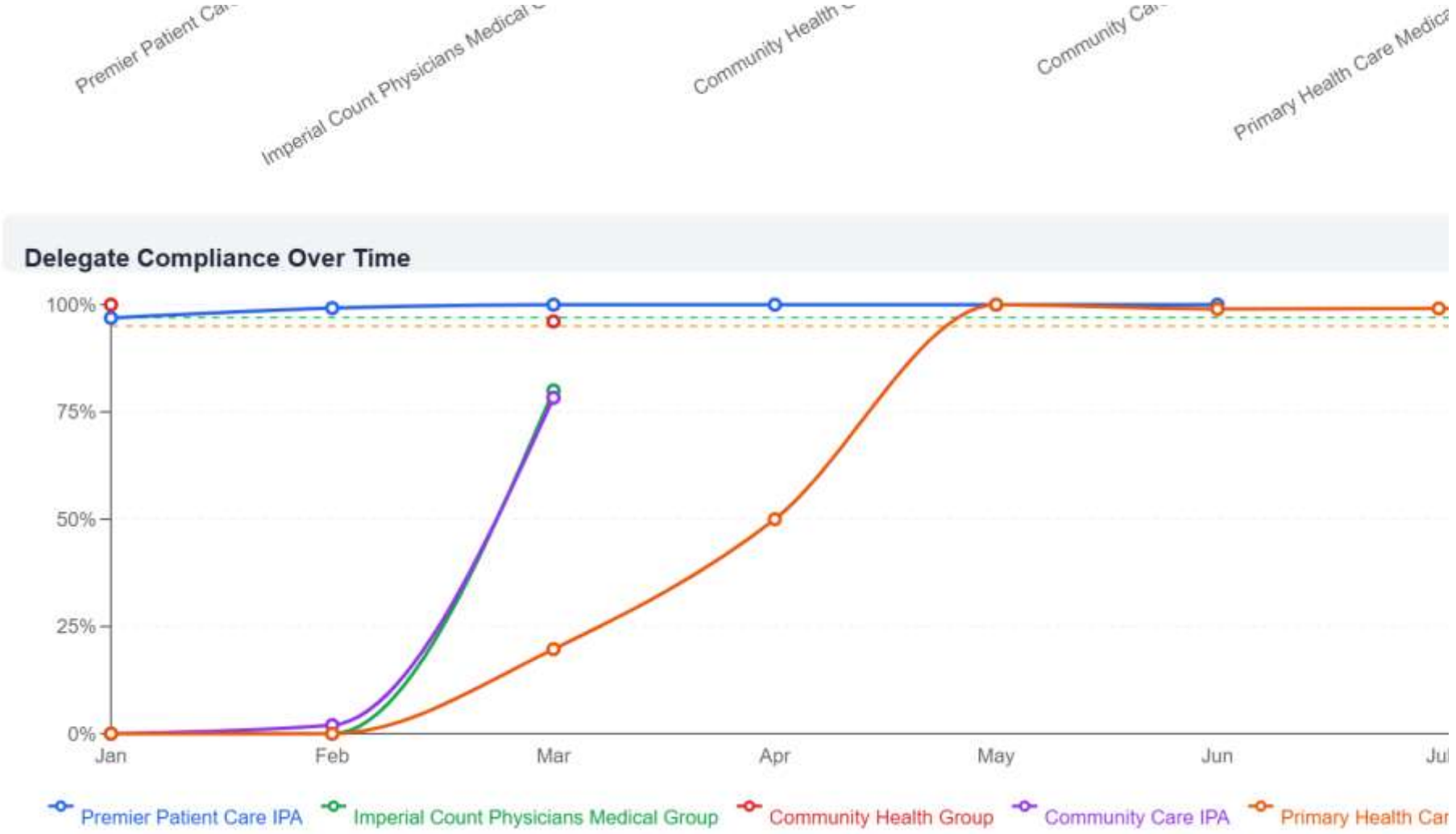
KPI Compliance



Compliance by Universe & KPI

KPI #	Name	Jan	Feb	Mar	Q1
ODAG: 1 OD	**All KPIs**	**0.00%**	**0.00%**	**66.67%**	**8.70%**
1.1	Standard Pre-Service OD Notification Timeliness	0.00%	0.00%	66.67%	11.11%
1.2	Part B Drug OD Notification Timeliness	—	—	—	—
1.3	Expedited Pre-Service OD Notification Timeliness	0.00%	—	—	0.00%
1.4	Expedited Part B Drug Pre-Service OD Notification	—	—	—	—
ODAG: 3 PYMT_C	**All KPIs**	—	—	**100.00%**	**100.00%**
1.10	Payment Reconsiderations Timeliness	—	—	—	—
1.9	Payment OD Timeliness	—	—	100.00%	100.00%

Trends


Premier Patient Ca
Imperial Count Physicians Medical
Community Health
Community Ca
Primary Health Care Medica
Delegate Compliance Over Time
100%
75%
50%
25%
0%
Jan
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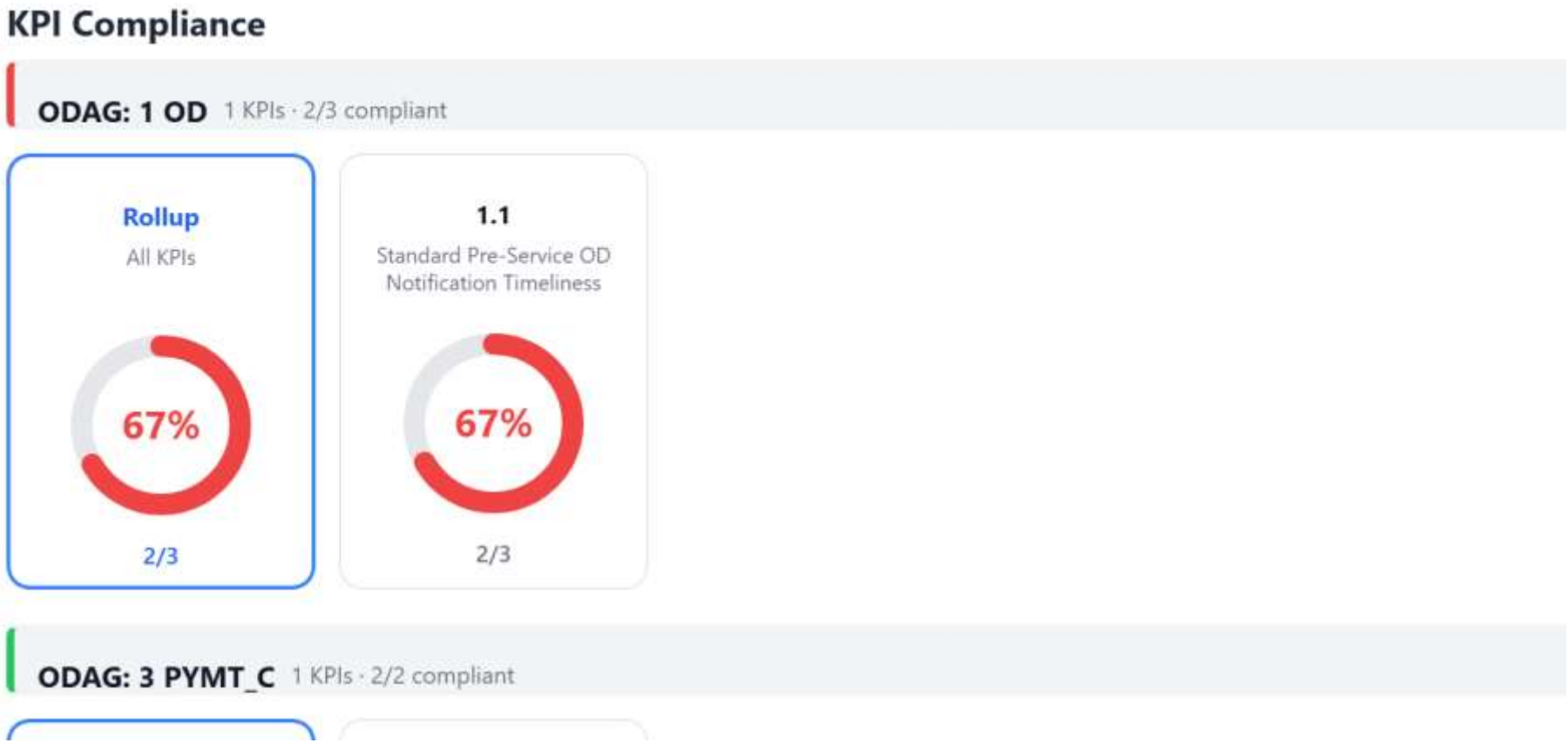
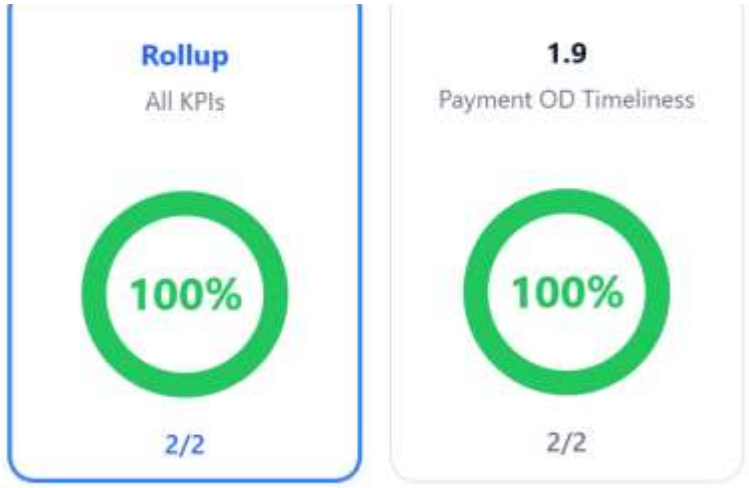
Premier Patient Care IPA
Imperial Count Physicians Medical Group
Community Health Group
Community Care IPA
Primary Health Car

Compliance Scorecard

Delegate	Imperial Count Physicians Medical Group
Period	March 2026
KPIs measured	2
Overall compliance	80% (4/5)
Generated	Aug 4, 2026, 4:48 PM

KPI Compliance





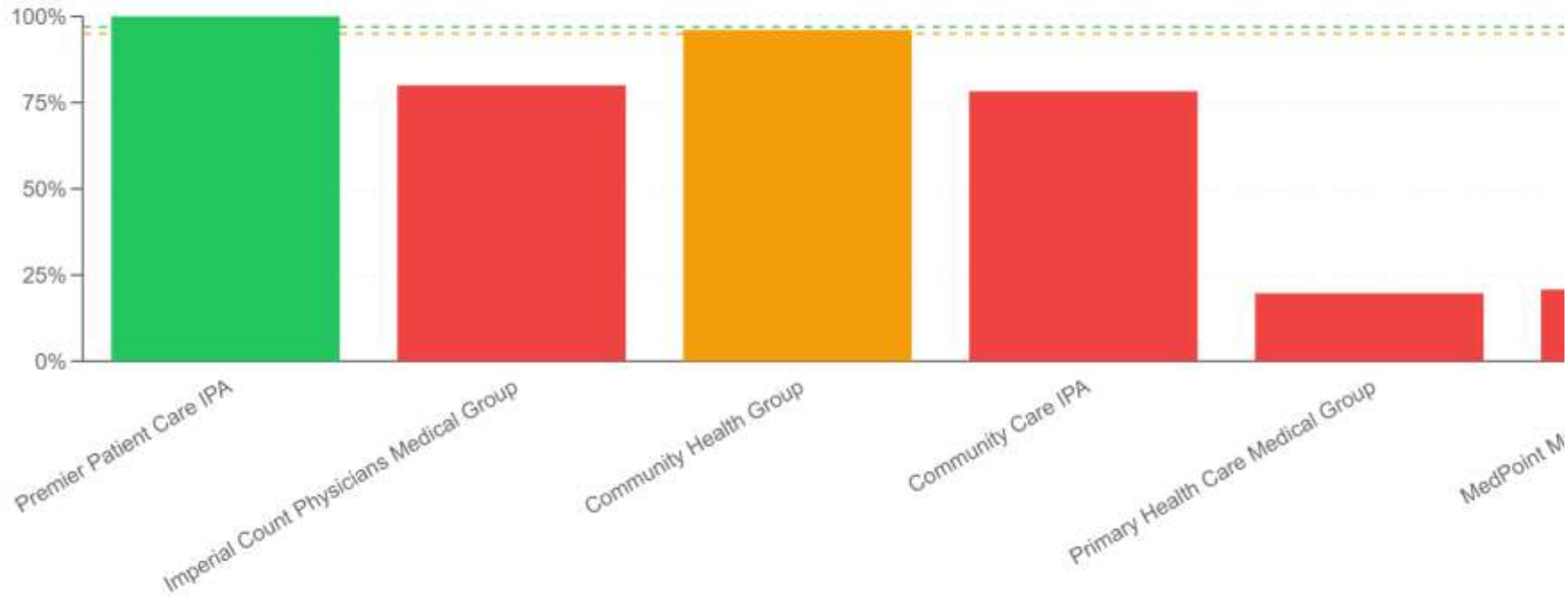
Compliance by Universe & KPI

KPI #	Name	Jan	Feb	Mar	Q1
ODAG: 1 OD	**All KPIs**	**0.00%**	**0.00%**	**66.67%**	**8.70%**
1.1	Standard Pre-Service OD Notification Timeliness	0.00%	0.00%	66.67%	11.11%
1.2	Part B Drug OD Notification Timeliness	—	—	—	—
1.3	Expedited Pre-Service OD Notification Timeliness	0.00%	—	—	0.00%
1.4	Expedited Part B Drug Pre-Service OD Notification	—	—	—	—
ODAG: 3 PYMT_C	**All KPIs**	—	—	**100.00%**	**100.00%**
1.10	Payment Reconsiderations Timeliness	—	—	—	—
1.9	Payment OD Timeliness	—	—	100.00%	100.00%

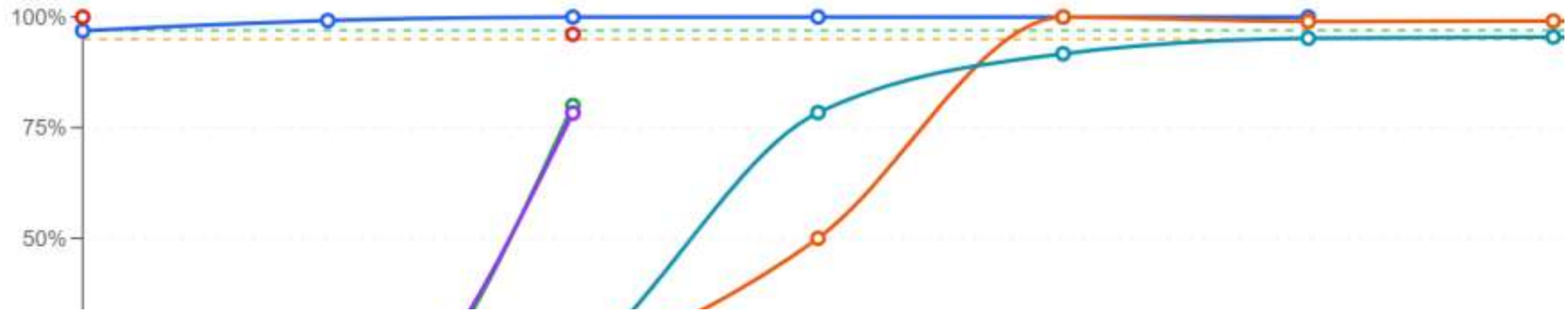
Trends

Trends

Delegate Comparison · Mar 2026



Delegate Compliance Over Time




25%
0%
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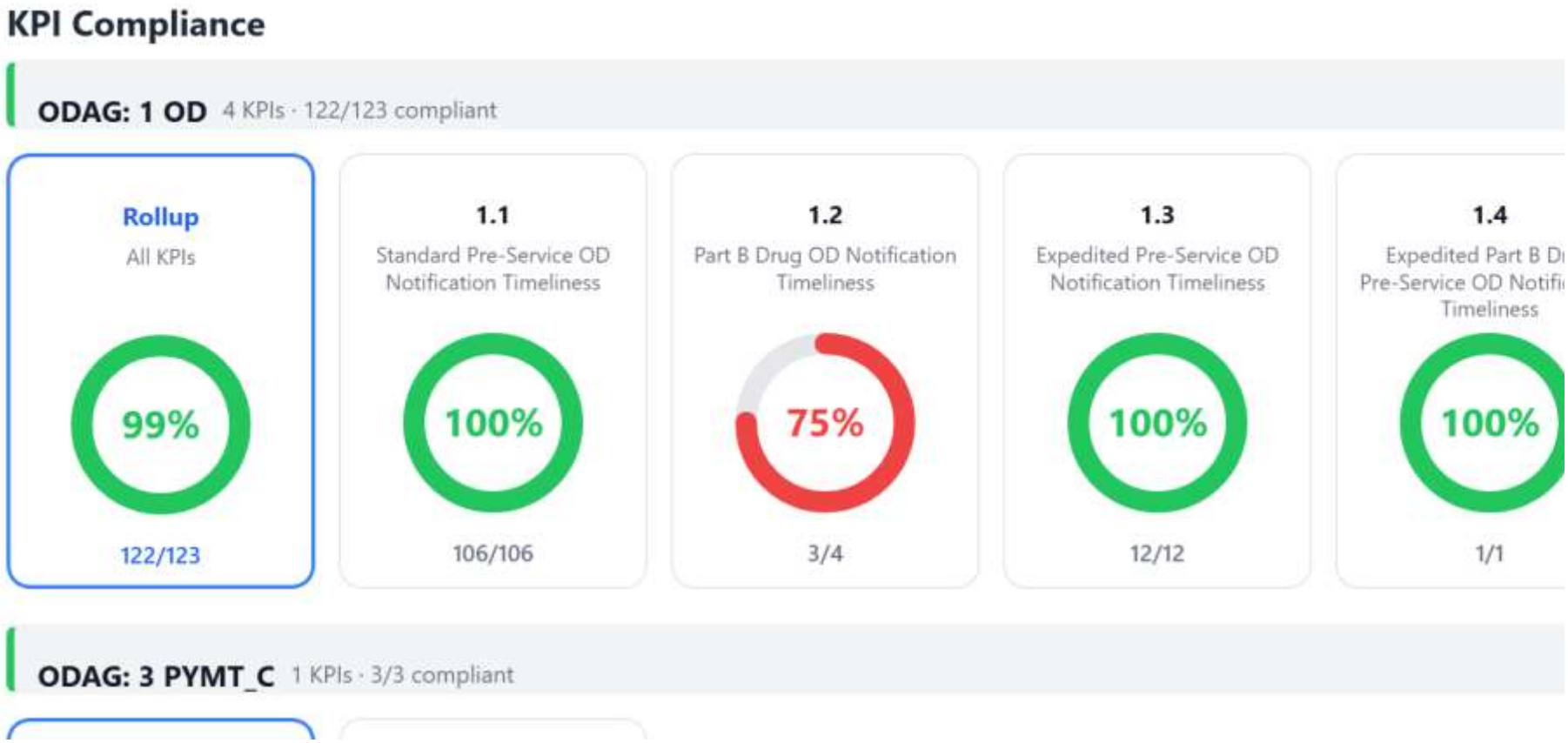
Premier Patient Care IPA
Imperial Count Physicians Medical Group
Community Health Group
Community Care IPA
Primary Health Car
MedPoint Management

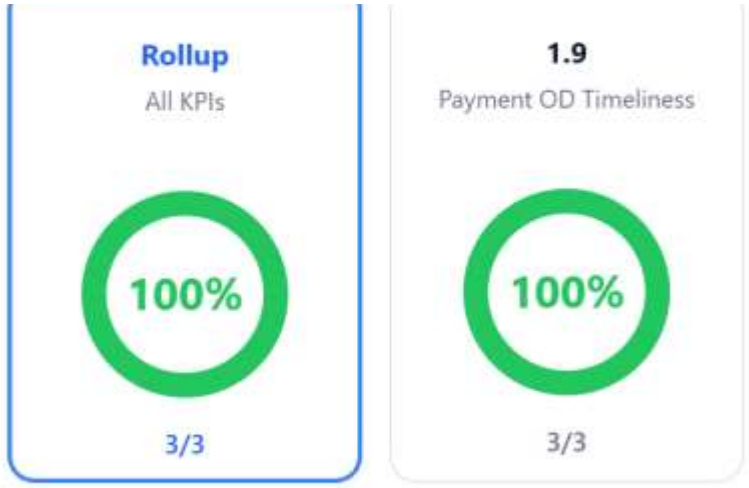
Exhibit I

Compliance Scorecard

Delegate	Premier Patient Care IPA
Period	February 2026
KPIs measured	5
Overall compliance	99.21% (125/126)
Generated	Aug 4, 2026, 4:48 PM

KPI Compliance





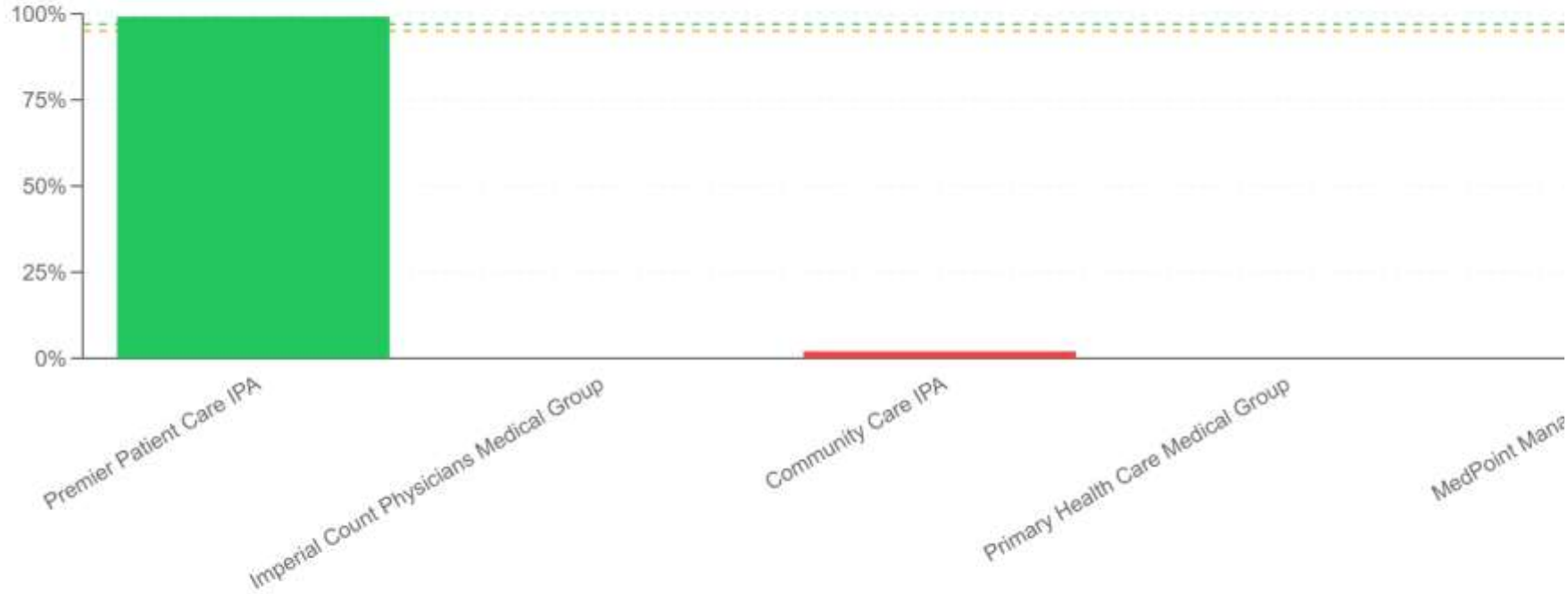
Compliance by Universe & KPI

KPI #	Name	Jan	Feb	Mar	Q1
ODAG: 1 OD	**All KPIs**	**96.88%**	**99.19%**	**100.00%**	**99.55%**
1.1	Standard Pre-Service OD Notification Timeliness	100.00%	100.00%	100.00%	100.00%
1.2	Part B Drug OD Notification Timeliness	66.67%	75.00%	100.00%	85.71%
1.3	Expedited Pre-Service OD Notification Timeliness	100.00%	100.00%	100.00%	100.00%
1.4	Expedited Part B Drug Pre-Service OD Notification	—	100.00%	100.00%	100.00%
ODAG: 3 PYMT_C	**All KPIs**	—	**100.00%**	**100.00%**	**100.00%**
1.10	Payment Reconsiderations Timeliness	—	—	—	—
1.9	Payment OD Timeliness	—	100.00%	100.00%	100.00%

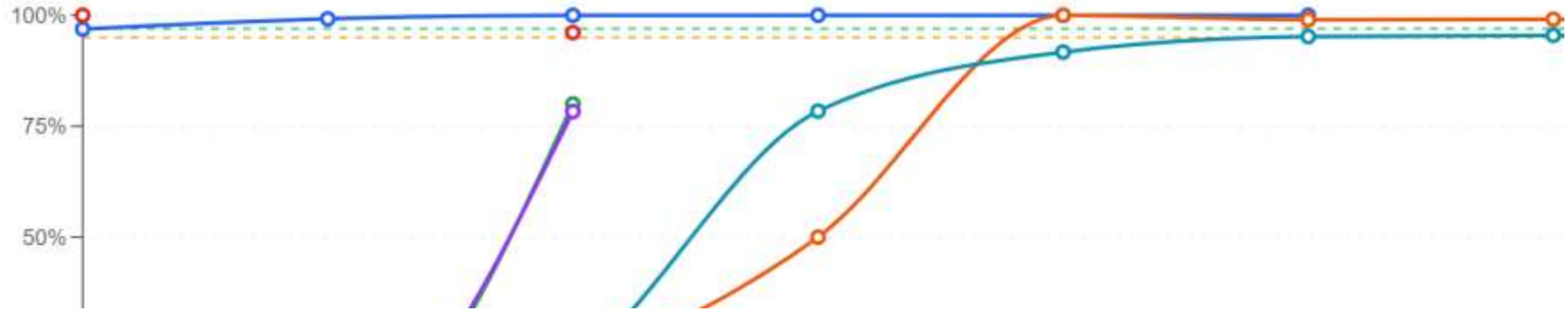
Trends

Trends

Delegate Comparison · Feb 2026



Delegate Compliance Over Time




25%
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Jul
Premier Patient Care IPA
Imperial Count Physicians Medical Group
Community Health Group
Community Care IPA
Primary Health Car
MedPoint Management

Compliance Scorecard

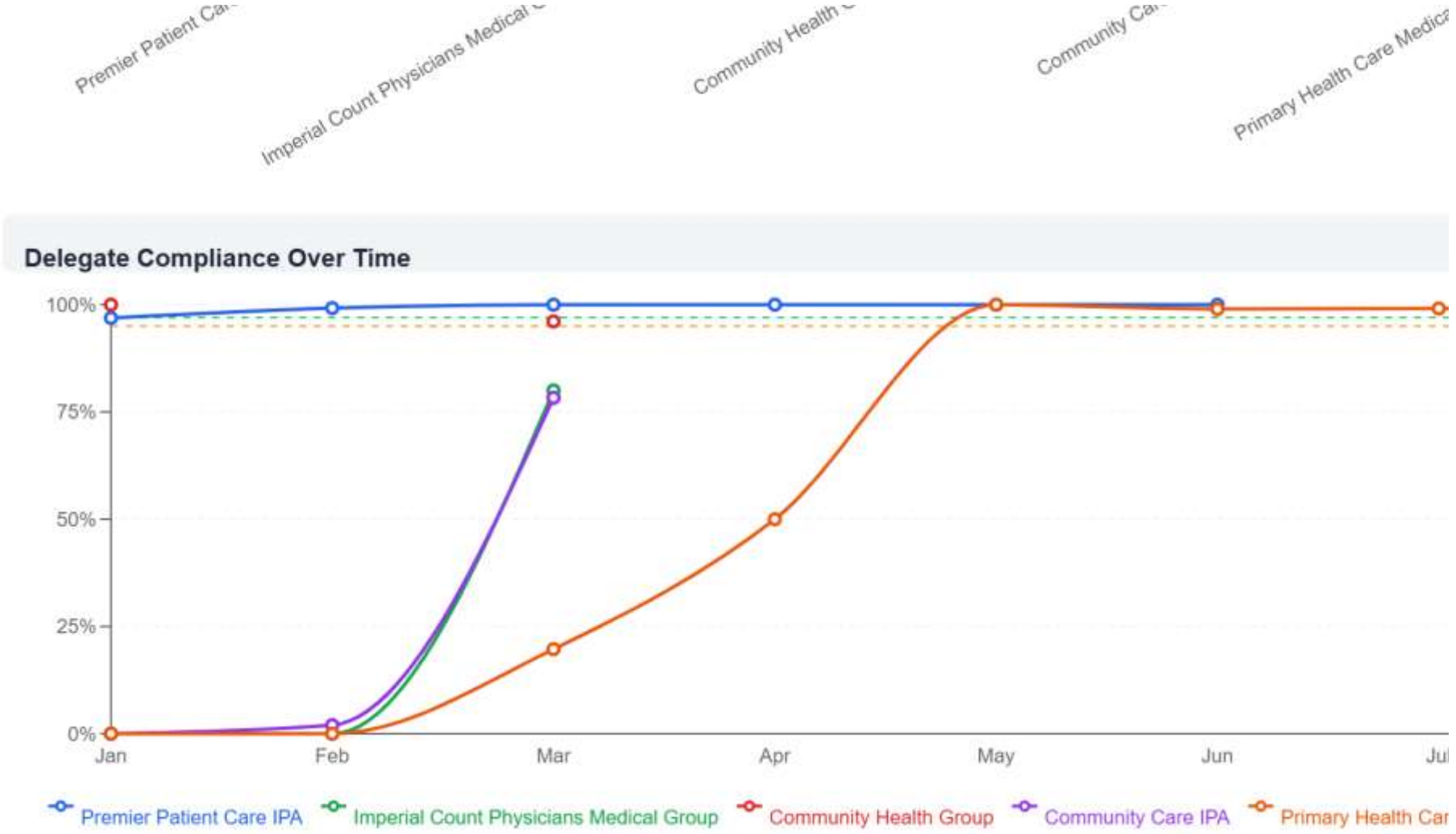
Delegate	Premier Patient Care IPA
Period	January 2026
KPIs measured	3
Overall compliance	96.88% (31/32)
Generated	Aug 4, 2026, 4:47 PM

KPI Compliance

Compliance by Universe & KPI

KPI #	Name	Jan	Feb	Mar	Q1
ODAG: 1 OD	**All KPIs**	**96.88%**	**99.19%**	**100.00%**	**99.55%**
1.1	Standard Pre-Service OD Notification Timeliness	100.00%	100.00%	100.00%	100.00%
1.2	Part B Drug OD Notification Timeliness	66.67%	75.00%	100.00%	85.71%
1.3	Expedited Pre-Service OD Notification Timeliness	100.00%	100.00%	100.00%	100.00%
1.4	Expedited Part B Drug Pre-Service OD Notification	—	100.00%	100.00%	100.00%
ODAG: 3 PYMT_C	**All KPIs**	—	**100.00%**	**100.00%**	**100.00%**
1.10	Payment Reconsiderations Timeliness	—	—	—	—
1.9	Payment OD Timeliness	—	100.00%	100.00%	100.00%

Trends


Premier Patient Ca
Imperial Count Physicians Medical
Community Health
Community Ca
Primary Health Care Medica
Delegate Compliance Over Time
100%
75%
50%
25%
0%
Jan
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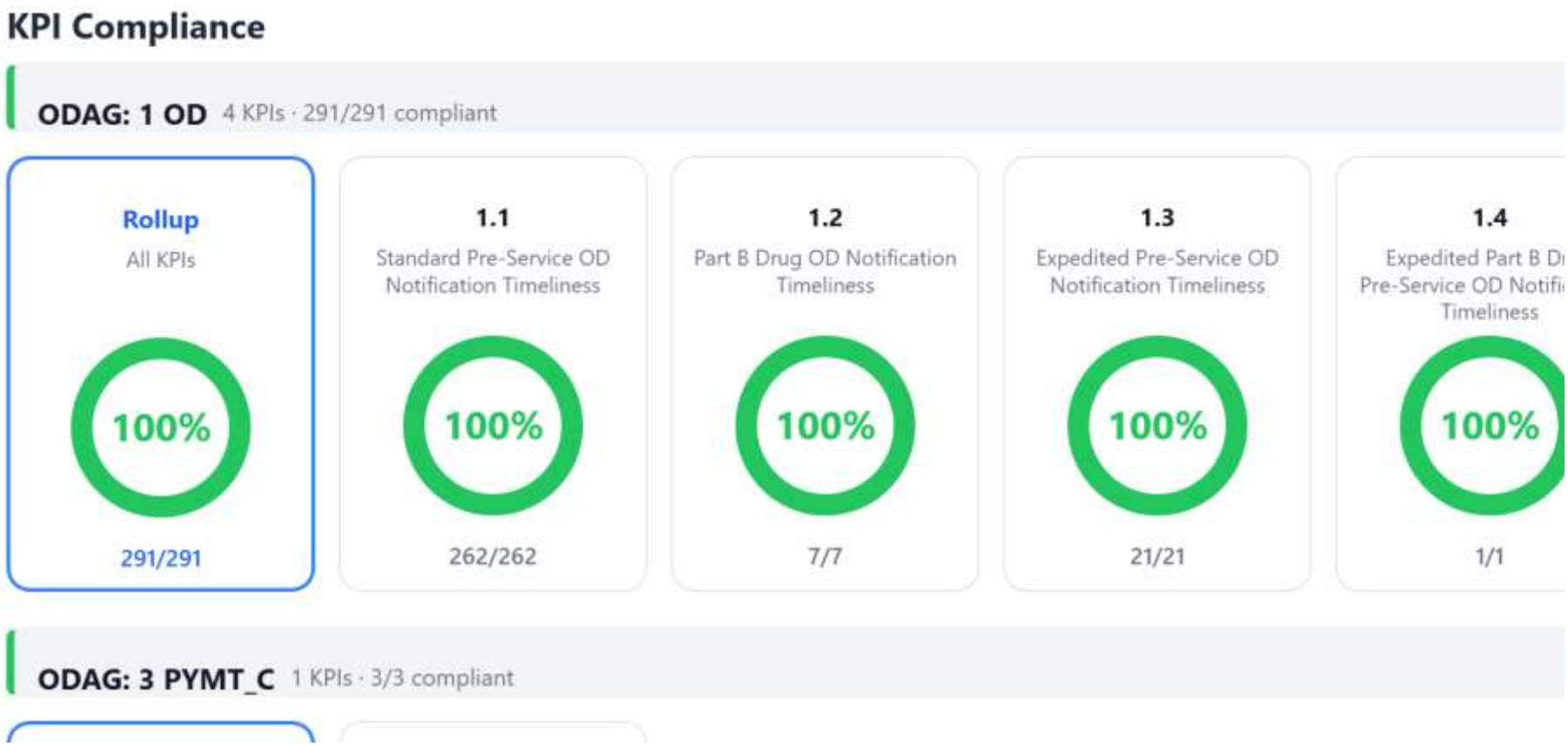
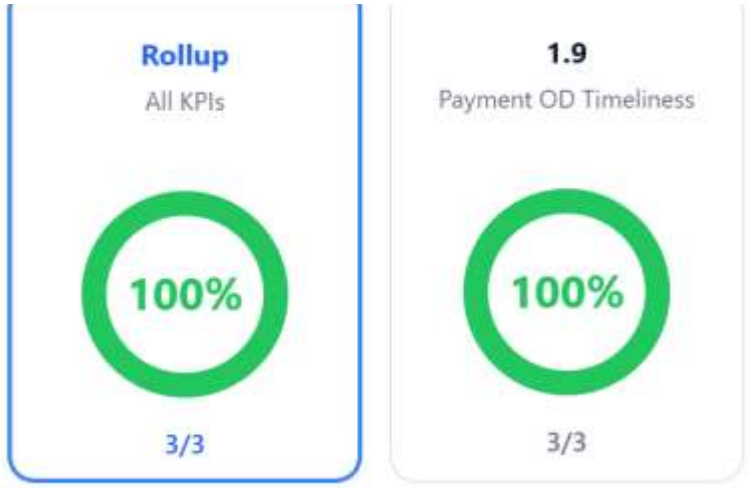
Mar
Apr
May
Jun
Premier Patient Care IPA
Imperial Count Physicians Medical Group
Community Health Group
Community Care IPA
Primary Health Car

Compliance Scorecard

Delegate	Premier Patient Care IPA
Period	March 2026
KPIs measured	5
Overall compliance	100% (294/294)
Generated	Aug 4, 2026, 4:48 PM

KPI Compliance





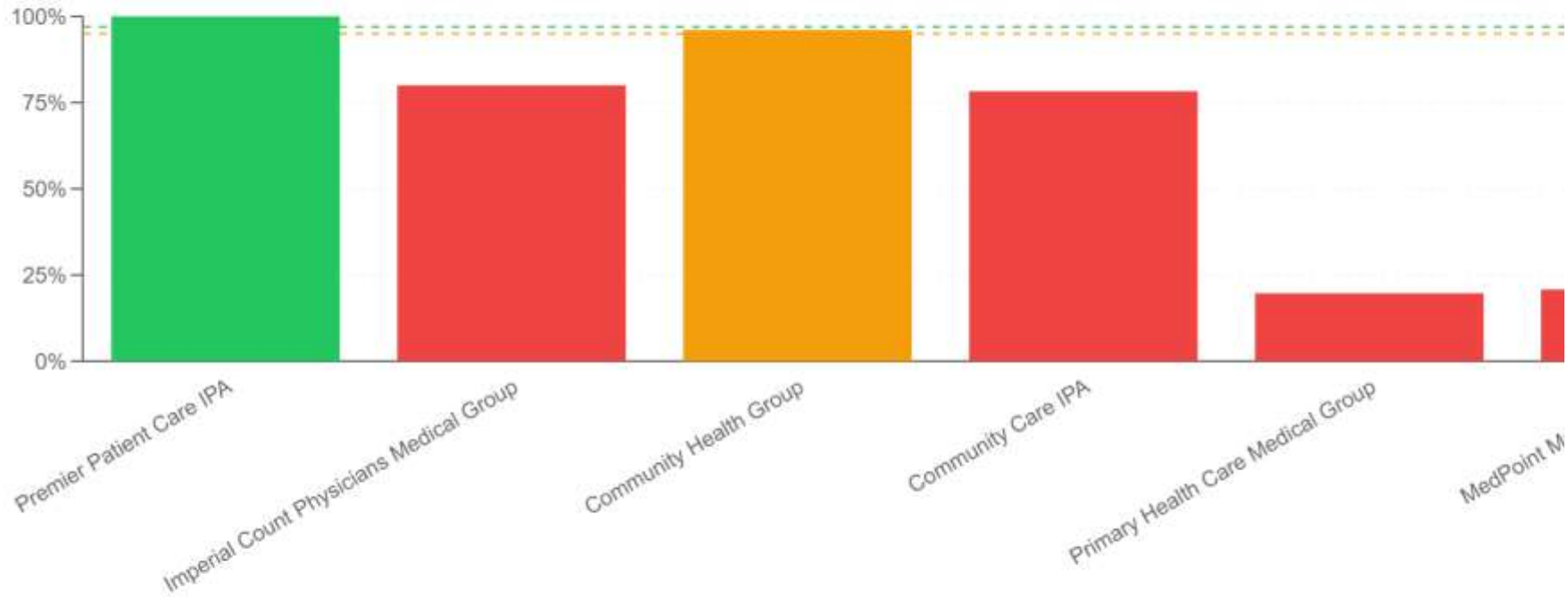
Compliance by Universe & KPI

KPI #	Name	Jan	Feb	Mar	Q1
ODAG: 1 OD	**All KPIs**	**96.88%**	**99.19%**	**100.00%**	**99.55%**
1.1	Standard Pre-Service OD Notification Timeliness	100.00%	100.00%	100.00%	100.00%
1.2	Part B Drug OD Notification Timeliness	66.67%	75.00%	100.00%	85.71%
1.3	Expedited Pre-Service OD Notification Timeliness	100.00%	100.00%	100.00%	100.00%
1.4	Expedited Part B Drug Pre-Service OD Notification	—	100.00%	100.00%	100.00%
ODAG: 3 PYMT_C	**All KPIs**	—	**100.00%**	**100.00%**	**100.00%**
1.10	Payment Reconsiderations Timeliness	—	—	—	—
1.9	Payment OD Timeliness	—	100.00%	100.00%	100.00%

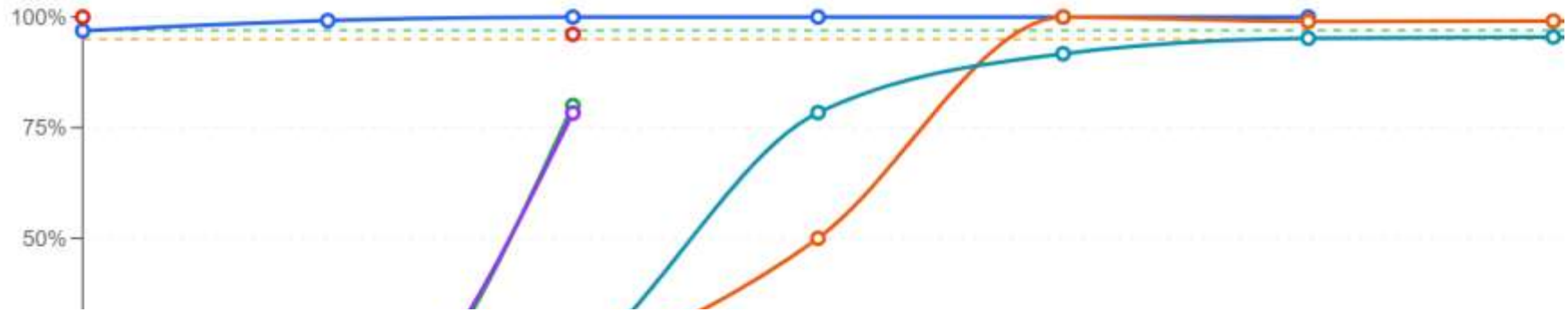
Trends

Trends

Delegate Comparison · Mar 2026



Delegate Compliance Over Time



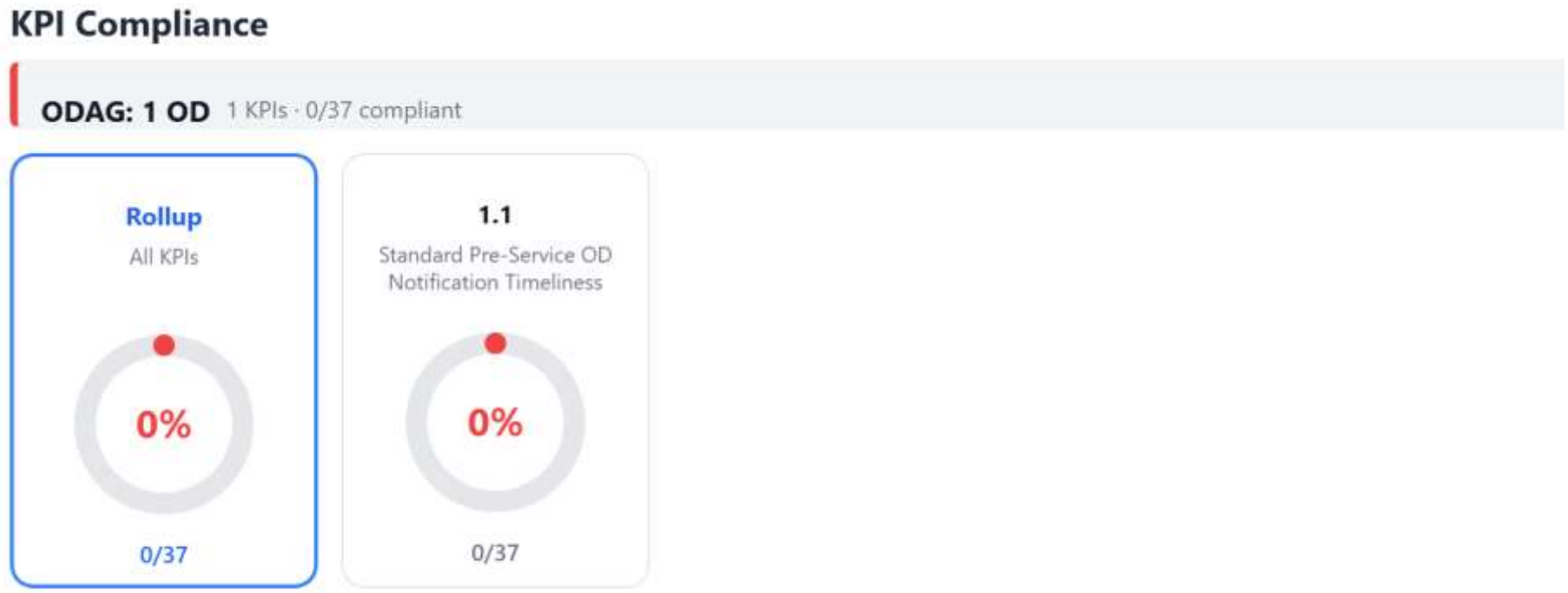

25%
0%
Jan
Feb
Mar
Apr
May
Jun
Jul
Premier Patient Care IPA
Imperial Count Physicians Medical Group
Community Health Group
Community Care IPA
Primary Health Car
MedPoint Management

Exhibit J

Compliance Scorecard

Delegate	Primary Health Care Medical Group
Period	February 2026
KPIs measured	1
Overall compliance	0% (0/37)
Generated	Aug 4, 2026, 4:48 PM

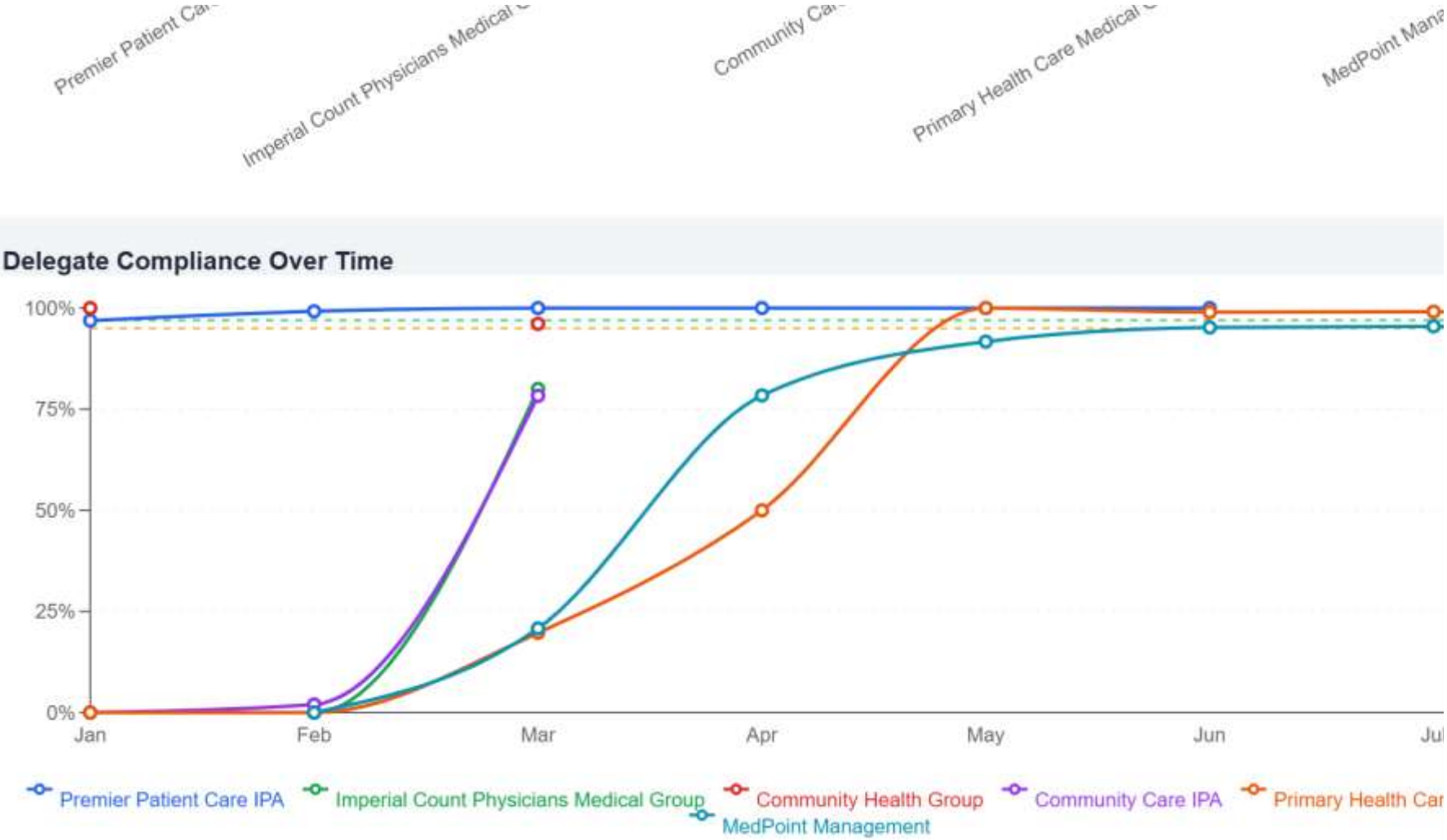
KPI Compliance



Compliance by Universe & KPI

KPI #	Name	Jan	Feb	Mar	Q1
ODAG: 1 OD	**All KPIs**	**0.00%**	**0.00%**	**19.67%**	**10.91%**
1.1	Standard Pre-Service OD Notification Timeliness	0.00%	0.00%	24.49%	12.24%
1.2	Part B Drug OD Notification Timeliness	—	—	—	—
1.3	Expedited Pre-Service OD Notification Timeliness	—	—	0.00%	0.00%
1.4	Expedited Part B Drug Pre-Service OD Notification	—	—	—	—
ODAG: 3 PYMT_C	**All KPIs**	—	—	—	—
1.10	Payment Reconsiderations Timeliness	—	—	—	—
1.9	Payment OD Timeliness	—	—	—	—

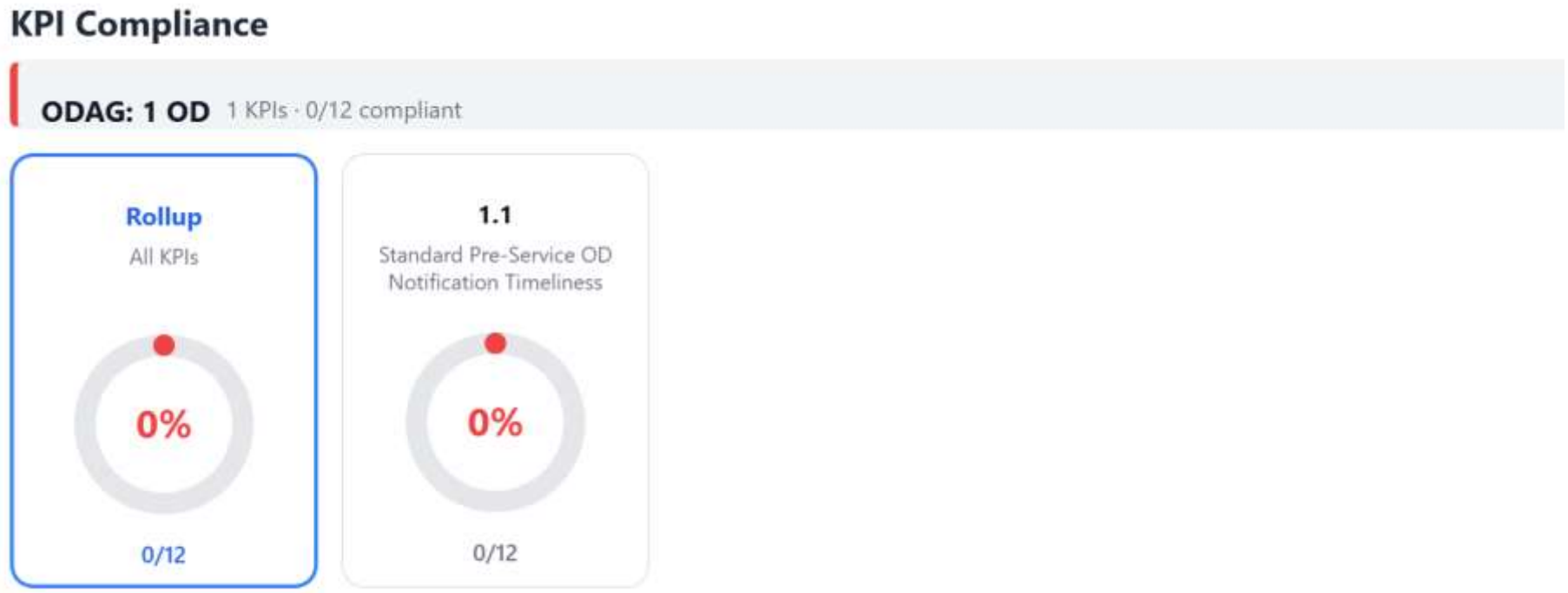
Trends


Premier Patient Ca
Imperial Count Physicians Medical G
Community Ca
Primary Health Care Medical G
MedPoint Mana
Delegate Compliance Over Time
100%
75%
50%
25%
0%
Jan
Feb
Mar
Apr
May
Jun
Jul
Premier Patient Care IPA
Imperial Count Physicians Medical Group
Community Health Group
Community Care IPA
Primary Health Car
MedPoint Management

Compliance Scorecard

Delegate	Primary Health Care Medical Group
Period	January 2026
KPIs measured	1
Overall compliance	0% (0/12)
Generated	Aug 4, 2026, 4:47 PM

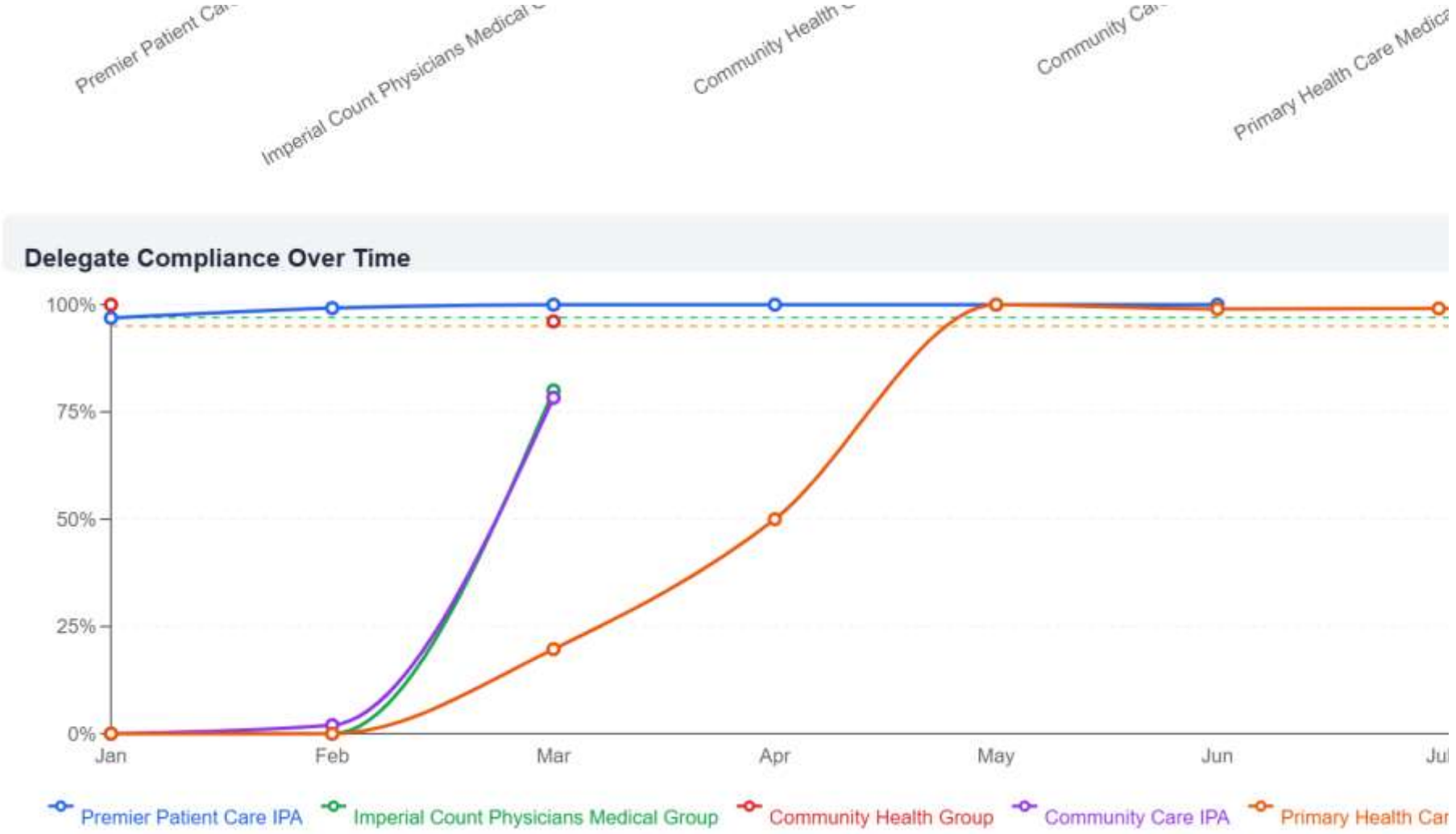
KPI Compliance



Compliance by Universe & KPI

KPI #	Name	Jan	Feb	Mar	Q1
ODAG: 1 OD	**All KPIs**	**0.00%**	**0.00%**	**19.67%**	**10.91%**
1.1	Standard Pre-Service OD Notification Timeliness	0.00%	0.00%	24.49%	12.24%
1.2	Part B Drug OD Notification Timeliness	—	—	—	—
1.3	Expedited Pre-Service OD Notification Timeliness	—	—	0.00%	0.00%
1.4	Expedited Part B Drug Pre-Service OD Notification	—	—	—	—
ODAG: 3 PYMT_C	**All KPIs**	—	—	—	—
1.10	Payment Reconsiderations Timeliness	—	—	—	—
1.9	Payment OD Timeliness	—	—	—	—

Trends


Premier Patient Ca
Imperial Count Physicians Medical
Community Health
Community Ca
Primary Health Care Medica
Delegate Compliance Over Time
100%
75%
50%
25%
0%
Jan
Feb
Mar
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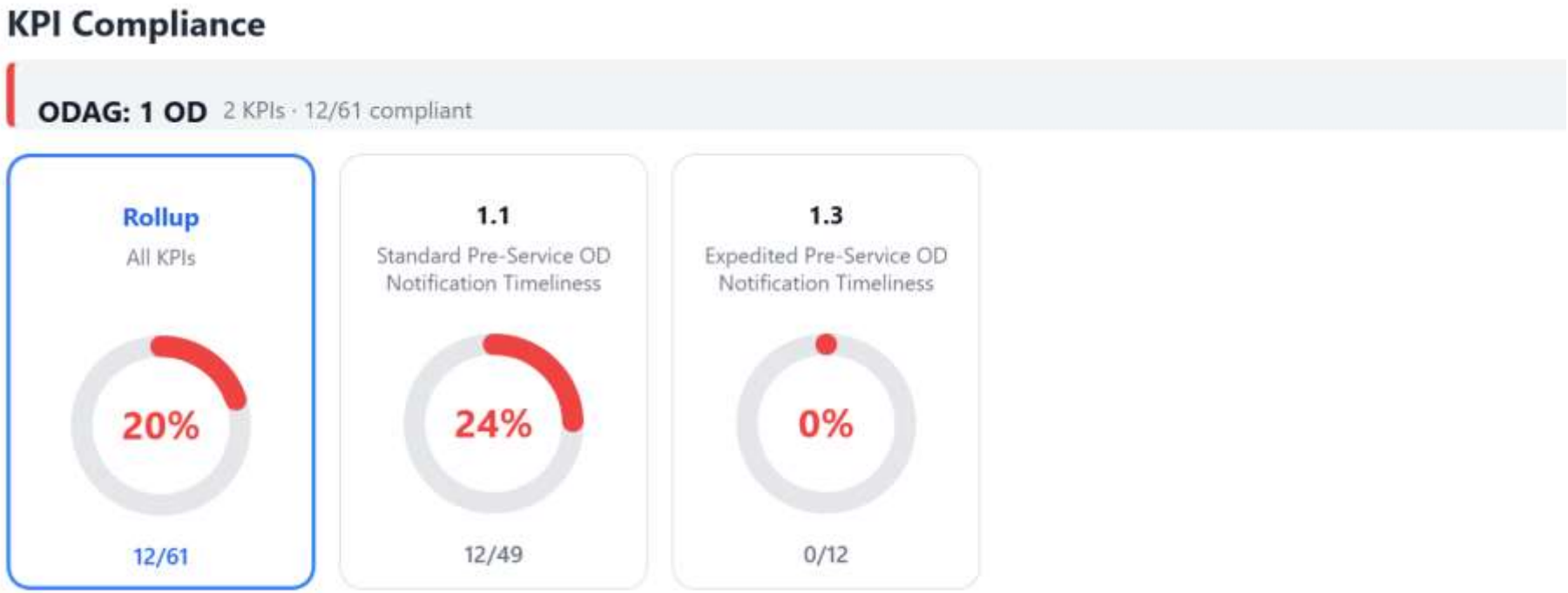
May
Jun
Premier Patient Care IPA
Imperial Count Physicians Medical Group
Community Health Group
Community Care IPA
Primary Health Car

Compliance Scorecard

Delegate	Primary Health Care Medical Group
Period	March 2026
KPIs measured	2
Overall compliance	19.67% (12/61)
Generated	Aug 4, 2026, 5:01 PM

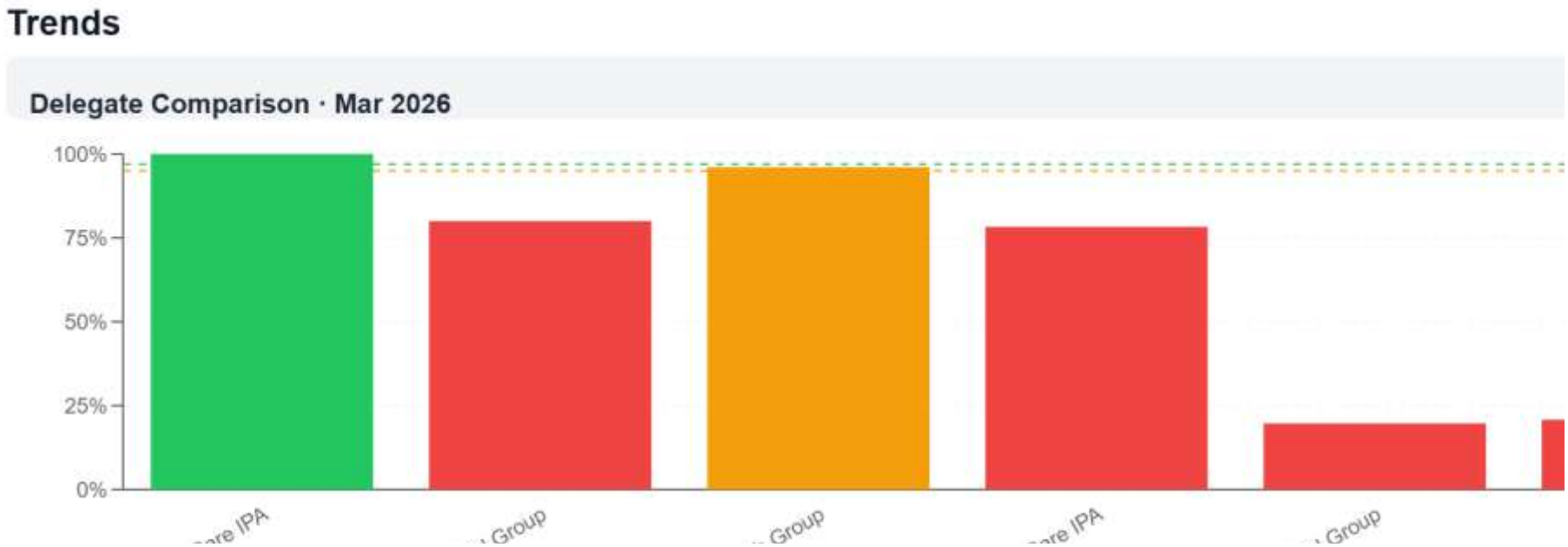
KPI Compliance

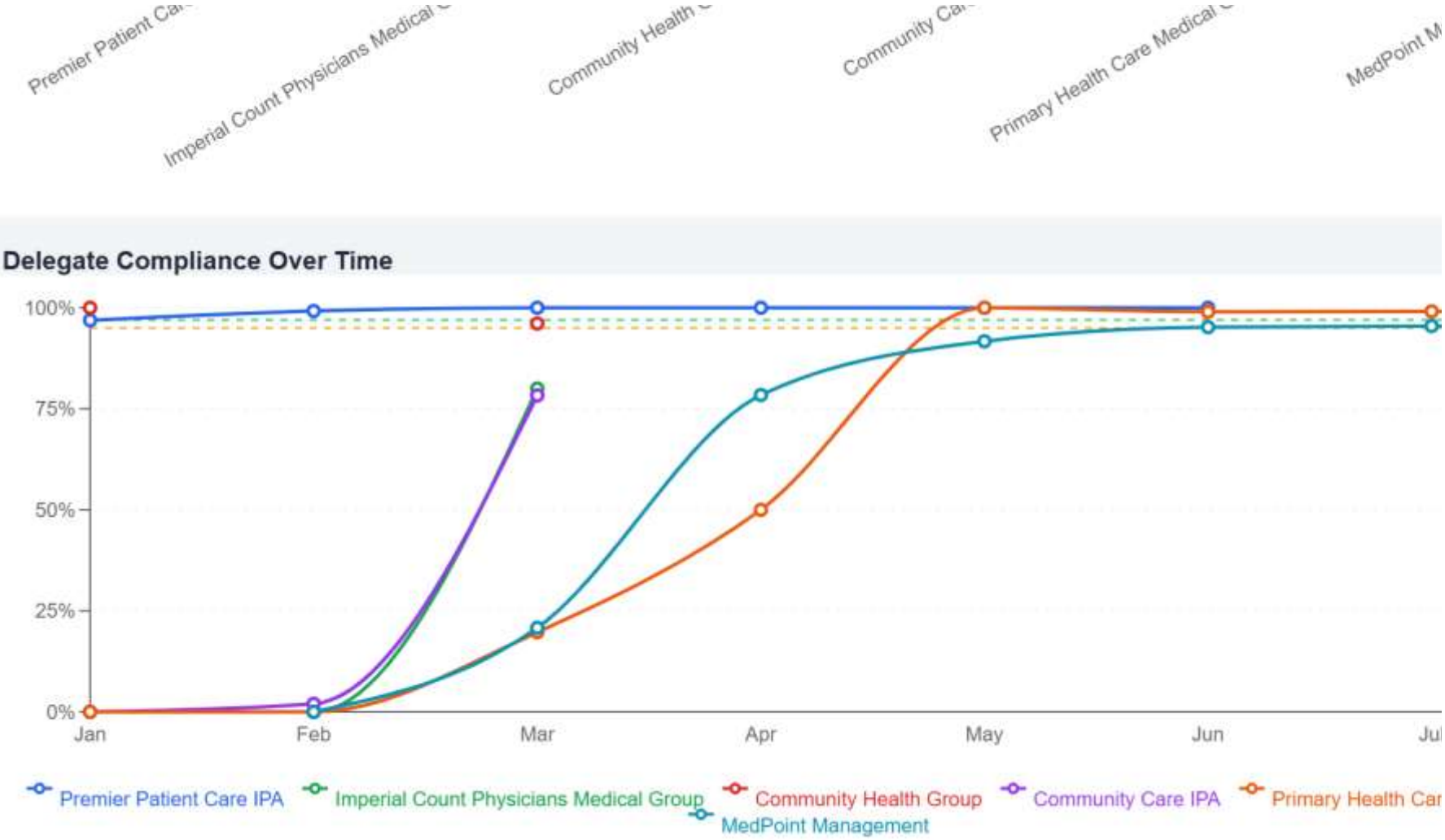


Compliance by Universe & KPI

KPI #	Name	Jan	Feb	Mar	Q1
ODAG: 1 OD	**All KPIs**	**0.00%**	**0.00%**	**19.67%**	**10.91%**
1.1	Standard Pre-Service OD Notification Timeliness	0.00%	0.00%	24.49%	12.24%
1.2	Part B Drug OD Notification Timeliness	—	—	—	—
1.3	Expedited Pre-Service OD Notification Timeliness	—	—	0.00%	0.00%
1.4	Expedited Part B Drug Pre-Service OD Notification	—	—	—	—
ODAG: 3 PYMT_C	**All KPIs**	—	—	—	—
1.10	Payment Reconsiderations Timeliness	—	—	—	—
1.9	Payment OD Timeliness	—	—	—	—

Trends




Premier Patient Ca
Imperial Count Physicians Medical G
Community Health G
Community Ca
Primary Health Care Medical G
MedPoint M
Delegate Compliance Over Time
100%
75%
50%
25%
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Jan
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Premier Patient Care IPA
Imperial Count Physicians Medical Group
Community Health Group
Community Care IPA
Primary Health Car
MedPoint Management