IMPERIAL COUNTY
Local Health Authority Commission

AGENDA

October 9th, 2023
5:30 PM
1224 W State Street Ste B
El Centro CA 92243

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

Committee Members	Representing	Present
Dr. Theodore Affue	LHA Commissioner – Imperial County Medical Society	
Dr. Bushra Ahmad	LHA Commissioner – County of Imperial – Chief Medical Officer	
Dr. Carlos Ramirez	LHA Commissioner – Unicare – CNO, COO	
Dr. Unnati Sampat	LHA Commissioner – MD, Imperial Valley Family Care Medical Group	
Dr. Allen Wu	LHA Commissioner – Innercare, Chief Medical Officer	
Damon Sorenson	LHA Commissioner – Chief Executive Officer – Pioneers	
Miguel Figueroa	LHA Commissioner – County of Imperial – Chief Executive Officer	
Paula Llanas	LHA Commissioner – County of Imperial – Director of Social Services	
Ryan E. Kelley	LHA Commissioner – County of Imperial – Board of Supervisors	
Pablo Velez	LHA Commissioner – ECRMC Chief Executive Officer	
Yvonne Bell	LHA Vice-Chair – Chief Executive Officer – Innercare	
Lee Hindman	LHA Chairperson – Joint Chambers of Commerce representing the public	

1. Call to Order *Lee Hindman, Chair*
2. Roll Call *Office & HR Manager, Michelle S. Ortiz*
3. Approval of the Agenda *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.

CONSENT CALENDAR

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5. Discussion/Action regarding financial reports: *Mark A. Southworth, CFO*
    a. Fund Balance Report
        i. Through August 31, 2023
    b. Detailed Transaction Report
        i. Through August 31, 2023
    c. Revenue and Expenditures Report
        i. Through August 31, 2023

6. Discussion/Action on Minutes from 09/12/2023 Meeting

CLOSED SESSION *Chair*

7. Pursuant to Welfare and Institutions Code § 14087.38 (m) *Larry Lewis, CEO*
    a. Update/Action on Contract with Health Net Community Solutions, Inc.
    b. Compliance Updates
    c. Office Space

INFORMATION/ACTION

8. Report on actions taken in Closed Session *William Smerdon, Attorney*
9. CEO Report *Larry Lewis, CEO*
10. Medical Society Annual Meeting Sponsorship *Larry Lewis, CEO*
11. Health Net Presentation – Transitions and Continuity of Care *Ed Mariscal & Dr. Kathleen Lang, HN*
12. Discussion/Action on Policies & Procedures *Elysse Tarabola, CCO*
13. Commissioner Remarks *Lee Hindman, Chairperson*

Adjournment

Next Regular Commission Meeting: Monday November 13, 2023

IMPERIAL COUNTY
Local Health Authority Commission

C.E.O. REPORT

OCTOBER 2023

General Updates

- **Health Services** — **Dr. Arakawa**
  - **Population Health Overview**
- **Finance** — **Mark**
  - **Updates – DMHC Financial Deliverables Update**
  - **Accounting and Reporting Update**
  - **Audit Update – Moss Adams**
  - **Interest Earnings**
- **Human Resources** — **Michelle**
  - **Staffing Updates since Commission**
  - **Retirement Plan Update**
- **Members** — **Michelle**
  - **Membership Calls - Molina**
- **Community** — **Michell**
  - **Community Advisory Committee Update**

Other Discussions

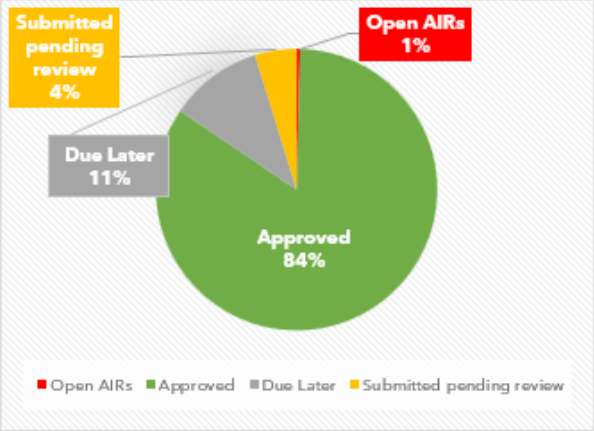
- **New Office Update** — **Larry**
- **Imperial Valley Continuity of Care Committee** — **10-12-2023**
- **Area Agency on Aging Advisory Council Presentation** — **10-19-2023**

PATHWAY TO HEALTH PLAN

DHCS Operational Readiness

DHCS Operational Readiness

	Count	%
Submitted, approved	211	84%
Submitted, pending DHCS review	12	4%
Open AIRs	1	1%
Due Later	27	11%
TOTAL	251	



OR Deliverable Update

- Septembers OR deliverables completed and submitted.
- Provider Directory deliverable completed and ready for submission.
- No upcoming OR deliverables for October and November.
- 10 deliverables due on 12/29/2023, all of which will be assigned to Health Net. Below is a high-level summary of the deliverables:
    - Executed MOUs with third-party entities and county programs.
    - Policies regarding the exchange of member information with Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) or county Drug Medi-Cal Programs and assessing the effectiveness of MOUs.

DMHC Knox Keene Application

- Timely submission of responses to the latest Comment Table issued on 9/22/2023.
    - Comments included revisions to the Member Handbook & ID Card, request for the renewed Tort Claims insurance policy, minor policy update, and revisions to the Request for Confidentiality exhibit.
- Submitted the revised fidelity insurance policy which DMHC has already confirmed meets the application requirements.
- Still pending the undertaking to address the additional application revisions noted in the conditional approval letter issued on 8/31/2023

IMPERIAL COUNTY
Local Health Authority Commission

Fact Sheet

Policies & Procedures: Seeking Commission Review and Approval

October 9, 2023

Agenda Item #

Policies & Procedures

P&P Title	Owner/ Department	Policy Purpose
ADM-001 Community Donations and Support	Larry Lewis, Executive Services	Establishes guidelines for Community Health Plan of Imperial Valley's (CHPIV) PARTICIPATION in community events, programs, projects, and activities involving external entities.
CM-001 Care Management Program	Dr. Arakawa, Health Services	Establish CHPIV's requirements around the Care Management Program
CMP-004 Implementation of Regulatory Notifications	Chelsea Hardy, Compliance	Established guidelines for CHPIV's Participation in community events, programs, projects, and activities involving external entities.
CMP-006 Compliance Training	Elysse Tarabola, Compliance	Compliance Training Program requirements for its CHPIV Employees, SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS.
CMP-007 Escalations of Non-Compliance Issues	Elysse Tarabola, Compliance	Addresses noncompliance promptly and efficiently while promoting transparency, fairness, and compliance with all applicable laws and regulations.
CMP-008 Selecting a Chief Compliance Officer	Elysse Tarabola, Compliance	Establishes a clear and standardized process for the selection of a CHIEF COMPLIANCE OFFICER (CCO) who will ensure adherence to all contractual requirements.

IMPERIAL COUNTY
Local Health Authority Commission

P&P Title	Owner/ Department	Policy Purpose
CMP-009 Fraud Waste and Abuse Program	Chelsea Hardy, Compliance	Ensure compliance with the Fraud Prevention Program requirements in the MEDI-CAL CONTRACT. Intended to prevent, detect, investigate, and report suspected health care FRAUD, WASTE, and ABUSE. It establishes CHPIV's oversight responsibilities of NETWORK PROVIDERS, SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS
CMP-010 Effective Lines of Communication	Elysse Tarabola, Compliance	Written policies, procedures and standards of conduct that mandate every employee will comply with all applicable Medi-Cal, Medicare, federal and state standards
CMP-011 Breach Notification	Chelsea Hardy, Compliance	Enables CHPIV to comply with applicable state and federal laws and regulations governing notice to affected persons in the event of a breach of Member privacy.
CMP-012 Notice of Privacy Practices	Chelsea Hardy, Compliance	identifies the required content of CHPIV's NOTICE OF PRIVACY PRACTICES (NPP) and the process by which the NPP is distributed to MEMBERS.
EXC-002 Delegation of Authority Executive Services	Larry Lewis, Executive Services	Establishes the roles and responsibilities of the DHCS Contracting Officer and the CHPIV's Representative
FIN-001 Delegated Provider Financial Solvency Oversight Process	Mark Southworth, Finance	Establish that CHPIV follows the CHPIV financial solvency criteria, related contractual requirements and that their financial status is stable and not deteriorating over time
FIN-002 Delegated Provider Financial Solvency Corrective Action Plan Process	Mark Southworth, Finance	Outlines CHPIV" or the "Plan" process to request, review and monitor CORRECTIVE ACTION PLANS (CAPs) required by delegated providers who are not in compliance with the CHPIV's financial solvency standard benchmarks, contracts, and the legal requirements set forth in the California Health & Safety Code.

IMPERIAL COUNTY
Local Health Authority Commission

P&P Title	Owner/ Department	Policy Purpose
PS-001 Pharmacy Services	Dr. Arakawa, Health Services	Addresses CHPIV or the "Plan" requirements for the provision of pharmaceutical services to its MEMBERS.
QM-002 Quality Improvement Health Equity Committee (QIHEC)	Dr. Arakawa, Health Services	Specifies the role, structure, and function of Community Health Plan of Imperial Valley's (CHPIV) QUALITY IMPROVEMENT AND HEALTH EQUITY COMMITTEE (QIHEC)

IMPERIAL COUNTY
Local Health Authority Commission

AGENDA

September 11, 2023
5:30 PM
1224 W State Street Ste B
El Centro CA 92243

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Dr. Theodore Affue	LHA Commissioner – Imperial County Medical Society	
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Dr. Carlos Ramirez	LHA Commissioner – Unicare – CNO, COO	A
Dr. Unnati Sampat	LHA Commissioner – MD, Imperial Valley Family Care Medical Group	
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Pablo Velez	LHA Commissioner – ECRMC Chief Executive Officer	
Yvonne Bell	LHA Vice-Chair – Chief Executive Officer – Innercare	A
Lee Hindman	LHA Chairperson – Joint Chambers of Commerce representing the public	

1. Call to Order *Lee Hindman, Chair*

   Meeting was called to order at 5:30 PM

2. Roll Call *Office & HR Manager, Michelle S. Ortiz*

   At the time of roll call the following were present: established at 5:30

3. Approval of the Agenda *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 the agenda by Dr. Affue, Second by Dr. Sampat.

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.

Dr. Kathleen Lang made an announcement that Covered California is now approved in Imperial County beginning 1/1/24.

CONSENT CALENDAR

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5. Discussion/Action regarding financial reports: *Mark A. Southworth, CFO*
    a. Fund Balance Report
        i. Through July 31, 2023
    b. Detailed Transaction Report
        i. Through July 31, 2023
    c. Revenue and Expenditures Report
        i. Through July 31, 2023

6. Discussion/Action on Financial Controls *Mark A. Southworth, CFO*

Motion to approve the consent calendar, Dr. Affue, seconded by Dr. Sampat.
Motion Passes Unanimously

CLOSED SESSION *Chair*

7. Pursuant to Welfare and Institutions Code § 14087.38 (m) *Larry Lewis, CEO*
    a. Update/Action on Contract with Health Net Community Solutions, Inc.
    b. Compliance Updates
    c. Office Space

Motion to authorize the CEO to Award the contract to A&N Quality Builders to renovate the Aten Building Space in the amount $238,750.

Motion made by: Dr. Sampat Seconded by: Pablo Velez.

INFORMATION/ACTION

William Smerdon reported to the public that there was a Motion to authorize the CEO to Award the contract to A&N Quality Builders to renovate the Aten Building Space in the amount $238,750. Motion made by: Dr. Sampat Seconded by: Pablo Velez. Motion Passes Unanimously

8. Report on actions taken in Closed Session — *William Smerdon, Attorney*
9. CEO Report — *Larry Lewis, CEO*
   - Get together with the other existing plans to work on the transition process for the members.
   - Dr. Gordon Arakawa made a summary explanation of the Quality Improvement and Health Equity Committee. He explained the hierarchy and process behind that committee that will begin to meet 1/1/24.
   - The team made the emphasis that come 1/1/24 there will be no impact to the member.
   - Staffing updates: Newest Staff member, Alejandro Franco who joined CHPIV as the Information Technology & Security Analyst. Michelle made an update that there are currently 4 job openings and showed a preview from the website.
   - Chelsea Hardy, Senior Director of Compliance informed of the status for DMHC & DHCS materials. CHPIV was awarded their conditional Knox Keene License.
   - Larry gave updates on the upcoming Public Policy Committee. This committee will consist of Staff and will report up to the full commission.
10. Compliance Updates — *Elysse Tarabola, CCO*
    - Elysse gave an update on the Delegation Oversight plan for pre-go live date.
    - Completing their KPI's for each department.
    - Implementation of the monitoring program for CHPIV oversight of HN.
11. Discussion/Action on Moss Adams Proposal (FS) — *Mark A. Southworth, CFO*

    Motion to Approve the Proposal from Moss Adams by Recommendation from the Finance/Executive Committee: Motion by: Miguel Figueroa, Seconded by. DR. Sampat, motion carried.
12. Discussion/Action for Conflict-of-Interest Policy — *Larry Lewis, CEO*

    Motion to approve the Conflict-of-Interest Policy: motion made by, Yvonne Bell, Second by Dr. Ahmad motion passes unanimously.
13. Discussion/Action on Employee Handbook — *Michelle S. Ortiz, Office Manager*
    a. Redlined Version
    b. Clean & Final Version

Motion to Approve the Employee Handbook by Pablo Velez, seconded by Dr. Sampat. Motion carried.

14. Commissioner Remarks — *Lee Hindman, Chairperson*

Adjournment @ 6:50 PM

Next Regular Commission Meeting: Monday October 9, 2023

Population Health Management (PHM)

Population Health Management

PHM Goals

CalAIM PHM Model

PHM Mechanics

Progress …

In Progress …

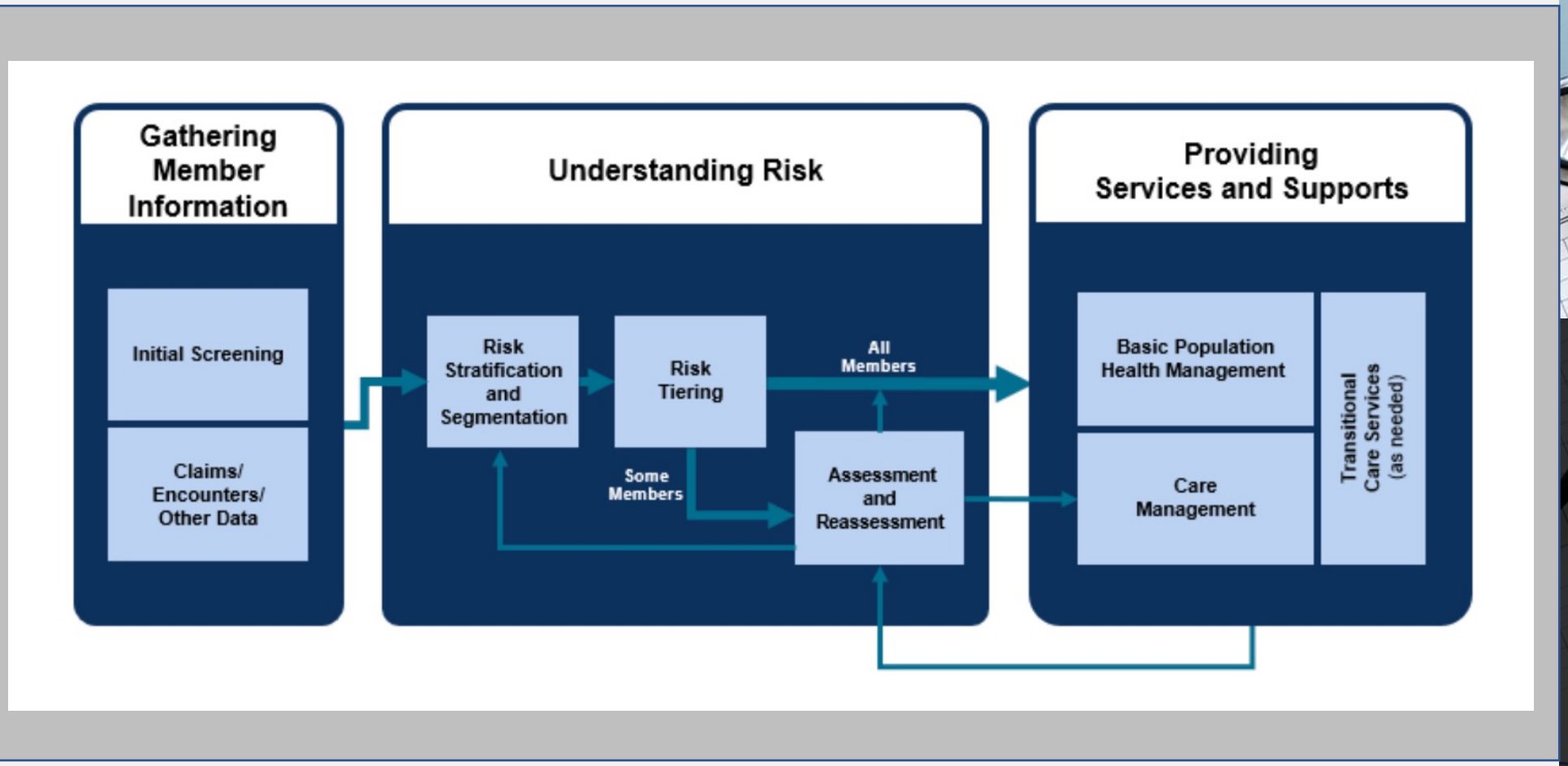
Topics

Population Health Management

- Gather data to identify opportunities for intervention
- Address upstream drivers of health, including BH/SDOH
- Support Members in staying healthy
- Provide care management services and TCS
- Reduce health disparities
- Establish pathway to value-based care

Goals

Population Health Management



CalAIM PHM Model

Population Health Management

Evaluation

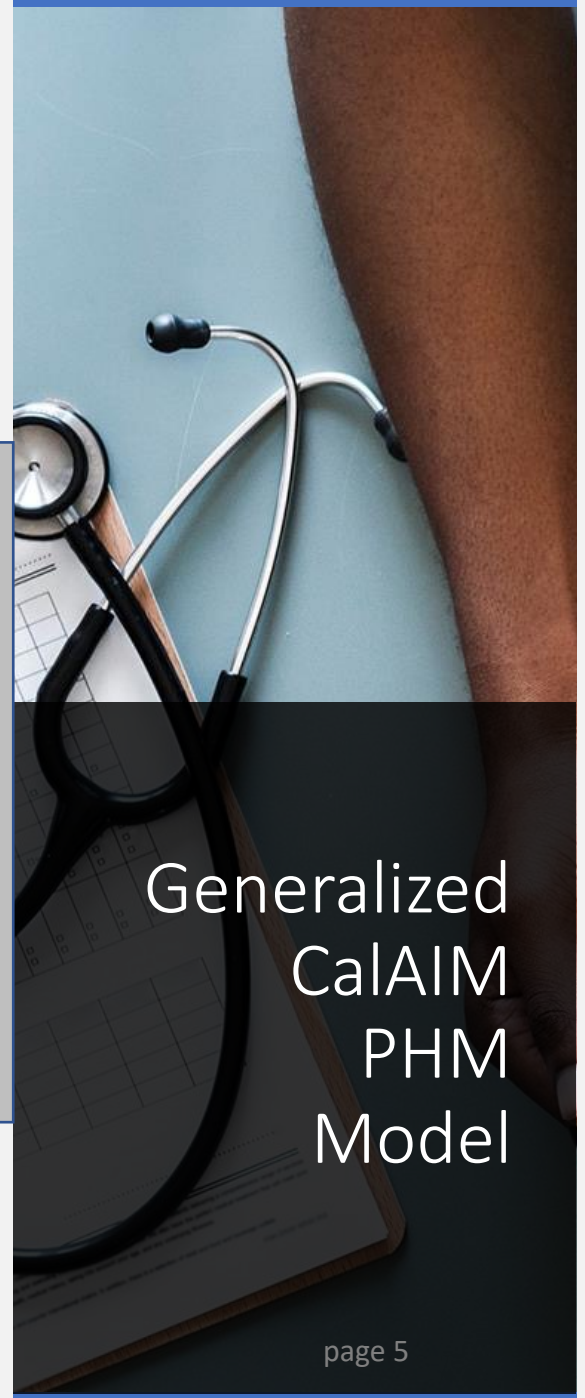
Screening & Data Gathering

Risk

Stratification
Segmentation
Risk Tiering

Care Management

Education
CM
CCM
SDOH care



Generalized CalAIM PHM Model

Population Health Management

- Health Assessments
- Referrals and Authorizations
- Claims Data
- Electronic Health Records
- Pharmacy & Laboratory Data
- Socioeconomic/SDOH Data
- DHCS PHM “Service”

Population Health Management

- Risk Score
- Risk Tiering
- DHCS Risk Score Assignment

Member Risk

Population Health Management

- Assignment to Care Management “Levels”
- Increased Intervention "Dimensionality"
- Enhanced Care Management (ECM)
- Community Supports (CS)

Population Health Management

- "Whole Person Care" approach
- Reactive to Proactive
- Shift #1 – Well Members
- Shift #2 – Rising Risk Members
- Shift #3 – Complex Members

Population Health Management

- Member Health Assessments
- Risk Stratification
- Care Management Inefficiencies
- Evaluating PHM Results
- PHM model “improvement”
- Disconnect: Population and Member

Population Health Management

Questions ???

Compliance Update

October 9, 2023

Community Health Plan
OF IMPERIAL VALLEY

Agenda

1. Policy and Procedure Review and Approval
2. Knox Keene Application
3. DHCS Operational Readiness
4. Material Review
5. Monitoring
6. Pre-Delegation Audit

P&Ps for Review and Approval

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Knox Keene Application

Knox Keene Application

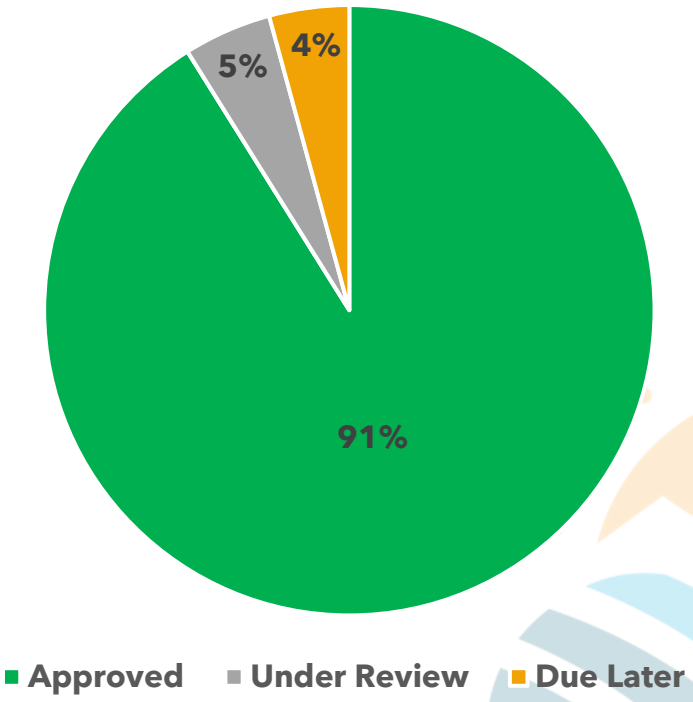
- Received **conditional approval** of Knox Keene Application on 8/31/2023
  - Approval is to meet the DHCS September 1, 2023, "Go/No Go Letter" deadline
  - Review of the License Application is ongoing
  - DMHC may require more revisions for compliance, including changes to handbooks, documents, advertisements, bonds, and policies after further review
- Latest **comment table** issued by DMHC on 9/22/2023.
  - Submitted responses timely on 9/29/2023
  - Comments included revisions to the Member Handbook & ID Card, request for the renewed Tort Claims insurance policy, minor policy updates, and revisions to the Request for Confidentiality exhibit.
- Pending the **undertaking** to address the additional application revisions noted in the conditional approval letter issued on 8/31/2023

DHCS Operational Readiness

DHCS Operational Readiness

OR Submission Status

	Count
Submitted, approved	215
Submitted, pending DHCS review	11
Open AIRs	0
Due Later	10
TOTAL	236

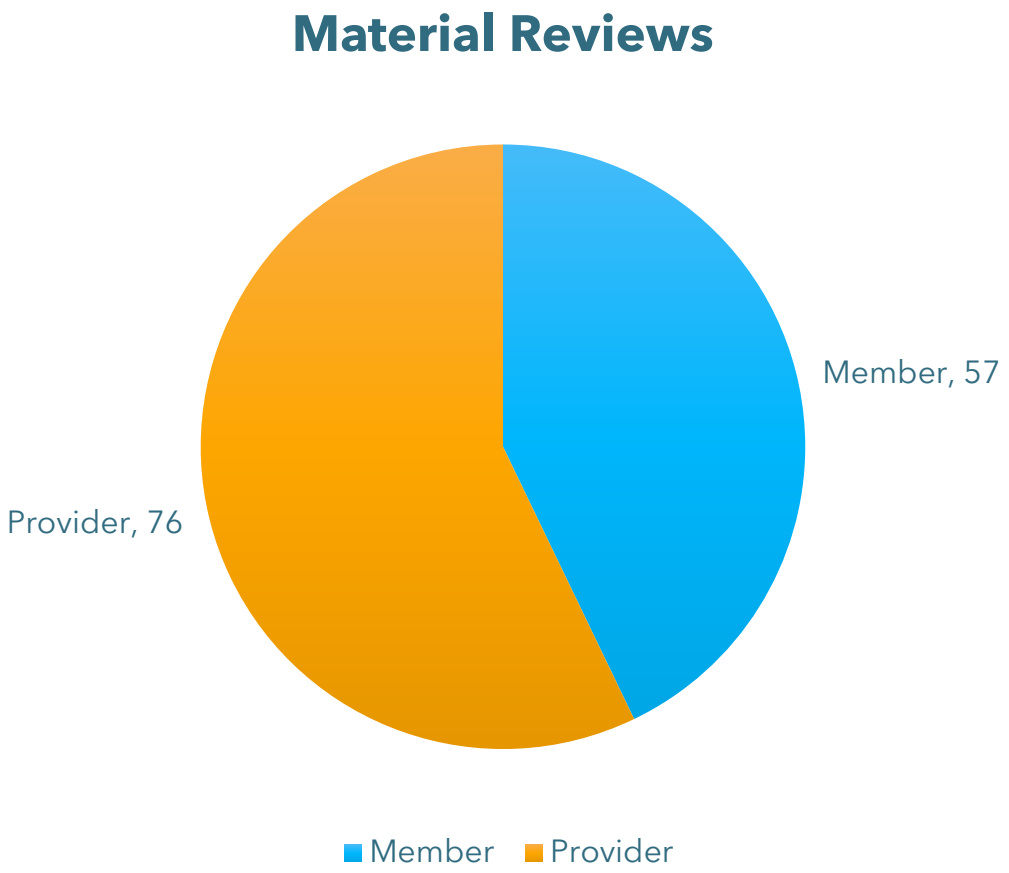


OR Deliverable Update

- 15 TBD deliverables due in 2025
- September deliverables completed and submitted
- No upcoming deliverables for October and November
- 10 deliverables due in December assigned to Health Net

Material Review

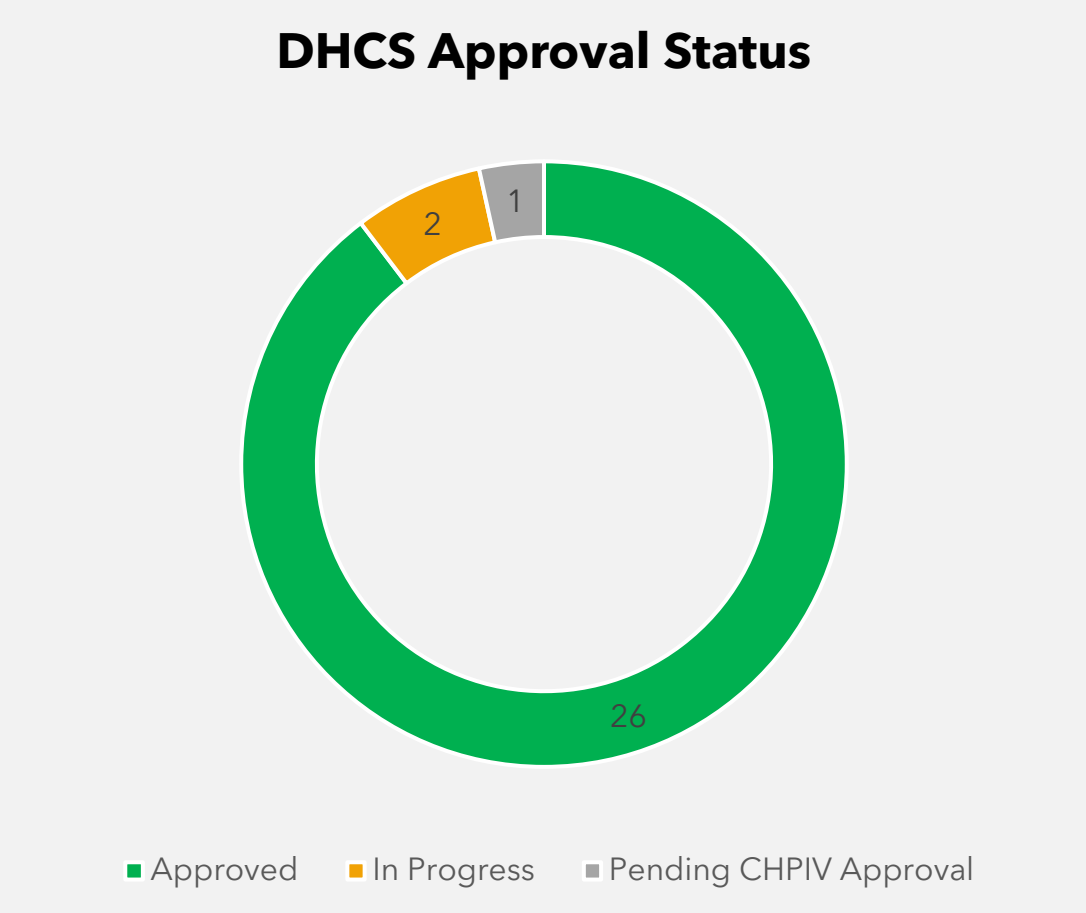
CHPIV Material Review Status

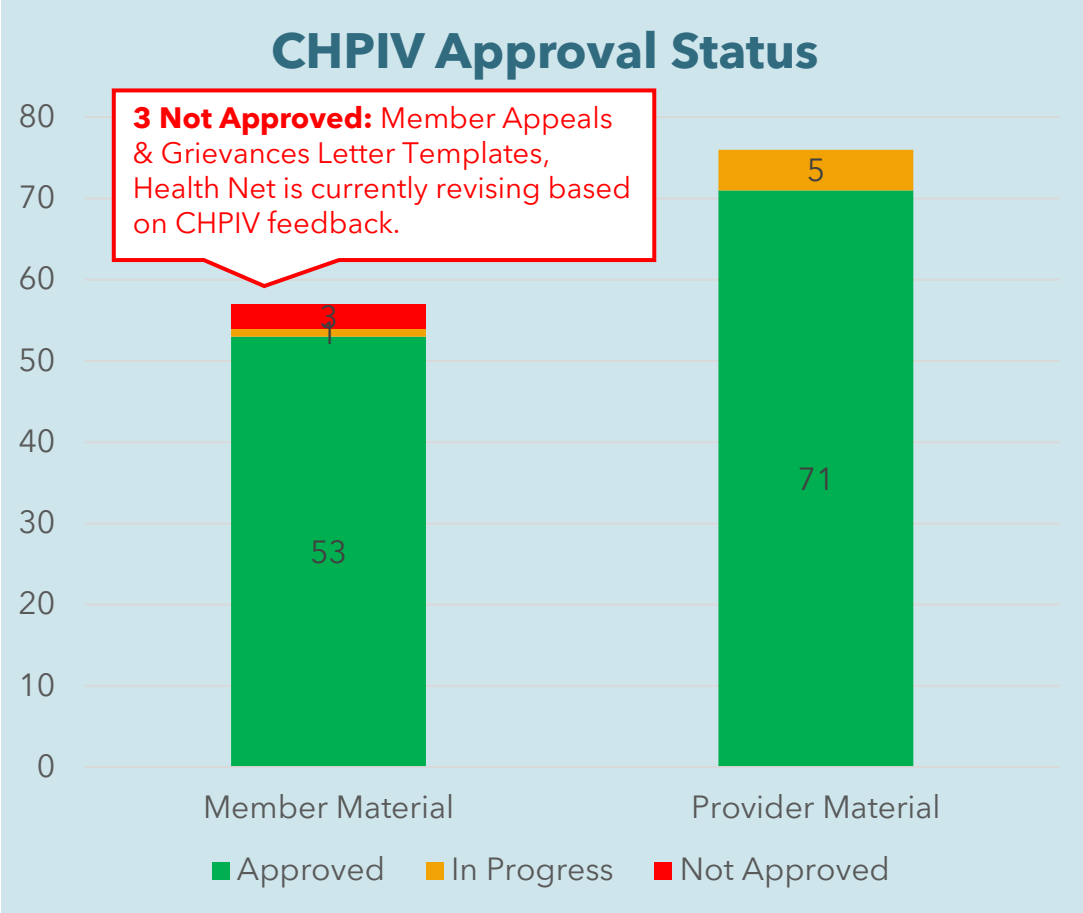


- **Member Material:** Welcome Kit, Handbook/Evidence of Coverage, Member Letters, Regulatory Notices and Health Education.

- **Provider Material:** Provider Directory, Medi-Cal Operations Guide, Provider Communication Templates and Health Education.

CHPIV Material Review Status





Monitoring

Delegation Oversight Program

While audits offer a systematic review of all aspects, monitoring prioritizes areas with higher potential risks, allowing for more efficient resource allocation and quicker response to deficiencies.

Audits

- **Objective:** Assess compliance with predefined standards and protocols.
- **Scope:** Comprehensive review of all processes, documentation, and operations.
- **Frequency:** Annually
- **Outcome:** Identification of non-compliance, recommendations for corrective actions.

Monitoring

- **Objective:** Focus on areas that are most likely to pose significant risks to members
- **Scope:** Not always comprehensive; tailored to potential risks identified.
- **Frequency:** Monthly/quarterly
- **Outcome:** Early detection and mitigation of potential risks

Monitoring: Phased Approach

Phase	Risk	Measure Areas
1	Critical	• UM • Continuity of Care • Appeals • Grievances • Member Services
2	High	• Claims • PDR • Quality Improvement • Access & Availability • Population Health Management • Enhanced Care Management/Community Supports • Transitional Care Services
3	Medium	• Behavioral Health • Provider Qualifications (Credentialing, Training)
4	Low	• C&L/Language Assistance • Health Education

Phase 1 Measures

Utilization Management

Quantitative

- Decision Timeliness
- Member Notification Timeliness
- Provider Notification Timeliness

Qualitative

- Clinical Decision Making
- Notice of Action (NOA) Letters

Continuity of Care

Quantitative

- Processing Timeliness
- Notification Timeliness
- End of CoC Notification Timeliness

Qualitative

- Appropriate Coordination of Services
- Appropriate Completion of CoC Requests
- Member Notification Content
- CoC Period Restart
- CoC Protections

Appeals

Quantitative

- Timely Acknowledgement
- Timely Decision
- Timely Effectuation of Overturned Appeals
- Member Notification Timeliness

Qualitative

- Appropriate Decision Making
- Acknowledgement Letter Content
- Immediate notification of right to contact DMHC
- Notice of Appeal Resolution (NAR) Letter Content

Grievances

Quantitative

- Timely Acknowledgement
- Timely Grievance Resolution
- Member Notification Timeliness

Qualitative

- Resolution
- Acknowledgement Letter
- Immediate notification of right to contact DMHC
- Grievance Letter

Member Services

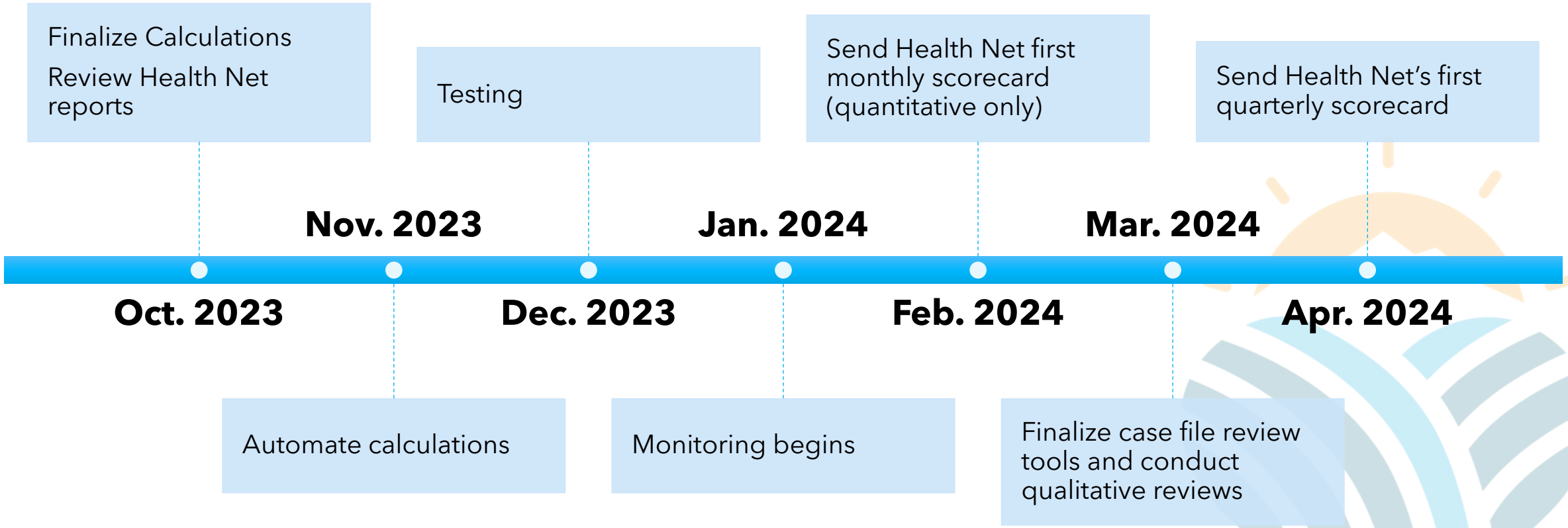
Quantitative

- Calls Answered within 30 seconds
- Call Center Abandonment Rate Level
- Timely loading of 834 Eligibility Files
- Timely Issuance of Member ID Cards

Qualitative

- Correct call classification and initiation of appropriate action

Monitoring Implementation Timeline: Phase 1



Pre-Delegation Audit

Pre-Delegation Audit

Phase	Audit Scope/Category	Scope Overview
1	Processes and workflows	Review Health Net's processes and workflows to ensure readiness to meet Plan-to-Plan and DHCS requirements
2	Key Performance Indicators and Finance Reports	Tests Health Net's ability to submit complete and accurate data to CHPIV. Data elements are required to measure compliance and performance
3	DHCS 2023 All Plan Letter (APL) Implementation	Validated Health Net's timely implementation of regulatory changes issued by DHCS in 2023

Pre-Delegation Audit: Phase 1 Timeline

8/28/23

- Pre-Delegation Audit Kick Off

9/8/23

- Phase 1 deliverables due

9/26/23

- Received all documents requested after 3 extension requests
- 18-day delay
  - Extension #1: 9/18/23
  - Extension #2: 9/25/2023

10/11/23

- Health Net to submit supplemental documents for preliminary findings

10/18/23

- Final Phase 1 Pre-Delegation Audit Report sent to Health Net

Pre-Delegation Audit: Phase 2 Timeline

9/22/23

- Phase 2 deliverables due

10/13/23

- Health Net submits KPI Logs and Finance Reports
- 21-day delay
  - Extension #1: 9/22/2023
  - Extension #2: 10/6/2023
  - Extension #3: 10/13/2023

10/20/23

- CHPIV sends preliminary findings to Health Net

10/25/23

- Health Net to submit supplemental documents for preliminary findings

10/27/23

- CHPIV and HMA review supplemental documents

10/31/23

- Final Phase 2 Pre-Delegation Audit Report sent to Health Net

Pre-Delegation Audit

Meeting with Health Net on 10/4/2023

- Discussed multiple extension requests and significant delays in pre-delegation audit. Emphasized the importance of adhering to timelines as the pre-delegation audit requires time to remediate issues identified prior to go-live
- Reviewed Phase 1 Timeline
- Health Net committed to submitting Phase 2 documents (KPI Logs and Finance Reports) no later than 10/13
- Clarified CHPIV's expectations for Phase 3 (APL implementation)

Compliance will review the Phase 1 and Phase 2 Pre-Delegation Audit Report at the next Commission Meeting

Questions

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

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

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

ATTACHMENTS

- None

AUTHORITIES/REFERENCES

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

HISTORY	
Revision Date	**Description of Revision**

I. OVERVIEW

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

II. POLICY

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

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

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

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

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

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

1. The financial PARTICIPATION will be used by the external entity to provide a service that complements, or enhances, one that CHPIV provides; or
2. There is an identifiable benefit to CHPIV and/or its members.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

III. PROCEDURE

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

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

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

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

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

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

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

1. Requests shall be submitted to the CEO's Office, in writing, at least thirty (30) calendar days in advance of the date for which an entity wishes to distribute items branded with the CHPIV master logo.

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

IV. DEFINITIONS

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

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

	Care Management Programs	CM-001
	Department	Healthcare Services
	Functional Area	Care Management
	Impacted Delegate	☒ Subcontractor ☐ NA

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

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

ATTACHMENTS

- NA

AUTHORITIES/REFERENCES

- **Internal**
  - TCS policy "Transitional Care Services CM-002
- **Federal**
  - 42 CFR section 438.3(e)(2)
  - 42 USC section 1396a(a)(43), section 1396d(a)(4)(B) and (r), and 42 CFR section 441.50 et seq., as required by W&I Code sections 14059.5(b) and 14132(v).
  - 42 CFR section 438.208.
  - 45 CFR parts 160 and 164 subparts A and E.
  - 42 USC sections 1396d(a), 1396d(r), and1396n(g)(2), and Welfare & Institutions (W&I) Code section 14059.5(b).
- **State**
  - Medi-Cal Managed Care Plans Imperial County Health Authority Exhibit A, Attachment III
- **Accreditation**
  - NCQA 2021 Health Plan Accreditation PHM Standards. PHM 5: Complex Case Management.

HISTORY

Revision Date	Description of Revision
	Policy Creation

I. OVERVIEW

A. This policy addresses Community Health Plan of Imperial Valley's ("CHPIV" or the "Plan") Care Management Program(s) requirements, policy, and procedures.

II. POLICY

A. Care Management Programs:
Utilizing a comprehensive population health managed approach CHPIV will ensure all members have equitable access to necessary, wellness and prevention services including care coordination, COMPLEX CARE MANAGEMENT (CCM), TRANSITIONAL CARE SERVICES (TCS), and ENHANCED CARE MANAGEMENT (ECM). From assessing the needs of Members on a population basis, to identifying and stratifying members' risk on an individual basis, CHPIV will ensure the systems (including data analytic capabilities), processes, and people (including ECM providers in network with direct experience working with specific populations of focus) are compliant and support appropriate POPULATION HEALTH MANAGEMENT (PHM) functions.

1. Delivery Infrastructure:
    a. CHPIV will ensure a PHM delivery infrastructure is maintained to ensure that the needs of its entire member population are met across the continuum of care. The infrastructure provides members with the appropriate level of care management through person-centered interventions based on the intensity of health and social needs and services required. The care management interventions are intended for specific segments of the population that require more intensive engagement than the BASIC PHM. Additionally, CHPIV will ensure members receiving care management have an assigned Care Manager and a CARE MANAGEMENT PLAN (CMP).
2. Screening and Assessments:
    b. Necessary screening and assessments are completed to gain timely information on the health and social needs of all members, in accordance with applicable state and federal laws and regulations, and NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) PHM standards.
    c. CPIV will ensure an initial screening or assessment of each member's needs is completed within 90 days of enrollment and that the information is shared with Department of Healthcare Services (DHCS), and other managed care health plans or providers serving the member, to prevent duplication of those activities. CHPIV will ensure at least three attempts are made to contact a member to conduct the initial screening or assessment using available modalities.
    d. CHIPIV ensures DHCS guidance is adhered to for member screening and assessment, including guidance for how to use the PHM service for the screening and assessment process.
    e. CHIPIV ensures monitoring is completed to determine what percentage of required assessments are completed per the specifications above.

3. BASIC POPULATION HEALTH MANAGEMENT (BPHM)
    a. BPHM is an approach to care that ensures that needed programs and services are made available to each member, regardless of the member's risk tier, at the right time

and in the right setting. (BASIC PHM includes federal requirements for CARE COORDINATION listed in accordance with 42 CFR section 438.208.) CHPIV will ensure at a minimum: policies and procedures are maintained that meet the following BASIC PHM requirements, and at a minimum:

i. Ensure each member has an ongoing source of care that is appropriate, ongoing, and timely to meet the member's needs;
ii. Ensure members have access to needed services including CARE COORDINATION, navigation and referrals to services that address members' developmental, physical, mental health, substance use disorder (SUD), dementia, Long Term Support Services (LTSS) palliative care, and oral health needs;
iii. Ensures that each member is engaged with their assigned Primary Care Physician (PCP) and that the member's assigned PCP plays a key role in the CARE COORDINATION functions.
iv. Ensure each Member receives all needed preventive services in partnership with the member's assigned PCP;
v. Ensures efficient CARE COORDINATION and continuity of care for members who may need or are receiving services and/or programs from Out-of-Network (OON) providers;
vi. Review member utilization reports to identify members not using primary care; stratify such reports, at minimum, by race and ethnicity to identify health disparities that result from differences in utilization of outpatient and preventive services; and develop strategies to address differences in utilization;
vii. Facilitate access to care for members by, at a minimum, helping to make appointments, arranging transportation, ensuring member health education on the importance of primary care for members who have not had any contact with their assigned medical home/PCP or have not been seen within the last 12 months, particularly members less than 21 years of age;
viii. Ensure all services are delivered in a culturally and linguistically competent manner that promotes health equity for all members;
ix. Coordinate health and social services between settings of care, across other Medi-Cal managed care health plans, delivery systems, and programs (e.g., targeted case management, specialty mental health services), with external entities outside of contractor's provider network, and with COMMUNITY SUPPORTS and other community-based resources, even if they are not covered services, to address members' needs and to mitigate impacts of SDOH;
x. Coordinate warm hand-offs to other public benefits programs including, but not limited to, California Work Opportunity and Responsibility to Kids (CalWORKs), CalFresh, Women, Infants and Children (WIC) Supplemental Nutrition Program, Early Intervention Services, Supplemental Security Income (SSI), and all other programs requiring Memorandums of Understanding (MOUs);
xi. Assist members, members' parents, family members, legal guardians, authorized representatives, caregivers, or authorized support persons with navigating health delivery systems, including contractor's subcontractor and

downstream subcontractor networks, to access covered services as well as services not covered.

xii. Provide members with resources to address the progression of disease or disability, and improve behavioral, developmental, physical, and oral health outcomes;

xiii. Communicate to members' parents, family members, legal guardians, authorized representatives, caregivers, or authorized support persons all CARE COORDINATION provided to members, as appropriate;

xiv. Ensure that providers furnishing services to members maintain and share, as appropriate, members' medical records in accordance with professional standards and state and federal law;

xv. Facilitate exchange of necessary member information in accordance with any and all state and federal privacy laws and regulations, specifically pursuant to 45 CFR parts 160 and 164 subparts A and E, to the extent applicable; and maintain processes to ensure no duplication of services occurs.

b. In order to ensure that BASIC PHM is provided to all Members, CHIPIV will ensure the following resources are provided to providers at a minimum:

i. A system to electronically track and monitor network provider referrals not requiring prior authorization, including referrals for care management services, and the outcomes of referrals;

ii. Access to a current and continuously updated community resource directory to the network providers; and

iii. A toll-free telephone number for network providers to obtain contractor assistance in arranging referrals.

A. Telephone referral assistance must address referrals for mental health and SUD treatment, developmental services, dementia, palliative care, dental, personal care services, and LONG-TERM SERVICES AND SUPPORT (LTSS); and

B. Communicate the availability of the telephone referral assistance by providing the toll-free number on the home page of the contractor's website and in materials supplied to network providers, including the Provider Manual.

B. COMPLEX CARE MANAGEMENT (CCM):

1. CCM equates to "Complex Case Management," as defined by the NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA). CCM is a service for members who need extra support to avoid adverse outcomes but who are not in the highest risk group designated for ECM. These include coordination of services for high and medium/rising risk members through the CCM approach. CCM provides both ongoing chronic CARE COORDINATION and interventions for episodic, temporary needs, with a goal of regaining optimum health or improved functional capability in the right setting and in a cost-effective manner. CCM is an opt-out program – (i.e., members may choose not to participate in CCM if it is offered to them). CHPIV may delegate CCM to providers and other entities who are themselves NCQA-certified. CHPIV will ensure CCM services are provided in line with the requirement of meeting NCQA PHM Standards. CCM is inclusive of BPHM, which CHPIV will ensure is provided to all members. Care managers conducting CCM integrate all elements of BPHM into their CCM approach. CHIPIV ensures that at a minimum, the CCM program:

a. is designed and implemented to help members gain or regain optimum health or improved functional capability in the right setting;
b. includes a comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a CARE MANAGEMENT PLAN (CMP) with performance goals, monitoring and follow-up;
c. has an opt-out approach wherein members meeting criteria for CCM have the right to decline to participate;
d. includes a variety of interventions for members that meet the differing needs of high and medium/rising-risk populations, including longer-term chronic CARE COORDINATION and interventions for episodic, temporary needs;
e. and incorporates disease-specific management programs (including, but not limited to, asthma and diabetes) that include self-management support and health education.

2. Eligibility:
   a. CCM is a service intended for higher-and medium-rising-risk members and is deliberately more flexible than ECM. CHPIV will ensure the determination of eligibility criteria (within NCQA guidelines) is based on the risk stratification process outlined and local needs identified in the Population Needs Assessment (PNA).
3. Core Service Components
   a. CHPIV will ensure CCM includes:
      i. Comprehensive Assessment and Care Plan CHPIV will ensure that as in ECM, CCM includes a comprehensive assessment of each member's condition, available benefits, and resources (including COMMUNITY SUPPORTS), as well as development and implementation of a CMP with goals, monitoring, and follow-up.
      ii. CHPIV ensures this assessment is started within 30 days of identifying a member for CCM and completed within 60 days of identification.
   b. Services and Interventions:
      i. CHPIV will ensure that CCM includes a variety of interventions for members who meet the differing needs of high and medium-/rising-risk populations, including:
         A. CARE COORDINATION focused on longer-term chronic conditions.
            1. Interventions for episodic, temporary member needs
            2. Disease-specific management programs (including, but not limited to, asthma and diabetes) that include self-management support and health education.
            3. COMMUNITY SUPPORTS, if available and medically appropriate, and cost effective.
      ii. BPHM is included as part of the care management provided to members. For children and youth under age 21, CHPIV will ensure CCM includes EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) and all medically necessary services, including those that are not necessarily covered for adults, are provided if they are Medicaid-covered services.
4. Care Manager Role:
   a. Assignment of a Care Manager:

i. CHPIV will ensure that a care manager is assigned for every member receiving CCM. Following NCQA's requirements, CHPIV may delegate CCM to providers and other entities who are themselves NCQA-certified. PCPs may be assigned as care managers when they are able to fulfill all CCM requirements.
ii. If multiple providers perform separate aspects of CARE COORDINATION for a member, CHPIV will ensure that:
   A. A lead care manager has been identified.
   B. The identity of the care manager is communicated to all treating providers and the member.
   C. The member's PCP is provided with the identity of a member's assigned care manager (if the PCP is not assigned to this role) and a copy of the member's CARE MANAGEMENT PLAN (CMP).
   D. Policies and procedures are maintained to:
   E. Ensure compliance and non-duplication of medically necessary services
   F. Ensure delegation of responsibilities between the Plan and the member's providers meets all care management requirements.

5. Care Manager Responsibilities:
   a. CCM CARE MANAGERS are required to ensure all BPHM requirements and NCQA CCM standards are met. This includes conducting timely assessments of member needs to identify and close any gaps in care and completing a CMP for all members receiving CCM. CCM CARE MANAGERS must also ensure communication and information sharing on a continuous basis and facilitate access to needed services for members, including community support, and across physical and BEHAVIORAL HEALTH (BH) delivery systems. CHIPIV ensures these requirements are met and ensures assistance is provided with navigation and referrals, such as to COMMUNITY HEALTH WORKER (CHW's) or community-based social services. At a minimum CHIP ensures the case manager performs the following duties:
      i. Conduct member assessments as needed to identify and close any gaps in care and address the member's physical, mental health, (SUD), developmental, oral health, dementia, palliative care, chronic disease, and LTSS needs as well as needs due to Social Determinants of Health (SDOH);
      ii. Ensure continuous information sharing and communication with the member and their treating providers; and
      iii. Specify the responsibility of each provider that provides services to the Member.
      iv. Complete a CMP for all Members receiving CCM, consistent with the member's goals in consultation with the member.
         A. The CMP must:
            1. Address a member's health and social needs, including needs due to SDOH;
            2. Be reviewed and updated at least annually, upon a change in member's condition or level of care, or upon request of the member;
            3. Be in an electronic format and a part of the member's medical record, and document all of the member's services and treating providers;
            4. Be developed using a person-centered planning process that includes identifying, educating, and training the member's parents,

family members, legal guardians, authorized representatives, caregivers, or authorized support persons, as needed; and

5. Include referrals to community-based social services and other resources even if they are not covered services.

v. Ensure members receive all medically necessary services, including COMMUNITY SUPPORTS, to close any gaps in care and address the member's mental health, SUD, developmental, physical, oral health, dementia, palliative care needs as well as needs due to SDOH;

vi. Support and assist the member in accessing all needed services and resources, including across the physical and BEHAVIORAL HEALTH delivery systems;

vii. Communicate to members' parents, family members, legal guardians, authorized representatives, caregivers, or authorized support persons all CARE COORDINATION provided to members, as appropriate;

viii. Provide closed loop referrals to CHW's, peer counselors, and other community-based social services including, but not limited to, personal care services, LTSS, COMMUNITY SUPPORTS and local community organizations;

ix. Assess the member's understanding of the referral instructions and follow-up to determine whether the referral instructions were completed or whether the member needs further assistance to access the services, and if so, provide such assistance;

x. Complete a review and/or modification of the member's CMP, when applicable, to address unmet service needs;

xi. Facilitate and encourage the member's adherence to recommended interventions and treatment; and

xii. Ensure timely authorization of services to meet the member's needs in accordance with the member's CMP.

C. ENHANCED CARE MANAGEMENT (ECM):

1. ECM is community-based, interdisciplinary, high touch, person-centered, and provided primarily through in-person interactions. CHPIV will ensure the Plan is contracted with "ECM providers," existing community providers such as Federally Qualified Health Centers (FQHC's), counties, county BH providers, local health jurisdictions, Community Based Organizations (CBOs), and others, who will assign a lead care manager to each member. The lead care manager meets members wherever they are i.e., on the street, in a shelter, in their doctor's office, or at home. ECM eligibility is based on members meeting specific "populations of focus" criteria. ECM is inclusive of BPHM, which CHPIV will ensure is provided to all members. Care managers conducting ECM integrate all elements of BPHM into their ECM approach.
2. For children and youth under age 21, CHPIV will ensure that CCM includes EPSDT; all medically necessary services, including those that are not necessarily covered for adults, are provided as long as they are Medicaid-covered services.
3. Reporting requirements:
   a. DHCS monitors outcomes for the group served by ECM and evaluates whether and how the existing populations of focus definitions and policies may be improved over time to ensure that the ECM benefit continues to serve those with the highest needs. CHPIV will ensure the DHCS instituted Plan quarterly reporting requirements to monitor the implementation of ECM are completed as required.

4. ECM and CCM overlap policy and delegation:
    a. CHPIV will ensure that an individual is not enrolled in ECM and CCM at the same time; rather, CCM is on a care management continuum with ECM. CCM can be used to support members who were previously served by ECM, are ready to step down, and who would benefit from CCM; but not all members in CCM previously received ECM, and not all members who step down from ECM require CCM. CHPIV encourages providers to contract for a care management continuum of ECM and CCM programs, wherever possible, including as a way to maximize opportunities for members to step down from ECM to CCM or BPHM under the care of a single provider.

D. Other Population Health Requirements for Children:

1. For Members who are less than 21 years of age, CHPIV will ensure that as part of care management and BASIC PHM the following services for children are provided:
    a. EPSDT Case Management Responsibilities:
        i. Provide case management to assist Members less than 21 years of age in gaining access to all medical necessary medical, BH, dental, social, educational, and other services, as defined in 42 USC sections 1396d(a), 1396d(r), and1396n(g)(2), and Welfare & Institutions (W&I) Code section 14059.5(b). Case management services for Members less than 21 years of age also includes the data exchange necessary for the provision of services as well as the coordination of non-covered services such as social support services. Additionally, CHPIV will ensure EPSDT case management services are provided and that all medically necessary services for Members less than 21 years of age are initiated within timely access standards whether or not the services are covered services.
2. Children with Special Health Care Needs (CSHCN):
    a. CHPIV will ensure the development and implementation of policies and procedures to provide services for CSHCN. CHPIV will ensure that the policies and procedures include the following information, at a minimum, to encourage CSHCN Member participation:
        i. Methods for ensuring and monitoring timely access to pediatric specialists, sub-specialists, ancillary therapists, transportation, and DME and supplies. These may include assignment to a specialist as PCP, standing referrals, or other methods; and
        ii. Methods for monitoring and improving the quality, Health Equity, and appropriateness of care for CSHCN.
        iii. Methods for ensuring CARE COORDINATION with California Department of Developmental Services (DDS) and local CCS Programs, as appropriate.
3. Early Intervention Services:
    a. CHPIV will ensure the development and implementation of systems to identify Members who may be eligible to receive services from the Early Start program and that they are referred to the local Early Start program. These Members include those with a condition known to lead to developmental delay, those in whom a developmental delay is suspected, or whose early health history places them at risk for delay. CHPIV will ensure collaboration occurs with the local Regional Center or local Early Start program in determining the medically necessary diagnostic and preventive services and treatment plans for Members. CHPIV will ensure case

management and CARE COORDINATION to the Member are provided to ensure the provision of all medically necessary covered services identified in the Individualized Family Service Plan (IFSP) developed by the Early Start program, with PCP participation.

E. Wellness and Prevention Programs:

1. CHPIV will ensure comprehensive wellness and prevention programs are provided to all Members and in accordance with DHCS guidance.
2. CHPIV will ensure wellness and prevention programs are provided that meet NCQA PHM standards, including for the provision of evidence-based self-management tools;
3. CHPIV will ensure that the wellness and prevention programs align with the DHCS Comprehensive Quality Strategy;
4. CHPIV will ensure wellness and prevention programs are provided in a manner specified by DHCS, and in collaboration with Local Governmental Agencies as appropriate, that include the following, at a minimum:
   a. Identification of specific, proactive wellness initiatives and programs that address Member needs as identified in the PNA;
   b. Evidence-based disease management programs including, but not limited to, programs for diabetes, asthma, and obesity that incorporate health education interventions, target members for engagement, and seek to close care gaps for Members participating in these programs;
   c. Initiatives, programs, and evidence-based approaches to improving access to preventative health visits, developmental screenings, and services for Members less than 21 years of age;
   d. Initiatives, programs, and evidence-based approaches on improving pregnancy outcomes for women, including through 12 months post-partum;
   e. Initiatives, programs, and evidence-based approaches on ensuring adults have access to preventive care, as described and in compliance with all applicable state and federal laws;
   f. Process for monitoring the provision of wellness and preventive services by PCPs as part of Contractor's Site Review process;
   g. Health education materials, in a manner that meets Members' health education and cultural and linguistic needs, and
   h. Initiatives and programs that implement evidence-based best practices that are aimed at helping Members set and achieve wellness goals.
5. CHPIV will ensure that its wellness and prevention programs are submitted to DHCS for review and approval in a form and method prescribed by DHCS.

F. TRANSITIONAL CARE SERVICES (TCS)

1. Care transitions are defined as a member transferring from one setting or level of care to another, including, but not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home-or community-based settings, COMMUNITY SUPPORTS, post-acute care facilities, or long-term care (LTC) settings. CHPIV will ensure that TCS are provided to all members regardless of health risk. (See additional details regarding the TCS program in TCS policy "Transitional Care Services CM-002").

III. PROCEDURE

A. Delegation:

1. CHPIV delegates the Care Management process to its Subcontractor, Health Net.
2. Delegation Oversight
   a. CHPIV shall provide oversight and continually assess the delegated functions, responsibilities, processes, and performance of Health Net. CHPIV will ensure Health Net's compliance with regulatory and contractual requirements through the following activities which are detailed in CHPIV Policy CMP-002: Delegation Oversight Policy and Procedure:
      i. Ongoing monitoring
      ii. Performance reviews
      iii. Data analysis
      iv. Utilization of benchmarks, if available
      v. Annual desktop and on-site audits

IV. DEFINITIONS

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

TERM	DEFINITION
Basic Population Health Management (Basic PHM)	An approach to care that ensures that needed programs and services are made available to each Member, regardless of the Member's Risk Tier, at the right time and in the right setting. Basic PHM includes federal requirements for Care Coordination.
Behavioral Health	A mental health condition and/or Substance Use Disorder (SUD) condition.
Care Coordination	Coordination of services for a member between settings of care that includes appropriate discharge planning for short term and long-term hospital and institutional stays, and appropriate follow up after an emergency room visit; coordinating services the member receives from any other managed care health plan; services the member receives in Fee-For-Service (FFS); services the member receives from OON providers; and services the member receives from community and social support providers.
Care Management Plan (CMP)	A written plan that is developed with input from the Member and/or their family member(s), parent, legal guardian, authorized representative, caregiver, and/or other authorized support person(s) as appropriate to assess strengths, risks, needs, goals, and preferences, and make recommendations for clinical and non-clinical service needs.
CCM Care Manager	An individual identified as a single point-of-contact responsible for the provision of CCM services for a member.
Community Health Worker (CHW)	A skilled and trained individual who is able to render clinically appropriate Medi-Cal covered benefits and services and is an enrolled Medi-Cal provider.
Community Supports	Substitute services or settings to those required under the California Medicaid State Plan that Contractor may select and offer to their Members pursuant to 42 CFR section 438.3(e)(2) when the substitute

	service or setting is medically appropriate and more cost-effective than the service or setting listed in the California Medicaid State Plan.
Complex Care Management (CCM)	CCM equates to "Complex Case Management," as defined by NCQA. CCM is a service for MCP members who need extra support to avoid adverse outcomes but who are not in the highest risk group designated for ECM. CCM provides both ongoing chronic care coordination and interventions for episodic, temporary needs, with a goal of regaining optimum health or improved functional capability in the right setting and in a cost-effective manner. CCM is an opt-out program – (i.e., members may choose not to participate in CCM if it is offered to them)
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	The provision of Medically Necessary comprehensive and preventive health care services provided to Members less than 21 years of age in accordance with requirements in 42 USC section 1396a(a)(43), section 1396d(a)(4)(B) and (r), and 42 CFR section 441.50 et seq., as required by W&I Code sections 14059.5(b) and 14132(v). Such services may also be Medically Necessary to correct or ameliorate defects and physical or behavioral health conditions.
Enhanced Care Management (ECM)	ECM is community-based, interdisciplinary, high touch, person-centered, and provided primarily through in-person interactions. The plan contracts with "ECM Providers," existing community providers such as Federally Qualified Health Centers (FQHCs), counties, county BH providers, local health jurisdictions, Community Based Organizations (CBOs), and others, who assign a lead care manager to each member. The lead care manager meets members wherever they are – on the street, in a shelter, in their doctor's office, or at home. ECM eligibility is based on members meeting specific "Populations of Focus" criteria.
Long-Term Services & Supports (LTSS)	Services and supports designed to allow a member with functional limitations and/or chronic illnesses the ability to live or work in the setting of the Member's choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting. LTSS includes both LTC and HCBS and includes carved-in and carved-out services.
National Committee for Quality Assurance	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
Population Health Management (PHM)	An approach to care that ensures that needed programs and services are made available to each Member, regardless of the Member's Risk Tier, at the right time and in the right setting
Transitional Care Services	Service provided to all Members transferring from one institutional care setting, or level of care, to another institution or lower level of care, including home settings.

	Implementation of Regulatory Notifications	CMP-004
	Department	Compliance
	Functional Area	Compliance
	Impacted Delegate	☒ Subcontractor ☐ NA

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

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

ATTACHMENTS

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

AUTHORITIES/REFERENCES

- NA

HISTORY

Revision Date	Description of Revision
	Policy Creation

I. OVERVIEW

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

II. POLICY

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

III. PROCEDURE

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

7. Once comments are received from the impacted business units, Compliance will compile all CHPIV comments into one document and submit them to DHCS, DMHC, and/or the health plan association by the requested due dates, on behalf of CHPIV.

B. Final REGULATORY NOTIFICATIONS

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

IV. DEFINITIONS

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

TERM	DEFINITION
Commission	The governing body of the Local Health Authority (LHA). It is comprised of thirteen voting members that represent different sectors of the health system, the public, Medi-Cal beneficiaries, and businesses as outlined in LHA Establishing Ordinance.
Delegated Entities (Delegate)	A contracted entity which CHPIV authorizes to perform certain functions on its behalf. Although, CHPIV can delegate the authority to perform a function, it cannot delegate the responsibility for ensuring that the function is performed according to CHPIV and National Committee on Quality Assurance (NCQA) standards.
Department of	The State agency responsible for administration of the federal Medicaid

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

	Compliance Training	CMP-006
Department	Compliance	
Functional Area	Compliance	
Impacted Delegate	☐ Subcontractor ☐ NA	

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

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

ATTACHMENTS

NA

AUTHORITIES/REFERENCES

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

HISTORY

Revision Date	Description of Revision

I. OVERVIEW

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

II. POLICY

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

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

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

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

III. PROCEDURE

A. Training Content

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

included in Employee evaluations;

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

B. Distributing Training for Existing CHPIV Employees

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

C. Distributing Training for New Employees

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

D. Distributing Training to Subcontractors and Downstream Subcontractors

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

E. Documentation of Compliance with Training

1. All CHPIV Employees and SUBCONTRACTORS/DOWNSTREAM SUBCONTRACTORS must complete the Compliance Training Program with a score of eighty percent (80%) or greater.

2. Failure to successfully complete all required Compliance training modules may lead to disciplinary action (up to and including termination). The Compliance Department will have a systematic indicator that identifies those who fail to comply within the mandated timeframes; non-compliance will result in revoking CHPIV system access.
3. SUBCONTRACTORS/DOWNSTREAM SUBCONTRACTORS shall provide annual attestations confirming completion of all Compliance training as stated in this policy. Failure to provide timely attestation will lead to further CORRECTIVE ACTION.
4. The Compliance Department is responsible for monitoring and auditing the compliance of Employees and SUBCONTRACTORS/DOWNSTREAM SUBCONTRACTORS with the Compliance training and education requirements.
5. CHPIV shall maintain all evidence of Compliance-related training completion for at least ten (10) years. Such materials include, but are not limited to:
    a. Attendance;
    b. Topic;
    c. Certificates of Completion;
    d. Subcontractor/Downstream Subcontractor Attestations;
    e. Test scores; and
    f. Tests administered to Employees.

IV. DEFINITIONS

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

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

	Escalation of Noncompliance Issues	CMP-007
Department	Compliance	
Functional Area	Compliance	
Impacted Delegate	☒ Subcontractor ☐ NA	

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

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

ATTACHMENTS

- NA

AUTHORITIES/REFERENCES

- CMP-001 Corrective Action Plan
- CHPIV Compliance Program and Plan
- CHPIV Delegation Oversight Program
- CHPIV Contract with Department of Healthcare Services (DHCS)
- Delegation Agreements
- Department of Health Care Services All-Plan Letter (APL) 17-004: Subcontractual Relationships and Delegation
- Title 42, Code of Federal Regulations (C.F.R.), §438.230

HISTORY

Revision Date	Description of Revision
	Policy creation

I. OVERVIEW

A. The purpose of this policy is to establish a clear and structured framework for handling noncompliance issues within Community Health Plan of Imperial Valley (CHPIV). Noncompliance refers to instances where MEMBERS, providers, or employees fail to adhere to the established rules, regulations, and policies, which may lead to potential risks or disruptions in the provision of healthcare services. This policy aims to address noncompliance promptly and efficiently while promoting transparency, fairness, and compliance with all applicable laws and regulations.

II. POLICY

A. The policy ensures a systematic approach to identify, report, investigate, and resolve noncompliance issues promptly and effectively. By following this policy, we aim to uphold the highest standards of ethics, quality of care, and compliance with all relevant laws and regulations.

III. PROCEDURE

A. Identification of Noncompliance: Noncompliance issues may arise from DELEGATED ENTITIES, providers, or employees failing to follow established policies, contractual obligations, ethical guidelines, or relevant laws and regulations. Noncompliance can be identified through AUDITS, MONITORING, feedback from MEMBERS and providers, or self-reporting.

B. Reporting Noncompliance: Any individual who becomes aware of a noncompliance issue must report it immediately to their immediate supervisor, any MEMBER of the leadership team, Chief Compliance Officer, or Compliance department. Anonymous reporting is available through the CHPIV website and Compliance Hotline.

C. Initial Assessment: Upon receiving a report of noncompliance, the Compliance department shall conduct an initial assessment to determine the severity and legitimacy of the reported issue.

D. Investigation: The Compliance department will lead a formal investigation, document findings, and require a CORRECTIVE ACTION PLAN, as appropriate.

E. Executive Management Involvement: All compliance issues will be escalated to the Chief Compliance Officer. Compliance issues that pose a significant risk to CHPIV's integrity will be brought to the attention of the Chief Executive Officer for discussion. Upon the Chief Executive Officer's agreement, the Compliance Issue will progress through successive levels of escalation, involving the COMPLIANCE & POLICY COMMITTEE, Leadership Team, the Commission, and the regulatory agencies. Additionally, the CCO has the authority and direct access to the Commission should they choose to escalate matters directly at that level.

F. Self-Disclosures to Regulatory Agencies: CHPIV encourages a culture of transparency and self-policing. If noncompliance issues identified have regulatory implications, CHPIV is responsible for self-disclosing matters to the appropriate regulatory authorities.

G. Training: Employees may undergo training related to the noncompliance.

H. Corrective Action Plans: CORRECTIVE ACTION PLANS are required to correct noncompliance issues in accordance with CAP requirements set forth in CHPIV P&P CMP-003 CORRECTIVE ACTION PLANS.

1. The elements of the CAP must be resolved in accordance with CHPIV P&P CMP-003: CORRECTIVE ACTION PLANS.
2. In the event the elements of the CAP are not successfully completed within ninety (90) calendar days, the Compliance department shall report to the CPC following the CAP period. CPC will review the outstanding CAP items to determine, at its discretion, whether the CAP deadline should be extended.
    a. The Compliance Department must demonstrate to the reasonable satisfaction of the CPC the reason for such an extension and provide a detailed, step action plan to ensure that the items for correction are being addressed in a timely manner.
3. CORRECTIVE ACTION PLANS are monitored in accordance with CHPIV P&P CMP-003: CORRECTIVE ACTION PLANS.

I. Disciplinary actions: CHPIV may impose progressive disciplinary actions with consistent performance issues or findings regarding significant compliance issues.

1. Staff: In addition to CORRECTIVE ACTION PLANS, noncompliance issues involving CHPIV staff may result in the following disciplinary actions:
    a. Additional Training: Employees may undergo additional training related to the violation.
    b. Verbal and Written Warnings: For minor noncompliance, a verbal and written warning will be issued to remind the employee of the expected standards of conduct, outlining the violation and potential consequences.
    c. Probationary Period: Serious or repeated noncompliance may result in probation with close MONITORING for improvement.
    d. Suspension: Significant noncompliance may lead to a temporary suspension as a serious warning.
    e. Termination: Severe or repeated noncompliance may lead to employment termination.
2. Noncompliance issues and disciplinary actions related to DELEGATED ENTITIES are further outlined in P&P CMP-002 Delegation Oversight.

IV. DEFINITIONS

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

TERM	DEFINITION
Auditing	A Systematic evaluation of performance to ensure consistency with ethical standards, federal or state statute, regulations, policies, contractual obligations and National Committee for Quality Assurance

TERM	DEFINITION
	(NCQA) requirements. 1. External Audit – Evaluation of CHPIV as conducted by an external regulatory or accreditation body; 2. Internal Audit – Evaluation of CHPIV operational areas, department, or systems as conducted by Regulatory Affairs and Compliance (RAC); or 3. Oversight Audit – Evaluation of delegate/SUBCONTRACTOR as conducted by CHPIV, at least annually.
Compliance & Policy Committee (CPC)	An internal committee comprised of CHPIV management staff that monitors compliance activities and makes recommendations for action to CHPIV staff, including CHPIV's executive staff, and the Commission.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CHPIV, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CHPIV departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CHPIV and its regulators.
Delegated Entity (Delegate)	A contracted entity which CHPIV authorizes to perform certain functions on its behalf. Although, CHPIV can delegate the authority to perform a function, it cannot delegate the responsibility for ensuring that the function is performed according to CHPIV and National Committee on Quality Assurance (NCQA) standards.
Delegation Agreement	Mutually agreed upon document, signed by both parties, which includes, without limit: 1. CHPIV responsibilities; 2. Duration of the agreement; 3. Termination of the agreement; 4. Delegated Entity responsibilities and Delegated Services; 5. Types and frequency of reporting to the Delegated Entity; 6. Process by which the CHPIV evaluates the Delegated Entity's performance (Performance Measurements); 7. Use of confidential CHPIV information including Member Protected Health Information (PHI) by the Delegated Entity; and 8. Remedies available to the CHPIV if the Delegated Entity does not fulfill its obligations.
Member	A beneficiary enrolled in a CHPIV program.
Monitoring	The mechanism for ongoing collection and review of performance data against benchmarks derived from statues, regulations, policy, contractual obligations, and/or NCQA standards.

	Selecting a Chief Compliance Officer	CMP-008
Department	Compliance	
Functional Area	Compliance	
Impacted Delegate	☐ Subcontractor ☒ NA	

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

APPROVALS			
Internal		**Regulator**	
Name	Larry Lewis	☒ DHCS ☐ NA ☐ DMHC	
Title	Chief Executive Officer		

ATTACHMENTS
• NA

AUTHORITIES/REFERENCES
• DHCS Contract Section 1.3.1 Compliance Program

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

I. OVERVIEW

A. This policy establishes a clear and standardized process for the selection of a CHIEF COMPLIANCE OFFICER (CCO) who will ensure adherence to all contractual requirements.

II. POLICY

A. The designated CHIEF COMPLIANCE OFFICER (CCO) must be independent. This means the CCO should not serve in a dual capacity, especially in both compliance and

operational roles. Examples of conflicting roles include the Chief Operating Officer, Finance Officer, or General Counsel.

B. The CCO will report directly to the CHIEF EXECUTIVE OFFICER (CEO) and the Commission (governing board).

III. PROCEDURE

A. Job Description
1. CHPIV will maintain a detailed job description for the CCO position.
2. This description will include roles, responsibilities, authority, qualifications required, and other relevant information.

B. Selection Process
1. A selection committee, consisting of the CHIEF EXECUTIVE OFFICER and representatives from HR and senior management, will review applications.
2. Suitable candidates will undergo a series of interviews with the selection committee.
3. The final candidate will be vetted for potential conflicts of interest to ensure their independence.

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 (COO)	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 (CEO)	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.

	Fraud, Waste, and Abuse Program	CMP-009
Department	Compliance	
Functional Area	Compliance	
Impacted Delegate	☒ Subcontractor ☐ NA	

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

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

ATTACHMENTS

- NA

AUTHORITIES/REFERENCES

- Program Integrity Requirements - 42 CFR §438.608(a)(4) and §438.608(a)(8)
- DHCS APL 15-026 – Actions Following Notice of Credible Allegation of Fraud
- DHCS APL 17-003 – Treatment of Recoveries Re: Overpayments to Providers
- DHCS APL 21-003 – Medi-Cal Network Provider & Subcontractor Terminations
- PLAN- 2024 DHCS Contract Exhibit A, Attachment III, Subsection 1.3.4.D CHPIV's Obligations Regarding Suspended, Excluded and Ineligible Providers – Actions to be taken where Credible Allegation of Fraud
- PLAN- 2024 DHCS Contract Exhibit E Section 1.3.7.B Federal False Claims Act Compliance and Support – Cooperation with the Office of Attorney Genera Division of Medi-Cal Fraud & Elder Abuse ('DMFEA") and the U.S. Department of Justice ("DOJ") Investigations and Prosecutions
- U.S. Department of Health and Human Services (HHS) Office of Inspector General ("OIG")
- PLAN- 2024 DHCS Contract Exhibit E Section 3.1.6.A.10 Requirements for Network Provider Agreements, Subcontractor Agreements and Downstream Subcontractor Agreements
- Anti-Kickback Regulations – 42 U.S.C.A. § 1320a-7b(b)
- Mail and Wire Fraud – 18 U.S.C. § 1341
- False Claims Act – 31 U.S.C. § 3729 *et seq.*
- Program Fraud Civil Remedies Act – 31 U.S.C. §§ 3801-3812
- Deficit Reduction Act of 2005
- CA False Claims Act - CA Code § 12650 *et seq.*
- HIPAA – 45 CFR, Part 164
- Provider Self-Disclosure Protocol – 63 Fed. Reg. 58, 399-403 (1998)

HISTORY

Revision Date	Description of Revision
	Policy Creation

I. OVERVIEW

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

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

1. Ensure that all Staff, NETWORK PROVIDERS, SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS or agents are educated regarding the federal and state false claims laws and the role of such laws in preventing and detecting FWA;
2. Ensure communication of all requirements of this Policy, and referenced obligations, to its NETWORK PROVIDERS, SUBCONTRACTORS, and DOWNSTREAM SUBCONTRACTORS, and will have a process to ensure its NETWORK PROVIDERS, SUBCONTRACTORS, and DOWNSTREAM SUBCONTRACTORS acknowledge receipt and understanding of the requirements contained within this Policy;
3. Perform audits that include reviewing, researching and documenting potential FWA activities within the organization;
4. Ensure identification and investigation of potential FRAUD from reports and referrals;
5. Ensure implementation of a process to conduct timely inquiry into potential violations;
6. Conduct FWA awareness training for Staff;
7. Ensure documentation and retention of all records pertaining to corrective actions imposed as a result of violations;
8. Ensure that NETWORK PROVIDERS, SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS have a robust FWA program in place, which includes the requirements of this Policy and ongoing monitoring and mandatory annual training;

9. Fully disclose to State and federal regulatory agencies any FRAUD or misconduct within the Plan, NETWORK PROVIDERS, SUBCONTRACTORS or DOWNSTREAM SUBCONTRACTORS; and
10. Fully cooperate with DHCS, DMFEA, OIG, and DOJ investigations and prosecutions in the event of allegations of FRAUD.

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

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

II. POLICY

A. Fraud Prevention

1. CHPIV provides a confidential FRAUD hotline for FRAUD reports from Staff, MEMBERS, SUBCONTRACTORS, DOWNSTREAM SUBCONTRACTORS, NETWORK PROVIDERS, and any other individuals with a need to report suspected FRAUD and ensures that its SUBCONTRACTORS provide a confidential FRAUD hotline for FRAUD reports from their staff, MEMBERS, NETWORK PROVIDERS, DOWNSTREAM SUBCONTRACTORS, and any other individuals with a need to report suspected FRAUD.
2. CHPIV provides multiple mechanisms for reporting, including the confidential hotline, Staff exit interview surveys, email reporting, and a dedicated address for submission via U.S. Mail.
3. CHPIV ensures FRAUD prevention activities and suspected FRAUD are reported directly to regulatory and law enforcement agencies as required by law.
4. FRAUD activities and suspected FRAUD identified by NETWORK PROVIDERS, SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS are communicated to CHPIV.
5. CHPIV ensures FRAUD and ABUSE Activities include, but are not limited to:
    a. Complying with 42 CFR Part 455, §§ 455.104 (Disclosure by Medicaid providers and fiscal agents: Information on ownership and control), 455.105 (Disclosure by providers: Information related to business transactions), 455.106 (Disclosure by providers: Information on persons convicted of crimes), and 42 CFR section 438.610 (Prohibited affiliations);
    b. Ensure that SUBCONTRACTORS are requiring NETWORK PROVIDERS and DOWNSTREAM SUBCONTRACTORS to enroll and remain enrolled in the Medi-Cal program, to the extent required under the MEDI-CAL CONTRACT;
    c. Ensure that SUBCONTRACTORS are confirming the identity of NETWORK PROVIDERS, and any Person with an Ownership or Control Interest or who is an agent or Managing Employee of a Network Provider, upon contract execution or renewal and credentialing, through routine checks of State and federal databases;

The databases to be checked are the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES) and the Excluded Provider Lists maintained by the State;

d. Tracking SUBCONTRACTORS and ensuring SUBCONTRACTORS are tracking NETWORK PROVIDERS and DOWNSTREAM SUBCONTRACTORS through review of the following exclusionary databases and lists no less frequently than monthly and upon contract execution or renewal, and upon provider credentialing, taking appropriate action in accordance with ALL PLAN LETTER (APL) 15-026, and APL 21-003:
    i. List of suspended and ineligible providers located at https://files.medi-cal.ca.gov/pubsdoco/SandILanding.aspx,
    ii. List of OIG Excluded Individuals and Entities (LEIE) located at https://oig.hhs.gov/exclusions/exclusions_list.asp,
    iii. Excluded Parties List System (EPLS) within the HHS System for Award Management (SAM) database located at https://sam.gov/content/home;
e. Ensuring training of Staff, directors, NETWORK PROVIDERS, and SUBCONTRACTORS (and ensuring NETWORK PROVIDERS and SUBCONTRACTORS ensure training of DOWNSTREAM SUBCONTRACTORS) on FRAUD schemes, FRAUD detection and FRAUD prevention activities at least annually. Training may consist of an online course, in-person sessions, and/or distribution of written materials. Training topics will also include:
    i. Federal and State FALSE CLAIMS ACT statutes,
    ii. Federal remedies for false claims and statements,
    iii. State laws containing civil or criminal penalties for false statements
    iv. WHISTLEBLOWER protections,
    v. How to handle instances of suspected health care FRAUD;
f. Ensuring that FRAUD prevention efforts are communicated in provider manuals, NETWORK PROVIDER and MEMBER newsletters, internal newsletters or information blasts, targeted mailings or in-service meetings;
g. Ensuring that a method is maintained to verify, by sampling or other methods, that services that have been represented to have been delivered by NETWORK PROVIDERS were in fact received by MEMBERS (42 CFR §438.608(a)(5)). CHPIV will provide proof of compliance with this requirement when requested by DHCS, in a form and manner specified by DHCS through APL, or other similar instruction.
h. Ensuring that there is monitoring and oversight of activities and reports to detect and deter fraudulent behavior, such as:
    i. MEMBER and provider grievances,
    ii. Claims review, including
        A. Clinical edits for invalid gender, out of normal age range, invalid diagnosis for procedure billed, redundant billing, and others
        B. Billings for non-covered benefits
        C. Claims for ineligible individuals
        D. Reviews for emergency diagnosis, emergency place of service and conformance to the definition of "emergency" and "medical necessity"
        E. Claims pended for review by the Claims Supervisor

1. All claims received from other countries
2. All MEMBER reimbursements for proper documentation,

iii. Medical management audits,
iv. Utilization management activities, including checking out-of-area claims to ensure the MEMBER lives within the service area,
v. Quality management activities,
vi. Operational reviews conducted by CHPIV's internal audit department, including eligibility audits,
vii. Financial audits to ensure compliance with State and federal rules for reinsurance and the identification and return of overpayments;

i. Communicating an email address and an address for U.S. Mail to report suspicious behavior of FWA, confidentially or otherwise. Also, maintaining a toll-free hotline (866)685-8664 for confidential reporting of suspected FRAUD and ABUSE. The hotline is monitored by Staff. All reports of suspected FRAUD received from Staff, NETWORK PROVIDERS, SUBCONTRACTORS, DOWNSTREAM SUBCONTRACTORS, MEMBERS, or other credible sources will be logged, investigated, and tracked;
j. Ensuring investigation and resolution of all reported and/or suspected instances of FRAUD and taking action against confirmed FRAUD, including, but not limited to, reporting to law enforcement agencies as required by the MEDI-CAL CONTRACT, termination of the MEMBER or Staff, termination of the contract with a Network Provider, Subcontractor, or Downstream Subcontractor, and/or removal of a NETWORK PROVIDER from the network;
k. Reporting suspected FRAUD as required under section titled "Reporting" in this Policy;
l. Filing an annual written report with DHCS and DMHC and other entities as required by law of CHPIV's efforts to deter, detect and investigate FRAUD; a log of all cases reported to government agencies; and the number of cases known to be prosecuted;
m. If DHCS, DMFEA, or DOJ, or any other authorized State or federal agency, determines there is a credible allegation of Fraud against a Network Provider, SUBCONTRACTOR or Downstream Subcontractor:
    i. CHPIV complies with the MEDI-CAL CONTRACT, all applicable State and federal laws, APL 15-026, and APL 21-003,
    ii. CHPIV ensures there are procedures in place to ensure immediate suspension of payments to the Network Provider, Subcontractor, or DOWNSTREAM SUBCONTRACTOR for which a State or federal agency determines there is a credible allegation of FRAUD (42 CFR § 438.608(a)(8)),
    iii. CHPIV may conduct additional monitoring, require temporary suspension, and/or termination of the Network Provider, SUBCONTRACTOR or Downstream Subcontractor,
    iv. When DHCS notifies CHPIV that a credible allegation of FRAUD has been found against a provider relating to provision of Fee-For-Service Medi-Cal services and that provider is also a Network Provider, one or more of the following four actions must be taken with submission of all supporting documentation to the MCQMD@dhcs.ca.gov inbox

A. Termination of the NETWORK PROVIDER from the network
B. Temporary suspension of the NETWORK PROVIDER from the network pending resolution of the FRAUD allegation
C. Temporary suspension of payment to the NETWORK PROVIDER pending resolution of the FRAUD allegation, and/or
D. Additional monitoring, including audits of the Network Provider's claims history and future claims submissions for appropriate billing,

v. CHPIV must notify DHCS as to which of the above four actions are taken. No action will be required that would interfere with State or federal criminal investigations,
vi. In the event of a Network Provider, Subcontract or, or DOWNSTREAM SUBCONTRACTOR termination, CHPIV will ensure all the requirements and guidance listed in APL 21-003: Medi-Cal NETWORK PROVIDER and SUBCONTRACTOR Terminations are followed,
vii. CHPIV will fully cooperate in any investigation or prosecution conducted by the DMFEA and the DOJ. CHPIV's cooperation must include without limitation
A. Providing upon request, information, and access to records, and
B. Making available Staff or, to the extent appropriate, SUBCONTRACTOR for in-person interviews, consultation, grand jury proceedings, pre-trial conference, depositions, and hearings at DHCS headquarters in Sacramento,
viii. CHPIV litigation support for CMS, DMFEA, and other agencies includes
A. Ensuring that NETWORK PROVIDERS timely gather, preserve, and provide to DHCS, CMS, DMFEA, and any authorized State or federal regulatory agencies, any records in Network Provider's possession, and
B. Ensuring that SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS timely gather, preserve, and provide to DHCS, CMS, DMFEA, and any authorized State or federal regulatory agencies, any records in their possession.

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

monitoring and reporting.

B. Administration

1. CHPIV ensures all potential FWA cases are logged, investigated, and monitored.
2. CHPIV's Fully Delegated Subcontractor's Compliance Officer/Fraud Prevention Officer shall attend and participate in DHCS's quarterly integrity meetings, as scheduled.
3. CHPIV ensures DHCS is notified of any changes in Member's circumstances that impact Medi-Cal coverage pursuant to Medi-Cal program eligibility requirements, including changes in the Member's residence, income, insurance status, and death (42 CFR § 438.608(a)(3)) in a form and manner specified by DHCS through APL or other similar instructions.
4. CHPIV ensures a report of potential instance of FWA is received, an inquiry is initiated as expeditiously as reasonably necessary, but no later than two weeks after the date that the potential misconduct is reported.
    a. If an individual believes that the response to his or her report is completed within a reasonable period of time, he or she is required to bring the matter to the attention of the Compliance Officer/Fraud Prevention Officer.
    b. Failure to report and disclose, or assist, in an investigation of FWA is a breach of the duty that all Staff have to CHPIV and CHPIV's Fully Delegated SUBCONTRACTOR and may result in disciplinary action, up to and including termination.
        i. The CHPIV Compliance Hotline number is (866) 685-8664.
        ii. Written reports may be mailed to: Centene Special Investigations Unit 7700 Forsyth Blvd. Clayton, MO 63105.
5. Files containing investigation materials must be kept in a confidential locked and secured location. Files must be retained a minimum of ten (10) years, unless a longer period of time is required by law or regulation.
6. All parties to the investigation: MEMBERS, NETWORK PROVIDERS, SUBCONTRACTORS, DOWNSTREAM SUBCONTRACTORS, Staff MEMBERS or others named in any form or fashion within the investigation are to be kept confidential to the extent allowable by law.
7. All parties having information relating to the subject of the investigation must hold all information strictly confidential to the extent allowable by law; failure to do so will result in disciplinary action up to and including termination.
8. CHPIV protects as "confidential information" all information shared by or received from DHCS, other State agencies, and federal agencies, and other Medi-Cal managed care plans in connection with any FWA referral, until formal criminal proceedings are made public. CHPIV receives the confidential information as a DHCS business associate in order to facilitate CHPIV's contractual obligations to maintain a FWA prevention program. PHCIV receives and maintains this confidential information in its capacity as a Medi-Cal managed care plan and uses such confidential information only for conducting an investigation into any potential FWA activities and in furtherance of any other program integrity activities.
9. Preliminary and quarterly reports are to be kept confidential and submitted to the DHCS Program Integrity Unit.
10. In the event CHPIV is required to share investigative information with a Network Provider, Subcontractor, or Downstream Subcontractor, CHPIV ensures that the Network Provider, Subcontractor, or DOWNSTREAM SUBCONTRACTOR acknowledges and

agrees that such information will be kept confidential by the Network Provider, Subcontractor, or Downstream Subcontractor.

C. Investigations

1. CHPIV ensures a complete investigation is conducted for all FWA referrals received from DHCS, other State agencies, federal agencies, and other Medi-Cal managed care plans, relating to CHPIV's NETWORK PROVIDERS, SUBCONTRACTORS, and DOWNSTREAM SUBCONTRACTORS. CHPIV submits to DHCS a completed investigation report and a quarterly status report, as set forth in this policy or otherwise required by DHCS in connection with all DHCS, State and federal agency, and Medi-Cal managed care plan referrals of FWA.
2. CHPIV ensures the prompt and thorough investigation of actual or potential FWA, and requires all Staff to assist in such investigations. Investigations may include but not be limited to the following activities:
    a. On-site visits to NETWORK PROVIDERS and SUBCONTRACTORS.
    b. On-site visits to CHPIV MEMBER homes. These visits could be accomplished in conjunction with the audit and/or medical review Staff, or State survey and certification Staff.
    c. Telephone calls or written questionnaires to a sample of CHPIV MEMBERS asking them to confirm the services they received.
    d. Telephone calls or written questionnaires to providers confirming the need for the services rendered.
    e. Telephone calls, correspondence or on-site visits to other pertinent entities.
3. The Compliance Officer/Fraud Prevention Officer must conclude investigations of potential misconduct within a reasonable time period after discovery of the alleged fraudulent activity and complete a FWA Investigation Report form.
4. Unless otherwise specified, the Compliance Officer/Fraud Prevention Officer shall complete a FWA Investigation Report form that includes, to the extent available, the following:
    a. Plan name, organization, and contact information for follow up
    b. Summary of the issue including
        i. The basic who, what, when, where, how, and why
        ii. Any potential legal violations
    c. Specific statutes and allegations including
        i. A list of civil, criminal, and administrative code or rule violations, State and federal
        ii. A detailed description of the allegations or pattern of FWA
    d. Incidents and Issues including
        i. A list of incidents and issues related to the allegations
    e. Background information
        i. Contact information for the complainant, the perpetrator or subject of the investigation, and beneficiaries, pharmacies, providers, or other entities involved
        ii. Additional background information that may assist investigators, such as names and contact information of informants, relators, witnesses, websites, geographic locations, corporate relationships, networks
        iii. The legal and administrative disposition of the case, if available, including

actions taken by law enforcement officials to whom the case has been referred

f. Perspectives of interested parties
    i. Perspective of CHPIV, DHCS, CMS, Member, and other interested parties
g. Data
    i. Existing and potential data sources
    ii. Graphs and trending
    iii. Maps
    iv. Financial impact estimates
h. Recommendations in pursuing the case
    i. Next steps, special considerations, cautions.

5. Within no more than ten (10) working days of completing the investigation, CHPIV shall submit to DHCS reports signed by an executive officer of CHPIV.
    a. Such prompt reporting demonstrates CHPIV's good faith efforts and willingness to work with the government to correct and remedy the problem. CHPIV will also make good faith efforts to cooperate with law enforcement regarding any misconduct reported to the government, including FRAUD and ABUSE.
    b. If an investigation results in a reasonably suspected case of FWA, or confirms that an incident of FWA has been committed, CHPIV will report the incident as deemed appropriate and required by law or regulation to the following government agencies:
        i. CMS
        ii. OIG (Medicare/Medicaid FRAUD)
        iii. California Department of Justice, Bureau of Medi-Cal FRAUD
        iv. California Department of Health Care Services, Program Integrity Unit
        v. California Department of Managed Health Care (DMHC)
        vi. Medical Board of California or other professional licensing regulatory body
        vii. Local law enforcement agencies
        viii. California Health Benefits Exchange
6. The Compliance Officer/Fraud Prevention Officer, with the assistance of legal counsel, review the case and determine if the reported allegation is a violation of State law, federal law, and/or CHPIV Code of Conduct.
7. CHPIV ensures appropriate corrective actions (for example, repayment of overpayments and disciplinary actions against responsible individuals) are taken in response to the potential violation referenced above.
    a. If an overpayment is of significant magnitude (to be determined on a case by case basis), legal counsel will be sought to determine if self-disclosure to a relevant regulatory agency is warranted.
        i. CHPIV has a duty to promptly conduct a reasonable inquiry upon receipt of information that a potential overpayment has occurred. Failure to make reasonable inquiry may be found to be reckless disregard or deliberate ignorance of the overpayment. When overpayment is identified, the Compliance Officer/Fraud Prevention Officer must report the overpayment to DHCS within 60 calendar days after the date on which the overpayment was identified (the 60-day clock does not start running until after CHPIV's

Fully Delegated SUBCONTRACTOR has had an opportunity to undertake reasonable inquiry into the basis of the alleged overpayment).

b. All overpayments should be reported using the self-reported overpayment refund process (SRORP).
c. The Compliance Officer/Fraud Prevention Officer must provide DHCS and/or CMS, in writing, the following information:
    i. Reason for overpayment (incorrect service date, duplicate payment, incorrect CPT code, insufficient documentation, lack of medical necessity, etc.)
    ii. How the error was identified
    iii. Claim number, as appropriate
    iv. Description of the corrective action plan to ensure the error does not occur again
d. CHPIV must report and refund overpayments received during the prior ten (10) years, and in accordance with APL 17-003 and the MEDI-CAL CONTRACT. CHPIV must comply with guidelines issued by DHCS pertaining to retention policies for the treatment of recoveries of all overpayments from CHPIV to a provider, including the treatment of recoveries of overpayments due to FWA.
e. The Claims Department or its delegate must send a letter, accompanied by supporting documentation, to the person who received an overpayment, recognizing the overpayment and providing a date on which the appropriate funds must be returned. The funds must be returned to CHPIV within 60 calendar days after the date on which the overpayment is identified.
f. Failing to report or return overpaid funds within the required timeframe may result in liability under the FALSE CLAIMS ACT and civil monetary penalties up to and including exclusion from participation in federal health care programs. An overpayment which is properly reported and explained, but is not timely repaid, will not give rise to FALSE CLAIMS ACT liability, unless there is evidence of improper avoidance.

D. Reporting

1. In accordance with 42 CFR § 438.608(a)(7), CHPIV ensures all FWA activities are referred, investigated, and reported to DHCS' Program Integrity Unit (PIU), in a manner prescribed by PIU as follows:

a. Preliminary FWA Reports: CHPIV files a preliminary report with DHCS' PIU detailing any suspected FWA identified by or reported to CHPIV, its NETWORK PROVIDERS, SUBCONTRACTORS, or its DOWNSTREAM SUBCONTRACTORS within ten working days of CHPIV's discovery or notice of such FWA. CHPIV submits a preliminary report in accordance with requirements set forth in an APL or other similar instructions. Subsequent to the filing of the preliminary report, a complete investigation of all reported or suspected FWA activities is promptly conducted;
b. Completed Investigation Report: Within ten working days of completing the FWA investigation (including both CHPIV-initiated and DHCS-initiated referrals), CHPIV submits a completed report to DHCS' PIU. This report includes CHPIV's findings, actions taken, and all documentation necessary to support any action taken by

PCHPIV, and any additional documentation as requested by DHCS or other State and federal agencies;

c. Quarterly FWA Status Report: CHPIV submits a quarterly report to DHCS' PIU on all FWA investigative activities ten working days after the close of every calendar quarter. The quarterly report contains the status of all preliminary, active, and completed investigations, and both CHPIV-initiated and DHCS-initiated referrals. In addition to quarterly reports, CHPIV provides updates and available documentation as DHCS may request from time to time;

d. Manner of Report Submission: CHPIV electronically submits all FWA reports in a form and manner specified by DHCS through APL, or other similar instructions. The required report submission includes without limitation the preliminary FRAUD report, the completed investigation report, and the quarterly status report, including all supporting documents, and any additional documents requested by DHCS.

E. Disciplinary Guidelines and Enforcement

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

2. Any employee included in suspected violation of the Compliance Program (including its Fraud Prevention Program, Code of Conduct, policies and procedures), laws, regulations or other types of misconduct, is expected to cooperate fully with the investigation process and assist in its resolution.

3. CHPIV prohibits retaliation against any individual who reports suspected violations to the Compliance Program (including its Fraud Prevention Program, Code of Conduct, policies, and procedures), laws, regulations, or other types of misconduct.

4. Anyone who knowingly violates the Compliance Program (including its Fraud Prevention Program, Code of Conduct, policies and procedures), laws, regulations or other types of misconduct, will be subject to disciplinary action up to and including termination of employment criminal or civil prosecution, and or monetary penalties.

5. Discipline and corrective action shall be applied and enforced consistently, fairly, and without prejudice, in a timely manner. Disciplinary action will be based on the seriousness of the violation. The following activities may lead to disciplinary action up to and including termination of employment or termination of a contract with contracted Staff:

a. A Staff member authorizes or participates in actions that knowingly violate CHPIV's Compliance Program (including its Fraud Prevention Program, Code of Conduct, policies and procedures), or laws or regulations;

b. A Staff member deliberately provides misleading information about violations of the Fraud Prevention Program, Code of Conduct, policies or procedures, or laws or regulations;

c. A Staff member fails to report suspected or known violations of the Fraud Prevention Program and/or Code of Conduct;

d. A Staff member is found to have engaged in intentional or reckless non-compliance;

e. A manager's or supervisor's actions reflect inadequate supervision or lack of diligence regarding violations of the Fraud Prevention Program and/or Code of Conduct, policies or procedures, or laws or regulations; and/or

f. Any manager or supervisor retaliates, directly or indirectly, or encourages others to retaliate against an associate who reports a violation of the Fraud

Prevention Program and/or Code of Conduct, policies or procedures, or laws or regulations.

6. NETWORK PROVIDERS, SUBCONTRACTORS, and DOWNSTREAM SUBCONTRACTORS also have the duty to follow the Fraud Prevention Program and Code of Conduct or similar standards that comply with all laws and regulations and to report any potential non-compliant, unethical, or fraudulent behavior without the fear of retaliation. Failure to comply may result in corrective or disciplinary action up to and including termination of a NETWORK PROVIDER or termination of a contract with a SUBCONTRACTOR or Downstream Subcontractor, and/or referral to governmental authority.
7. The Compliance Officer/Fraud Prevention Officer and the Compliance Committee shall be responsible for determining appropriate corrective action after being informed, briefed, and fully reviewing a complaint regarding potential FRAUD. The Compliance Officer/Fraud Prevention Officer and the Compliance Committee are responsible for all discipline or corrective actions relating to serious violations of the Code, policies or procedures, laws and regulations or other acts of wrongdoing, including possible criminal or civil FRAUD activities.
8. Expectations and disciplinary guidelines are well publicized through a variety of methods, including, but not limited to: the Code of Conduct, supporting policies and procedures, Compliance Program, Fraud Prevention Program, training (including Compliance, FWA, and HIPAA), CHPIV's policy CMP-007 Escalation of Noncompliance Issues.
9. Disciplinary records are retained for a period of ten (10) years, unless a longer time period is required by law or regulation, and reviewed periodically to ensure disciplinary actions are appropriate to the violation and consistently administered.

III. PROCEDURE

A. Delegation Oversight

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

IV. DEFINITIONS

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

TERMS	DEFINITION
Abuse	Practices that are inconsistent with sound fiscal and business practices

TERMS	DEFINITION
	or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program.
All Plan Letter (APL)	The means by which Medi-Cal Managed Care conveys information or interpretation of changes in policy or procedures at the Federal or State levels. APLs provide instruction, if applicable, on how to implement changes on an operational basis.
Downstream Subcontractor	Means an individual or an entity that has a Downstream SUBCONTRACTOR Agreement with a SUBCONTRACTOR or a Downstream Subcontractor. A Network Provider is not a Downstream SUBCONTRACTOR solely because it enters into a Network Provider Agreement.
False Claims Act (FCA)	Federal and state statutes that generally prohibit making, using, or presenting a false statement or document in order to get the federal or state government to pay money. It also applies where false statements or documents are used to avoid paying money to the Government that would otherwise be owed, or for failing to identify and return an overpayment.
Fraud	As defined in Title 42 Code of Federal Regulations (section 455.2) fraud is, "An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law." Fraud also includes potential violations or activities prohibited by applicable federal or state laws including, without limitation, the Federal False Claims Act, 31 U.S.C. Sections 3729-3731 and the California False Claims Act, California Government Code, Sections 12650 – 12656.
Member	A beneficiary enrolled in a CHPIV program.
Network Provider	Provider or entity that has a Network Provider Agreement with Contractor, Contractor's Subcontractor, or Contractor's Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under this Contract. A Network Provider is not a SUBCONTRACTOR or Downstream SUBCONTRACTOR by virtue of the Network Provider Agreement.
Subcontractor	An individual or entity that has a subcontract with the MCP that relates directly or indirectly to the performance of the MCP's obligations under the contract with DHCS. A network provider is not a subcontractor by virtue of the network provider agreement, as per 42 CFR § 438.2.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare, Medicaid

TERMS	DEFINITION
	or any health care benefit program. Waste is generally not considered to be caused by criminally negligent actions.
Whistleblower	Someone who reports wrongdoing (by a co-worker, employer, or other person or company) to a person in a position of authority or publicly, such as to the media. More specifically, in a legal sense, it usually means someone who observes or learns of illegal activity, or at least activity believed to be unlawful, and reports it either to (1) a supervisor or other designated reporting recipient in the organization where the Whistleblower is employed or (2) to a governmental agency with responsibility to investigate or enforce laws regarding the alleged wrongdoing.

	Effective Lines of Communication	CMP-010
Department	Compliance	
Functional Area	Compliance	
Impacted Delegate	☒ Subcontractor ☐ NA	

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

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

ATTACHMENTS

- NA

AUTHORITIES/REFERENCES

- Title 42 Code of Regulations (CFR): 422.503(b)(4)(vi); 423.504(b)(4(vi)
- Prescription Drug Benefit Manual, Chapter 9 – Compliance Program Guidelines
- Medicare Managed Care Manual, Chapter 21 – Compliance Program Guidelines, Sections 40 and 50.
- CHPIV Compliance Program

HISTORY

Revision Date	Description of Revision
	Policy creation

I. OVERVIEW

A. Community Health Plan of Imperial Valley (CHPIV) is dedicated to conducting business in an ethical and legal manner. CHPIV's Compliance Program describes our comprehensive and effective compliance program, including measures to prevent, detect, and correct program noncompliance and FRAUD, WASTE, and ABUSE. CHPIV has written policies, procedures and standards of conduct that mandate every employee will comply with all applicable Medi-Cal, Medicare, federal and state standards. CHPIV pursues allegations of health care FRAUD, WASTE and ABUSE and matters of noncompliance. In this regard, CHPIV enforces effective lines of communication as a primary component of its Compliance Program.

B. CHPIV's Compliance Program is overseen by Compliance Department which is led by the CHIEF COMPLIANCE OFFICER (CCO), who reports directly to the Chief Executive Officer and has the authority to report compliance issues directly to the Commission.

C. The CCO ensures that policies and procedures relating to compliance, FRAUD, WASTE and ABUSE promote effective interdepartmental and external lines of communication. In addition, the CCO ensures processes are in place to monitor and oversee activities performed by operational areas and Delegates. With the support of CHPIV leadership and the Compliance & Policy Committee, the CCO ensures consistent disciplinary guidelines are enforced for incidents of non-compliance with company standards.

II. POLICY

A. The purpose of this policy is to establish and reinforce effective lines of communication, ensuring confidentiality, between the CHIEF COMPLIANCE OFFICER, members of the Compliance & Policy Committee, CHPIV employees, managers, the Commission, and business partners. Such lines of communication are accessible to all and allow compliance issues to be reported including a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified.

III. PROCEDURE

A. For a Compliance Program to be effective, employees must be able to ask questions and report problems. Supervisors play a key role in responding to employee concerns and it is appropriate that they serve as a first line of communications.

B. CHPIV supports an open-door policy in order to foster dialogue between management and employees. CHPIV also distributes training and policies to encourage communications, confidentiality and non-retaliation to all employees.

C. The CHIEF COMPLIANCE OFFICER serves as a contact point for reporting problems and initiating appropriate responsive action.

D. The Compliance Department also maintains the Compliance Hotline and online form to foster an open atmosphere for employees and others to report issues and concerns anonymously and free from retaliation.

E. Employees, subcontractors, providers, and members may report suspected cases of FRAUD anonymously, or they may use the Compliance Hotline and other communication systems to report issues or concerns regarding FRAUD, WASTE, ABUSE or other violations of or concerns related to the Code of Conduct.

F. The Compliance Hotline is available twenty-four (24) hours a day, seven (7) days a week. Callers may choose to remain anonymous. All calls are investigated and remain confidential. Written confidentiality and non-retaliation policies have been developed to encourage open communication and the reporting of incidents of suspected FRAUD, WASTE, ABUSE or other concerns of noncompliance.

G. The Compliance Department distributes in writing any modifications of, or amendments to, the Compliance Plan, standards of conduct or applicable policies.

H. All business units are responsible for escalating concerns to the Compliance Department as necessary.

I. Committee and Commission Reporting

1. All issues discovered by and reported to the Compliance Department are tracked through resolution and status is reported to the Compliance & Policy Committee.
2. There is a Compliance & Policy Committee (CPC) meeting that serves as a medium to exchange information between the Compliance Department and the rest of the organization. The CPC is established by and reports to the Regulatory Compliance Committee of the Commission to assist the Commission in fulfilling its oversight responsibilities.
3. The CPC periodically reports to the Commission on the state of CHPIV's compliance functions, including a summary of the results of any compliance investigations conducted, potential patterns of noncompliance identified, any significant disciplinary actions against any personnel or any other issues that may reflect any systemic or widespread problems in compliance or regulatory matters exposing the organization to substantial compliance risk. In advance of such reports, CPC and other Committees can, through their respective chairs or otherwise, shall confer on any matters of mutual interest considering their respective responsibilities.

J. Reporting of Noncompliance to Regulators

1. If the investigation confirms the existence of non-compliance that falls under the purview of DEPARTMENT OF HEALTHCARE SERVICES (DHCS) and DEPARTMENT OF MANAGED HEALTH CARE (DMHC) regulations, the CHIEF COMPLIANCE OFFICER, in coordination with senior management, will prepare and submit a formal self-disclosure to the respective regulatory authorities.

K. Confidentiality and Non-Retaliation:

1. Confidentiality: CHPIV will treat all reporting of noncompliance issues and related investigations with the utmost confidentiality to the extent allowed by law.
2. Non-Retaliation: CHPIV strictly prohibits any form of retaliation against employees or agents who make good-faith noncompliance reporting. Any such retaliation will be subject to disciplinary action.

IV. DEFINITIONS

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

TERM	DEFINITION
Abuse	Abuse involves payment for items or services where there is no legal entitlement to that payment and the one receiving the payment has not knowingly and/or intentionally misrepresented facts to obtain payment.
Chief Compliance Officer	CHPIV staff member who serves as the focal point for compliance activities as well as manages the Compliance Department of CHPIV. The Chief Compliance Officer reports directly to the Chief Executive Officer and the Commission. The Chief Compliance Officer is responsible for, without limitation, 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, assisting in the formulation of corrective action plans, and overseeing and/or verifying implementation of corrective action.
Department of Health Care Services (DHCS)	The State agency responsible for administration of the federal Medicaid (referred to as Medi-Cal in California) Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP) and other health related programs.
Department of Managed Health Care (DMHC)	The State agency responsible for administering the "Knox-Keene Health Care Service Plan Act of 1975."
Fraud	As defined in Title 42 Code of Federal Regulations (section 455.2) fraud is, "An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law." Fraud also includes potential violations or activities prohibited by applicable federal or state laws including, without limitation, the Federal False Claims Act, 31 U.S.C. Sections 3729-3731 and the California False Claims Act, California Government Code, Sections 12650 – 12656.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare, Medicaid or any health care benefit program. Waste is generally not considered to be caused by criminally negligent actions.

	Breach Notification	CMP-011
Department	Compliance	
Functional Area	Compliance	
Impacted Delegate	☒ Subcontractor ☐ NA	

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

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

ATTACHMENTS

- NA

AUTHORITIES/REFERENCES

- CHPIV Contract with the Department of Health Care Services (DHCS) for Medi-Cal
- CHPIV Compliance Plan
- HIPAA Breach Notification Rules, 45 CFR §164.400 et seq.
- HHS Commentary Re: Breach Notification Rules, 74 FR 42740 (Aug. 24, 2009) and 78 FR 5638 (Jan. 25, 2013)
- HHS Guidance for Securing Protected Health Information, 74 FR 42741 (Aug. 24, 2009); also available at www.hhs.gov/ocr/privacy.
- Information Practices Act at California Civil Code section 1798.3(a)

HISTORY

Revision Date	Description of Revision
	Policy creation

I. OVERVIEW

A. The purpose of this policy is to enable CHPIV to comply with applicable state and federal laws and regulations governing notice to affected persons in the event of a breach of Member privacy.

B. Violation of this Policy may result in disciplinary action, up to and including termination of employment and/or contract, civil and/or criminal action, and other legal and other remedies available to CHPIV.

II. POLICY

A. The Senior Director of Compliance serves as CHPIV's Privacy Officer.

B. CHPIV workforce members will maintain the privacy and security of MEMBERS' PROTECTED HEALTH INFORMATION (PHI) consistent with CHPIV's policies, procedures, and applicable laws and regulations. CHPIV will notify the Member, U.S. Department of Health and Human Services (HHS), DEPARTMENT OF HEALTH CARE SERVICES (DHCS), and in some cases, local media if there is a breach of unsecured PHI unless CHPIV can demonstrate a low probability that the information has been compromised.

C. This Policy applies to all CHPIV workforce members, including CHPIV administration, medical staff, clinical and administrative workforce members, volunteers, and CHPIV's business associates.

D. Breaches of PHI. This policy applies only if there is a breach of a Member's individually identifiable health information. For purposes of this policy, a breach is presumed if there is an unauthorized access, acquisition, use or disclosure of unsecured PHI unless, (1) CHPIV can demonstrate that there is a low probability that the information was compromised based on a risk assessment of certain factors described below, or (2) the situation fits within one of the following exceptions to the breach notification rule:

1. Any unintentional acquisition, access or use of PHI by a CHPIV workforce member or a person acting under CHPIV's authority if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in violation of the HIPAA PRIVACY RULES.
2. Any inadvertent disclosure by a person who is authorized to access PHI at CHPIV to another person authorized to access Member information at CHPIV and the Member information disclosed is not further used or disclosed in violation of the HIPAA PRIVACY RULES.
3. A disclosure of PHI if CHPIV has a good faith belief that the person to whom the disclosure was made would not reasonably have been able to retain such information.
4. The use or disclosure involves PHI that has been "secured" according to standards published by HHS. Currently, this only applies to electronic Member information that has been properly encrypted consistent with standards published by HHS. HHS will publish future guidance for securing Member information on its website, https://www.hhs.gov/hipaa/index.html. (45 CFR § 164.402)

III. PROCEDURE

A. Mitigating Potential Breaches. If CHPIV workforce members improperly access, acquire, use or disclose PHI and immediate action may cure or mitigate the effects of such use or disclosure, CHPIV workforce members should take such action. For example, if CHPIV workforce members improperly access or acquire PHI, they should immediately stop, close,

and/or return the information. If CHPIV workforce members mistakenly disclose PHI to the wrong person, they should immediately request the return of the information and confirm that no further improper disclosures will be made. If the potential breach is significant or requires further action to mitigate its effects, CHPIV workforce members should immediately contact their supervisor and the Senior Director of Compliance for assistance and direction.

B. Reporting Potential Breaches to the Senior Director of Compliance. CHPIV workforce members shall immediately report any suspected breach of PHI in violation of HIPAA PRIVACY RULES or CHPIV's privacy policies to the Senior Director of Compliance. Failure to timely report suspected breaches may result in sanctions as described below.

C. Anonymously reporting HIPAA Violations. Potential breaches may be reported anonymously to CHPIV through the Compliance Hotline (800-919-4947)

D. Investigating Potential Breaches. The Compliance department shall promptly investigate any reported privacy breach or related Member complaint to determine whether there has been a "breach" of PHI as defined above, and if so, how notice should be given. To determine whether a breach has occurred, the Compliance department shall consider:

1. Whether the alleged breach involved PHI.
2. Whether the alleged breach violates the HIPAA PRIVACY RULES. Disclosures that are incidental to an otherwise permissible use or disclosure (e.g., a Member overhears a customer service representative speaking with another MEMBER, or sees information about another MEMBER on a whiteboard or sign-in sheet) does not violate the privacy rule so long as CHPIV implemented reasonable safeguards to avoid improper disclosures. (45 CFR § 164.502(a)(1)(iii))
3. Whether there is a low probability that the PHI has been compromised considering relevant factors, including at least the following: (1) the nature and extent of the information involved; (2) the unauthorized person who used or received the information; (3) whether the information was actually acquired or viewed; and (4) the extent to which the risk to the information has been mitigated. (45 CFR § 164.402)
4. Whether the alleged breach fits within one of the exceptions identified in Section II.3 (a)-(d), above. (45 CFR § 164.402) The Senior Director of Compliance shall document his or her investigation and conclusions, including facts relevant to the risk assessment. (45 CFR §§ 164.414 and 164.530)

E. Notice—In General. If the Compliance department determines that a breach of unsecured PHI has occurred, the Senior Director of Compliance shall notify the MEMBER, HHS, DHCS, and the media (if required) consistent with this policy and the requirements of 45 CFR §§ 164.404 et seq. Any notice provided pursuant to this policy must be approved and directed by the Senior Director of Compliance and/or CHPIV senior leadership. No other CHPIV workforce members are authorized to provide the notice required by this policy unless expressly directed by the Senior Director of Compliance .

F. Notice to MEMBERS. If a breach of PHI has occurred, the Compliance department shall notify the affected MEMBER(S) without unreasonable delay and in no case later than 60 days after the breach is discovered. The notice shall include to the extent possible: (1) a brief description of what happened (e.g., the date(s) of the breach and its discovery); (2) a description of the types of information affected (e.g., whether the breach involved names, social security numbers, birthdates, addresses, diagnoses, etc.); (3) steps that affected MEMBERS should take to protect themselves from potential harm resulting from the breach; (4) a brief description of what CHPIV is doing to investigate, mitigate, and protect against further harm or breaches; and (5) contact procedures for affected persons to ask questions

and receive information, which shall include a toll-free telephone number, e-mail address, website, or postal address at which the person may obtain more information. The notice shall be written in plain language. (45 CFR § 164.404)

1. Notice by Mail or Email. The Compliance department shall notify the MEMBER by first class mail to the Member's last known address. If the MEMBER agrees, the notice may be sent by e-mail. The notice may be sent by one or more mailings as information is available. (45 CFR § 164.404(d))
2. Substitute Notice. If CHPIV lacks sufficient contact information to provide direct written notice by mail to the MEMBER, the Compliance department must use a substitute form of notice reasonably calculated to reach the MEMBER. (45 CFR § 164.404(d))
    a. Fewer than 10 affected MEMBERS. If there is insufficient contact information for fewer than 10 affected MEMBERS, the Compliance department shall provide notice by telephone, e-mail, or other means. If the Compliance department lacks sufficient information to provide any such substitute notice, the Compliance department shall document same. (45 CFR § 164.404(d)(2)(i))
    b. 10 or more affected MEMBERS. If there is insufficient contact information for 10 or more affected MEMBERS, the Compliance department shall do one of the following after consulting with CHPIV senior leadership: (1) post a conspicuous notice on the home page of CHPIV's website for 90 days with a hyperlink to the additional information required to be given to individuals as provided above; or (2) publish a conspicuous notice in major print or broadcast media in the area where affected MEMBERS reside. The notice must include a toll-free number that remains active for at least 90 days so individuals may call to learn whether their PHI was breached. (45 CFR § 164.404(d)(2)(ii))
3. Immediate Notice. If the Senior Director of Compliance believes that PHI is subject to imminent misuse, the Senior Director of Compliance may provide immediate notice to the MEMBER by telephone or other means. Such notice shall be in addition to the written notice described above. (45 CFR § 164.404(d)(3))

G. Deceased MEMBER; Notice to Next of Kin. If the MEMBER is deceased and CHPIV knows the address for the Member's next of kin or personal representative, the Compliance department shall mail the written notice described above to the next of kin or personal representative. If the CHPIV does not know the address for the next of kin or personal representative, CHPIV is not required to provide any notice to the next of kin or personal representative. The Compliance department shall document the lack of sufficient contact information. (45 CFR § 164.404(d)(1))

H. Notice to Regulators.

1. Notice to HHS. If the Compliance department determines that a breach of PHI has occurred, the Compliance department shall also notify HHS of the breach as described below.
    a. Fewer than 500 Affected MEMBERS. If the breach involves the PHI of fewer than 500 MEMBERS, the Compliance department may either (1) report the breach immediately to HHS as described in subsection (b), or (2) maintain a log of such breaches and submit the log to HHS annually within 60 days of the end of the calendar year. Instructions for maintaining and submitting the log are posted on the HHS website. (45 CFR § 164.408(c))
    b. 500 or More Affected MEMBERS. If the breach involves 500 or more persons, the Compliance department shall notify HHS of the breach at the same time the

Compliance department notifies the MEMBER or next of kin. Instructions for maintaining and submitting the log are posted on the HHS website. (45 CFR § 164.408(b))

2. Notice to DHCS.
   a. CHPIV shall notify DHCS immediately upon the discovery of a suspected breach or security incident that involves Social Security Administration data. This notification will be provided by email upon discovery of the breach. If CHPIV is unable to provide notification by email, then CHPIV shall provide notice by telephone to DHCS.
   b. CHPIV shall notify DHCS within 24 hours by email (or by telephone if CHPIV is unable to email DHCS) of the discovery of:
      i. Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;
      ii. Any suspected security incident which risks unauthorized access to PHI and/or other confidential information;
      iii. Any intrusion or unauthorized access, use or disclosure of PHI in violation of the DHCS Contract; or
      iv. Potential loss of confidential data affecting the DHCS Contract.
   c. Notice shall be provided to CHPIV's DHCS Contract Manager. Further, CHPIV shall also notify the DHCS Privacy Office and the DHCS Information Security Office (collectively, "DHCS Contacts") using the DHCS Contact Information noted below.

DHCS Privacy Officer	DHCS Information Security Office
Privacy Office c/o: Office of HIPM Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov	Information Security Office DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov

   d. Notice shall be made using the current DHCS "Privacy Incident Reporting Form" ("PIR Form;" the initial notice of a security incident or breach that is submitted is referred to as an "Initial PIR Form") and shall include all information known at the time the incident is reported. The form is available online at https://www.dhcs.ca.gov/formsandpubs/laws/priv/Documents/Privacy-Incident-Report-PIR.pdf.
   e. DHCS requires CHPIV to immediately investigate a security incident or confidential breach. CHPIV must provide a complete report of the investigation to the DHCS contacts within ten (10) working days of the discovery of the security incident or breach. This "Final PIR Form" must include any applicable additional information not included in the Initial PIR Form. The Final PIR Form shall include an assessment of all known factors relevant to a determination of whether a breach occurred under the HIPAA PRIVACY RULES and other applicable federal and state laws. The report shall also include a full, detailed corrective action plan, including its implementation date and information on mitigation measures taken to halt and/or contain the improper use or disclosure. If DHCS requests

information in addition to that requested through a PIR Form, business associate shall make reasonable efforts to provide DHCS with such information. A "Supplemental PIR Form" may be used to submit revised or additional information after the Final PIR Form is submitted. DHCS will review and approve or disapprove CHPIV's determination of whether a breach occurred, whether the security incident or breach is reportable to the appropriate entities, if individual notifications are required, and CHPIV's corrective action plan. If CHPIV does not complete a Final PIR Form within the ten (10) working day timeframe, CHPIV must request approval from DHCS within the ten (10) working day timeframe of a new submission timeframe for the Final PIR Form.

f. Upon discovery of a breach or suspected security incident, intrusion, or unauthorized access, use or disclosure of PHI, CHPIV shall take:
   i. Prompt action to mitigate any risks or damages involved with the security incident or breach; and
   ii. Any action pertaining to such unauthorized disclosure required by applicable federal and state law.

I. Notice to Media. If a breach of PHI involves more than 500 residents in the state of California, CHPIV will also notify prominent media outlets in California. The notice shall be provided without unreasonable delay but no later than 60 days after discovery of the breach. The notice shall contain the same elements of information as required for the notice to the MEMBERS described above. The Senior Director of Compliance shall work with CHPIV senior leadership to develop an appropriate press release concerning the breach. (45 CFR § 164.406)

J. Notice from CHPIV Business Associate. If CHPIV's business associate discovers a breach of PHI, the business associate shall immediately notify the CHPIV Senior Director of Compliance of the breach. The business associate shall, to the extent possible, identify each person whose information was breached and provide such other information as needed by CHPIV to comply with this policy. Unless the Senior Director of Compliance directs otherwise and with the approval of the Senior Director of Compliance in writing such as via email, the business associate shall notify MEMBERS, HHS, DHCS, and, in appropriate cases, the media as described above after review and approval of any such notifications by CHPIV. (45 CFR § 164.410)

K. Delay of Notice Per Law Enforcement's Request. The Senior Director of Compliance shall delay notice to the MEMBER, HHS, DHCS, and the media if a law enforcement official states that the notice would impede a criminal investigation or threaten national security. If the officer's statement is in writing and specifies the time for which the delay is required, the Senior Director of Compliance shall delay the notice for the required time. If the officer's statement is verbal, the Senior Director of Compliance shall document the statement and the identity of the officer, and shall delay the notice for no more than 30 days from the date of the statement unless the officer provides a written statement confirming the need and time for delay. (45 CFR § 164.412)

L. Training Workforce Members. CHPIV shall train its workforce members concerning this Policy, including workforce members' obligation to immediately report suspected privacy violations. The Senior Director of Compliance shall ensure that this policy is included in training given to new workforce members, and thereafter in periodic training as relevant to the workforce members' job duties. (45 CFR § 164.530)

M. Sanctions. CHPIV workforce members may be sanctioned for a violation of this policy, including but not limited to the failure to timely report a suspected privacy violation. CHPIV may impose the sanctions it deems appropriate under the circumstances, including but not limited to termination of employment or contract. (45 CFR § 164.530)

N. Documentation. The Compliance department shall prepare and maintain documentation required by this Policy for a period of six (6) years or such other period of time as required by law or CHPIV's retention policy, including but not limited to reports or complaints of privacy violations; results of investigations, including facts and conclusions relating to the risk assessment; required notices; logs of privacy breaches to submit to HHS and DHCS; sanctions imposed; etc. (45 CFR § 164.530)

IV. DEFINITIONS

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

TERM	DEFINITION
Department of Health Care Services (DHCS) Contract	The written agreement between CHPIV and the Department of Health Care Services (DHCS) pursuant to which CHPIV is obligated to arrange and pay for the provision of covered services to Members in the CHPIV Medi-Cal program, i.e., California's Medicaid health care program that pays for medical services for children and adults with limited income and resources and is supported by federal and state funding.
HIPAA Privacy Rules	Federal regulations promulgated under the Health Insurance Portability and Accountability Act provisions related to the privacy protection of Member PHI (45 CFR Part 160 and Part 164)
Member	A beneficiary enrolled in a CHPIV Medi-Cal program.
Protected Health Information (PHI)	*Individually identifiable health information* that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. *Individually identifiable health information* relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care. The information either identifies an individual or there is reasonable basis to believe the information can be used to identify the individual. (45 CFR § 160.103)

	Notice Of Privacy Practices	CMP-012
	Department	Compliance
	Functional Area	
	Impacted Delegate	☒ Subcontractor ☐ NA

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

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

ATTACHMENTS

- Attachment A – Member Notice of Privacy Practices

AUTHORITIES/REFERENCES

- CHPIV Contract with the Department of Health Care Services (DHCS) for Medi-Cal
- DHCS All Plan Letter (APL) 06-001: Notice of Privacy Practices and Notification of Breaches
- DHCS All Plan Letter (APL) 22-026: Interoperability and Patient Access Final Rule
- CHPIV Plan Compliance Plan
- Title 45, Code of Federal Regulations (C.F.R.), §160.202
- Title 45, Code of Federal Regulations (C.F.R.), §164.105(c)(2)
- Title 45, Code of Federal Regulations (C.F.R.), §164.508(a)(2)-(a)(4)
- Title 45, Code of Federal Regulations (C.F.R.), §164.508(b)(5)
- Title 45, Code of Federal Regulations (C.F.R.), §164.520(b)(1)(ii)(A) or (B)
- Title 45, Code of Federal Regulations (C.F.R.), §164.530(g)
- Patient Protection and Affordable Care Act §1557
- NCQA Standard MED5 Privacy and Confidentiality: Element A: Adopting Written Policies, Factor 1-2107

HISTORY

Revision Date	Description of Revision
	Policy creation

I. OVERVIEW

A. This NOTICE OF PRIVACY PRACTICES Policy (this Policy) identifies the required content of CHPIV's NOTICE OF PRIVACY PRACTICES (NPP) and the process by which the NPP is distributed to MEMBERS.

B. CHPIV ensures internal compliance with federal and state privacy and security requirements through ongoing monitoring.

C. CHPIV ensures its Business Associate's compliance with federal and state privacy and security requirements through ongoing monitoring and audits in accordance with this Policy and the BAA.

D. Violation of this Policy may result in disciplinary action, up to and including termination of employment and/or contract, civil and/or criminal action, and other legal and other remedies available to CHPIV.

II. POLICY

A. CHPIV MEMBERS have the right to adequate notice of the USES and DISCLOSURES of PROTECTED HEALTH INFORMATION (PHI) that may be made by CHPIV and of the MEMBERS' rights and CHPIV's legal duties with respect to PHI.

B. CHPIV shall provide information that directs MEMBERS on the process to file complaints with CHPIV and its regulators and will not retaliate against MEMBERS who file complaints when they believe their privacy rights have been violated.

C. CHPIV shall provide the NPP to MEMBERS and former MEMBERS as Required by Law, including providing the NPP upon enrollment and providing notice upon material revisions of the NPP in an easily accessible location on CHPIV's public website.

D. The CHPIV NPP shall describe steps the MEMBERmay consider taking to help protect privacy and security of their PHI.

E. Upon a material change to the NPP, CHPIV shall prominently post the change, or the revised NPP, on the CHPIV website by the effective date of the material change to the notice.

III. PROCEDURE

A. The content of the NPP shall be written in plain language and contain the following elements:

1. Mandated header;
2. Description and one (1) example each, of the types of USE and DISCLOSURES that CHPIV is permitted under state and federal regulations for the purposes of TREATMENT, PAYMENT, and HEALTH CARE OPERATIONS. If a USE or DISCLOSURE for any purpose described in paragraphs (b)(1)(ii)(A) or (B) of Title 45, Code of Federal Regulations, Section 164.520 is prohibited or materially limited by other applicable law, the description of such USE or DISCLOSURE must reflect the more stringent law;
3. A description of the types of USES and DISCLOSURES that require an authorization under Section 164.508(a)(2)-(a)(4), a statement that other USE and DISCLOSURES not described in this notice will be made only with the Member's written authorization, and

a statement that the MEMBER may revoke such authorization as provided by Section 164.508(b)(5);

4. Statement to describe the Member's rights concerning his or her PHI, how to exercise these rights, and restrictions on such rights, which shall include information on:
    a. Restrictions concerning certain USE and DISCLOSURES of PHI, and provision that CHPIV is not required to agree to those restrictions, except in case of a DISCLOSURE restricted under Section 164.522(a)(1)(vi);
    b. Right to receive confidential communications of PHI;
    c. Right to inspect and copy PHI;
    d. Right to request amendment to PHI;
    e. Right to receive accounting of DISCLOSURES, with certain exceptions; and
    f. Right to receive a paper copy of the NPP, in accordance with this Policy.
5. Statement specifically describing CHPIV's duties and rights under the privacy rule, including:
    a. A statement that CHPIV is Required by Law to maintain the privacy of the Member's PHI, to provide individuals with notice of its legal duties and privacy practices with respect to PHI, and to notify affected MEMBERS following a breach of unsecured PHI, and in accordance with CHPIV policies, which shall include processes to ensure internal protection of verbal (i.e., when talking to individuals on the telephone or in person about a Member), and written information;
    b. The responsibility to abide by the terms of the NPP currently in effect;
    c. Reserve CHPIV's right to make changes to the terms of the NPP when we make changes to our privacy practices; and
    d. A description of how CHPIV provides MEMBERS with a revised NPP.
6. Statement that the MEMBER may file a complaint as part of their privacy rights, and without retaliation, to CHPIV's Customer Service Department or Privacy Officer, the California Department of Health Care Services (DHCS), and/or the United States Department of Health and Human Services (HHS), if the MEMBER believes his or her privacy rights have been violated, and include contact title and telephone number for filing the complaint with CHPIV, or to get further information concerning the notice. The contact information should include:
    a. Attn: Privacy Officer
    CHPIV
    512 west Aten Rd
    Imperial, CA
    Telephone: 760-332-6447
    b. CHPIV Customer Service Department
    Toll-free: 1-833-236-4141
    TTY: 711
    c. California Department of Health Care Services
    Privacy Officer

c/o: Office of HIPAA Compliance
Department of Health Care Services
P.O. Box 997413 MS 4722
Sacramento CA 95899-7413
Email: privacyofficer@dhcs.ca.gov
Telephone: 1-916-445-4646
Fax: 1-916-440-7680

d. U.S. Dept. of Health and Human Services
Office for Civil Rights
Regional Manager
90 7th Street Suite 4-100
San Francisco CA 94103
Phone: 1-800-368-1019
Fax: 1-415-437-8329
TDD: 1-800-537-7697
Email: OCRComplaint@hhs.gov

7. Effective date of the notice.
   a. The NPP shall be made available to anyone, upon request, by calling or writing to the CHPIV Customer Service Department. CHPIV's Customer Service Department shall make the NPP available in THRESHOLD LANGUAGES to anyone by mail, in person, or through the CHPIV website. CHPIV shall distribute the NPP by:
      i. Ensuring initial distribution by mail to all MEMBERS;
      ii. Including copies in all new enrollment packets;
      iii. Posting a copy in the Customer Service Department lobby in THRESHOLD LANGUAGES;
      iv. Posting the NPP on the CHPIV website;
      v. Providing a revised NPP, or information about the material change and how to obtain the revised NPP, in the next annual mailing to MEMBERS;
      vi. Notifying all MEMBERS at least once every three (3) years that a copy of the NPP is available upon request or may be obtained on the CHPIV website at www.CHPIV.org; and
      vii. Ensuring all mailings of the NPP comply with CHPIV's Cultural and Linguistic Services guidelines.

B. Documentation and Retention:
1. CHPIV shall document compliance with this Policy and retain copies of the notices issued for a period of ten (10) years from the effective date of the notice.

IV. DEFINITIONS

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

TERM	DEFINITION
Disclosure/Disclose	The release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information. (45 CFR § 160.103)
Health Care Operations	Includes without limitation in accordance with federal regulation, quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule. (45 CFR § 164.501)
Member	A beneficiary enrolled in a CHPIV Medi-Cal program.
Notice of Privacy Practices (NPP)	Notice provided to a Member that describes CHPIV's practices in the Use and Disclosure of Protected Health Information, Member rights, and CHPIV legal duties with respect to Protected Health Information.
Payment	Includes without limitation in accordance with federal regulation: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services. (45 CFR § 164.501)
Protected Health Information (PHI)	*Individually identifiable health information* that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. *Individually identifiable health information* relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care. The information either identifies an individual or there is reasonable basis to believe the information can be used to identify the individual. (45 CFR § 160.103)
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).

TERM	DEFINITION
Treatment	The provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another. (45 CFR § 164.501)
Use	With respect to individually identifiable health information, means the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information. (45 CFR § 160.103)

	Delegation of Authority	EXC-002
Department	Executive Services	
Functional Area	Executive Services	
Impacted Delegate	☐ Subcontractor ☒ NA	

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

APPROVALS			
Internal		**Regulator**	
Name	Larry Lewis	☐ DHCS ☐ NA ☐ DMHC	
Title	Chief Executive Officer		

ATTACHMENTS

- None

AUTHORITIES/REFERENCES

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

HISTORY

Revision Date	Description of Revision

I. OVERVIEW

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

II. POLICY

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

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

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

III. PROCEDURE

A. Delegation of Authority to AUTHORIZED REPRESENTATIVES

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

B. Designation and Notification Process

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

DHCS Address:
California Department of Health Care Services
Managed Care Operations Division
Attn: DHCS Contract Manager
MS 4407

P.O. Box 997413
Sacramento, CA 95899-7413

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

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

IV. DEFINITIONS

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

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

	Delegated Entity Financial Solvency Oversight Process	FIN-001
	Department	Network Management
	Functional Area	Finance
	Impacted Delegate	☒ Subcontractor ☐ NA

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

APPROVALS		
Internal		**Regulator**
Name	Mark Southworth	☒ DHCS ☐ NA ☐ DMHC
Title	Chief Financial officer	

ATTACHMENTS

- None

AUTHORITIES/REFERENCES

- **State**
  - California Health and Safety Code Sections
  - 1300.75.4-1300.75.4.8 and 1300.76 of Title 28 of the California Code of Regulations (These regulations were promulgated pursuant to authority in sections 1344 and 1375.4 of the California Health and Safety Code)

- **Related Policices**
  - FIN-002 Delegated Provider Financial Solvency CAP Process
  - Pre-Contractual Due Diligence

HISTORY

Revision Date	Description of Revision

I. OVERVIEW

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

II. POLICY

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

III. PROCEDURE

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

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

C. Financial Solvency Review Process

1. Delegated entities are required to submit quarterly and/or annual audited FINANCIAL STATEMENTS to CHPIV. If a delegated entity is not meeting the financial solvency requirements, they may be asked to also provide monthly FINANCIAL STATEMENTS to CHPIV.
    a. Quarterly and annual audited FINANCIAL STATEMENTS are due to CHPIV as follows:
        i. Quarterly FINANCIAL STATEMENTS are due within 45 days of the end of each calendar quarter.
        ii. Audited annual FINANCIAL STATEMENTS are due within 150 days of the end of each fiscal year.
    b. Prior to each due date, CHPIV requests delegated entities to submit the applicable FINANCIAL STATEMENTS.
        i. Reminders are sent to delegated entities who have not responded.

ii. Non-responsive delegated entities will be reviewed to determine if additional actions are required (i.e., escalate to the appropriate oversight committee).

c. CHPIV assesses the financial solvency of each delegated provider based on CHPIV's established criteria and the DMHC required grading criteria. Delegated providers must meet the minimum acceptable liquidity, profitability, efficiency, and stop-loss protection levels.

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

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

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

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

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

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

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

D. DMHC RBO Non-Filer Process

1. Following the end of a reporting period, the DMHC will provide a list of RBO non-filers to CHPIV, as appropriate. The non-filers are RBOs who failed to file quarterly or annual audited financial surveys to the DMHC within the required timeframe.
    a. Upon receipt of the notification from the DMHC, CHPIV informs applicable department contacts regarding the RBO identified by DMHC as a "Non-Filer." CHPIV notifies the RBO directly to advise the RBO to comply within the required time frame. The notice to the RBO shall include a punitive statement such as,"... failure by RBO to comply within the required time frame shall result in an administrative action against the health plan by DMHC's Office of Enforcement, including freeze of membership assignment and other possible sanctions, up to and including termination of contract."
    b. CHPIV will respond to the DMHC regarding CHPIV's policies and procedures to make sure it complies with the requirements.
    c. CHPIV communicates the RBO's status to the applicable oversight committees, as needed, until the delegated entity completes the required filing
    d. If an RBO does not comply with DMHC requirements, CHPIV may be sanctioned by the DMHC. For these situations, CHPIV keeps the applicable oversight committees and/or departments in the loop on the progress or non-progress of the RBO. The applicable oversight committee is responsible for determining final decisions to remediate RBO noncompliance up to and including termination that is based on a decision-making criteria process.

E. Financial Solvency Reporting Process

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

F. Pre-contractual Due Diligence Financial Solvency Review Process

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

IV. DEFINITIONS:

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

TERM	DEFINITION
Cash-to-Claims Ratio (CCR)	Provider's cash, readily available marketable securities, and receivables, excluding all risk pool, risk- sharing, incentive payment program and pay -for- performance receivables, reasonably anticipated to be collected within sixty (60) days divided by Provider 's unpaid claims liability.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CHPIV, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CHPIV departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CHPIV and its regulators.
Department of Managed Health Care (DMHC)	The State agency responsible for administering the "Knox-Keene Health Care Service Plan Act of 1975."
Downstream Subcontractor	An individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.
Financial Statements	A balance sheet, an income statement, a statement of cash flows, and footnote disclosures.
Generally Accepted Accounting Principles (GAAP)	GAAP is the adopted accounting framework of the U.S. Securities and Exchange Commission and the Internal Revenue Service for healthcare accounting
Hospital	Refers to delegated or risk-bearing hospitals only
Medical Cost Ratio (MCR)	Metric used in managed health care and health insurance to measure medical costs as a percentage of premium revenues
Network Provider	Provider or entity that has a Network Provider Agreement with Contractor, Contractor's Subcontractor, or Contractor's Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under this Contract. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement.
Risk Bearing	A risk bearing organization (RBO) is either a professional medical

TERM	DEFINITION
Organization (RBO)	corporation, other form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempt from licensure pursuant to subdivision (l) of Section 1206 of the Health and Safety Code, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services. An RBO does not include an individual or a health care service plan. An RBO does all of the following
Sponsoring Organization	A sponsoring organization is one that has a tangible net equity of a level to be established by the director that is in excess of all amounts that it has guaranteed to any person or entity.
Subcontractor	An individual or entity that has a subcontract with the MCP that relates directly or indirectly to the performance of the MCP's obligations under the contract with DHCS. A network provider is not a subcontractor by virtue of the network provider agreement, as per 42 CFR § 438.2.
Tangible Net Equity (TNE)	Net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; obligations of officers, directors, owners, or affiliates which are not fully secured, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with nonaffiliates and which are not more than sixty (60) days past due; long term prepayments of deferred charges, and nonreturnable deposits.
Working Capital (WC)	The difference between current assets and current liabilities

	Delegated Entity Financial Solvency Corrective Action Plan Process	FIN-002
	Department	Network Management
	Functional Area	Finance
	Impacted Delegate	☒ Subcontractor ☐ NA

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

APPROVALS		
Internal		**Regulator**
Name	Mark Southworth	☒ DHCS ☐ NA ☐ DMHC
Title	Chief Financial Officer	

ATTACHMENTS

- None

AUTHORITIES/REFERENCES

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

HISTORY

Revision Date	Description of Revision
5/25/2023	Policy created

I. OVERVIEW

A. This policy applies to any SUBCONTRATCOR (including any Plan-to-Plan, or P2P, SUBCONTRACTORS), DOWNSTREAM SUBCONTRACTOR, or NETWROK PROVIDER who has accepted and been delegated financial risk for the provision of Covered Services for one or more lines of business. For purposes of this policy only, they shall collectively be referred to as "delegated entities".
The purpose of this policy is to outline the Community Health Plan of Imperial County's ("CHPIV" or "Plan") process to request, review and monitor CORRECTIVE ACTION PLANS (CAPs) required by delegated providers who are not in compliance with the CHPIV's financial solvency standard benchmarks, contracts, and the legal requirements set forth in the California Health & Safety Code.

II. POLICY

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

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

III. PROCEDURE

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

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

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

documentation is needed, CHPIV may arrange a meeting with the delegated entity or RBO to review.

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

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

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

in scope and breadth depending upon the nature and degree of the deficiency, and acceptable to DMHC.

e. Describe the timeframe for completing the corrective actions and specify a schedule for submitting progress reports to the DMHC and the RBO's contracting health plans. Except in situations where the RBO can demonstrate to the DMHC's satisfaction and written approval that an extended period of time is necessary and appropriate to correct the deficiency:
    i. Timeframes for correcting WORKING CAPITAL deficiencies shall not exceed 12 months.
    ii. Timeframes for correcting TNE deficiencies shall not exceed 12 months.
    iii. Timeframes for IBNR deficiencies shall not exceed three months.
    iv. Timeframes for correcting claims timeliness deficiencies shall not exceed six months.
    v. Timeframes for correcting cash-to-claims ratio deficiencies shall not exceed 12 months.
f. Identify the name, title, telephone and facsimile numbers, and postal and email addresses for the person responsible at the delegated entity or RBO for ensuring compliance with the final CAP.
g. An RBO may avoid submitting a self-initiated CAP proposal if it demonstrates to the DMHC that necessary and prudent capital investments have caused or may cause a temporary deficiency in its TNE, working capital, or cash-to-claims ratios and that the RBO has implemented an appropriate business plan that will correct the deficiency within a reasonable time period without causing a deficiency in the RBO's claims processing timeliness. The RBO shall seek and receive written approval from the DMHC to avoid submitting a self-initiated CAP proposal.

2. To the extent possible, the self-initiated CAP proposal shall be set forth in a single document that addresses the concerns of all plans with which the RBO maintains a contract that includes a risk arrangement.
3. The DMHC will notify CHPIV when a delegated entity or RBO has submitted a self-initiated proposed CAP. Upon receipt of this notification, CHPIV shall log onto the DMHC secured web portal to access the latest message and instruction pertaining to the CAP from the DMHC and RBO. CHPIV also downloads a copy of the delegated entity's or RBO's proposed CAP or on-going CAP update from the portal. CHPIV is responsible for tracking and monitoring CAP status.
    a. Applicable committees and/or departments are notified when the CAP is available for review to determine if the CAP adequately addresses the identified deficiencies and provide a recommendation to accept or object/suggest changes back to the RBO and the DMHC.
    b. In an event the initial or on-going CAP submitted has inadequate financial projection, i.e., less than three (3) quarter projections required by the DMHC and by recommendation from CHPIV, CHPIV will automatically request from the RBO additional projections. This action will be done without filing an objection by the health plan to the DMHC. The DMHC will

take similar action by requesting the same information from the RBO before proceeding with its review and determination.

c. Per ICE guidelines, health plans can object to CAP and require the delegated entity or RBO to submit two or more additional projections as it deemed necessary based on the CAP review results.
d. All CAPs are saved in the secure Financial Oversight network drive. Each delegated provider has a separate folder where current and archived copies are stored.
    i. If the CAP is related to claims timeliness, it's forwarded to the oversight department.
    ii. CHPIV is responsible for filing the health plan response to the DMHC via the web portal. CHPIV response is either to Accept or Object to the CAP as determined by CHPIV.
e. Within 15 calendar days of receipt of the RBO's self-initiated CAP proposal, CHPIV will provide written notice to the DMHC (filed electronically through the DMHC Web portal) accepting the CAP or stating the reason for its objections and recommendations for revisions. If CHPIV does not respond within this timeline, the self-initiated CAP shall be considered a final CAP; however, it is CHPIV's intent and process to always provide a response within this timeline.

4. In the event that CHPIV files a written objection with the DMHC and a delegated entity or RBO, the DMHC shall, within 10 calendar days, review the objections and inform the delegated entity or RBO if revisions to the CAP proposal are needed or if the objections can be resolved. If the objections can be resolved, the self-initiated CAP proposal shall be considered the final CAP subject to approval by the DMHC. If revisions to the CAP proposal are required, the delegated entity or RBO will have 10 calendar days to do the following:
    a. Implement all corrective action strategies contained in its self-initiated CAP proposal that were not objected to by CHPIV or another contracted plan; and,
    b. Submit to the DMHC a revised CAP proposal that addresses the concerns raised by the objecting contracting health plan including CHPIV. To the extent possible, the revised CAP proposal shall be prepared as a single document that addresses the concerns of all plans including CHPIV with which the subcontracted entity or RBO maintains a contract that includes a risk arrangement. Upon receipt of the auto notification from DMHC, CHPIV will access and download a copy of the revised CAP from the DMHC web portal.
5. Within seven calendar days of receipt of the revised self-initiated CAP proposal, CHPIV will provide to the delegated entity or RBO and the DMHC its acceptance or objections and recommended revisions, in an electronic format prepared by the DMHC, to the self-initiated revised CAP proposal. If there are no objections, the self-initiated revised CAP proposal shall become the final CAP subject to approval by the DMHC.
    a. CHPIV performs the review of the revised CAP proposal to determine if the revised CAP adequately addresses the identified deficiencies and provide a

recommendation to accept or object/suggest changes back to the delegated entity or RBO and the DMHC.

b. If CHPIV needs clarification or additional documentation regarding the revised CAP, CHPIV may arrange a meeting or conference call with the delegated entity or RBO representatives. CHPIV may require the delegated entity or RBO to submit supporting documentation to any new CAP relevant information discussed prior to or during the meeting.
c. CHPIV is responsible for notifying the DMHC regarding its recommendations.

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

D. CAP Reporting

1. Each periodic progress report prepared pursuant to a final CAP shall be submitted to the DMHC and CHPIV and shall include a written verification stating that the periodic progress report is true and correct to the best knowledge and belief of a principal officer of the RBO.
2. In addition to the quarterly progress reports specified in a CAP, every contract involving a risk arrangement between CHPIV and a RBO shall require that:
    a. The delegated entity or RBO shall advise CHPIV and the DMHC within five calendar days if the delegated entity or RBO experiences an event that materially alters the delegated entity's or RBO's ability to remain compliant with the requirements of a final CAP, and

b. The RBO, upon DMHC's request, will provide additional documentation to the DMHC and CHPIV to demonstrate the delegated entity's or RBO's progress towards fulfilling the requirements of a CAP.

3. Non-disclosure of CAP documentation and supporting work papers:
   a. All draft, preliminary and final CAPs and all CAP compliance reports required by a final CAP, including supporting documentation and supplemental financial information, submitted to the DMHC shall be received and maintained on a confidential basis and shall not be disclosed, except for the information outlined in section 1300.75.4.4(c)(3) to any party other than the RBO and, as necessary, to its contracting health plans including CHPIV that are participating in the CAP.
4. CHPIV communicates delegated entity or RBO CAP status to the applicable committees and/or departments on a monthly or quarterly basis, as defined.

E. Plan Obligation

1. CHPIV shall advise the DMHC and the RBO in writing within five days of becoming aware that (H&S Code 1300.75.4.5.(a)(5)):
   a. A delegated entity or RBO is not in compliance with the requirements of a final CAP; or when,
   b. A delegated entity's or RBO's conduct may cause CHPIV to be subject to disciplinary action pursuant to Health and Safety Code section 1386.
2. If a delegated entity or RBO fails to substantially comply with the requirements of a final CAP for a period of more than 90 calendar days, as determined by the DMHC, then appropriate actions will be identified by the DOW. If the additional actions identified by the DOW are not successful, the matter will be escalated to the DOC for decision.
   a. CHPIV is responsible for notifying the applicable committees and/or departments of the DMHC notice of Cease-and-Desist order and pursues obtaining additional information from the RBO as needed.
      i. CHPIV shall notify the delegated entity or RBO of any administrative action handed down by the DMHC to the health plan related to the CAP. If the administrative action requires a response from the delegated entity or RBO, the health plan notice shall include a statement such as,"... failure by delegated entity or RBO to comply with the requirement, shall result in an administrative action against the health plan by DMHC's Office of Enforcement, including freeze of membership assignment and other possible sanctions, up to and including termination of contract."
      ii. The DMHC prohibition shall take effect 30 calendar days after the date of the DMHC's notification to CHPIV and shall remain in effect until the DMHC notifies CHPIV in writing that the delegated entity's or RBO's non-compliance has been remedied.
   b. CHPIV is responsible for submitting a formal response to the DMHC regarding the action(s) taken by CHPIV.

F. Delegated Entity or RBO Obligation

1. The delegated entity or RBO will advise CHPIV and the DMHC within five business days after discovering that the RBO experienced any event that materially alters

the RBO's financial situation or threatens the RBO's solvency (H&S Code 1300.75.4.2.(f)).

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

IV. DEFINITIONS

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

TERM	DEFINITION
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CHPIV, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CHPIV departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CHPIV and its regulators.
Department of Managed Health Care (DMHC)	The State agency responsible for administering the "Knox-Keene Health Care Service Plan Act of 1975."
Financial Statements	A balance sheet, an income statement, a statement of cash flows, and footnote disclosures (footnote disclosure required when submitting CPA-reviewed and audited financial statements).
Incurred But Not Reported (IBNR)	The amount owed by an insurer to all valid claimants who have had a covered loss but have yet reported it.
Risk Bearing Organization (RBO)	A risk bearing organization (RBO) is either a professional medical corporation, other form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempts from licensure pursuant to subdivision (l) of Section 1206 of the Health and Safety Code, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services. An RBO does not include an individual or a health care service plan.
Subcontractor	An individual or entity that has a subcontract with the MCP that relates directly or indirectly to the performance of the MCP's

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

	Pharmacy Services	PS-001
Department	Health Services	
Functional Area	Pharmacy Services	
Impacted Delegate	☒ Subcontractor ☐ NA	

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

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

ATTACHMENTS

- NA

AUTHORITIES/REFERENCES

- **Internal**
  - CHPIV, Delegation Oversight Policy and Procedure, CMP-002
- **Federal**
  - 42 CFR Section 438.3(s); 42 CFR 438.900 et. seq; 42 USC Section 1396r - 8(g), and Section 1004;
- **State**
  - DHCS: DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III, Section 5.3.7.H; APL 22-012
- **Accreditation**
  - NCQA: UM 11, Elements A-E – Pharmaceutical Management Procedures

HISTORY

Revision Date	Description of Revision
	Policy Creation

I. OVERVIEW

A. This policy addresses Community Health Plan of Imperial Valley's ("CHPIV" or the "Plan") requirements for the provision of pharmaceutical services to its MEMBERS.

II. POLICY

A. CHPIV will ensure the development and implementation of an effective Drug Utilization Review (DUR) and treatment outcome process, as directed in APL 17-008 and APL 19-012, to ensure that drug utilization is appropriate, MEDICALLY NECESSARY, and will not result in adverse events.

B. CHPIV will ensure the implementation of the following:

1. Retrospective claims review automated process to monitor when a MEMBER is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics.
2. A program to monitor the appropriate use of antipsychotic, mood stabilizers, and anti-depressant medications by all children 18 years of age and under, including foster children enrolled under the California Medicaid State Plan.
3. A fraud and abuse identification processes for potential fraud or abuse of controlled substances by MEMBERS, PROVIDERS, and pharmacies.

C. CHPIV will ensure the submission to DEPARTMENT OF HEALTH CARE SERVICES (DHCS) annually of a detailed report in a format specified by DHCS on their DUR Program activities.

D. CHPIV will ensure that there are no imposed Quantitative Treatment Limitation (QTL) or Non-Quantitative Treatment Limitation (NQTL) more stringently for mental health and substance use disorder drugs prescriptions than for medical/surgical drugs, in accordance with 42 CFR 438.900 et. seq.

E. Effective January 1, 2022, and per Executive Order (EO) N-01-19, Medi-Cal pharmacy services transitioned from the managed care delivery system to the Fee-For-Service (FFS) delivery system known as Medi-Cal Rx offering the following benefits to MEMBERS:

1. Standardized Medi-Cal pharmacy benefit statewide.
2. Improved access to pharmacy services with a pharmacy network that includes approximately 94 percent of the state's licensed outpatient pharmacies.
3. Applied statewide utilization management protocols to all covered outpatient drugs.
4. Strengthened California's ability to negotiate state supplemental drug rebates with drug manufacturers, thereby creating additional cost-savings for the state.

F. While majority of pharmaceutical services transitioned to Medi-Cal Rx, CHPIV is responsible for a number of pharmaceutical services activities and will ensure to have processes in place for the following:

1. Processing and paying all pharmacy services billed on medical or institutional claims.
2. Overseeing and maintaining all activities necessary for MEMBER care management and coordination, and related activities consistent with legal and contractual obligations.
3. Providing oversight and management of all the clinical aspects of pharmacy adherence, including providing disease and medication management.
4. Ensuring that claims for PADs are processed as a medical benefit. Processing and covering PADs, which are expected to be submitted on medical claims.

5. Providing retrospective DUR services.
6. Participating in the Medi-Cal Global DUR Board and other DHCS organized pharmacy committee meetings.
7. Ensuring that DUR program meets or exceeds applicable provisions of Section 1004 requirements of the SUPPORT for Patient and Communities Act: A retrospective claims review process that monitors when an individual is concurrently prescribed opioids and benzodiazepines, opioids and antipsychotics, or opioids and Medication Assisted Treatment (MAT).
8. Developing and implementing effective retrospective DUR and treatment outcome processes to assure that drug utilization is appropriate, medically necessary, and not likely to result in adverse events.
9. Reimbursing pharmacist professional services as required by Assembly Bill (AB) 1114 (Chapter 602, Statutes of 2016) in a community-based outpatient pharmacy setting.
10. Processing and payment of all pharmacist professional services allowed by AB 1114 that are billed on medical and institutional claims.

III. PROCEDURE

A. CHPIV delegates applicable pharmaceutical services to its SUBCONTRACTOR, Health Net.

B. Delegation Oversight

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

IV. DEFINITIONS

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

TERM	DEFINITION
Department of Health Care Services (DHCS)	The State agency responsible for administration of the federal Medicaid (referred to as Medi-Cal in California) Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP) and other health related programs.
Medically Necessary/Medical Necessity	Means all Covered Services that are reasonable and necessary to protect life, prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attain, maintain, or regain

	functional capacity per Title 22 CCR Section 51303(a) and 42 CFR 438.210(a)(5).When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and W & I Code Section 14132 (v). For individuals under 21 years of age, EPSDT service is considered medically necessary or a medical necessity when it is necessary to correct or ameliorate defects and physical and mental illnesses and conditions that are discovered by screening services. A service need not cure a condition in order to be covered under EPSDT. Services that maintain or improve the child's current health condition are also covered under EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. The common definition of "ameliorate" is to "make more tolerable". Additional services must be provided if determined to be medically necessary for an individual child.
Member	A beneficiary enrolled in a CHPIV program.
Provider	Individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Subcontractor	An individual or entity that has a subcontract with the MCP that relates directly or indirectly to the performance of the MCP's obligations under the contract with DHCS. A network provider is not a subcontractor by virtue of the network provider agreement, as per 42 CFR § 438.2.

	Quality Improvement Health Equity Committee (QIHEC)	QM-002
	Department	Health Services
	Functional Area	Quality Management
	Impacted Delegate	☒ Subcontractor ☐ NA

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

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

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
08/01/2023	Policy creation

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). Associated committees and subcommittees may also participate in these 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.

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.
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:
    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).

2. Institute actions to address performance deficiencies, including policy recommendations.
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 managed care plan can operate as a Fully Delegated Subcontractor.

TERM	DEFINITION
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.