COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

AGENDA

Local Health Authority Commission

November 18th, 2024

5:30 PM

512 W. Aten Rd., Imperial, CA 92251

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

Committee Members	Representing	Present
Dr. Theodore Affue	LHA 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	
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*

A. Roll Call *Donna Ponce, Commission Clerk*

B. Approval of Agenda

1. Items to be pulled or added from the Information/Action/Closed Session Calendar
2. Approval of the order of the agenda

2. PUBLIC COMMENT *Lee Hindman, Chair*

Public Comment is limited to items NOT listed on the agenda. This is an opportunity for members of the public to address the Commission on any matter within the Commission's jurisdiction. Any action taken as a result of public comment shall be limited to the direction of 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 Chairperson. Individuals will be given three (3) minutes to address the board.

3. CONSENT AGENDA

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

A. Approval of Minutes from 10/14/2024

B. Accept the monthly financial reports as reviewed and accepted by the Finance Committee.

1. Enrollment Report
2. Statement of Revenues, Expenses, and Changes in Net Position
3. Statement of Net Position (Assets)
4. Statement of Net Position (Liabilities & Net Position)
5. Summarized TNE Calculation
6. Cash Transaction Report

4. ACTION

A. Motion to Approve Updated GA-001 and UM-007 Policies (*Chelsea Hardy, SDC)*

5. INFORMATION

A. Health Services Report *(Dr. Gordon Arakawa, CMO)*

B. Financial Services Report *(David Wilson, CFO)*

C. Compliance Report *(Elysse Tarabola, CCO & Chelsea M. Hardy, Senior Director of Compliance)*

D. Community Relations Report *(Michelle S. Ortiz, Head of Member Experience Development and Julia Hutchins, Chief Operating Officer*

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

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

6. CLOSED SESSION

Pursuant to Welfare and Institutions Code § 14087.38 (n) Report Involving Trade Secret new product discussion (estimated date of disclosure, 01/2025)

A. Update/Action on Contract with Health Net Community Solutions, Inc.

B. Budget Update

7. RECONVENE OPEN SESSION

A. Report on actions taken in closed session.

8. COMMISSIONER REMARKS

9. ADJOURNMENT

Next meeting: December 9th, 2024

Location: Maranatha Steakhouse

COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

MINUTES

Local Health Authority Commission
October 14th, 2024
5:30 PM
512 W. Aten Rd., Imperial, CA 92251

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	A
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	✓
Miguel Figueroa	LHA Commissioner – County of Imperial – Chief Executive Officer	A
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	A
Lee Hindman	LHA Chairperson – Joint Chambers of Commerce representing the public	✓

1. CALL TO ORDER *Lee Hindman, Chair*

Meeting called to order at 5:32 p.m.

A. Roll Call *Donna Ponce, Commission Clerk*

Roll call taken and quorum confirmed. Attendance is as shown.

B. Approval of Agenda

1. Items to be pulled or added from the Information/Action/Closed Session Calendar
2. Approval of the order of the agenda

(Sampat/Kelley) To approve the agenda. Motion carried.

2. PUBLIC COMMENT *Lee Hindman, Chair*

Public Comment is limited to items NOT listed on the agenda. This is an opportunity for members of the public to address the Commission on any matter within the Commission's jurisdiction. Any action taken as a result of public comment shall be limited to the direction of 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 Chairperson. Individuals will be given three (3) minutes to address the board.

None.

3. CONSENT AGENDA

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

A. Approval of Minutes from 9/9/2024

B. Accept the monthly financial reports as reviewed and accepted by the Finance Committee.

1. Enrollment Report
2. Statement of Revenues, Expenses, and Changes in Net Position
3. Statement of Net Position (Assets)
4. Statement of Net Position (Liabilities & Net Position)
5. Summarized TNE Calculation
6. Cash Transaction Report

C. Accept the updated and new Policy & Procedures, as recommended by the Regulatory Compliance Oversight Committee.

D. Motion to approve update/edit to the At-Risk Compensation Policy, as recommended by the Executive Committee

E. Motion to approve a resolution to support California Proposition 35 (MCO Tax), as recommended by the Executive Committee

4. ACTION

A. Motion to approve the Wakely Statement of Work for CY 26 Medicare Bid preparation, not to exceed $265,000.
(Ramirez/Wu) To approve the Wakely Statement of Work for CY 26 Medicare Bid preparation, not to exceed $265,000. Motion carried.

B. Motion to approve the SOW for licensing and implementation of NetSuite ERP (phase 1), not to exceed $106,000. *(David Wilson, CFO)*
(Velez/Ramirez) To approve the SOW for licensing and implementation of NetSuite ERP (phase 1), not to exceed $106,000. Motion carried.

5. INFORMATION

A. Health Services Report *(Dr. Gordon Arakawa, CMO)*
CMO, Dr. Gordan Arakawa, presented updates on DHCS Quality Sanctions and Executive Director of Healthcare Services, Jeanette Crenshaw presented updates on NCQA.

B. Financial Services Report *(David Wilson, CFO)*
CFO, David Wilson went over financial reports.

C. Compliance Report *(Chelsea M. Hardy, Senior Director of Compliance)*
SDC, Chelsea Hardy presented updated and new Policy & Procedures and Delegation Oversight and Monitoring Program.

D. Human Resources and Community Relations Report *(Michelle S. Ortiz-Trujillo, (SDHRCR)*
SDHRCR, Michelle Ortiz updated the commission on the new payroll system, Rippling, DEI training for staff and commissioners, Community Relations, and CAC feedback.

E. CEO Report (*Larry Lewis, CEO)*
CEO, Larry Lewis, informed the commission regarding a required percentage, up to 5%-7% of our net income, invested in our community. A budget that is a part of the 2025 budget will need to be developed.

Larry gave an update regarding leadership changes. Executive Director of D-SNP Strategic Development, Julia Hutchins, will have a title change of Chief Operating Officer. SDHRCR, Michelle Ortiz will be focusing on community engagement and member experience and will be working remotely. Human Resource functions will be through a fractional company with a contract of six months at 20 hours a week.

F. Other new or old business (*Lee Hindman, Chair)*
Chair Hindman reminded the commission that the LHA Commission meeting scheduled for November 11, 2024, coincides with the Veterans Day holiday. It is recommended that a poll be conducted among the commissioners to determine their availability for rescheduling to either November 12, 2024, or November 18, 2024.

6. CLOSED SESSION

Pursuant to Welfare and Institutions Code § 14087.38 (n) Report Involving Trade Secret new product discussion (estimated date of disclosure, 01/2025)

Chair Hindman announces the commission will enter closed session.

A. Update/Action on Contract with Health Net Community Solutions, Inc.

B. DSNP Progress Report

7. RECONVENE OPEN SESSION

A. Report on actions taken in closed session.

Chair Hindman announced the commission has reconvened into open session and reports no action has been taken.

8. COMMISSIONER REMARKS

None.

9. ADJOURNMENT

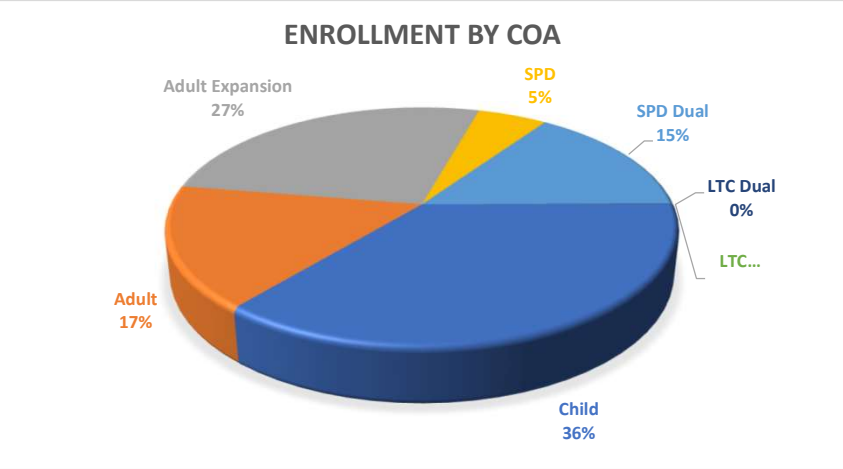
The meeting was adjourned at 8:19 p.m.

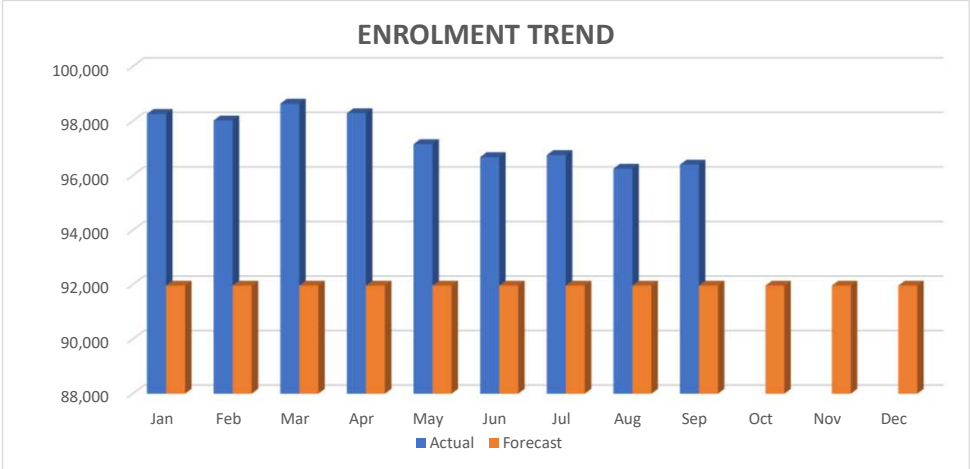
Next Meeting: November 11, 2024

Imperial County Local Health Authority
DBA Community Health Plan of Imperial Valley
Enrollment Report
For September 2024

	2024*													
Category of Aid (COA)	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**YTD Months**	**YTD Δ**
Child	34,676	34,687	35,020	37,747	35,024	34,820	34,754	34,461	34,586				**315,775**	**-0.3%**
Adult	17,191	17,152	17,133	14,133	16,014	15,872	15,855	15,764	15,841				**144,955**	**-7.9%**
Adult Expansion	26,741	26,461	26,559	26,341	25,975	25,717	25,798	25,590	25,435				**234,617**	**-4.9%**
SPD	5,039	4,985	5,070	5,059	5,095	5,105	5,177	5,158	5,291				**45,979**	**5.0%**
SPD Dual	14,520	14,644	14,767	14,903	14,940	15,063	15,061	15,167	15,141				**134,206**	**4.3%**
LTC	11	11	10	18	16	14	17	20	19				**136**	**72.7%**
LTC Dual	81	79	76	84	87	85	88	90	87				**757**	**7.4%**
Total Medicaid	98,259	98,019	98,635	98,285	97,151	96,676	96,750	96,250	96,400				**876,425**	**-1.9%**
Monthly Change		*-0.2%*	*0.6%*	*-0.4%*	*-1.2%*	*-0.5%*	*0.1%*	*-0.5%*	*0.2%*				*-0.2%*	

** Source: DHCS Remittance summary; includes retroactivity*





Medi-Cal Rates by COA (PMPM)†

	SIS		UIS	
COA	**Rate**	**%**	**Rate**	**%**
Child	$ 114.38	98%	$ 32.59	2%
Adult	$ 229.31	95%	$ 156.28	5%
Adult Expansion	$ 263.91	97%	$ 143.07	3%
SPD	$ 842.58	98%	$ 462.92	2%
SPD Dual	$ 206.61	100%	$ 59.89	0%
LTC	$ 7,969.68	78%	$ 1,145.35	22%
LTC Dual	$ 7,117.92	99%	$ 113.51	1%

† Does not include Maternity, AIHS and GEMT

September At Risk Revenue

COA	**Base Rate**	**ECM**	**GEMT**	**Maternity**	**Total**
Child	$ 3,781,669	$ 84,826	$ 15,634	$ -	$ 3,882,129
Adult	$ 3,342,738	$ 191,034	$ 19,552	$ 593,760	$ 4,147,085
Adult Expansion	$ 6,209,778	$ 424,445	$ 45,718	$ 112,333	$ 6,792,273
SPD	$ 4,221,986	$ 235,915	$ 31,946	$ -	$ 4,489,847
SPD Dual	$ 3,004,292	$ 123,076	$ 28,538	$ -	$ 3,155,905
LTC	$ 150,223	$ 520	$ 552	$ -	$ 151,294
LTC Dual	$ 616,714	$ 1,568	$ 274	$ -	$ 618,556
Total	$ 21,327,400	$ 1,061,384	$ 142,212	$ 706,094	$ 23,237,090

Imperial County Local Health Authority
DBA Community Health Plan of Imperial Valley
Statement of Revenues, Expenses, and Changes in Net Position
For September 2024

	August	September				September (YTD)			
				Variance - B/(W)					
	Actual	Actual	Forecast	vs. Forecast	vs. Prior Month	Actual	Budget	Variance - B/(W)	Current Month Explanations
REVENUE									
Premium	$ 23,210,332	$ 23,237,090	$ 22,249,362	**$ 987,728**	**$ 26,758**	$ 205,246,954	$ 200,244,255	**$ 5,002,699**	
Pass-Through	353,313	352,208	883,592	**(531,384)**	**(1,105)**	5,386,785	7,952,325	**(2,565,540)**	
HN Settlements	-	-	-	**-**	**-**	602,764	1,135,000	**(532,236)**	
Government Grants	-	-	-	**-**	**-**	134,859	-	**134,859**	
TOTAL REVENUE	**23,563,645**	**23,589,298**	**23,132,953**	**456,344**	**25,653**	**211,371,362**	**209,331,580**	**2,039,782**	Favorable due to member volume ($1.1M), offset by rate/mix (-$0.7M)
HEALTH CARE COSTS	**$ 22,867,335**	**$ 22,892,195**	**$ 22,465,472**	**$ (426,722)**	**$ (24,860)**	**$ 204,379,757**	**$ 202,189,252**	**$ (2,190,504)**	
Gross Margin	**696,310**	**697,103**	**667,481**	**29,622**	**793**	**6,991,605**	**7,142,328**	**(150,722)**	
ADMINISTRATIVE EXPENSE									
Salaries & Wages	$ 234,558	$ 192,808	$ 238,122	**$ 45,314**	**$ 41,750**	$ 2,145,744	$ 2,084,000	**$ (61,744)**	Salaries and Wages favorable due to recalss of travel
Benefits and Bonus	39,147	56,590	77,707	**21,117**	**(17,443)**	445,576	680,630	**235,053**	to Other Admin
Total Labor Costs	273,705	249,398	315,828	**66,431**	**24,307**	2,591,320	2,764,630	**173,310**	
Consulting, Legal, & Other Professional	$ 195,637	$ 133,982	$ 15,508	**$ (118,473)**	**$ 61,655**	$ 688,590	$ 99,575	**$ (589,015)**	Legal, consulting related to DSNP and finance transition
Insurance and Banking	3,934	3,934	6,380	**2,446**	**-**	32,522	57,422	**24,900**	
IT Hardware/Software	6,370	1,255	34,820	**33,565**	**5,115**	12,687	168,377	**155,690**	
Office Expense	25,625	95,830	14,606	**(81,224)**	**(70,204)**	407,206	131,454	**(275,752)**	Largely due to NCQA fees, LHPC fees, and Manifest MedEx
Other Admin	4,831	50,437	12,443	**(37,994)**	**(45,605)**	118,560	81,656	**(36,904)**	Reclass of travel expenses from Salaries & Wages
Total Administrative Expense	**510,102**	**534,835**	**399,586**	**(135,249)**	**(24,732)**	**3,850,885**	**3,303,113**	**(547,772)**	
Non-Operating Income									
Dividend, Interest & Investment Income	$ 119,586	$ 84,221	$ 100,347	**$ (16,125)**	**$ (35,364)**	$ 726,360	$ 789,626	**$ (63,266)**	
Rental Income	1,450	1,450	-	**1,450**	**-**	13,050	-	**13,050**	
Total Non-Operating Income	121,036	85,671	100,347	**(14,675)**	**(35,364)**	739,410	789,626	**(50,216)**	
Depreciation & Amortization									
Change in Net Position	**$ 307,243**	**$ 247,939**	**$ 368,241**	**$ (120,302)**	**$ (59,304)**	**$ 3,880,130**	**$ 4,628,840**	**$ (748,711)**	
Key Metrics									
Enrollment	96,250	96,400	91,964	**4,437**	**150**	876,425	827,672	**48,754**	
Revenue PMPM	$244.82	$244.70	$251.54	**($6.84)**	**($0.11)**	$241.17	$252.92	**($11.74)**	
MLR	97.04%	97.04%	97.1%	**7 bps**	**0 bps**	96.8%	96.6%	**(17) bps**	
Admin Ratio	2.2%	2.3%	1.7%	**(54) bps**	**(11) bps**	1.8%	1.6%	**(24) bps**	
Net Income PMPM	$3.19	$2.57	$4.00	**($1.43)**	**($0.62)**	$4.43	$5.59	**($1.17)**	
Net Income %	1.3%	1.0%	1.6%	**(54) bps**	**(25) bps**	1.8%	2.2%	**(37) bps**	

Imperial County Local Health Authority dba
Community Health Plan of Imperial Valley
Statement of Net Position
As of September 30, 2024

ASSETS

Current Assets	Aug 2024	Sep 2024	Change
Cash and Investments			
Chase - Checking	$ 200,000	$ 198,000	$ (2,000)
Chase - Money Market	3,040,694	2,779,241	(261,453)
JPMorgan Securities	11,765,894	12,254,545	488,651
First Foundation Bank	202,021	300,264	98,243
Receivables			
Accounts Receivable	2,773	2,773	-
Dividend Receivable	11,266	21,758	10,492
Interest Receivable	21,212	7,702	(13,510)
Premium Receivable	23,210,332	23,237,090	26,758
Pass-Through Receivable	353,313	352,208	(1,105)
Other Current Assets			
Prepaid Expenses	44,623	138,844	94,221
Total Current Assets	**38,852,129**	**39,292,426**	**440,297**
Noncurrent Assets			
Restricted Deposit			
First Foundation Bank - Restricted	300,000	300,000	-
Capital Assets			
Buildings - Net	2,991,696	2,983,148	(8,548)
Computers & Office Equipment - Net	8,404	8,236	(168)
Improvements - Net	47,625	47,217	(408)
Intangible Assets - Net	20,953	20,557	(395)
Operating ROU Asset (Copier) - Net	7,601	7,319	(281)
Total Noncurrent Assets	**3,376,278**	**3,366,478**	**(9,800)**
Total Assets	**$ 42,228,407**	**$ 42,658,903**	**$ 430,496**

Imperial County Local Health Authority dba
Community Health Plan of Imperial Valley
Statement of Net Position
As of September 30, 2024

	Aug 2024	Sep 2024	Change
LIABILITIES			
CURRENT LIABILITIES			
Payables			
Accounts Payable	$ 35,256	$ 144,398	$ 109,142
Capitation Payable	22,514,022	22,539,132	25,110
Pass-Through Payable	353,313	352,208	(1,105)
Credit Card Payable	10,170	19,160	8,990
Other Current Liabilities			
Short Term Lease Liability - Copier	3,329	3,344	15
Bonus Accrual	95,356	107,275	11,919
Salaries Accrual	106,627	129,146	22,520
Vacation Accrual	98,930	105,152	6,222
Total Current Liabilities	**23,217,001**	**23,399,815**	**182,813**
NON-CURRENT LIABILITIES			
Long Term Lease Liability - Copier	4,426	4,140	(286)
Total Noncurrent Liabilities	**4,426**	**4,140**	(286)
Total Liabilities	**23,221,428**	**23,403,955**	**182,527**
NET POSITION			
Net investment in Capital Assets	3,376,278	3,366,478	(9,800)
Restricted by Legislative Authority	300,000	300,000	-
Unrestricted	11,698,540	11,708,341	9,800
Net Revenue	3,632,161	3,880,130	247,969
Total Net Position	**19,006,979**	**19,254,948**	**247,969**
Total Liabilities and Net Position	**$ 42,228,407**	**$ 42,658,903**	**$ 430,496**

Imperial County Local Health Authority dba
Community Health Plan of Imperial Valley
Summarized Tangible Net Equity Calculation
As of September 30, 2024

	Net Equity	$ 19,254,948
	Add: Subordinated Debt and Accrued Subordinated Interest	$ 0
	Less: Report 1, Column B, Line 27 including: Unsecured Receivables from officers, directors, and affiliates; Intangibles	$ 0
	Tangible Net Equity (TNE)	$ 19,254,948
	Required Tangible Net Equity *	$ 4,330,716
	TNE Excess (Deficiency)	$ 14,924,232

	Full Service Plan		
			1
A.	Minimum TNE Requirement	$	1,000,000
B.	REVENUES:		
	2% of the first $150 million of annualized premium revenues (lines 1, 2, 4, 5, 7, 9 from Income Statement)	$	3,000,000
	Plus		
	1% of annualized premium revenues in excess of $150 million	$	1,330,716
	Total	$	4,330,716

* Calculated Required Tangible Net Equity	
23,589,298	- Current Month Premium
x 12	
283,071,576	- Annualized
150,000,000	
x 2%	
3,000,000	
133,071,576	
x 1%	
1,330,716	
4,330,716	- Required TNE

Community Health Plan of Imperial Valley
September 2024 Cash Transactions

Date	Account	Vendor	Memo/Description	Amount
Chase Checking				
09/03/2024	Chase Checking	Jones Brothers Glass Co. Inc.	Chase Bill Pay - Invoice 34777	$ -3,837.25
09/03/2024	Chase Checking	Conveyor Group	Chase Bill Pay - Invoice 11232	-1,830.00
09/03/2024	Chase Checking	Imperial Irrigation District	Chase Bill Pay - Service Period: 07/25/24 - 08/22/24	-1,809.87
09/03/2024	Chase Checking	Jeffrey Scott Agency	Chase Bill Pay - Invoice 08/10/24	-1,760.89
09/03/2024	Chase Checking	State Compensation Insurance Fund	Chase Bill Pay - Invoices 1002048094 / 1002048095	-1,630.16
09/03/2024	Chase Checking	American Trust Retirement Services	Chase Bill Pay - Invoice 446798	-1,483.58
09/03/2024	Chase Checking	CLEANBC, LLC	Chase Bill Pay - Invoice 011	-700.00
09/03/2024	Chase Checking	VDC Arellano 3 LLC	Chase Bill Pay - Invoice VDC-1023	-417.00
09/03/2024	Chase Checking	Brawley Rotary Club	Chase Bill Pay - Jul & Aug 2024 Statements	-415.00
09/03/2024	Chase Checking	VDC Arellano 3 LLC	Chase Bill Pay - Invoice 99527	-380.00
09/03/2024	Chase Checking	Rick's Roadrunner Lock & Safe	Chase Bill Pay - Invoice 22876	-347.01
09/03/2024	Chase Checking	Great America Financial Services	Chase Bill Pay - Invoice 37257013	-306.01
09/03/2024	Chase Checking	Quench USA	Chase Bill Pay - Invoices INV07607365 / INV07737380	-258.60
09/03/2024	Chase Checking	Imperial Desert Landscape	Chase Bill Pay - Invoice 24-195	-250.00
09/03/2024	Chase Checking	I.V. Termite & Pest Control	Chase Bill Pay - Invoice 340785	-120.00
09/03/2024	Chase Checking	KY Cakes	Chase Bill Pay - Invoices 0006 & 0007	-120.00
09/03/2024	Chase Checking	ADT Security Services	Chase Bill Pay - Service Period: 08/21/24 - 09/28/24	-66.31
09/03/2024	Chase Checking	AccuSourceHR	Chase Bill Pay - Invoice 56525	-57.09
09/03/2024	Chase Checking	Great America Financial Services	Chase Bill Pay - Invoice WA2782408	-45.00
09/06/2024	Chase Checking	JPMorgan Chase	Dividend Income - Aug 2024	11,266.21
09/06/2024	Chase Checking	JPMorgan Chase	Service Charges - Aug 2024	-2,008.14
09/06/2024	Chase Checking	Department of Managed Health Care	Chase Check# 6673	-181.69
09/06/2024	Chase Checking	Shalom Events Professionals	Chase Check# 6674 - Tables and Chair Rental	-129.00
09/10/2024	Chase Checking	Liebert, Cassidy Whitmore	Chase Bill Pay - Invoices 267838 / 271212 / 275827	-11,024.00
09/10/2024	Chase Checking	Epstein, Becker and Green PC	Chase Bill Pay - Invoice 1170618	-6,049.00
09/10/2024	Chase Checking	Dancing For A Dream	Chase Bill Pay - Dancing For A Dream Sponsorship	-2,000.00
09/10/2024	Chase Checking	Law Offices of William Smerdon	Chase Bill Pay - Invoice 2612	-907.50
09/10/2024	Chase Checking	PMH Foundation	Chase Check# 6676 - PMH Foundation Sponsorship	-800.00
09/10/2024	Chase Checking	Junior's Café	Chase Bill Pay - Invoice 13-16892	-452.57
09/10/2024	Chase Checking	AM Copiers	Chase Bill Pay - Invoice INV5624	-407.28
09/10/2024	Chase Checking	Rotary Club of El Centro	Chase Bill Pay - Invoices 9139 / 9189 / 9235	-252.00
09/10/2024	Chase Checking	Stericycle, Inc.	Chase Bill Pay - Invoice 8007721358	-225.08
09/10/2024	Chase Checking	City of Imperial	Chase Bill Pay - Service Period: 07/25/24 - 08/24/24	-169.46
09/13/2024	Chase Checking	Department of Health Care Services	09/12 Receipt - DHCS	1,191.58
09/13/2024	Chase Checking	Department of Health Care Services	09/12 Receipt - DHCS	23,737.43
09/13/2024	Chase Checking	Department of Health Care Services	09/12 Receipt - DHCS	59,125.05
09/13/2024	Chase Checking	Department of Health Care Services	09/12 Receipt - DHCS	428,681.80
09/13/2024	Chase Checking	Department of Health Care Services	09/12 Receipt - DHCS	23,050,908.80
09/13/2024	Chase Checking	Mid Atlantic Trust Company	09/09 - ACH Payment	-7,468.45
09/20/2024	Chase Checking	Local Health Plans of California	09/24 - Online Payment	-106,936.79
09/20/2024	Chase Checking	Health Management Associates, Inc.	Chase Bill Pay - Invoice 206100-0000018	-36,731.25
09/20/2024	Chase Checking	Smith-Kandal Insurance Agency	Chase Bill Pay - Invoice 5399	-6,484.61
09/20/2024	Chase Checking	AM Copiers	Chase Bill Pay - Invoice IN5839	-527.96
09/20/2024	Chase Checking	Great America Financial Services	Chase Bill Pay - Invoice 37466187	-373.79
09/20/2024	Chase Checking	Shalom Events Professionals	Chase Bill Pay - Rental Dates 09/25/24 and 10/24/24	-271.00
09/20/2024	Chase Checking	Republic Services	Chase Bill Pay - Invoice 0467-001721916	-141.17
09/20/2024	Chase Checking	ADT Security Services	Chase Bill Pay - Service Period: 09/21/24 - 10/28/24	-139.84
09/20/2024	Chase Checking	Quench USA	Chase Bill Pay - Invoice INV07849462	-129.30
09/30/2024	Chase Checking	Health Net	Rental Income - Sep 2024	1,450.00
09/30/2024	Chase Checking	Health Net	09/27/24 - Health Net Payment	-22,867,344.70
09/30/2024	Chase Checking	Mid Atlantic Trust Company	09/24 - ACH Payment	-15,942.96
09/30/2024	Chase Checking	Smith-Kandal Insurance Agency	09/26 - Online Payment	-14,161.20
09/30/2024	Chase Checking	Rippling, Inc.	Direct Deposit Test #1	0.06
09/30/2024	Chase Checking	Rippling, Inc.	Direct Deposit Test #2	0.06
First Foundation Bank				
09/30/2024	FFB Payroll	First Foundation Bank	09/03/24 - Wire Fee	-10.00
09/30/2024	FFB Payroll	First Foundation Bank	09/04/24 - Credit Card Payment	-10,269.18
09/30/2024	FFB Payroll	Paychex, Inc.	09/05/24 - Paychex Payroll	-69,502.80
09/30/2024	FFB Payroll	Paychex, Inc.	09/05/24 - Paychex Taxes	-37,123.92
09/30/2024	FFB Payroll	Paychex, Inc.	09/06/24 - Paychex EIB Invoice	-49.48
09/30/2024	FFB Payroll	Paychex, Inc.	09/13/24 - Paychex HRS PMT	-60.00
09/30/2024	FFB Payroll	First Foundation Bank	09/13/24 - Wire Fee	-10.00
09/30/2024	FFB Payroll	Paychex, Inc.	09/19/24 - Paychex Payroll	-76,545.63
09/30/2024	FFB Payroll	Paychex, Inc.	09/19/24 - Paychex Taxes	-38,056.36
09/30/2024	FFB Payroll	Paychex, Inc.	09/20/24 - Paychex EIB Invoice	-49.48
09/30/2024	FFB Payroll	Paychex, Inc.	09/20/24 - Paychex OAB Invoice	-49.50
09/30/2024	FFB Payroll	First Foundation Bank	09/30/24 - Wire Fee	-10.00
09/30/2024	FFB Payroll	Pablo Velez	Commission Member Check# 10301 - Pablo Velez	-100.00
J.P. Morgan Securities				
09/30/2024	J.P. Morgan Securities	J.P. Morgan Securities	Investment Income - Sep 2024	$ 76,008.89

IMPERIAL COUNTY
Local Health Authority Commission

Fact Sheet: Seeking Commission Review and Approval for Policies Required for NCQA Accreditation

November 2024

Agenda Item #

Recommendations

Motion to approve updated GA-001 and UM-007 policies.

Background

The current policy approval process involves the review of policies and procedures by the internal CHPIV Compliance & Policy Committee (CPC). Following CPC review, policies are brought before the Regulatory Compliance Oversight Committee (RCOC) of the Commission for approval. All policies required for NCQA approval need to be approved and final by December 1, 2024. While most policies required for NCQA were reviewed and approved by the RCOC in November, two policies were further revised after the November RCOC meeting requiring final approval at the LHA Commission meeting in order to meet NCQA timelines.

Policies for Approval

We are requesting approval of the following udpated policies:

- GA-001
  - Policy updated to align with the NCQA Accreditation standards
- UM-007
  - Policy updated to align with the NCQA Accreditation standards

Key Points

- Requesting approval of updated GA-001 & UM-007
- These updated policies are required to be reviewed and approved by 12/1/2024 in order to meet NCQA Accreditation timeframes.

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

DATES			
Policy Effective Date	6/12/2023	**Reviewed/Revised Date**	11/12/2024
Next Annual Review Due	11/13/2025	**Regulator Approval**	12/15/2023

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

ATTACHMENTS

None

AUTHORITIES/REFERENCES

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

HISTORY

Revision Date	Description of Revision

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

I. OVERVIEW

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

II. POLICY

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

1. CHPIV ensures MEMBERS are allowed to file a GRIEVANCE at any time to express dissatisfaction about any matter other than a notice of ABD:
    a. GRIEVANCES may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the MEMBER's right to dispute an extension of time proposed by the MCP to make an authorization decision.
    b. A COMPLAINT is the same as a GRIEVANCE. If the MCP is unable to distinguish between a GRIEVANCE and an INQUIRY, it must be considered a GRIEVANCE.
    c. An INQUIRY is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other MCP processes.
2. CHPIV ensures MEMBERS are allowed to file a GRIEVANCE to contest the unilateral decision to extend the timeframe for RESOLUTION of an APPEAL or expedited APPEAL.
3. CHPIV ensures every GRIEVANCE involving clinical issues is reported to qualified medical professionals with appropriate clinical expertise and is escalated to the MEDICAL DIRECTOR as needed, to ensure the GRIEVANCE is properly handled.
4. CHPIV ensures GRIEVANCES are monitored to identify issues that require Corrective Action. GRIEVANCES related to medical Quality of Care issues must be referred to qualified medical professionals with appropriate clinical expertise and is escalated to the MEDICAL DIRECTOR as needed.
5. CHPIV ensures written acknowledgement is provided within five (5) calendar days of receipt of the GRIEVANCE. The acknowledgement letter must advise the MEMBER that the GRIEVANCE has been received, provide the date of the receipt, and provide the name, telephone number, and address of the representative who the MEMBER or their Provider or AUTHORIZED REPRESENTATIVE may contact about the GRIEVANCE.
6. The GRIEVANCES Process shall address the receipt, handling, and disposition of MEMBER GRIEVANCES and APPEALS, in accordance with the Department of Health

Care Services (DHCS) Contract and applicable state and federal statutes, regulations and DHCS All Plan Letters.

7. CHPIV will ensure The Plan's GRIEVANCE system is established in writing (approved by the Department of Health Care Services (DHCS) Title 22 CCR Section 53858(a)(1)) and provides for procedures that receive, review and resolve GRIEVANCES as quickly as MEMBER'S health condition requires, not to exceed 30 calendar days of receipt by the plan, or any provider or entity with delegated authority to administer and resolve the plan's GRIEVANCE system [Title 28, CCR1300.68(a), §438.408(b)(1), RR3.A.4]. The Plan's internal GRIEVANCE process includes only one level of review [Title 28, CCR 1300.68(a) (4)(A)].
8. The GRIEVANCE and APPEAL process ensures that MEMBERS s are given a reasonable opportunity to present evidence and testimony, and make legal or factual arguments, in person, by telephone or in writing, in support of their GRIEVANCE or APPEAL. The Plan will inform MEMBERS that they must submit additional evidence for Contractor to consider within the 30-calendar day review timeframe for an APPEAL and within 72 hours timeframe for resolving an expedited APPEAL. In the case of a GRIEVANCE subject to expedited review, MEMBER Services informs the MEMBER of the limited time available to present evidence. Specific to APPEALS, the process provides the MEMBER and his or her representative opportunity, before and during APPEALS process, to examine the MEMBER'S case file, including medical records, and any other documents and records considered during the APPEALS process or within 30 calendar days for an APPEAL and within 72 hours for an expedited APPEAL. [§ 438.406(b)(3), DHCS Contract Exhibit A, Attachment 14, 2H, DHCS Contract Exhibit A, Attachment 14, 4C].
9. Medi-Cal MEMBERS are notified within 7 days of enrollment and annually thereafter about The Plan's GRIEVANCE process, including information on the plan's procedures for filing and resolving an issue, and the toll-free telephone number and address for obtaining forms, requesting information or presenting an issue [Title 28, CCR 1300.68(b)(2), 1300.68(b)(4), Title 22 CCR Section 53858(a)(2)(A)]. Notices additionally include:
    a. A statement that GRIEVANCE forms are available in the office of each primary care provider, or in each MEMBER services department of the plan [Title 22 CCR Section 53858(a)(2)(B)].
    b. A statement that GRIEVANCES may be filed in writing (by mail, facsimile, email, or The Plan's website) or verbally (by telephone) or in person directly at The Plan's local office or with the plan in which the MEMBER is enrolled or at any office or facility of the contracted plan's providers [Title 22 CCR Section 53858(a)(2)(C)].
    c. An explanation of the state's Medi-Cal Managed Care Ombudsman program and the program's voice number [Title 22 CCR Section 53858(a)(2)(F)].
10. CHPIV provides forms for GRIEVANCESs to be given to subscribers and enrollees who wish to register written GRIEVANCES. The forms are approved by the regulator director in advance as to formal [1368(a)(3)] and are available at primary care providers' offices [Title 22 CCR Section 53858(f)].

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

d. Who has authority to require corrective action.

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

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

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

22. CHPIV will ensure all appeals and grievances are documented within The Plan's on-line system and contains date received, member's name, plan representative receiving or recording the appeal, case substance and description, actions taken including follow-up activities, resolution, name of the person resolving the case, date member was notified of the resolution, case correspondence, medical records, Member Handbook, research, issue determination (disposition), complaint history and other relevant information upon which the plan relied in reaching its decision

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

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

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

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

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

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

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

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

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

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

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

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

III. PROCEDURE

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

IV. DEFINITIONS

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

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

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

A&G Clinical Specialist II	A Registered Nurse who provides clinical expertise in Clinical Grievance resolution and coordinates case as appropriate with the Medical/Dental Director, PPG/Provider and Third-Party Reviewer Organization.
Case Coordinator	A non-clinician knowledgeable associate involved in grievance resolution.
Complaint	is the same as "grievance."
Complainant	is the same as "grievant," and means the person who filed the grievance including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee.
Medical Director	A physician reviewer who is involved in grievance review and resolution.
Resolved	Means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the plan's grievance system, including entities with delegated authority.

	Collection of Ethnicity and Diversity Data	UM-007
Department	Health Services	
Functional Area	Utilization Management	
Impacted Delegate	☒ Subcontractor ☐ NA	

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

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

ATTACHMENTS
• Attachment A – Desktop Procedure

AUTHORITIES/REFERENCES
• KB #120898, Medi-Cal Addressing Different Call Scenarios • Centralpoint articles – Customer Contact Center (CCC) Interpreter and Translation Requests, Language Preference Updates, Changes Made to the OMNI 2.0 Member Preferences Intent • Training & Development sharepoint - Medi-Cal – *Medi-Cal Address Different Call Scenarios*

HISTORY	
Revision Date	**Description of Revision**

I. OVERVIEW

A. Community Health Plan of Imperial Valley (CHPIV) will ensure that its subcontractor Healthnet will capture MEMBERS gender identity along with their spoken and written language preferences acknowledge any cultural or ethnic needs of the MEMBER in compliance with applicable laws, contract requirements, regulatory agency requirements, and oversight agency guidelines.

II. POLICY

A. CHPIV will ensure that the Customer Service Representatives will note in the systems of record when it is necessary to update a MEMBER'S gender identity, sexual orientation, spoken/written language preference or their ethnicity/race and diversity needs. This is done to ensure all applicable Departments are notified and systems are updated allowing MEMBERS to receive information in the language or wording that meets their preference. MEMBERS must be able to fully understand any communication received from The Plan.

B. To provide The Plan associates with guidelines on how to obtain and consolidate MEMBER demographic data (race/ethnicity) from various sources of data to support internal teams, especially HEDIS and Health Equity, in their analyses for health disparities.

C. Collection Process

1. Race/ETHNICITY data sources include data collected directly from MEMBERS and obtained through indirect methods. Raw race/ETHNICITY values are rolled-up to HEDIS/OMB race/ETHNICITY categories per NCQA document "Race and ETHNICITYStratification for Auditors: Resource Guide," 2022. Details of the roll-up logic are available in the resource "Document for REL Data Sources."
2. ~~2.~~ OMB Standards
    a. Ethnic Categories
        i. Hispanic or Latino
    b. Racial Categories
        i. American Indian or Alaska Native
        ii. Asian
        iii. Black or African American
        iv. Native Hawaiian or Other Pacific Islander
        v. White
3. Sexual Orientation and Gender Identity (SOGI) direct data collection began in 2024 and stored in Omni. Collection processes are still being determined throughout the enterprise. Fields are finalized and follow industry standards. This Policy will be updated to reflect collection processes once finalized.
    a. Sexual Orientation Categories – Personal Identity Demographics
        i. Lesbian/gay/homosexual
        ii. Straight/heterosexual
        iii. Bisexual
        iv. Something else (e.g., Queer, Pansexual, Asexual)
        v. Don't Know
        vi. Decline to State
    b. Gender Identity Categories – Personal Identity Demographics
        i. Female
        ii. Male
        iii. Transgender Female
        iv. Transgender Male
        v. Neither exclusively female/male nonbinary
        vi. Declined to State

vii. Other

c. Sex Assigned at Birth Categories – Personal Identity Demographics
   i. Female
   ii. Male
   iii. Intersex
   iv. Declined to State

d. Pronoun
   i. He, him, his, himself
   ii. She, her, hers, herself
   iii. They, them, their, theirs, themselves
   iv. Something else, please specify

D. Direct Sources
   1. Oracle Data Warehouse (ODW) table: BR607 MEMBER EXPANDED
      a. Includes two data fields: "race" and "ethnicity."
      b. Sources for these two data fields are mainly Medicaid 834 enrollment file, or MEMBER self-reported data from either Customer Service Portal OMNI or MEMBER portal.
      c. If the source is from Medicaid 834 enrollment file, then only one value, either race or ethnicity, is available. Raw values of "race and "ethnicity" are rolled-up to HEDIS/OMB race categories and ETHNICITY categories. Please refer to sheet "odw_rawrace_recode" and "odw_rawethn_recode" in the Document for REL Data Sources for detailed roll-up logic.
      d. If the rolled-up values are "Unknown," "AskedButNoAnswer" for either race or ethnicity, then race/ETHNICITY data from California Immunization Registry (CAIR) is used if the rolled-up values are one of the valid categories other than "Unknown." Please see sheet "CAIR_RE_Recode" for roll-up logic. Race/ETHNICITY data from CAIR are MEMBER reported data and collected by providers to CAIR.

E. Indirect Sources for Race and Ethnicity:
   1. Indirect sources for ethnicity:
      a. If a MEMBER'S preferred written language or written language is "Spanish" then the imputed ETHNICITY value is "Hispanic or Latino." This method is validated by checking: among MEMBERS who report both ETHNICITY values (Hispanic or Latino") and preferred spoken/written language: if the preferred spoken/written language is "Spanish" then more than 98.6% of them report "Hispanic or Latino."
   2. Indirect sources for race:
      a. Imputed race category is "Asian" if a MEMBER'S preferred written language or written language is one of the following: Cambodian, Khmer, Cantonese, Chinese, Hindi, Hmong (Blue/Green), Hmong (White), Liacano (Iloko), Japanese.
      b. Imputed race category is "White" if a MEMBER'S preferred written language or written language is one of the following: Armenian, Russian. This method is validated among MEMBERS who report both race values

and language: 97.6% of the MEMBERS whose languages are listed above report "White."

III. PROCEDURE

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

IV. DEFINITIONS

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

TERM	DEFINITION
Ethnicity	Cultural ties, background, nationality, origin
Member	Active Enrollee
OMNI	Pega based application for the Customer Contact Center

Health Services Report

1. Community Health Improvement Project Update
2. NCQA Update
3. Q3 QIHEC Summary

Q3 CHPIV Quality Improvement Health Equity Committee Summary

Q3 CHPIV QIHEC Agenda

Topics

- Call Center Metrics
- Utilization Management
- Appeals & Grievances
- Healthcare Effectiveness Data & Information Set (HEDIS)
- Care Management KPI Report
- Enhanced Care Management/Community Supports
- Quality Improvement Projects
- Peer Review Credentialing

Call Center Metrics

Call Center Metrics - Members

KPI	Target	April 2024	May 2024	June 2024	Q2	Q1
Member Services						
Calls Offered		3,989	3,595	2,785	10,369	21,197
Calls Handled		3,968	3,555	2,765	10,288	20,473
% Calls Abandoned	<5%	0.53%	1.11%	0.72%	0.79%	4.46%
% SVL (all abn calls)	>80% w/in 30 seconds	98.17%	97.82%	98.41%	98.13%	87.49%
Average Speed Answer	<= 30	0:00:05	0:00:04	0:00:05	0:00:05	0:00:25

Call Center Metrics - Members

Member Call Volume for Q2-2024: CHPIV - 10,369

Top member call types:

- Benefits & Eligibility
- PCP update
- Update Member Demographics
- PCP/PPG search

Call Center Metrics - Providers

KPI	Target	April 2024	May 2024	June 2024	Q2	Q1
Provider Services						
Calls Offered		1,536	1,539	1,413	4,488	5,301
Calls Handled		1,521	1,532	1,394	4,447	5,233
% Calls Abandoned	<5%	0.98%	0.45%	1.34%	0.92%	1.28%
% SVL (all abn calls)	>60% w/in 45 seconds	99.15%	98.89%	96.59%	98.21%	89.27%
Average Speed Answer	<= 45	0:00:06	0:00:07	0:00:13	0:00:09	0:00:14

Call Center Metrics - Providers

Provider Call volume for Q2-2024: CHPIV - 4,488

Top provider call types:

- Eligibility, Claim status
- Claim adjustments
- PCP transfer
- Authorization inquiries.

Utilization Management Metrics

Utilization Management Key Metrics

	2024-Q1	2024-Q2
	Combined	Combined
Admissions per Thousand	43.9	36.8
Bed Days per Thousand	180.0	153.4
Average Length of Stay	4.1	4.2
Percent 30-Day Readmission	9.2%	6.5%
ER per Thousand	466.1	443.0
Outpatient Surgery per Thousand	142.7	143.0

Utilization Management Key Metrics

UM CHPIV Medi-Cal Activities

UM Activities	Jan 2024	Feb 2024	Mar 2024	Q1	Apr 2024	May 2024	Jun 2024	Q2
Approvals	555	905	2,348	3,808	2,298	2,930	2,262	7,490
Denials	34	36	45	115	40	45	21	106
Deferrals	19	14	15	48	18	18	19	55
Modifications (Partially Approved)	45	27	26	98	33	36	49	118

2024 Q1 to Q2 Trends

Approvals increased by 49%, Denials decreased by 8%

Appeals decreased by 48%

Overall casework increased by 48%

Appeals & Grievances

Appeals & Grievances

Appeals and Grievances – Rolling Year Totals

2024 Appeals	Q1	Q2	YTD
CHPIV	7	15	22

2024 Grievances	Q1	Q2	YTD
CHPIV	96	145	241

Appeals & Grievances

Q2 – Top 5 QOC Grievances

Description	Volume	PTMPY
Quality of Care - PCP - Inadequate Care	3	0.09
Quality of Care - PCP – Delay in Referral by PCP	2	0.06
Quality of Care – PCP- Treatment Delay	1	0.03
Quality of Care - PCP – Specialist-Delay in Referral by Specialist	1	0.03
Quality of Care- PCP-Cultural-Cultural Competency-Perceived Discrimination	1	0.03

1. 9 QOC Grievances filed in Q2
2. All cases referred to Health Net Clinical Department for assignment of severity level
    1. 5 cases – level 0
    2. 2 cases – level 1
    3. 2 cases – level 2
3. All cases reviewed by Dr. Arakawa

Appeals & Grievances

PQIs

- For Q1 & Q2, there were 0 Cases or Investigations

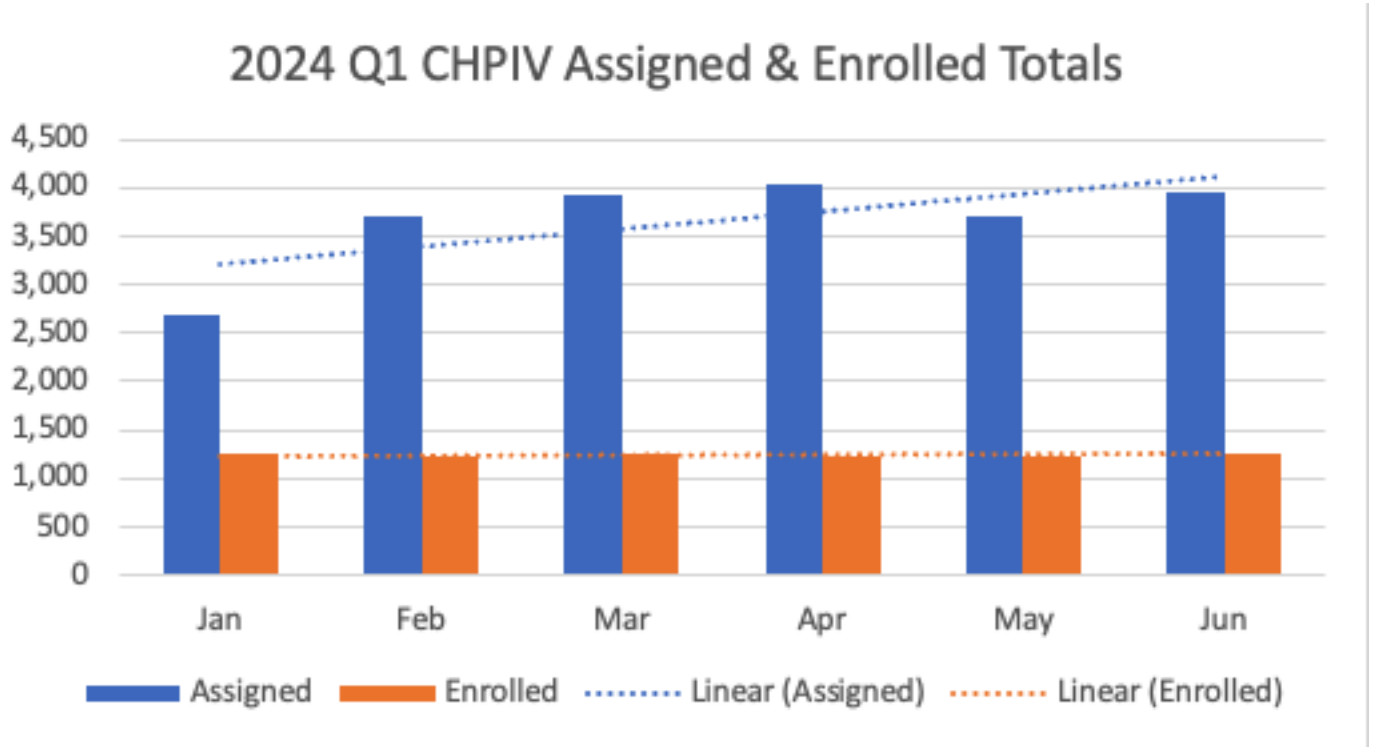
HEDIS Measures RY2025

MEASURE_ID	Goal Rate	DEN YTD	Rate YTD	Rate SMLY	Rate Change YOY	Rate Status YTD	Gaps to Reach Goal YTD	Gaps Per Month YTD	Pacing Per Month YTD	Pacing On Track
Asthma Med Ratio	65.61%	1309	69.90%	69.49%	0.41%	QC 50th	0	0	0.00%	On Track
Breast CA Screen	52.60%	3688	51.17%	50.64%	0.53%	QC 25th	53	18	0.49%	On Track
Control BP	61.31%	5057	24.88%	38.46%	-13.58%	QC <25th	1843	615	12.16%	Not On Track
Cervical CA Screen	57.11%	19820	47.17%	51.76%	-4.59%	QC <25th	1971	657	3.31%	Not On Track
Development Screen	34.70%	3263	46.61%	45.48%	1.13%	DHCS 50th	0	0	0.00%	On Track
Chlamydia Screen	56.04%	1745	44.18%	44.61%	-0.43%	QC <25th	207	69	3.95%	Not On Track
Child Immuno Status	30.90%	1287	24.40%	28.55%	-4.15%	QC <25th	84	28	2.18%	Not On Track
Colon CA Screen	49.88%	8778	31.85%	30.02%	1.83%	QI 25th	1583	528	6.02%	Not On Track
Follow-up Sub Abuse	36.34%	207	37.68%	21.60%	16.08%	QC 50th	0	0	0.00%	On Track
Follow-up BH	54.87%	76	31.58%	10.26%	21.32%	QC <25th	18	6	7.89%	On Track
Blood Glucose Control	37.96%	5108	70.56%	70.86%	0.30%	QC <25th	1666	556	10.88%	Not On Track
Adol Immuno Status	34.31%	1623	38.32%	35.52%	2.80%	QC 50th	0	0	0.00%	On Track
Lead Screen	62.79%	1298	73.50%	74.88%	-1.38%	QC 75th	0	0	0.00%	On Track
Post Partum Care	78.10%	773	67.27%	59.97%	7.30%	QC <25th	84	28	3.62%	Not On Track
Prenatal Care	84.23%	773	77.36%	74.12%	3.24%	QC <25th	54	18	2.33%	Not On Track
Topical Fluoride	19.30%	35187	0.94%	0.56%	0.38%	DHCS <25th	6461	2154	6.12%	Not On Track
Well Child Visit 0-15	58.38%	678	41.89%	37.56%	4.33%	QC <25th	112	38	5.60%	On Track
Well Child Visit 15-30	66.76%	1274	72.45%	66.28%	6.17%	QC 75th	0	0	0.00%	On Track
Well Child Visit 3+	48.07%	33439	22.20%	22.30%	-0.10%	QC <25th	8651	2884	8.62%	Not On Track

Enhanced Care Management (ECM) & Community Supports (CS)

Enhanced Care Management (ECM) & Community Supports (CS)

ECM Enrollment



Assigned & Membership By County	Jan 2024		Feb 2024		Mar 2024		Apr 2024		May 2024		Jun 2024	
County	Assigned	Membership	Assigned	Membership	Assigned	Membership	Assigned	Membership	Assigned	Membership	Assigned	Membership
Imperial	2,686	1,251	3,692	1,224	3,931	1,253	4,029	1,240	3,691	1,226	3,941	1,262

Quality Improvement Projects

Performance Improvement Projects - 2024

CHPIV Non-Clinical Behavioral Health Topic of Focus

Targeted Interventions that result in improvement in the rate of provider notifications for members with SUD/SMH diagnoses following or within 7 days of an emergency department visit in Imperial County.

CHPIV Clinical Topic of Focus

Measure: Increase WCV care gap closure rate
Participant: Dr. Vishwa Kapoor
Progress: On Schedule

Quality Measure Improvement Projects

HEDIS/MCAS Gap Closure Projects Q1 & Q2

Controlling Blood Pressure
HbA1c Control
Timeliness of Prenatal Visits
Post Partum Care
Topical Fluoride Varnish

Peer Review Credentialing

Peer Review Credentialing and Access Reports

Investigations

For Q1 & Q2

1. 0 Investigative Cases brought before Peer Review Committee
2. 0 incidences of Appointment Availability Resulting in Substantial Harm
3. 0 incidences of Adverse Injury Occurred During a Procedure by a Contracted Practitioner

Peer Review Credentialing and Access Reports

Credentialing/Recredentialing

For Q1 & Q2

1. 1 Provider received initial credentialing
2. 4 Network Providers were recredentialed
3. 6 Network Facilities were recredentialed

Questions & Comments

Updated and New Policies & Procedures

At the November 12, 2024, Regulatory Compliance and Oversight Committee of the Commission, 16 new and revised policies and procedures were approved. Most of these were existing policies updated to meet NCQA accreditation standards.

The table below lists the 16 policies that were approved along with the summary of changes.

P&P #	P&P Name	Department	Functional Area	Summary of Changes
CMP-005	Confidentiality and Member Privacy	Compliance	Compliance	Updated to align with NCQA requirements
CMP-012	Notice of Privacy Practices	Compliance	Compliance	Updated to align with NCQA requirements
CMP-013	Key Personnel Change	Compliance	Compliance	New policy
UM-004	Appropriate Professionals and Use of Board-Certified Physician Consultants in Utilization Management Decision Making	Health Services	Utilization Management	New policy; includes NCQA language
UM-005	Medical Necessity Criteria, Technology Assessment and Hierarchy of Resources	Health Services	Utilization Management	New policy; includes NCQA language
UM-006	Utilization Management System Controls	Health Services	Utilization Management	New policy; includes NCQA language
UM-007	Collection of Ethnicity & Diversity Data	Health Services	Utilization Management	New policy; includes NCQA language
GA-001	Grievances Process	Health Services	Grievances & Appeals	Updated to align with NCQA requirements
PNM-002	Provider Directory	Operations	Provider Network	Updated to add PAAS DMHC requirements
CR-001	Credentialing and Recredentialing	Operations	Provider Network	New policy; includes NCQA language
CR-002	Credentialing Appeals Process	Operations	Provider Network	New policy; includes NCQA language
MS-001	Language Assistance Program	Operations	Member Services	New policy; includes NCQA language

IT-001	Device Tracking and Management Using Microsoft Intune	Finance & Informatics	Information Technology	New policy
HR-006	Diversity, Equity & Inclusion	Human Resources	Human Resources	New policy; includes NCQA language
HR-007	Equal Employment Opportunity & Affirmative Action	Human Resources	Human Resources	New policy; includes NCQA language
HR-008	Organizational Readiness	Human Resources	Human Resources	New policy; includes NCQA language

Delegation Oversight Monitoring Program – 2024 Quarter 2

The CHPIV Delegation Oversight reviewed Health Net's performance across various high-risk delegated functions for 2024 Quarter 2 (April through June) and issued the Q2 final scorecard on 09/30/2024.

CHPIV Delegation Oversight identified three KPIs that failed to meet compliance standards for two consecutive quarters, triggering Corrective Action Plans (CAPs). These areas include Member Services - ID Cards with 90.61% issuance timeliness, Utilization Management with 90.2% provider notification timeliness, and Continuity of Care with 80% processing timeliness. Health Net has submitted all 3 CAPs and CHPIV Delegation Oversight has approved them as of 11/06/2024. Corrective actions for all 3 functional areas have been implemented, and we will continue to monitor implementation effectiveness.

The table below highlights the KPIs that were noncompliant for two consecutive quarters:

Category	KPI	Q1 Results	Q2 Results	Thresholds*	CAP Status
Member Services	MS003: Timely Issuance of Member ID Cards	**81.3%**	**90.6%**	Green: 100% Yellow: NA Red: <100%	**Approved;** Health Net has implemented corrective actions as of 10/15/2024
Continuity of Care	COC001: CoC Processing Timeliness	**73.1%**	**80%**	Green: >96% Yellow: 95-96% Red: <95%	**Approved;** Health Net has implemented corrective actions as of 10/31/2024
Utilization Management	UM003: Provider Notification Timeliness	**89.1%**	**90.2%**	Green: >96% Yellow: 95-96% Red: <95%	**Approved;** has implemented corrective actions as of 10/11/2024

** Thresholds are established based on the performance standards outlined in Exhibit A-5 of CHPIV's Plan-to-Plan agreement with Health Net*

Noncompliant KPIs from Quarter 2 2024:

Functional Area	KPI #	KPI	Quarter 2 Results	Thresholds
CoC	COC001	CoC Processing Timeliness	**80%**	Green: 100% Yellow: NA Red: <100%
Member Services	MS003	Timely Issuance of Member ID cards	**90.61%**	Green: >96% Yellow: 95-96%

				Red: <95%
UM	UM002	Member Notification Timeliness	**94.6%**	Green: >96% Yellow: 95-96% Red: <95%
UM	UM003	Provider Notification Timeliness	**90.2%**	Green: >96% Yellow: 95-96% Red: <95%

See **Exhibit A: Quarter 2 2024 Monitoring Scorecard** for all quarter 2 results.

Delegation Oversight Monitoring Program – 2024 Quarter 3

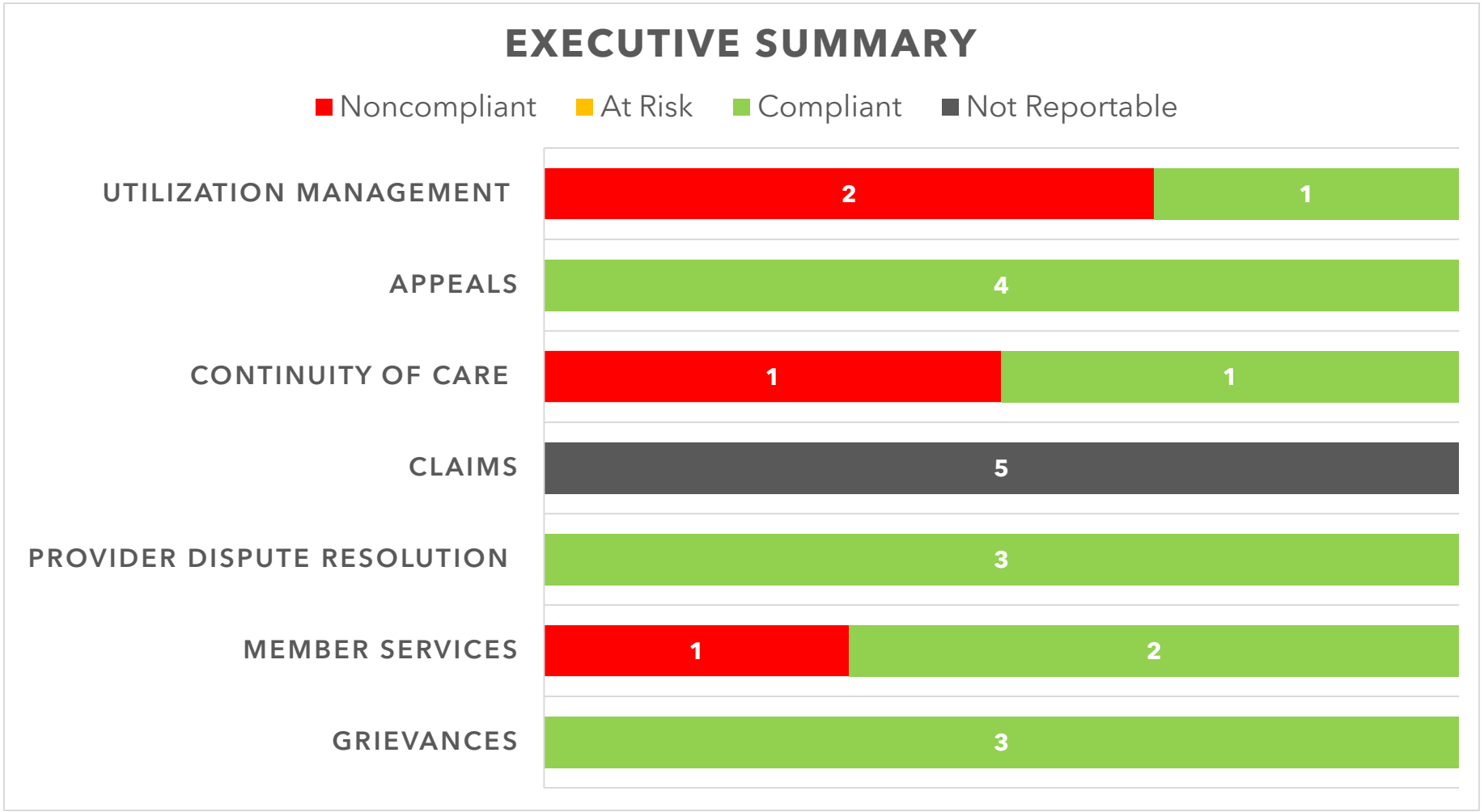
The CHPIV Delegation Oversight team is currently performing data validation for Quarter 3 logs to ensure accuracy which is expected to be completed by 11/22/2024. Once the data is deemed accurate, the CHPIV Delegation Oversight team will move forward with the compliance calculations. Scorecards are schedule to be disseminated by 11/27/2024.

DELEGATION OVERSIGHT

Health Net 2024 Quarter 2 *Preliminary* Scorecard

Report Issued: September 13, 2024

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



DELEGATION OVERSIGHT

Health Net 2024 Quarter 2 *Preliminary* Scorecard

Report Issued: September 13, 2024

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

HIGH PERFORMING AREAS

- ✓ 100% Appeals Acknowledgement, Decision, Effectuation of Overturned Appeals and Member Notification Timeliness
- ✓ 100% Continuity of Care Notification Timeliness
- ✓ 98.11% Calls Answered within 30 seconds
- ✓ 0.78% Call Center Abandonment Rate Level
- ✓ 100% Grievance Resolution and Member Notification Timeliness
- ✓ 97.9% Grievance Acknowledgement Timeliness
- ✓ 99.92% PDR Written Determination Timeliness
- ✓ 100% PDR Acknowledgement and Interest Payment on Late PDRs Timeliness
- ✓ 99.6% UM Decision Timeliness

NON-COMPLIANT AREAS

- ☒ 90.61% Timely Issuance of Member ID Cards
- ☒ 94.6% UM Member Notification Timeliness
- ☒ 90.2% UM Provider Notification Timeliness
- ☒ 80% Continuity of Care Processing Timeliness

NOT REPORTABLE

- Claims Log

ACTIONS REQUIRED

FUNCTIONAL AREA	ACTION	DUE DATE
UTILIZATION MANAGEMENT	*TBD*	*TBD*
APPEALS	None	NA
CONTINUITY OF CARE	*TBD*	*TBD*
CLAIMS	*TBD*	*TBD*
PROVIDER DISPUTE RESOLUTION	None	NA
MEMBER SERVICES	*TBD*	*TBD*
GRIEVANCES	None	NA

DELEGATION OVERSIGHT

Health Net 2024 Quarter 2 *Preliminary* Scorecard

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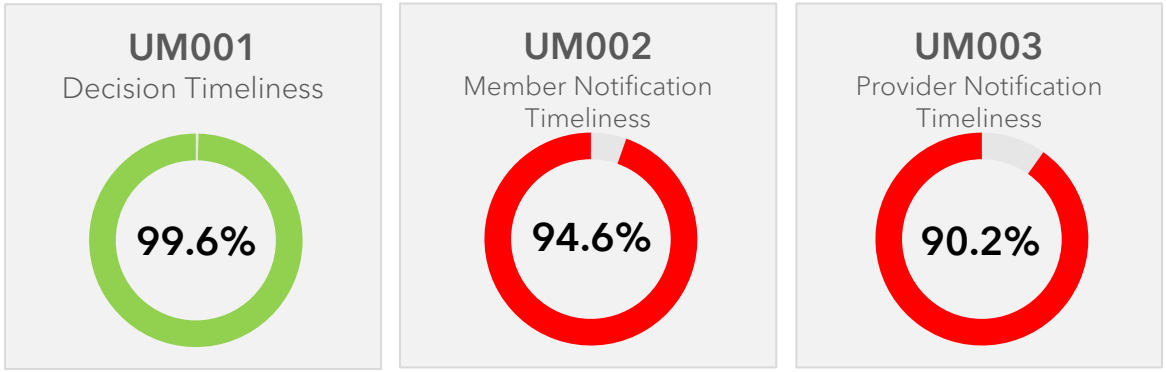
UTILIZATION MANAGEMENT



KPI #	KPI	Quarter 1	Quarter 2	Quarter 3	Quarter 4
UM001	**Decision Timeliness**	**98.3%**	**99.6%**		
UM001SP	▸ Standard Preservice	98.3%	98.3%		
UM001EP	▸ Expedited Preservice	95.2%	100%		
UM001C	▸ Concurrent	98.9%	100%		
UM001R	▸ Retrospective	100%	100%		
UM001PS	▸ Post Stabilization	No cases	No cases		
UM002	**Member Notification Timeliness**	**96%**	**94.6%**		
UM002SP	▸ Standard Preservice	100%	98.3%		
UM002EP	▸ Expedited Preservice	86.8%	66.7%		
UM002C	▸ Concurrent	97%	93.2%		
UM002R	▸ Retrospective	100%	100%		
UM003	**Provider Notification Timeliness**	**89.1%**	**90.2%**		
UM003SP	▸ Standard Preservice	89.7%	100%		
UM003EP	▸ Expedited Preservice	85.4%	100%		
UM003C	▸ Concurrent	89.2%	86.4%		
UM003R	▸ Retrospective	100%	100%		

DELEGATION OVERSIGHT

Health Net 2024 Quarter 2 *Preliminary* Scorecard

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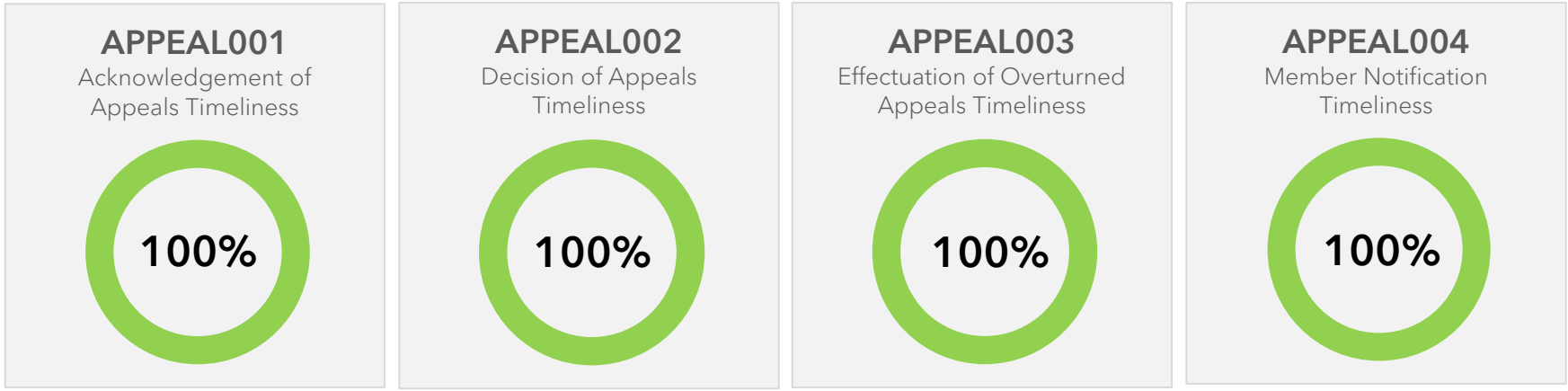
APPEALS



KPI #	KPI	Quarter 1	Quarter 2	Quarter 3	Quarter 4
APPEAL001	**Acknowledgement of Appeals Timeliness**	**100%**	**100%**		
APPEAL002	**Decision of Appeals Timeliness**	**100%**	**100%**		
APPEAL002S	▸ Standard	100%	100%		
APPEAL002E	▸ Expedited	No cases	100%		
APPEAL003	**Effectuation of Overturned Appeals Timeliness**	**80%**	**100%**		
APPEAL004	**Member Notification Timeliness**	**100%**	**100%**		
APPEAL004S	▸ Standard	100%	100%		
APPEAL004E	▸ Expedited	No cases	100%		

DELEGATION OVERSIGHT

Health Net 2024 Quarter 2 *Preliminary* Scorecard

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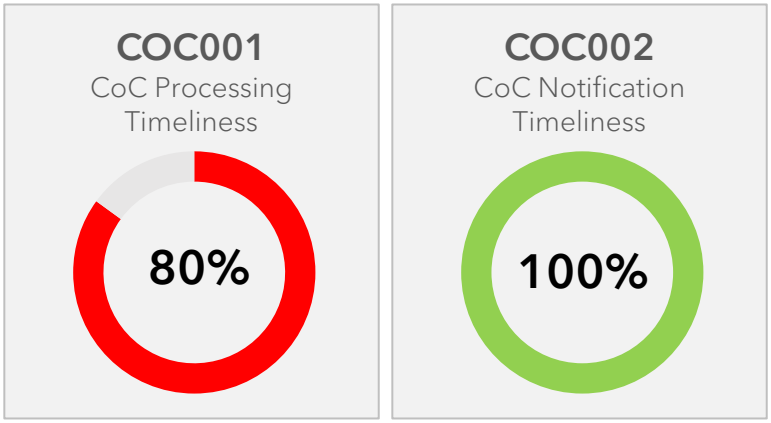
CONTINUITY OF CARE



KPI #	KPI	Quarter 1	Quarter 2	Quarter 3	Quarter 4
COC001	**CoC Processing Timeliness**	**73.08%**	**80%**		
COC001N	▸ Non-Urgent	100%	80%		
COC001I	▸ Immediate	No Cases	No Cases		
COC001U	▸ Urgent	36.36%	No Cases		
COC002	**CoC Notification Timeliness**	**100%***	**100%**		
COC002N	▸ Non-Urgent	100%	100%		
COC002I	▸ Immediate	No Cases	No Cases		
COC002U	▸ Urgent	100%	No Cases		

*Percentage does not include the backlog of cases that have not been completed/processed and have passed the required timeframe

DELEGATION OVERSIGHT

Health Net 2024 Quarter 2 *Preliminary* Scorecard

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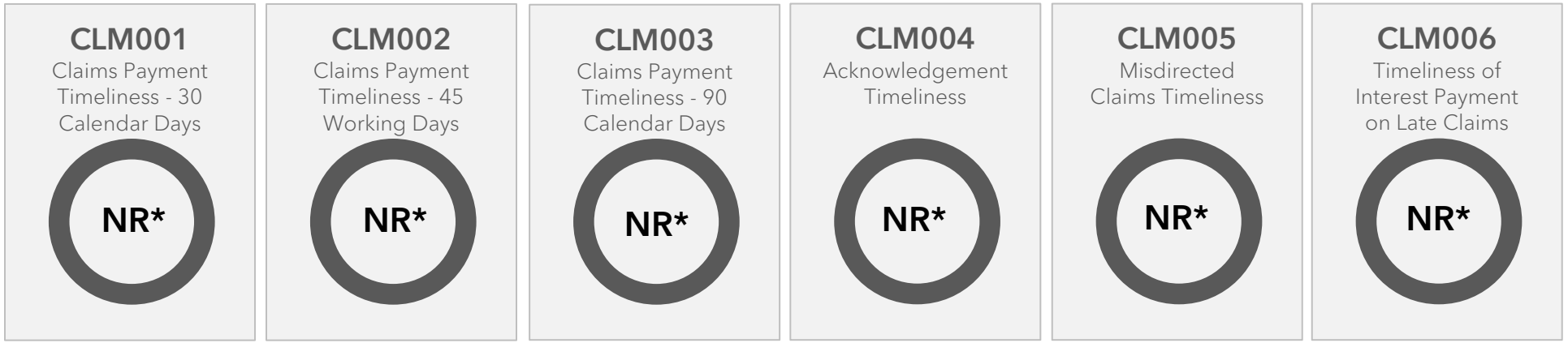
CLAIMS



KPI #	KPI	Quarter 1	Quarter 2	Quarter 3	Quarter 4
CLM001	**Claims Payment Timeliness - 30 Calendar Days**	**99.86%**	**Not Reportable***		
CLM002	**Claims Payment Timeliness - 45 Working Days**	**100%**	**Not Reportable***		
CLM003	**Claims Payment Timeliness - 90 Calendar Days**	**100%**	**Not Reportable***		
CLM004	**Acknowledgement Timeliness**	**99.76%**	**Not Reportable***		
CLM004E	▸ Acknowledgement Timeliness - Electronic	100%	Not Reportable*		
CLM004P	▸ Acknowledgement Timeliness - Paper	93.69%	Not Reportable*		
CLM005	**Misdirected Claims Timeliness**	**99.9%**	**Not Reportable***		
CLM006	**Timeliness of Interest Payment on Late Claims**	**0%**	**Not Reportable***		

** Data did not pass data validation, pending resubmission of Claims log*

DELEGATION OVERSIGHT

Health Net 2024 Quarter 2 *Preliminary* Scorecard

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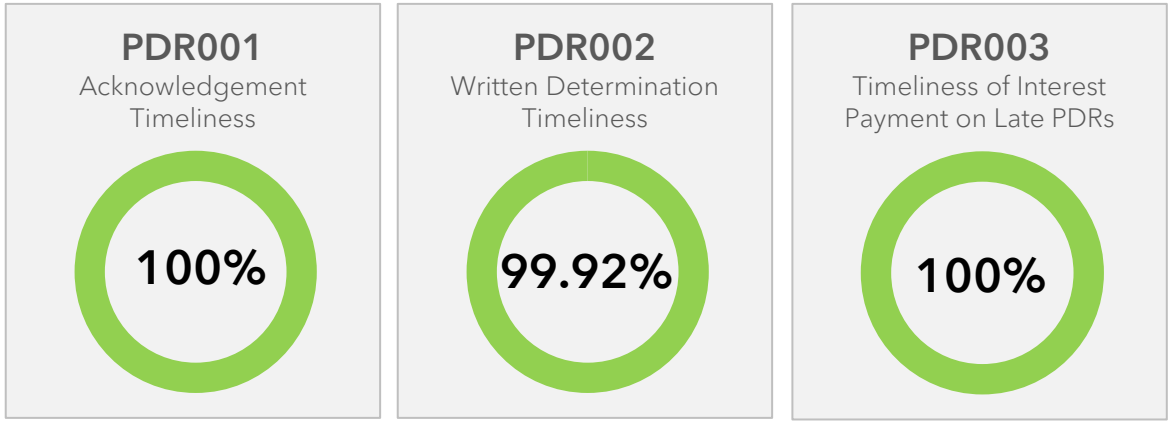
PROVIDER DISPUTE RESOLUTION



KPI #	KPI	Quarter 1	Quarter 2	Quarter 3	Quarter 4
PDR001	**Acknowledgement Timeliness**	**99.25%**	**100%**		
PDR001E	▸ Acknowledgement Timeliness - Electronic	No Cases	No Cases		
PDR001P	▸ Acknowledgement Timeliness - Paper	99.25%	100%		
PDR002	**Written Determination Timeliness**	**100%**	**99.92%**		
PDR003	**Timeliness of Interest Payment on Late PDRs**	**100%**	**100%**		

DELEGATION OVERSIGHT

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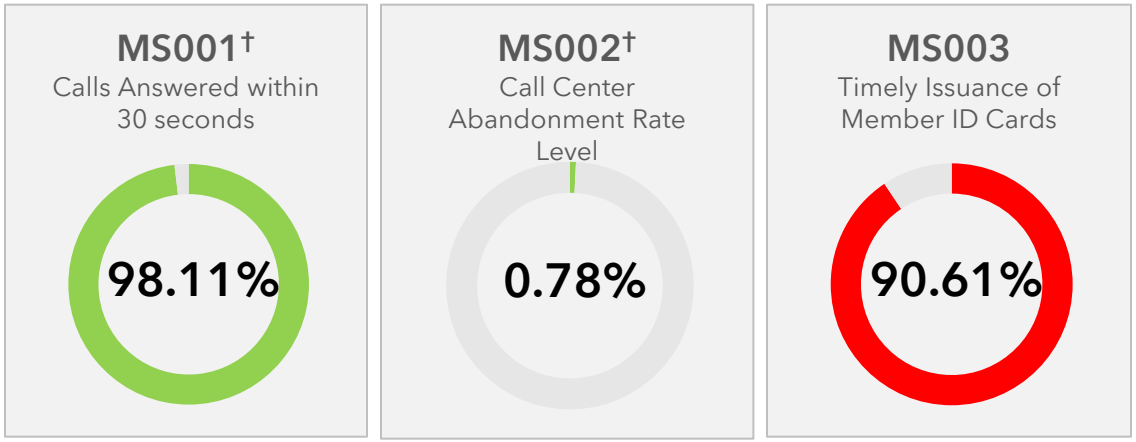
MEMBER SERVICES



KPI #	KPI	Quarter 1	Quarter 2	Quarter 3	Quarter 4
MS001	**Calls Answered within 30 seconds**	**83.17%†**	**98.11%†**		
MS002	**Call Center Abandonment Rate Level**	**3.42%†**	**0.78%†**		
MS003	**Timely Issuance of Member ID Cards**	**81.27%**	**90.61%**		

† Self-reported compliance rate

DELEGATION OVERSIGHT

Health Net 2024 Quarter 2 *Preliminary* Scorecard

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GRIEVANCES

KPI #	KPI	Quarter 1	Quarter 2	Quarter 3	Quarter 4
GRV001	**Acknowledgement Letter Timeliness**	**95.3%**	**97.9%**		
GRV002	**Grievance Resolution Timeliness**	**100%**	**100%**		
GRV002S	▸ Standard	100%	100%		
GRV002E	▸ Expedited	100%	100%		
GRV003	**Member Notification Timeliness**	**100%**	**100%**		
GRV003S	▸ Standard	100%	100%		
GRV003E	▸ Expedited	100%	100%		

Appendix 1 – KPI Details

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

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

DELEGATION OVERSIGHT

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Functional Area	KPI Type	KPI #	KPI	Thresholds			Log
				Green	Yellow	Red	
Provider Dispute Resolution (PDR)	Quantitative	PDR001	PDR Acknowledgement Timeliness	>96%	95-96%	<95%	PDR Log
Provider Dispute Resolution (PDR)	Quantitative	PDR002	PDR Written Determination Timeliness	>96%	95-96%	<95%	PDR Log
Provider Dispute Resolution (PDR)	Quantitative	PDR003	Timeliness of Interest Payment on Late PDRs	>96%	95-96%	<95%	PDR Log
Member Services	Quantitative	MS001	Calls Answered within 30 seconds	>90%	80%-90%	<80%	Call Center SLA Log
Member Services	Quantitative	MS002	Call Center Abandonment Rate Level	less than 5%	5%	>5%	Call Center SLA Log
Member Services	Quantitative	MS003	Timely Issuance of Member ID cards	100%	NA	<100%	Member ID Cards Log
Grievances	Quantitative	GRV001	Timely Acknowledgement Letter	>96%	95-96%	<95%	Grievance Log
Grievances	Quantitative	GRV002	Timely Grievance Resolution	>96%	95-96%	<95%	Grievance Log Call Log
Grievances	Quantitative	GRV003	Member Notification Timeliness	>96%	95-96%	<95%	Grievance Log