COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

AGENDA

Local Health Authority Commission

August 12th, 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	
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	
Christopher Bjornberg	LHA Commissioner-Chief Executive Office of PMHD	
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 7/8/2024

B. Accept Monthly Financial Reports as reviewed and accepted by the Finance Committee.

1. June 2024 P&L Variance Report
2. June 2024 Cash Transactions
3. June 2024 Statement of Revenues, Expenses, and Changes in Net Position
4. June 2024 Statement of Net Position
5. June 2024 Statement of Revenues, Expenses, and Changes in Net Position (YTD)

4. ACTION

A. Approval of the 2024 CHPIV Utilization Management Program Description *(Dr. Gordon Arakawa, CMO)*

5. INFORMATION

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

B. Financial Services Report *(Tony Godinez, Senior Manager of Accounting)*

C. Compliance Report *(Chelsea M. Hardy, Senior Director of Compliance)*

D. Human Resources and Community Relations Report *(Michelle S. Ortiz-Trujillo, HRCR)*

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, 01/2024)

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

7. RECONVENE OPEN SESSION

A. Report on actions taken in closed session.

8. COMMISSIONER REMARKS (*Lee Hindman, Chair)*

9. ADJOURNMENT

COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

MINUTES

Local Health Authority Commission

July 8th, 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	✓ R
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	A
Christopher Bjornberg	LHA Commissioner-Chief Executive Office of PMHD	✓ R
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 5:33 p.m.

A. Roll Call *Donna Ponce, Commission Clerk*

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

B. Approval of Agenda

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

(Ramirez/Sampat) To approve the 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.

Six members of the public, former employees of Innercare, addressed the commission regarding their past concerns regarding working for Innercare. Chair Hindman informed the public that these issues fell outside the commission's jurisdiction, thus limiting the commission's ability to intervene. Nonetheless, the members were given the opportunity to proceed with their statements.

3. CLOSED SESSION

Pursuant to Welfare and Institutions Code § 14087.38 (n) Report Involving Trade Secret new product discussion (estimated date of disclosure, 01/2024)

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

4. RECONVENE OPEN SESSION

A. Report on actions taken in closed session.
No action taken.

5. 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 6/10/2024

B. Accept Monthly Financial Reports reviewed and accepted by the Finance Committee.

1. May 2024 P&L Variance Report
2. May 2024 Cash Transactions
3. May 2024 Cash Reconciliation
4. May 2024 Statement of Revenues, Expenses, and Changes in Net Position
5. May 2024 Statement of Net Position
6. May 2024 Statement of Revenues, Expenses, and Changes in Net Position (YTD)

C. Employee Dependent Medical Insurance Premium Coverage will be added at 75%
(Ramirez/Sampat) To approve the consent agenda. Motion carried.

6. ACTION

A. Accept Health Management Associates (HMA) Interim CFO Agreement
(Velez/Ramirez) To accept the HMA Interim CFO agreement. Motion carried.

7. INFORMATION

A. Health Services Report *(Dr. Gordon Arakawa, CMO)*
CMO, Dr. Gordon Arakawa updated the commission on the following:
1. *Review of Health Net's Q2 QIHEC Materials*
2. *National Commission for Quality Assurance Accreditation*
3. *Meetings with Health Net Counterparts*

B. Financial Services Report *(Tony Godinez, Senior Manager of Accounting)*
SMA, Tony Godinez updated the commission on the following:
May 2024 Financial Reports

C. Compliance Report *(Elysse Tarabola, CCO)*
CCO, Elysse Tarabola and Senior Director of Compliance, Chelsea Hardy, updated the commission on the following:
Delegation Oversight Monitoring Program Report

D. Human Resources and Community Relations Report *(Michelle S. Ortiz-Trujillo, SDHRCR)*
SDHRCR, Michelle Stephanie Ortiz-Trujillo updated the commission on the following:
1. *Human Resources*
   a. *Workplace Violence Prevention Training near completion*
2. *Community Relations*
   a. *Building Connections with CBOs*
   b. *Community Advisory Committee Q3 06-06-2024*
   c. *Selection Committee Meeting Minutes*

Imperial Valley Food Bank Volunteers Presentation

E. CEO Report (*Larry Lewis, CEO)*
CEO, Larry Lewis reported on the following:
1. *CFO Recruitment*
   Interviews will be held within the next three weeks
2. *Facilities*
   Three air conditioning units have been replaced.

F. Other new or old business (*Lee Hindman, Chair) None*

G. Commissioner Remarks (*Lee Hindman, Chair) None.*

Adjournment
The meeting was adjourned at 6:12 p.m.

IMPERIAL COUNTY LOCAL HEALTH AUTHORITY
dba Community Health Plan of Imperial Valley
Year to Date P&L Variance
1/1/2024 to 6/30/2024

	June Forecast	June Actual	June Variance	Year To Date Variance	Explanation
REVENUE					
HN Settlements	1,000,000	-	(1,000,000)	(397,377)	$603K profit share received in prior month.
Premium	22,249,362	23,093,850	844,488	2,149,067	Actual premium more than projected.
Pass-Through	883,592	376,851	(506,741)	(985,748)	Actual pass-through less than projected.
TOTAL REVENUE	24,132,953	23,470,701	(662,253)	765,942	
HEALTH CARE COSTS	22,465,472	22,777,885	312,413	1,002,263	
Gross Margin	**1,667,481**	**692,815**	**(974,666)**	**(236,321)**	
ADMINISTRATIVE EXPENSE					
Salaries	236,186	204,181	(32,004)	1,831	Decrease attributed to vacant CFO position.
Benefits and Bonus	77,093	88,839	11,746	(159,816)	
Total Labor Costs	313,279	293,021	(20,258)	(157,985)	
Consulting, Audit, Legal, other Prof	10,508	83,425	72,916	194,892	Increase fluctuation due to legal fees.
Office Occupancy	14,606	12,926	(1,680)	35,080	
Other Misc Admin	53,643	69,058	15,415	66,181	Increase fluctuation due to membership fees.
Total Administrative Expense	392,036	458,429	66,393	138,168	
Non-Operating Income					
Dividend & Investment Income	100,347	99,193	(1,154)	(76,215)	
Rental Income	-	2,900	2,900	8,700	
Total Non-Operating Income	100,347	102,093	1,746	(67,515)	
Excess Revenues from Operations	1,375,791	336,479	(1,039,313)	(442,004)	

Community Health Plan of Imperial Valley
June 2024 Cash Transactions

Date	Account	Vendor	Memo/Description	Amount
Chase Checking				
06/21/2024	Chase Checking	Department of Health Care Services	06/13 Receipt - DHCS	$ 24,136,673.14
06/21/2024	Chase Checking	Department of Health Care Services	06/13 Receipt - DHCS	406,353.69
06/21/2024	Chase Checking	Department of Health Care Services	06/13 Receipt - DHCS	59,552.90
06/21/2024	Chase Checking	Department of Health Care Services	06/13 Receipt - DHCS	23,925.41
06/21/2024	Chase Checking	Department of Health Care Services	06/13 Receipt - DHCS	1,044.63
06/07/2024	Chase Checking	JPMorgan Chase	Dividend Income - May 2024	17,680.91
06/07/2024	Chase Checking	Health Net	Rental Income - Jun 2024	1,450.00
06/28/2024	Chase Checking	Health Net	Rental Income - Jun 2024	1,450.00
06/28/2024	Chase Checking	Health Net	06/28 - Health Net Payment	-23,900,861.00
06/07/2024	Chase Checking	JPMorgan Chase	Service Charges - May 2024	-1,048.02
06/17/2024	Chase Checking	AccuSourceHR	Background Check - Ariday Rosales	-55.32
06/17/2024	Chase Checking	Imperial Desert Landscape	Chase Bill Pay 06/17/24 - Invoice# 40052 / 41358	-375.00
06/17/2024	Chase Checking	AM Copiers Inc.	Chase Bill Pay 06/17/24 - Invoice# IN5312	-350.16
06/17/2024	Chase Checking	America's Finest Fire Pro	Chase Bill Pay 06/17/24 - Invoice# 26M 903963 / 26M 905328	-1,958.55
06/17/2024	Chase Checking	Brawley Chamber of Commerce	Chase Bill Pay 06/17/24 - Invoice# 23246	-100.00
06/17/2024	Chase Checking	Brawley Rotary Club	Chase Bill Pay 06/17/24 - Statement for May 2024	-105.00
06/17/2024	Chase Checking	City of Imperial	Chase Bill Pay 06/17/24 - Service Period: 04/23/24 - 05/24/24	-190.81
06/17/2024	Chase Checking	CLEANBC, LLC	Chase Bill Pay 06/17/24 - Invoice# 008	-700.00
06/17/2024	Chase Checking	Epstein Becker & Green, P.C.	Chase Bill Pay 06/17/24 - Invoice# 1160658 / 1160659	-8,783.00
06/17/2024	Chase Checking	Health Management Associates, Inc.	Chase Bill Pay 06/17/24 - Invoice# 206100-0000016	-3,956.25
06/17/2024	Chase Checking	i.Access, Inc.	Chase Bill Pay 06/17/24 - Invoice# WA2782405	-45.00
06/17/2024	Chase Checking	Imperial Valley Food Bank	Chase Bill Pay 06/17/24 - Invoice# CHPIV0624	-500.00
06/17/2024	Chase Checking	Imperial Valley Food Bank	Chase Check# 6670 - Harvest Bowl Sponsorship	-1,200.00
06/17/2024	Chase Checking	I.V. Termite & Pest Control	Chase Bill Pay 06/17/24 - Invoice# 0338268	-120.00
06/17/2024	Chase Checking	KY Cakes	Chase Bill Pay 06/17/24 - Invoice# 0005	-30.00
06/17/2024	Chase Checking	Law Office of William S. Smerdon	Chase Bill Pay 06/17/24 - Invoice# 2551	-687.50
06/17/2024	Chase Checking	Local Health Plans of California	Chase Bill Pay 06/17/24 - Invoice# 2024-24	-53,468.40
06/17/2024	Chase Checking	Moss Adams	Chase Bill Pay 06/17/24 - Invoice# *****4501	-10,500.00
06/17/2024	Chase Checking	Quench USA	Chase Bill Pay 06/17/24 - Invoice# INV07466186	-129.30
06/21/2024	Chase Checking	Southworth, Mark (Former Employee)	M. Southworth - Final Paycheck	-10,059.04
06/21/2024	Chase Checking	Mid Atlantic Trust Company	06/10 - ACH Payment	-9,243.90
06/21/2024	Chase Checking	Mid Atlantic Trust Company	06/21 - ACH Payment	-8,022.75
06/28/2024	Chase Checking	Great America Financial Services	Chase Bill Pay - Invoice# 36814250	-306.01
06/28/2024	Chase Checking	Republic Services	Chase Bill Pay - Invoice# WA2782406	-141.17
06/28/2024	Chase Checking	Vic's Air Conditioning & Electrical	Chase Bill Pay - Invoices# 98296 / 98325 / 98767	-9,037.00
First Foundation Bank				
06/28/2024	FFB Payroll	Paychex, Inc.	06/17 - Paychex TPS Taxes	2,631.23
06/28/2024	FFB Payroll	Paychex, Inc.	06/17 - Paychex Payroll	5,230.30
06/28/2024	FFB Payroll	Paychex, Inc.	06/13 - Paychex TPS Taxes	-35,078.46
06/28/2024	FFB Payroll	Paychex, Inc.	06/13 - Paychex Payroll	-66,660.30
06/28/2024	FFB Payroll	Paychex, Inc.	06/14 - EIB Invoice	-50.64
06/28/2024	FFB Payroll	Paychex, Inc.	06/18 - EIB Invoice	-24.64
06/28/2024	FFB Payroll	Paychex, Inc.	06/20 - OAB Invoice	-49.50
06/28/2024	FFB Payroll	Paychex, Inc.	06/27 - Paychex TPS Taxes	-31,737.82
06/28/2024	FFB Payroll	Paychex, Inc.	06/27 - Paychex Payroll	-68,228.40
06/28/2024	FFB Payroll	Paychex, Inc.	06/28 - EIB Invoice	-54.12
06/28/2024	FFB Payroll	First Foundation Bank	06/12 - Wire Fee	-10.00
06/28/2024	FFB Payroll	First Foundation Bank	06/24 - Wire Fee	-10.00
06/28/2024	FFB Payroll	First Foundation Bank	06/24 - Wire Fee	-10.00
06/28/2024	FFB Payroll	Pablo Velez	06/10 - Check# 10181	-100.00
J.P. Morgan Securities				
06/28/2024	J.P. Morgan Securities	J.P. Morgan Securities	Investment Income - Jun 2024	$ 84,578.95

Community Health Plan of Imperial Valley
Statement of Revenues, Expenses, and Changes in Net Position
For June 2024

REVENUES	
DHCS Premium	$ 23,093,850
DHCS Pass-Through	376,851
Total Operating Revenues	**23,470,701**
OPERATING EXPENSES	
Medical Expenses	
Healthcare Capitation	22,401,034
Healthcare Pass-Through	376,851
Total Medical Expenses	**22,777,885**
Administrative Expenses	
Salaries, Wages, and Employee Benefits	293,021
Professional fees	83,425
Office Expenses & Administrative	68,963
Occupancy - Cleaning, Landscape, Rent, Utilities	3,355
Supplies & Services	95
Depreciation and Amortization	9,571
Total Administrative Expenses	**458,429**
Total Operating Expenses	**23,236,315**
OPERATING INCOME	**234,386**
NON-OPERATING REVENUES	
Dividend Income - Chase Money Market	14,614
Investment Income - J.P. Morgan Securities	84,579
Rental Income - HealthNet Office Space	2,900
Total Non-Operating Revenues	**102,093**
Increase In Net Position	**336,479**
NET POSITION, beginning of period	**18,110,908**
NET POSITION, ending of period	**$ 18,447,387**

Community Health Plan of Imperial Valley
Statement of Net Position
As of June 30, 2024

ASSETS	
Current Assets	
Cash and Investments	
Chase - Checking	$ 198,800
Chase - Money Market	2,771,975
JPMorgan Securities	9,404,065
First Foundation Bank	196,549
Receivables	
Accounts Receivable	2,028,239
Dividend Receivable	14,614
Premium Receivable	23,093,850
Pass-Through Receivable	376,851
Other Current Assets	
Prepaid Expenses	7,534
Total Current Assets	**38,092,476**
Noncurrent Assets	
Restricted Deposit	
First Foundation Bank - Restricted	300,000
Capital Assets	
Buildings - Net	3,008,791
Computer Hardware & Office Equipment - Net	8,740
Improvements - Net	20,883
Intangible Assets - Net	21,743
Operating ROU Asset (Copier) - Net	8,164
Total Noncurrent Assets	**3,368,321**
Total Assets	**$ 41,460,797**

Community Health Plan of Imperial Valley
Statement of Net Position
As of June 30, 2024

LIABILITIES	
CURRENT LIABILITIES	
Payables	
Accounts Payable	$ 87,258
Capitation Payable	22,401,034
Pass-Through Payable	376,851
Credit Card Payable	8,255
Other Current Liabilities	
Short Term Lease Liability - Copier	3,298
Bonus Accrual	71,517
Vacation Accrual	60,204
Total Current Liabilities	**23,008,417**
NON-CURRENT LIABILITIES	
Long Term Lease Liability - Copier	4,994
Total Noncurrent Liabilities	**4,994**
Total Liabilities	**23,013,410**
NET POSITION	
Net investment in Capital Assets	3,368,321
Restricted by Legislative Authority	300,000
Unrestricted	11,706,497
Net Revenue	3,072,568
Total Net Position	**18,447,387**
Total Liabilities and Net Position	**$ 41,460,797**

Community Health Plan of Imperial Valley
Statement of Revenues, Expenses, and Changes in Net Position
As of June 30, 2024

REVENUES		
DHCS Premium	$	135,645,238
DHCS Pass-Through		4,315,801
Profit Share Revenue		602,764
Health Net Contributions		134,859
Total Operating Revenues		**140,698,662**
OPERATING EXPENSES		
Medical Expenses		
Healthcare Capitation		131,479,297
Healthcare Pass-Through		4,315,801
Total Medical Expenses		**135,795,098**
Administrative Expenses		
Salaries, Wages, and Employee Benefits		1,661,326
Professional fees		271,176
Office Expenses & Administrative		174,390
Occupancy - Cleaning, Landscape, Rent, Utilities		66,694
Supplies & Services		22,064
Depreciation and Amortization		56,418
Total Administrative Expenses		**2,252,067**
Total Operating Expenses		**138,047,165**
OPERATING INCOME		**2,651,496.72**
NON-OPERATING REVENUES		
Dividend Income - Chase Money Market		137,958
Investment Income - J.P. Morgan Securities		272,395
Interest Income - County of Imperial		2,018
Rental Income - HealthNet Office Space		8,700
Total Non-Operating Revenues		**421,071**
Increase In Net Position		**3,072,568**
NET POSITION, beginning of year		**15,374,819**
NET POSITION, ending of period	**$**	**18,447,387**

2024

Health Net Community Solutions, Inc.
and
Community Health Plan of Imperial Valley

Utilization Management Program Description

TABLE OF CONTENTS

Section 1

Introduction and Background

Introduction and Background

Introduction

The Community Health Plan of Imperial Valley (CHPIV) Utilization Management (UM) Program Description summarizes the policies, processes and standards that govern UM programs. Detailed policies and procedures support this document to assist in program implementation and to provide a step-by-step procedural instruction for Utilization Management staff in the program execution of both delegated and non-delegated models.

The Program is structured to assure that medical decisions are made by qualified health professionals, using written criteria based on sound clinical evidence, without undue influence or concerns for the plan's fiscal performance.

The Utilization Management Program Description summarizes the utilization management policies and procedures, the utilization management process, and the use of utilization management standards.

The Utilization Management Program delegates specified aspects of medical management to utilization management committees established by each Participating Provider Group (PPG).

The level of delegation is based on Health Net's pre-contractual and annual evaluation of the PPG's performance of utilization management functions.

Background

CHPIV is responsible for ensuring that utilization management services are available for all its Members. Health Net Community Solutions, Inc. (Health Net) is contracted with CHPIV to provide and arrange for utilization management services. Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation, a publicly traded company. Health Net is a registered service mark of Health Net, LLC.

Provider Network

Health Net operates largely as a delegated group network model for the delivery of health care. Services are provided under the following types of contractual arrangements:

- Practitioners and providers contracted with Health Net's network of Participating Provider Groups (PPGs)
- Practitioners and providers contracted directly with Health Net.

Health Net contracts with many multi-specialty Participating Provider Groups (PPGs) throughout California who, in turn, contract with or employ primary care and specialty

care practitioners. Health Net maintains contracts with a full range of providers including acute care hospitals, home health care, infusion therapy, dialysis, durable medical equipment, outpatient surgery, radiology/imaging, skilled nursing, custodial care/long term care, intermediate care facility, rehabilitation, laboratory services and hospices.

Health Net delegates to its PPGs and selected providers specific credentialing, utilization management, medical records and claims functions, where appropriate.

Confidentiality

Health Net has policies and procedures for the collection, handling, storage and release of confidential information to protect the privacy and confidentiality rights of members, employees, providers and the Company, and to ensure the appropriate and legitimate use of information. Health Net contracts require that practitioners and providers maintain the confidentiality of member information and records. Information or copies of records may be released only to authorized individuals as permitted by state and federal law.

Prior to participation in the UM Program, participants are educated regarding confidentiality requirements. All protected member information is maintained in a secure fashion in accordance with federal and state law. All staff charged with handling any confidential member information is regularly updated in privacy and confidentiality policies and procedures. Full access to HIPAA (Health Insurance Portability and Accountability Act) policies and procedures as well as self-paced, online resources, is available to all HN staff via the corporate intranet websites, including “Archer” and “Centene University”.

The Health Net Privacy Office is responsible to review, approve and disseminate confidentiality policies and practices regarding the collection, use and disclosure of medical information.

Information Systems and Analysis

Health Net’s Information Systems consist of various integrated subsystem databases, which support UM. The major sources of data utilized for UM activities are obtained from the following subsystems:

- Membership
- Benefits
- Provider
- Claims
- Billing
- Capitation
- Encounters
- Credentialing
- Population Health and Clinical Operations (PHCO)
- Customer Service
- Appeals and Grievance

Analytical resources are directly available from the following Health Net departments: Information Systems, Quality Improvement and Pharmacy Operations. Other analytical support resources include Actuary, Finance, Provider Network Management, Medical Advisory Council, Customer Service and Claims. Additional sources of information include member and provider feedback.

Section 2

Purpose

About Health Net

Health Net provides access to high-quality health care, innovative programs and a wide range of health solutions that help families and individuals get well, stay well, and be well.

Mission

Transforming the health of the communities we serve, one person at a time.

Values

Accountability • Courage • Curiosity • Trust • Service

Health Net Community Solutions UM Purpose

The purpose of Health Net's Utilization Management Program is to design and implement programs that facilitate the highest level of the member's health care outcomes, and to monitor and evaluate the effectiveness of these programs in compliance with the Community Health Plan of Imperial Valley Medi-Cal Contract, and State and Federal regulations.

The Utilization Management Program identifies and manages members who are currently accessing health care services.

The purpose of the UM Program is to:

- Assist in the coordination of medically necessary health care services provided to members, as indicated by clinical criteria
- Provide a mechanism to address access and timeliness of care
- Initiate documentation to support investigation of potential quality of care issues
- Identify and resolve problems that result in excessive resource utilization and inefficient delivery of health care services
- Identify and resolve problems that result in under or over utilization
- Assess the effects of cost containment activities on the quality of care delivered
- Promote the role of the primary care physician in the management of patient care
- Identify opportunities to improve the health of members through integration and coordination within PHCO and external Public Health Programs
- Optimize the member's health benefits by linking and coordinating services with the appropriate county/state sponsored programs

Goals and Objectives

The Program has the following specific objectives:

- Monitor consistency in application of all UM functions for members
- Review and evaluate health care services for quality, medical necessity and appropriate levels of care
- Identify actual and potential quality issues through this review process and refer to the appropriate quality management personnel
- Evaluate the need for care management and discharge planning in coordination with the hospital and the PCP
- Aggregate utilization data to identify favorable and aberrant practice patterns, and recommend the necessary changes that will improve program effectiveness and efficiency
- Maintain compliance with regulatory timeliness
- Prepare and implement improvement plans for identified problem areas
- Provide a mechanism for maintaining confidentiality of member and provider
- Coordinate Utilization Management, Care Management and Quality Management activities to provide a continuous quality improvement process
- Work collaboratively with Delegation Oversight to determine delegation status for UM activities
- Evaluate the UM Program on a regular basis to respond to changes in the health care environment
- Collaborate with county Public Health-Linked Programs
- Provide members with equitable access to care including eliminating identified health disparities such as, structural racism and social risk, social determinates of health (SDoH), and community needs; make recommendations to improve individual and community health outcomes.

Section 3

Description of Program

Description of Program

Utilization and Care Management

The Health Net Utilization Management Program is designed for all members to receive quality, medically necessary health care services, delivered at the appropriate level of care in a timely, effective manner by Health Net's delegated and non-delegated providers. The Utilization Management Program is under the clinical supervision of the Health Net, LLC Chief Medical Officer who has substantial involvement in developing and implementing the Program.

Scope of Utilization Management

The scope of Health Net's non-delegated Utilization Management activities includes timely, direct referrals, prior authorization, concurrent review, discharge planning, care management and care coordination with Public Health-Linked Programs. Health Net conducts all utilization management activities in accordance with CA Health and Safety Code 1367.01.

Through Health Net's Provider Oversight Process, Participating Provider Groups (PPGs) may be delegated the responsibility for the aforementioned UM activities.

Health Net has developed, implemented, and continuously updates and improves the UM Program to ensure appropriate processes are in place to review and approve the provision of medically necessary covered services. The plan has qualified staff who are responsible for the UM Program. The plan separates its medical decisions from fiscal and administrative management to assure the medical decisions are not unduly influenced by fiscal and administrative management. The plan ensures covered services are provided as set forth in the California Code of Regulations (CCR), Title 22, Chapter 3, Article 4, beginning with Section 51301 and CCR, Title 17, Division 1, Chapter 4, Subchapter 13, beginning with Section 6840, except as excluded under the terms of the Plan's Medi-Cal contract and as referenced in applicable Medi-Cal Managed Care Division (MMCD) All Plan Letters. Additionally, Health Net's Utilization Management Programs adhere to all applicable requirements set forth by CMS, DHCS, DMHC and Managed Risk Medical Insurance Board (MRMIB) for Utilization Management and Care Coordination activities.

The Program is conducted in accordance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910(d) and 42 CFR 438.900 et seq.

Prior authorization is not required for emergency services, family planning services, preventive services, basic prenatal care, services related to the treatment of sexually transmitted infections, HIV counseling and testing, therapeutic and elective pregnancy termination, biomarker testing for an insured with advanced or metastatic stage 3 or 4 cancer and immunizations at the Local Health Department (LHD). Utilization

Management policies and procedures are available to members and providers upon request.

Health Net Utilization Management nurses provide decision support, member advocacy, identification and recommendation of alternative plans of care, identification and use of alternative funding and community resources to support the plan of care.

Direct Referrals/Self-Referrals

For delegated PPGs, Health Net allows the medical groups to establish policies and procedures for direct referrals. Health Net has established direct referrals for non-delegated practitioners when the member's Primary Care Physician refers the member directly to a specialist for consultation and evaluation without prior authorization or prior review by the Health Net Medical Director. Health Net and its delegated PPGs do not require prior authorization for emergency services, family planning services (including abortion), preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing as outlined under the Scope of Utilization Management section of the UM Program Description. Direct referrals enhance the member's ability to directly access specialists.

Preauthorization/Prior Authorization

Health Net requires delegated PPGs to create and maintain programs, policies and procedures, which at a minimum, meet Health Net's established standards. Health Net Utilization Management staff determines pre-service decisions for request types that are not delegated.

Pre-service decisions include both the initial determination of requests for urgent and non-urgent services and requests for continuity of care services. Pre-service decisions are required for elective inpatient admissions, selected ambulatory surgery, durable medical equipment, home IV infusion, and selected diagnostic and radiology procedures. The purpose of obtaining a pre-service decision is to prospectively evaluate proposed services to determine if they are medically necessary, covered by the member's benefit plan, the most current and appropriate medical interventions utilizing criteria for determining medical and behavioral health appropriateness that are based on sound clinical evidence, provided by a contracted practitioner or provider, where appropriate or possible, and provided in the most appropriate setting.

Health Net has established a tracking process to track and monitor referrals requiring prior authorization. Health Net's authorization tracking system includes authorized, denied, deferred and/or modified authorizations. The process of authorization tracking includes monitoring of timeliness.

Inpatient Facility Concurrent Review

Concurrent Review (CCR) is an assessment that determines medical necessity or appropriateness of services as they are rendered, i.e., an assessment of the need for continued inpatient care for patients or when member is stabilized following an emergency admission and requires pos-stabilization care. Any review for continued

benefit coverage and provision of an approved ongoing course of treatment over a period of time or number of treatments. Concurrent review is a member-centric process that includes medical necessity review, discharge and transitional care planning and coordination of care.

A goal of CCR is to support the Member and Member's health care team to optimize health outcomes in the event the Member experiences a health status change. This is done in collaboration with the PPG, Member and the Interdisciplinary Care Team to:

1) Ensure services are accessed timely,
2) Educate the Member's health care team on the Member's benefit structure and resources,
3) Facilitate expeditious authorization of services when appropriate, and
4) Facilitate referrals to appropriate Member resources, such as the behavioral health team, care management, and community resources or carve our programs such as California Children's Services program, the Local Education Agency (LEA) program, or the County Mental Health Program etc.

The CCR nurse supports a smooth transition from the acute care setting or SNF to the next level of care/community by bridging the inpatient to outpatient process through facilitation of health care services and Member care management support programs. Health Net nurses and Medical Directors conduct, and delegated partners participate in onsite or telephonic concurrent review of patients admitted to hospitals, rehabilitation units, custodial care/long term care, intermediate care facility, or skilled nursing facilities. HN may monitor and provide concurrent review support for selected delegated partners, which retain a UM delegated status. The inpatient review process occurs within 1 business day from the day of hospital admission or within 1 business day of notification of admission and continues throughout the patient's hospital stay. For post-stabilization care, the Plan make a decision within 30 minutes whether to approve or disapprove an admission or transfer the member (if they are currently in a non-participating facility). If the response to approve or disapprove the request is not given within 30 minutes, the post-stabilization care request is authorized. The review process includes application of standardized nationally recognized criteria for medical appropriateness review, levels of care, discharge planning, and transitional care management including assessment of medically appropriate alternatives to inpatient care.

The concurrent review nurses use nationally recognized criteria, which includes InterQual® criteria, Hayes, Medicare Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) or Guidelines and Health Net's Medical Hierarchy Policy to assess the appropriateness of the admission, level of care, and length of stay. The determination of medical appropriateness includes consideration of the individual patient's needs, as well as the capacity of the local delivery system such as in remote sections of the state. Board-certified physician specialists are utilized in making medical determinations as needed.

Health Net non-clinical staff supports pre-service and concurrent review with data entry, receipt and documentation of notification, and receipt and attachment of clinical content.

Reviews of requests that do not meet guidelines or criteria for certification are referred to a Health Net Medical Director for second level case review. During the concurrent review process, nurses assess for member specific care management and disease/ chronic condition management needs and refer such cases to Care Management for evaluation. Concurrent Review Nurses collaborate with Care Managers on all members identified in active care management.

CCR goals include supporting the member and member's health care team to optimize health outcomes in the event the member experiences a health status change. This is done through work and advocacy with the PPG, member and/or the interdisciplinary care team to 1) ensure services are accessed timely, 2) educate to the member's health care team on the member's benefit structure and resources, 3) facilitate expeditious authorization of services when appropriate, and 4) facilitate referrals to appropriate member resources, where appropriate, such as the behavioral health team, care management, and community resources. The CCRN supports a smooth transition from the acute care setting or SNF to the next level of care/community by bridging the inpatient to outpatient process through facilitation of health care services and member care management support programs.

Discharge Planning

HN and/or delegated partners conduct and facilitate discharge planning to promote continuity and coordination of care in conjunction with the practitioner, member, and member's family to ensure a timely and safe discharge. Discharge planning begins pre-service or on the first day of the member's admission, whenever possible. The concurrent review nurse is responsible for facilitating, coordinating and authorizing referrals for discharge needs, including but not limited to, home health care, durable medical equipment and/or transfers to a lower level of care (e.g., skilled nursing facility, custodial care/long term care, intermediate care facility or acute rehabilitation).

HN Concurrent Review nurses identify potential care management cases and refer such cases to Care Management and other outpatient programs for post discharge evaluation and/or services.

The criteria used for evaluating and guiding timely discharge planning is nationally recognized criteria including InterQual®, Hayes, Medicare Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) or Guidelines and Health Net's Medical Hierarchy policy. Discharge planning is part of the Utilization/Care Management Program and includes, but is not limited to:

- Assessment of continuity of care, including Community Supports and Complex Care Management needs.
- Assessment of member's support system to determine necessary services and support needs.

- Development of a discharge plan of care based on short-term medical/psychosocial needs.
- Coordination and implementation of services requested in the plan of care.

Post Service/Retrospective Review

Delegated PPGs conduct post service or retrospective review activities in compliance with Health Net standards. Conversely, Health Net performs this activity for non-delegated providers.

Health Net and its delegated partners perform post-service or retrospective review of medical records when services rendered have not been authorized. Any services failing to meet criteria are forwarded to Health Net and delegated partners' medical directors for final determination and payment adjudication recommendations. The purpose of post-service review is to evaluate the request for authorization against documented medical record evidence that the member received the services and that services meet the criteria for medical necessity. Determinations are processed after obtaining all necessary information required to review the request.

Second Opinion

A member, member's authorized representative or provider may request a second opinion for medical, surgical or behavioral health conditions. PCPs usually refer their assigned members who request a second opinion to a participating physician within their medical group. If a member requests a second opinion about specialty care from a participating specialist physician who practices outside of the member's PCP's medical group, the request will be forwarded to Health Net utilization management for review. Health Net does not routinely require prior authorization for such services given that the second opinion is provided within or outside the member's Participating Physicians Group or Network, but within the Health Net Network. However, in the event the member's plan requires prior authorization of such services, the determination will be made in a timely manner consistent with state specific mandates. The organization provides for second opinion from an in-network provider or arranges for the member to obtain a second opinion outside the network. There is no cost to the member for second opinion either in network, or authorized out of network.

Members may obtain a second opinion from a qualified health care professional. If an appropriate professional is not available in-network, Health Net will arrange for the member to obtain a second opinion out-of-network at no cost to the member.

Management of Information Systems

Health Net utilizes automated documentation systems to enter, view, and audit medical management information.

Provider Participation

Health Net contracts with primary and multi-specialty group practices, individual providers, hospitals and ancillary service providers to deliver quality, cost effective medical services to members and their dependents. Selection of a Primary Care Provider (PCP) and establishment of a relationship with that provider is the foundation for members obtaining appropriate health care services. PCPs include Internists, Family Practitioners, General Practitioners, Pediatricians, Nurse Practitioners and Women's Health Care Providers (WHCP).

Access/Availability to Health Care Services

An ongoing review of the Health Plan's network is conducted to ensure the availability and access to all needed levels of care. The review includes an analysis of the scope of the network physicians, including Primary Care Physicians, specialists, facilities and ancillary services in relationship to members' needs. Site and medical record reviews are also conducted to ensure that access to care and services, and the confidentiality of member records are met. Recruitment will take place in areas where unmet needs are identified.

Coordination with Quality Improvement Programs

The Health Net Utilization Management Department and the delegated PPGs identify and refer sentinel events and potential quality of care/service issues to the Health Net Quality Management Department for tracking and trending, investigation and peer review. This review occurs throughout the scope of utilization/care management activities. Quality of care, quality of service and member complaints are monitored and analyzed by the Peer Review Investigations Team (PRIT) to determine whether further actions are needed, including but not limited to: review by the Peer Review Committee (PRC). Corrective actions, as appropriate, may be imposed by the PRC and are designed and monitored to continually improve member care and service.

Coordination with Internal Programs

For delegated providers, Health Net requires regular, standardized UM reports. For non-delegated providers and with the aforementioned submitted material, Health Net's Utilization Management Department:

- Identifies and refers sentinel events and potential quality of care/service issues to the Quality Management Department for tracking and trending, investigation and peer review. This review occurs throughout the scope of utilization management and care management activities.
- Identifies and refers appropriate members for Public Health, Long Term Services and Supports (LTSS), waiver programs and "Carve Out" services, e.g., CCS, Members with Serious Mental Health, School Based Services (LEA carve out) and Regional Centers.
- Identifies and refers appropriate members for Health Education Services, including tobacco cessation and obesity prevention programs.
- Identifies and refers appropriate members for Cultural and Linguistic Services, including members needing translation of documents or interpreter service for office visits.

- Offers disease/chronic condition management Programs for all members who meet enrollment criteria for specific gateway conditions regardless of a member's delegated provider group status. Disease/chronic condition management activities are provided in coordination with Health Net and/or PPG UM activities.

Behavioral Health Care Services

The behavioral health team administers the Medi-Cal mild to moderate mental health services carved into the Managed Care Plans.

The behavioral health team provides early and periodic screening, diagnosis and treatment services for members ages 0 to 21. These services include medically necessary Behavioral Health Treatment (BHT) services such as Applied Behavioral Analysis (ABA) and other evidence-based behavioral intervention services that develop or restore to the maximum practicable, the functioning of the members diagnosed with Autism Spectrum Disorder (ASD) as well as other disorders that result in behavioral disturbances.

The behavioral health team will manage specified mental health benefits to adults and children who are diagnosed with a mental health disorder, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM) resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning. Members with moderate to severe distress or impairment as well as members seeking other services not provided by the behavioral health team, will be referred to the County Specialty MHP.

The behavioral health team's utilization management decisions are based on the behavioral health team's evidence-based criteria set forth by nonprofit professional associations for the relevant clinical specialty; and the Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). The behavioral health team's evidence-based criteria guidelines include the American Psychiatric Association Practice Guidelines, the American Psychological Association and the Council of Autism Service Providers.

Federal law requires a health insurance issuer to establish parity in the terms and conditions applicable to medical and mental health benefits, as specified. All covered mental health and substance use disorder benefits must be provided in compliance with the provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) and all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26 and Section 10112.27). the behavioral health team and Health Net do not impose Quantitative Treatment Limitations (QTL), or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and substance use disorder services than are imposed on medical/surgical services in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq., to timelines and processes. Community Health Plan of Imperial Valley shall also ensure direct access to an initial mental health assessment by a licensed mental health provider within the Plan's provider network. Community Health Plan of Imperial Valley will not require a referral from a PCP or prior authorization for an initial mental health assessment performed by a network mental health provider. Community Health Plan of

Imperial Valley will cover the cost of an initial mental health assessment completed by an out-of-network provider only if there are no in-network providers that can complete the necessary service.

Utilization management techniques are considered an NQTL under the definitions of the federal rules. The behavioral health team may not impose an NQTL with respect to mental health or substance use disorder benefits in any classification unless the processes, strategies, evidentiary standards, and other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used in applying the limitation with respect to medical/surgical benefits in the classification, timelines and processes in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq.,

Further, the underlying processes, strategies, and evidentiary standards, considered by the behavioral health team and Health Net when determining if a NQTL will apply to a service, will be conducted in an equitable manner across all medical/surgical and mental health and substance use disorder benefits. Factors considered in the determination process are supported by internal data reports, internal medical records review, credible medical literature, peer-reviewed journals and other scientific evidence.

The core objective of utilization management at the behavioral health team is to manage available behavioral health care benefits to achieve the best possible clinical outcomes for members with the most efficient use of resources. The focus of the process is on care, not costs. To that end, the behavioral health team has developed a clinical infrastructure to support its system as follows:

- Treatment is in the least restrictive setting at which safe and effective treatment can be rendered; this helps to preserve and foster as much independence, freedom and autonomy for the patient as possible.
- Multidisciplinary cooperation incorporates the unique perspectives and skills of behavioral health disciplines.
- A systems orientation views the patient as a member of his/her family, job, social system, and community network, all of which may be involved in the treatment plan.
- The behavioral health team utilization management program provides clinical review for services requiring authorization. The bulk of the outpatient services provided by the behavioral health team do not require authorization. All behavioral health team staff making utilization management decisions are appropriately licensed Care Managers and Medical Directors.

The behavioral health team coordinates Continuity of Care (COC) for members following existing COC provisions under California state law.

Pharmacy

The corporate pharmacy division of Health Net, Centene Pharmacy Services, administers and manages the medical drug benefit for Health Net's Medi-Cal

membership. Programs are developed to ensure appropriate utilization of medications: Medical Benefit Drug Prior Authorization, Education programs for physicians and members, and Pharmaceutical Safety.

A Pharmacy and Therapeutics Committee, consisting of community practicing Physicians, Health Net Pharmacists and Medical Directors review and approve all medications administered under the medical benefit, as well as approve all criteria guiding prior authorization decisions.

Continuity and Coordination of Care

Several mechanisms are implemented to monitor, evaluate and facilitate continuity and coordination of care among its members served by delegated and non-delegated providers. These activities include:

- The administration of care management for complex cases requires the use of multiple health services. Care Managers act as facilitators, resource finders and coordinators who are responsible for bridging communication and problem solving with practitioners. In addition, they assist in facilitating members and their families to implement a smooth and coordinated plan of care.

- Implementation of specific population-based, chronic condition management or disease-focused interventions such as interventions for frequent emergency room utilization, high risk perinatal care management, asthma or diabetes.

- Coordinating transition of care for members who are currently under care and are new to the Plan or are changing providers: All Medi-Cal Plan members with pre-existing provider relationships have the right to request continuity of care in accordance with state law, and the Plan Medi-Cal contract, with some exceptions.

- Members/Providers who make a continuity of care request to the Plan are given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. These eligible members may require continuity of care for services they have been receiving through Medi-Cal FFS or through another Managed Care Plan (MCP). The Plan will automatically provide 12 months of Continuity of Care for a member in a skilled nursing facility or for the provision of completing covered services by a terminated or out of network provider.

- The continuity of care process is facilitated by licensed nurses based on member or provider request and meeting of continuity of care conditions per DHCS and DMHC regulatory requirements.

- Care Managers are patient advocates and assist members to ensure that they receive timely and uninterrupted medical care during the transition process.

<u>Primary Care Physician responsibility:</u>

The Primary Care Physician is responsible for the management and coordination of a member's complete medical care including initial and primary care, initiating specialty referral, and maintaining continuity of care to include coordination of specialty care, emergency services, and inpatient services.

Health Net supports the medical home model of primary care, and provides significant support to the primary care provider practices. This support ensures the primary care doctor has all care plans, and health risk assessments created by Health Net's programs or by one of the County or carve out programs such as CCS on file. Health Net requires that primary care providers provide in-office access to patients at a minimum of 20 hours per week and have availability for urgent and emergent member needs 24 hours a day, 7 days a week.

As an additional aid to the primary care provider, Health Net provides a nurse advice line 24 hours a day, 7 days a week. Health Net strives to continually meet the access and availability standards through our network relationships, member and provider education and triage services.

Over and Under Utilization

All providers are required to submit to Health Net claim/encounter data for all services. Multiple methodologies are utilized to monitor under and over utilization, referral timeliness, provider appeals, denials and member appeals and grievances. The types of methods include:

- Annual on-site evaluation of network-wide PPGs Medi-Cal utilization management programs
- Over/Under utilization identified through member complaints tracking
- Focused audits
- Analysis of medical group-specific inpatient utilization, ER usage, and pharmacy data
- Evaluation of individual direct contract physician practice patterns

Health Net's Utilization Management Department and the behavioral health team facilitates the delivery of health care services and monitors the impact of the UM Program to detect and correct potential under- and over-utilization through these comprehensive monitoring efforts:

- Establishing thresholds for compliance and measures compliance to guidelines
- Monitoring utilization data collected to detect potential under- and over-utilization.
- Routinely analyzing all data collected to detect under- or over-utilization.
- Analysis occurs on a semi-annual basis at minimum to ensure appropriate service and to identify opportunities for improvement.
- Tracks performance against established goals
- Implementing appropriate interventions when problems are identified.
- Educates and addresses variances from agreed upon clinical criteria
- Monitors provider prescribing patterns including medication utilization metrics
- Conducts provider outreach programs to modify performance

- Measuring whether the interventions have been effective and implementing strategies to achieve appropriate utilization.

Examples of data types and metrics identified that are relevant to provision of medically necessary services for all members. Examples:

- For outpatient services, units/1000.
- For outpatient services, unique patients/1000.
- For outpatient services, units/unique patient.
- Report likely driving factors for the above patterns of utilization.
- Population Health Management key performance indicator metrics
- Dental anesthesia data is analyzed to identify and mitigate issues that may adversely impact the provision of medically necessary services received by members.
- In addition, suspected fraud, waste and abuse of medical services is monitored and reported.
- Provider prescribing patterns including medication utilization metrics

Health Net completes the Quality Management education process with its contracted providers through local interaction with the Medical Directors at the Joint Operations Meetings, the Delegation Oversight team, the Provider Manual and Provider Updates, corrective action plans, the peer review and credentialing process.

Utilization Decision Criteria

Health Net's Utilization Management Program use the following guidelines to make medical necessity decisions (numbered in order of significance) on a case-by-case basis, based on the information provided on the member's health status:

A. State law/guidelines (Title 22 CCR, Title 17 CCR, Medi-Cal Managed Care Division (MMCD) All Plan, Policy and Duals Plan Letters, and California Department of Health Care Services (CA DHCS) Medi-Cal Provider Manuals. State definition of medical necessity: Title 22 CCR Section 51303(a) and expanded for those under the age of 21 in W & I Code Section 14132 (v))
B. Plan-specific clinical policy (including plan-specific clinical policies in InterQual® as custom content and vendor specific criteria);
C. Centene clinical policy (including Centene clinical policies in InterQual® as custom content);
D. If no Plan, or Centene specific clinical policy exists, then nationally recognized decision support tools such as InterQual® Clinical Decision Support Criteria or MCG (formerly Milliman Care Guidelines®) criteria are used;
E. In the case of no guidance from A-D, additional information that the applicable Health Plan Medical Director will consider, when available, includes:
    1. Reports from peer reviewed medical literature, where a higher level of evidence and study quality is more strongly considered in determinations;
    2. Professional standards of safety and effectiveness recognized in the US for diagnosis, care, or treatment;
    3. Nationally recognized drug compendia resources such as Facts & Comparisons®, DRUGDEX®, and The National Comprehensive Cancer Network® (NCCN®) Guidelines
    4. Medical association publications;

5. Government-funded or independent entities that assess and report on clinical care decisions and technology such as Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, National Institute for Health and Care Excellence (NICE), etc.;
6. Published expert opinions;
7. Opinion of health professionals in the area of specialty involved;
8. Opinion of attending provider in case at hand.

Benefit determinations are based on the following:
A. Medi-Cal Benefit Plan Contract
B. Applicable State and Federal Requirements
C. Member Handbook/Evidence of Coverage
D. Preferred Drug List (PDL)

When state Medicaid coverage provisions conflict with the coverage provisions in Plan- or Centene-specific clinical policy, state Medicaid coverage provisions take precedence. Refer to the state Medicaid manual for any coverage provisions. Clinical policies, benefit provision, guideline, protocol or criteria are available upon request per Federal and State regulatory guidelines.

Separation of Medical Decisions from Fiscal and Administrative Management

In Health Net's UM Program, medical decisions made by Plan or PPG medical directors will not be unduly influenced by fiscal or administrative management. In order to accomplish this, Health Net affirms that:

- Utilization management decisions are based on medical necessity and medical appropriateness
- Health Net does not compensate physicians or nurse reviewers for denials of service requests
- Health Net does not offer incentives to encourage denials of coverage or service and attention is paid to the risk of under-utilization
- Health Net and its delegates distribute to all practitioners, providers, and employees a statement describing Health Net's policies and restrictions on financial incentives
- Utilization management decision making is based only on appropriateness of care and service and existence of coverage
- Health Net delegates do not reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service
- Health Net Medi-Cal Medical Directors and the Health Net Community Solutions CMO/VP Medical Director do not report to Health Net's Chief Financial Officer or its Marketing Director

Consistency of Application of Utilization Decision Criteria

Inter-rater Reliability (IRR) Review Process:

New hire and annually, IRR testing are conducted on all licensed UM clinicians with the responsibility to conduct, educate, audit, and/or oversee UM medical necessity reviews.

New UM staff are required to successfully complete IRR testing prior to being released from training oversight.

Staff are required to test on the Medical Necessity Criteria products applicable to their role. All staff must score 90% or greater for any new hire and annual IRR test. If a staff member scores < 90% for any subset the staff must complete remediation and successfully retest within 30 days of completing remediation. Documented Coaching will be initiated by the People Leader for any staff with a final score of less than 90% for any IRR test. Documented Coaching may include but is not limited to the following: precepting of staff, retraining of the staff by reviewing the Initial/Retake IRR test(s) or auditing five (5) cases in production, for any IRR Product(s) not passed. In the event the New Hire and Annual IRR test(s) are not completed within the designated testing period, a failure of all applicable IRR tests is applied, and Documented Coaching is initiated by the People Leader.

IRR results are reported annually at the HNCS Quality Improvement Health Equity Committee Meeting and subsequently to CHPIV.

Health Net evaluates delegated PPGs' consistency of application of decision criteria through:

- Annual PPG oversight audit, which requires a file audit of denial files using Health Net Provider Delegation Audit Tool with Medi-Cal Addendum
- Annual PPG oversight audit with specific inter-rater reliability verification
- Routine reporting of UM activities on a quarterly basis
- Health Net's Medical Directors evaluate and review all member appeals for PPG denied services for appropriate use of medical necessity criteria. Health Net's Medical Directors provide feedback as needed to PPG Medical Directors through letters or telephonic communication as needed

Standards of Timeliness of UM Decision Making

Health Net follows established time frames for internal and delegated PPG decision making to minimize any disruption in the provision of health care. The established time frames regarding medical necessity and authorization depend on the urgency of the clinical situation. Turnaround Time (TAT) Standards for requests are based on current DHCS, DMHC, and/or State regulatory guidelines, whichever guideline maintains the most stringent standard, is applied.

Health Net's delegated providers are informed of the decision timeliness standards in the Provider Operations Manual. Health Net Delegation Oversight, monitors the compliance of each medical group monthly and performs an annual evaluation including review of timeliness. All requests for determination are communicated back to the member and the provider within the timeframes and methods dictated by the DHCS, DMHC, and/or State regulatory guidelines, whichever is the most stringent requirement.

Denials

A member case is referred to the appropriate clinical practitioner, i.e., a Medical Director or a Pharmacist when UM medical necessity criteria are not met. He/she may request additional pertinent clinical information, may contact the requesting practitioner by telephone to discuss the case, or may consult with a board-certified medical specialist before making the determination of medical necessity.

For any Major Organ Transplant (MOT) denial consideration, the HNCS Chief Medical Officer (CMO), or a delegated HNCS senior Medical Director reviews the request and determines the appropriateness of a denial.

The appropriate clinical practitioner makes UM medical necessity denial decisions, clearly stating the reason for the denial. Members, practitioners and providers receive written notification of all denials in accordance with all regulatory guidelines.

Denial notification letters include the reason for the denial, criteria utilized in the decision, benefit coverage when appropriate, the appeal mechanism, the right to a Fair Hearing, DHCS and DMHC required specific language, and alternative treatment recommendations when applicable. Health Net has implemented translation of denial letters into “threshold languages” in collaboration with Health Industry Collaboration Effort (HICE).

Rationale contained in denial letters includes a summary denial reason/rationale that is easily understandable for the member. In addition, a detailed denial reason/rationale is included which outlines benefit provisions, guidelines, protocols or similar criteria on which the denial is based.

Should the requesting practitioner wish to discuss the case related to the denial decision, they are provided with the telephone number of the individual who issued the denial and the Medical Director contact information is available on the provider portal website.

Appeals

A licensed physician reviews all member medical necessity appeals.

Community Health Plan of Imperial Valley has established procedures and turnaround times for standard and expedited appeals including the right to an external review.

Under the Administrative Service Agreement with CHPIV, Health Net is responsible for appeals for their members. Health Net receives the appeal, collects the clinical information, prepares the case and initial review and determinations are made by a Health Net Medical Director.

Health Net maintains well-publicized and readily available appeal mechanisms for members and practitioners for medical necessity denials issued by CHPIV or its delegates.

Each denial letter that is sent to the member includes the member’s right to appeal and/or fair hearing, independent medical review, and instructions on how to initiate a routine or expedited appeal.

The member's right of appeal is communicated to the practitioners in the Provider Operations Manual and to the members in the copies of denial notifications sent. The Member Handbook also delineates the appeals process describing how to initiate an appeal verbally by contacting the Member Services Department by phone. The Member Services representative then forwards requests for member appeals to the Appeals and Grievances Department.

Practitioner appeals are forwarded to the Provider Services Department. Appeals initiated by practitioners on behalf of a member for medical services that have not yet been provided are considered to be member appeals.

Health Net Medical Directors will utilize board certified physician consultants from appropriate specialty areas, including behavioral health, to determine medical necessity when specialty specific input is deemed necessary.

Evaluation of Medical Technology and Procedures

Health Net has a formal process for recognizing and evaluating advances in new medical technologies, behavioral health procedures, pharmaceuticals, devices, and new applications of existing technologies to ensure members have equitable access to safe and effective care and for inclusion in applicable benefit packages.

The Change Healthcare/Optum InterQual® criteria, the Hayes, Inc. Medical Technology Directory and other evidence-based resources are used as primary sources. This includes:

- Nationally recognized drug compendia resources such as Facts & Comparisons®, DRUGDEX®, and the National Comprehensive Cancer Network® (NCCN®) Guidelines.
- Medical association publications, government-funded, or independent entities that assess and report on clinical care decisions and technology, including Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, and National Institute for Health and Care Excellence (NICE).

In addition to Health Net's primary sources, Centene's Corporate Clinical Policy Department and Clinical Policy Committee in conjunction with Health Net of California's Medical Advisory Council are responsible for the evaluation of new technology that may be sought by members. A critical appraisal of the current published medical literature from peer-reviewed publications is undertaken to assist in the evaluation of medical technology.

Satisfaction with the Utilization Management Process

At least annually, Health Net surveys members and practitioners regarding their satisfaction with utilization management procedures and addresses identified areas and sources of dissatisfaction with interventions implemented by Health Net or delegated PPGs. Reports are presented at the HNCS QIHEC where recommendations for

corrective action are made. Member and practitioner satisfaction information is reported at the HNCS QIHEC Committee.

Communication Services

The Plan, the behavioral health team and the delegated partners provide access to Utilization Management staff for members and practitioners seeking information about the utilization management process and the authorization of care. Staff within Health Net, the behavioral health team and delegated partners are available at least eight hours a day during normal business days to receive and respond to inbound inquiries. In addition, Medi-Cal members have 24/7 access to the nurse advice line. Inbound and outbound communication regarding utilization management issues is accomplished through the following:

- Toll-free member/provider services telephone number/fax or email.
- Voicemail message capability during and after business hours; message retrieval for messages left after hours performed the next business day.
- Free translation and interpreter services for CHPIV members upon request

The Plan will notify contracting health care providers, as well as members and potential enrollees upon request of all services that require prior authorization, concurrent authorization or post-service authorization and ensure that all contracting health care providers are aware of the procedures and timeframes necessary to obtain authorization for these services.

Emergency Services

Health Net and its delegated PPGs provide geographically accessible coverage for emergency services to all members. Emergency services are for covered medical, surgical or psychiatric conditions manifesting themselves by acute symptoms of sufficient severity such that a prudent layperson with an average knowledge of health and medicine could reasonably expect serious impairment of his or her person from the presenting symptoms without such care. Emergency services are covered inpatient and outpatient services when furnished by a qualified provider and needed to stabilize an emergency medical condition. Emergency services are covered both inside and outside the plan or network and do not require pre-authorization.

Monitoring of Health Net's Performance in Providing and Management of Utilization Management Services

CHPIV monitors Health Net performance via a combination of Quality-based and Compliance-based approaches. Various metrics (e.g., prior auth denials, auth approval turn-around times) are monitored on a continuous basis. Other metrics (e.g., case file reviews) are audited on a quarterly/semiannual/yearly cadence. Health Net's

performance is also reviewed via participation in various committees (e.g., Quality Improvement Health Equity Committee, UM Review Committee).

Evaluation of the Health Net UM Program Description and the UM Policies and Procedures

After Health Net completes its internal review and approval process, the CHIPV UM Program Description is forwarded to CHIPV for review and approval.

Section 4

Organizational Structure and Resources

Organizational Structure and Resources

Community Health Plan of Imperial Valley Staff Resources and Accountability

CHPIV Chief Medical Officer/Chief Health Equity Officer (CMO/CHEO)

The CHPIV CMO/CHEO's responsibilities include chairing the Quality Improvement Health Equity Committee and work group, providing oversight of Quality Improvement Health Equity Programs, and assuring that the Quality Improvement, Health Equity and Utilization Management Programs are compatible and interface appropriately with the provider network, overseeing compliance with regulatory standards and reporting requirements; and achieving consistency in Utilization Management operations. This position makes recommendations to the LHA Commission to initiate major program revisions and communicates the LHA Commission's directives to both internal and external stakeholders.

Department Resources

CHPIV staff, with assistance from HNCS interdisciplinary staff, contributes to the success of the CHPIV UM Program. These administrative and clinical staff work with CHPIV's CMO/CHEO and Director of Medical Management to oversee UM activities for CHPIV's Medi-Cal members and provider network. The resources and responsibilities of departments most involved in the UM process are described below.

Medical Management Team

The Medical Management team will include a CMO/CHEO, Director of Medical Management Services, who is a Registered Nurse, a Medical Management Manager, a Nurse Analyst, and an Administrative Coordinator to monitor and evaluate the adequacy and appropriateness of health and administrative services on a continuous and systematic basis. CHPIV and HNCS will ensure that staff involved with the Utilization Management program are appropriately trained and experienced in Utilization Management, Safety, Public Health, Health Administration, and Care Management.

CHPIV Quality Improvement Health Equity Committee

The purpose of the CHPIV Quality Improvement Health Equity Committee (QIHEC) is to provide oversight and guidance for CHPIV's QI, HE, UM, and Credentialing Programs, monitor delegated activity, and provide professional input into development of medical policies.

The QIHEC Committee monitors the quality and safety of care and services rendered to members, identifies clinical and administrative opportunities for improvement, recommends policy decisions, evaluates the results of QI and UM activities, institutes needed actions, and ensures follow up as appropriate.

The QIHEC Committee is given its authority by and reports to the Imperial Local Health Authority (LHA) Commission in an advisory capacity. Members of the committee are appointed by the LHA Commission Chairperson. The Committee is chaired by the CHPIV CMO/CHEO.

Committee size is determined by the LHA Commission with the advice of the CMO/CHEO.

The QIHEC Committee is composed of Participating health care providers, including physicians, behavioral health practitioners, as well as other health care professional's representative of the CHPIV and the Health Net provider network. The Committee composition may also include Commission members who are participating health care providers and shall be composed of less than a quorum of voting Commissioners. Committee membership shall reflect an appropriate geographic and specialty mix of participating practitioners including practitioners that serve the Seniors and Persons with Disabilities (SPD) population and provide mental health services. Participating Practitioners from other specialty areas are retained as necessary to provide specialty input.

Health Net Organizational Structure and Resources

Health Net LLC's Chief Medical Officer has direct responsibility for the Utilization Management Program.

Population Health and Clinical Operations (PHCO) Resources

Health Net, LLC Chief Medical Officer (CMO)

The Health Net, LLC CMO's responsibilities include assuring that the QI and Utilization Management Programs are compatible and interface appropriately with the provider network; overseeing compliance with regulatory standards and reporting requirements; and achieving consistency in QI Utilization Management operations.

The CMO has overall decision-making responsibilities for Health Net medical matters. The CMO oversees, directs and coordinates all health services functions in partnership with Senior Medical Directors, Medical Directors and other PHCO leadership team members. PHCO departments for which he/she has clinical oversight responsibility to include: Quality Improvement, Utilization Management, Care Management, Appeals and Grievances, Compliance, Program Accreditation and Disease/Chronic Condition Management.

The CMO's responsibilities include, but are not limited to: leading the health plan in California PHCO initiatives and corporate strategic directives; overseeing medical activities, programs and initiatives to monitor quality of care, delivery and access; directing the implementation of the Utilization Management Program; working collaboratively with other Health Net departments (e.g., Sales, Marketing, Contracting, Network Management and Pharmacy Management); leading analysis of management, financial and utilization reports to target areas for improvement; and overseeing compliance with accreditation standards and regulatory requirements.

Health Net Community Solutions (HNCS) CMO/ Vice President (VP) Medical Director

The HNCS CMO/VP Medical Director, is responsible for Utilization Management and Care Management activities for Medi-Cal. In addition, the HNCS CMO/VP Medical

Director is responsible for QI activities for these programs. The HNCS CMO/VP Medical Director is the chair of the Health Net Community Solutions Quality Improvement Health Equity Committee and is actively involved in implementing the UM Program. The HNCS CMO/VP Medical Director reports to HN LLC's CMO.

This position makes recommendations to the Health Net Community Solutions Board of Directors to initiate major program revisions and communicates Board of Directors' directives to both internal and external stakeholders.

Medical Directors

The Medical Directors administer and coordinate the overall development of medical policies, utilization and care management programs and integrating physician services with the organization's medical service and delivery systems to ensure the best possible quality care for the Health Net members in all product lines. The Medical Directors provide input and recommendations to the various departments within the organization as to policies and procedures that impact the delivery of medical care. The Senior Medical Directors participate actively in quality improvement committees and programs to obtain and ensure continued accreditation with regulatory bodies.

Health Net Medical Directors are physicians with current, unrestricted licenses responsible and accountable for ensuring appropriate clinical relevance and focus of the Utilization Management Program for all product lines.

The Medical Directors interface with Participating Provider Groups (PPG), individual practitioners and facilities on a day-to-day basis to ensure the performance of the provider community meets established Health Net standards. They facilitate utilization review and quality improvement initiatives to ensure quality and cost-effective delivery of health services. The Medical Directors maintain effective, constructive and innovative relationships with the physician groups statewide. They provide expert clinical support and assistance to the Health Net's Utilization Management staff and other Health Net staff.

Additionally, each Medical Director recommends policy/program changes to improve performance and enhance the Quality Improvement Programs as well as serving as consultants and clinical resources to the Quality Improvement and Utilization Management staff. Committee involvement comprises of Health Net Quality Improvement and Health Equity Committee, Credentialing Committee, Peer Review Committee, Delegation Oversight Committee and Medical Advisory Council.

Vice President of Population Health and Clinical Operations (VP PHCO)

The VP PHCO is a registered nurse with experience in utilization management and care management activities. The VP PHCO is responsible for overseeing the activities of the Plan's Utilization Management and Care Management Programs. The VP PHCO reports to the Plan Chief Operating Officer. The VP PHCO, in collaboration with the HNCS CMO/VP Medical Director, assists with the development of the Utilization Management Program strategic vision in alignment with the corporate and Plan objectives, policies, and procedures.

The VP PHCO is responsible for executing the Utilization Management Program, which includes but is not limited to, pre-service, inpatient concurrent review, retrospective review and care/chronic condition management. This individual is responsible for the organization-wide implementation, assessment and measurement of utilization management activities in order to improve the quality of care and services provided to the membership.

Utilization Management (UM) Resources

Director, PHCO

The Directors are responsible for statewide oversight of the UM Program and:

- Oversee the daily operational processes to assure continuum of care.
- Participates in planning and development of processes and procedures to assure organizational and regulatory requirements are met.
- Ensures a patient advocacy approach with a seamless integration of services and balance within the member's benefit structure.
- Emphasizes continuity of transition of care, assisting members in obtaining access to care, and member education.
- Ensures the appropriate coordination and timely CCS referrals.

Health Net UM Clinical Staff

HN UM clinical nursing staff (i.e., Review Nurses) has responsibilities, which may include but are not limited to:

- First level approvals of pre-service, concurrent and post-service approvals of care,
- Case review for inpatient, outpatient, and ancillary service requests,
- Discharge planning and authorizations for post-hospital support and care,
- Referral of potential UM denial cases to a Medical Director,
- Referral of members to Care/Chronic Condition Management when appropriate,
- Management of out-of-area cases, and
- All UM LVN, LCSW and RN staff are under the direct supervision of a Manager, who is an RN.

Additional Resources

- Additional licensed and clerical staff supports UM activities.
- Referral of members to County CCS offices when eligible
- Referral of members to LTSS and Waiver Programs
- Coordination with Regional Centers to ensure Medi-Cal members receive the full range of benefits to which they are entitled
- Coordination with CCS offices, PPG's and facilities to ensure the CCS eligible members are receiving their full benefits through managed care and carve out programs
- Referral to Local Educational Agencies (LEA) for therapeutic and diagnostic services related to educational performance
- Coordination with County programs, such as County social services for in home support services and County mental health

- Monitoring effectiveness of delegated entities and contracted providers

The Behavioral Health Team Medical Director and Medical Staff

The behavioral health Medical Director is a board-certified psychiatrist responsible for providing clinical and administrative leadership in the area of behavioral health. In addition to overseeing the implementation of behavioral health program and clinical policies, the behavioral health team Medical Director advises the quality improvement committee/sub-committees on behavioral health issues and provides specialty consultation for UM activities as well as Appeals and Grievances.

The behavioral health team Medical Staff has duties which encompass two areas: overseeing the comprehensive quality improvement program for all aspects of BH care delivery, and ensuring that adequate and timely BH services are available to all HN members. The behavioral health team Medical Staff works with the HN Quality Improvement/Program Accreditation Department staff to collect and analyze data on availability, access, member satisfaction, and continuity and coordination of behavioral health care. Data are analyzed and reported to the HNCS QIHEC. The behavioral health team Medical Staff sits on the following committees: HNCS QIHEC, HN Credentialing Committee, the HN Pharmacy and Therapeutics Committee, and the HN Medical Advisory Council.

Only physicians, doctoral-level clinical psychologists (as appropriate for behavioral health reviews), and pharmacists may issue medical necessity denial determinations. All licensed staff has education, training and professional experience in clinical practice.

Health Net Community Solutions (HNCS) Quality Improvement Health Equity Committee (QIHEC)

The HNCS QIHEC reports directly to the HNCS Board of Directors. The committee is charged with the monitoring of the PHCO and quality of care and services rendered to members within HNCS including identification and selection of opportunities for improvements, monitoring interventions and addressing UM, QI, PMH and Health Equity activities which effect implementation and effectiveness. In order to integrate UM activities into the QI system, the HNCS QIHEC quarterly reviews reports of the number and types of appeals, denials, deferrals and modifications. The Committee membership includes a designated behavioral health care practitioner for any discussion of behavioral health aspects of UM/QI. The Committee membership also includes practicing network physician representatives. The HNCS QIHEC is co-chaired by the HNCS CMO/VP Medical Director and the Chief Health Equity Officer for HNCS and meets quarterly.

Section 5

Delegation

Delegation

Health Net delegates utilization management to eligible contracted Participating Provider Groups (PPGs), contracted vendors and strategic partners (delegated partners).

Health Net has a thorough process in place to assess a potential delegate's readiness for delegation and to systematically monitor the performance. Health Net has designated Utilization Management (UM) Compliance Auditors to perform this evaluation. UM Compliance Auditors evaluate and monitor delegated partners annually, or more frequently if needed, to ensure compliance with Federal, State, Contractual and Health Net's criteria for delegated activities. Additionally, UM Compliance Auditors are the responsible party to oversee Corrective Action Plans (CAPs) when such plans are needed.

Outside of scheduled audits, UM Compliance Auditors, in conjunction with the Medical Directors, focus efforts on delegated partners with areas of noncompliance that indicate potential problems in the UM process to implement improvement strategies. UM Compliance Auditors evaluate and report on the effectiveness of the improvement strategy to the Delegation Oversight Workgroups (DOW)/Delegated Oversight Committee (DOC). Summary reports are provided to CHPIV's monthly Management Oversight Meeting.

Delegated partners are required to submit monthly/quarterly reports (for Medi-Cal) to Health Net. Reports are reviewed and assessed for content and feedback is given for reports submitted.

Responsibility of Delegation Oversight includes, but is not limited to:

A. Assessing and determining the appropriateness of delegation for each component of the delegated responsibilities: utilization management, credentialing and recredentialing, claims processing and payment. Communicates all delegation decisions, as well as any recommendations and requests for corrective action plans (CAPs), to the delegated partners in writing.

B. Performing ongoing monitoring of any open CAP items as requested by the Delegation Oversight Workgroup (DOW)/Delegation Oversight Committee (DOC). This may include additional file reviews, policy and procedure reviews, and educational sessions, on site meetings to ensure the delegated partner is meeting compliance.
C. Performing any additional delegation oversight activities as requested by the DOC.

Delegation Oversight Committee

A. Reviews Delegation Oversight activities and recommendations of the DOW and, as needed identifies corrective actions specific to delegated partner(s) that are not meeting compliance. The DOC will review the results of annual or focused audits, the corrective actions recommended and already undertaken by the delegate, minutes from the follow-up meetings or correspondence with the delegate, and results of follow-up audits, as appropriate.

B. As needed, initiates remedial actions specific to delegated partner(s) in order to maintain Health Net's compliance with regulatory and accreditation requirements. Remedial actions may include but are not limited to:

- Increasing monitoring/oversight.
- Freezing membership.
- Revoking delegation.
- Terminating the organization's contract with Health Net.
- Imposing financial penalties as allowed per contract.
- Removes sanctions, if appropriate.

Sub-delegation

Delegated partners are obligated to provide oversight and documented evidence of monitoring the utilization review process whenever a sub-delegated provider and/or review organization perform this process. The delegate is required to document evaluation of the following oversight of the sub-delegate activities:

- Written agreement to participate in the delegate evaluation process by the sub-delegate.
- Approval of the sub-delegated contractor's utilization management program.
- A signed sub-delegation agreement.
- Mechanisms for evaluating the sub-delegate's program reports.
- Concise documentation of all utilization management activities that are delegated to a sub-delegate.
- Adherence to reporting requirements by oversight of the sub-delegate.
- At least annual review of the sub-delegate's program.

A review of the contracted delegates shall be performed annually. More frequent assessments shall be performed, as needed. Documentation of these oversight activities shall be maintained by the delegate but must be available for Health Net's review upon request.

Section 6

Utilization and Care Management (UM/CM) Program Evaluation

UM/CM Program Evaluation

Health Net's Vice President of PHCO annually prepares the CHPIV Utilization/Care Management Program Evaluation and presents the evaluation to CHPIV for review.

The annual evaluation of the CHPIV Utilization/Care Management Program provides structure for the determination of program effectiveness and the impact of the program on members and providers. The process identifies program strengths and barriers, improvement opportunities and activities not completed, in addition to assessing demographics and effectiveness of the UM/CM Program initiatives.

The process of evaluation includes a comparison of the results of utilization/care management improvement activities against past year's performance. The evaluation documents evidence of resolution of identified problems or areas needing improvement.

Additional sources of data utilized to obtain feedback from providers and members on CHPIV Utilization/Care Management Program and to identify opportunities for improvement include:

- Member grievances
- Member appeals
- Results of member satisfaction surveys
- Provider appeals
- Provider grievances
- Provider satisfaction surveys
- UM decision making timeliness
- Identification and referral of members eligible for carve-out programs
- HEDIS results
- Information from QI studies
- Joint Operation Meeting information
- PPG Report Cards
- Data and other feedback from Public Health-Linked Programs
- Over and under utilization
- Community Advisory Councils

UM/CM Program Work Plan

Health Net Community Solutions CMO/VP Medical Director and Vice President Population Health and Clinical Operations annually develop the CHPIV UM/CM Work Plan using the previous year's evaluation and adding new UM/CM activities when appropriate. The development of the work plan provides a disciplined approach to UM/CM activity monitoring. The work plan process also encourages measurement throughout the year of progress towards the outlined plan.

Section 7

Approvals

Imperial Local Health Authority Approval

Imperial County Local Health Authority Commission has reviewed and approved this Program Description.

Lee Hindman, Imperial County
Local Health Authority Commission Chairperson

Date

Gordon Arakawa

Gordon Arakawa, MD, PhD
Chief Medical Officer/Chief Health Equity Officer
Chair, Community Health Plan of Imperial Valley QIHEC Committee

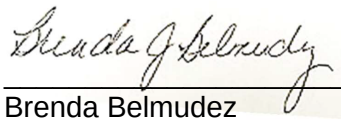
08-05-2024
Date

Health Net Medi-Cal Utilization Management Program Approval

The Chief Medical Officer and Vice President of Medical Management have reviewed and approved this Program Description.

Date 05/21/2024

Alex Chen, MD
Chief Medical Officer



Date 05/21/2024

Brenda Belmudez
Vice President of Population Health and Clinical Operations

Health Services Report

1. Q2 QIHEC Summary
    a. PPT Presentation
2. NCQA Update

Q2 CHPIV Quality Improvement Health Equity Committee Presentation

Utilization Management Metrics

Utilization Management Key Metrics

2024-Q1	Combined
Admissions per Thousand	44.2
Bed Days per Thousand	176.9
Average Length of Stay	4.0
Percent 30-Day Readmission	8.6%
ER per Thousand	344.5
Outpatient Surgery per Thousand	85.4

ED Utilization Recommendations:

1. Comparison to 2023 CHW data
   - Consistent with 2023 data

2. Explore further characterization
   - Q by Q comparisons
   - By Condition(s)
   - By Provider

Appeals & Grievances

Appeals & Grievances

Grievance “Severity”

- Quality of Service (QOS)
- Quality of Care(QOC)
- Potential Quality Issue (PQI)

Appeals & Grievances

Top QOS Grievance Types

QOS	
Transportation - General Complaint Vendor	20
Access to Care - Prior Authorization delay	12
Administrative Issues - Health Plan	6
Access to Care - Network Availability	5
Administrative Issues - Incorrect Info - Health Plan	4
Administrative Issues - Unhappy with Benefits	4

Appeals & Grievances

Top QOC Grievance Types

QOC	
Quality of Care - PCP - Delay in referral by PCP	2
Quality of Care - PCP - Refusal to Treat	1
Quality of Care - Specialist - Inadequate Care	1
Quality of Care - PCP - Misdiagnosis	1

Appeals & Grievances

PQIs

- For Q1, there were 0 Cases or Investigations

HEDIS Measures RY2024

Healthcare Effectiveness Data & Information Set (HEDIS) Measures RY2024

Asthma Medication Ratio	Breast Cancer Screening	Controlling Blood Pressure	Cervical Cancer Screening	Chlamydia Screening (women)	Combo - 10	Combo - 2	Postpartum Care	Prenatal Care Timeliness	10-15 Months	First 15 Months	Child/Adolescent WCV	Follow up ED Substance Abuse	Follow up ED Mental Illness	Poor Hb A1c Control	Lead Screening	Developmental Screening	Topical Fluoride
<25	75	50	25	25	50	75	<25	<25	50	25	50	50	<25	90	75	50	<25
268	0	0	23	2	0	0	11	17	0	2	0	0	21	0	0	0	3412

HEDIS Measures RY2024

Measure Performance – Takeaway Points

1. 10/18 Measures > 50%ile.
2. RY2024 results do not impact CHPIV directly.
3. Regarding the 8 “failed” measures:
   - 2 measures (AMR, Topical Fluoride) appeared out of reach.
   - 6 measures required < 25 Members to pass.
4. Leverage ECM and CHWs to help address the failed measures.

HEDIS Measure Recommendations:

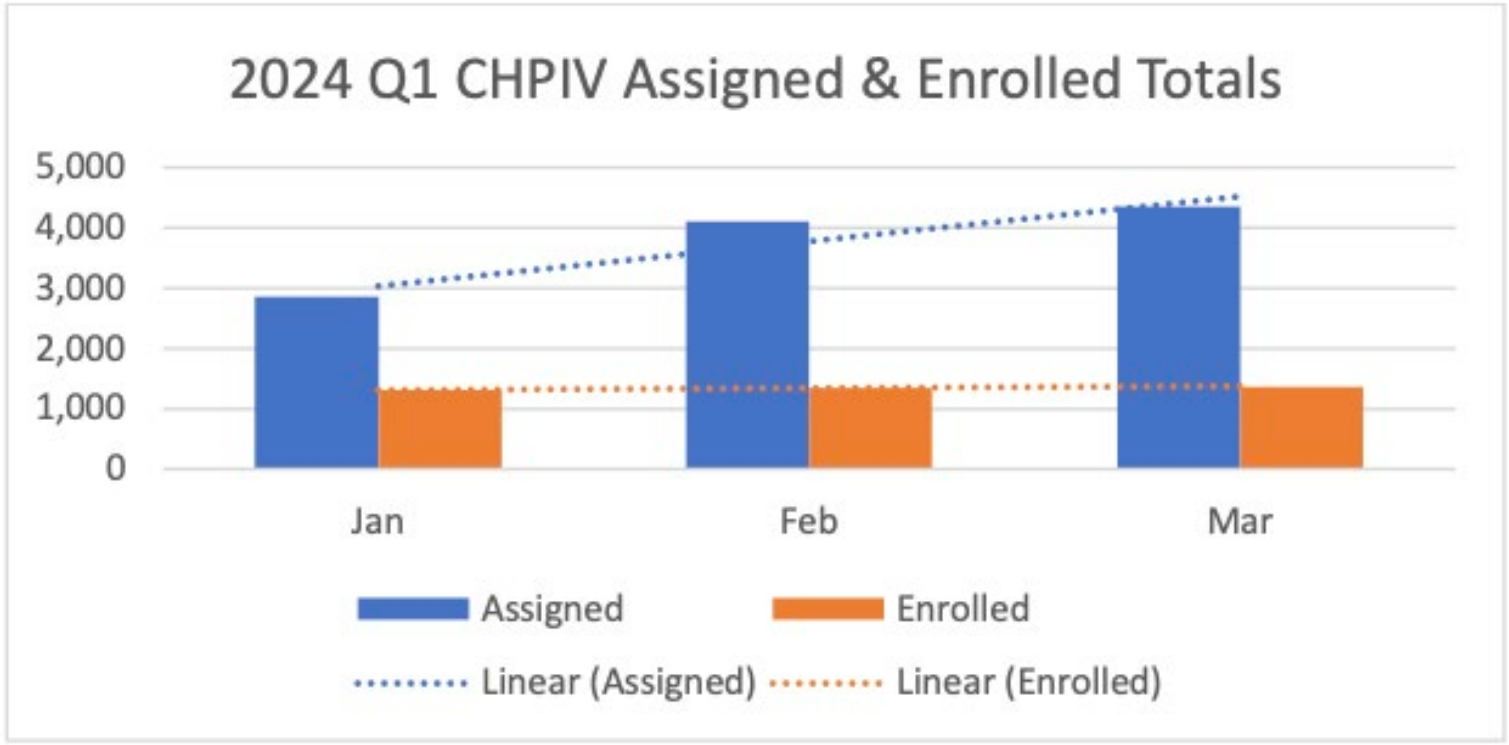
1. Provider engagement
   - Cozeva Utilization
   - **Cozeva Integration**
   - Provider Relations
   - Funding opportunities (e.g., EDGE funding)

2. Explore ways to identify trends earlier
   - Health Net has extensive tracking system

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

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

ECM Enrollment



Q1-Q4 Cumulative Enrollment Totals			
County	**Assigned**	**Membership**	**% Enrolled**
Imperial	**4,352**	**1,370**	**31.5%**

ECM Recommendations

1. Elucidate the Member assignment process

2. Explore ways to increase enrollment ratios

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

CS Authorizations to Claims Count

Behavioral Health

Behavioral Health/SUD

IMPERIAL COUNTY

Q1 2024 Screening Tools Completed:

Screening Tool Type	202401	202402	202403	Total
Adult	**17**	**11**	**4**	**32**
MCP (NSMHS)	14	10	4	28
MHP (SMHS)	3	1	0	4
Youth	**5**	**6**	**2**	**13**
MCP (NSMHS)	5	6	2	13
MHP (SMHS)	0	0	0	0
Grand Total	**22**	**17**	**6**	**45**

Behavioral Health/Substance Abuse Disorder Recommendations

1. Explore ways to evaluate the true volume of BH/SUD screening taking place
   - Physician’s Offices, County Behavioral Health/SUD

Quality Improvement Projects

Quality Improvement Projects - 2024

IHI/DHCS Child Health Equity Initiative - Increase Completion of Well Child Visits (WCV)

12 Month Collaborative Sprint (4/24 - 4/25)

Population of Focus: 0-18-year-old Members

Imperial County - **Dr. Vishwa Kapoor**

Five Interventions to be completed at each Pilot Site

1. Focused Intervention each 1-3 months
2. Test and Implement Changes

Quality Improvement Projects - 2024

IHI/DHCS Child Health Equity Initiative

1. Equity and Transparent, Stratified, and Actionable Data
2. Understand Provider and Patient/Caregiver Experiences
3. Reliable and Equitable Scheduling Processes
4. Asset Mapping and Community Partnerships
5. Partnering for Effective Education and Communication

Peer Review Credentialing

Peer Review Credentialing and Access Reports

Investigations

For Q1

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

Credentialing/Recredentialing

Q1 & Q2 Data to be presented at Q3 QIHEC

Questions & Comments

Delegation Oversight Monitoring Program – 2024 Quarter 1

The CHPIV Delegation Oversight Monitoring Program is currently evaluating Health Net's performance across various high-risk delegated functions for 2024 Quarter 1 (January through March). Performance metrics are classified into four categories based on data accuracy and availability: compliant (green), at risk (yellow), non-compliant (red), and not reportable (grey).

The final quarter 1 scorecard (**Exhibit 1**) was delivered to Health Net on July 11, 2024. High performing areas are appeals timeliness of acknowledgement, decisions, and member notifications, continuity of care notification timeliness, calls answered within 30 seconds, call center abandonment rates, and grievance timeliness of resolutions and member notifications.

The following table outlines the non-compliant areas identified:

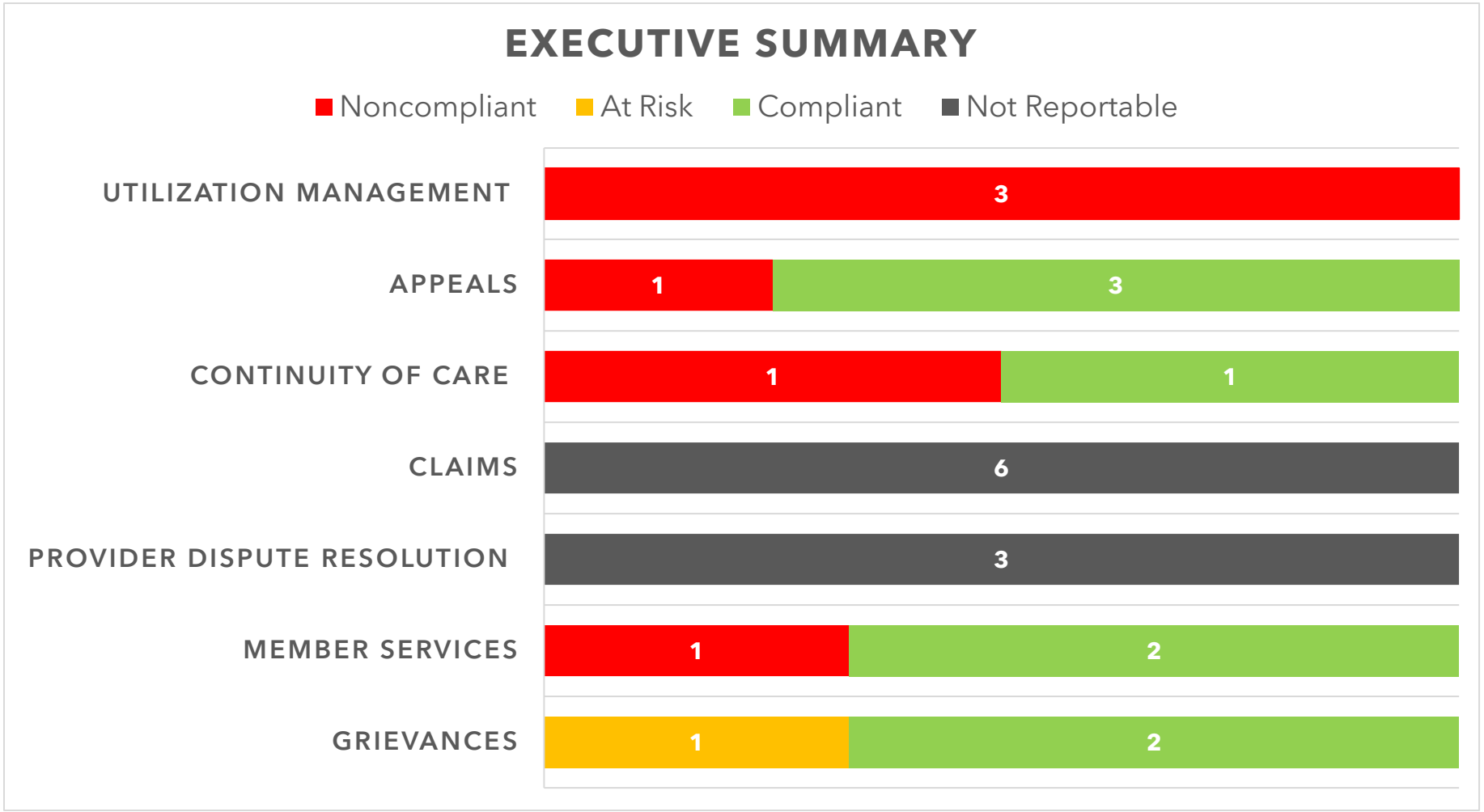
Functional Area	**Non-compliant areas**	**Corrective Actions Required**
Utilization Management	• 92.10% UM Decision Timeliness • 49.48% UM Member Notification Timeliness • 46.37% UM Provider Notification Timeliness	
Appeals	• 80% Effectuation of Overturned Appeals	
Continuity of Care	• 73.08% Continuity of Care Processing Timeliness	
Claims	Reporting Issues • Incorrect dates for claims acknowledgement • Inability to pull Remittance Advice (RA) and Explanation of Benefit (EOB) mailed date.	Letter of Non-Compliance Issued on July 11, 2024. Resubmission of Q1 Log due on July 19, 2024.
Provider Dispute Resolution (PDR)	Reporting Issues • Incorrect reporting of dispute number, dispute submission type, resolution date • Inability to pull Remittance Advice (RA) and Explanation of Benefit (EOB) mailed date.	Letter of Non-Compliance Issued on July 11, 2024. Resubmission of Q1 Log due on July 19, 2024.
Member Services	• 81.27% Timely Issuance of Member ID Cards	

DELEGATION OVERSIGHT

Health Net 2024 Quarter 1 Final Scorecard

Report Issued: July 11, 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 1 Final Scorecard

Report Issued: July 11, 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 Timeliness of Acknowledgement, Decisions, and Member Notifications
- ✓ 100% Continuity of Care Notification Timeliness
- ✓ 83% Calls Answered within 30 seconds
- ✓ 3.42% Call Center Abandonment Rate Level
- ✓ 100% Grievance Timeliness of Resolutions and Member Notification

NON-COMPLIANT AREAS

- ☒ 80% Effectuation of Overturned Appeals
- ☒ 81.27% Timely Issuance of Member ID Cards
- ☒ 92.10% UM Decision Timeliness
- ☒ 49.48% UM Member Notification Timeliness
- ☒ 46.37% UM Provider Notification Timeliness
- ☒ 73.08% Continuity of Care Processing Timeliness

NOT REPORTABLE

- Claims Log
- Provider Dispute Resolution Log

ACTIONS REQUIRED

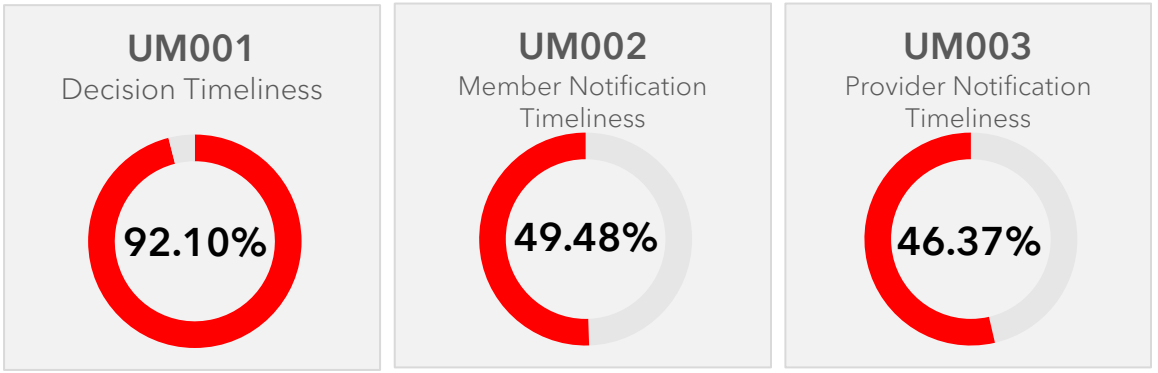
FUNCTIONAL AREA	ACTION	DUE DATE
UTILIZATION MANAGEMENT	Warning Letter	NA
APPEALS	Warning Letter	NA
CONTINUITY OF CARE	Warning Letter	NA
CLAIMS	Notice of Non-Compliance	07/19/2024
PROVIDER DISPUTE RESOLUTION	Notice of Non-Compliance	07/19/2024
MEMBER SERVICES	Warning Letter	NA
GRIEVANCES	None	NA

DELEGATION OVERSIGHT

Health Net 2024 Quarter 1 Final Scorecard

Report Issued: July 11, 2024

UTILIZATION MANAGEMENT



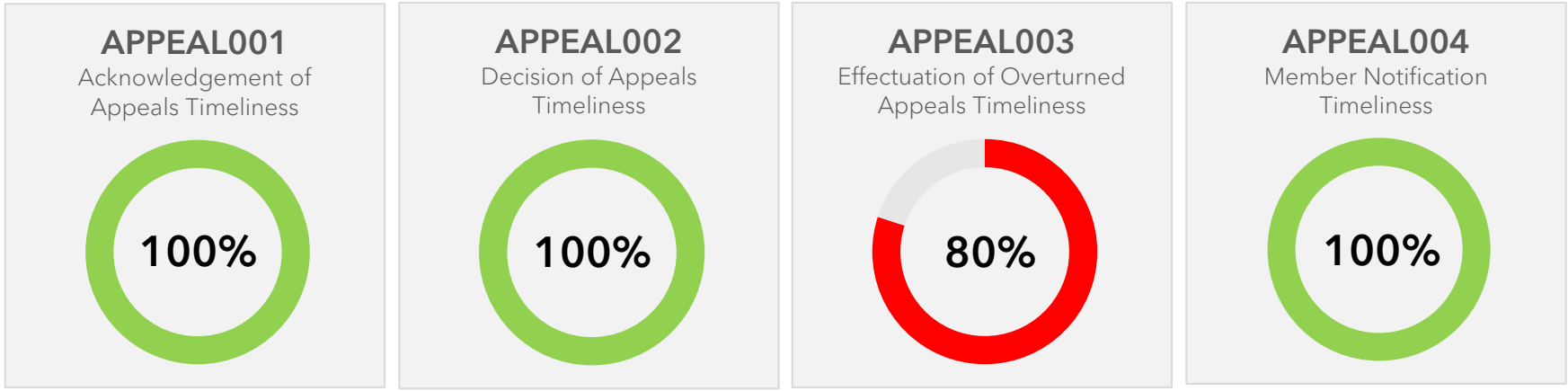
KPI #	KPI	Quarter 1	Quarter 2	Quarter 3	Quarter 4
UM001	**Decision Timeliness**	**92.10%**			
UM001SP	▸ Standard Preservice	81.03%			
UM001EP	▸ Expedited Preservice	90.48%			
UM001C	▸ Concurrent	95.58%			
UM001R	▸ Retrospective	100%			
UM001PS	▸ Post Stabilization	No cases			
UM002	**Member Notification Timeliness**	**49.48%**			
UM002SP	▸ Standard Preservice	100%			
UM002EP	▸ Expedited Preservice	81.58%			
UM002C	▸ Concurrent	47.52%			
UM002R	▸ Retrospective	100%			
UM002PS	▸ Post Stabilization	No cases			
UM003	**Provider Notification Timeliness**	**46.37%**			
UM003SP	▸ Standard Preservice	31.03%			
UM003EP	▸ Expedited Preservice	73.81%			
UM003C	▸ Concurrent	42.54%			
UM003R	▸ Retrospective	100%			
UM003PS	▸ Post Stabilization	No cases			

DELEGATION OVERSIGHT

Health Net 2024 Quarter 1 Final Scorecard

Report Issued: July 11, 2024

APPEALS



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

DELEGATION OVERSIGHT

Health Net 2024 Quarter 1 Final Scorecard

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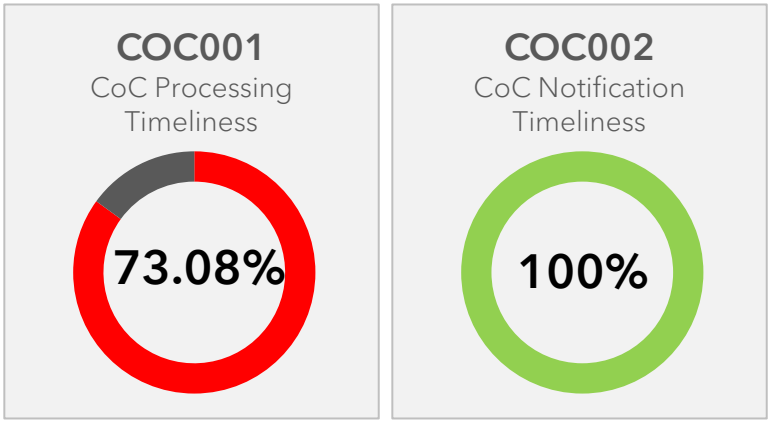
CONTINUITY OF CARE



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

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

BACKLOG	
CoC Member Notification	6

DELEGATION OVERSIGHT

Health Net 2024 Quarter 1 Final Scorecard

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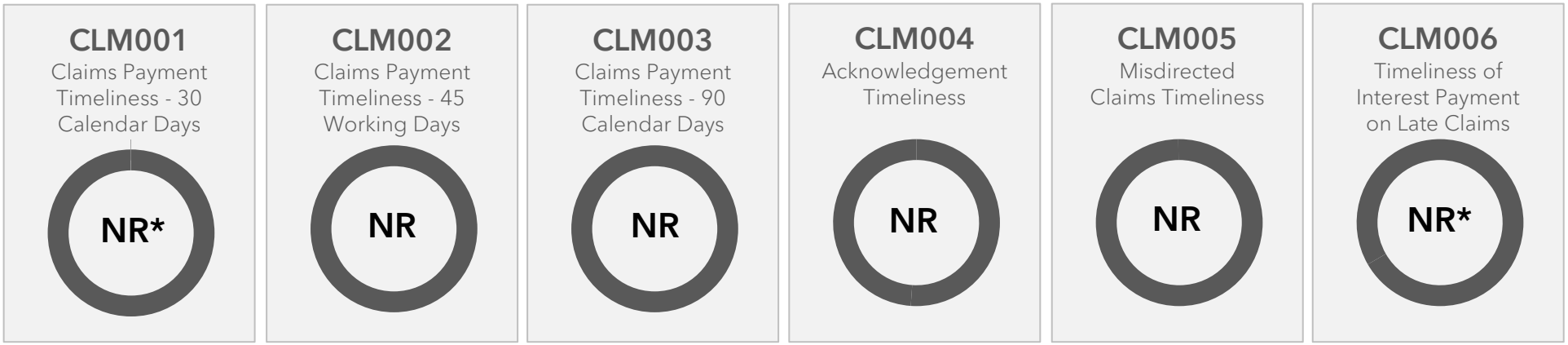
CLAIMS



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

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

DELEGATION OVERSIGHT

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PROVIDER DISPUTE RESOLUTION

KPI #	KPI	Quarter 1	Quarter 2	Quarter 3	Quarter 4
PDR001	**Acknowledgement Timeliness**	**Not Reportable***			
PDR001E	▸ Acknowledgement Timeliness - Electronic	Not Reportable*			
PDR001P	▸ Acknowledgement Timeliness - Paper	Not Reportable*			
PDR002	**Written Determination Timeliness**	**Not Reportable***			
PDR003	**Timeliness of Interest Payment on Late PDRs**	**Not Reportable***			

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

DELEGATION OVERSIGHT

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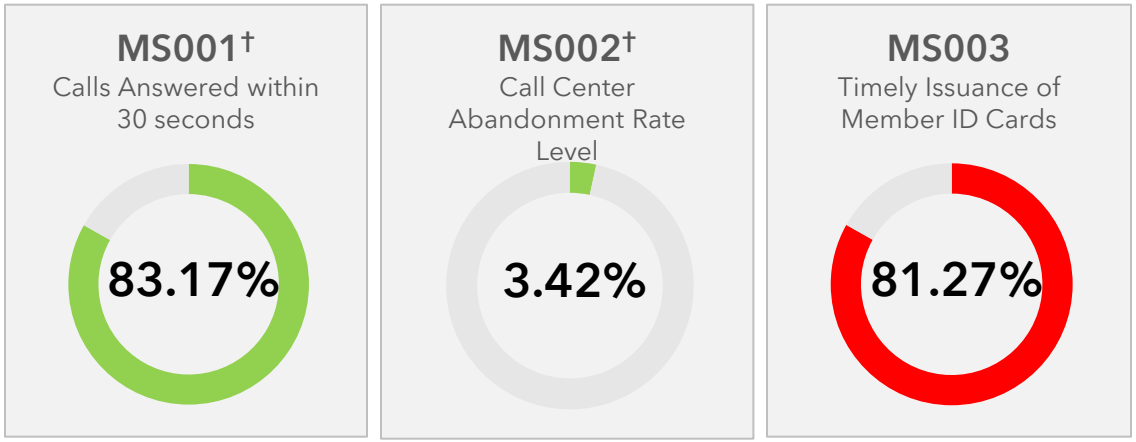
MEMBER SERVICES



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

† Self-reported compliance rate

DELEGATION OVERSIGHT

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GRIEVANCES

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

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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

Human Resources | Member Services | Community Relations

August 2024

Human Resources:

1. We have been working on reviewing other payroll systems that will enhance employee experience and productivity. Once we make a decision, we will come back to the commission to share.

Member Services:

1. We have worked on tracking and logging the ongoing traffic within the CHPIV to ensure that the physical staff we have on board is enough to address the needs of our community. Moving forward we will present a report on what ongoing inquiries we receive, and how many people on average in the month stop by the office.

Community Relations:

1. Dr. Gordon Arakawa and Michelle S. Ortiz-Trujillo participated in the Imperial Valley Food Bank's 2 day training where they were able to introduce ECM & CS support to over 100 members in the course of two days.
2. With the success of the presentation, we have enrolled in Marketing Training from the HN Marketing Team, at no cost to us, to continue to make county-wide presentations with information to better serve our members and providers.
3. Community Advisory Committee Q3 09/26/2024 at 12 PM.
   a. Link to register: please click here.

Member Services Call Log Data Analysis

Monthly: JUNE 2024

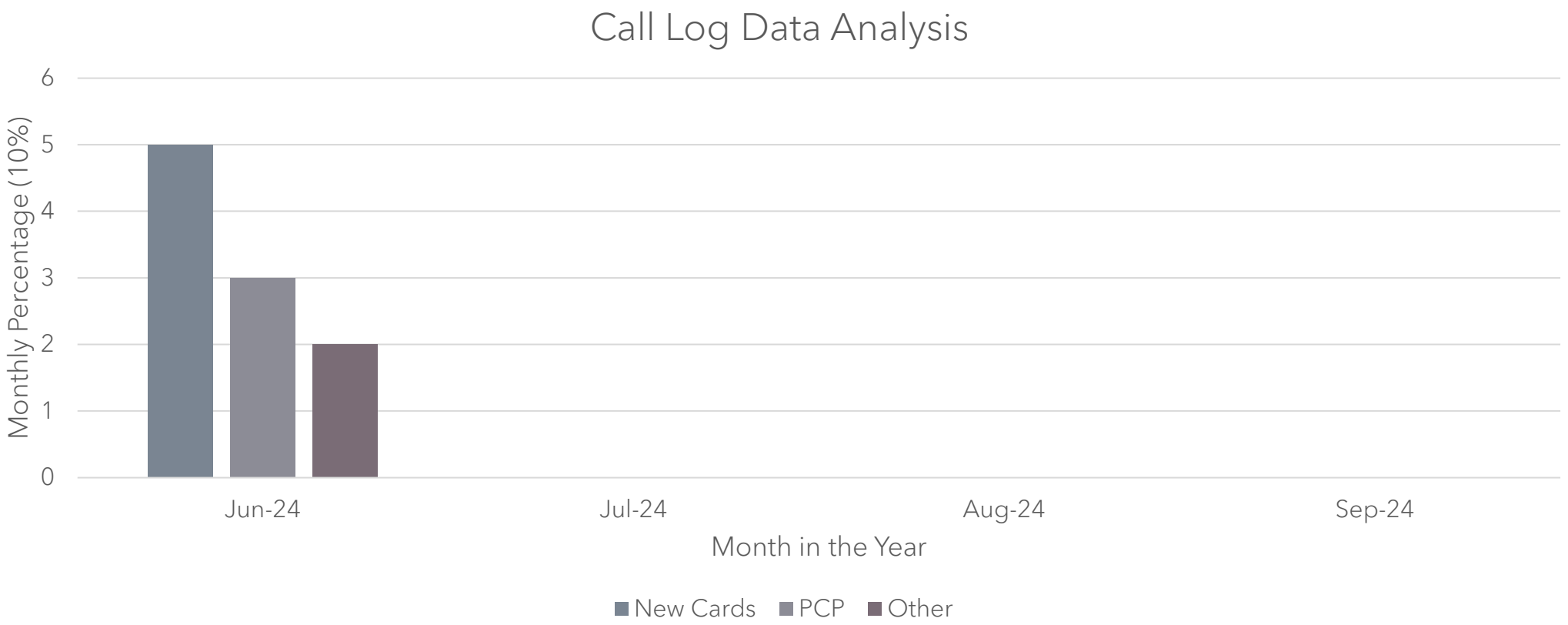
Community Health Plan OF IMPERIAL VALLEY

Generated/Monitored by:

Ariday L. Rosales – *Member Services Coordinator*

Michelle S. Ortiz-Trujillo – *Senior Director of HR & Community Relations*

JUNE 2024 - Data Entry



JUNE 2024 – Data Logistics

- In the month of June, the prominent issue leading by
  - ***10/20 50%*** **- New Member cards (New & Returning Members)**
    - not being acquired (existing members)
    - requested but not yet received [New/Updated Cards/Members]

- Following up, the second leading member issue by
  - ***6/20 30%*** **- PCP and/or Specialist**
    - policy changes (unauthorized & authorized)
    - treatment/procedure approvals
    - incorrect PCP shown on Member Cards (resulting in PCP denying treatments/visits)

- Lastly, the most infrequent member issues by
  - ***4/20 20%*** **- Pharmacy, Billing, Dental**
    - pharmacies denying member medications
    - Member receiving medical billing to at home address stating ‘Past Due’,
    - Dental procedures not being covered by practices/providers in the Imperial Valley

Summary

- In accordance with each member, [Ariday R] has been able to successfully assist, resolve and guide member(s) to the appropriate/corresponding agency for quality assurance.
- The following report will be generated on/before the fifth day of every month for data analysis purposes.

Community Health Plan OF IMPERIAL VALLEY

You Can Help Improve Community Health Plan of Imperial Valley Medi-Cal

JOIN AN ADVISORY COMMITTEE AND BE THE VOICE OF YOUR COMMUNITY!

Help us better serve you and your community!

Local Community Advisory Committees provide a forum for Medi-Cal members to express the needs of the communities Community Health Plan of Imperial Valley serves. Advisory Committee Members meet with Community Health Plan of Imperial Valley every three months to suggest health programs and services for their counties.

Your voice matters

When **you join** a Community Advisory Committee **your voice** helps to let Community Health Plan of Imperial Valley know what your **community needs**. Advisory Members also learn about policy and help shape health equity decisions by:

- **Bringing local level ideas to address:**
  - Quality
  - Health equity
  - Health care disparities
- **Giving feedback on our Cultural and Linguistic Services Program**
- **Sharing your views on:**
  - Population health
  - Children's services
  - Important Community Health Plan of Imperial Valley projects

Date	Thursday September 26th 2024
Time	12:00 PM
Location	512 W Aten Rd Imperial CA 92251
Zoom link	

Why attend an Advisory Committee meeting?

1. **Discuss your health care needs and concerns**
2. **Learn about health and local resources**
3. **Share your ideas**

Best of all, Advisory Committees bring Community Health Plan of Imperial Valley and members together to improve the Community Health Plan of Imperial Valley Medi-Cal program!

Join us and help shape the future of healthcare.

Are you in?

Contact us at cac@chpiv.org

Call Member Services (toll free) 833-236-4141 (TTY: 711)
24 hours a day, 7 days a week

Scan the QR Code Here to Register!

Nondiscrimination Notice

Community Health Plan of Imperial Valley follows State and Federal civil rights laws and does not discriminate, exclude people or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation.

Community Health Plan of Imperial Valley provides:

- Free aids and services to people with disabilities to communicate better with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services or to request this document in an alternative format, contact the Community Health Plan of Imperial Valley (CHPIV) at 1-833-236-4141 (TTY: 711), 24 hours a day, 7 days a week.

If you believe that Community Health Plan of Imperial Valley has failed to provide these services or unlawfully discriminated in another way, you can file a grievance with Community Health Plan of Imperial Valley by phone, in writing, in person or electronically:

- By phone: Contact us 24 hours a day, 7days a week by calling 1-833-236-4141. Or, if you cannot hear or speak well, please call (TTY/TDD 711) to use the California Relay Service.
- In writing: Fill out a complaint form or write a letter and send it to Community Health Plan of Imperial Valley Member Appeals and Grievances Department P.O. Box 10287 Van Nuys CA 91410-0287.
- In person: Visit your doctor's office or Community Health Plan's office and say you want to file a grievance.
- By fax: Community Health Plan of Imperial Valley Member Appeals and Grievances Dept. 1-833-405-0312.
- Electronically: Visit Community Health Plan of Imperial Valley's website at http://chpiv.org/.

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing or electronically:

- By phone: Call 916-440-7370. If you cannot speak or hear well, please call 711.
- In writing: Fill out a complaint form or write a letter and send it to Deputy Director, Office of Civil Rights, Department of Health Care Services, Office of Civil Rights, P.O. Box 997413, MS 0009, Sacramento, CA 95899-7413.
  Complaint forms are available at http://www.dhcs.ca.gov/Pages/Language Access.aspx.
- Electronically: Send an email to CivilRights@dhcs.ca.gov.

If you believe you have been discriminated against because of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing or electronically:

- By phone: 1-800-368-1019 (TDD: 1-800-537-7697).
- In writing: Fill out a complaint form or send a letter to U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201.
  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

English: If you, or someone you are helping, need language services, call 1-833-236-4141 (TTY: 711). Aids and services for people with disabilities, like accessible PDF and large print documents, are also available. These services are at no cost to you.

Arabic: إذا كنت أنت، أو أي شخص تساعده، بحاجة إلى الخدمات اللغوية، فاتصل بالرقم 1-833-236-4141 (TTY: 711). تتوفر أيضاً المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل الملفات المنقولة (PDF) التي يمكن الوصول إليها والمستندات المطبوعة الكبيرة. تتوفر هذه الخدمات بدون تكلفة بالنسبة لك.

Armenian: Եթե դուք կամ որևէ մեկը, ում դուք օգնում եք, ունեն լեզվական օգնության կարիք, զանգահարեք 1-833-236-4141 (TTY՝ 711) հեռախոսահամարով: Հաշմանդամություն ունեցող մարդկանց համար հասանելի են օգնություն և ծառայություններ, ինչպես օրինակ՝ մատչելի PDF և մեծ տպագրությամբ փաստաթղթեր: Այս ծառայությունները ձեզ համար անվճար են:

Cambodian: ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ ត្រូវការសេវាផ្នែកភាសា សូមទូរសព្ទទៅលេខ 1-833-236-4141 (TTY: 711) ។ ជំនួយ និងសេវាកម្មផ្សេងៗសម្រាប់មនុស្សពិការ ដូចជា PDF ដែលអាចប្រើសម្រាប់មនុស្សពិការបាន និងឯកសារព្រីនអក្សរធំៗ ក៏ត្រូវបានផ្តល់ជូនផងដែរ។ សេវាកម្មទាំងនេះមិនមានគិតតម្លៃសម្រាប់អ្នកទេ។

Chinese: 如果您或者您正在帮助的人需要语言服务，请致电1-833-236-4141 (TTY: 711)。还可提供面向残障人士的帮助和服务，例如无障碍 PDF 和大字版文档。这些服务免费为您提供。

Farsi: اگر شما یا هر فرد دیگری که به او کمک می‌کنید نیاز به خدمات زبانی دارد، با شمارهٔ 1-833-236-4141 (TTY: 711) تماس بگیرید. کمک‌ها و خدماتی مانند مدارک با چاپ درشت و PDF دسترس‌پذیر نیز برای معلولان قابل عرضه است. این خدمات هزینه‌ای برای شما نخواهد داشت.

Hindi: यदि आपको, या जिसकी आप मदद करे हैं उसे, भाषा सेवाएँ चाहिए, तो कॉल करें 1-833-236-4141 (TTY: 711)। विकलांग लोगों के लिए सहायता और सेवाएं, जैसे सुलभ PDF और बड़े प्रिंट वाले दस्तावेज़, भी उपलब्ध हैं। ये सेवाएँ आपके लिए मुफ़्त उपलब्ध हैं।

Hmong: Yog hais tias koj, los sis ib tus neeg twg uas koj tab tom pab nws, xav tau cov kev pab cuam txhais lus, hu rau 1-833-236-4141 (TTY: 711). Tsis tas li ntawd, peb kuj tseem muaj cov khoom siv pab thiab cov kev pab cuam rau cov neeg xiam oob qhab tib si, xws li cov ntaub ntawv PDF uas tuaj yeem nkag cuag tau yooj yim thiab cov ntaub ntawv luam tawm uas pom tus niam ntawv loj. Cov kev pab cuam no yog muaj pab yam tsis xam nqi dab tsi rau koj them li.

Japanese: ご自身またはご自身がサポートしている方が言語サービスを必要とする場合は、1-833-236-4141（TTY: 711）にお問い合わせください。障がいをお持ちの方のために、アクセシブルなPDFや大きな文字で書かれたドキュメントなどの補助・サービスも提供しています。これらのサービスは無料で提供されています。

Korean: 귀하 또는 귀하가 도와주고 있는 분이 언어 서비스가 필요하시면 1-833-236-4141 (TTY: 711)번으로 연락해 주십시오. 장애가 있는 분들에게 보조 자료 및 서비스(예: 액세스 가능한 PDF 및 대형 활자 인쇄본)도 제공됩니다. 이 서비스는 무료로 이용하실 수 있습니다.

FLY062045EP00 (07/23)

Laotian: ຖ້າທ່ານ, ຫຼື ບຸກຄົນໃດໜຶ່ງທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ຕ້ອງການບໍລິການແປພາສາ, ໂທ 1-833-236-4141 (TTY: 711). ນອກນັ້ນ, ພວກເຮົາຍັງມີອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ການບໍລິການສຳລັບຄົນພິການອີກດ້ວຍ, ເຊັ່ນ ເອກະສານ PDF ທີ່ສາມາດເຂົ້າເຖິງໄດ້ສະດວກ ແລະ ເອກະສານພິມຂະໜາດໃຫຍ່. ການບໍລິການເຫຼົ່ານີ້ແມ່ນມີໄວ້ຊ່ວຍເຫຼືອທ່ານໂດຍບໍ່ໄດ້ເສຍຄ່າໃດໆ.

Mien: Da'faanh Meih, Fai Heuc Meih Haih Tengx, Oix Janx-kaeqv waac gong, Heuc 1-833-236-4141 (TTY: 711). Jomc Caux gong Bun Yangh mienh Caux mv fungc, Oix dongh eix PDF Caux Bunh Fiev dimc, Haih yaac kungx nyei. Deix gong Haih buatc Yietc liuz maiv jaax-zinh Bieqc Meih.

Punjabi: ਜੇ ਤੁਹਾਨੂੰ, ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਨੂੰ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਜ਼ਰੂਰਤ ਹੈ, ਤਾਂ 1-833-236-4141 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਪਹੁੰਚਯੋਗ PDF ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਾਲੇ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਹਨ।

Russian: Если вам или человеку, которому вы помогаете, необходимы услуги перевода, звоните по телефону 1-833-236-4141 (TTY: 711). Кроме того, мы предоставляем материалы и услуги для людей с ограниченными возможностями, например документы в специальном формате PDF или напечатанные крупным шрифтом. Эти услуги предоставляются бесплатно.

Spanish: Si usted o la persona a quien ayuda necesita servicios de idiomas, comuníquese al 1-833-236-4141 (TTY: 711). También hay herramientas y servicios disponibles para personas con discapacidad, como documentos en letra grande y en archivos PDF accesibles. Estos servicios no tienen ningún costo para usted.

Tagalog: Kung ikaw o ang taong tinutulungan mo ay kailangan ng mga serbisyo sa wika, tumawag sa 1-833-236-4141 (TTY: 711). Makakakuha rin ng mga tulong at serbisyo para sa mga taong may mga kapansanan, tulad ng naa-access na PDF at mga dokumentong malaking print. Wala kang babayaran para sa mga serbisyong ito.

Thai: หากคุณหรือคนที่คุณช่วยเหลือ ต้องการบริการด้านภาษา โทร 1-833-236-4141 (TTY: 711) **นอกจากนี้ยังมีความช่วยเหลือและบริการสำหรับผู้ทุพพลภาพ เช่น** PDF **ที่เข้าถึงได้และเอกสารที่พิมพ์ขนาดใหญ่ บริการเหล่านี้ไม่มีค่าใช้จ่ายสำหรับคุณ**

Ukrainian: Якщо вам або людині, якій ви допомагаєте, потрібні послуги перекладу, телефонуйте на номер 1-833-236-4141 (TTY: 711). Ми також надаємо матеріали та послуги для людей з обмеженими можливостями, як-от документи в спеціальному форматі PDF або надруковані великим шрифтом. Ці послуги для вас безкоштовні.

Vietnamese: Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ cần dịch vụ ngôn ngữ, hãy gọi 1-833-236-4141 (TTY: 711). Chúng tôi cũng có sẵn các trợ giúp và dịch vụ dành cho người khuyết tật, như tài liệu dạng bản in khổ lớn và PDF có thể tiếp cận được. Quý vị được nhận các dịch vụ này miễn phí.