COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

AGENDA

Executive Committee
May 8th, 2024
12:00 PM
512 W. Aten Rd.
Imperial, CA 92251

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

Committee Members	Representing	Present
Lee Hindman	LHA Chairperson – Joint Chambers of Commerce Nominee	
Yvonne Bell	LHA Vice-Chair & Finance Committee Vice-Chair – CEO, Innercare	
Dr. Carlos Ramirez	Finance Committee Chair – CEO/Consultant DCRC	
Dr. Unnati Sampat	LHA Commissioner – Imperial Valley Medical Society	
Dr. Allan Wu	LHA Commissioner – Innercare	

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. 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.
B. Draft Bylaws Update-General Counsel Report (*Bill Smerdon, Legal Counsel)*
C. Employee Benefits

4. RECONVENE OPEN SESSION

A. Report on actions taken in closed session.

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 4/3/2024

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

1. March 2024 P&L Variance Report
2. March 2024 Cash Transactions
3. March 2024 Cash Reconciliation
4. March 2024 Statement of Activity
5. March 2024 Statement of Financial Position
6. March 2024 Year-To-Date-Statement of Activity

C. Approval of New and Updated Policies & Procedures (P&Ps)

1. CMP-001: Writing and Processing P&Ps
2. UM-003: Continuity of Care
3. BH-001: Behavioral Health
4. QM-001: Quality Management and Improvement
5. CLM-001: Claims & Provider Dispute Resolution (PDR)
6. BC-001: States of Emergency
7. PNM-001: Standards of Network Accessibility and Timely Access to Care
8. PNM-002: Provider Directory

D. Approval for Delegation of Policy Review and Approval to Regulatory Compliance and Oversight Committee (RCOC)

6. INFORMATION

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

B. Financial Services Report *(Mark Southworth, CFO)*

C. Compliance Report *(Elysse Tarabola, CCO)*

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)*

G. Commissioner Remarks (*Lee Hindman, Chair)*

Adjournment
Next Meeting: June 5th, 2024

COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

MINUTES

Executive Committee
April 3rd, 2024
12:00 PM
512 W. Aten Rd.
Imperial, CA 92251

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

Committee Members	Representing	Present
Lee Hindman	LHA Chairperson – Joint Chambers of Commerce Nominee	✓
Yvonne Bell	LHA Vice-Chair & Finance Committee Vice-Chair – CEO, Innercare	A
Dr. Carlos Ramirez	Finance Committee Chair – CEO/Consultant DCRC	✓
Dr. Unnati Sampat	LHA Commissioner – Imperial Valley Medical Society	✓
Dr. Allan Wu	LHA Commissioner – Innercare	A

1. CALL TO ORDER *Lee Hindman, Chair*

A. Roll Call *Donna Ponce, Commission Clerk*

Meeting called to order at 12:02 p.m.

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.

None.

3. CONSENT CALENDAR

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 3/6/2024

(Ramirez/Sampat) To approve the consent calendar. Motion carried.

4. CLOSED SESSION *Larry Lewis, CEO*

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.
B. Draft Bylaws Update-General Counsel Report (*Bill Smerdon, Legal Counsel)*
C. Employee Benefits

5. ACTION CALENDAR

A. Report on actions taken in closed session.
Information and direction provided. No action taken.

B. Motion to recommend to the full Committee approval of the financial reports as presented. (*Mark A. Southworth, CFO)*
(Ramirez/Sampat) To accept the financial reports as recommended by the Finance Committee. Motion carried.

1. Revenue & Expenses – February 29, 2024

2. Statement of Financial Position – February 29, 2024

3. Cash Transactions – February 29, 2024

6. INFORMATION

A. Health Services Report *(Dr. Gordon Arakawa, CMO)*
CMO, Gordon Arakawa updated the commission on the following:
1. Meetings
Commissioner Sampat commented that there are currently no home health contracts for Medi-Cal. Commissioner Ramirez responded that there are contracts for home health through Medi-Cal but very few patients are taken due to reimbursement issues.
Commissioner Sampat added that she would like to see a home health representative on the Provider Advisory Council (PAC).
Commissioner Sampat also suggested that a representative from Health Net be present at the Quality Improvement Health Equity Committee (QIHEC) meeting.

2. NCQA Accreditation
3. Health Services Monitoring/Auditing Meetings

Commissioner Hindman asked how the auditing from Health Services differs from the pre-delegation audit. Dr. Arakawa responded that the pre-delegation audit ensures that systems are in place so that CHPIV can perform proper delegation oversight over Health Net processes. The Health Services audits discussed here refer to the actual audits and audit processes that Health Services performs to oversee Health Net's activities.

B. Financial Services Report *(Mark Southworth, CFO)*

CFO, Mark Southworth updated the commission on the following:

1. Finance Issues Dashboard

C. Compliance Report *(Elysse Tarabola, CCO)*

CCO, Elysse Tarabola updated the commission on the following:

1. Compliance Training
2. Updated and New Policies and Procedures (P&Ps)
3. Go-Live Issues

Commissioner Sampat commented that more outreach and information to medical providers is needed.

4. Pre-Delegation Audit
5. Regulatory Compliance Oversight Committee (RCOC) of the Commission

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

SDHRCR, Michelle S. Ortiz-Trujillo updated the commission on the following:

1. Human Resources
2. Member Services
3. Community Relations

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

CEO, Larry Lewis update the commission on the following:

1. Facility Update

Includes desert landscape, new thermostats, parking lot lights, and a new security system. Larry added that once the new Receptionist is hired, Executive Assistant, Donna Ponce will be moving to SDHRCR, Michelle Ortiz' old office and Michelle will be moving into one of the vacant offices.

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

None.

G. Commissioner Remarks (*Lee Hindman, Chair)*

None.

Adjournment

Meeting adjourned at 2:01 p.m.

IMPERIAL COUNTY LOCAL HEALTH AUTHORITY
dba Community Helath Plan of Imperial Valley
Year to Date P&L Variance
1/1/2024 to 3/31/2024

	March Forecast	March Actual	March Variance	Year To Date Variance	Explanation
REVENUE					
HN Settlements	-	-	-	(142)	
Premium	22,249,362	22,249,361	-1	(2)	
Pass-Through	883,592	883,592	0	1	
Interest Income	100,347	57,368	(42,978)	(53,260)	Chase sweep issue affected February and March
TOTAL REVENUE	23,233,300	23,190,321	(42,979)	(53,403)	
HEALTH CARE COSTS	22,465,472	22,465,472	(0)	(1)	
Gross Margin	**767,827**	**724,849**	**(42,978)**	**(53,401)**	
ADMINISTRATIVE EXPENSE				-	
Salaries	235,344	212,762	(22,582)	(57,453)	Three Paycheck Month coming up
Benefits and Bonus	76,826	24,374	(52,452)	(123,212)	Bonsu Accruals not implemented yet
Total Labor Costs	312,170	237,136	(75,034)	(180,665)	
Consulting, Audit, Legal, other Prof	10,508	44,367	33,859	76,805	Frontloaded Audit. Higher than expected legal
Office Occupancy	14,606	13,497	(1,109)	1,247	
Other Misc Admin	46,976	25,022	(21,955)	(27,825)	Misc new office expenses
Total Administrative Exense	384,261	320,022	(64,239)	(130,438)	
Non-Operating	-	-	-	-	
Excess Revenues from Operations	383,566	404,827	21,261	77,037	

Community Health Plan of Imperial Valley
March 2024 Cash Transactions

Date	Account	Vendor	Memo/Description	Amount
Chase Checking				
03/01/2024	Chase Checking	JPMorgan Chase	Dividend Income - Feb 2024	$ 32,258.41
03/01/2024	Chase Checking	Brawley Rotary Club	Chase Bill Pay 2024-03-01 / Feb 2024 Statement	-90.00
03/01/2024	Chase Checking	CLEANBC, LLC	Chase Bill Pay 2024-03-01 / Invoice# 004	-700.00
03/01/2024	Chase Checking	Imperial Irrigation District	Chase Bill Pay 2024-03-01 / Service Date: 01/25/24 - 02/23/24	-1,163.24
03/01/2024	Chase Checking	Republic Services	Chase Bill Pay 2024-03-01 / Service Date: 03/01 - 03/31	-179.04
03/01/2024	Chase Checking	State Compensation Insurance Fund	Chase Bill Pay 2024-03-01 / Invoice# 1002048089	-815.08
03/01/2024	Chase Checking	VDC Arellano 3 LLC	Chase Bill Pay 2024-03-01 / Invoice# VDC3-0944	-2,500.00
03/11/2024	Chase Checking	360 Business Products	Chase Bill Pay 2024-03-11 / Invoice# OE-65543-1	-99.87
03/11/2024	Chase Checking	AccuSourceHR	Chase Bill Pay 2024-03-11 / Invoice# 43919	-66.29
03/11/2024	Chase Checking	Department of Managed Health Care	Chase Bill Pay 2024-03-11 / Invoice# 23-10444	-298.21
03/11/2024	Chase Checking	Granicus	Chase Bill Pay 2024-03-11 / Invoice# 155045	-9,936.73
03/11/2024	Chase Checking	Health Management Associates, Inc.	Chase Bill Pay 2024-03-11 / Invoice# 0000013	-10,915.53
03/11/2024	Chase Checking	I Do Events	Chase Check# 6659 / Invoice# 1609	-552.50
03/11/2024	Chase Checking	Law Office of William S. Smerdon	Chase Bill Pay 2024-03-11 / Invoice# 2482	-3,382.50
03/11/2024	Chase Checking	Nossaman LLP	Chase Bill Pay 2024-03-11 / Invoice# 559096	-8,346.00
03/11/2024	Chase Checking	Nossaman LLP	Chase Bill Pay 2024-03-11 / Invoice# 559102	-2,675.50
03/15/2024	Chase Checking	AM Copiers Inc.	Chase Bill Pay 2024-03-15 / Invoice# IN4692	-222.52
03/15/2024	Chase Checking	City of Imperial	Chase Bill Pay 2024-03-15 / Service Date: 01/24/24 - 02/24/24	-265.38
03/15/2024	Chase Checking	Conveyor Group	Chase Bill Pay 2024-03-15 / Invoice# 11037	-1,440.00
03/15/2024	Chase Checking	Economic Group Pension Services	Chase Bill Pay 2024-03-15 / Invoice# 163318	-1,650.00
03/15/2024	Chase Checking	Economic Group Pension Services	Chase Bill Pay 2024-03-15 / Invoice# 163319	-1,605.00
03/15/2024	Chase Checking	Moss Adams	Chase Bill Pay 2024-03-15 / Invoice# 102561763	-10,500.00
03/15/2024	Chase Checking	Moss Adams	Chase Bill Pay 2024-03-15 / Invoice# 102559655	-24,150.00
03/15/2024	Chase Checking	Rick's Roadrunner Lock & Safe	Chase Bill Pay 2024-03-15 / Invoice# 22499	-348.56
03/15/2024	Chase Checking	Texas Workforce Commission	Chase Bill Pay 2024-03-15 / Invoice# 004	-131.06
03/31/2024	Chase Checking	Department of Health Care Services	03/14 Receipt	25,341,535.19
03/31/2024	Chase Checking	Department of Health Care Services	03/14 Receipt	454,128.90
03/31/2024	Chase Checking	Department of Health Care Services	03/14 Receipt	60,853.72
03/31/2024	Chase Checking	Department of Health Care Services	03/14 Receipt	8,985.65
03/31/2024	Chase Checking	Department of Health Care Services	03/14 Receipt	884.25
03/31/2024	Chase Checking	Imperial County Public Health Department	Chase Check# 6658 - Reimbursement for check received in error	-6,000.00
03/31/2024	Chase Checking	Centene	--	-19,537,226.61
03/31/2024	Chase Checking	Mid Atlantic	03/11 Retirement	-4,103.16
03/31/2024	Chase Checking	Mid Atlantic	03/25 Retirement	-4,029.41
03/31/2024	Chase Checking	JPMorgan Chase	Feb 2024 Service Charges	-1,787.39
First Foundation Bank				
03/11/2024	FFB Payroll	First Foundation Credit Card	03/04 - Credit Card Payment	-19,009.69
03/31/2024	FFB Payroll	Payce, Inc.	03/11 Receipts	2,778.21
03/31/2024	FFB Payroll	Paychex, Inc.	03/07 - TPS Taxes	-36,438.19
03/31/2024	FFB Payroll	Paychex, Inc.	03/07 - Payroll	-65,711.84
03/31/2024	FFB Payroll	Paychex, Inc.	03/08 - EIB Invoice	-68.12
03/31/2024	FFB Payroll	Paychex, Inc.	03/20 - OAB Invoice	-49.50
03/31/2024	FFB Payroll	Paychex, Inc.	03/21 - TPS Taxes	-40,640.30
03/31/2024	FFB Payroll	Paychex, Inc.	03/21 - Payroll	-72,749.88
03/31/2024	FFB Payroll	Paychex, Inc.	03/22 - EIB Invoice	-69.29
03/31/2024	FFB Payroll	Blue Shield CA	03/27 - Insurance Payment	-14,555.31
03/31/2024	FFB Payroll	First Foundation Bank	03/06 - Wire Fee	-10.00
03/31/2024	FFB Payroll	First Foundation Bank	03/19 - Wire Fee	-10.00
J.P. Morgan Securities				
03/28/2024	J.P. Morgan Securities	Centene	--	-25,090,396.07
03/28/2024	J.P. Morgan Securities	J.P. Morgan Securities	Investment Income - Mar 2024	$ 42,308.13

Community Health Plan of Imperial Valley
Cash Reconciliation - March 2024

Chase Bank - Checking Account #3723			
Bank Balance - March 2024	$	200,000.00	
Add: Deposits in Transit		0.00	
Less: Outstanding Transactions		0.00	
CHPIV Balance - March 2024	$	200,000.00	[A]

Chase Bank - Operating Account #3723			
Bank Balance - March 2024	$	2,938,721.16	
Add: Deposits in Transit		0.00	
Less: Outstanding Transactions		0.00	
CHPIV Balance - March 2024	$	2,938,721.16	[A]

J.P. Morgan Securities - Bond Account #4427			
Bank Balance - March 2024	$	8,172,420.19	
Add: Deposits in Transit		0.00	
Less: Outstanding Transactions		0.00	
CHPIV Balance - March 2024	$	8,172,420.19	[A]

First Foundation Bank - Payroll Account #2698			
Bank Balance - March 2024	$	63,378.46	
Add: Deposits in Transit		0.00	
Less: Outstanding Transactions		0.00	
CHPIV Balance - March 2024	$	63,378.46	[A]

First Foundation Bank - Restricted Deposit #4602			
Bank Balance - March 2024	$	300,000.00	
Add: Deposits in Transit		0.00	
Less: Outstanding Transactions		0.00	
CHPIV Balance - March 2024	$	300,000.00	[A]

Total Cash Reconciliation			
QuickBooks - Cash (Current)	$	11,374,519.81	
QuickBooks - Cash (Noncurrent)		300,000.00	
Total Cash Per QuickBooks		11,674,519.81	
Total Cash Per Reconciliation		11,674,519.81	Σ[A]
Difference	$	-	

NOTE: The County of Imperial fund has been closed.

Preparer: Tony Godinez, Jr. - Senior Accounting Manager

Approver: Mark Southworth - Chief Financial Officer

Community Health Plan of Imperial Valley

Statement of Net Position
For March 2024

REVENUES	
DHCS Premium	$ 22,249,361
DHCS Pass-Through	883,592
Total Operating Revenues	23,132,953
OPERATING EXPENSES	
Medical Expenses	
Healthcare Capitation	21,581,880
Healthcare Pass-Through	883,592
Total Medical Expenses	22,465,472
Administrative Expenses	
Salaries, Wages, and Employee Benefits	237,136
Professional fees	47,034
Office Expenses & Administrative	12,832
Occupancy - Cleaning, Landscape, Rent, Utilities	4,079
Supplies & Services	9,523
Depreciation and Amortization	9,418
Total Administrative Expenses	320,022
Total Operating Expenses	22,785,494
OPERATING INCOME	347,459.16
NON-OPERATING REVENUES	
Dividend Income - Chase Money Market	15,060
Investment Income - J.P. Morgan Securities	42,308
Total Non-Operating Revenues	57,368
Increase In Net Position	404,827
NET POSITION, beginning of period	16,328,002
NET POSITION, ending of period	$ 16,732,829

Community Health Plan of Imperial Valley

Statement of Financial Position
As of March 31, 2024

ASSETS	
Current Assets	
Cash and Investments	
Chase - Checking	$ 200,000
Chase - Money Market	2,938,721
JPMorgan Securities	8,172,420
First Foundation Bank - Payroll	63,378
Receivables	
Accounts Receivable	2,773
Dividend Receivable	15,060
Premium Receivable	20,740,225
Pass-Through Receivable	2,650,776
Profit Share Receivable	1,422,701
Other Current Assets	
Prepaid Expenses	20,019
Total Current Assets	**36,226,074**
Noncurrent Assets	
Restricted Deposit	
First Foundation Bank - Restricted	300,000
Capital Assets	
Buildings - Net	3,034,435
Computer Hardware & Office Equipment - Net	9,244
Improvements - Net	2,905
Intangible Assets - Net	22,929
Operating ROU Asset (Copier) - Net	9,008
Total Noncurrent Assets	**3,378,521**
Total Assets	**$ 39,604,595**

Community Health Plan of Imperial Valley

Statement of Financial Position
As of March 31, 2024

LIABILITIES	
CURRENT LIABILITIES	
Payables	
Accounts Payable	$ 23,046
Capitation Payable	20,118,017
Pass-Through Payable	2,650,776
Credit Card Payable	10,392
Other Current Liabilities	
Payroll Accrual	243
Short Term Lease Liability - Copier	2,423
Vacation Accrual	60,204
Total Current Assets	**22,865,100**
NON-CURRENT LIABILITIES	
Long Term Lease Liability - Copier	6,665
Total Noncurrent Liabilities	**6,665**
Total Liabilities	**22,871,766**
NET POSITION	
Net investment in capital assets	3,069,513
Unrestricted	12,305,306
Net Revenue	1,358,011
Total Net Position	**16,732,829**
Total Liabilities and Net Position	**$ 39,604,595**

Community Health Plan of Imperial Valley

Statement of Net Position
As of March 31, 2024

REVENUES	
DHCS Premium	$ 66,748,083
DHCS Pass-Through	2,650,776
Health Net Contributions - 2023	134,859
Total Operating Revenues	69,533,718
OPERATING EXPENSES	
Medical Expenses	
Healthcare Capitation	64,745,640
Healthcare Pass-Through	2,650,776
Total Medical Expenses	67,396,416
Administrative Expenses	
Salaries, Wages, and Employee Benefits	689,366
Professional fees	111,824
Office Expenses & Administrative	53,313
Occupancy - Cleaning, Landscape, Rent, Utilities	17,403
Supplies & Services	13,813
Depreciation and Amortization	27,858
Total Administrative Expenses	913,577
Total Operating Expenses	68,309,993
OPERATING INCOME	1,223,724.36
NON-OPERATING REVENUES	
Dividend Income - Chase Money Market	89,961
Investment Income - J.P. Morgan Securities	42,308
Interest Income - County of Imperial	2,018
Total Non-Operating Revenues	134,286
Increase In Net Position	1,358,011
NET POSITION, beginning of year	15,374,819
NET POSITION, ending of period	$ 16,732,829

IMPERIAL COUNTY
Local Health Authority Commission

Fact Sheet: Seeking Commission Review and Approval for New and Updated Policies & Procedures

May 2024

Agenda Item #5C

New and Updated Policies & Procedures

The Regulatory Compliance Oversight Committee (RCOC) of the Commission has reviewed the attached packet of new and updated P&Ps and recommends Full Commission approval.

Moving forward, RCOC requests the delegation of authority to review and approve P&Ps.

P&P #	P&P Name	Department	Functional Area	Summary of Changes
CMP-001	Writing and Processing P&Ps	Compliance	Compliance	Added section on dissemination to subcontractors; moved Compliance approval after legal approval
UM-003	Continuity of Care	Health Services	Utilization Management	DMHC Knox Keene updates
BH-001	Behavioral Health	Health Services	Behavioral Health	New Policy
QM-001	Quality Management and Improvement	Health Services	Quality Management	DMHC Knox Keene updates
CLM-001	Claims & PDR	Finance, Network & Informatics	Claims	DMHC Knox Keene updates
BC-001	States of Emergency	Finance, Network & Informatics	Business Continuity	DMHC Knox Keene updates & added DHCS requirements
PNM-001	Standards of Network Accessibility and Timely Access to Care	Finance, Network & Informatics	Provider Network Management	DMHC TAR filing & DHCS APL 23-006 updates

IMPERIAL COUNTY
Local Health Authority Commission

P&P #	P&P Name	Department	Functional Area	Summary of Changes
PNM-002	Provider Directory	Finance, Network & Informatics	Provider Network Management	DMHC Knox Keene updates

	Writing And Processing Policies and Procedures	CMP-001
Department	Compliance	
Functional Area	Compliance	
Impacted Delegate	☐ Subcontractor ☒ NA	

DATES			
Policy Effective Date	6/12/2023	**Last Revised Date**	
Next Annual Review Due	6/12/2024	**Regulator Approval**	Not Applicable

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

ATTACHMENTS

- Attachment A – Policy Template
- Attachment B – Policy Template Guide
- Attachment C – Definitions Repository

AUTHORITIES/REFERENCES

- Medi-Cal Managed Care Division (MMCD) All-Plan Letter 00-003, "Policy and Procedure Revisions"

HISTORY

Revision Date	Description of Revision
6/12/2023	Policy created

I. OVERVIEW

A. Community Health Plan of Imperial Valley (CHPIV) will develop policies and procedures that define the rules governing organizational actions, that assign organizational functions and responsibilities, and that demonstrate compliance with regulatory, contractual, and accreditation requirements. CHPIV's Compliance Department is the designated responsible organizational unit and repository for all CHPIV policies and procedures.

II. POLICY

A. Policies and procedures shall be developed and processed in accordance with this policy and procedure, including the documents included in the "References" and "Attachments" sections of this policy and procedure, and documented by using CHPIV's system of record.
B. All CHPIV policies and procedures, and the applicable attachments, shall be made accessible to all employees on the CHPIV One Drive.
C. The Compliance Department is authorized to revise the policy and procedure template, as well as the policy and procedure process, without immediate revisions to this policy and procedure. CHPIV departments are not required to implement a revised template until the next review date for their policies and procedures, including annual review or immediate review and revision because of changes to state and federal regulatory, contractual or accreditation requirements.
D. Policies and procedures should be reviewed and revised, immediately, if changes are necessary to comply with new or revised state and federal regulatory, contractual and accreditation requirements. CHPIV departments must not wait until the annual review date to make such changes.
E. Changes to attachments and references may require changes to be made to the policies and procedures.

III. PROCEDURE

A. Drafting Policies and Procedures
    1. The ORIGINATOR will draft new policies and procedures or revise existing policies and procedures.
        a. The Overview should reflect the scope, purpose, and background of the policy.
        b. The Policy should outline CHPIV's guidelines for how to conduct business and reflect the requirements that the implemented process will satisfy.
        c. Policies involving multiple functional areas require cross-functional collaboration that involves all functional owners and agreement on drafted policy language.
        d. All revisions to existing policies must be redlined and indicate reference to the regulatory, contractual, or accreditation requirement, as applicable.
        e. The procedures should describe the process that is being implemented to satisfy the requirements in the policy.
            i. All policies should have procedures in the same document.
            ii. All procedures should be linked to a policy, either in the same document or by reference.

A. If DESKTOP PROCEDURES are required (desk level procedures, technical procedures, job aids, etc.), then a separate document is appropriate and should be listed in the "Attachments" section.
B. DESKTOP PROCEDURES (desk level procedures, technical procedures, job aids, etc.) do not have to go through the formal approval process outlined in the Approval Processing section of this policy.

iii. Definitions should be included in the policies and procedures templates.
A. Definitions should be specific to the policies and procedures.
B. The ORIGINATOR should use the standardized definitions, provided by the Compliance Department.
C. If the ORIGINATOR has a new definition or has a suggested change for an existing definition, it must be submitted to the Compliance Department at compliance@chpiv.org for review and addition to the standardized definitions.

iv. For assistance with regulatory, contractual, and accreditation requirements, the policy ORIGINATOR should consult with the Compliance Department, prior to submitting policies and procedures into CHPIV's system of record.

2. Once the policy and procedure is ready for review and approval, the ORIGINATOR will submit the draft policy to Compliance to begin the Approval Process

B. Standard Approval Process

1. The following reviews will occur consecutively as applicable.

~~a. Compliance Review~~
~~i. The Compliance Department shall review all policies and procedures.~~
~~ii.i. Compliance will have seven (7) calendar days to review.~~

~~b.~~a. NCQA Review
i. If the policy or procedure is being used to fulfill National Committee for Quality Assurance (NCQA) requirements, designated staff within Health Services shall review.
ii. Designated staff within Health Services will have seven (7) calendar days to review.

~~c.~~b. Legal Review
i. If the policy or procedure is related to Human Resources processes, CHPIV's Legal team shall review.
ii. If the policy or procedure is required to be filed with DMHC, CHPIV's Legal team may review at the discretion of the ORIGINATOR or Compliance.
iii. Legal will have seven (7) calendar days.

c. Compliance Review
i. The Compliance Department shall review all policies and procedures.
Compliance will have seven (7) calendar days to review.

d. Committee Review
i. After Compliance, NCQA, and/or Legal review, Compliance will notify the ORIGINATOR. The ORIGINATOR will take the policies and procedures to the COMPLIANCE & POLICY COMMITTEE (CPC) for review and approval.
ii. If the CPC requests changes to be made to the policies and procedures, and the changes impact the sections reviewed by Compliance, NCQA,

and/or Legal, the policies and procedures may need to revisit one or more of the previous steps in the review process, prior to being approved.

e. COMMISSION Review:
   i. After CPC approval, Compliance will notify the ORIGINATOR. The ORIGINATOR will take the policies and procedures to the Regulatory Compliance Oversight Committee of the COMMISSION for review and approval.
   ii. The COMMISSION approval is considered the final approval.

C. Expedited Approval Process
1. The Expedited Approval Process applies when there is an urgent regulator submission that the Standard Approval Process timeframes will not meet.
2. The following reviews will occur concurrently, as applicable. The timeframe for the concurrent review will be determined by Compliance based on regulator due dates.
   ~~a. Compliance Review~~
      ~~i. The Compliance Department shall review all policies and procedures.~~
   ~~b.~~a. NCQA Review
      i. If the policy or procedure is being used to fulfill National Committee for Quality Assurance (NCQA) requirements, designated staff within Health Services shall review.
   ~~c.~~b. Legal Review
      i. If the policy or procedure is related to Human Resources processes, CHPIV's Legal team shall review.
      ii. If the policy or procedure is required to be filed with DMHC, CHPIV's Legal team may review at the discretion of the ORIGINATOR or Compliance.
   c. Compliance Review
      i. The Compliance Department shall review all policies and procedures.

3. Committee Review
   i. After Compliance, NCQA, and/or Legal review, Compliance will send the policy for unanimous electronic committee approval.
   ii. If the CPC requests changes to be made to the policies and procedures, and the changes impact the sections reviewed by Compliance, NCQA, and/or Legal, the policies and procedures may need to revisit one or more of the previous steps in the review process, prior to being approved.
4. COMMISSION Review:
   i. After CPC approval, Compliance will send the policies and procedures electronically to the chair of the Regulatory Compliance Oversight Committee of the COMMISSION for review and approval.
      A. The Chair of the Regulatory Compliance Oversight Committee of the COMMISSION is the designated reviewer for the expedited approval process.
   ii. The COMMISSION approval is considered the final approval.

D. Posting
1. After COMMISION approval, Compliance will
   a. Remove all red-lines and comments from the policies and procedures
   b. Formatting

c. Complete the review or revision details to the History section of the policies and procedures
d. Add the appropriate dates
    i. The Commission approval date is the Policy Effective Date/Last Revised Date.
e. Publish the policies and procedures to CHPIV's system of record.

2. At any time, the CHIEF COMPLIANCE OFFICER (CCO), the COMPLIANCE & POLICY COMMITTEE (CPC) and/or the COMMISSION can review policies and procedures, and request changes to be made by the ORIGINATING DEPARTMENT.

E. When approval is not required
1. Polices and Procedures are not required to go through the formal approval processes outlined above if the revisions include non-substantive changes.
    a. Examples of non-substantive changes include formatting changes, updates to definitions, changes to header information, and corrective typos.
2. Updated policies and procedures that do not require formal approval shall be submitted to Compliance to be posted to the P&P Repository.

F. Regulatory Agency Filings
1. The Compliance Department will ensure that all applicable policies and procedures are filed with the appropriate regulatory agencies, to demonstrate compliance with laws and regulations.
    a. CHPIV is required to file certain policies and procedures with DMHC within thirty (30) calendar days after its effective date or review date.
    b. Regulatory agencies may request revisions to CHPIV policies.
2. The Compliance Department can request that changes be made to policies and procedures prior to submitting them to regulatory agencies.
    a. Substantive revisions, especially revisions due to non-compliance, will be required to be routed back through the full review process.

G. Policy and Procedure Archives
1. The Compliance Department will maintain an archive of all policies and procedures, as well as policy-related written correspondence submitted to and received from SUBCONTRACTORS, for a period of ten (10) years.

H. Annual Review
1. All policies and procedures must be reviewed by the ORIGINATING DEPARTMENT, on an annual basis.
    a. The ORIGINATOR will review the policies and procedures, to ensure that they reflect the most current state and federal regulatory, contractual and accreditation requirements. If significant or material revisions are made to a policy and procedure, it may need refiling with the DMHC and/or other regulatory agency.
    b. The ORIGINATOR will ensure that the policies and procedures are on the current template, and will follow the appropriate process outlined herein, and in all supporting documents.
    c. Failure to review the policies and procedures by the due date could result in the following DISCIPLINARY ACTIONS for the management of the ORIGINATING DEPARTMENT:
        i. Reporting to ICC
        ii. Requirement for submission of a CORRECTIVE ACTION PLAN (CAP)

I. Dissemination of P&Ps to SUBCONTRACTORS

1. The ORIGINATOR and Compliance department will identify which P&Ps need to be disseminated based on delegated functions, relevance, regulatory obligations, and business needs.
2. When a new P&P or update to an existing P&P is developed, CHPIV will disseminate it to the relevant subcontractors and delegated entities.
3. P&Ps are shared via email.
4. Any time a regulatory change affects a P&P, the policy will be updated and redlined to clearly show changes.
5. Upon receipt of the P&Ps, SUBCONTRACTOR is required to acknowledge receipt and understanding.
6. The Compliance Department maintains a log of all P&Ps sent, the date of acknowledgment, and any feedback or queries raised by the recipient.
7. As needed, CHPIV will provide training sessions or support materials to subcontractors/delegated entities to aid in the understanding and implementation of the P&Ps.
8. SUBCONTRACTORS are encouraged to provide feedback or seek clarifications on any P&Ps. Feedback will be reviewed by the ORIGINATING DEPARTMENT and Compliance Department and, where necessary, changes will be made to the P&Ps or additional guidance provided.

IV. DEFINITIONS

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

TERM	DEFINITION
Chief Compliance Officer (CCO)	CHPIV staff member who serves as the focal point for compliance activities as well as manages the Compliance Department of CHPIV. The CCO reports directly to the Chief Executive Officer and the COMMISSION. The CCO is responsible for developing, operating, and monitoring the compliance program. This includes establishing an auditing and monitoring plan, overseeing compliance audit functions, continuously reviewing organizational risk areas to identify necessary auditing and monitoring activities, assisting in the formulation of correction action plans, and overseeing and/or verifying implementation of corrective action.
Commission	The governing body of the Local Health Authority (LHA). It is comprised of thirteen voting members that represent different sectors of the health system, the public, Medi-Cal beneficiaries, and businesses as outlined in LHA Establishing Ordinance.
Compliance & Policy Committee (CPC)	An internal committee comprised of CHPIV management staff that monitors compliance activities and makes recommendations for action to CHPIV staff, including CHPIV's executive staff, and the Commission.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CHPIV, the Centers

	for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CHPIV departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CHPIV and its regulators.
Desktop Procedure	Document used to provide additional detailed information that is not in a policy but will assist in conducting day-to-day operations (also known as technical procedures or job aids).
Disciplinary Action	A formal action taken in response to unacceptable performance or misconduct.
Originating Department	Any department within CHPIV that develops, produces, manages, coordinates, and/or submits any Member Communications material or policies and procedures to the Compliance Department for review and to obtain approval from the Regulatory Agencies.
Originator	Member of a department that is designated to submit and process policies and procedures for their department.
Subcontractor	An individual or entity that has a subcontract with the MCP that relates directly or indirectly to the performance of the MCP's obligations under the contract with DHCS. A network provider is not a subcontractor by virtue of the network provider agreement, as per 42 CFR § 438.2.

	Continuity of Care	UM-003
	Department	Health Services
	Functional Area	Utilization Management
	Impacted Delegate	☒ Subcontractor ☐ NA

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

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

ATTACHMENTS

NA

AUTHORITIES/REFERENCES

- **Internal**
  - CHPIV, Delegation Oversight Policy and Procedure, CMP-002
- **Federal**
  - Title 42 Code of Federal Regulations ("CFR") 418.3
- **State**
  - California Health and Safety Code Sections ("H&S Code") 1367(d), 1373.95, 1373.96
  - Title 22 California Code of Regulations Rules ("CCR") 51340, 51340.1, 53887, 53923.5
  - Title 28 CCR Rules 1300.67.1 (a) – (e); 1300.67.1.3 (b)
  - DMHC: Technical Assistance Guide ("TAG") "Continuity of Care" (last published 06/27/2014); All Plan Letter ("APL") 19-013
  - DHCS: DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III, Section 5.2.12 ; APLs 15-019, 16-002, 17-007, 20-017, 21-003; 22-032, 22-032
  - Knox-Keen Health Care Service Act and Regulations, Section 1373.95
- **Accreditation**
  - NCQA: Network Management (NET) 4, Element B: Continued Access to Practitioners
  - NCQA: Quality Management and Improvement (QI) 3, Element D: Transition to Other Care

HISTORY

Revision Date	Description of Revision
6/12/2023	Policy creation
7/6/2023	Policy revision to include additional 1373.95 provisions

I. OVERVIEW

A. ~~This policy addresses~~ Community Health Plan of Imperial Valley's ("CHPIV" or the "Plan") is responsible for ensuring there are CONTINUITY OF CARE ("CoC") processes in place that are in strict adherence to the guidelines and processes stated herein.~~requirements, policy, and procedures. The purpose of this policy is to establish a comprehensive CoC process for newly enrolled Members at CHPIV who request CONTINUITY OF CARE.~~ CHPIV delegates its CoC processes to CHPIV's Subcontractor, Health Net, who performs the function on behalf of CHPIV.

II. POLICY

A. CHPIV ~~provides~~ will ensure continued access for up to 12 months to an OUT-OF-NETWORK PROVIDER with whom the MEMBER has an ONGOING RELATIONSHIP, as long as CHPIV has no Quality of Care issues with the PROVIDER and the PROVIDER will accept either CHPIV's or the Medi-Cal FFS Rates, whichever is higher, pursuant to W&I Code section 14182(b)(13) – (14).

B. CHPIV will ensure the MEMBER's right to continue receiving Medi-Cal services covered under the CHPIV's Contract when transitioning to CHPIV even in circumstances in which the Member does not continue receiving services from their pre-existing Provider. CHPIV will ensure CoC for Covered Services without delay to the Member with a Network Provider, or if there is no Network Provider to provide the Covered Service, with an OON Provider.

C. CHPIV will ensure that active prior treatment authorizations for services remain in effect for 90 days and must be honored without a request by the MEMBER, authorized representative, or Provider for MEMBERS transitioning to CHPIV. CHPIV will ensure arrangement of services authorized under the active prior treatment authorization with a Network Provider, or if there is no Network Provider to provide the service, with an OON Provider.

D. CHPIV will ensure that all MEMBERS are allowed~~allows all MEMBERSs~~ to request CONTINUITY OF CARE in accordance with 42 CFR section 438.62 and APL 22-032.

E. CHPIV will ensure that additional ~~provide for additional~~ CONTINUITY OF CARE Protections are provided for MEMBERS with specific conditions as defined in H&S Code section 1373.96.

F. CHPIV will ensure proper evaluation of denied Medical Exemption Requests (MER) as automatic CONTINUITY OF CARE requests.

G. CHPIV ~~has a~~ensures there is a comprehensive process for block transfers of MEMBERs from a NETWORK PROVIDER GROUP or HOSPITAL to a new PROVIDER GROUP or HOSPITAL.

~~G.~~H. CHPIV ~~provides~~ will ensure a review for the completion of Covered Services at the request of a MEMBER in accordance with H&S Code section 1373.~~96~~95. All MEMBERSs with PRE-EXISTING RELATIONSHIP with the PROVIDER who make a CONTINUITY OF CARE

request must be given the option to continue treatment for up to 12 months with an OUT-OF-NETWORK PROVIDER, if the following criteria are met:

1. The MEMBER has seen the OUT-OF-NETWORK PROVIDER at least once within the 12 months before Enrollment with CHPIV;
2. The OUT-OF-NETWORK PROVIDER accepts CHPIV's rate offered in accordance with H&S Code section 1373.96(d)(2) or €(2); and
3. The OUT-OF-NETWORK PROVIDER meets CHPIV's applicable professional standards and has no disqualifying Quality of Care issues.

I. CHPIV ~~will~~ensures facilitate~~i~~ion of the completion of covered services in accordance with H&S Code section 1373.96 for the following conditions:
   1. An acute condition. Completion of covered services shall be provided for the duration of the acute condition.
   2. A serious chronic condition. Completion of covered services shall be provided for a period necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by CHPIV in consultation with the MEMBER and the terminated provider or nonparticipating provider and consistent with good professional practice.
   3. A pregnancy. Completion of covered services shall be provided for the duration of the pregnancy.
   4. Care of a newborn child between birth and age 36 months.
   ~~1.~~5. Surgery or other procedure that is authorized by CHPIV.

J. CHPIV ~~will~~ensures ~~send~~ an Enrollee Transfer ~~n~~ Notice is sent to MEMBERs describing its policy and informing MEMBERs of their right of completion of covered services

K. CHPIV ensures that reasonable consideration is given to the potential clinical effect on the MEMBER's treatment caused by a change of PROVIDER.

~~H.~~L. CHPIV will ensure ~~has~~ a process for accepting requests from the MEMBER, authorized representative, or PROVIDER over the telephone, according to the requester's preference, and must not require the requester to complete and submit a paper or online form if the requester prefers to make the request by telephone. To complete a telephone request, the MCP may take any necessary information from the requester over the telephone.

M. CHPIV will ensure~~has~~ a process for accepting and approving retroactive CoC requests and for reimbursing PROVIDERS for services that were already provided if the request meets all CoC requirements.

~~I.~~N. CHPIV ensures the development and implementation of procedures that further describe the following:

1. Date of CoC process initiation.
2. Validation of has a PRE-EXISTING RELATIONSHIP with the PROVIDER by requesting all relevant treatment information from the OUT-OF-NETWORK (OON) PROVIDER,
3. Timelines for making CoC determinations:
   a. 30 calendar days for non-urgent requests;
   b. 15 calendar days if the MEMBER's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or
   c. As soon as possible, but no longer than three calendar days for urgent requests (i.e., there is an identified risk of harm to the MEMBER).

4. Acknowledgment of the CoC request within the required timeframes, advising the MEMBER that the CoC request was received, the date of receipt, and the estimated timeframe for resolution.
5. Decision notification by using the MEMBER's known preference of communication or by notifying the MEMBER using one of these methods in the following order: telephone call, text message, email, and then notice by mail:
    a. For non-urgent requests, within seven calendar days of the decision.
    b. For urgent requests, within the shortest applicable timeframe that is appropriate for the MEMBER's condition, but no longer than three calendar days of the decision.
6. Content of MEMBER notification:
    a. Denial notifications:
        i. A statement of the MCP's decision.
        ii. A clear and concise explanation of the reason for denial.
        iii. The MEMBER's right to file a grievance or appeal. For additional information on grievances and appeals, refer to APL 21-011 or subsequent iterations of this APL.
    b. Approval notifications:
        i. A statement of the MCP's decision.
        ii. The duration of the CONTINUITY OF CARE arrangement.
        iii. The process that will occur to transition the MEMBER's care at the end of the CONTINUITY OF CARE period.
        iv. The MEMBER's right to choose a different Network PROVIDER.
7. Process for notifying MEMBERSs within 30 calendar days before the end of the CONTINUITY OF CARE period, using the MEMBER's preferred method of communication, about the process that will occur to transition the MEMBER's care to a IN-NETWORK PROVIDER at the end of the CONTINUITY OF CARE period. This process includes engaging with the MEMBER and PROVIDER before the end of the CONTINUITY OF CARE period to ensure continuity of services through the transition to a new PROVIDER.

III. PROCEDURE

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

IV. DEFINITIONS

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

TERM	DEFINITION
Member	A beneficiary enrolled in a CHPIV program.
Active Course of Treatment	Means an ongoing treatment in which discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes. Treatment typically involves regular visits with the practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment, or modify a treatment protocol.
Acute Condition	Means a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Examples include a heart attack, pneumonia, or appendicitis.
Block Transfer	Means a transfer or redirection of two thousand (2,000) or more members by CHPIV from a Terminated Provider Group or Terminated Hospital to one or more contracting providers that takes place as a result of the termination or non-renewal of a Provider Contract.
Continuity of Care ("COC")	Means the process by which the member and the Provider are cooperatively involved in ongoing health care management toward the goal of high quality, cost-effective medical care.
Chronic	Means a condition that is long-term and ongoing and is not acute. Examples include diabetes, asthma, allergies, and hypertension.
Medically Necessary/Medical Necessity	Means all Covered Services that are reasonable and necessary to protect life, prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity per Title 22 CCR Section 51303(a) and 42 CFR 438.210(a)(5).When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and W & I Code Section 14132 (v). For individuals under 21 years of age, EPSDT service is considered medically necessary or a medical necessity when it is necessary to correct or ameliorate defects and physical and mental illnesses and conditions that are discovered by screening services. A service need not cure a condition in order to be covered under EPSDT. Services that maintain or improve the child's current health condition are also covered under EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. The common definition of

TERM	DEFINITION
	"ameliorate" is to "make more tolerable". Additional services must be provided if determined to be medically necessary for an individual child.
Non-Participating Provider or Out-of-Network Provider	Means a health care professional or facility that does not have a service contract with the Plan and/or its delegate HNCS that is responsible for providing health care services for the Member who has requested completion of services with that professional or facility at the in-network benefit level.
Ongoing Relationship or Pre-Existing Relationship	Means the member has seen the requested out-of-network provider (PCP or Specialist) at least once during the 12 months prior to the date of the member's initial enrollment in the managed care plan for a non-emergency visit. The Plan and/or its delegate HNCS determines if a relationship exists using data provided by DHCS to the Plan and/or its delegate HNCS, such as Medi-Cal FFS utilization data. The member or their provider may also provide information to the Plan and/or its delegate HNCS that demonstrates a pre-existing relationship with a provider. A member may not attest to a pre-existing relationship (instead of actual documentation being provided).
Participating Provider or In-Network Provider	Means a health care professional or facility that is contracted with the Plan and/or its delegate HNCS, who or that provides covered services to Plan members.
Prior Authorization	Means the formal process that requires a Provider to obtain advanced approval from the Plan and/or its delegate HNCS to provide specific services or procedures. Prior authorization is required for most services or care; however, prior authorization is not required for emergency or out-of-area urgent care services.
Provider	Means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Pregnancy	Means a pregnancy with a three trimester duration and immediate postpartum period.
Seniors and Persons with Disabilities (SPDs)	Means a member who falls under a specific SPD aid code as defined by DHCS.
Serious Chronic Condition	Means a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and that does either of the following: Persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.
Terminal Illness	Means a terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less.
Terminated Provider	Means a Provider whose contract to provide covered services to members is terminated or not renewed by the Plan and/or its delegate HNCS.

	Behavioral Health	BH-001
Department	Health Services	
Functional Area	Behavioral Health	
Impacted Delegate	☒ Subcontractor ☐ NA	

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

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

ATTACHMENTS

- NA

AUTHORITIES/REFERENCES

- **Internal**
  - CHPIV, Delegation Oversight Policy and Procedure, CMP-002
- **Federal**
  - 42 CFR section 438.900 et seq.;
- **State**
  - DHCS: DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III, Section 2.2.10.F-G., 4.3.14.C, 4.4.3.C., 4.4.8.F, 5.0, 5.3.4.F, 5.5.2, 5.5.4

HISTORY

Revision Date	Description of Revision
7/5/2023	Policy Creation

I. OVERVIEW

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

II. POLICY

A. CHPIV adheres to all requirements set forth in Exhibit A, Attachment 5.5 (Mental Health and Substance Use Disorder Benefits) for the provision of mental health and substance use disorder services to Members less than 21 years of age.

B. CHPIV collaborates with the Department of Health Care Services (DHCS) in its effort to implement the California Children and Youth Behavioral Health Initiative.

C. To facilitate the provision of Medically Necessary services to Children, CHPIV will execute a Memorandum of Understanding (MOU) with Local Education Agencies (LEAs) in each EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) county within its Service Area for school-based services, including but not limited to EPSDT and Behavioral Health Services for Members less than 21 years of age. CHPIV will ensure that Members' Primary Care Providers cooperate and collaborate with LEAs in the development of Individualized Education Plans (IEPs) or Individualized Family Service Plans (IFSPs) and ultimately ensure that care is coordinated regardless of financial responsibility.

D. CHPIV will ensure the implementation of interventions that increase access to preventive, early intervention, and Behavioral Health services by school-affiliated Behavioral Health Providers for children in publicly funded childcare and preschool, and TK-12 children in public schools, in accordance with the interventions, goals, and metrics set forth in W&I Code section 5961.3(b).

E. CHPIV will ensure the prioritization of county behavioral health staff or behavioral health Providers to serve in the ENHANCED CARE MANAGEMENT (ECM) Provider role, provided they agree and are able to coordinate all services needed by those Populations of Focus, not just their behavioral health services.

F. If a Member receives services from a mental health provider for Serious Emotional Disturbance (SED), Substance Use Disorder (SUD), or Serious Mental Illness (SMI) and the Member's behavioral health Provider is a contracted ECM Provider, CHPIV must ensure that the Member is assigned to that behavioral health Provider as the ECM Provider, unless the Member indicates otherwise or CHPIV identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

G. CHPIV will ensure access to evidence-based behavioral health care, with a focus on integration with physician health and earlier identification and engagement in treatment for children, youth, and adults.

H. CHPIV will ensure provision of Medically Necessary Behavioral Health Treatment (BHT) services in accordance with a recommendation from a licensed Physician, surgeon, or a licensed psychologist and must ensure continuation of BHT services under continuity of care.

I. CHPIV ensures Member's treatment plan is reviewed, revised, and/or modified no less than every six months by a BHT service provider. The Member's behavioral treatment plan may

be modified or discontinued only if it is determined that the services are no longer Medically Necessary under the EPSDT Medical Necessity standard.

J. CHPIV will ensure the provision of Medically Necessary BHT services and coordination with LEAs, Regional Centers (RCs), and other entities that provide BHT services so that Members timely receive all Medically Necessary BHT services, consistent with the EPSDT benefit.

K. CHPIV must ensure the provision of Medically Necessary BHT services across settings, including home, school, and in the community, which are not duplicative of BHT services actively provided by another entity.

L. CHPIV must ensure good faith attempts to enter into MOUs with RCs and LEAs, and CHPIV must enter into MOUs with County Mental Health Plans (MHPs) in accordance with Exhibit A, Attachment III, Section 5.6.1 (*MOUs with Third-Party Entities and County Programs*), to facilitate the coordination of services for Members with developmental disabilities, including Autism Spectrum Disorder (ASD), as permitted by federal and State law, and specified by California Department of Healthcare Services DHCS in All Plan Letter (APL) APL 18-009 and APL 21-XXX. If CHPIV is unable to ensure an MOU or a one-time case agreement with a RC, as required by APL 18-009, Contractor must inform DHCS why it could not reach an agreement with the RC and must demonstrate, by providing all evidence of contracting efforts, a good faith effort to enter into an agreement with the RC.

M. CHPIV must comply with all mental health parity requirements in 42 CFR section 438.900 *et seq*. CHPIV must ensure it is not applying any financial or treatment limitation to mental health or SUD benefits in any classification that is more restrictive than the predominant financial or treatment limitation applied to medical and surgical benefits in the same classification.

N. CHPIV ensures the coverage of Non-specialty Mental Health Services (NSMHS) including individual and group mental health evaluation and treatment, including psychotherapy, family therapy, and dyadic services; psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition; outpatient services for the purposes of monitoring drug therapy; psychiatric consultation; and outpatient laboratory, drugs, supplies, and supplements.

O. CHPIV will ensure the coverage of hypnotherapy, health behavior assessments and interventions, psychiatric collaborative care, and other NSMHS services described in the Medi-Cal Provider Manual as mental health evaluation and treatment NSMHS. CHPIV covers mental health screening services described in the Medi-Cal Provider Manual as NSMHS, including but not limited to Adverse Childhood Experiences (ACE) screening, brief emotional/behavioral assessments, depression screening, general developmental screening, autism spectrum disorder screening, and other screening services in accordance with Exhibit A, Attachment III, Subsection 5.5.2.F (*Non-specialty Mental Health Services and Substance Use Disorder Services*).

P. CHPIV will ensure the coverage of SUD services including: drug and alcohol Screening, Assessment, Brief Intervention and Referral to Treatment (SABIRT) services; tobacco cessation counseling; Medications for Addiction Treatment (MAT) (also known as medication-assisted treatment) when delivered in Primary Care offices, emergency departments, inpatient hospitals, and other contracted medical settings; and Medically Necessary behavioral health services. Covered NSMHS and SUD Services can be delivered

in person and via telehealth/telephone as specified in Exhibit A, Attachment III, Subsection 5.3.1 (*Covered Services*).

Q. If a Member is receiving NSMHS and is determined to meet the criteria for Specialty Mental Health Services (SMHS) as defined by W&I Code section 14184.402, CHPIV must ensure the use of DHCS-approved standardized transition tools in accordance with Exhibit A, Attachment III, Subsection 5.5.2.K (Non-specialty Mental Health Services and Substance Use Disorder Services) as required when Members who have established relationships with contracted mental health Providers experience a change in condition requiring SMHS.

R. If a Member is receiving SMHS and is determined to meet the criteria for NSMHS as defined by W&I Code section 14184.402, CHPIV must ensure the use of DHCS-approved standardized transition tools in accordance with Exhibit A, Attachment III, Subsection 5.5.2.K (Non-specialty Mental Health Services and Substance Use Disorder Services) as required when Members who have established relationships with SMHS providers experience a change in condition requiring NSMHS.

S. For Members 21 years of age and over who meet the criteria for NSMHS, CHPIV ensures the coverage of Medically Necessary Services in accordance with W&I Code section 14059.5 as well as Medically Necessary Covered SUD services in accordance with W&I Code section 14059.5.

T. For Members under 21 years of age, CHPIV will ensure coverage of Medically Necessary Covered NMHS in accordance with W&I Code section 14184.402(b)(2) as well as Medically Necessary Covered SUD services.

U. CHPIV ensures coverage of mental health and SUD screening, including, but not limited to, tobacco, alcohol and illicit drug screening, in accordance with American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule and United States Preventive Services Taskforce (USPSTF) grade A and B recommendations for adults, ACE screening, brief emotional/behavioral assessments, depression screening, general developmental screening, autism spectrum disorder screening, and Screening, Assessment, Brief Intervention and Referral to Treatment (SABIRT) Services.

V. CHIPIV must ensure the development and implementation of policies and procedures for mental health and substance use screenings and services provided by a Primary Care Provider (PCP) including but not limited to provision of SABIRT Services, and referrals for additional assessments and treatments as indicated by the discovery of condition or potential conditions from screening services, as required by Exhibit A, Attachment III, Subsections 4.3.13 (Mental Health Services) and 4.3.14 (Alcohol and SUD Treatment Services).

W. CHPIV will ensure the coverage of a mental health assessment without requiring Prior Authorization. CHPIV must follow the authorization criteria requirements outlined in Exhibit A, Attachment III, Section 2.3 (Utilization Management Program) of the DHCS Contract for authorizing additional mental health and SUD services.

X. CHPIV must ensure the development and implementation of policies and procedures for tracking mental and behavioral health screenings, assessments, and treatment services provided by licensed mental health care Providers.

Y. CHPIV must ensure coverage and pay for all Medically Necessary covered mental health and SUD services for the Member, including the following:

1. Emergency room professional services as described in 22 CCR section 53855;
2. Facility charges for emergency room visits that do not result in a psychiatric admission;
3. All laboratory and radiology services necessary for the diagnosis, monitoring, or treatment of a member's mental health condition;
4. Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services required by Members to access Medi-Cal covered mental health services and SUD services, in compliance with APL 17-010 and this Contract;
5. NMT services and, for Members less than 21 years of age, NEMT services, to and from Drug Medi-Cal (DMC) services, Drug Medi-Dal Organized Delivery System (DMC-ODS) services, and SMHS, in compliance with APL 17-010 and this Contract;
6. Medically Necessary Covered Services after Contractor has been notified by a DMC, DMC-ODS, MHP, or mental health Provider that a Member has been admitted to an inpatient psychiatric facility, including an Institution for Mental Diseases (IMD) as defined by 9 CCR section 1810.222.1, regardless of the age of the Member;
7. All Medically Necessary Medi-Cal-covered psychotherapeutic drugs, when administered in the outpatient setting as part of medical services for Members not otherwise excluded under the DHCS Contract.
8. CHPIV shall ensure that access to Covered Services is not materially delayed through the application of Utilization Review controls, such as Prior Authorization, or by requiring that Covered Services be provided through CHPIV's Network, consistent with CHPIV's assurance to provide timely Covered Services.

Z. CHPIV must ensure the use of DHCS-approved standardized screening tools (including standardized screening tools specific for adults and standardized screening tools specific for children and youth) to ensure Members seeking mental health services who are not currently receiving covered NSMHS or SMHS are referred to the appropriate delivery system for mental health services, either in CHPIV's network or the MHP network, in accordance with the No Wrong Door policies set forth in W&I Code section 14184.402(h) and specified in Exhibit A, Attachment III, Subsection 4.3.13 (Mental Health Services).

1. If a member becomes eligible for SMHS during the course of receiving covered NSMHS, CHPIV must ensure the provision of non-duplicative, Medically Necessary NSMHS even if the Member is simultaneously accessing SMHS.
2. CHPIV must make its best efforts to ensure a member's existing mental health Provider is notified during an Urgent Care situation, when possible. CHPIV must allow the Member's existing mental health Provider to coordinate care with the MHP or emergency room personnel for Urgent Care.
3. CHPIV must ensure the development and implementation of policies and procedures for the provision of psychiatric emergencies during non-business hours.
4. CHPIV must ensure monitoring and tracking of utilization data for NSMHS as specified in Exhibit A, Attachment III, Subsection 2.3.3 (Review of Utilization Data).
5. CHPIV must have an MOU with the MHP to refer Members in need of urgent and emergency care, including person-to-person telephone transfers, to the county crisis program during their call center hours. The MOU must be executed in accordance with the requirements specified in Exhibit A, Attachment III, Sections 4.3 (*Population Health Management and Coordination of Care*) and 5.3 (*Scope of Services*).

III. PROCEDURE

A. CHPIV delegates the COC process to its Subcontractor, Health Net, for Mild to Moderate BH, BH-related Case Management, and Medical Needs for Member while Imperial County retains responsibility for SMI services.

B. Delegation Oversight

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

IV. DEFINITIONS

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

TERM	DEFINITION
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	The provision of Medically Necessary comprehensive and preventive health care services provided to Members less than 21 years of age in accordance with requirements in 42 USC section 1396a(a)(43), section 1396d(a)(4)(B) and (r), and 42 CFR section 441.50 et seq., as required by W&I Code sections 14059.5(b) and 14132(v). Such services may also be Medically Necessary to correct or ameliorate defects and physical or behavioral health conditions.
Enhanced Care Management (ECM)	ECM is community-based, interdisciplinary, high touch, person-centered, and provided primarily through in-person interactions. The plan contracts with "ECM Providers," existing community providers such as Federally Qualified Health Centers (FQHCs), counties, county BH providers, local health jurisdictions, Community Based Organizations (CBOs), and others, who assign a lead care manager to each member. The lead care manager meets members wherever they are – on the street, in a shelter, in their doctor's office, or at home. ECM eligibility is based on members meeting specific "Populations of Focus" criteria.

	Quality Management and Improvement	QM-001
	Department	Health Services
	Functional Area	Quality Management
	Impacted Delegate	☒ Subcontractor ☐ NA

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

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

ATTACHMENTS

NA

AUTHORITIES/REFERENCES

- **Internal**
  - CHPIV, Delegation Oversight Policy and Procedure, CMP-002
- **Federal**
  - Code of Federal Regulations (CFR): 42 CFR 438.330 and 430.340: Quality Assessment and Performance Improvement Program; 28 CCR section 1300.70
- **State**
  - California Health and Safety Code Sections ("H&S Code") 1367(a) – (c), (i), 1369, 1370,
  - California Business and Professions Code Section ("B&P Code") 805
  - Title 28 California Code of Regulations Rules ("CCR") Rules 1300.51(d)(H)(iii) & (d)(j)(1)(b), 1300.67.2€, 1300.69, 1300.70 & 1300.70 (b)(2), 1300.74.16(e)
  - DMHC: Technical Assistance Guide ("TAG") "Quality Management" (last published 06/09/2014); All Plan Letter ("APL") 22-028
  - DHCS: DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III, Section 2.2 TAG Quality Improvement; APLs 19-017
  - Knox-Keen Health Care Service Act and Regulations, Section 1300.70
- **Accreditation**
  - NCQA: Quality Management and Improvement (QI) 1, Elements A-D

HISTORY

Revision Date	Description of Revision
6/12/2023	Policy creation

I. OVERVIEW

A. ~~This policy addresses~~ Community Health Plan of Imperial Valley's ("CHPIV" or the "Plan") is responsible for maintaining a comprehensive Quality Management and Improvement ("QM/QI") program in strict adherence to the guidelines and processes stated herein. CHPIV retains aspects of the QM/QI program, such as appointment of a Chief Health Equity Officer and establishment of a Quality Improvement and Health Equity Committee. All other components of the QM/QI process are delegated to CHPIV's Subcontractor, Health Net. ~~requirements, policy, and procedures.~~

II. POLICY

A. CHPIV is responsible for the quality and HEALTH EQUITY of all COVERED SERVICES regardless of whether those services have been delegated to a SUBCONTRACTOR, DOWNSTREAM SUBCONTRACTOR, or NETWORK PROVIDER.

1. CHPIV will ensure its SUBCONTRACTOR, DOWNSTREAM SUBCONTRACTOR, or NETWORK PROVIDER are compliant with the Quality Improvement Health Equity standards as follows:
    a. Organization and Operation (28 CCR 1300.51(d)(j)(1)(b))
        i. Explanation of the review system covering the matters depicted in the governing body organization chart and the following:
            1. The key people involved.
            2. Titles and qualification.
            3. The extent and type of support staff.
            4. Areas of authority and responsibility of the key persons and the committees, if divided among persons and committees.
            5. The frequency of meetings of the committees and the portion of their time devoted to the review system by key people.
    b. Program Requirements (28 CCR 1300.70 (b)(2)):
        i. Written QA plan describing the goals and objectives of the program and governing body organization arrangements, including staffing, the methodology for on-going monitoring and evaluation of health services, the scope of the program, and required levels of activity.
        ii. Written documents shall delineate QA authority, function, and responsibility, and provide evidence that the plan has established quality assurance activities and that the governing body has approved the QA Program. To the extent that the governing body QA responsibilities are within the plan or to a contracting provider, the governing body documents shall provide evidence of an oversight mechanism for ensuring that QA functions are adequately performed.
        iii. The governing body, its QA committee, if any, and any internal or contracting providers to whom QA responsibilities have been delegated, shall each meet on a quarterly basis, or more frequently if problems have been identified, to oversee their respective QA program responsibilities.

The governing body must maintain records of its QA activities and actions, and report to the governing body on a regularly scheduled basis, at least quarterly, which reports shall include findings and actions taken as a result of the QA program. The governing body is responsible for establishing a program to monitor and evaluate the care provided by each contracting provider group to ensure that the care provided meets professionally recognized standards of practice. Reports to the governing body shall be sufficiently detailed to include findings and actions taken as a result of the QA program and to identify those internal or contracting provider components which the QA program has identified as presenting significant or chronic quality of care issues.

iv. Implementation of the QA program shall be supervised by a designated physician(s), or in the case of specialized plans, a designated dentist(s), optometrist(s), psychologist(s) or other licensed professional provider, as appropriate.

v. Physician, dentist, optometrist, psychologist, or other appropriate licensed professional participation in QA activity must be adequate to monitor the full scope of clinical services rendered, resolve problems, and ensure that corrective action is taken when indicated. An appropriate range of specialist providers shall also be involved.

vi. There must be administrative and clinical staff support with sufficient knowledge and experience to assist in carrying out their assigned QA activities for the governing body.

vii. Medical groups or other provider entities may have active quality assurance programs which the governing body may use. In all instances, however, the governing body must retain responsibility for reviewing the overall quality of care delivered to plan enrollees. If QA activities are delegated to a participating provider to ensure that each provider has the capability to perform effective quality assurance activities, the plan must do the following:

1. Inform each provider of the plan's QA program, of the scope of that provider's QA responsibilities, and how it will be monitored by the governing body.
2. Ascertain that each provider to which QA responsibilities have been delegated has an in-place mechanism to fulfill its responsibilities, including administrative capacity, technical expertise, and budgetary resources.
3. Have ongoing oversight procedures in place to ensure that providers are fulfilling all delegated QA responsibilities.
4. Require that standards for evaluating that enrollees receive health care consistent with professionally recognized standards of practice are included in the provider's QA program and be assured of the entity's continued adherence to these standards.
5. Ensure that for each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, and appropriate preventive

health services based on reasonable standards established by the governing body and/or delegated providers.

6. Ensure that health services include appropriate preventive health care measures consistent with professionally recognized standards of practice. There should be screening for conditions when professionally recognized standards of practice indicate that screening should be done.

viii. A governing body that has capitation or risk-sharing contracts must:

1. Ensure that each contracting provider has the administrative and financial capacity to meet its contractual obligations; the governing body shall have systems in place to monitor QA functions.
2. Have a mechanism to detect and correct under-service by an at-risk provider (as determined by its patient mix), including possible underutilization of specialist services and preventive health care services.

ix. Inpatient Care

1. A governing body must have a mechanism to oversee the quality of care provided in an inpatient setting to its enrollees which monitors that:
   a. providers utilize equipment and facilities appropriate to the care; and
   b. if hospital services are fully capitated that appropriate referral procedures are in place and utilized for services not customarily provided at that hospital.

~~1.~~2. The governing body may delegate inpatient QA functions to hospitals and may rely on the hospital's existing QA system to perform QA functions. If the governing body does delegate QA responsibilities to a hospital, the plan must ascertain that the hospital's quality assurance procedure will specifically review hospital services provided to the governing body 's enrollees and will review services provided by governing body physicians within the hospital in the same manner as other physician services are reviewed.

~~A.~~B. CHPIV will ensure that a QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM (QIHETP) is implemented, ~~CHPIV will implement a QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM (QIHETP) that~~ ~~includes~~including, at a minimum, the standards set forth in 42 CFR sections 438.330 and 438.340, 28 CCR section 1300.70, and be consistent with the principles outlined in the DHCS Comprehensive Quality Strategy.

C. CHPIV ~~will ensure to~~has a process to ensure the implementation of a peer review body to review the basic qualifications, staff privileges, employment, medical outcomes, or professional conduct of licentiates to address necessary improvements in the quality of care delivered by all its Providers in any setting and take appropriate action to improve upon HEALTH EQUITY.

1. As a result of an action of a peer review body, the CHPIV will ensure that a process is in place to monitor, evaluate, and take timely action to address necessary improvements in

the quality of care delivered by all its Providers in any setting, and take appropriate action to improve upon HEALTH EQUITY.

~~B.~~D. CHPIV has a process to ensure the delivery of quality care that enables its Members to maintain health, improve, or manage a chronic illness or disability in the following areas:

1. Clinical quality of physical health care;
2. Clinical quality of BEHAVIORAL HEALTH care focusing on prevention, recovery, resiliency and rehabilitation;
3. Access to primary and specialty health care Providers and services;
4. Availability and regular engagement with Primary Care Providers (PCP);
5. Continuity and Care Coordination across settings and at all levels of care, including transitions in care, with the goal of establishing consistent provider-patient relationships; and
6. Member experience with respect to clinical quality, access and availability, and culturally and linguistically competent health care and services, and continuity and coordination of care.

~~C.~~E. CHPIV will ensure ~~it applies~~ the principles of continuous quality improvement (CQI) are applied to all aspects of its service delivery system through analysis, evaluation, and systematic enhancements of the following:

1. Quantitative and qualitative data collection and data-driven decision-making;
2. Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;
3. Feedback provided by Members and NETWORK PROVIDERS in the design, planning, and implementation of its CQI activities;
4. Other issues identified by CHPIV or state regulator.

~~D.~~F. CHPIV will ensure~~s~~ the development of ~~it has developed~~ Population Health Management interventions designed to address SOCIAL DRIVERS OF HEALTH, reduce disparities in health outcomes experienced by different subpopulations of Members, and work towards achieving HEALTH EQUITY by:

1. Developing equity focused interventions intended to address disparities in the utilization and outcomes of physical and BEHAVIORAL HEALTH CARE SERVICES; and
2. Engaging in a Member and family-centric approach in the development of interventions and strategies, and in the delivery of all health care services.

~~E.~~G. CHPIV will ensure that a QIHETP is implemented, maintained, periodically updated, and includes~~CHPIV will develop and ensures that it has developed, implemented, maintained, and periodically update its QIHETP and associated policies and procedures that include~~, at a minimum, the following:

1. CHPIV's commitment to the delivery of quality and equitable health care services;
2. CHPIV's FULLY DELEGATED SUBCONTRACTOR's, and DOWNSTREAM FULLY DELEGATED SUBCONTRACTOR's organizational chart, listing the key staff and the committees responsible for QIHETP activities, including reporting relationships of the QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM (QIHEC)to executive staff;
3. Qualification and identification of staff who are responsible for QI and HEALTH EQUITY activities;

4. A process for sharing QIHETP findings with SUBCONTRACTORS, DOWNSTREAM SUBCONTRACTORS, and NETWORK PROVIDERS;
5. The role, structure, and function of the QIHEC;
6. The policies and procedures to ensure that all COVERED SERVICES are available and accessible to all Members regardless 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, or identification with any other persons or groups defined in Penal Code section 422.56, and that all COVERED SERVICES are provided in a culturally and linguistically appropriate manner;
7. The policies and procedures designed to identify, evaluate, and reduce Health Disparities, by performing the following:
   a. Analyzing data to identify differences in quality of care and utilization, as well as the underlying reasons for variations in the provision of care to its Members;
   b. Developing equity-focused interventions to address the underlying factors of identified Health Disparities, including SOCIAL DRIVERS OF HEALTH (SDOH); and
   c. Meeting disparity reduction targets for specific populations and/or measures as identified by DHCS and as directed under Exhibit A, Attachment III, Subsection 2.2.9.A (External Quality Review (EQR) Requirements, Quality Performance Measures).
8. CHPIV ensures that it includes description of the integration of Utilization Management (UM) activities into the QIHETP as specified in Exhibit A, Attachment III, Section 2.3 (Utilization Management Program), including a process to integrate reports on the number and types of service requests, denials, deferrals, modifications, Appeals, and Grievances to PLAN's medical director or the medical director's designee;
9. CHPIV ensures its Policies and procedures to adopt, disseminate, and monitor the use of clinical practice guidelines that:
   a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the relevant field;
   b. Consider the needs of Members;
   c. Stem from recognized organizations that develop or promulgate evidence-based clinical practice guidelines, or are developed with involvement of board-certified Providers from appropriate specialties;
   d. Have been reviewed by a medical director, as well as SUBCONTRACTORS, DOWNSTREAM SUBCONTRACTORS, and NETWORK PROVIDERS, as appropriate; and
   e. Are reviewed and updated at least every two years.
10. CHPIV ensures it has the inclusion of Population Health Management (PHM) activities, including the findings of the annual Population Needs Assessment (PNA), as required in Exhibit A, Attachment III, Subsection 4.3.2 (Population Needs Assessment [PNA]);
11. CHPIV ensures that it has Policies and procedures that ensure the delivery of Medically Necessary non-specialty and Specialty Mental Health Services as outlined in Exhibit A, Attachment III, Section 5.5 (Mental Health and Substance Use Disorder Benefits);
12. CHPIV ensures that its SUBCONTRACTORS, DOWNSTREAM SUBCONTRACTORS, NETWORK PROVIDERS, and other entities with which CHPIV contracts for the delivery of health care services comply with all mental health parity requirements in 42 CFR section 438.900 et seq.;

13. CHPIV ensures mechanisms to detect both over- and under-utilization of services including, but not limited to, outpatient prescription drugs;
14. CHPIV ensures it has mechanisms to continuously monitor, review, evaluate, and improve access to and availability of all COVERED SERVICES. The mechanisms shall include oversight processes that ensure Members are able to obtain Medically Necessary appointments within established standards for time or distance, timely access, and alternative access in accordance with APL 20-003, and W&I Code sections 14197 and 14197.04;
15. CHPIV ensures it has mechanisms to continuously monitor, review, evaluate, and improve quality and HEALTH EQUITY of clinical care services provided, including, but not limited to, preventive services for Children and adults, perinatal care, Primary Care, specialty, emergency, inpatient, BEHAVIORAL HEALTH and ancillary care services; and
16. CHPIV ensures that it has mechanisms to continuously monitor, review, evaluate, and improve coordination and continuity of care services to all Members, including Seniors and Persons with Disability (SPDs), Children with Special Health Care Needs (CSHCN), Members with chronic conditions, including BEHAVIORAL HEALTH, Members experiencing homelessness, Members recently released from incarceration, Members who use Long-Term Services & Supports (LTSS), and Children in child welfare.
17. Participation from a broad range of providers, including Physician, dentist, optometrist, psychologist or other appropriate licensed professional, to adequately monitor the full scope of clinical services rendered, resolve problems, and ensure that corrective action is taken when indicated. An appropriate range of specialist providers shall also be involved.

~~F.~~H. CHPIV will ensure the ~~ensures~~ development of an annual comprehensive assessment of QI and HEALTH EQUITY activities that includes an evaluation of the effectiveness of QI interventions and include, at a minimum, the following components:

1. A written analysis of required quality performance measure results, and a plan of action to address performance deficiencies, including analyses of each FULLY DELEGATED SUBCONTRACTOR's and DOWNSTREAM FULLY DELEGATED SUBCONTRACTOR's performance measure results and actions to address any deficiencies;
2. An analysis of actions taken to address any CHPIV-specific recommendations in the annual External Quality Review (EQR) technical report and evaluation reports;
3. An analysis of the delivery of services and quality of care of CHPIV and its FULLY DELEGATED SUBCONTRACTORS and DOWNSTREAM FULLY DELEGATED SUBCONTRACTORS, based on data from multiple sources, including quality performance results, Encounter Data, Grievances and Appeals, Utilization Review and the results of consumer satisfaction surveys;
4. Planned equity-focused interventions to address identified patterns of over- or under-utilization of physical and BEHAVIORAL HEALTH CARE SERVICES;
5. A description of CHPIV's commitment to member and/or family focused care through member and community engagement such as review of CAC findings, Member listening sessions, focus groups or surveys, and collaboration with local community organizations; and how CHPIV utilizes the information from this engagement to inform its policies and decision-making;
6. PHM activities and findings;
7. Outcomes/findings from Performance Improvement Projects (PIPs), consumer satisfaction surveys and collaborative initiatives.

~~G.~~I. CPHIV's annual plan includes evaluation and findings specific to the FULLY DELEGATED SUBCONTRACTOR's and DOWNSTREAM FULLY DELEGATED SUBCONTRACTOR's performance in QI and HEALTH EQUITY.

~~H.~~J. CHPIV policies and procedures describe the oversight and participation of its Governing Board and describe its QUALITY IMPROVEMENT AND HEALTH EQUITY COMMITTEE (QIHEC). Policies and procedures further include the following:

1. Specify that activities are supervised by ~~CHPIV's medical director or the medical director's designee, in collaboration~~ with CHPIV's Chief HEALTH EQUITY Officer;
2. Describe activities supervised by CHPIV's ~~medical director and the~~ Chief HEALTH EQUITY Officer; and
3. Indicate that QIHEC must include participation of a broad range of NETWORK PROVIDERS, including but not limited to hospitals, clinics, county partners, physicians, community health workers, and other non-clinical providers in the process of QIHETP development and performance review.

cdfv

III. PROCEDURE

A. CHPIV will maintain a Chief Health Equity Officer as well as its own Quality Improvement and Health Equity Committee (QIHEC).

B. CHPIV delegates the remainder of the Quality Management and Improvement process, including the Quality Improvement Health Equity Transformation Program (QIHETP), to its Subcontractor, Health Net.

~~A. CHPIV delegates the Quality Management and Improvement process to its Subcontractor, Health Net.~~

~~B.~~C. Delegation Oversight

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

IV. DEFINITIONS

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

TERM	DEFINITION
Behavioral Health	A mental health condition and/or Substance Use Disorder (SUD) condition.
Behavioral Health Care Services	Specialty Mental Health Services, Non-specialty Mental Health Services, and SUD treatment.

TERM	DEFINITION
Covered Services	Health care services, set forth in Welfare and Institutions (W&I) Code sections 14000 *et seq.* and 14131 *et seq.,* 22 CCR section 51301 *et seq*., 17 CCR section 6800 *et seq*., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, this Contract, and APLs that are made the responsibility of Contractor pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS.
Downstream Subcontractor	Individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.
Downstream Fully Delegated Subcontractor	A Downstream Subcontractor that contractually assumes all duties and obligations of Contractor under the Contract, through the Subcontractor, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A managed care plan can operate as a Downstream Fully Delegated Subcontractor.
Downstream Partially Delegated Subcontractor	A downstream Subcontractor that contractually assumes some, but not all, duties and obligations of a Subcontractor under the Contract, including, for example, obligations regarding specific Member populations or obligations regarding a specific set of services. Individual Physician Associations and Medical Groups often operate as Downstream Partially Delegated SUBCONTRACTORS.
Downstream Administrative Subcontractor	A Downstream Subcontractor that contractually assumes administrative obligations of a Subcontractor under the Contract. Administrative obligations include functions such as credentialing verification or claims processing. However, functions related to coordinating or directly delivering health care services for Members, such as Utilization Management or Care Coordination, are not administrative functions.
Fully Delegated Subcontractor	A subcontractor that contractually assumes all duties and obligations of Contractor under the Contract, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A managed care plan can operate as a Fully Delegated Subcontractor.
Health Disparity	Differences in health, including mental health, and outcomes closely linked with social, economic, and environmental disadvantage, which are often driven by the social conditions in which individuals live, learn, work, and play. Characteristics such as race, ethnicity, age, disability, sexual orientation or gender identity, socio-economic status, geographic location, and other factors historically linked to exclusion or discrimination are known to influence the health of individuals, families, and communities.
Health Equity	The reduction or elimination of Health Disparities, Health Inequities, or other disparities in health that adversely affect vulnerable populations.
Health Inequity	Systematic difference in the health status of different population groups arising from the social conditions in which Members are born, grow,

TERM	DEFINITION
	live, work, and/or age, resulting in significant social and economic costs both to individuals and societies.
Network	PCPs, Specialists, hospitals, ancillary Providers, facilities, and other Providers with whom Contractor enters into a Network Provider Agreement.
Provider	Means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Network Provider Agreement	Means a written agreement between a Network Provider and Contractor, Subcontractor, or Downstream Subcontractor.
805 Report	Written report required under Business and Professions Code Section 805(b).
Quality Improvement (QI)	Means a systematic and continuous actions that lead to measurable improvements in the way health care is delivered and outcomes for Members.
Quality Improvement and Health Equity Committee (QIHEC)	Means a committee facilitated by CHPIV's medical director, or the medical director's designee, in collaboration with the Health Equity officer, to meet at least quarterly to direct all QIHETP findings and required actions.
Quality Improvement and Health Equity Transformation Program (QIHETP)	Means the systematic and continuous activities to monitor, evaluate, and improve upon the Health Equity and health care delivered to Members in accordance with the standards set forth in applicable laws, regulations, and this Contract.
Senior and Person with Disability (SPD)	Means a member who falls under a specific SPD aid code as defined by DHCS.
Social Drivers of Health	Means the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risk
Subcontractor	Means an individual or entity that has a Subcontractor Agreement with Contractor that relates directly or indirectly to the performance of Contractor's obligations under this Contract. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.
Subcontractor Agreement	Means a written agreement between Contractor and a Subcontractor. The Subcontractor Agreement must include a delegation of Contractor's duties and obligations under the Contract.

	Claims and Provider Dispute Resolution	CLM-001
Department	Finance, Network & Informatics	
Functional Area	Claims, Provider Dispute Resolution	
Impacted Delegate	☒ Subcontractor ☐ NA	

DATES			
Policy Effective Date	6/12/23	**Reviewed/Revised Date**	
Next Annual Review Due	6/12/24	**Regulator Approval**	

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

ATTACHMENTS
NA

AUTHORITIES/REFERENCES

- **Internal**
  - CHPIV, Delegation Oversight Policy and Procedure, CMP-002
- **Federal**
  - 42 Code of Federal Regulations ("CFR") 438.114(b)(c)(d)
- **State**
  - California Health and Safety Code Sections ("H&S Code") 1317, 1317.1, 1363.5, 1367 (g) – (j), 1367.01, 1367.02 (c) – (d), 1368(a), 1370, 1370.2, 1371, 1371.1, 1371.2, 1371.8, 1371.22, 1371.30, 1371.31, 1371.35, 1371.36, 1371.37, 1371.38, 1371.39, 1371.4, 1371.5, 1371.8, 1371.9, 1375.1, 1375.4, 1399.55, 1399.56
  - Title 28 California Code of Regulations Rules ("CCR") 1300.67.3, 1300.68(d), 1300.71, 1300.71.31, 1300.71.38, 1300.71.39, 1300.71.4, 1300.74.30 (a) – (c), 1300.77.4, 1300.75.4.1(b), 1300.75.4.5, 1300.77.2, 1300.77.4, 1300.85.1
  - DMHC: Technical Assistance Guide ("TAG") "Claims Management and Processing" (last published 01/31/2020); All Plan Letter ("APL") 23-008
  - DHCS: DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III, Section 3.2.2, 3.2.3, 3.3.5

HISTORY

Revision Date	Description of Revision
6/12/2023	Policy creation

I. OVERVIEW

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

II. POLICY

A. CHPIV ensures payment of all CLEAN CLAIMS submitted by Network Providers in accordance with the Department of Health Care Services (DHCS) Medi-Cal Contract, and federal and state laws and regulations, unless agreed in writing to an alternate payment schedule.
B. CHPIV ensures compliance with 42 USC section 1396u-2(f) and Health and Safety Code sections 1371-1371.36 and their implementing regulations, unless agreed in writing to an alternate payment schedule. CHPIV shall be subject to any penalties and sanctions, including interest payments, provided by law if CHPIV fails to meet the standards specified in the DHCS Medi-Cal Contract.
C. CHPIV ensures payment of 90% of all CLEAN CLAIMS from Providers within 30 calendar days of the DATE OF RECEIPT, and 99% of all CLEAN CLAIMS from Providers' claims, within 90 calendar days of the DATE OF RECEIPT. For purposes of determining timeliness, the DATE OF RECEIPT shall be the date CHPIV receives the claim, as indicated by CHPIV's date stamp on the claim. The date of CHPIV's payment shall be the date of CHPIV's check or other form of payment.
D. CHPIV ensures accrued interest at the rate of 15% per annum for non-paid CLEAN CLAIMS beginning with the first calendar day after 45-working-days from the DATE OF RECEIPT.
E. CHPIV maintains procedures for pre-payment and post-payment claims review, including review of any data associated with Providers, MEMBERS, and the Covered Services for which payment is claimed, to ensure the proper and efficient payment of claims.
F. CHPIV ensures sufficient claims processing, tracking, and payment systems capability to comply with applicable State and federal law, regulations, and Contract requirements, to determine the status of received claims and to estimate incurred and unreported claims (IBNR) amounts as specified by 28 CCR sections 1300.77.1 and 1300.77.2.
G. CHPIV ensures development and maintenance of protocols for payment of claims to Out-of-Network Providers, and for communicating and interacting with Out-of-Network Providers regarding services and claims payment.
H. CHPIV ensures clinical protocols and evidence-based practice guidelines governing Prior Authorization, Utilization Management and Retrospective Review are provided to all Out-of-Network Providers providing services to its MEMBERS. Contractor must arrange to provide these protocols and guidelines at the time that Contractor enters into an agreement with an Out-of-Network Provider or anytime an Out-of-Network Provider submits a claim for services provided to Contractor's MEMBERS.

I. CHPIV ensures in accordance with the Health and Safety (H&S) Code section 1367, Contractor must have a fast, fair, and cost-effective dispute resolution process in place for Providers, Network Providers, Subcontractors, and Downstream Subcontractors to submit disputes. CHPIV maintains separate dispute resolution mechanism for contracted and non-contracted provider disputes and separate dispute resolution mechanisms for claims and other types of billing and contract disputes.

J. CHPIV ensures there is a formal procedure to accept, acknowledge, and resolve Provider, Network Provider, Subcontractor, and Downstream Subcontractor disputes. The resolution process must occur in accordance with the timeframes set forth in H&S Code sections 1371 and 1371.35 for both contracted and non-contracted Providers. Any Provider of Medi-Cal services may submit a dispute to Contractor regarding:
    1. The authorization or denial of a service;
    2. The processing of a payment or non-payment of a claim by Contractor; or
    3. The timeliness of the reimbursement on an uncontested CLEAN CLAIM and any interest Contractor is required to pay on claims reimbursement.

K. Contractor's Provider Dispute Resolution process must be set forth in all Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements.

L. Any provider that submits a claim dispute to the plan's capitated provider's dispute resolution mechanism involving an issue of medical necessity or utilization review shall have an unconditional right of appeal for that claim dispute to CHPIV's dispute resolution process for a de novo review and resolution for a period of 60 working days from the capitated provider's DATE OF DETERMINATION.

M. CHPIV assumes the responsibility for the processing and timely reimbursement of provider claims if the claims processing organization or the capitated provider fails to timely and accurately reimburse its claims (including the payment of interest and penalties). CHPIV obligation to assume responsibility for the processing and timely reimbursement of a capitated provider's provider claims may be altered to the extent that the capitated provider has established an approved corrective action plan.

    ~~4.~~1. CHPIV's contract with a claims processing organization or a capitated provider shall not relieve CHPIV of its obligations to comply with sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28.

~~K.~~N. Contractor must inform all Providers, Network Providers, Subcontractors, and Downstream Subcontractors that provide services to Contractor's MEMBERS of its Provider Dispute Resolution process, regardless of contracting status.

~~L.~~O. Contractor must resolve Provider, Network Provider, Subcontractor, and Downstream Subcontractor disputes within the timeframes set forth in H&S Code section 1371.35 of receipt of the dispute, including supporting documentation. Contractor and Provider, Network Provider, Subcontractor, or Downstream Subcontractor may agree that additional time is needed. If Contractor unilaterally requests additional time, it must show good cause for the extension and provide supporting good cause documentation to DHCS upon request.

~~M.~~P. Contractor must submit a Provider Dispute Resolution Report annually to DHCS which includes information on the number of Providers who utilized the dispute resolution mechanism, delineated by Providers, Network Providers, Subcontractors, and Downstream

Subcontractors and a summary of the disposition of those disputes, in accordance with H&S Code section 1367(h)(3).

~~N.~~Q. On an annual basis Contractor must assess the Providers, Network Providers, Subcontractors, and Downstream Subcontractors that regularly utilize the Provider Dispute Resolution process to identify trends and systemic issues. Contractor must submit the results of its annual assessment to DHCS with discussion on how it is addressing trends and systemic issues identified based on the assessment.

III. PROCEDURE

A. CHPIV delegates the Claims and Provider Dispute Resolution process to its Subcontractor, Health Net.

~~A.~~B. CHPIV retains a separate dispute resolution mechanism to resolve claims payment disputes when providers exhaust the Provider Dispute Resolution process with Health Net.

~~B.~~C. Delegation Oversight

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

IV. DEFINITIONS

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

TERM	DEFINITION
Member	A beneficiary enrolled in a CHPIV program.
Authorized Representative	Means any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member.
Clean Claim	Means a claim that can be processed without obtaining additional information from the Provider or from a third party.
Contracted Provider Dispute or Appeal	A contracted provider's written notice to the Plan and/or its delegate HNCS challenging, appealing or requesting post-service reconsideration of a claim (including a bundled group of substantially similar multiple claims that are individually numbered) that has been denied (including due to being "not medically necessary"), adjusted or contested, or seeking resolution of a billing determination or other contract dispute (or

TERM	DEFINITION
	a bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered) or a request for reimbursement of an overpayment of a claim. The dispute must contain, at a minimum, the following information: the provider's name; the provider's identification number; contact information; and • If the appeal concerns a claim or a request for reimbursement of an overpayment of a claim, a clear identification of the disputed item, including the original claim ID or submission ID number, the date of service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect; • If the appeal is not about a claim, a clear explanation of the issue and the provider's position thereon (e.g. not medically necessary denial or contract dispute); and/or • If the appeal involves a member or group of members: the name and identification number(s) of the member or members, a clear explanation of the disputed item, including the date of service, original claim ID or submission ID number, and the provider's position thereon.
Contested Claim	When the Plan and/or its delegated HNCS has determined that it has not received the Complete Claim and all of the information necessary to determine payer liability for the claim, or has not been granted reasonable access to information concerning practitioner services. Information necessary to determine payer liability for the claim includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for the Plan and/or its delegate HNCS to determine the medical necessity for the health care services provided. The notice that a claim, or portion thereof, is contested by the Plan and/or its delegate HNCS will identify the portion of the claim that is contested, by revenue code, and the specific information needed from the provider to reconsider the claim.
Date of Contest/Date of Denial/Date of Notice	The date of postmark or electronic mark accurately setting forth the date when the contest, denial, or notice was electronically transmitted or deposited in the US Mail or another mail or delivery service, correctly addressed to the claimant's office or other address of record with proper postage.
Date of Determination	The date of postmark or electronic mark on the written provider dispute determination or amended provider dispute determination that is delivered, by physical or electronic means, to the claimant's office or other address of record. To the extent that a postmark or electronic mark is unavailable to confirm the Date of Determination, the Plan and/or its delegate HNCS will consider the date the check is printed for any monies determined to be due and owing to the provider and the date the check is presented for payment.

TERM	DEFINITION
Date of Receipt	The Working Day when the provider dispute or amended provider dispute, by physical or electronic means, is first delivered to the Plan and/or its delegate HNCS' designated Provider Appeals Unit or post office box.
Non-Contracted Provider Dispute or Appeal	A non-contracted provider's written notice to the Plan and/or its delegate HNCS challenging, appealing or requesting post-service reconsideration of a claim (including a bundled group of substantially similar claims that are individually numbered), which has been denied (including for not being "not medically necessary"), adjusted or contested, or disputing a request for reimbursement of an overpayment of a claim. The dispute must contain, at a minimum, the following information: the provider's name, the provider's identification number, contact information and: • If the dispute concerns a claim or a request for reimbursement of an overpayment of a claim, a clear identification of the disputed item, including the original claim ID or submission ID number, including the date of service, and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, contest, denial, request for reimbursement of an overpayment of a claim or other action is incorrect. • If the dispute is not about a claim, a clear explanation of the issue and the provider's position thereon (e.g. medical necessity); and • If the dispute involves a member or group of members, the name and identification number(s) of the member or members, a clear explanation of the disputed item, including the date of service, original claim ID or submission ID number, and the provider's position thereon.
Overpayment	Reimbursement of a claim that has been determined to have been overpaid. The Plan and/or its delegate HNCS notifies the provider in writing through a separate notice identifying the overpayment and the amount of the overpayment, the provider shall reimburse the Plan and/or its delegate HNCS within 30 working days of receipt by the provider of the notice of overpayment unless the overpayment or portion thereof is contested by the provider in which case the Plan and/or its delegate HNCS shall be notified, in writing, within 30 working days. The provider's notice contesting the validity of an overpayment shall identify the portion of the overpayment that is contested and the specific reasons for contesting the overpayment.
Reasonably Relevant Information	The minimum amount of itemized, accurate and material information generated by or in the possession of the provider related to the billed services that enables a claims adjudicator with appropriate training, experience, and competence to timely and accurately process claims to determine the nature, cost, if applicable, and extent of the Plan and/or its delegate HNCS' liability, if any, and to comply with any governmental information requirements.
Working Days	Means Monday through Friday, except for state holidays as identified at

TERM	DEFINITION
	the California Department of Human Resources State Holidays page.

	States of Emergency	BC-001
	Department	Finance, Network & Informatics
	Functional Area	Business Continuity
	Impacted Delegate	☒ Subcontractor ☐ NA

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

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

ATTACHMENTS

NA

AUTHORITIES/REFERENCES

- **Internal**
  - CHPIV, Delegation Oversight Policy and Procedure, CMP-002
- **State**
  - California Health and Safety Code Sections ("H&S Code") 1368.7
  - California Government Code Sections 8625 and 101080
  - DMHC: All Plan Letter ("APL") 23-002
  - DHCS: DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III, Section 6.~~0~~ 1.5, 6.2, & 6.3

HISTORY

Revision Date	Description of Revision
6/12/2023	Policy creation
7/6/2023	Policy revised to include references to health emergency
2/7/2024	Policy revised to include DHCS timeframe requirements

I. OVERVIEW

A. This policy addresses Community Health Plan of Imperial Valley's ("CHPIV" or the "Plan") States of EMERGENCY requirements, policy, and procedures. The purpose of this policy is to establish an EMERGENCY PREPAREDNESS and Response Plan.

II. POLICY

A. CHPIV ensures there is an EMERGENCY PREPAREDNESS and Response Plan in place which includes, at a minimum:
   1. BUSINESS CONTINUITY EMERGENCY PLAN, as described in Exhibit A, Attachment III, Section 6.2 *(BUSINESS CONTINUITY EMERGENCY PLAN);*
   2. MEMBER EMERGENCY PREPAREDNESS PLAN, as described in Exhibit A, Attachment III, Section 6.3 *(MEMBER EMERGENCY PREPAREDNESS PLAN);* and
   3. Ensuring policies and procedures comply with all the requirements set forth in Article 6.

B. CHPIV ensures that the EMERGENCY PREPAREDNESS and Response Plan will be approved by DHCS prior to the start of CHPIV operations and will comply with guidance issued by the Department related to the emergency. Any updates to deliverables identified in this section must be submitted to DHCS as requested.

~~C.~~ CHPIV ensures enrollee who has been displaced by a state of EMERGENCY, as declared by the Governor pursuant to Section 8625 of the Government Code, or a health emergency, as declared by the State Public Health Officer pursuant to Section 101080 are provided access to medically necessary health care services.

C.

~~D.~~ CHPIV will notify DHCS within 24 hours of a federal, State, or county declared state of Emergency located within CHPIV's Service Area as to whether CHPIV and its subcontractors within Imperial County has experienced or expects to experience any disruption to its operations. CHPIV will report the status of its operations once a day to DHCS, or as directed by DHCS. CHPIV's daily report to DHCS must include, at a minimum, the following information:

D.

1. The number of Members in CHPIV's Service Area affected by the Emergency, per county, including the number of medium-to-high health risk Members, as identified through the Population Needs Assessment;
2. Information, to the extent available, relating to Network Provider site closures, including:
   a. The number of Network Provider site closures by Provider type, per county;
   b. The number of Members served by each closed Network Provider, per county;
   c. The number of hospitalized Members who need to be transferred;
   d. The location(s) of where Members were transferred; and
   e. For each closed Network Provider, a list of the alternative Providers or facilities where Members can receive care.
3. The number of CHPIV offices that are closed;
4. How CHPIV is communicating with impacted Members, Network Providers, Subcontractors, and Downstream Subcontractors;

5. The actions CHPIV has taken or will take to meet the continued health care needs of its Members; and
6. The Network Provider, Subcontractor, Downstream Subcontractor, or Member issues CHPIV has received.

CHPIV will submit a filing with DMHC wWithin 48 hours of a declaration by the Governor of a state of EMERGENCY or a declaration by the State Public Health Officer of a health emergency that displaces or has the immediate potential to displace enrollees or health care providers., CHPIV ensures a notificationthe filing describing describes whether the plan has experienced or expects to experience any disruption to the operation of CHPIV and its subcontractors within Imperial County is filed with the department., explaining how CHPIV is communicating with potentially impacted enrollees, and summarizing the actions CHPIV has taken or is in the process of taking to ensure that the health care needs of enrollees are met.

E. CHPIV will take actions, including, but not limited to, the following:
   1. Shorten time limits plans to approve prior authorization, precertification, or referrals, and extend the time that prior authorizations, precertifications, and referrals remain validRelaxed time limits for prior authorization, precertification, or referrals.
   2. Extended filing deadlines for claims.
   3. Suspend prescription refill limitations and allow an impacted enrollee to refill his or her prescriptions at an out-of-network pharmacy.
   4. Authorize an enrollee to replace medical equipment or supplies.
   5. Allow enrollees to access an appropriate out-of-network provider if an in-network provider is unavailable due to the state of EMERGENCY or if the enrollee is out of the area due to displacement.
   6. Have a toll-free telephone number that an affected enrollee may call for answers to questions, including questions about the loss of health insurance identification cards, access to prescription refills, or how to access health care.

A. CHPIV will notify DHCS as to whether CHPIV and its subcontractors within Imperial County has experienced or expects to experience any disruption to its operations. CHPIV will report the status of its operations once a day to DHCS, or as directed by DHCS.

III. PROCEDURE

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

IV. DEFINITIONS

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

TERM	DEFINITION
Member	A beneficiary enrolled in a CHPIV program.
Emergency	Means unforeseen circumstances that require immediate action or assistance to alleviate or prevent harm or damage caused by public health crises, natural and man-made hazards, or disasters.
Emergency Preparedness	Means a continuous cycle of planning, organizing, training, equipping, exercising, evaluating, and taking Corrective Action to ensure effective coordination during incident response
Business Continuity Emergency Plan	Means a document consisting of the critical information and processes HealthNet's needs to continue operating during an Emergency
Member Emergency Preparedness Plan	Means a required subsection of the Emergency Preparedness and Response Plan that details the required coordination between CHPIV and its Members, Network Providers, Subcontractors, and Downstream Subcontractors to ensure Member access to health care services in the event of an Emergency.

	Standards of Network Accessibility and Timely Access to Care	PNM-001
Department	Finance, Network & Informatics	
Functional Area	Provider Network Management	
Impacted Delegate	☒ Subcontractor ☐ NA	

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

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

ATTACHMENTS
NA

AUTHORITIES/REFERENCES

- **Internal**
  - CHPIV, Delegation Oversight Policy and Procedure, CMP-002
- **Federal**
  - Title 42 Code of Federal Regulations ("CFR") 438.3(f)(1), 438.68, 438.206, 438.207
  - 42 United States Code ("USC") Section 18116
- **State**
  - California Health and Safety Code Sections ("H&S Code") 1317, 1345(b), 1367.03, 1367.031,
  - Title 22 California Code of Regulations Rules ("CCR") 14087.48 (b)(2) and (b)(4);
  - Title 28 CCR Rules 1300.51(H) and (J), 1300.67, 1300.67.04, 1300.67.2, 1300.68
  - DMHC All Plan Letters ("APLs") 22-024, 22-026, 22-027, and 22-029
  - 2024 DHCS Contract Exhibit A Attachment III Sections 5.2.4, 5.2.5, 5.2.7, 5.2.8, 5.2.9, 5.2.10, 5.2.12, 5.2.13
  - DHCS All Plan Letters ("APLs") 18-022, 20-003, 21-003, 21-004, 23-001
- **Accreditation**
  - NCQA: Network Management (NET) 1, Elements B-D; NET 2, Elements A-C; NET 3, Elements A-C

HISTORY

Revision Date	Description of Revision
6/12/2023	Policy creation
10/20/2023	Policy revision
1/30/2024	Policy revision: DMHC filling and DHCS APL 23-006

HISTORY	

I. OVERVIEW

A. This policy addresses Community Health Plan of Imperial Valley's ("CHPIV" or the "Plan") standards of NETWORK adequacy and accessibility and timely access to care requirements, policy, and procedures. This policy addresses NETWORK adequacy, accessibility, and timely access to care standards contained within relevant federal and state statutes, regulations, the Medi-Cal contract with the state Department of Health Care Services (DHCS), and if applicable, accreditation standards. Access to NETWORK PROVIDERS and Covered Services

II. POLICY

A. CHPIV ensures the development and maintenance of the NETWORK Accessibility and Timely Access to Care policies and procedure(s) to provide NETWORK Accessibility and Timely Access to Care services in compliance with all Legal Authority.

B. Access to NETWORK PROVIDERS and Covered Services

1. Primary Care

- **a.** CHPIV ensures that each Member has an assigned Primary Care Provider (PCP) who is available and physically present at the Service Location for sufficient time to ensure access and appointments for the assigned Member when medically required. This requirement does not preclude an appropriately licensed Provider from being a substitute for the Member's assigned PCP in the event of vacation, illness, or other unforeseen circumstances.
- **b.** CHPIV ensures it has processes in place to assist Members in selecting PCPs who are accepting new patients.
- **c.** CHPIV ensures that Members have the option of selecting an Indian Health Service Program (IHS), Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC), as their PCP, where available.

2. Specialists

- **a.** CHPIV ensures that Members have access to Specialists for Medically Necessary Covered Services in accordance with W&I Code section 14197, 22 California Code of Regulations (CCR) section 53853, and 28 CCR section 1300.67.2.2.
- **b.** CHPIV ensures the maintenance of an adequate NETWORK that includes adult and pediatric Specialists, and at a minimum, the core Specialists required in W&I Code section 14197(h)(2), within its NETWORK to ensure Medically Necessary specialty care is available in accordance with 22 CCR section 53853(a), and W&I Code sections 14182(c)(2) and 14087.3.

3. CHPIV ensures its NETWORK PROVIDERS, SUBCONTRACTORS, and DOWNSTREAM SUBCONTRACTOR have adequate NETWORKs and staff within its Service Area, including Physicians, Nurses, administrative, and other support staff to ensure that they have sufficient capacity to provide and coordinate care for Covered Services are provided in

accordance with 22 CCR section 53853, W&I Code section 14197, 28 CCR section 1300.67.2.2 and all requirements in this contract.

4. CHPIV will monitor its SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS to ensure they can adequately deliver culturally and linguistically competent care including offering interpreter services when a Limited English Proficient (LEP) Member accesses a Provider who does not speak the Member's language.
5. CHPIV ensures that Members have access to all Non-specialty Mental Health and Substance Use Disorder Covered Services in accordance with 42 CFR section 438.900 et seq. and will coordinate care for all Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) services and provide referrals including mechanisms to track completion of follow up visits, to the county mental health plan (MHP) and Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services as outlined in Exhibit A, Attachment III, Section 5.5 (Mental Health and Substance Use Disorder Benefits)

C. NETWORK Capacity

1. CHPIV maintains a NETWORK adequate to provide the full scope of benefits to 60 percent of all Potential Members or current Member Enrollment, whichever is higher, within its Service Area. CHPIV must increase the capacity of the NETWORK as necessary to accommodate all Enrollment growth beyond 60 percent.
2. CHPIV requests to renegotiate its NETWORK capacity requirement with DHCS if utilization by CHPIV's Members does not exceed 75 percent of the required NETWORK capacity, after the first 12 months of operation. Any such change is subject to DHCS review and approval.

D. NETWORK Composition

1. CHPIV maintains an adequate NETWORK within CHPIV's Service Area, in compliance with W&I Code section 14197, and if necessary to ensure contract compliance with NETWORK adequacy. CHPIV may offer to contract with Providers in adjoining Service Areas but must make good faith efforts to contract with Providers within CHPIV's Service Area. CHPIV's NETWORK must include at a minimum adult and pediatric PCPs, obstetrics, and gynecology (OB/GYNs), adult and pediatric behavioral health Providers, adult and pediatric Non-specialty outpatient mental health service (NSMHS) Providers, adult and pediatric Specialists, hospitals, and Long-Term Care (LTC) Providers to ensure adequate access to all Medically Necessary Covered Services for all Members and to meet all NETWORK adequacy requirements.
2. CHPIV maintains an adequate NETWORK of Allied Health Personnel, supportive paramedical personnel, public hospitals and health care systems, care navigators, caseworkers, and public health nurses, and an adequate number of accessible service sites to ensure adequate access to all Medically Necessary Covered Services for all Members.
3. CHPIV includes in its NETWORK, where available, IHS, FQHC, RHCs, Freestanding Birthing Centers (FBC), Certified Nurse Midwives (CNM), and Licensed Midwives (LM) in accordance with W&I Code section 14087.325, Medicaid State Health Official Letter #16-006, and APL 18-022. 1)

4. CHPIV contracts with a sufficient number of and include at least one FQHC, one RHC, and one FBC in the NETWORK, where available in Contractor's Service Area(s), to the extent that the FQHC, RHC, and FBC Providers are licensed and recognized under State law.
5. CHPIV offers to contract with all IHS available in Imperial County in accordance with 22 CCR section 55120. If CHPIV is unable to contract with an IHS, it must allow eligible members to obtain services from out-of-network IHS as per 42 CFR section 438.14.
6. CHPIV continually ensures that the composition of its NETWORK meets the ethnic, cultural, and linguistic needs of CHPIV's Members.
7. CHPIV ensures it has an adequate number of NSMHS Providers to provide Medically Necessary, NSMHS based on current and anticipated utilization trends for its Members.
8. CHPIV includes in its NETWORK any traditional and Safety-Net Provider that is willing to contract under the same terms and conditions that CHPIV offers to any other similar Provider in accordance with 22 CCR section 53800(b)(2)(C)(1).
9. CHPIV ensures that every LTC Provider in its Service Area is licensed by the California Department of Public Health (CDPH) as a qualified LTC Provider is included in their NETWORK, to the extent that the Provider remains licensed, certified, operating, and is willing to enter into a NETWORK Provider Agreement on mutually agreeable terms and meets Credentialing and quality standards. If CHPIV determines that additional LTC Providers are necessary to meet the needs of its Members, it will offer to contract or enter into a letter of agreement with any additional CDPH licensed LTC Providers in its Service Area or in adjoining Service Areas.
10. CHPIV receives a preapproval or assessment of suitability from CDPH prior to the execution of a NETWORK Provider Agreement for LTC Providers undergoing a change of ownership. NETWORK Provider Agreements must have a clause that LTC Providers must notify CHPIV if it is undergoing a change of ownership to obtain preapproval or assessment of suitability from CDPH.
11. CHPIV contracts with a sufficient number of Community-Based Adult Service (CBAS) Providers to timely meet the needs of Members who are CBAS eligible. CHPIV must have an adequate number of CBAS Providers that are geographically located within one hour's transportation time and that are appropriate for and proficient in addressing CBAS-eligible Members' specialized health needs and acuity, communication, cultural, and language needs and preferences. CHPIV must also meet expected CBAS utilization without a waitlist. CHPIV may, but is not obligated to, contract with CBAS Providers licensed as Adult Day Health Cares (ADHC) and certified by California Department of Aging (CDA) to provide CBAS on or after April 1, 2012.
12. CHPIV's Ssubcontractor ~~shall have~~maintains a process for identifying network providers and verifying that the information and data collected for reporting is true and correct and does not contain misstatements or omissions of material fact. CHPIV's subcontractor utilizes an external vendor to validate provider data included in the Timely Access Compliance Report to ensure its accuracy. CHPIV ~~The process shall include a description of how the plan designates an individual to serve as a~~ 's Chief Ccompliance ~~o~~Officer, whose qualifications are described in CHPIV's Compliance ~~Plan~~Program, ~~who~~ is responsible for reviewing and submitting the required reports and information.

13. CHPIV shall not prevent, discourage, or discipline a network provider or employee for informing an enrollee or subscriber about the timely access standards.

E. NETWORK Ratios

1. CHPIV ensures it complies with 22 CCR section 53853(a)(1) - (2) and ensure that its NETWORK meets the following full-time equivalent (FTE) Physician to Member ratios:
- **a.** FTE Primary Care Providers that are Physicians: Member: 1:2,000
- **b.** FTE Total Physicians: Member 1:1,200

2. CHPIV ensures that FTE non-physician medical practitioner's Member caseload does not exceed 1,000 patients in accordance with 22 CCR section 53853(a)(3).

3. CHPIV ensures compliance with 22 CCR sections 51240 and 51241, and Business and Professions Code sections 3516 and 2836.1 and full-time equivalent Physician supervisor to non-physician medical practitioner ratios do not exceed the following:
- Physician Supervisor: Nurse Practitioners 1:4
- Physician Supervisor: Physician Assistants 1:4
- A Physician supervisor may not supervise more than four non-physician medical practitioners in any combination.

F. NETWORK Adequacy Standards

1. Timely Access

a. CHPIV ensures compliance with 22 CCR sections 51240 and 51241, and Business and Professions Code sections 3516 and 2836.1 and full-time equivalent Physician supervisor to non-physician medical practitioner ratios do not exceed the following:

i. CHPIV on a quarterly basis shall perform a review of all information available to The Plan regarding The Plans ability to meet timey access requirements as required by CCR section 1300.67.2.2 and 1300.68

b. CHPIV ensures the development, implementation, and maintenance of procedures to monitor and ensure that its NETWORK PROVIDERS, SUBCONTRACTORS, and DOWNSTREAM SUBCONTRACTORS:

i. CHPIV shall comply with the following requirements for Members to obtain appointments for routine care, Urgent Care, routine specialty referral appointments, prenatal care, Children's preventive periodic health assessments, and adult initial health assessments in accordance with W&I Code section 14197, and 28 CCR section 1300.67.2.2:

A. Urgent Care appointment for services that do not require Prior Authorization within 48 hours of a request;

B. Urgent Care appointment for services that do require Prior Authorization within 96 hours of a request;

C. Non-urgent appointments for Primary Care within ten (10) business days of request;

D. Non-urgent appointments with Specialist Physicians within 15 business days of request;

E. Non-urgent appointment with a non-physician mental health Provider with ten (10) business days of request;

F. Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness within fifteen (15) business days of request;

G. Availability of LTC Providers within seven (7) business days of request;

H. Non-urgent follow-up appointments with a nonphysician mental health care (NPMH) or substance use disorder provider must be offered within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition, except as provided in Section 1367.03(a)(5)(H);

I. Substance use disorder providers have been added to the standards applicable to mental health care providers set forth in Section 1367.03, including the time-elapsed non-urgent appointment standard;

J. A referral to a specialist by a primary care provider or another specialist shall be subject to the relevant time-elapsed standard, unless the requirements in Section 1367.03, sub. (a)(5)(H) or (I) are met.

c. In the event that CHPIV, or a delegated subcontractor, has a shortage of one or more types of providers, CHPIV shall ensure timely access to covered health care services as required by this section, including applicable time-elapsed standards, by referring enrollees to, or, in the case of a preferred provider organization or point-of-service network, by assisting enrollees to locate, available and accessible network providers in neighboring network service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs.

i. A plan shall arrange for the provision of covered of services from providers outside the plan's network if unavailable within the network, when medically necessary for the enrollee's condition. As with in-network services, members will not have any cost obligations, and out-of-network providers are prohibited from balance billing CHPIV members. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific network provider. If medically necessary treatment of a mental health or substance use disorder is not available in network within the geographic and timely access standards set by law or regulation, a health care service plan shall arrange coverage outside the plan’s network in accordance with subdivision (d) of Section 1374.72.

d. CHPIV shall comply with all time-elapsed standards set forth in Section 1367.03(a) and Rule 1300.67.2.2(c) and will evaluate overall compliance in a manner consistent with the definition of "patterns of non-compliance" set forth in Rule 1300.67.2.2(b)(12)(A) unless the plan has received an Order of Approval from the

Department for an alternative time-elapsed standard, an alternative to time-elapsed standards, or an alternative standard to the threshold rate of compliance.

e. CHPIV shall ensure that all plan and provider processes necessary to obtain covered health care services, including the processes required under section 1367.01 of the Knox-Keene Act, are completed in a manner that assures the provision of covered health care services to enrollees in a timely manner appropriate for the enrollee's condition and in compliance with the requirements of this Rule

2. CHPIV offers Members appointments for Covered Services within a time frame appropriate for their health condition but no longer than the appointment timeframes set forth in 28 CCR section 1300.67.2.2, unless the Member's preference is to wait for a later appointment from a specific NETWORK Provider. The applicable waiting time for a particular appointment may be extended if the following conditions are met:

a. The Member's medical record notes that waiting will not have a detrimental impact on the Member's health, as determined by the referring or treating licensed health care Provider, or by the health professional providing triage or screening services, who is acting within the scope of their practice consistent with professionally recognized standards of practice.

b. The Provider's decision to extend the applicable waiting time is noted in the Member's Medical Record and made available to DHCS upon request; and

c. CHPIV ensures that the Member receives notice of the Provider's decision to extend the applicable waiting time with an explanation of the Member's right to file a Grievance disputing the extension.

3. CHPIV provides the appointment time standards to NETWORK PROVIDERS, SUBCONTRACTORS, and DOWNSTREAM SUBCONTRACTORS, and monitors appointment waiting times in NETWORK PROVIDERS' offices pursuant to 42 CFR section 438.206, W&I Code section 14197, and 28 CCR section 1300.67.2.2.

4. CHPIV ensures that NETWORK PROVIDERS comply with requirements for follow up on missed appointments.

5. CHPIV offers hours of operation to Members that are no less than the hours of operation offered to non-Medi Cal patients, or to Medi-Cal Fee-For-Service (FFS) beneficiaries if the NETWORK Provider serves only Medi-Cal beneficiaries.

6. CHPIV maintains procedures for triaging Members' telephone calls, providing telephone medical advice, and accessing telephone interpreters 24 hours a day, seven days a week.

7. During normal business hours, the waiting time for a member to speak by telephone with a customer service representative knowledgeable and competent regarding the Member's questions and concerns must not exceed ten minutes.

8. CHPIV ensures it has a medical director or licensed Physician who is available 24 hours a day, seven days a week to assist with access issues.

9. For vision, chiropractic, and acupuncture services, CHPIV shall ensure that network providers employ an answering service or a telephone answering machine during nonbusiness hours, which provide instructions regarding how an enrollee may obtain urgent or emergency care, including, if applicable, how to contact another provider who

has agreed to be on call to triage or screen by phone, or if needed, deliver urgent or emergency care.

10. Advanced Access Verification Requirements

a. Advanced Access Verification Requirements shall include the definition set forth in Rule 1300.67.2.2(b)(1).

b. If CHPIV or its SUBCONTRACTORS, and DOWNSTREAM SUBCONTRACTORS uses Advanced Access to demonstrate compliance with the PAAS (Provider Appointment Availability Survey), then CHPIV ensures that NETWORK PROVIDERS comply with-the primary care time-elapsed standards established in 1300.67.2.2(b)(1) through implementation of standards, processes, and systems providing advanced access to primary care appointments in accordance with 1367.2.2(c)(5)(1

~~a.~~**c.** CHPIV's fully delegated SUBCONTRACTOR currently does not have an Advanced Access Program.

~~**b.** Advanced Access Verification Requirements shall include reviewing access and availability for providers offering advanced access appointments as well as enrollee grievances and appeals pursuant to Rule 1300.67.2.2(d)(2)(D).~~

~~**c.** Advanced Access Verification Requirements shall include the process for verifying at least once every three years that advanced access providers are scheduling appointments consistent with the definition of advanced access set forth in Rule 1300.67.2.2(b)(1).~~

~~**d.** Advanced Access Verification Requirements shall include requiring providers give written notice to plan no more than 30 calendar days after provider stops offering advanced access appointments.~~

G. Time or Distance

1. CHPIV ensures that its NETWORK PROVIDERS, SUBCONTRACTORS, and DOWNSTREAM SUBCONTRACTORS meet the time or distance standards for adult and pediatric PCPs, adult and pediatric core Specialists, OB/GYN primary and specialty care, adult and pediatric mental outpatient health Providers, and hospitals, as required by W&I Code section 14197(b) and (c).

2. CHPIV either exhausts all other reasonable options for contracting with Providers, including offering to contract with Providers in adjoining Service Areas, or provides evidence to DHCS demonstrating that its delivery structure is capable of delivering the appropriate level of care and access as required by W&I Code section 14197 prior to submitting an Alternate Access Standard (AAS) request to DHCS.

3. If CHPIV is unable to comply with the time or distance standards set forth in W&I Code section 14197, CHPIV must submit a AAS request to DHCS for review and approval in accordance with APL 21-006 detailing how it intends to arrange for Covered Services in accordance with W&I Code section 14197(e)(3).

4. Approved AAS requests must be published in its website in accordance with W&I Code section 14197.04.

5. If CHPIV has received an AAS approval from DHCS for a core Specialist, upon a Member's request, CHPIV must assist the Member in obtaining an appointment with the appropriate

core Specialist in accordance with W&I Code section 14197.04. CHPIV must either make its best effort to establish a Member-specific case agreement with an out-of-network Provider or arrange for an appointment with a NETWORK Provider in an adjoining Service Area within the time or distance standards in accordance with W&I Code section 14197.04. If needed, CHPIV must assist in arranging transportation for the Member. CHPIV must not be held liable for fulfilling these requirements if either there is no core Specialist within the time or distance standards of this Contract, or the core Specialist has refused to contract in the previous 12 months.

H. Quality Assurance

1. CHPIV shall develop and maintain policies, procedures and quality assurance monitoring systems that ensure its networks maintain compliance with the clinical appropriateness standard.
2. CHPIV shall document its standards and description of its process for monitoring triage standards including:
    a. Provision, 24 hours per day, 7 days per week of triage or screening services by telephone.
    b. Telephone triage or screening services are provided in a timely manner appropriate for the enrollee's condition, and the triage or screening waiting time does not exceed 30 minutes.
3. CHPIV's written quality assurance processes shall address tracking and documenting network capacity and availability with respect to the standards set forth in: Subsections (c)(1)-(4), (c)(5)(G)-(I), (c)(6), and (c)(8)-(9) of this Rule, except as provided by subsection (d)(2)(F) of this Rule.
4. CHPIV's written quality assurance processes shall address tracking and documenting network capacity and availability of network providers with respect to the standards set forth in Section 1367.03(a)(5)(A)-(G) and Rule 1300.67.2.2(c)(5)(A)-(F) by administering the Provider Appointment Availability Survey, pursuant to Rule 1300.67.2.2(f) of this Rule.
5. CHPIV's quality assurance monitoring process for identifying and addressing patterns of non-compliance shall include:
    a. The plan's definition(s) of "pattern of non-compliance", which at a minimum shall include the definitions set forth in Rule 1300.67.2.2(b)(12).
    b. The plan's mechanism and sources of information or data used to identify any patterns of non-compliance. CHPIV's subcontractor will investigate and request corrective actions when timely access to care requirements are not met. If CHPIV's subcontractor identifies providers and PPGs that are non-compliance with appointment and after-hours access requirements, a Corrective Action Plan (CAP) is issued. The CAP notification to the provider/PPG includes a description of the identified deficiencies, the rationale for the corrective action, and the contact information of the person authorized to respond to provider concerns regarding the corrective action. CHPIV oversees its subcontractor's compliance process according to CHPIV policy titled *CMP-002 Delegation Oversight*.
    c. The plan's process for implementing a corrective action plan when a pattern of non-compliance is identified, which shall describe the steps the plan intends to

take in order to address the non-compliance as outlined in CHPIV policy titled *CMP-003 Corrective Action Plan*.

6. CHPIV's quality assurance monitoring process for identifying and addressing incidents of non-compliance resulting in substantial harm to an enrollee shall include:
   a. The plan's definition of an incident of non-compliance resulting in substantial harm to an enrollee which at a minimum means substantial harm means loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, severe and chronic physical pain, or significant financial loss ~~shall include the definition set forth~~as defined in Civil Code section 3428. ~~in Civil Code section 3428.~~
   b. The plan's mechanism and sources of information used to identify and investigate incidents of non-compliance resulting in substantial harm to an enrollee. CHPIV's subcontractor will investigate and request corrective actions when timely access to care requirements are not met. If CHPIV's subcontractor identifies providers and PPGs that are non-compliance with appointment and after-hours access requirements, a Corrective Action Plan (CAP) is issued. The CAP notification to the provider/PPG includes a description of the identified deficiencies, the rationale for the corrective action, and the contact information of the person authorized to respond to provider concerns regarding the corrective action. CHPIV oversees its subcontractor's compliance process according to CHPIV policy titled *CMP-002 Delegation Oversight*.
   ~~b.~~
   c. The plan's process for implementing corrective action plan when an incident of non-compliance resulting in substantial harm to an enrollee is identified, which shall describe the steps the plan intends to take in order to address the non-compliance as outlined in CHPIV policy titled *CMP-003 Corrective Action Plan.*

I. Access to Emergency Service Providers and Emergency Services

1. CHPIV ensures it has, at a minimum, a designated Emergency Services facility, providing care 24 hours a day, seven days a week. This designated Emergency Services facility will have one or more Physicians and one nurse on duty in the facility at all times.
2. CHPIV ensures that Members with Emergency Medical Conditions are seen on an emergency basis and that Emergency Services are available and accessible within Contractor's Service Area seven days a week, 24 hours a day, in accordance with 42 United States Code (USC) sections 1395dd and 1396u-2(b)(2), and 42 Code of Federal Regulations (CFR) section 438.114.
3. CHPIV ensures it reimburses the costs of Emergency Services without Prior Authorization pursuant to 42 USC section 1395dd, 42 CFR section 438.114, 28 CCR section 1300.67(g), and 22 CCR section 53216 and 53855.
4. CHPIV ensure it has a medical director or licensed Physician acting on behalf of Contractor's medical director, who is available 24 hours a day, seven days a week to authorize Medically Necessary Post-Stabilization Care Services, to respond to hospital inquiries within 30 minutes, and to coordinate the transfer of a Member whose Emergency Medical Condition is stabilized.

5. CHPIV ensures that Members have timely access to Medically Necessary follow-up care including but not limited to appropriate referrals to Primary Care, Behavioral Health Services, and social services for Members who have been screened in the emergency room and do not require emergency care.
6. CHPIV coordinates access to Emergency Services in accordance with Contractor's DHCS-approved emergency department protocol, as required in Exhibit A, Attachment III, Section 3.2 (Provider Relations).
7. If CHPIV's Delegates downstream its Emergency Services and Post-Stabilization Care Services oversight obligations to NETWORK PROVIDERS, SUBCONTRACTORS, or DOWNSTREAM SUBCONTRACTORS, it must ensure a licensed Physician is available seven days a week, 24 hours a day, to authorize Medically Necessary Post-Stabilization Care Services and coordinate the transfer of stabilized Members in an emergency department to an appropriate NETWORK Provider, if necessary, as required under Health and Safety (H&S) Code section 1371.4.

J. Out-of-network Access

1. CHPIV must authorize and arrange for out-of-network access in the following circumstances:
   - **a.** CHPIV does not meet NETWORK adequacy requirements set forth in W&I Code section 14197;
   - **b.** CHPIV does not have an AAS approved by DHCS and fails to meet the NETWORK adequacy standards set forth in W&I Code section 14197;
   - **c.** CHPIV fails to comply with the requirements for timely access to appointments; or
   - **d.** CHPIV must arrange for access to out-of-network LTC when Medically Necessary for a Member in cases where CHPIV does not have in-NETWORK LTC capacity.
   - **e.** CHPIV ensures it authorizes and arranges for services from out-of-network Providers when the Provider type is unavailable within the NETWORK but available in an adjoining county(ies). If there is no NETWORK PROVIDER in the adjoining county(ies), it will authorize out-of-network services to the most appropriate Provider as close to time or distance requirements as possible.
   - **f.** CHPIV provides Non-Emergency Medical Transportation (NEMT) or Non-Medical Transportation (NMT) to the out-of-network Provider, at no cost to the Member and informs Members of their right to obtain NEMT or NMT services to access out-of-network services in accordance with W&I Code section 14197.04.
   - **g.** CHPIV adequately and timely covers and reimburses Providers for out-of-network services rendered to its Members for as long as it is unable to provide these services in its NETWORK. CHPIV ensures that it ensures that the Member is not charged for services furnished out-of-network, and that. CHPIV ensures that Members are not balance-billed for any service provided out-of-network.

K. Specific Requirements for Access to Programs and Covered Services

1. Family Planning Services
   - **a.** CHPIV ensures Members have access to family planning services through any available family planning Provider regardless of whether they are in or out of the

NETWORK, without requiring Prior Authorization. CHPIV shall provide family planning services in a manner that ensures Members have the freedom to choose their preferred method of family planning consistent with 42 CFR section 441.20.

b. CHPIV does not restrict a Member's Provider choice for family planning services covered pursuant to W&I Code section 14132.07, and 42 CFR section 431.51(a)(3).

c. CHPIV ensures that their Member Handbook must inform Members of their right to access any qualified family planning Provider regardless of whether the Provider is in the NETWORK and without Prior Authorization, in addition to requirements included in Exhibit A, Attachment III, Section 5.1 (Member Services).

d. CHPIV ensures that Members are advised of their options for all contraceptive methods to allow them to provide informed consent for their choice of contraceptive method, including sterilization, as required by 22 CCR sections 51305.1 and 51305.3.

e. Members of childbearing age may access the following services from an out-of-network family planning Provider to temporarily or permanently prevent or delay pregnancy:

i. Health education and counseling necessary to make informed choices and understand contraceptive methods;

ii. Limited history and physical examination;

iii. Laboratory tests if medically indicated as part of the decision-making process in choice of contraceptive methods, except pap smears if Contractor provides pap smears to meet the United States Preventive Services Taskforce (USPSTF) guidelines;

iv. Follow-up care for complications associated with contraceptive methods provided or prescribed by the family planning Provider;

v. Provision of contraceptive pills, devices, and supplies;

vi. Tubal ligation;

vii. Vasectomies; and

viii. Pregnancy testing and counseling.

2. Sexually Transmitted Diseases

a. CHPIV ensures Members have access to Sexually Transmitted Disease (STD) services from any NETWORK PROVIDER or out-of-network Provider without requiring Prior Authorization or referral. CHPIV allows Members to access out-of-network STD services through Local Health Department (LHD) clinics, family planning clinics, or through other community STD service Providers.

3. HIV Testing and Counseling

a. CHPIV ensures that Members have access to confidential Human Immunodeficiency Virus (HIV) counseling and testing services from any NETWORK PROVIDER or out-of-network Provider without requiring Prior Authorization.

4. Minor Consent Services

a. CHPIV ensures access to Minor Consent Services for Members less than 18 years of age from any NETWORK PROVIDER or out-of-network Provider without requiring Prior Authorization.

b. CHPIV ensures Members are informed of the availability of these services without Prior Authorization. Minors less than 18 years of age do not need parental or legal guardian consent to access these services, and CHPIV and its NETWORK PROVIDERS, SUBCONTRACTORS, or DOWNSTREAM SUBCONTRACTORS are prohibited from disclosing any information relating to Minor Consent Services without the express consent of the minor Member. Minor Consent Services include treatment for the following:

- **i.** Sexual assault, including rape;
- **ii.** Drug or alcohol abuse for children ages 12 and over;
- **iii.** Pregnancy;
- **iv.** Family planning;
- **v.** STDs in children ages 12 and over; and
- **vi.** NSMHS for children ages 12 and over who are mature enough to participate intelligently in their health care pursuant to Family Code section 6924.

5. Immunizations

a. Members may access LHD clinics for immunizations regardless of whether the LHD is in the NETWORK or out-of-network, without Prior Authorization.

b. Upon request, CHPIV will provide updated information on the status of the Member's immunizations to the LHD clinic.

c. CHPIV ensures it reimburses LHD clinics that provide immunizations to its Members after receipt of claims and supporting immunization records.

6. Indian Health Service Programs

a. CHPIV ensures qualified Members have timely access to IHS Providers within its NETWORK, where available, as required by 42 USC section 1396j, and Section 5006 of Title V of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. § 1396o(a)).

b. IHS Providers, whether in the NETWORK or out-of-network, can provide referrals directly to NETWORK PROVIDERS without requiring a referral from a NETWORK PCP or Prior Authorization in accordance with 42 CFR section 438.14(b).

c. CHPIV must also allow for access to an out-of-network IHS Provider without requiring a referral from a NETWORK PCP or prior authorization in accordance with 42 CFR section 438.14(b).

7. Nurse Midwife and Certified Nurse Practitioner Services

a. CHPIV ensures that its Members have access to CNM services as required by 42 USC section 1396(d)(a)(17) and 22 CCR section 51345.

b. CHPIV ensures its Members have access to Certified Nurse Practitioner (CNP) services as required in 22 CCR section 51345.1.

c. CHPIV informs its Members that they have a right to obtain out-of-network CNM services if CNM services are not available in-NETWORK.

8. Services to Which NETWORK PROVIDER, Subcontractor, or DOWNSTREAM SUBCONTRACTOR Has a Moral Objection

a. If a NETWORK PROVIDER, Subcontractor, or DOWNSTREAM SUBCONTRACTOR has religious or ethical objections to perform or otherwise support the provision of

Covered Services, CHPIV timely arranges for, coordinates, and ensures the Member receives the Covered Services through referrals to a Provider that has no religious or ethical objection to performing the requested service or procedure, at no additional expense to DHCS or the Member.

b. CHPIV's Member Handbook must identify services to which a NETWORK PROVIDER, Subcontractor, or DOWNSTREAM SUBCONTRACTOR may have a moral objection and explain that the Member has a right to obtain such services from another Provider.

c. CHPIV's informs the Member that it will assist the Member in locating a NETWORK PROVIDER who will perform the service or procedure.

9. Federally Qualified Health Center, Rural Health Clinic, and Freestanding Birthing Center Services

a. CHPIC meets meet federal requirements for access to FQHC, RHC, and FBC services consistent with 42 USC section 1396b(m) and Medicaid State Health Official Letter #16-006.

10. Community Based Adult Services

a. CHPIV provides Members with access to CBAS as set forth in the California Medi-Cal 2020 Demonstration, Number 11-W-00193/9 Special Terms and Conditions, amended December 29, 2020, or as set forth in any subsequent demonstration amendment or renewal, or successor demonstration, waiver, or other Medicaid authority.

i. Without limitation, CHPIV ensures it does the following:

A. Provides and coordinates the provision of unbundled CBAS services for affected CBAS recipients as needed for continuity of care if there is a 5 percent reduction in CBAS Provider capacity in a county within the Service Area relative to the capacity that existed on April 1, 2012; and

B. Arranges Medically Necessary Covered Services for Members with similar clinical conditions as CBAS recipients if there is insufficient CBAS Provider capacity in a county in which ADHC was available prior to April 1, 2012, and coordinate their access to community resources to assist them to remain in the community.

L. NETWORK and Access Changes to Covered Services

1. DHCS Notification Requirements

a. CHPIV provides notification to DHCS immediately upon discovery of a NETWORK PROVIDER initiated termination or at least 60 calendar days before any change occurs in the availability or location of services Contractor's Covered Services.

b. CHPIV provides this notice if the change impacts more than 2,000 Members or impacts the ability to meet NETWORK adequacy standards in accordance with APL 21-003. In the event of an emergency or other unforeseeable circumstance,

c. CHPIV notifies DHCS of the change in the availability or location of services as expeditiously as possible.

d. CHPIV provides notification to DHCS immediately, or within 10 calendar days of learning of a Provider's exclusionary status from any database or list included in APL 21-003 or subsequent revisions.

e. CHPIV notifies DHCS when it is unable to contract with a certified CBAS Provider or upon termination of a CBAS NETWORK PROVIDER Agreement. If the CBAS Provider cannot come to an agreement on terms, CHPIV ensures notification DHCS within five Working Days of decision to exclude the CBAS Provider from its NETWORK. DHCS may attempt to resolve the contracting issue when appropriate.

f. In accordance with APL 21-003, CHPIV ensures it notifies DHCS within 60 calendar days of termination of a LTC NETWORK PROVIDER or immediately if the termination is a result of the LTC NETWORK PROVIDER having been decertified by CDPH. DHCS will attempt to resolve the contracting issue when appropriate. If termination of a LTC NETWORK PROVIDER Agreement is for a cause related to Quality of Care or patient safety concerns, CHPIV may expedite termination of the LTC NETWORK PROVIDER Agreement and transfer Members to an appropriate, contracted LTC Provider in an expeditious manner. DHCS must be notified of the termination within 72 hours of said termination. CHPIV must not continue to assign or refer Members to a LTC NETWORK PROVIDER during the 60 calendar days between notifying DHCS and the termination effective date.

2. Member Notification Requirements

a. Pursuant to 42 CFR section 438.10(f), CHPIV ensures Members are notified in writing of any changes in the availability or location of Covered Services, of any termination of a NETWORK PROVIDER, Subcontractor, or DOWNSTREAM SUBCONTRACTOR, or any other changes in information listed in 42 CFR section 438.10(f), either 30 calendar days prior to the effective date of the contract termination or at least 15 calendar days after receipt of issuance of the termination notice, whichever is longer, unless directed by DHCS. The notification must be provided to each Member who received Primary Care from, or was seen on a regular basis by, the terminated Provider. This notification must also be submitted to DHCS in writing for approval before its release.

b. CHPIV obtains DHCS approval before sending a notice of termination to its Members no later than 60 calendar days prior to the effective date of the termination. CHPIV may use a member notice template previously approved by DHCS. Any changes from the approved template must be submitted to DHCS 60 calendar days prior to the effective date of the termination for review and approval before mailing the notice. In the event of an emergency or other unforeseeable circumstance, Contractor must provide notice of the emergency or other unforeseeable circumstance to DHCS as soon as possible.

M. Access Rights

1. Equal Access for Linguistic Services

a. CHPIV ensures equal access to the provision of high-quality interpreter and linguistic services for LEP Members and Potential Members, and for Members and Potential Members with disabilities, in compliance with federal and State law, and APL 21-004.

2. Linguistic Services
    a. CHPIV complies with W&I Code section 14029.91 and ensure that all monolingual, non-English-speaking, or LEP Members and Potential Members receive 24-hour interpreter services at all key points of contact, as defined in Paragraph B.4) of this Provision, either through interpreters, telephone language services, or other legally compliant electronic options.
    b. CHPIV shall provide interpreter services to be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment without imposing delay on the scheduling of the appointment.
    c. CHPIV ensures that any lack of interpreter services does not impede or delay a Member's timely access to care.
    d. CHPIV complies with Title VI of the Civil Rights Act of 1964 and 42 CFR section 438.10(d) and have the capacity to provide, at minimum, the following linguistic services at no cost to Members or Potential Members:
    e. Oral interpreters, sign language interpreters, or bilingual Providers and Provider staff at all key points of contact. These services must be provided in all languages spoken by Members and Potential Members and not limited to the Threshold or Concentration Standards languages;
    f. Full and immediate translation of written materials pursuant to 42 CFR sections 438.10(d)(3), 438.404, and 438.408; W&I Code 14029.91; 22 CCR sections 53876 and 53884 for LEP Members and Potential Members who speak Threshold or Concentration Standard Languages, fully translated Member Information, including: the Member Handbook, Provider Directory, welcome packets, marketing information, Member rights information, form letters and individual notices, including Notice of Action (NOA) letters, all notices related to Grievances and Appeals including Grievance and Appeal acknowledgement and resolution letters, and any other materials as required by Title VI of the Civil Rights Act of 1964 and APL 21-004;
    g. Referrals to culturally and linguistically appropriate community service programs; and
    h. Auxiliary Aids such as Telephone Typewriters (TTY)/ Telecommunication Devices for the Deaf (TDD), qualified interpreters including American Sign Language interpreters, and information in alternative formats including Braille, large print text (20 point font or larger), audio, and electronic formats.
    i. Key points of contact include:
    j. Medical care settings, such as telephone, advice and Urgent Care transactions, and outpatient Encounters with Providers; and
    k. Non-medical care settings, such as Member services, orientations, and appointment scheduling.
3. Access for Persons with Disabilities
    a. CHPIV complies with the requirements of Titles II and III of the Americans with Disabilities Act of 1990, section 1557 of the Affordable Care Act of 2010, sections 504 and 508 of the Rehabilitation Act of 1973, Government Code

sections 11135 and 7405, and all applicable implementing regulations, and must ensure access for people with disabilities including, without limitation, accessible web and electronic content, ramps, elevators, accessible restrooms, designated parking spaces, and accessible drinking water.

N. Cultural and Linguistic Programs and Committees

1. Cultural and Linguistic Program

a. CHPIV must develop and implement policies and procedures for assessing the performance of its employees, contracted staff and other individuals who provide linguistic services, addressing any identified gaps in the provision of cultural and linguistic services by staff, and for overall monitoring and evaluation of its cultural and linguistic services programs.

b. CHPIV has in place and continually monitors, improves and evaluates cultural and linguistic services that support the delivery of Covered Services to Members. CHPIV ensures it has proper policies and procedures in place to provide appropriate cultural and linguistic services for all of its Members.

c. CHPIV takes immediate action to improve the delivery of culturally and linguistically appropriate services when deficiencies are noted.

d. CHPIV ensures it is active in recruiting and retaining culturally and linguistically competent Providers that reflect the needs of the Medi-Cal population in the CHPIV's Service Area.

e. CHPIV ensures it has a cultural and linguistic services program, as required by 22 CCR section 53876, that incorporates all requirements of applicable federal and state law, including without limitation those requirements cited in Exhibit A, Attachment III, Subsection 5.2.10 (Access Rights), 22 CCR sections 51202.5 and 51309.5(a), 28 CCR sections 1300.67.04(c)(2)(A) - (B) and 1300.67.04 (c)(2)(G)(v) - (c)(4), and 42 CFR section 438.206(c)(2). CHPIV ensures immediate translation of all critical Member Information as required by 42 CFR sections 438.10 and 438.404 and W&I Code section 14029.91.

f. CHPIV must review and update its cultural and linguistic services programs to align with the Population Needs Assessment (PNA). CHPIV ensures its NETWORK PROVIDERS, SUBCONTRACTORS, DOWNSTREAM SUBCONTRACTORS cultural and Health Equity linguistic services programs also align with the PNA.

g. CHPIV ensures it implements and maintains a written description of its cultural and linguistic services program which must include, at a minimum, the following:

h. Its organizational commitment to deliver culturally and linguistically appropriate health care services;

i. Services that comply with Title VI of the Civil Rights Act of 1964, section 1557 of the Affordable Care Act of 2010, 42 CFR section 438.10, Exhibit A, Attachment III, Section 5.2.10 (Access Rights), and APL 21-004

j. Use of National standards for Culturally and Linguistically Appropriate Services (CLAS) for reference;

k. An organizational chart showing the key staff with overall responsibility for cultural and linguistic services programs;

l. A narrative explaining the organizational chart and describing the oversight and direction to the Community Advisory Committee (CAC), requirements for support staff and reporting relationships. Qualifications of staff, including appropriate education, experience, and training must also be included;

m. The role of the PNA to inform cultural and linguistic services program priorities in compliance with Exhibit A, Attachment III, Subsection 4.3.3 (Population Needs Assessment);

n. The implementation and maintenance of annual sensitivity, diversity, communication skills, Health Equity, and cultural competency training and related trainings (e.g., providing gender affirming care) for employees and contracted staff (clinical and non-clinical), as determined by Section C of this Provision, Diversity, Equity, and Inclusion Training; and

o. CHPIV administrative oversight and compliance monitoring of the cultural and linguistic services program and requirements for the delivery of culturally and linguistically appropriate health care services.

2. Linguistic Capability of Employees and Contracted Staff

a. CHPIV ensures it assesses and tracks the linguistic capability of its interpreters or bilingual staff and contracted staff (clinical and non-clinical).

b. CHPIV implements a system to provide adequate training regarding its language assistance programs to all employees and contracted staff who have routine contact with LEP Members or Potential Members and systematically address any identified gaps in addressing Members' cultural and linguistic needs. The training must include instruction on:

c. Policies and procedures for language assistance;

d. How to work effectively with LEP Members and Potential Members;

e. How to work effectively with interpreters in person and through video, telephone, and other media; and,

f. Understanding the cultural diversity of Members and Potential Members, and sensitivity to cultural differences relevant to delivery of health care interpretation services, in accordance with Exhibit A, Attachment III, Subsection 5.2.11 (Cultural and Linguistic Programs and Committees)
NETWORK Reports

O. NETWORK Reports

1. Annual NETWORK Certification Report

a. CHPIV ensures it annually submits its NETWORK certification report to DHCS. The report must demonstrate its capacity to serve the current and expected membership for its Service Area in accordance with 42 CFR section 438.207(b), W&I Code section 14197(f)(1), and APL 20-003.

b. CHPIV ensures it demonstrates how it will arrange for Covered Services to Members through the use of NEMT, NMT, and Telehealth if it does not meet time or distance standards for adult and pediatric PCPs, core Specialist and

outpatient mental health Providers in accordance with W&I Code section 14197(f)(2).

c. CHPIV submits its annual NETWORK certification report before the contract year begins as outlined in APL 20-003.

2. NETWORK Access Profile

a. CHPIV shall submit an annual Network Access Profile in accordance with Title 28 CCR 1300.67.2.2 (h)(8).

3. SUBCONTRACTOR Network Certification

a. CHPIV ensures it annually submits its SUBCONTRACTOR Network Certification (SNC) report to DHCS. The SNC report must demonstrate compliance with network adequacy and access for the Provider Networks of CHPIV's DELEGATES and/or SUBCONTRACTORS' that have assumed risk per the DELEGATES and/or SUBCONTRACTORS' Agreements in accordance with CalAIM 1915(b) Waiver STCs, and APL 23-006.

b. CHPIV will ensure the annual SNC includes all Subcontractor Networks reported via the 274 Provider Network data file, unless the Subcontractor Network is exempt per the criteria listed below and the required documentation provided substantiates the exemption.

c. Subcontractor Networks that are exempt from SNC:

- If CHPIV only contracts with one Subcontractor Network in the Service Area, and no Providers directly contract with CHPIV.
- The Subcontractor Network only provides specialty or ancillary services; or
- The Subcontractor Network only provides care through single case agreements and is not available to all CHPIV's Members upon enrollment.

d. CHPIV will submit the required SNC documentation to DHCS with the correct file naming conventions through the DHCS Secure File Transfer Protocol site no later than 45 days following the RY (calendar year) or if the date falls on a weekend, the next Working Day.

- SNC submission consists of three parts (1) the Subcontractor Network Exemptions Request template, (2) the Network Adequacy and Access Assurances Report (NAAAR), and (3) verification documents.
- Failure to submit complete and accurate SNC documentation to DHCS by the SNC annual submission date, CHPIV will be subject to the imposition of a corrective action plan (CAP) and/or other enforcement actions by DHCS.

e. CHPIV identifies SUBCONTRACTOR Network deficiencies impacting Member access to care, CHPIV will ensure that the delegated SUBCONTRACTOR must authorize Covered Services from Out-of-Subcontractor Network (OOSN) Providers for Members in the deficient Subcontractor Network regardless of associated transportation or Provider costs until deficiency is addressed.

f. f. CHPIV will ensure that the deficient SUBCONTRACTOR or DOWNSTREAM SUBCONTRACTOR informs Members that OOSN access to

services is available, and the SUBCONTRACTOR's Member services staff are trained on Members' right to request OOSN access for Covered Services and transportation to Providers where the SUBCONTRACTOR or DOWNSTREAM SUBCONTRACTOR is unable to comply with Network adequacy or access standards

g. CHPIV found non-compliant with the SNC requirements.

- CHPIV will respond to the initial CAP response, no later than 30 calendar days after the issuance of the CAP notification letter, that details a plan of action and sets forth steps CHPIV will take to correct the deficiencies identified.
- CHPIV will ensure all deficiencies are corrected within 6 months during which CHPIV will provide DHCS with monthly status updates that demonstrate action steps the MCP is undertaking to address the CAP.

P. Periodic Reporting Requirements

1. CHPIV reports to DHCS any time there is a Significant Change to its NETWORK that affects NETWORK capacity and Contractor's ability to provide health care services, such as the following:
2. Change in Covered Services or benefits;
3. Change in geographic Service Area;
4. Change in the composition of, or the payments to, its NETWORK PROVIDERS, SUBCONTRACTORS, or DOWNSTREAM SUBCONTRACTORS; or enrollment of a new population.

5. CHPIV provides supporting documentation detailing any Significant Change to DHCS. DHCS will determine what information must be provided it reports a Significant Change to its NETWORK pursuant to 42 CFR section 438.207.

~~5.~~**6.** CHPIV enters into a new risk-based Subcontractor Agreement with a Subcontractor that expands to CHPIV's existing Provider Network.

~~6.~~**7.** NETWORK Change Report

a. CHPIV submits to DHCS, in a format specified by DHCS, a report summarizing changes in the NETWORK. CHPIV shall submit the report 30 calendar days following the end of the reporting quarter.

~~a.~~**b.** If a significant change occurs within 90 calendar days prior to the SNC annual submission date, CHPIV will document the change as part of the RY (calendar year) SNC filling.

Q. Subcontractor and DOWNSTREAM SUBCONTRACTOR Certification Report

1. CHPIV ensures it develops, implements, and maintains a process to annually certify its SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS that provide Medi-Cal covered services for compliance with
2. NETWORK Ratios set forth in Subsection 5.2.4 (NETWORK Ratios),
3. NETWORK Adequacy Standards set forth in Section 5.2.5 (NETWORK Adequacy Standards), and
4. NETWORK Composition requirements set forth in Section 5.2.3.B (NETWORK Composition) of this Contract.

5. CHPIV submits complete and accurate NETWORK PROVIDER, Subcontractor, and DOWNSTREAM SUBCONTRACTOR data to confirm its Subcontractor's and DOWNSTREAM SUBCONTRACTOR's NETWORK(s) is compliant with all applicable NETWORK adequacy requirements, as set forth in Section 2.1.4 (NETWORK PROVIDER DATA Reporting)
6. CHPIV has a process in place to impose Corrective Action and sanctions and report to DHCS when SUBCONTRACTORs and DOWNSTREAM SUBCONTRACTORS that provide Medi-Cal Covered Services fail to meet NETWORK adequacy standards as set forth in APL 21-006, or any subsequent revisions as outlined in CHPIV policy titled *CMP-002 Delegation Oversight*. CHPIV shall ensure all Members assigned to a SUBCONTRACTOR or DOWNSTREAM SUBCONTRACTOR that is under a Corrective Action continue access to Medically Necessary Covered Services within timely access standards and applicable time or distance standards as set forth in Section 5.2.5 (NETWORK Adequacy Standards) by supplementing the SUBCONTRACTOR's or DOWNSTREAM SUBCONTRACTOR's NETWORK until the Corrective Action is resolved.
7. CHPIV submits the results of its certification to DHCS annually in a format specified by DHCS and post its submitted certification on its website.

R. Timely Access Compliance Report

1. CHPIV shall gather and report all Timely Access Compliance Report data and information set forth in Rule 1300.67.2.2(h)(6) including subcontracted plan data.
2. With respect to the Provider Appointment Availability Survey (PAAS) Report Forms, the process shall also include how the plan identifies potential inaccuracies and steps the plan will take to verify that key data is accurate, including:
    a. Process for collecting information to identify network providers reported to the Department in the PAAS Report Forms
    b. How the plan identifies potential inaccuracies
    c. A description of the sources the plan uses to verify provider information
    d. Steps the plan will take to verify that key data, such as provider location and provider specialty, is accurate
    e. Process for incorporating updated information from provider directory verification efforts into the PAAS Report Forms
    f. Process for using the prior year's ineligible information to improve the PAAS Contact List.
    g. CHPIV will include subcontracted plan data in its Timely Access Compliance Report, including the PAAS Report Forms.
    h. CHPIV's process for administering and reporting the results of the PAAS, which complies with the methodology set forth in the PAAS Manual, incorporated in Rule 1300.67.2.2, and reporting requirements set forth in the Timely Access and Annual Network Submission Instruction Manual, incorporated in Rule 1300.67.2.2. ~~(The plan may incorporate the PAAS Manual by reference into the plan's policies and procedures.)~~

S. Enrollee Experience Survey

1. CHPIV shall offer members an Enrollee Experience Survey on an annual basis. The survey will be developed based on the following guidelines:
    a. Enrollee Experience Survey shall be conducted in accordance with a statistically valid and reliable survey methodology.
    b. Enrollee Experience Survey shall obtain enrollee perspectives and concerns regarding experience obtaining timely appointments within the standards set forth in (c).
    c. Enrollee Experience Survey shall inform enrollees of their right to obtain an appointment within each of the time-elapsed standards in Rule 1300.67.2.2(c)(1) and (5) including notice of their right to receive interpreter services at that appointment, as required by (c)(4).
    d. Enrollee Experience Survey shall evaluate the experience of limited English proficient enrollees in obtaining interpreter services by obtaining enrollees' perspectives and concerns regarding coordination of appointments with an interpreter, availability of interpreters who speak the enrollee's preferred language and the quality of interpreter services received.
    e. Enrollee Experience Survey shall be translated into the enrollee's preferred language in those situations where the plan is aware of the enrollee's language and the enrollee's preferred language is one of the top 15 languages spoken by limited English proficient individuals in California as determined by DHCS.
    f. The plan's Enrollee Experience survey questions and the process used for evaluating and comparing the results against prior years.

T. Provider Satisfaction Survey

1. CHPIV shall conduct a Provider Satisfaction Survey in accordance with a statistically valid and reliable survey methodology.
2. The Provider Satisfaction Survey shall obtain from physicians and non-physician mental health providers perspectives and concerns regarding compliance with the standards set forth in (c).
3. The Provider Satisfaction Survey shall obtain provider perspectives and concerns with the plan's language assistance program regarding coordination of appointments with an interpreter, availability of an interpreter based on the needs of an enrollee; and the ability of the interpreter to effectively communicate with the provider on behalf of the enrollee.
4. CHPIV's submission shall include the Provider Satisfaction survey questions and set forth the process used for evaluating and comparing the results against prior years.

III. PROCEDURE

A. Delegation Oversight

1. CHPIV delegates its Network to its SUBCONTRACTOR, ~~Health Net~~.
2. CHPIV will oversee its SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS compliance with the standards consistent with the Health Care Providers' Bill of Rights, and a material change in the obligations of CHPIV's NETWORK PROVIDERS shall be

considered a material change to the provider contract as set forth in HSC 1367.03 subsection (c).

3. CHPIV shall provide oversight and continually assess the delegated functions, responsibilities, processes, and performance of ~~Health Net~~. CHPIV ensures ~~Health Net~~'s compliance with regulatory and contractual requirements through the following activities which are detailed in *CHPIV Policy CMP-002: Delegation Oversight Policy and Procedure*:
   - **i.** Ongoing monitoring
   - **ii.** Performance reviews
   - **iii.** Data analysis
   - **iv.** Utilization of benchmarks, if available
   - **v.** Annual desktop and on-site audits

IV. DEFINITIONS

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

TERM	DEFINITION
Appointment Waiting Time	Means the time from the initial request to the plan or a provider for covered health care services by an enrollee, an enrollee's representative or the enrollee's treating provider to the earliest date offered for the appointment for services. Appointment waiting time is inclusive of time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its network providers. A grievance, as defined in Rule 1300.68(a)(1), regarding a delay or difficulty in obtaining an appointment for a covered health care service may constitute an initial request for an appointment for covered health care services.**Means** ~~the time from the initial request for health care services by a Member or the Member's treating provider to the earliest date offered for the appointment for services inclusive of the time for obtaining authorization from the plan, and completing any other condition or requirement of the plan or its contracting providers.~~
Downstream Subcontractor	Means an individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.
Network	Means a discrete set of network providers, as defined in subsection (b)(10) of CCR 28 § 1300.67.2.2, the plan has designated to deliver all covered services for a specific network service area, as defined in subsection (b)(11) of CCR 28 § 1300.67.2.2.~~Means PCPs, Specialist, hospital, ancillary Providers, facilities, and other Providers with whom Contractor enters into a Network Provider Agreement.~~
Network Adequacy	Means the sufficiency of a plan's network to ensure the delivery of all covered services, on an ongoing basis, in a manner that meets the network accessibility, availability, and capacity requirements set forth in the Knox-Keene Act, including subsection (a)(5) of section 1371.31, subsections (d) and (e) of section 1367 and section 1375.9, and Rules 1300.51, 1300.67.2, subsection (c)(7) of CCR 28 § 1300.67.2.2, and 1300.67.2.1~~Means all~~

TERM	DEFINITION
	~~regulatory requirements for an adequate provider network within CHPIV's Service Area, in compliance with W&I Code section 14197.~~
Network Provider	Means any provider as defined in subsection (i) of section 1345 of the Knox-Keene Act, located inside or outside of the network service area of a designated network, meeting all of the following criteria: **(A)** The provider is available to provide covered services to all plan enrollees in all product lines using the designated network. **(B)** The provider is one or more of the following: **(i)** An employee of the plan; **(ii)** An individual health professional or health facility contracted directly with the plan consistent with the Knox-Keene Act and implementing regulations, including the contractual requirements for providers within sections 1348.6, 1367(h), 1367.04, 1367.27, 1367.62, 1373.65(f), 1375.7, 1379 and subsection (d) of section 1351; **(iii)** An individual health professional or health facility contracted with the plan through an association, provider group, or other entity, consistent with the Knox-Keene Act and implementing regulations, including the contractual requirements for providers within sections 1348.6, 1367(h), 1367.04, 1367.27, 1367.62, 1373.65(f), 1375.5, 1379, and subsection (d) of 1351; **(iv)** An individual health professional or health facility designated to deliver covered services to enrollees in the network through a plan-to-plan contract, as defined in subsection (b)(13) of CCR 28 § 1300.67.2.2; or **(v)** An individual health professional or health facility required to be part of the plan's network under any of the following circumstances; **a.** a corrective action plan submitted to the Department by the plan or its delegated entity; **b.** as required by the Department pursuant to section 1373.65 of the Knox-Keene Act; or **c.** as otherwise required by order of the Department. **(C)** The provider is accessible to enrollees of the designated network without limitations other than established: **(i)** In-network referral or authorization processes; or **(ii)** Processes for changing provider groups consistent with section 1373.3 of the Knox-Keene Act, in networks where enrollees are assigned to a provider group. **(D)** A network provider shall not include: **(i)** Providers made available through single-case agreements, letters of intent, or contract agreements that do not include the provider contracting requirements of the Knox-Keene Act as described in subsection (b)(10)(B)(ii) and (iii) of CCR 28 § 1300.67.2.2; **(ii)** For any line-of-business that includes an out-of-network benefit (e.g., preferred provider organization (PPO) or point-of-service (POS)), providers who are available to enrollees only at non-participating or out-of-network cost-share levels; or

TERM	DEFINITION
	(iii) Noncontracting individual health professionals, as defined in subsection (f)(5) of section 1371.9 of the Knox-Keene Act.~~Means any Provider or entity that has a Network Provider Agreement with Contractor, Contractor's Subcontractor, or Contractor's Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under this Contract. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement.~~
Network Provider Data	Means information concerning all Network Providers in a Network, regardless of location, which render Covered Services to Members in a Contractor's Service Area and the provider groups, Subcontractors, and/or Downstream Subcontractors, if any, under which a Network Provider renders those services. This includes, but is not limited to, information about the contractual relationship between Network Providers, provider groups, Subcontractors, and Downstream Subcontractors within the Network, information regarding the facilities where services are rendered, and information about a Network Provider's area(s) of specialization.
Network Service Area	Means the geographical area, and population points contained therein, where the plan is approved by the Department to arrange health care services consistent with network adequacy requirements. "Population points" shall mean a representation of where people live and work in the state of California based on United States Census Bureau population data and United States Postal Service (USPS) delivery route data, and made available annually by the Department on the web portal accessible at www.dmhc.ca.gov.
Patterns of Non-compliance	"Patterns of non-compliance," with respect to the standards set forth in subsection (c) of CCR 28 § 1300.67.2.2, means any of the following: **(A)** For purposes of the Provider Appointment Availability Survey: Fewer than 70% of the network providers, as calculated on the Provider Appointment Availability Survey Results Report Form, for a specific network had a non-urgent or urgent appointment available within the time-elapsed standards set forth in subsection (c)(5)(A)-(F) of CCR 28 § 1300.67.2.2 for the measurement year. A pattern of non-compliance shall be identified using the information reported to the Department in the "Rate of Compliance Urgent Care Appointments (All Provider Survey Types)" field and the "Rate of Compliance Non-Urgent Appointments (All Provider Survey Types)" field in the Summary of Rate of Compliance Tab of the Results Report Form. **(B)** The Department receives information establishing that the plan was unable to deliver timely, available, or accessible health care services to enrollees. The Department may consider any of the following factors in evaluating whether each instance identified is part of a pattern of non-compliance that is reasonably related: **(i)** Each instance is a violation of the same standard set forth in subsection (c) of CCR 28 § 1300.67.2.2; **(ii)** Each instance involves the same network; **(iii)** Each instance involves the same provider group, or subcontracted plan; **(iv)** Each instance involves the same provider type; **(v)** Each instance involves the same network provider;

TERM	DEFINITION
	(vi) Each instance occurs in the same region. For purposes of this subsection, a region is a county in which a network provider practices, and the counties next to or adjoining that county; **(vii)** The number of enrollees in the health plan's network and the total number of instances identified as part of a pattern; **(viii)** Whether each instance occurred within the same twelve-month period; or **(ix)** Whether each instance involves the same category of health care services.~~For purposes of the Provider Appointment Availability Survey: Fewer than 70% of the network providers, as calculated on the Provider Appointment Availability Survey Results Report Form, for a specific network had a non-urgent or urgent appointment available within the time-elapsed standards set forth in subsection (c)(5)(A)-(F) for the measurement year. A pattern of non-compliance shall be identified using the information reported to the Department in the "Rate of Compliance Urgent Care Appointments (All Provider Survey Types)" field and the "Rate of Compliance Non-Urgent Appointments (All Provider Survey Types)" field in the Summary of Rate of Compliance Tab of the Results Report Form.~~ ~~The Department receives information establishing that the plan was unable to deliver timely, available, or accessible health care services to enrollees.~~
Plan-to-plan Contract	Means an arrangement between two plans, in which the subcontracted plan makes network providers available to primary plan enrollees, and may be responsible for other primary plan functions. Plan-to-plan contracts include administrative service agreements, management service agreements or other contracts between a primary and subcontracted plan.
Preventive Care	Means health care provided for prevention and early detection of disease, illness, injury, or other health conditions and, in the case of a full-service plan includes all of the following health care services required by sections 1345(b)(5), 1367.002, 1367.3 and 1367.35 of the Knox-Keene Act, and Rule 1300.67(f).~~Means health care provided for prevention and early detection of disease, illness, injury or other health condition and, in the case of a full service plan includes but is not limited to all of the basic health care services required by subsection (b)(5) of Section 1345 of the Act, and Section 1300.67(f) of Title 28.~~
Primary Plan	Means a licensed plan that holds a contract with a group, individual subscriber, or a public agency, to arrange for the provision of health care services.
Subcontracted Plan	Means a licensed plan or specialized plan that is contracted to allow a primary plan's enrollees access to the subcontracted plan's network providers. The contract may be between the primary plan and the subcontracted plan or between two subcontracted plans.
Subcontractor	An individual or entity that has a Subcontractor Agreement with Contractor that relates directly or indirectly to the performance of Contractor's obligations under this Contract. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.

	Provider Directory	PNM-002
Department	Finance, Network & Informatics	
Functional Area	Provider Network Management	
Impacted Delegate	☒ Subcontractor ☐ NA	

DATES			
Policy Effective Date	6/12/2023	**Reviewed/Revised Date**	7/10/2023
Next Annual Review Due	7/10/2024	**Regulator Approval**	

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

ATTACHMENTS

NA

AUTHORITIES/REFERENCES

- **Internal**
  - CHPIV, Delegation Oversight Policy and Procedure, CMP-002
- **Federal**
  - 42 CFR, Section 438.10
  - 42 CFR section 431.70
- **State**
  - California Health and Safety Code Section ("H&S Code") 1367.27
  - Department of Health Care Services (DHCS) APL23-002
  - DHCS: DHCS Plan Contract (2024) Section 5.1.3
  - DHCS: All Plan Letter 22-026, "Interoperability and Patient Access Final Rule" (dated November 29, 2022)
  - DHCS: All Plan Letter 19-003, "
  - Medi-Cal Managed Care Division (MMCD) Policy Letter 00-002, Supersedes Policy Letter 97-09: Health Plan Provider Directory Policy, Guidelines, and Delivery Standards N. Medi-Cal Managed Care Division (MMCD) Policy Letter 11-009, Update to Policy Letter 00-002: Update to Health Plan Provider Directory Policy and Guidelines
- **Accreditation**
  - NCQA: Network Management (NET) 5, Elements A-J

HISTORY

Revision Date	Description of Revision
6/12/2023	Policy creation

7/10/2023	Policy revised to update the frequency on updating the electronic provider directory and add the requirements for providing the printed copy of the provider directory to members and potential members.

I. OVERVIEW

A. This policy addresses Community Health Plan of Imperial Valley's ("CHPIV" or the "Plan") PROVIDER DIRECTORY requirements, policy, and procedures. The purpose of this policy is to establish a process to meet the required PROVIDER DIRECTORY statutory, regulatory, contractual, and, if applicable, accreditation standards ("Legal Authority").

II. POLICY

A. CHPIV establishes and maintains PROVIDER DIRECTORY processes pursuant to applicable statutory, regulatory, and contractual requirements.
B. CHPIV submits the PROVIDER DIRECTORY to DHCS for review and approval prior to initial operations.
C. CHPIV makes the PROVIDER DIRECTORY available in paper and electronic formats to all MEMBERS and potential MEMBERS. Potential MEMBERS can request a printed copy of the PROVIDER DIRECTORY upon request.
D. A printed copy of the PROVIDER DIRECTORY can be requested by contacting CHPIV's toll-free number, electronically or in writing. The printed copy of the PROVIDER DIRECTORY shall be provided to the requester by mail postmarked no later than 5 business days following the date of request and may be limited to the geographic region in which the MEMBER or potential MEMBER resides or works or intends to reside or work.
E. The electronic format PROVIDER DIRECTORY is made available in a machine-readable file and accessible format, with search functionality in accordance with Title 42 of the Code of Federal Regulations, section 438.10(h)(4), and section 1367.27(c)(2) of the California Health and Safety Code.
F. PROVIDER DIRECTORY information shall be included with CHPIV's written MEMBER Information for new MEMBERS, and thereafter available upon request in printed hardcopy. SPD MEMBERS are provided with a paper hardcopy PROVIDER DIRECTORY. Non-SPD MEMBERS may be provided with a notice on how to access the PROVIDER DIRECTORY electronically.
G. The PROVIDER DIRECTORY shall include information of DELEGATED PROVIDER GROUPS, hospitals, PRIMARY CARE PROVIDERS (PCPs), OB/GYNs, specialists, behavioral health PROVIDERS, managed long-term services and support (MLTSS) PROVIDERS, urgent care centers, ECM and Community Support PROVIDERS, ancillary PROVIDERS, Facilities, pharmacies, and any other PROVIDERS who are credentialed and contracted with CHPIV for Medi-Cal services, or through a subcontracted agreement:
    1. The PROVIDER's or site's location name and any group affiliation(s), NPI number, address, telephone number, and, if applicable, web site URL for each Service Location;

2. PROVIDER's specialty type and paneling status that allows them to treat specific populations, including but not limited to, whether they are a CCS paneled PROVIDER;
3. Whether the PROVIDER is accepting new patients;
4. Information on the PROVIDER's affiliated medical group or IPA, NPI number, address, telephone number, and, if applicable, web site URL for each Physician PROVIDER of affiliated group or IPA;
5. The hours and days when each Service Location is open;
6. The services and benefits available, including accessibility symbols approved by DHCS confirming whether the office/FACILITY (exam room(s), equipment, etc.) can accommodate MEMBERS with physical disabilities as required by PL 11-009;
7. The PROVIDER's cultural and linguistic capabilities, including whether non-English languages and American Sign Language are offered either by the PROVIDER or a skilled medical interpreter at the PROVIDER's FACILITY;
8. The telephone number to call after normal business hours;
9. Identification of Network PROVIDERS or sites that are not available to all or new MEMBERS
10. The link to the Medi-Cal Rx Pharmacy Locator.
~~10.~~11. Information regarding the standards for timely access to care in a separate section titled "Timely Access to Care."

H. CHPIV ensures the paper PROVIDER DIRECTORY is updated and submitted to DHCS as follows:
   1. Paper Directory: Monthly
   2. Electronic Directory: Weekly or more frequently as needed after updated PROVIDER information is received.
   3. If CHPIV establishes a mobile-enabled, electronic PROVIDER DIRECTORY, the paper PROVIDER DIRECTORY will be updated quarterly.

I. CHPIV submits its PROVIDER DIRECTORY is submitted to DHCS every six (6) months and shall includes a copy which DHCS can use for distribution, as needed.

J. Changes to information for a PROVIDER or FACILITY in the PROVIDER DIRECTORY are reported on an ongoing basis in accordance with this Policy.

K. CHPIV ensures PROVIDER data utilized for the PROVIDER DIRECTORY are validated and verified for accuracy and completeness. This includes verifying data in partnership with contracted PROVIDERS and tracking Suspended, Excluded, and Ineligible PROVIDERS at least monthly and taking appropriate action, including removal from PROVIDER DIRECTORY, in accordance with APL 15-026 and APL 21-003.

L. CHPIV maintains a publicly accessible standards-based PROVIDER DIRECTORY API as described in 42 CFR section 431.70. Online PROVIDER DIRECTORY data is updated at least weekly after the CHPIV receives the PROVIDER information or is notified of any information that affects the content or accuracy of the PROVIDER DIRECTORY.
   1. CHPIV ensures its PROVIDER DIRECTORY API is updated in accordance with 42 CFR section 438.10(h)(3) and Health and Safety Code section 1367.27
   2. CHPIV ensures accurate and complete information of reported data, screen the data for completeness, logic, and consistency, and collect service information in

standardized formats to the extent feasible and appropriate. CHPIV makes all collected data available to DHCS and CMS, upon request.

3. CHPIV ensures there is routine testing and monitoring, and updates systems as appropriate, to ensure the APIs function properly, including conducting assessments to verify that the APIs are fully and successfully implementing required privacy and security features.

III. PROCEDURE

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

IV. DEFINITIONS

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

TERM	DEFINITION
Provider Directory	Contractor's listing of all Network Providers and that includes the Providers' contact information, whether the Provider is accepting new Members, the hours of operation, what languages are available in the Provider's office and whether the Provider's office has accommodations, including offices, exam rooms and equipment, for people with physical disabilities.
Delegated Provider Group	A physician group contracted with CHPIV or its downstream subcontractors to provide Covered Services to Members assigned to that Delegated Provider Group.
Facility	For purposes of this policy, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities.
Member	A beneficiary enrolled in CHPIV's Medi-Cal plan.
Primary Care Provider	A physician who focuses his or her practice of medicine on general practice or who is a board verified or board eligible internist, pediatrician, obstetrician/gynecologist, or family practitioner. The PCP is responsible for supervising, coordinating, and providing initial and primary care to Members, initiating referrals, and maintaining the continuity of Member care.

TERM	DEFINITION
Provider	For purposes of this Policy, any individual, entity, Health Network, or Delegated Provider Group that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
API	Application Programming Interface. A software intermediary enables two applications to communicate with each other.

IMPERIAL COUNTY
Local Health Authority Commission

Fact Sheet: Seeking Commission Approval for Delegation of Policy Review and Approval to Regulatory Compliance and Oversight Committee (RCOC)

May 2024

Agenda Item #5D

Background

The current process involves the review of policies and procedures by the internal CHPIV Compliance & Policy Committee (CPC). Following CPC review, recommendations are presented to the Executive Committee of the Commission for further consideration. Finally, policies are brought before the Full Commission for approval.

Proposed Changes

We propose delegating the review and approval process to the Regulatory Compliance Oversight Committee (RCOC) of the Commission. This adjustment aims to streamline the process, enhance efficiency, and ensure thorough compliance oversight. By involving the RCOC in the review and approval process, we aim to ensure that all policies undergo comprehensive review while providing ample opportunity for input and clarification from all Commissioners.

Revised Process

1. Policies and procedures will be reviewed by the RCOC.
2. Upon completion of the review, recommendations will be forwarded to the Executive Committee and Full Commission for approval.
3. Policies approved by the Full Commission will be placed on the Executive Committee and Full Commission agenda for informational purposes.
4. Commissioners will have the opportunity to ask questions during this stage.
5. The Full Commission retains the authority to request further consideration of any policy by the RCOC if necessary.

Key Points

- Delegation of policy review and approval to RCOC.
- Full Commission retains ultimate authority.
- Increased transparency and accountability.
- Opportunity for Commissioners to ask questions and seek clarification.

Health Services Report

1. Meetings
   a. Provider Advisory Group
   b. Quality Improvement Health Equity Committee

2. National Commission for Quality Assurance Accreditation

3. Health Services Monitoring/Auditing Meetings

Finance Commission Presentation

May 2024

Action Item - Motion to accept the financials as reported:

1. March 2024 Commission P&L Variance Report
2. March 2024 Cash Transactions
3. March 2024 Cash Reconciliation
4. March 2024 Statement of Activity
5. March 2024 Statement of Financial Position
6. March 2024 Year-to-Date Statement of Activity

Discussion:

1. Finance Issues Dashboard

Imperial County Local Health Authority
Finance Committee Governance Dashboard
May, 2024

Risk	Urgency	Issue	Date Added	Description	Status Date	Status
		Financial Audit	3/1/2024	Moss Adams annual financial audit for CY2023. Planned to be finished in April.	5/3/2024	We may need to move some $1.13m 2024 budgeted revenue into 2023 accruals. We also need to conveinve an audit committee to review the draft and final audit report
		Chase Sweep Floor	3/1/2024	After our first $20m capitation revenue from the State Chase reduced our daily swept ammount to the contract minimum of $3m (from a variable $10m+). This costs us $4,000 a day in lost interest	3/28/2024	Set up a bond trading account at JP Morgan and bought T-Bills directly.
		County Fund Close-Out	3/1/2024	Close to shutting the county 'claim on cash' fund.	3/28/2024	We are closed out of the county fund at of 3/23/2024
		Investment Account Setup	3/1/2024	We need to designate reserve funds, an investment manager, and move reserves into a diversified account.	3/28/2024	Account setup is underway at CNB, and we have a fixed income alternative with JPMorgan.

Overview

The executive summary includes a detailed overview of Compliance Training, policies requiring review and approval, go-live issues, pre-delegation audit, and the Regulatory Compliance Oversight Committee (RCOC) of the Commission.

Regulatory Compliance Oversight Committee (RCOC) of the Commission

The Commission's RCOC had its first inaugural meeting on April 23, 2024. Chaired by Dr. Allan Wu, the Committee is set to meet quarterly, functioning independently of CHPIV's operational management to ensure transparency, accountability, and continuous improvement. Its key responsibilities include overseeing the CHPIV Compliance Program, facilitating effective communication on compliance matters, and ensuring adherence to all relevant policies, regulations, and contractual obligations.

Compliance Training

We are pleased to report that we have achieved 100% compliance in Compliance Training. The final two Commissioners, who were previously noted as noncompliant in our last report, have successfully completed their required training sessions. This marks a significant achievement and reflects the collective effort and commitment of all parties involved.

Policies and Procedures (P&Ps)

The Regulatory Compliance Oversight Committee (RCOC) of the Commission has reviewed the attached packet of new and updated P&Ps and recommends Full Commission approval.

Moving forward, RCOC requests the delegation of authority to review and approve P&Ps.

Pre-Delegation Audit

In updating the status of the Pre-Delegation Audit, significant progress can be noted in the recent period as the audit has now been closed.

- For Phase 1, Health Net submitted their corrective action plans (CAPs) responses by February 28, 2024, and additional documents on March 25, 2024. Upon review of these submissions, CHPIV found that all 12 of the previously open and unsatisfactory CAPs have now been deemed satisfactory. This resulted in the issuance of a CAP closure letter sent to the organization on March 26, 2024. This concludes Phase 1 of the audit.
- For Phase 3, Health Net received 100% as CHPIV was able to validate Health Net's timely implementation of regulatory changes issued via Department of Health Care Services (DHCS) All Plan Letters (APLs) through a P&P review process. The initial findings during the Pre-Delegation Audit, which were due to Health Net's failure to submit the required documents during the audit period, have now been resolved.

The submission of additional documentation after the audit reports were issued has sufficiently demonstrated Health Net's operational readiness. With CHPIV now fully operational, we remain fully committed to ensuring Health Net’s adherence to regulatory standards and operational performance. Continuous oversight will be maintained through ongoing monitoring and audits.

Delegation Oversight Monitoring Program

CHPIV has established a comprehensive Monitoring Program Protocol designed to frequently assess Health Net's performance with a focus on areas critical to member and provider services. These high-risk areas include Appeals, Grievances, Utilization Management, Continuity of Care, Claims, and Provider Dispute

Resolution. Under this protocol, Health Net is required to submit monthly reports of self-assessed Key Performance Indicators (KPIs). Furthermore, Health Net must provide raw data, known as Universes/Logs, on a quarterly basis. CHPIV will utilize this raw data to conduct independent evaluations of Health Net's performance. To ensure the reliability and accuracy of these evaluations, CHPIV will also carry out data validations every quarter, cross-checking the self-reported KPI metrics against this raw data.

As part of the protocol, Health Net is currently submitting their Quarter 1 2024 (January - March) Universes/Logs, which will facilitate CHPIV's objective assessment of their performance. We anticipate finalizing the first scorecard for this period in May 2024. This slight postponement stems from it being Health Net's initial attempt at compiling this data, during which we are addressing any inconsistencies that have surfaced. Moving forward, we expect to streamline this process, allowing for the Quarter 2 Universes to be submitted in a more timely manner.

Human Resources | Community Engagement

Community Advisory Committee

1. Minutes Attached (Review and Accept)
2. Next Meeting: June 6th 2024 at Noon
3. CAC Selection Meeting scheduled for May 9th 2024 at 2:00pm.
4. Member Demographic Report

Human Resources

1. Receptionist/Administrative Assistant opening still ongoing.

Imperial County
Q1 Community Advisory Committee Meeting

March 21, 2024 Minutes

ATTENDEES

Medi-Cal Member 32	LaVon Jaksch: Disability Rights, Board Member	Medi-Cal Member 33	Dr. Carlos Ramirez: Rose Crest Assisted Living, Administrator
Brenda Sanchez: Imperial County	Jose Lepe: Imperial County	Michelle Cardenas: Volunteers of America	Isabel Andrade - Imperial Valley Food Bank
Mary Esquer: Imperial County	Medi-Cal Member 34	Sayeda Khan: Project Food Box	Medi-Cal Member 35
Medi-Cal Member 36	Michelle Soto: Imperial County Dept. of Public Health - California Children's Services Program Supervisor II	Mersedes Martinez: El Centro Regional Medical Center - Chronic Care Manager	Peggy Price - InnerCare
Ava Froble: Roots Food Group - Community Support Dietitian	Daniela Flores: Imperial Valley Equity & Justice Coalition - Executive Organizer	Paul Monarrez: Serene Health	Janette Angulo: Imperial County - Director
Adriana Ramirez: Imperial County - Manager			

CHPIV ATTENDEES
Michelle Stephanie Ortiz-Trujillo, Dr. Gordon Arakawa, Alejandro Franco, Elysse Tarabola, Chelsea Hardy, and Jadira Alcaraz

HEALTH NET ATTENDEES
Ayleen Dimailig, Mia Manic, Dr. Pooja Mittal, Dr. Kathleen Lang, Frances Arce, Jamey Mann II, Armine Kelechian, and Ayah Said

The purpose of the Community Advisory Committees is to empower members to bring their voices to the table to ensure Health Net is actively driving interventions and solutions to build more equitable care. The CAC advocates for Health Net members by ensuring that Health Net is responsive to their diverse health care needs.

AGENDA ITEM	DISCUSSION	NEXT STEPS / ACTION	OWNER
Call to order, Introductions, Meeting Minutes Approval, & Agenda Overview	• Call to order at 2:03pm. • Members, CHPIV staff, and HN staff introduced themselves. • Q3 2023 meeting minutes approved by committee.	N/A	N/A
CAC Recommendations Update	Ayleen Dimailig (Program Manager, Community Advisory Committee) reviewed the draft of the 'Member Rights' one-page resource with the committee, thanked them for their feedback, and informed them that the one-pager will go through an approval process for dissemination.	N/A	N/A

Cultural Appropriateness of Messaging	Jamey Mann II (Senior Writer, Communications) presented Health Net's approach on developing marketing materials that are culturally appropriate, easy to read, and informative. • Committee members confirmed Health Net's approach in developing inclusive materials.	N/A	N/A
Member Experience Survey and Why It's Important	Frances Arce (Program Manager III, CAHPS) reviewed the CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey, Health Net's scores, and how Health Net uses the results. • Committee members recommended automatically sending all communications and surveys in English and Spanish for Imperial County. • Committee members shared that getting surveys in the mail can be inconvenient and would prefer an online option. ○ Health Net shared that, although the plan has no control in the dissemination of the survey, Health Net will bring the suggestion to the vendor.	N/A	N/A
Health Equity Workplan and Social Needs	Armine Kelechian (Senior Health Equity Specialist) reviewed the Health Equity department's 2024 workplan and highlights from the 2023 workplan. Ayah Said (Health Equity Specialist) went over FindHelp Community Connect and the goals related to social needs. Committee members were polled on the FindHelp Community Connect strategy.	N/A	N/A
Community Sharing/Open Forum	Committee members were invited to share items for Community Sharing. Members requested support on issues they were experiencing. • Meeting was adjourned at 3:30pm.	Will send out requested information to Members.	Ayleen Dimailig

NEXT MEETING

Date: Thursday - June 6, 2024
Time: 12pm – 1:30pm
Location / Dial-in #: Join in-person at the Community Health Plan of Imperial Valley office:
512 W. Aten Rd.
Imperial, CA 92251

or

Join via Zoom at
https://centene.zoom.us/j/95797897645?pwd=aEhWMnZlQXJ2cmE5dmlMOExHMU9DUT09
Call in: **669.444.9171** or **646.931.3860** then enter **Meeting ID: 957 9789 7645**

Community Health Plan of Imperial Valley (CHPIV) Annual Community Advisory Committee (CAC) Demographic Report

Table of Contents

1. Overview

The purpose of this report is to ensure Community Advisory Council (CAC) membership represents the community served in Imperial County as described in **Exhibit A Attachment III Section 5.2.11** of the contract. Community Health Plan of Imperial Valley (CHPIV) shall complete and submit a CAC Demographic Report to the Department of Health Care Services (DHCS) annually.

2. Report Template

CAC Demographic Composition

1. **How many local CACs has CHPIV established?**
   CHPIV has established 1 local Community Advisory Committee that meets quarterly. The first CHPIV CAC was held on March 21, 2024 where committee members participated virtually and in-person.

2. **What percentage of the total CAC membership are Members and/or enrollees[1]? If there are less than 10% consumers on a particular CAC, please explain why and provide a plan with milestones to increase consumer representation.**
   CHPIV understands the importance of establishing a local bi-directional forum for Medi-Cal Members to advocate for themselves and the communities they represent directly with CHPIV. We believe the CAC empowers Members to bring their voices to the table to ensure the Plan Is actively driving interventions and solutions to build more equitable care. In 2024, we are working to ensure 10% of our committee participants are Medi-Cal Members. We are pleased to report that CHPIV has exceeded its goal! **During the March CAC, 7 Medi-Cal Members participated in the first quarterly CAC, which is approximately 35% of the total committee participants.** Please see question #4 below for insights on the additional organizational partner.

3. **Describe the demographic composition of each CAC. Please include race, ethnicity, gender identity, language, chronic conditions, and disability information for CAC**

[1] *Member and/or enrollees* are defined as persons who are not employees of the plan, providers of health care services, subcontractors to the plan or group contract brokers, or persons financially interested in the plan.

Members (where possible) in the description.
The Plan has been working diligently to ensure the Medi-Cal Member representation of the committee reflects the general Medi-Cal Member population in Imperial County and meets the 2024 contractual requirements. **In a short amount of time, the Plan has engaged with Medi-Cal Members who can represent the Seniors and Persons with Disabilities (SPD), individuals with Limited English Proficiency and individuals from diverse cultural and ethnic backgrounds.** We acknowledge there is more work to do to engage individuals with chronic conditions, adolescents and/or parents and/or caregivers of children, including foster youth. Below is a summary of the demographic composition of the 7 Medi-Cal Members who participated in the first quarterly CAC of 2024.

- 57% of the Medi-Cal Members who participated reported Hispanic as their primary race and ethnicity. All of which also report Spanish being their preferred spoken and written language. The remaining Medi-Cal Members did not report a race or ethnicity but did inform the Plan their primary spoken and written language is English. As noted in the Plan's response to question #6 below majority of the Imperial County community identify as Hispanic with Spanish as the preferred spoken and written language.
- 100% of the Medi-Cal Members who participated identify as female. CHPIV recognizes that male Medi-Cal member participation is needed considering 44% of the population of the County is male. We intend to continue to make efforts to recruit Medi-Cal Members.
- According to Plan Member data majority, or 67%, of the Medi-Cal Members who participate in the CAC are between the ages of 19 – 44 years old. We have representation from 1 Medi-Cal Members who represents the 45-64 years old age group and another representing the 65 years and over age group. We recognize there is a gap in Medi-Cal Member representation on the CAC for 0 – 18 years old, however there are 2 participants who are mothers with young children. These stakeholders have already begun to use the CAC as an opportunity to share their child's healthcare experience. Based on publicly available and Plan Member data we understand 36% of the population in Imperial County are children ages 0 – 18. CHPIV is committed to ensuring this population has their voice heard and we will continue to recruit individuals who can represent this population.
- CHPIV also compared the aid codes of the participating Medi-Cal Members to the general Medi-Cal population. According to Publicly available data and Plan

Member data the top 2 aid codes of the Medi-Cal population are SPD and ACA Medicaid Expansion Adults Age 19 – 64. The participating Medi-Cal Members align with the Imperial County Medi-Cal population and represent the following Aid Code categories M1: Adult Expansion, M3: Adult/Family/ OTLIC, and 1H: Seniors and Persons with Disabilities (SPD).

4. **(A) Please note all organizational partners who are voting CAC members.**
CHPIV has successfully engaged representation from the required stakeholders according to the 2024 contract, which includes Community Based Organizations (CBOs), Community Advocates, Health Care Service Providers, and County Partners as outlined in the 2024 contract requirements. Below is a summary of the organizations have agreed to participate on the CAC. CHPIV has not yet initiated the CAC Selection Committee but intends to go through the formal process of selecting all participating CAC Members at the beginning of quarter 2.

County Partners & Local Government Agencies	Healthcare Services Providers	Community Based Organizations (CBO)	Community Advocates
• Imperial County • San Diego Regional Center	• InnerCare • Pioneers Memorial Healthcare District • Roots Food Group • El Centro Regional Medical Center • Sonnisa Village • El Centro Post Acute • Rose Crest Assisted Living • Serene Health	• Moores Cancer Center • Imperial Valley Food Bank • Volunteers of America • Project Food Box	• Disability Rights of California • Imperial Valley Equity & Justice Coalition

(B) Below, please check all boxes that represent these partners. Note: A CAC member may represent more than one sector or category.

☒County Partners & Local Government Agencies
☒Health Care Service Providers
☒Community-Based Organizations
☒Community Advocates
☐Other (Please list)

5. **Describe approach to CAC member recruitment, including ongoing, updated, and new efforts and strategies to ensure adequate CAC representation.**
   CHPIV's approach to CAC recruitment started with analyzing Plan Member data to understand the individuals and stakeholders we needed to engage to ensure the committee adequately represents the Medi-Cal population of Imperial County. The Plan leveraged a multi-pronged approach to recruit stakeholders and test which method of outreach was the most impactful.
   - Prior to the launch of the 2024 contract the Plan looked internally for CAC stakeholder recruitment support and established processes to refer stakeholders with the call center, Member Connections team, Case Management, and Mobile RV team to help spread the word of the opportunity to engage directly with the Plan through the CAC.
   - The Plan offers a $100 gift card as an incentive for any CHPIV Medi-Cal Member who attends a quarterly CAC meeting. We will also provide a $25 gas card for any Member who attends the meeting in-person. If the Plan is made aware of the Member's needs we will coordinate child care and interpreter services upon request.
   - The Plan identified the high-volume Enhanced Care Management (ECM) providers in Imperial County to engage and referrals for Medi-Cal Members they support. The Plan met with and educated these providers on the CAC opportunity and gift card incentive for those Medi-Cal Members who participate.
   - The Plan invested in social media posts inviting individuals from Imperial County to attend the quarterly meetings.
   - Partnering with advocacy organizations to spread awareness of the CAC engagement opportunity and incentive.

- The Plan has created a public facing CAC webpage where individuals from the community can directly contact CHPIV if interested in learning more about the CAC or to receive an invite and participate.
- At each CAC the Plan reminds participating committee members that CACs are open to all and support spreading awareness within their own circles or communities is needed.
- **The most productive strategies to recruit Medi-Cal Members included leveraging the Plan's Member facing portal and several direct email campaigns**. Prior to the next quarterly CAC we intend to continue posting information to the Member facing portal and the direct email campaign to all CHPIV Members who have shared their email address.
- **Local Plan staff who live and work in Imperial County leverage their relationships and connections within the community to encourage Medi-Cal Members to attend the CAC.** They spread awareness through word of mouth, partnerships with city leadership and the Chamber of Commerce.

Going forward the Plan intends to pursue a targeted call campaign to ensure we engage individuals with chronic conditions, adolescents and/or parents and/or caregivers of children, including foster youth. We will also continue to partner with advocacy organizations to spread awareness and ensure their community's voice is heard. Finally at ever quarterly CAC, the Plan will remind participants their friends, family, and community partners are encouraged and welcomed to attend.

6. **Describe any barriers or challenges to achieving alignment between CAC membership with the demographics of the Members within the Service Area.**
   In general, recruiting Medi-Cal Members from any population to participate in the quarterly CAC meetings has proven to be a challenge. Despite our best efforts we cannot force Medi-Cal Members to participate, even though an $100 gift card incentive is offered. The Plan was also not able to deploy a call campaign prior to the first quarterly CAC due to redetermination outreach and support being a top priority for the Plan's call center. We are actively working to coordinate a targeted call campaign to ensure we engage the remaining required Medi-Cal Members to participate in the Plan's CAC. This includes targeting Medi-Cal Members with chronic conditions, adolescents and/or parents and/or caregivers of children, including foster youth.

7. **Define the demographics and diversity of CHPIV's Members and Potential Members within**

the Service Area.
The chart below defines the demographics and diversity of Imperial County. Please see question #8 for the data sources used and numbered references.

	DHCS Total Reporting Unit[1]				Plan Member Data[2]		
		n	p			n	p
	TOTAL	100,536	100.0%		**TOTAL**	97,967	100.0%
Gender	Female	55,378	55.1%		Female	54,006	55.1%
	Male	45,158	44.9%		Male	43,961	44.9%
Age	Age 00-18	37,032	36.8%		Age 00-18	35,768	36.5%
	Age 19-44	32,873	32.7%		Age 19-44	32,137	32.8%
	Age 45-64	16,704	16.6%		Age 45-64	16,228	16.6%
	Age 65+	13,927	13.9%		Age 65+	13,834	14.1%
Race/Ethnicity[3]	AI/AN	622	0.6%		American Indian or Alaska Native	373	0.4%
	ASIAN	435	0.4%		Asian	372	0.4%
	BLACK	896	0.9%		Black	832	0.8%
	HISPANIC	88,544	88.1%		Hispanic	88,212	90.0%
	NOT REPORTED	5,298	5.3%		Native Hawaiian or Other Pacific Islander	18	0.0%
	WHITE	4,741	4.7%		Other	104	0.1%
					Unknown	3,704	3.8%
					White	4,238	4.3%

Language[4]	Spanish	57,507	57.2%		SPANISH	56,817	58.0%
	English	42,611	42.4%		ENGLISH	41,040	41.9%
	Missing/Unknown	287	0.3%		OTHER	37	0.0%
	Cantonese	31	0.0%		CHINESE	32	0.0%
	Other Non-Eng	20	0.0%		KOREAN	15	0.0%
Enrollment Categories	SPD[5]	19,165	19.1%		SPD	18,414	18.8%
	ACA MCE[6]	27,601	27.5%		ACA MCE	27,131	27.7%
Chronic Conditions	na	na			Adult Diabetic[7]	4,130	4.2%
	na	na			Adult Hypertensive (ages 18-85 years)[8]	4,364	4.5%
	na	na			Asthmatic (ages 5-64)[9]	1,780	1.8%

8. **Identify the data sources relied upon to validate that its CAC membership aligns with Member demographics.**

   The Plan leveraged publicly available DHCS enrollment data for January 2024 and the Plan Member enrollment and HEDIS data as of 1/31/2024. Below are the following data sources used to validate the CHPIV CAC membership aligns with the Medi-Cal Member demographics of Imperial County. The below numbering also aligns with the numbered references in the chart above:

   1. DHCS enrollment for January 2024 per https://data.chhs.ca.gov/dataset/medi-cal-certified-eligibles-tables-by-county-from-2010-to-most-recent-reportable-month
   2. CHPIV enrollment data as of 1/31/2024
   3. CHPIV R/E data includes DHCS enrollment plus supplemental, self-reported data from call-center encounters and California Immunization Registry (CAIR) among other sources.
   4. Top 5 highest-volume languages in the Reporting Unit(s). CHPIV languages indicate preferred

written language for correspondence.

5. Seniors and Persons with Disabilities
6. ACA Medicaid Expansion Adult Age 19 to 64
7. Adult members included in the HbA1c Control for Patients with Diabetes (HBD) HEDIS® denominator per NCQA. (https://www.ncqa.org/wp-content/uploads/2023/02/01.-Diabetes-Care.pdf)
8. Internal Plan HEDIS data was leveraged. For more information on the measures please see: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/
9. Internal Plan HEDIS data was leveraged. For more information on the measures please see: https://www.ncqa.org/hedis/measures/medication-management-for-people-with-asthma-and-asthma-medication-ratio/

9. **Provide a description of the CAC's ongoing role and impact in decision-making about Health Equity, health-related initiatives, cultural and linguistic services, resource allocation, and other community-based initiatives, including examples of how CAC input impacted and shaped CHPIV's initiatives and/or policies.**

The Plan has implemented a process to capture recommendations and additional insights from the CAC and circulate those findings internally. Recommendations from the CAC are vetted internally within the Internal Health Equity Governance eco-system before they are approved for operation. The CAC is kept informed of the status of their recommendations progress through the Plan's internal eco-system by way of a standing agenda item called the "Recommendation Update" during each CAC. Our CAC participants are supportive of this process and appreciate the level of awareness the Plan providers. All recommendations from the CAC approved for implementation are also shared with the Quality Improvement Health Equity Committee (QIHEC) for awareness. For example, the Plan is working to implement a recommendation from the CAC to create a simple one-pager that informs the Member or advocate of the Member's Medi-Cal rights. The resource provides an overview of their rights and the tools available to advocate, file a grievance, or change Plans.

The Plan's Health Equity department regularly engages with CACs to obtain feedback and guidance in the delivery of culturally and linguistically appropriate health care and to establish and maintain community linkages. In compliance with DHCS guidelines, the Plan's empowers members of the CAC to ensure the Plan is actively driving interventions and solutions to build more equitable care by:

- Obtaining local level feedback, insights, and perspectives to inform and address our quality and health equity strategy,
- Providing the Plan with the community's perspective on health equity and disparities, population health, children's services, and relevant plan operations and programs, and
- Informing the Plan's cultural and linguistic services program.

Information provided by the CAC participants is included in the development of Health Equity Department materials, health education materials and programs and Quality Improvement Projects. They provide critical feedback for Health Net to understand that perception, experience, and satisfaction of services.

CEO Report

1. Facility Update
    - Landscaping
    - Security Installed
    - Thermostats
    - Parking Lot Lighting Improvement
    - Office Changes
2. Local Health Plans of California (LHPC)
    - Coalition to Protect Access to Care
    - DHCS Next Waiver Planning
        - ECM Proliferation Barrier
        - Provider Rate Increase Implementation
        - Children Now & First 5-Warm Hand-Off Project Planning (PHM)