IMPERIAL COUNTY
Local Health Authority Commission
Regulatory Compliance Oversight Committee of the Commission

AGENDA

Date/Time: August 12, 2024, 12:00 PM
Location: Community Health Plan of Imperial Valley, 512 West Aten Road, Imperial, CA 92251

Members of the committee, staff and the public can attend the meeting in person at the address listed above. Public comments can be made live and in person at the meeting. To listen to the meeting via videoconference please join by calling +1 469-998-7368 (audio only, Phone Conference ID: 109 351 941#) or clicking on the link below:

Click here to join the meeting
Meeting ID: 245 755 013 370
Passcode: a47jxi

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

Committee Members	Representing	Present
Dr. Allan Wu (Chair)	LHA Commissioner and Regulatory Compliance Oversight Committee Chair Chief Medical Officer, Innercare	
Dr. Theodore Affue	LHA Commissioner Chief Medical Officer, County of Imperial	
Pablo Velez	LHA Commissioner Chief Executive Officer, El Centro Regional Medical Center	
CHPIV Staff	**Job Title**	**Present**
Lawrence Lewis	Chief Executive Officer	
Elysse Tarabola	Chief Compliance Officer	
Dr. Gordon Arakawa	Chief Medical Officer	
Tony Godinez	Senior Manager of Accounting	
Michelle Ortiz-Trujillo	Senior Director of Human Resources and Community Services	
Chelsea Hardy	Senior Director of Compliance	
Jadira Alcaraz	Delegation Oversight Manager	
Rosa Sanchez	Compliance Advisor	
Fernanda Ortega	Delegation Oversight Specialist	
Amanda Delgado	Compliance Coordinator	
Donna Ponce	Executive Assistant/Commission Clerk	

1. Call to Order — Dr. Allan Wu, *Chair*

2. Roll Call — Donna Ponce, *Executive Assistant/Commission Clerk*

3. Approval of the Agenda — Dr. Allan Wu, *Chair*

   a. Items to be pulled or added from the Consent/Information/Action/Closed Session Calendar
   b. Approval of the order of the agenda

4. Public Comment — *Chair*

   This is an opportunity for members of the public to address the Commission on any subject matter within the Commission's jurisdiction. Any action taken

as a result of public comment shall be limited to the direction to staff. When addressing the Commission, state your name for the record prior to providing your comments. Please address the Commission as a whole, through the Chairman. Individuals will be given 3 minutes to address the Commission; groups or topics will be given a maximum of 15 minutes. Public comments will be limited to a maximum of 30 minutes. If additional time is required for public comments, they will be heard at the end of the meeting.

5. Approval of Minutes from April 23, 2024 — *Chair*

6. Chairperson's Report

7. Chief Compliance Officer Report (page. ##) — Chelsea Hardy, *Senior Director of Compliance*

   a. Approve Updated and New Policies & Procedures — Chelsea Hardy, *Senior Director of Compliance*; Dr. Gordon Arakawa, *Chief Medical Officer*; Michelle Ortiz-Trujillo, *Senior Director of Human Resources and Community Services*

   b. New All Plan Letters (APLs) and Status — Rosa Sanchez, *Compliance Advisor*

   c. Regulatory Submissions — *Compliance Advisor*

   d. Regulatory Member Issues — *Compliance Advisor*

   e. Health Net Deliverables — Fernanda Ortega, *Delegation Oversight Specialist*

   f. Delegation Oversight Program: Quarter 1 Results — Jadira Alcaraz, *Delegation Oversight Manager*; Rosa Sanchez, *Compliance Advisor*; Chelsea Hardy, *Senior Director of Compliance*

8. Adjourn to Closed Session — Dr. Allan Wu, *Chair*
   Pursuant to Welfare and Institutions Code § 14087.38 (m)
9. Reconvene in Open Session — *Chair*
10. Adjournment — *Chair*

Regulatory Compliance Oversight Committee (RCOC)

August 12, 2024

Community Health Plan
OF IMPERIAL VALLEY

Introductions/Quorum

- ***Chair:*** Dr. Allan Wu; LHA Commissioner and Regulatory Compliance Oversight Committee Chair & Chief Medical Officer, Innercare
- Dr. Theodore Affue; LHA Commissioner & Chief Medical Officer, County of Imperial
- Pablo Velez; LHA Commissioner & Chief Executive Officer, El Centro Regional Medical Center

Agenda

- Review and Approve RCOC Minutes (April 23, 2024)
- Updated and New Policies and Procedures
- New All Plan Letters (APLs) Released and Status
- Regulatory Submissions
- Regulatory Member Issues
- Health Net Deliverables
- DO Monitoring Program: Quarter 1 Results

Review/Approve RCOC Minutes

See Exhibit A – RCOC Minutes

Updated and New Policies and Procedures

Updated and New P&Ps

P&P #	P&P Name	Department	Functional Area	Summary of Changes
CMP-002	Delegation Oversight	Compliance	Compliance	Updates for DHCS APL 23-006
CMP-003	Corrective Action Plans	Compliance	Compliance	Annual review; no changes
CMP-005	Confidentiality and Member Privacy	Compliance	Compliance	Annual review; updated to align with AB 254 & AB 352
UM-001	Utilization Management	Health Services	Utilization Management	Annual review; minor non-substantive changes
UM-002	Referrals	Health Services	Utilization Management	Annual review; no changes
QM-001	Quality Management and Improvement	Health Services	Quality Management	Annual review; updates to align with DHCS requirements
GA-001	Grievances Process	Health Services	Appeals & Grievances	Annual review; no updates
GA-002	Appeals Process	Health Services	Appeals & Grievances	Annual review; added the requirement HSC 1368.01(b)
GA-003	Independent Medical Review (IMR)	Health Services	Appeals & Grievances	Annual review; no updates
CPR-001	Public Policy Committee	Executive Services	Community & Public Relations	Annual review; no updates
HR-004	After-Hours Communication	Human Resources	Human Resources	New policy
HR-005	New Positions	Human Resources	Human Resources	New policy

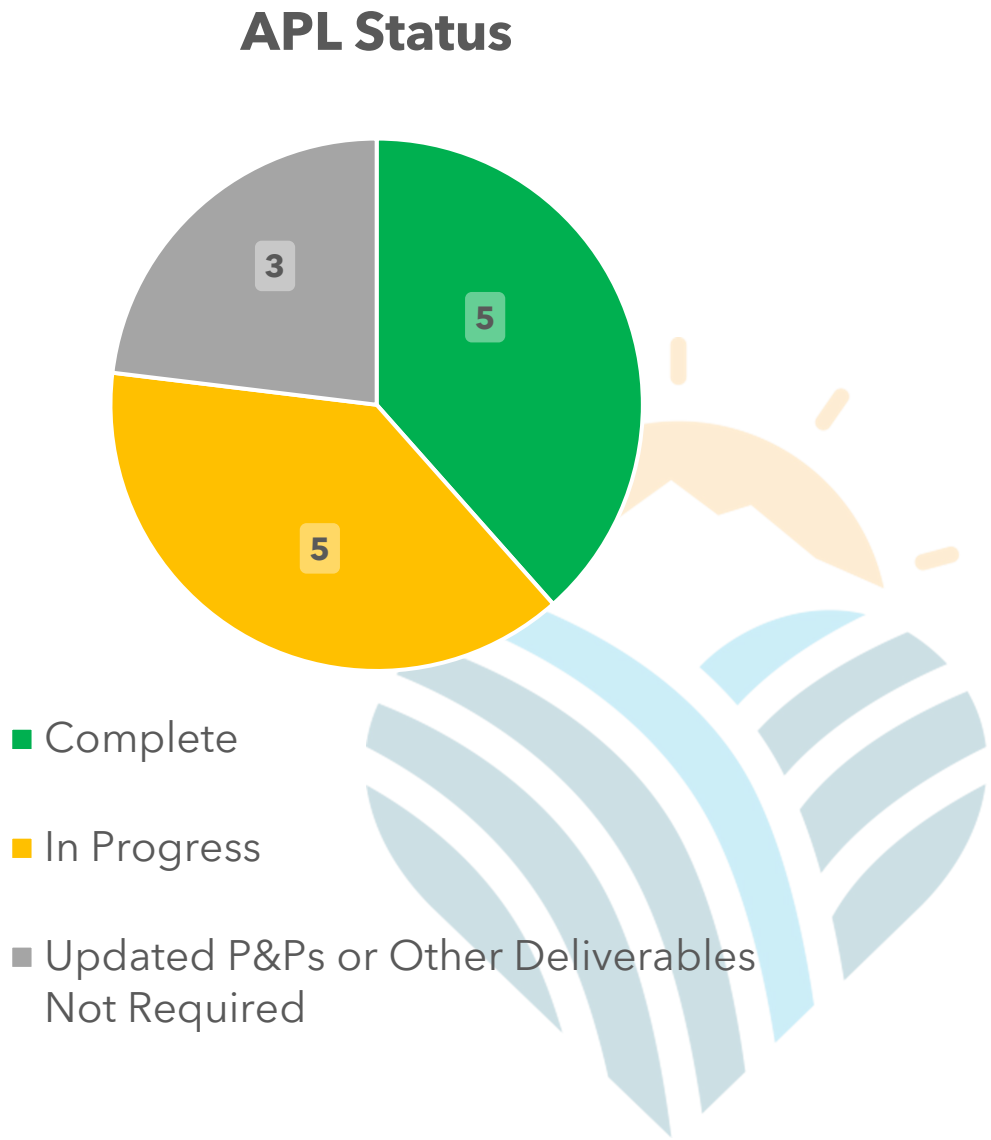
See Exhibit B – Policy Packet

New All Plan Letters (APLs) Released and Status

New APLs Released and Status

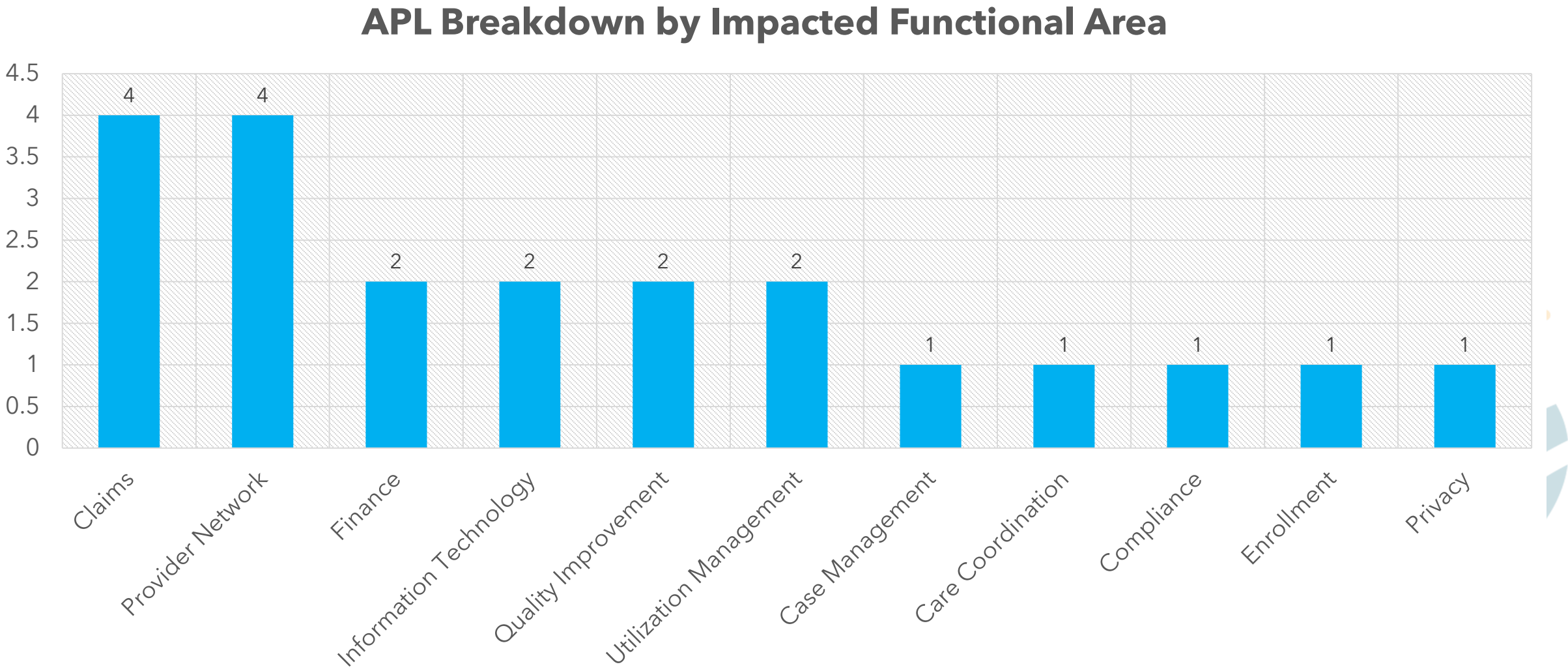
April – July 2024

- APLs are communications from DHCS & DMHC providing updates and guidance on policy changes and procedures.
- In most cases, Medi-Cal plans are expected to submit updated policies reflecting the APL updates or other deliverables outlined within the APL.
- 13 APLs released since our last meeting
  - 6 DHCS
  - 7 DMHC
  - 9 were related to functions delegated to Health Net
  - 4 were related to functions delegated to both delegated and in-house functions



New APLs released and Status

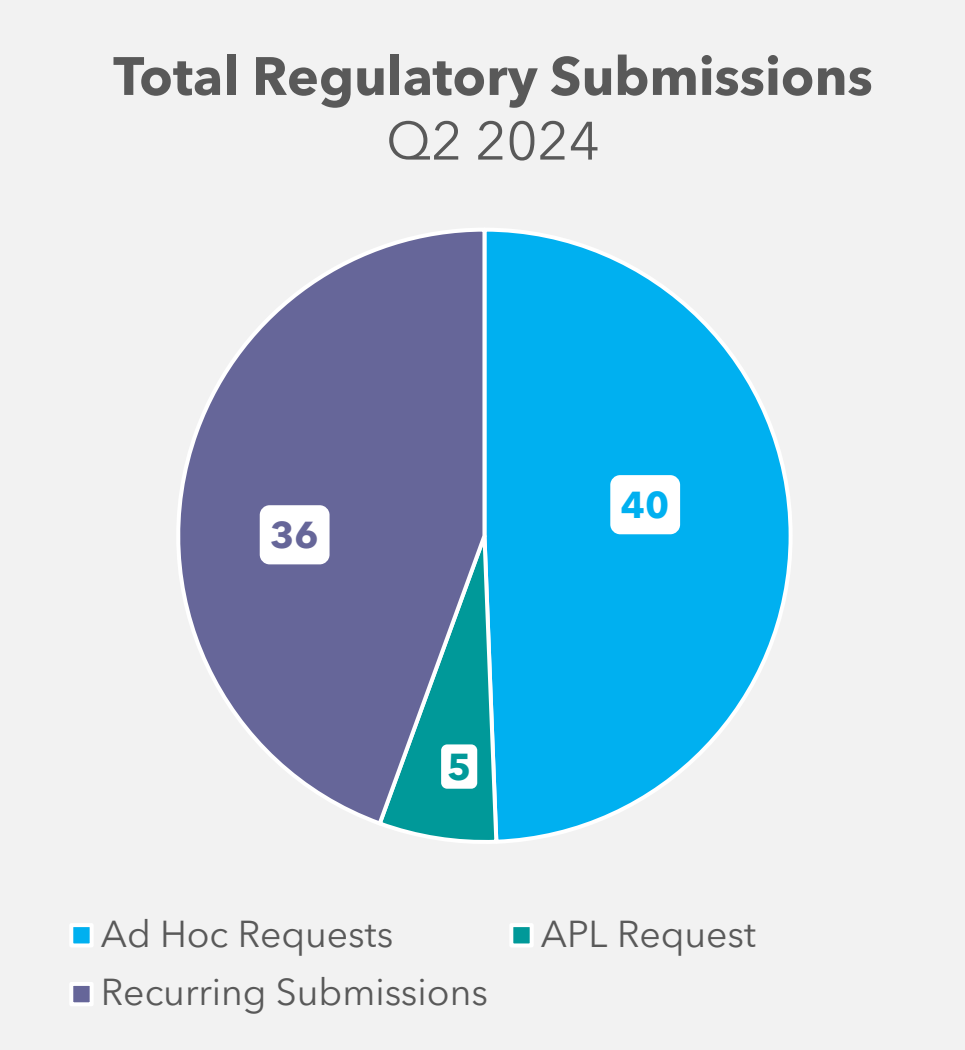
April – July 2024

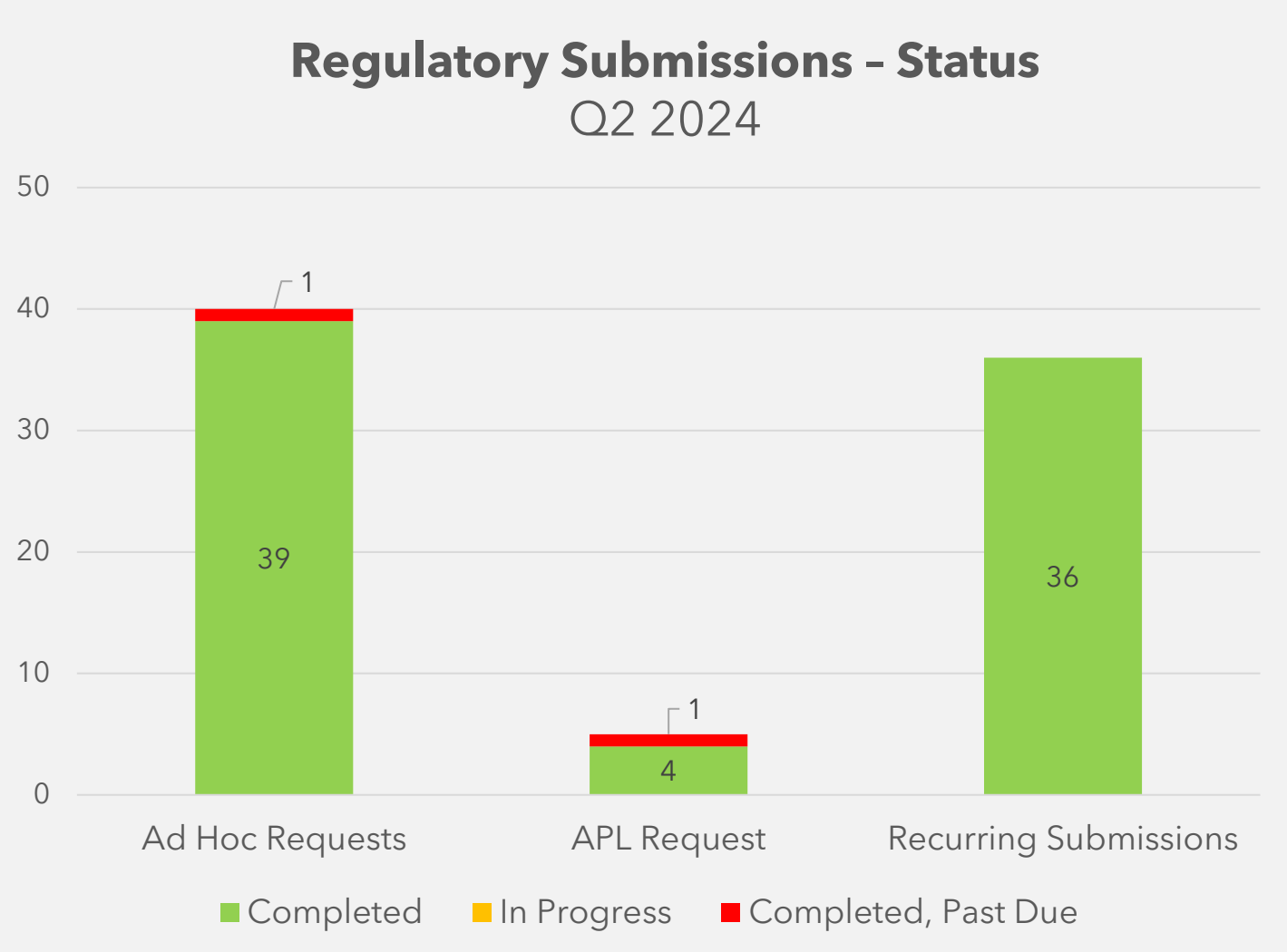


Regulatory Submissions

Regulatory Submissions – *Q2 2024*

Total Regulatory Submissions in Q2 2024: 81





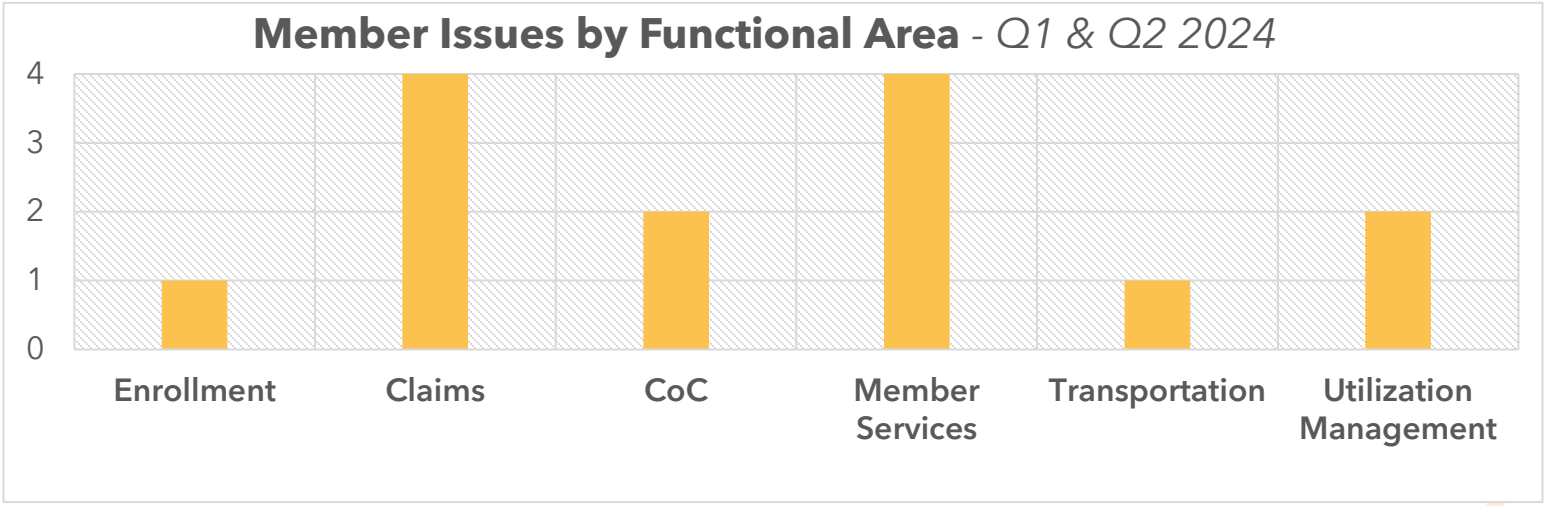
Regulatory Member Issues

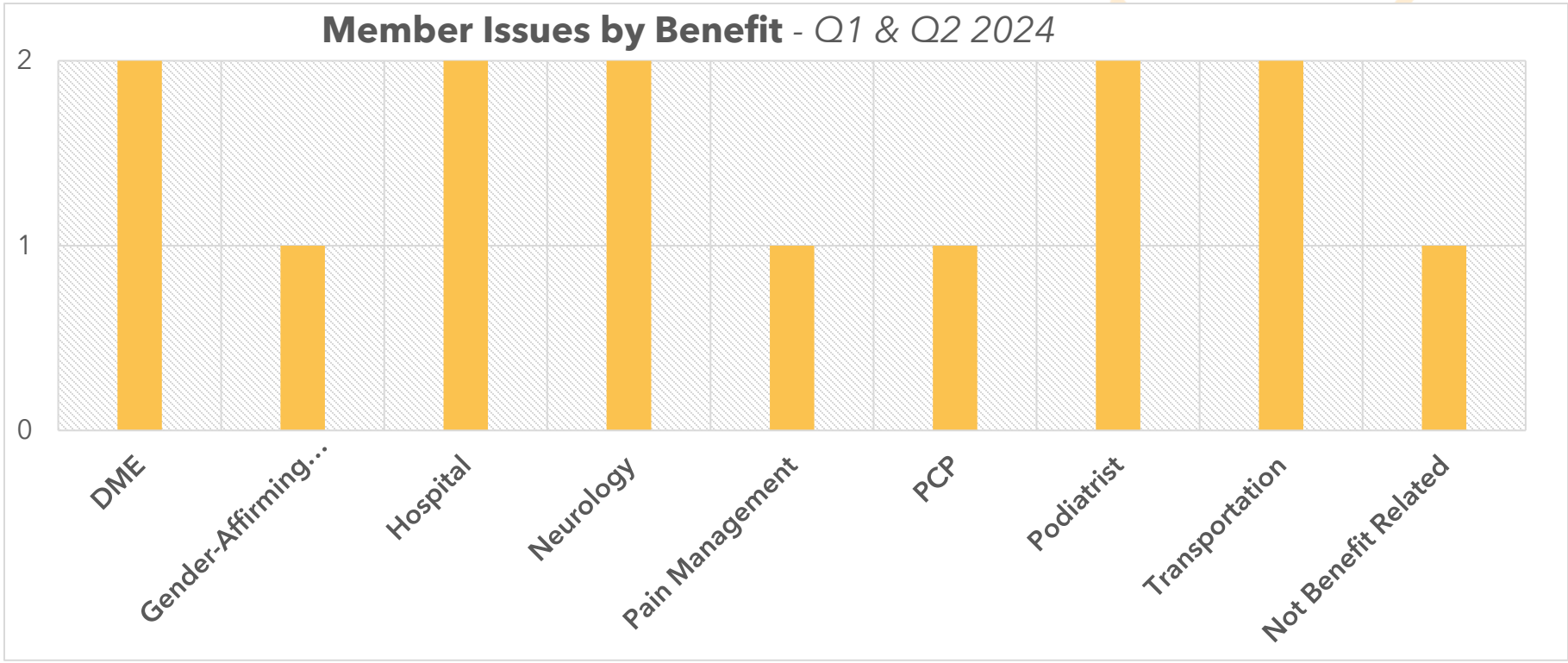
Regulatory Member Issues

Regulatory member issues occur when members directly report concerns to regulators, who then notify us and request resolution.

- 7 total regulatory member issues in Q2 2024
  - 5 DMHC Complaint
  - 2 DHCS Ombudsman Complaints

No trends identified in Q1 & Q2 2024 that require corrective action

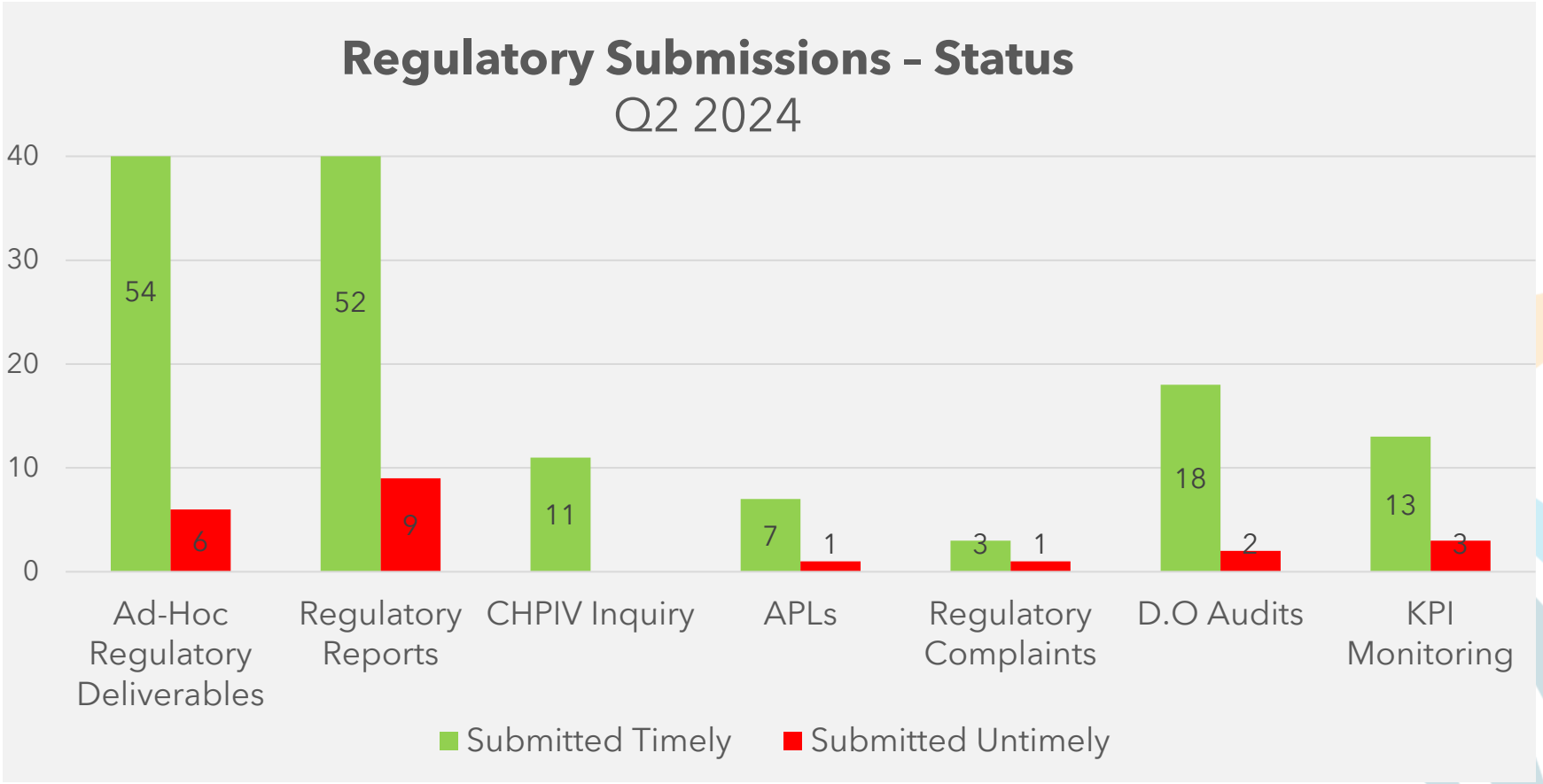




Health Net Deliverables

HN Deliverables Submissions

Total Deliverables Submissions in Q2 2024: 180



Health Net's untimely submissions in Q2 2024 resulted in CHPIV having to request an extension from our regulators.

DO Monitoring Program: Quarter 1 Results

Data Log Issues

The table below summarizes data log issues that were identified prior to data validation audits, which required multiple resubmissions. Examples include formatting issues.

Log	Issues	Status
Appeals	• Formatting issues (report specifications not followed in some columns) • Time discrepancies (case reported effectuation time prior to decision time) • Discrepancies in total appeals reported in log vs. SurveyMonkey data for post-transitional monitoring from DHCS.	Corrected
Claims	• Formatting issues (report specifications not followed in some columns) • Reporting discrepancies (cases reported that fell outside the reporting period)	Corrected
Continuity of Care	• Missing CoC Determination Letter Mailed Date, which is required to determine the member letter notification timeliness.	Corrected
Grievances	• Date and Time discrepancies (few cases reported resolution dates/times prior to decision dates/time) • Discrepancies in total grievances reported in log vs. SurveyMonkey data for post-transitional monitoring from DHCS.	Corrected
Member Services - Call Center	• Missing call data for 01/01/24-01/18/24. • Discrepancies identified in the total count of calls reported in Call Log against the counts reported in the Call Center Service Level Agreements (SLAs). • Discrepancies in total calls reported in log vs. SurveyMonkey data for post-transitional monitoring from DHCS. • Call Resolution and Call Notes for many calls is not providing detailed information and CHPIV is unable to review the call information.	Corrected
Member Services - ID Card	• Discrepancies identified with the reported effective date (7k+ cases reported effective date several months later than the member ID card mailed date)	Corrected
Provider Dispute Resolution (PDR)	• Formatting issues (report specifications not followed in some columns) • Reporting discrepancies (cases reported that did not belong to CHPIV (DOS prior to 01/01/2024) and cases that fell outside the reporting period)	Corrected
Utilization Management	• Formatting issues (report specifications not followed in some columns) • Date discrepancies (case reported decision date prior to received date) • Reporting discrepancies (cases reported that fell outside the reporting period) • Lacks critical data fields related to member and provider notification timeliness	Corrected

Data Validation Results

The purpose of data validation is to ensure the accuracy and integrity of the data logs submitted by Health Net. This process includes live webinars reviewing Health Net's systems and data sources to validate data points. Key performance indicators are measured through the logs and finalized only when they pass data validation and are deemed accurate.

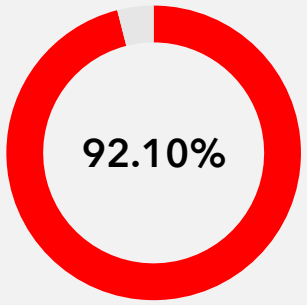
Log	Pass/Fail
Appeals	Pass
Claims	Not Reportable
Continuity of Care	Pass
Grievances	Pass
Member Services - ID Card	Pass
Provider Dispute Resolution (PDR)	Not Reportable
Utilization Management	Pass

Delegation Oversight Monitoring Program

Quarterly KPI Metrics (Q1 2024) - Results

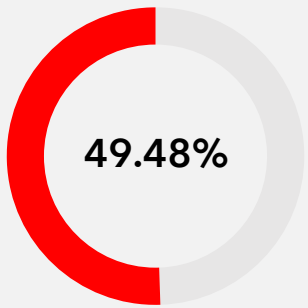
UTILIZATION MANAGEMENT

UM001*
Decision Timeliness



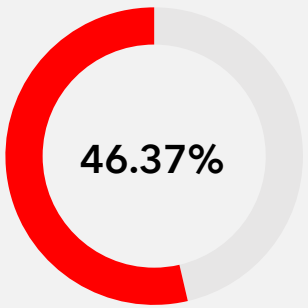
Standard	81.03%
Expedited	90.48%
Concurrent	95.58%
Retrospective	100%
Post Stabilization	No Cases

UM002*
Member Notification Timeliness



Standard	100%
Expedited	81.58%
Concurrent	47.52%
Retrospective	100%
Post Stabilization	No Cases

UM003*
Provider Notification Timeliness



Standard	31.03%
Expedited	73.81%
Concurrent	42.54%
Retrospective	100%
Post Stabilization	No Cases

**Overall score is comprised of subcategories; subcategory scores provided below overall score.*

Delegation Oversight Monitoring Program

Quarterly KPI Metrics (Q1 2024) - Results

APPEALS

APPEAL001

Timely Acknowledgement of Appeals

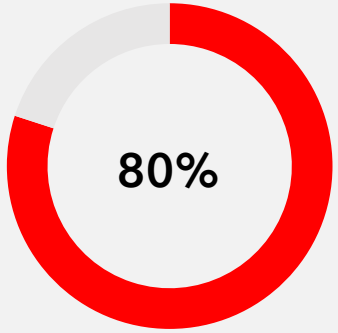
APPEAL002*

Timely Decision of Appeals

▸ **Standard**	100%
▸ **Expedited**	No Cases

APPEAL003

Effectuation of Overturned Appeals Timeliness



APPEAL004*

Member Notification Timeliness

▸ **Standard**	100%
▸ **Expedited**	No Cases

**Overall score is comprised of subcategories; subcategory scores provided below overall score.*

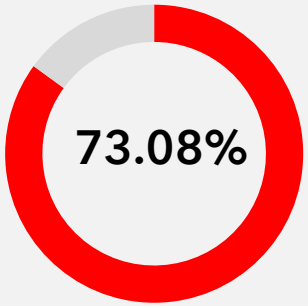
Delegation Oversight Monitoring Program

Quarterly KPI Metrics (Q1 2024) - Results

CONTINUITY OF CARE

COC001*

CoC Processing Timeliness



▸ **Non-Urgent**	100%
▸ **Immediate**	No Cases
▸ **Urgent**	36.36%

COC002*

CoC Notification Timeliness

▸ **Non-Urgent**	100%
▸ **Immediate**	No Cases
▸ **Urgent**	100%

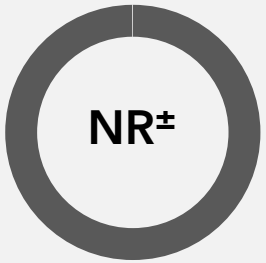
**Overall score is comprised of subcategories; subcategory scores provided below overall score.*

Delegation Oversight Monitoring Program

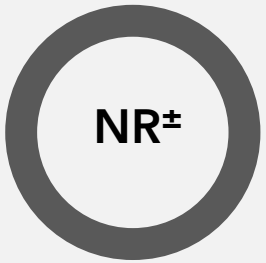
Quarterly KPI Metrics (Q1 2024) - Results

CLAIMS

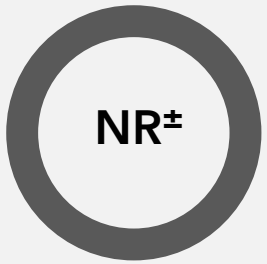
CLM001
Claims Payment Timeliness - 30 Calendar Days



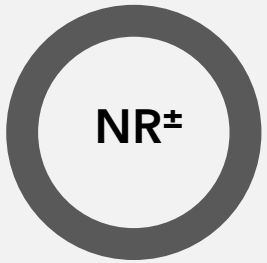
CLM002
Claims Payment Timeliness - 45 Calendar Days



CLM003
Claims Payment Timeliness - 90 Calendar Days

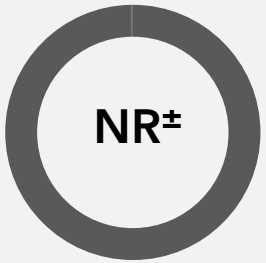


CLM004*
Acknowledgement Timeliness

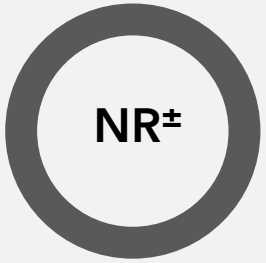


▸ Electronic	NR±
▸ Paper	NR±

CLM005
Misdirected Claims Timeliness



CLM006
Timeliness of Interest Payment on Late Claims



± Data did not pass data validation; pending resubmission of Claims log

Delegation Oversight Monitoring Program

Quarterly KPI Metrics (Q1 2024) - Results

PROVIDER DISPUTE RESOLUTION

PDR001*
Acknowledgement Timeliness

▸ Electronic	NR±
▸ Paper	NR±

PDR002
Written Determination Timeliness

PDR003
Timeliness of Interest Payment on Late PDRs

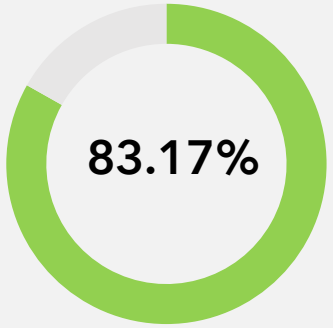
± Data did not pass data validation; pending resubmission of PDR log

Delegation Oversight Monitoring Program

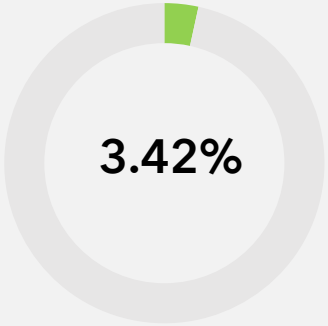
Quarterly KPI Metrics (Q1 2024) - Results

MEMBER SERVICES

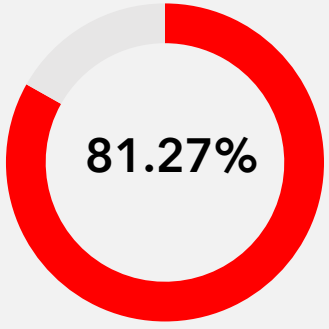
MS001*
Calls Answered within 30 seconds



MS002*
Call Center Abandonment Rate Level



MS003
Timely Issuance of Member ID Cards



** Self-reported KPIs from Health Net.*

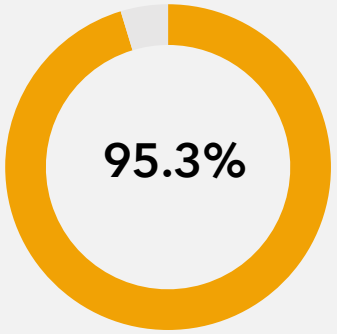
Delegation Oversight Monitoring Program

Quarterly KPI Metrics (Q1 2024) - Results

GRIEVANCES

GRV001

Timely Acknowledgement Letter



GRV002*

Timely Grievance Resolution

▸ **Standard**	100%
▸ **Expedited**	100%

GRV003*

Timely Member Notification

▸ **Standard**	100%
▸ **Expedited**	100%

**Overall score is comprised of subcategories; subcategory scores provided below overall score.*

Delegation Oversight Monitoring Program

Quarterly KPI Metrics (Q1 2024) – Actions Required

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

DO Monitoring Program: Quarter 2

- **Q2 2024 Log Collection**
  - Health Net's Q2 2024 logs were due on July 19, 2024

- **Data Validation Audits**
  - Currently conducting data validations. Targeting to have data validations completed by August 23, 2024, or before which includes additional revalidation audits if needed

- **Scorecard Dissemination**
  - Disseminate Q2 2024 scorecard to Health Net by August 30, 2024

Questions

IMPERIAL COUNTY
Local Health Authority Commission

Regulatory Compliance Oversight Committee of the Commission

MEETING MINUTES
Date/Time: April 23, 2024, 2:00 PM
Location: Community Health Plan of Imperial Valley, 512 West Aten Road, Imperial, CA 92251

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

Committee Members	Representing	Present
Dr. Allan Wu (Chair)	LHA Commissioner and Regulatory Compliance Oversight Committee Chair Innercare, Chief Medical Officer	☐
Dr. Carlos Ramirez	LHA Commissioner and Regulatory Compliance Oversight Committee Member	☒
Pablo Velez	LHA Commissioner and Regulatory Compliance Oversight Committee Member	☒
Dr Theodore Affue	LHA Commissioner and Regulatory Compliance Oversight Committee Member	☒
	REMOTE	
Ryan Kelley	LHA Commissioner and Regulatory Compliance Oversight Committee Member	☐

CHPIV Staff	Job Title	Present
Lawrence Lewis	Chief Executive Officer	☒
Elysse Tarabola	Chief Compliance Officer	☒
Dr. Gordon Arakawa	Chief Medical Officer	☒
Michelle Ortiz-Trujillo	Senior Director of Human Resources and Community Services	☒
Chelsea Hardy	Senior Director of Compliance	☒
Jadira Alcaraz	Delegation Oversight Manager	☒
Rosa Sanchez	Compliance Advisor	☒
Fernanda Ortega	Delegation Oversight Specialist	☒
Amanda Delgado	Compliance Coordinator	☒
Donna Ponce	Executive Assistant/Commission Clerk	☒

IMPERIAL COUNTY
Local Health Authority Commission

Regulatory Compliance Oversight Committee of the Commission

AGENDA ITEM/ PRESENTER	MOTION/MAJOR DISCUSSIONS	ACTIONS TAKEN
Call to Order Dr. Allan Wu, *Chair*	Meeting called to order: 2:10 p.m.	
Approval of the Agenda Dr. Allan Wu, *Chair*	A. Items to be pulled or added from the Consent/Information/Action/Closed Session Calendar	
	B. Approval of the order of the agenda	**Motion by:** Carlos Ramirez **Motion Second by:** Pablo Velez
Public Comment Dr. Allan Wu, *Chair*	No official public comment was made	
Chairperson's Report Dr. Allan Wu, *Chair*		
Chief Compliance Officer Report Elysse Tarabola, *Chief Compliance Officer*	A. Compliance Training – Amanda Delgado, *Compliance Coordinator,* presented information in regards to the compliance training and the two reports escalated to the Finance and Executive Committee and the Compliance Policy Committee *Chelsea Hardy, communicated that a new commissioner has been assigned training with a 90-day completion deadline. She underscored the importance of maintaining compliance.* *Elysse Tarabola, the Chief Compliance Officer, added that the full commission recommended implementing an automated training process. Compliance has diligently researched vendors, compared prices, and ensured content relevance. They are on the verge of presenting a recommendation to the leadership team and this committee.*	

AGENDA ITEM/ PRESENTER	MOTION/MAJOR DISCUSSIONS	ACTIONS TAKEN
	Carlos Ramirez then added how the trainings were not complicated	
	B. Chelsea Hardy, *Senior Director of Compliance,* presented the eight approved updated and new Policies & Procedures *Elysse Tarabola mentioned that they are currently seeking approval from the full commission to delegate authority to this committee for policy review and approval. Additionally, they plan to share a comprehensive packet of all policies with the full commission and the executive committee, inviting their feedback for revisions. The goal is to achieve full delegation to this committee. In response to this, Dr. Wu inquired about whether the approved policies would be available in hard copy or on a shared drive. To which Chelsea clarified that the final approved policies are currently accessible via the Monday Board.* *Elysse Tarabola noted that compliance has not yet received full approval for delegation and suggested that it may be prudent to present the policies to the executive committee. Dr. Wu concurred and questioned whether this should be conducted via formal communication, to which the CEO affirmed*	**Motion Approved:** Dr. Wu **Motion Second by**: Carlos Ramirez **All in favor**: 3 Ayes (Dr. Arakawa, Pablo Velez, Carlos Ramirez)
	C. Rosa Diaz, the *Compliance Advisor, presented the* New All Plan Letters (APLs) and Status. She covered how many had been released since June 2023, how many were completed, and in progress. She also broke down the APLs impact on each functional area. *Elysse succinctly noted that these APLs constitute regulatory modifications dispatched to Health Net and how it is incumbent upon compliance to verify their integration into their specific business sector*	
	D. Chelsea Hardy, *Senior Director of Compliance,* presented the Regulatory Submissions Status for *Q1 2024.* *Elysse remarked that the graph's intent was to illustrate volume metrics and facilitate internal progress tracking. Subsequently, Pablo Velez inquired whether the delayed submissions*	

AGENDA ITEM/ PRESENTER	MOTION/MAJOR DISCUSSIONS	ACTIONS TAKEN
	pertained to Health Net, to which Chelsea clarified that the delay was due to an extended internal review	
	E. Chelsea Hardy*, the Senior Director of Compliance,* presented the DHCS Transition Monitoring Results. She meticulously covered the report's purpose, its frequency, and the survey focus. Additionally, she delved into special populations, community support, and enhanced care management. Furthermore, she illustrated the total calls per report period and the transition-related calls per report period. *Ramirez initiated an inquiry regarding the special population. Elysse characterized it as an extensive table. Subsequently, Ramirez specified that they were considering pediatrics and children. Elysse clarified that this special population constitutes a subset of the broader group. Larry inquired whether they were identical to the population of focus. Finally, Elysse explained that while they share similarities, they are not entirely identical.*	
	F. Chelsea Hardy, during her presentation on Regulatory Member Issues, meticulously reviewed the Q1 2024 graph on member issues by functional area and analyzed the Q1 2024 graph on member issues by benefit. *Elysse highlighted a crucial distinction between the issues observed in grievances and appeals versus those originating directly from the regulator. The latter are escalated, necessitating a response within a day. In contrast, the previous slide covered appeals and grievances managed by Health Net. Carlos Ramirez then inquired about the resolution of the four complaints to which Chelsea confirmed the resolution. Carlos Ramirez then sought clarification on whether they are archived separately, and Elysse explained that they are stored in a distinct internal tracker*	
	G. Go-Live Issues – Jadira Alcaraz*, Delegation Oversight Manager* *No further inquiries or remarks were raised*	
	H. Jadira Alcaraz delivered a presentation on Health Net Deliverables, showcasing a bar graph that depicted the key components.	

AGENDA ITEM/ PRESENTER	MOTION/MAJOR DISCUSSIONS	ACTIONS TAKEN
	Dr. Wu inquired whether there was a financial penalty for the plan due to late submission. Jadira responded that no penalty was incurred as they had requested an extension. Elysse emphasized the importance of being cautious about the frequency of extension requests, even though the submissions were timely according to regulators. Currently, no penalties have been imposed.	
	I. Jadira Alcaraz, *the Delegation Oversight Manager* & Fernanda Ortega the *Delegation Oversight Specialist*, presented the Pre-Delegation Audit Overview. She went over Phase 1,2, and three results, and the phase 1 CAPs. *Dr. Wu asked about the score on the Corrective Action Plan report. Jadira confirmed its existence and explained how they received the overall report. Elysse clarified that the score reflects their performance after implementing corrective actions and submitting additional documents. By closing the CAP, they concluded the audit process. Wu inquired about the next audit's timing. Elysse informed him that the current one is a preoperational audit, with a comprehensive audit of operations scheduled for the beginning of 2024.Pablo Velez shifted the discussion to the committee tracking claims payment timeliness across different entities within the California Board Association. They focus on addressing the issue of bad payers, which has led to payment delays ranging from 45 to 160 days. Regulators are actively involved in resolving this concern. In response, Elysse assured Pablo that Jadira would explore their monitoring program. If high-risk areas impacting members, providers, or timely claims payment are identified, they will collect raw data to address these challenges effectively.*	

AGENDA ITEM/ PRESENTER	MOTION/MAJOR DISCUSSIONS	ACTIONS TAKEN
	J. Jadira Alcaraz*, the Delegation Oversight Manager,* presented the Delegation Oversight Program Update *Elysse added that we propose proactive monitoring of our operations, starting from Q1 (claims). A report on claims requested for payment from January through March will be shared with the committee. Corrective action plans will be implemented if any untimeliness is identified. Wu then added how infographics for both hospitals would enhance our transition making the recommendation of including them in every general meeting. Pablo Velez made the comment and recommendation that many patients ready for discharge face placement challenges. Some occupy beds for extended periods due to social issues. Monitoring related cases from Health Net could provide insights. Carlos Ramirez then inquired whether these cases were mostly psychiatric to which Pablo Velez responded that they were mostly homeless individuals, those with drug abuse issues, and patients unwanted by their families and how the daily count fluctuates, sometimes between 6 and 7.*	
Adjourn to Closed Session Dr. Allan Wu, *Chair*		
Reconvene in Open Session Dr. Allan Wu, *Chair*	No Comments Made	
Adjournment Dr. Allan Wu, *Chair*	M*eeting adjourned at 2:59pm*	

	Delegation Oversight	CMP-002
Department	Compliance	
Functional Area	Compliance	
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	Elysse Tarabola	☒ DHCS ☐ NA ☒ DMHC
Title	Chief Compliance Officer	

ATTACHMENTS

NA

AUTHORITIES/REFERENCES

- CMP-~~001~~ 003 Corrective Action Plans
- CHPIV Compliance Program and Plan
- CHPIV Delegation Oversight Program
- CHPIV Contract with Department of Healthcare Services (DHCS)
- Delegation Agreements
- Department of Health Care Services All-Plan Letter (APL) 17-004: Subcontractual Relationships and Delegation & All-Plan Letter (APL) 23-006: Delegation and Subcontractor Network Certification
- Title 42, Code of Federal Regulations (C.F.R.), §438.230

HISTORY

Revision Date	Description of Revision
6/12/2023	Policy creation
12/27/2023	Policy Revision

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I. OVERVIEW

A. This policy is set to establish standardized procedures for contracted DELEGATES and/or SUBCONTRACTORS' performance of assigned responsibilities in accordance with federal or state statutes, regulations, contractual obligations, Community Health Plan of Imperial Valley (CHPIV) policies and procedures, and nationally recognized accreditation standards.

~~**B.**~~ This policy defines the process for OVERSIGHT of a DELEGATED ENTITY to ensure compliance with statutory, regulatory, and contractual requirements, and Health Plan policies and procedures to ensure continuous improvement of MEMBER care, all applicable Medicaid laws and regulations, including all sub regulatory guidance and contract provisions, as well as the applicable state and federal laws, management, and administrative processes. DELEGATED ENTITIES will be assessed annually on their ability to meet CHPIV, California Department of Health Care Services, and (DHCS) Department of Managed Health Care (DMHC) requirements.

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II. POLICY

A. CHPIV shall provide OVERSIGHT of the functions and responsibilities, processes, and performance of a DELEGATED ENTITY and its DELEGATED SERVICES, including, PRE-DELEGATION EVALUATION as applicable, no less than annual review of DELEGATION AGREEMENT/grid, MONITORING of PERFORMANCE DATA, and OVERSIGHT AUDITING of delegated functions.

B. CHPIV OVERSIGHT activities include review of compliance with regulatory requirements, contractual requirements and CHPIV policies and procedures. CHPIV's Compliance department identifies whether a DELEGATED ENTITY's performance is adequate or inadequate and collaborates with the functional (Health Services, Finance, Operations, etc.) business owners to monitor a DELEGATED ENTITY's performance to ensure that improvement occurs where performance is inadequate.

C. CHPIV shall continually assess a DELEGATED ENTITY's ability to perform delegated functions through initial reviews, ongoing MONITORING, performance reviews, analysis of data, and utilization of benchmarks, if available. The DELEGATED ENTITY shall provide requested information in accordance with the timeframes for record keeping and as required.

D. At a minimum, audits of DELEGATED ENTITIES will be conducted annually by desktop review and by on-site review and/or webinar. CHPIV shall ensure audits are conducted at reasonable times at the DELEGATED ENTITY's place of business or another mutually agreeable location.

E. Successful completion of a READINESS ASSESSMENT and resolution of any corrective actions will be required prior to delegating any function to a DELEGATED ENTITY, except as provided in this Policy. This includes Delegation to a new DELEGATED ENTITY, Delegation of a new function to an existing DELEGATED ENTITY, or a DELEGATED ENTITY that changes its MANAGEMENT SERVICES ORGANIZATION (MSO).

F. If CHPIV or any authorized representative including, but not limited to, the State or Federal government, Department of Health Care Services (DHCS), Centers for Medicare & Medicaid Services (CMS), or the Department of Health and Human Services (DHHS) Inspector General, determines there is a reasonable possibility of FRAUD or similar risk, the aforementioned agencies may inspect, evaluate, and audit the DELEGATED ENTITY at any time.

G. CHPIV shall revoke the delegation of activities or obligations or specify other remedies in instances where DHCS or CHPIV determine that the DELEGATED ENTITY has not performed satisfactorily.

H. CHPIV shall inform the DELEGATED ENTITY of prospective requirements to be met before the effective agreement date. The DELEGATED ENTITY shall comply with the new requirements within thirty (30) days of the effective date, unless otherwise instructed by CHPIV.

I. The DELEGATED ENTITIES shall maintain contracts, books, documents, records, encounter data and financial statements for a minimum of ten (10) years from the final date of the contract period or from completion of any audit or investigation, whichever is later and shall be available for inspection, evaluation, MONITORING, and AUDITING to:

1. CHPIV or its DESIGNEE;
2. Any authorized representative of the state or federal government, including the DHCS, CMS, the U.S. Health and Human Services Office of Inspector General, the Comptroller General, the U.S. Department of Justice, and the Department of Managed Health Care (DMHC); and
3. Any quality improvement organization, accrediting organization (e.g., NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA)), their DESIGNEES, and other representatives of regulatory or accrediting organizations.

J. Upon request, CHPIV or its designated representatives shall have the right to inspect, review, and make copies of such records, at the DELEGATED ENTITY's expense, to facilitate CHPIV's obligation to conduct OVERSIGHT activities.

K. CHPIV retains the right to publish data obtained from audits and performance reviews and may distribute such data to MEMBERS or the general public without further notice to, or consent from, a DELEGATED ENTITY.

L. CHPIV's Compliance Department shall maintain documentation of DELEGATED ENTITY OVERSIGHT activities described herein.

M. Notwithstanding the processes described in this Policy, CHPIV's Delegation of activities and responsibilities to DELEGATED ENTITY is subject to CHPIV Commission's approval of the underlying business relationship/contract.

N. DHCS Data Reporting: CHPIV shall monitor the quality and compliance (complete, accurate, reasonable, and timely) of SUBCONTRACTOR data submitted to DHCS and/or other entities, pursuant to reporting responsibilities under state and federal laws. This includes, but is not limited to:

1. Encounter data;
2. Monthly 274 Provider Network data files;
3. Data reported through quarterly templates;

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4. Electronic visit verification reporting; and
~~4.~~ Any other ad hoc data requests required by DHCS.

O. CHPIV will maintain and communicate with the DELEGATED ENTITY their policies and procedures for monitoring the DELEGATED ENTITY'S compliance with all requirements related to all delegated activities, obligations, and related reporting responsibilities in accordance with DHCS APL 23-006, page 3: Monitoring Subcontractors, A. Delegation Accountability.

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III. PROCEDURES

A. CHPIV delegates activities to its DELEGATED ENTITIES through the Plan-to-Plan contract which incorporates DHCS and CMS contract requirements, regulations, and guidance.

B. CHPIV shall provide OVERSIGHT of all DELEGATED ENTITIES, including proposed DELEGATED ENTITIES. Such OVERSIGHT shall be conducted using, without limitation, the following actions:

1. Engagement Letter;
2. READINESS ASSESSMENT (desktop and on-site reviews);
3. Annual audit (desktop and on-site reviews);
4. Focused and ad hoc reviews, audits and MONITORING;
5. Periodic reviews and audits; and
6. On-going MONITORING.

C. The areas of OVERSIGHT focus include, without limitation, the following:

Oversight Activities	Responsible Department
Quality Management and Quality Improvement (e.g., program, work plan, committee composition);	Health Services Compliance
Credentialing, recredentialing and facility site review;	Health Services Compliance
Staff and provider training and communication;	Finance/Operations Compliance
Care management, continuity of care and care transitions;	Health Services Compliance
Financial solvency and minimum insurance requirements;	Finance Compliance
Utilization Management (e.g., program structure, workplan, committee composition, criteria, consistent application of criteria, adherence to established criteria of medical necessity, MEMBER and provider notification, rates of admissions and readmissions, emergency room visits, under and over utilization, second opinions, expedited and standard review process, daily census for planned and unplanned admissions, screening MEMBERS admitted for potential transition of care issues, discharge planning, retrospective review, out-of-network process, urgent care services, timeliness,	Health Services Compliance

Oversight Activities	Responsible Department
clinical decisions, denial notices, emergency services, and structure);	
Claims processing/adjudication and timely payment;	Finance/Operations Compliance
Encounters;	Finance/Operations Compliance
Information systems management;	Finance/Operations Compliance
Cultural and linguistic services/language assistance;	Health Services Compliance
Compliance Program;	Compliance
Care Delivery Model (e.g., Model of Care and Practice Guidelines);	Health Services Compliance
Provider disputes and claim appeals;	Finance/Operations Compliance
MEMBER rights;	Health Services Compliance
MEMBER service;	Health Services Compliance
Network management, including provider relations and provider network contracting;	Finance/Operations Compliance
Access and availability, including Americans with Disabilities Act (ADA);	Finance/Operations Compliance
Systems;	Finance/Operations Compliance
Ownership and control disclosures; 1. CHPIV shall notify the DHCS contract manager within ~~three~~ ten (10~~3~~) ~~business~~ working days upon discovery of a violation of compliance with the requirements, and/or if a disclosure reveals any potential violation(s) of the ownership and control requirements in accordance with APL 23-006.~~;~~ ~~CHPIV shall notify the DHCS contract manager within three (3) business days upon discovery of a violation of compliance with the requirements, and/or if a disclosure reveals any potential violation(s) of the ownership and control requirements;~~ 2. To identify potential conflicts of interest, CHPIV will collect and review their DELEGATED ENTITIES ownership and control disclosures.	Compliance

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Oversight Activities	Responsible Department
3. CHPIV will require and ensure DELEGATED ENTITIES accurately provide all required information in their disclosures such as: a. Date of Birth b. Social security number for each person with ownership or control interest c. Social security number for each managing employee	
Policies and procedures: DELEGATED ENTITIES shall facilitate and document an annual review of all policies and procedures to ensure compliance with regulatory, statutory, and contractual requirements. DELEGATED ENTITIES shall review and obtain approval from all applicable executive management staff and from a regulatory agency, as appropriate. DELEGATED ENTITIES shall distribute policy and procedure updates to their employees, providers, and contractors, and ensure updated policies are posted in an accessible location for reference;	Compliance
Reporting and MONITORING;	Compliance
Sub-Delegation;	Compliance
Sub-Contractual, which is the area of focus that identifies the DELEGATED ENTITIES of First Tier Entity and the policies and procedures used by the First Tier Entity to perform Delegation Oversight;	Compliance
Marketing;	Compliance
Provider network contracting;	Finance/Operations Compliance
Provider relations;	Finance/Operations Compliance
Translation Services;	Health Services Compliance
Insurance;	Finance/Operations Compliance
Medi-Cal addendum, which is the area of focus for Medi-Cal related changes relating to All Plan Letters that affect the First Tier Entities;	Compliance
MEMBER connections, which is an NCQA area of focus; and	Health Services Compliance

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Oversight Activities	Responsible Department
Regulatory initiatives, including but may not be limited to, Whole Child Model, California Advancing and Innovating Medi-Cal (CalAIM).	Health Services Compliance

D. Annual Audit Process

1. At least annually, the Compliance Department shall schedule an audit with the DELEGATED ENTITY. OVERSIGHT audits are required annually and shall be conducted as desktop and on-site Audits. The Compliance Department or the COMPLIANCE & POLICY COMMITTEE (CPC) may determine to conduct more frequent audits and/or targeted audits.
2. Using an audit tool developed, the Audit will evaluate, at a minimum, the DELEGATED ENTITY's performance of delegated activities and responsibilities, as evidenced by the DELEGATION AGREEMENT, and compliance with applicable legal requirements, and CHPIV policies and procedures.
~~2.~~3. The audit will include validation based on documentation (e.g., policies & procedures, training, reports, systems) and file review(s) based on percentages for elements assessed and passed.
~~3.~~4. If the DELEGATED ENTITY receives a score of less than one hundred percent (100%) on any Audit element of the Delegation standards, the DELEGATED ENTITY shall be required to develop a CORRECTIVE ACTION PLAN (CAP).
    a. The auditor shall have ultimate responsibility for the CAP remediation and for MONITORING and reporting the CAP to the CPC. The auditor shall report the findings of the audit, the CAPs, if any, and the timeline for CAP remediation to the CPC.
~~4.~~5. Annual audit findings will be presented to the CPC, and the CPC shall determine the following based upon the Compliance Department's recommendations:
    a. Continued Delegation without interruption if one hundred percent (100%) of the annual Audit elements are met;
    b. Continued Delegation without interruption under a CAP in accordance with CHPIV P&P CMP-003 CORRECTIVE ACTION PLANS, if scores are less than one hundred percent (100%); or
    c. Any SANCTION that shall be imposed, such as suspension, revocation or termination, suspension of enrollment or other action if less than eighty percent (80%) of the annual Audit elements are met.
~~5.~~6. CHPIV shall provide a DELEGATED ENTITY with a written report within thirty (30) calendar days after completing a review.
~~6. The elements of the CAP must be resolved in accordance with CHPIV P&P CMP-003. CORRECTIVE ACTION PLANS.~~
    ~~a. In the event the elements of the CAP are not successfully completed within ninety (90) calendar days, the Compliance department shall report to the CPC~~

~~following the CAP period. CPC will review the outstanding CAP items to determine, at its discretion, whether the CAP deadline should be extended or whether the DELEGATED SERVICES should be revoked or terminated.~~

~~i. The Compliance Department must demonstrate to the reasonable satisfaction of the CPC the reason for such an extension and provide a detailed, step action plan to ensure that the items for correction are being addressed in a timely manner.~~

7. CHPIV may impose progressive disciplinary actions on DELEGATED ENTITY with consistent performance issues or findings regarding significant complaints. The Compliance Department shall refer all incidents to the CPC for further action.
8. The CPC may recommend de-Delegation to the Regulatory Oversight Committee of the Commission (RCOC).
9. If the RCOC agrees and recommends de-Delegation, the CONTRACT OWNER will be notified by the Compliance Department.
10. If, at any time during the term of the DELEGATION AGREEMENT, a non-compliance of Delegation issue arises, it should be referred immediately to the Compliance Department, who will alert the CPC. The CPC shall determine whether ad hoc Audits, reviews, and/or other remediation are necessary to resolve any identified issues. Issues escalated will be reviewed by the Compliance Department, CPC, and RCOC, as applicable.
11. CHPIV will require DELEGATED ENTITIES to submit complete, accurate, and timely Network Provider encounter data to the CHPIV for all items and services furnished to Members either directly or through Downstream Subcontractors or other arrangements with Providers.
~~10.~~12. CHPIV will report any significant instances to DHCS (i.e., in terms of gravity, scope and/or frequency) of noncompliance, imposition of corrective actions, or financial sanctions pertaining to their obligations under the contract with DHCS to their MCOD Contract Managers within three (3) Working Days of the discovery or imposition.

E. MONITORING

1. The Compliance Department and functional business owners are responsible for conducting ongoing MONITORING of DELEGATES' performance.
2. Ongoing MONITORING shall be conducted in accordance with CHPIV's Delegation Oversight Monitoring Program and include a review of quantitative and qualitative Key Performance Indicators.
3. The Compliance Department shall collect data from DELEGATED ENTITIES on a monthly or quarterly basis to:
   a. Evaluate performance for quantitative metrics through data analysis and calculations and
   b. Select samples for qualitative case file reviews.
4. Data submitted by the DELEGATED ENTITY is subject to a data validation review to ensure data completeness and accuracy.

5. CHPIV shall monitor a DELEGATED ENTITY through reports, communication materials, and continuous improvement activities submitted by the delegates on a periodic basis.
6. The CPC shall monitor the dashboards and may make recommendations for Corrective Action should metrics fall below the threshold.
7. If there is a consistent pattern of noncompliance by the DELEGATED ENTITY, the Compliance Department will conduct a focused review or request Corrective Action.
8. If the results of the focused review are unfavorable, the Compliance Department will escalate to the CPC and/or RCOC for further action.

F. CORRECTIVE ACTION PLANS

1. If any area of deficiency or non-compliance is identified through any internal or external sources, including but not limited to, MEMBER or provider complaints, READINESS ASSESSMENT Reviews, regulatory audits, regular reports, OVERSIGHT reviews, and ongoing MONITORING, the Compliance Department may require a DELEGATED ENTITY to respond to and submit a CAP.
2. A DELEGATED ENTITY shall comply with CAP requirements as set forth in CHPIV P&P CMP-003 CORRECTIVE ACTION PLANS.
3. The elements of the CAP must be resolved in accordance with CHPIV P&P CMP-003: CORRECTIVE ACTION PLANS.
    a. In the event the elements of the CAP are not successfully completed within ninety (90) calendar days, the Compliance department shall report to the CPC following the CAP period. CPC will review the outstanding CAP items to determine, at its discretion, whether the CAP deadline should be extended or whether the DELEGATED SERVICES should be revoked or terminated.
        i. The Compliance Department must demonstrate to the reasonable satisfaction of the CPC the reason for such an extension and provide a detailed, step action plan to ensure that the items for correction are being addressed in a timely manner.

~~2.~~4. CHPIV may impose progressive disciplinary actions on DELEGATED ENTITY with consistent performance issues or findings regarding significant compliance issues.

G. Sub-Delegation Oversight Process

1. To ensure the Compliance Department has OVERSIGHT of all sub-delegate arrangements and sub-delegate(s) are compliant with regulatory requirements, the Compliance Department shall monitor sub-Delegation through the READINESS ASSESSMENT and annual Audit of the DELEGATED ENTITIES. The sub-Delegation attestation will be reviewed and signed during the DELEGATED ENTITY READINESS ASSESSMENT and annual Audit and more frequently, if required by CHPIV.
2. Each DELEGATED ENTITY shall attest if they use sub-delegates to perform DELEGATED SERVICES.
3. DELEGATED ENTITIES that sub-delegate DELEGATED SERVICES shall provide a list of all sub-delegates and their functions.

4. DELEGATED ENTITIES that have sub-delegates must provide evidence of a Business Associates agreement holding the sub-delegate to all contractual obligations as outlined in the Business Associates agreement between the DELEGATED ENTITY and CHPIV.
5. DELEGATED ENTITIES that have sub-delegates shall have contract provisions with the sub- delegate that require that sub-delegate to make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, and DOJ, or their DESIGNEES.
6. DELEGATED ENTITIES that have sub-delegates shall retain all records and documents for a minimum of ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

H. Revocation of Delegation

1. Delegation may be revoked in instances where CHPIV or a regulatory agency determines that the DELEGATED ENTITY has not performed satisfactorily, including failing to implement a CAP or quality improvement plan and or upon determination of FRAUD.
2. CHPIV may also terminate the DELEGATION AGREEMENT at any time for cause related to findings of significant deficiencies including a full investigation of FRAUD. DHCS reserves the right to suspend or terminate the DELEGATED ENTITY from participation in the Medi-Cal program, seek recovery of payments made to the DELEGATED ENTITY, impose other SANCTIONS provided under the State Plan, and direct CHPIV to terminate their DELEGATION AGREEMENT with the DELEGATED ENTITY due to FRAUD.
3. The CPC may recommend complete or partial de- Delegation of activities to a DELEGATED ENTITY to the RCOC.
4. Upon revocation or termination of Delegation, performed DELEGATED SERVICES shall be conducted by CHPIV or will be delegated to another party.
5. If the RCOC approves de-Delegation of activities from the DELEGATED ENTITY, CHPIV shall:
    a. Provide the DELEGATED ENTITY with a thirty (30) calendar day written notice of CHPIV's intent to de-delegate;
    b. Inform MEMBERS and providers of the de-Delegation, and provide instructions for continued services;
    c. Adjust the DELEGATED ENTITY's payments as appropriate to the DELEGATED ENTITY activity; and
    d. Prepare appropriate CHPIV departments to provide the de-delegated activities.
6. A DELEGATED ENTITY shall cooperate with CHPIV to ensure smooth transition and continuous care for MEMBERS during the de-Delegation transition period.
7. In the event CHPIV determines, in its sole discretion, that the circumstances warrant re-evaluation of a DELEGATED ENTITY's ability to perform delegated activities that were

previously de-delegated, CHPIV shall conduct such re-evaluation no earlier than twelve (12) months after the effective date of the de-Delegation.

a. CHPIV shall utilize the READINESS ASSESSMENT process.
b. CHPIV shall delegate activities to the DELEGATED ENTITY based on the READINESS ASSESSMENT results.
c. If the CPC approves Delegation of activities to the DELEGATED ENTITY, CHPIV shall re- delegate such activities, and adjust the DELEGATED ENTITY's payment accordingly.
d. If the CPC denies re-Delegation of activities to the DELEGATED ENTITY, it may recommend additional SANCTIONS on the DELEGATED ENTITY, up to and including termination of the CHPIV Service Agreement.

IV. DEFINITIONS

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

TERM	DEFINITION
Auditing	A Systematic evaluation of performance to ensure consistency with ethical standards, federal or state statute, regulations, policies, contractual obligations and National Committee for Quality Assurance (NCQA) requirements. 1. External Audit – Evaluation of CHPIV as conducted by an external regulatory or accreditation body; 2. Internal Audit – Evaluation of CHPIV operational areas, department, or systems as conducted by Regulatory Affairs and Compliance (RAC); or 3. Oversight Audit – Evaluation of delegate/SUBCONTRACTOR as conducted by CHPIV, at least annually.
Compliance & Policy Committee (CPC)	An internal committee comprised of CHPIV management staff that monitors compliance activities and makes recommendations for action to CHPIV staff, including CHPIV's executive staff, and the Commission.
Contract Owner	The one individual within CHPIV with ultimate responsibility for the relationship between CHPIV and the Delegated Entity. Contract Owner responsibilities include, but are not limited to, initial contact, procurement, negotiation of contract terms, compliance remediation, on- going entity relations, site closings, hours of operations, etc. The Contract Owner is the individual with responsibility for ensuring that the documentation regarding the relationship between CHPIV and the Delegated Entity is complete and accurate.
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

TERM	DEFINITION
	for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CHPIV departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CHPIV and its regulators.
Delegated Entity (Delegate)	A contracted entity which CHPIV authorizes to perform certain functions on its behalf. Although, CHPIV can delegate the authority to perform a function, it cannot delegate the responsibility for ensuring that the function is performed according to CHPIV and National Committee on Quality Assurance (NCQA) standards.
Delegated Services	Services delegated to a Delegated Entity through a Delegation Agreement, which may include, but are not limited to, administration and management services, marketing, utilization management, quality assurance, case management, claims processing, claims payment, credentialing, network management, provider claim appeals, Member service, enrollment, disenrollment, billing, sales and adjudicating organization determinations and appeals.
Delegation Agreement	Mutually agreed upon document, signed by both parties, which includes, without limit: 1. CHPIV responsibilities; 2. Duration of the agreement; 3. Termination of the agreement; 4. Delegated Entity responsibilities and Delegated Services; 5. Types and frequency of reporting to the Delegated Entity; 6. Process by which the CHPIV evaluates the Delegated Entity's performance (Performance Measurements); 7. Use of confidential CHPIV information including Member Protected Health Information (PHI) by the Delegated Entity; and 8. Remedies available to the CHPIV if the Delegated Entity does not fulfill its obligations.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Fraud	As defined in Title 42 Code of Federal Regulations (section 455.2) fraud is, "An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law." Fraud also includes potential violations or activities prohibited by applicable federal or state laws including, without limitation, the Federal False Claims Act, 31 U.S.C. Sections 3729-3731 and the California False Claims Act,

TERM	DEFINITION
	California Government Code, Sections 12650 – 12656.
Full scope audit	A systematic review of data, documentation, and records for all functions which the entity is delegated to perform.
Limited scope audit	A focused review of data, documentation, and records for a selected portion of functions which the entity is delegated to perform.
Management Services Organization (MSO)	For purposes of this policy, an entity that provides management and administrative support services on behalf of a Delegated Entity.
Member	A beneficiary enrolled in a CHPIV program.
Monitoring	The mechanism for ongoing collection and review of performance data against benchmarks derived from statues, regulations, policy, contractual obligations, and/or NCQA standards.
National Committee for Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
Oversight	Continual performance evaluation through auditing and monitoring consistent with CHPIV policy and contractual obligations.
Performance data	Data, documentation, or information in the demonstration of compliance with agreed upon performance standards and delegated responsibility. This may include, but is not limited to: 1. Regular reports (utilization, timeliness, complaints/grievances, network certification, etc.); 2. Regulatory or accreditation deliverables; 3. Program descriptions and/or evaluations; or 4. Policies and procedures and/or template documents
Pre-delegation evaluation	The review of an external entity's policy, procedures, program descriptions, and other materials as necessary, to determine the entity's capacity to perform functions on behalf of CHPIV, prior to delegating responsibilities.
Readiness Assessment	An assessment conducted by a review team prior to the effective date of a Delegated Entity's or other contracted entity's contract with CHPIV of the Delegated Entity's or contracted entity's compliance with all or a specified number of operational functional areas as determined by CHPIV.

TERM	DEFINITION
Sanction	An action taken by CHPIV, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CHPIV Programs.
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.

	Corrective Action Plans	CMP-003
	Department	Compliance
	Functional Area	Compliance
	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	Elysse Tarabola	☒ DHCS	☐ NA
Title	Chief Compliance Officer	☒ DMHC	

ATTACHMENTS

- Attachment A – CHPIV CAP Template

AUTHORITIES/REFERENCES

- Medicare Managed Care Manual, Chapter 21, Section 50.7.2 (Compliance Program)
- Title 42, Code of Federal Regulations (CRF), 422.503 (b) (4)(vi)(E)
- Title 42, CFR, 423.504 (b)(4)(vi)(E)
- Title 42, CRF, 423.504 (b)(4)(vi)(F)
- PDBM, Chapter 9, Section 50.7.2

HISTORY

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

I. OVERVIEW

A. The purpose of this policy is to ensure Community Health Plan of Imperial Valley (CHPIV) develops and implements timely and effective CORRECTIVE ACTION PLANS. This policy outlines how CHPIV may initiate a CORRECTIVE ACTION PLAN. The policy reviews the responsibilities and methods for identifying root causes of noncompliance, initiating correction action(s), and performing follow-up to ensure that the corrective action(s) have been effective in preventing the reason for the noncompliance. CHPIV has a responsibility to ensure operations and services are in compliance with all applicable regulations and aligned with its mission and values.

II. POLICY

A. CHPIV shall promptly take corrective action to correct and/or prevent non-compliance and to ensure optimal operations and compliance with contractual obligations and organizational values.

III. PROCEDURES

A. The basis for corrective action may derive from internal/external compliance reviews and reports, self-disclosures of noncompliance, regulatory audits, monitoring activities, and other substantiated sources of noncompliant practices in any department by any person(s).

B. Elements of a CORRECTIVE ACTION PLAN – The following constitutes the minimum action which shall take place in response to noncompliance with CHPIV's standards. A CORRECTIVE ACTION PLAN for a violation of noncompliance shall include these elements:

1. A clear statement of the specific deficiency or findings to be corrected.
2. A summary of the method used that discovered the problem.
3. A summary of the findings that includes a root cause analysis of the noncompliance that will determine the extent and content of the CORRECTIVE ACTION PLAN.
    a. The root cause may include system or human error, system/technological failures, negligence, reckless disregard of CHPIV policies or procedures, and applicable laws and regulations, or willful misconduct. For example,
        1. Policies and procedures
            a. Do we have adequate or any policies to address the deficiency?
            b. Do we have adequate or any procedures to address the deficiency?
            c. Do we have workflows and desk level procedures to address the deficiency?
            d. Did staff have dedicated processes or workflows for the activity?
        2. Staffing challenges
            a. Number of staff
            b. Conflict or other challenges among staff
            c. Sufficient cross-functional coordination among departments
        3. Management oversight
            a. Was there adequate management oversight of and enforcement of performance standards?
        4. Quality improvement processes and staff

5. Reporting and analytics
6. Are there sufficient reports and systems to monitor the activity?
    b. System configuration
        1. Inadequate system
        2. Inadequate configuration
        3. Are staff sufficiently trained in system configuration?
    c. Staff and management training

4. Remediation activities, which at minimum, shall include actions that address all identified root causes.
5. Implementation documents that support the actions taken to remediate the issue shall be listed in the CAP to evidence completion of corrective actions.
6. Impact analysis, if required, to identify all parties subjected to or impacted by the issue of noncompliance

C. Compliance shall issue the CAP and the CAP Owner is required to draft the initial CAP.
1. If CAP involves multiple staff and/or functional areas, CAP Owner is responsible for working with all involved parties to ensure CAP completeness.

D. All CORRECTIVE ACTION PLANS are initially reviewed by Compliance and feedback is provided to the CAP owner. The CAP owner will have an opportunity to modify and incorporate any feedback before their final CAP is submitted back to Compliance. The timeline for this process will vary depending on business needs and the severity of the noncompliance. However, when regulatory timelines are set, the internal business unit or DELEGATE/SUBCONTRACTOR/vendor submitting the CAP will be responsible for ensuring that the CAP is submitted to Compliance by the required regulatory date. Unless otherwise stated, requested CAPs will need to be submitted to Compliance no later than 10 business days (2 weeks) from the requested date.

E. Documentation regarding CORRECTIVE ACTION PLANS will be filed and maintained by the CHIEF COMPLINCE OFFICER or their designee for a minimum of ten (10) years after implementation of the Plan.

F. CAP Monitoring
1. The CAP should describe and develop an implementation schedule for each corrective action initiative. The implementation schedule must identify major tasks, key personnel or components responsible for each activity, and a timeline for each action including target implementation dates, milestones, and the monitoring process. The Plan should also describe a systemic approach for tracking and reporting the status of the corrective actions (e.g. Reporting to COMPLIANCE & POLICY COMMITTEE (CPC)) to successful closure and implementation.
2. CORRECTIVE ACTION PLANS must be monitored for full implementation and effectiveness. CAPs will be monitored by the Compliance department.

G. If applicable, CAPs are reported to applicable REGULATORY AGENCIES.

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.
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	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CHPIV, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CHPIV departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CHPIV and its regulators.
Delegated Entity (Delegate)	A contracted entity which CHPIV authorizes to perform certain functions on its behalf. Although, CHPIV can delegate the authority to perform a function, it cannot delegate the responsibility for ensuring that the function is performed according to CHPIV and National Committee on Quality Assurance (NCQA) standards.
Regulatory Agency	State and federal governing bodies overseeing consumer rights to quality health care. This includes, but is not limited to, the Department of Managed Health Care (DMHC), the California Department of Health Care Services (DHCS), and the Centers for Medicare and Medicaid Services (CMS).
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.

	Confidentiality and Member Privacy	CMP-005
Department	Compliance	
Functional Area	Compliance	
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	Elysse Tarabola	☐ DHCS ☐ NA ☒ DMHC
Title	Chief Compliance Officer	

ATTACHMENTS
NA

AUTHORITIES/REFERENCES

- **Internal**
  - CHPIV, Delegation Oversight Policy and Procedure, CMP-002
- **Federal**
  - 45 Code of Federal Regulations ("CFR") Parts 160, 162, and 164
- **State**
  - California Assembly Bill 1184: The Confidentiality of Medical Information Act (CMIA)
  - ~~California Assembly Bill 254: Confidentiality of Medical Information Act: Reproductive or Sexual Health Application Information~~
  - California Civil Code Sections 56.05 & 56.10 et seq., 56.108, 56.109, 56.110 56.107, 1798 et seq.
  - California Code of Civil Procedure ("CCP") Sections 3421, 3424, 3427, 3428
  - Health and Safety Code Sections ("H&S Code") 1280.1, 1280.3, 1280.15, 1364.5, 123100 – 123149, 1364.5
  - California Code of Regulations ("CCR") Title 22 § 51009
  - DMHC All Plan Letter ("APL") 22-010 (OPL): Guidance Regarding AB 1184;
  - 2024 DHCS Contract Exhibit A, Attachment III 5.1.1(B)
- **Accreditation**
  - NCQA: Member Experience (ME) 3, Element B, Medicaid (MED) 4, Elements A-C

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

	Confidentiality and Member Privacy	CMP-005

5/17/2024	Policy revision to align with AB 254 & AB 352 updated requirements

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I. OVERVIEW

A. This policy addresses Community Health Plan of Imperial Valley's ("CHPIV" or the "Plan") Confidentiality and Member Privacy requirements, policies, and procedures. The purpose of this policy is to establish a process to protect the confidentiality of CHPIV's subscribers' and enrollee's Medical Information.

II. POLICY

A. CHPIV ensures there are processes to protect the confidentiality of a subscriber's or enrollee's Medical Information. This includes:
   1. Not requiring a protected individual to obtain the primary subscriber or other enrollee's authorization to receive sensitive services or to submit a claim for sensitive senses if the protected individual has the right to consent to care.
   2. Directing communications regarding a protected individual's receipt of sensitive senses as follows:
      a. Directly to the protected individual's designated alternative mailing address, email address, or telephone number OR
      b. In the absence of a designated alternative mailing address, email address or telephone number: to the address or telephone number on file in the name of the protected individual.
      c. Communications (written, verbal or electronic communications) regarding a protected individual's receipt of sensitive services shall include:
         i. Bills and attempts to collect payment.
         ii. A notice of adverse benefits determinations.
         iii. An explanation of benefits notice.
         iv. A plan's request for additional information regarding a claim.
         v. Notice of a contested claim.
         vi. The name and address of a provider, description of services provided, and other information related to a visit.
         vii. Any written, oral, or electronic communication from a plan that contains protected health information.

~~vii.~~B. CHPIV will not cooperate with any inquiry or investigation by or provide M~~m~~edical l~~i~~nformation to, any individual, agency, or department from another state or, to the extent permitted by federal law, to a federal law enforcement agency that would identify protected individual and that is related to the protected individual seeking or obtaining an abortion or abortion-related services that are lawful under the laws of California & Civil Code Section 56.108, unless the request for M~~m~~edical l~~i~~nformation is authorized under Civil Code Section 56.110.

C. CHPIV will not disclose, transmit, transfer, share or grant access M~~m~~edical l~~i~~nformation related sensitive health care services provided to a protected individual to the primary

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subscriber or any plan enrollees other than the protected individual receiving care, absent an express authorization of the protected individual. This includes Medical Information in an electronic health records system or through a health information exchange that would identify the protected individual and that is related to the protected individual seeking, obtaining, providing, supporting, or aiding in the performance of an abortion that is lawful under the laws of California to any individual from another state, unless the disclosure, transmittal, transfer, sharing, or granting is authorized under any of the conditions listed in Civil Code Sections 56.110.

D. CHPIV will disclose the content of health records containing Medical Information in accordance with Civil Code Section 56.110:
   1. A protected individual, or their personal representative, consistent with the Patient Access to Health Records Act.
   2. In response to an order of a California or federal court, but only to the extent clearly stated in the order and consistent with Penal Code Section 1543 (if applicable) and only if all information pertaining to the protected individual's identity and records are protected from public scrutiny through mechanisms, including but not limited to, a sealed proceeding or court record.
   3. When expressly required by federal law that preempts California law, but only to the extent expressly required.

~~B.~~

E. CHPIV permits and accommodate requests from subscribers or enrollees for confidential communication in the form and format requested, if readily producible in the requested form and format, or at alternative locations.

F. CHPIV will deem any entity that offers a Reproductive or Sexual Health Digital Service to the protected individual for the purpose of allowing the protected individual to manage their individual information, or for the diagnosis, treatment, or management of a medical condition of the individual, to be a health care provider subject to the requirements of the California Assembly Bill 254 and Civil Code Section 56.05. CHPIV will enable the entity offering Reproductive or Sexual Health Digital Service to the protected individual to the following in accordance with Civil Code Section 56.101:
   1. limit user access privileges to information systems that contain Medical Information related to sensitive services only to those persons who are authorized to access specified Medical Information.
   2. Prevent the disclosure, access, transfer, transmission, or processing of Medical Information related to sensitive services to persons and entities outside of California.
   3. Segregate Medical Information related to sensitive services from the rest of the protected individual's record.
   ~~C.~~4. Provide the ability to automatically disable access to segregated Medical Information related to sensitive services by individuals and entities in another state.

~~D.~~G. CHPIV ensures implementation of confidential communications requests within 7 calendar days of receipt of an electronic or telephonic request or within 14 calendar days of receipt by first-class mail. In addition, CHPIV ensures there is acknowledgment of receipt of confidential communications requests and advising the subscribers or

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enrollees of the status of implementation of the requests if the subscribers or enrollees contact the plan.

~~E.~~H. CHPIV ensures subscribers and enrollees are notified that they may request a confidential communication, how to make the request, and providing this information to subscribers and enrollees at initial enrollment and annually thereafter on renewal as follows:

1. In a conspicuously visible location in the evidence of coverage.
2. On the plan's internet website, accessible through a hyperlink on the internet website's home page in a manner allowing subscribers, enrollees, prospective subscribers, prospective enrollees and members of the public to easily locate the information.

~~F.~~I. CHPIV ensures that enrollment or coverage is not conditional based on the waiver of the confidentiality rights provided in Civil Code section 56.107.

~~G.~~J. CHPIV maintains implementation of a means of directing all electronic communications, including online portal communications, regarding a protected individual's receipt of sensitive services as required by Civil Code section 56.107, subdivisions (a)(3)(A), (B) and (C)(vii).

~~H.~~K. CHPIV ensures there are policies and procedures in place to ensure Members' Rights to confidentiality of PHI and PI in accordance with 45 CFR Parts 160 and 164, and in accordance with Civil Code section 1798 et seq.

1. CHPIV ensures its Subcontractors, DOWNSTREAM SUBCONTRACTORS, and NETWORK PROVIDERS have policies and procedures in place to guard against unlawful disclosure of PHI, PI, and any other CONFIDENTIAL INFORMATION to any unauthorized persons or entities.
2. CHPIV ensures its Subcontractor shall inform and advise Members on the right to confidentiality of their PHI and PI. Contractor shall obtain the Member's prior written authorization to release CONFIDENTIAL INFORMATION, unless such prior written authorization is not required by 22 CCR section 51009.

III. PROCEDURE

A. Delegation Oversight

1. CHPIV shall provide oversight and continually assess its subcontractor Health Net's responsibilities, processes, and performance for Confidentiality and Member Privacy. CHPIV will ensure Health Net's compliance with regulatory and contractual requirements through the following activities which are detailed in *CHPIV Policy CMP-002: Delegation Oversight Policy and Procedure*:
   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
Confidential Information	Means facts, documents, or records in any form that are recognized as "confidential" by any law, regulation, or contract.
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.
Medical Information	Means any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental health application information, reproductive or sexual health application information, mental or physical condition, or treatment.
Network Provider	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.
PI	Acronym which corresponds to Personal Information
PHI	Acronym which corresponds to Protected Health Information
Reproductive or Sexual Health Application information	Means information about a consumer's reproductive health, menstrual cycle, fertility, pregnancy, pregnancy outcome, plans to conceive, or type of sexual activity collected by a reproductive or sexual health digital service, including, but not limited to, information from which one can infer someone's pregnancy status, menstrual cycle, fertility, hormone levels, birth control use, sexual activity, or gender identity.
Reproductive or Sexual Health Digital Service	Means a mobile-based application or internet website that collects reproductive or sexual health application information from a consumer, markets itself as facilitating reproductive or sexual health services to a consumer, and uses the information to facilitate reproductive or sexual health services to a consumer.
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.

	Utilization Management	UM-001
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 ☐ NA ☒ DMHC	
Title	Chief Medical Officer		

ATTACHMENTS

NA

AUTHORITIES/REFERENCES

- **Internal**
  - CHPIV, Delegation Oversight Policy and Procedure, CMP-002
- **Federal**
  - Code of Federal Regulation (CFR): 42 CFR 438.206 and 438.915.
- **State**
  - California Health and Safety Code Sections ("H&S Code") 1262.8(i), 1317.1, 1317.4, 1363.5, 1367(d), 1367.01, 1368.1, 1371.4, 1374.16, 1374.30(i), 1383.1(a), 1383.15
  - California Business and Professions Code Section ("B&P Code") 805
  - Title 28 California Code of Regulations Rules ("CCR") Rules 1300.67.2(c), 1300.70, 1300.71.4, 1300.74.16
  - DMHC: Technical Assistance Guide ("TAG") "Utilization Management" (last published 08/09/2015)
  - DHCS: DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III, Section 2.3; TAG Utilization Management
  - Knox-Keen Health Care Service Act and Regulations, Section 1367.01, 1374.721
- **Accreditation**
  - NCQA: Utilization Management (UM) 1, Elements A-B

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") UTILIZATION MANAGEMENT ("UM") requirements, policy, and procedures.

II. POLICY

A. CHPIV ensures it has developed, implemented, updated at least annually, and improved its UTILIZATION MANAGEMENT (UM) program to ensure appropriate processes are used to review and approve the provision of MEDICALLY NECESSARY Covered Services for its MEMBERS. At a minimum, CHPIV's UM program:

1. Includes a designated medical director or clinical director responsible for the UTILIZATION REVIEW process in accordance with H&S Code section 1367.01, and qualified staff responsible for the UM program.
2. Prohibits medical decisions to be influenced by fiscal and administrative management. Compensation of individuals or entities that conduct UM activities must not be structured to provide incentives to deny, limit, or discontinue MEDICALLY NECESSARY services.
3. Allows for a second opinion from a qualified health professional within the Network, if available. If a qualified health professional within the Network is not available, Contractor must authorize an Out-of-Network Provider to provide the second opinion at no cost to the MEMBER, in accordance with 42 CFR section 438.206.
4. Makes available to NETWORK PROVIDERS and MEMBERS all relevant UM policies and procedures and clinical criteria upon request.
5. Provides training to NETWORK PROVIDERS on the procedures and services that require Prior Authorization for MEDICALLY NECESSARY services and ensures that all NETWORK PROVIDERS are aware of the procedures and timeframes necessary to obtain Prior Authorization for MEDICALLY NECESSARY services.
6. Has a Standing Referral process providing a determination within three Working Days from the date the request is made by the MEMBER or the MEMBER's Primary Care Providers (PCP) and all appropriate medical records and other items of information necessary to make the determination are provided.
7. Has a specialty referral system to track and monitor referrals requiring Prior Authorization. When Prior Authorization is delegated to SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS, CHPIV ensures that SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS have systems in place to track and monitor referrals requiring Prior Authorization and must furnish documentation of SUBCONTRACTOR's and DOWNSTREAM SUBCONTRACTOR's referrals to DHCS upon request.

8. CHPIV ensures it integrates UM activities into the Quality Improvement System (QIS) specified in Exhibit A, Attachment III, Section 2.2 (Quality Improvement and Health Equity Transformation Program), including a process to integrate reports on the number and types of service requests, denials, deferrals, modifications, Appeals, and Grievances to the medical director or their designee.
9. CHPIV ensures it has timelines and processes that do not impose Quantitative Treatment Limitations (QTL) or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and substance use disorder services than are imposed on medical/surgical services, in accordance with the parity in mental health and substance use disorder requirements in 42 CFR section 438.900, et seq.

B. CHPIV maintains procedures that address the following:
1. Authorization decisions are based on the Medical Necessity of a requested health care service and are consistent with criteria or guidelines supported by sound clinical principles and evidence based.
2. Policies, processes, strategies, evidentiary standards, and other factors used for UM or UTILIZATION REVIEW are consistently applied to medical/surgical, mental health, and substance use disorder services and benefits.
3. NETWORK PROVIDERS, as well as MEMBERS and Potential MEMBERS are informed of CHPIV's process for and timeframes of all services that require Prior Authorization, concurrent authorization, or retrospective authorizations.
4. Process for consulting with PROVIDERS as needed for Prior Authorization requests for the purposes of determining Medical Necessity for medical services unless doing so would lead to undue delay in care.
5. Decision-making process to deny or to authorize an amount, duration, or scope that is less than requested must be made by a qualified health care professional with appropriate clinical expertise in treating the medical or behavioral health condition and disease or Long-Term Services and Supports (LTSS) needs.
6. Qualified health care professionals must supervise the review of decisions, including service reductions, and must review all denials that are made, in whole or in part, based on Medical Necessity.
7. Written criteria or guidelines for UTILIZATION REVIEW that are developed with practicing health care PROVIDERS. The written criteria or guidelines must be based on sound clinical practices and processes which are evaluated and updated when necessary, and at least annually, in accordance with H&S Code section 1363.5.
8. Process for providing clear and concise written explanation of the reasons for denying, deferring, or modifying a service; a description of the criteria or guidelines used; and the clinical reasons for the decision based on Medical Necessity.
9. Process for notifying MEMBERS regarding denied, deferred or modified referrals.
10. The appeals process for both PROVIDERS and MEMBERS and how it is published on CHPIV's website.

11. The timelines for decisions and appeals that are made in a timely manner ensure they are not unduly delayed when MEMBER's medical condition requires time sensitive services.
12. Prior Authorization requirements and the services they are and are not applied to. For example, Prior Authorization requirements must not be applied to Emergency Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, Human Immunodeficiency Virus (HIV) testing, or initial mental health and substance use disorder (SUD) assessments.
13. Records relating to Prior Authorization requests, including any Notices of Action (NOA), must meet the retention requirements described in Exhibit E, Section 1.22 (Inspection and Audit of Records and Facilities).
14. Process for notifying the requesting Provider of any decision to deny, approve, modify, or delay a Service Authorization Request, or when authorizing a service in an amount, duration, or scope that is less than requested.
15. Ensure that authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR section 438.900, et seq.

C. CHPIV maintains procedures that address timeliness for medical authorization that include:

1. Emergency Care: CHPIV must not require Prior Authorization for emergency care for complaints or conditions that a prudent layperson would determine could seriously jeopardize their physical or mental health.
2. Post-Stabilization: CH~~I~~PIV must respond to a Provider's request for authorization for post-stabilization services within 30 minutes or the service is deemed approved in accordance with 22 CCR section 53855(a).
3. Non-Urgent Care Following an Exam in the Emergency Room: CHPIV must respond to a Provider's request for post-stabilization services within 30 minutes or the service is deemed approved.
4. Concurrent Review of Authorization for a Treatment Regimen Already in Place: CH~~I~~PIV must respond to a concurrent authorization request within five Working Days or less, consistent with the urgency of the MEMBER's medical condition and in accordance with H&S Code section 1367.01(h)(1).
5. Retrospective Authorization Request for Treatment Received: CHPIV must accept requests for retrospective authorization requests within a reasonably established time limit, not to exceed 365 calendar days from the date of service.
6. Routine Authorizations: CHPIV must respond to routine requests as expeditiously as the MEMBER's condition requires, but no longer than five Working Days from receipt of the information reasonably necessary and requested by Contractor to render a decision, and no longer than 14 calendar days from the receipt of the request, in accordance with 42 CFR section 438.210 and H&S Code section 1367.01. CHPIV may extend this deadline up to an additional 14 calendar days only if the MEMBER or the MEMBER's provider requests an extension or if CHPIV

justifies, to DHCS upon request, a need for additional information and how the extension is in the MEMBER's interest, in accordance with 42 CFR section 438.210.

7. Expedited Authorizations: CHPIV must make expedited authorization decisions for service requests where a MEMBER's provider indicates, or CHPIV, SUBCONTRACTOR, DOWNSTREAM SUBCONTRACTOR, or NETWORK PROVIDER determines that, following the standard timeframe for Prior Authorizations could seriously jeopardize the MEMBER's life; health; or ability to attain, maintain, or regain maximum function, in accordance with 42 CFR section 438.210 and H&S Code section 1367.01. CHPIV must provide its authorization decision as expeditiously as the MEMBER's health condition requires, but no longer than 72 hours after receipt of the request for services. CHPIV may extend this deadline up to an additional 14 calendar days only if the MEMBER or the MEMBER's provider requests an extension or if CHPIV justifies, to DHCS upon request, a need for additional information and how the extension is in the MEMBER's interest, in accordance with 42 CFR section 438.210.
8. Hospice Services: CHPIV~~C~~ may only require Prior Authorization for inpatient hospice care and must respond to inpatient hospice care authorization requests in accordance with 22 CCR section 51003 and all applicable DHCS APLs.
9. Therapeutic Enteral Formula: CHPIV must comply with all timeframes for medical authorization of MEDICALLY NECESSARY therapeutic enteral formula billed on a medical or institutional claim and the equipment and supplies necessary for delivery of enteral formula billed on a medical or institutional claim, as set forth in all applicable DHCS PLs and APLs, W&I Code section 14103.6, and H&S Code section 1367.01.
10. Physician Administered Drugs: For medical authorization of MEDICALLY NECESSARY Physician administered drugs billed on a medical or institutional claim, CHPIV must comply with the same timeframes as other medical services, a~~s~~st set out in this subsection.

D. CHPIV ensures it includes in its UM program mechanisms to detect both under- and over-utilization of health care services including Behavioral Health Services.
E. CHPIV ensures it has processes in place to monitor utilization data to appropriately identify MEMBERS eligible for ECM and applicable Community Supports as specified in Exhibit A, Attachment III, Subsection 4.4.6 (MEMBER Identification for ECM) and Subsection 4.5.6 (Identifying MEMBERS for Community Supports).
F. CHPIV ensures it has processes in place to monitor and track Non-specialty Mental Health Services utilization data for both adult and pediatric MEMBERS.

III. PROCEDURE

A. CHPIV delegates the Utilization Management 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.
Downstream Subcontractor	Means an individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor.
Medically Necessary or Medically Necessity	Means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury as required under W&I Code section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.
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.
Utilization Management (UM) or Utilization Review	Means Evaluation of the Medical Necessity appropriateness, and efficiency of the use of health care services, procedures, and facilities.
Provider	Individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Network Provider	Provider or entity that has a Network Provider Agreement with Contractor, Contractor's Subcontractor, or Contractor's Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under this Contract. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement.

	Referrals	UM-002
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 ☐ NA ☒ DMHC	
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") 1369d (r)(5), 438.298(c)(4)
  - Federal Public Health Service Act Section 2719 (42 U.S.C. Sec. 300gg-19)
- **State**
  - California Health and Safety Code Sections ("H&S Code") 1363.5, 1367.01, 1373.96, 1374.16
  - Welfare and Institutions Code Sections ("W&I Code") 14182(b)(13) and (14), 14450.5
  - Title 22 California Code of Regulations Rules ("CCR") 51340, 51340.1, 51014.2, 53894
  - Title 28 CCR Rules 1300.67.2.2, 1300.70(b)(2)(H) and (c), 1300.74.16
  - 2024 DHCS Contract Exhibit A, Attachment III, Section 2.3 Utilization Management Program
  - DHCS APL 18-008: Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care

HISTORY

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

I. OVERVIEW

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

II. POLICY

A. CHPIV shall maintain a STANDING REFERRAL process that provides a determination within four Working Days from the date the request is made by the MEMBER or the MEMBER's PRIMARY CARE PROVIDERS (PCP) and all appropriate medical records and other items of information necessary to make the determination are provided.
   1. Once a determination is made, the referral must be made within four Working Days of the date that the proposed treatment plan, if any, is submitted to the medical director or the medical director's designee.

B. CHPIV shall maintain a STANDING REFERRAL process for SPECIALISTS.
   1. CHPIV shall provide a STANDING REFERRAL to a SPECIALIST if the PCP determines, in consultation with the SPECIALIST and plan medical director or designee, that an enrollee needs continuing care from a SPECIALIST.
      a. The referral shall be made pursuant to an approved treatment plan in consultation with the plan, PCP, the SPECIALIST, and the MEMBER, if a treatment plan is deemed necessary to describe the course of the care.
      b. A treatment plan may be deemed to be not necessary provided that a current STANDING REFERRAL to a SPECIALIST is approved by CHPIV or any of its SUBCONTRACTORS.
      c. The treatment plan may limit the number of visits to the SPECIALIST, limit the period that the visits are authorized, or require that the SPECIALIST provide the PCP with regular reports on the health care provided to the MEMBER.

C. CHPIV provides a MEMBER with a condition or disease that requires specialized medical care over a prolonged period and is life-threatening, degenerative, or disabling a referral to a SPECIALIST or Specialty Care Center that has expertise in treating the condition or disease.
   1. The referral shall be made if the PCP, in consultation with the SPECIALIST or Specialty Care Center if any, and plan medical director or designee determines that this specialized medical care is MEDICALLY NECESSARY for the MEMBER.
   2. The referral shall be made pursuant to a treatment plan approved by the plan in consultation with the PCP, SPECIALIST or Specialty Care Center, and MEMBER, if a treatment plan is deemed necessary to describe the course of care.
   3. A treatment plan may be deemed to be not necessary provided that the appropriate referral to a SPECIALIST or Specialty Care Center is approved by CHPIV or any of its SUBCONTRACTORS.
      a. After the referral is made, the SPECIALIST shall be authorized to provide health care services that are within the SPECIALIST's area of expertise and training to the MEMBER in the same manner as the PCP, subject to the terms of the treatment plan.

D. CHPIV shall disclose or provide the policies, procedures, and the description of the process for STANDING REFERRALS to MEMBERS, Network Providers and/or SUBCONTRACTORS.

E. CHPIV's Quality Assurance Programs shall ensure an oversight mechanism in place will detect and correct any under-service, as determined by patient-mix for an at-risk provider, including possible underutilization of specialist services and preventive health care services.
    1. CHPIV shall design and implement reasonable procedures for continuously reviewing the performance of all health care personnel, and the utilization of services and facilities, and cost. The reasonableness of the procedures and the adequacy of the implementation thereof shall be demonstrated to the DHCS.

F. When the MEMBER's condition is such that the MEMBER faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the MEMBER, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, however:
    1. Decisions shall be made in a timely fashion appropriate for the nature of the MEMBER's condition, not to exceed 72 hours or, if shorter, the period of time required, after receipt of the information reasonably necessary and requested by the plan to make the determination.
        a. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall be applicable to all health plans and other entities conducting utilization review or utilization management.

G. CHPIV shall work with an approved out-of-network provider and its contracted network and must not refer the MEMBER to another out-of-network provider without authorization from CHPIV. In such cases, CHPIV will make the referral, if MEDICALLY NECESSARY, if CHPIV does not have an appropriate provider within its network.

III. PROCEDURE

A. CHPIV delegates the Referral 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 will ensure Health Net's compliance with regulatory and contractual requirements through the following activities which are detailed in *CHPIV Policy CMP-002: Delegation Oversight Policy and Procedure*:
        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.
Medically Necessary/Medical Necessity	Means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members less than 21 years of age, a service is Medically Necessary if it meets the EPSDT standard of Medical Necessity set forth in 42 USC section 1396d(r)(5), as required by W&I Code sections 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the Member's current health condition. Contractor must determine Medical Necessity on a case-by- case basis, considering the individual needs of the child
Network Provider	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.
Primary Care Provider (PCP)	Means a Provider responsible for supervising, coordinating, and providing initial and primary care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN). For SPD Members, a PCP may also be a Specialist or clinic.
Prior Authorization	Means a formal process requiring a Provider to obtain advance approval the amount, duration, and scope of non-emergent Covered 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.
Specialist	Means a Provider who has completed advanced education and clinical training in a specific area of medicine or surgery. Specialists include, but are not limited to, those Specialists listed in W&I Code section 14197.
Standing Referral	Means a referral by a PCP to a Specialist for more than one visit to the Specialist, as indicated in the treatment plan, if any, without the Primary Care Provider having to provide a specific referral for each visit.

TERM	DEFINITION
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.

	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**	5/13/2024
Next Annual Review Due	5/13/2025	**Regulator Approval**	12/15/2023

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
5/13/2024	Policy revision to include additional CCR 1300.51 & 1300.70 provisions

I. OVERVIEW

A. 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.

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.
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.

B. CHPIV will ensure that a QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM (QIHETP) is implemented, 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 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.

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.

E. CHPIV will ensure 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.
   5. Health Plans are required to attend (in-person) quarterly regional collaborative meetings facilitated by DHCS Nurse Consultants.

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F. CHPIV will ensure the development of 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.

G. CHPIV will ensure that a QIHETP is implemented, maintained, periodically updated, and includes, 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. Health Plans are required develop quality and health equity teams and designated contracts to lead the quality and health equity efforts across the MCP organization:
      a. Regional Quality and Health Equity Team to support the QI and health equity work.
      b. Performance Improvement Lead to report performance measurements to DHCS.

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~~3.~~5. A process for sharing QIHETP findings with SUBCONTRACTORS, DOWNSTREAM SUBCONTRACTORS, and NETWORK PROVIDERS;
~~4.~~6. The role, structure, and function of the QIHEC;
~~5.~~7. 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;
~~6.~~8. 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).
~~7.~~9. 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;
~~8.~~10. 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.
~~9.~~11. 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]);
~~10.~~12. 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);
~~11.~~13. 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.;

~~12.~~14. CHPIV ensures mechanisms to detect both over- and under-utilization of services including, but not limited to, outpatient prescription drugs;

~~13.~~15. 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;

~~14.~~16. 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

~~15.~~17. 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.

~~16.~~18. 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.

H. CHPIV will ensure the 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. Monitor and report quality performance measures through Managed Care Accountability Set (MCAS) measure requirements.

~~2.~~3. An analysis of actions taken to address any CHPIV-specific recommendations in the annual External Quality Review (EQR) technical report and evaluation reports;

~~3.~~4. 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.~~5. Planned equity-focused interventions to address identified patterns of over- or under-utilization of physical and BEHAVIORAL HEALTH CARE SERVICES;

~~5.~~6. 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;

7. PHM activities and findings;

8. MCPs/SHPs are required to conduct or participate in two Performance Improvement Projects (PIPs) per year as required by CMS.

~~6.~~9. Outcomes/findings from ~~Performance Improvement Projects (PIPs),~~ consumer satisfaction surveys and collaborative initiatives.

I. C~~P~~HPIV'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.

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 with CHPIV's Chief HEALTH EQUITY Officer;
   2. Describe activities supervised by CHPIV's 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.

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.
Managed Care Accountability Sets (MCAS)	The Managed Care Accountability Sets (MCAS), previously known as the External Accountability Set (EAS), is a set of performances measures that DHCS selects for annual reporting by Medi-Cal managed care health plans (MCPs)
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.

	Grievances Process	GA-001
Department	Health Services	
Functional Area	Grievances & Appeals	
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	Gordon Arakawa, MD	☐ DHCS ☐ NA ☒ DMHC	
Title	Chief Medical Officer		

ATTACHMENTS

NA

AUTHORITIES/REFERENCES

- **Internal**
  - CHPIV, Delegation Oversight Policy and Procedure, CMP-002
- **Federal**
  - 42 CFR Sections 438.3, 438.400, 438.402, 438.406, 438.408, 438.410, 438.416, 438.420, 438.424, 18446
- **State**
  - California Health and Safety Code Sections ("H&S Code") 1367.01, 1367.042, 1368, 1368.01, 1368.015, 1368.016, 1368.02, 1368.2, 1370.2, 1374.31, 1374.34
  - California Welfare and Institutions Code Sections ("W&I Code") 10950
  - Title 22 California Code of Regulations Rules ("CCR") 51014.1, 51014.2, 53858
  - Title 28 CCR Rules 1300.68, 1300.68.01, 1300.74.30
  - DMHC All Plan Letter ("APL") 22-021
  - 2024 DHCS Contract Exhibit A, Attachment III, 4.6 Member Grievance and Appeal System
  - DHCS APLs 21-011, 21-004, 20-022, 20-020, 20-015
- **Accreditation**
  - NCQA: Member Experience (ME) 7, Element A and Elements C-F

HISTORY

Revision Date	Description of Revision
6/12/2023	Policy creation
7/10/2023	Added the requirements related to expedited grievances

I. OVERVIEW

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

II. POLICY

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

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

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

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

E. CHPIV ensures prompt review and investigation of MEMBER GRIEVANCES are conducted by the appropriate department and/or staff delegated the responsibility to handle CHPIV's internal GRIEVANCE operations.
F. CHPIV ensures that every GRIEVANCE submitted by a MEMBER, or a provider or AUTHORIZED REPRESENTATIVE acting on behalf of a MEMBER and with the MEMBER's written consent, is reported to an appropriate level within its network (i.e., quality of care versus quality of service).
G. CHPIV ensures the immediate referral of all medical quality of care issues to a Medical Director or Designee for review.
H. CHPIV ensures MEMBERS, MEMBER's AUTHORIZED REPRESENTATIVES, or providers are not discriminated or retaliated against on grounds that he or she filed a GRIEVANCE as required by federal and State nondiscrimination law.
I. CHPIV ensures GRIEVANCES alleging discrimination are forwarded to the Department of Health Care Services (DHCS) Office of Civil Rights (OCR).
J. CHPIV GRIEVANCES processed for pharmacy services rendered or requested before implementation of Medi-Cal Rx.
K. CHPIV ensures the maintenance and availability for DHCS review, GRIEVANCE logs, including GRIEVANCE logs delineated by Subcontractor and Downstream Subcontractor. The record of each GRIEVANCE must contain, at a minimum, all the following information and must be accurately maintained in a manner accessible to the state and available upon request to CMS:
    1. A general description of the reason for the GRIEVANCE.
    2. The date received
    3. The date of each review or, if applicable, review meeting.
    4. A description of the action taken by the plan or provider to investigate and resolve the GRIEVANCE.
    5. RESOLUTION at each level of the GRIEVANCE, if applicable.
    6. The name of the plan provider or staff person responsible for resolving the GRIEVANCE
    7. Date of RESOLUTION at each level, if applicable.
    8. Name of the covered person for whom the GRIEVANCE was filed.

III. PROCEDURE

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

IV. DEFINITIONS

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

TERM	DEFINITION
Member	A beneficiary enrolled in a CHPIV program.
Adverse Benefit Determination ("ABD")	Means any of the following actions taken by Contractor: • The denial or limited authorization of a requested service, including determinations based on the type or level of a Covered Service, Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; • The reduction, suspension, or termination of a previously authorized Covered Service; • The denial, in whole or in part, of payment for a Covered Service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of Clean Claim is not an Adverse Benefit Determination; • The failure to provide Covered Services in a timely manner; • The failure to act within the required timeframes for standard resolution of Grievances and Appeals; • The denial of the Member's request to obtain services out of Network when a Member is in an area with only one Medi-Cal managed care health plan; or • The denial of a Member's request to dispute financial liability.
Authorized Representative	Means any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews, and in any other capacity, as specified by the Member or Potential Member.
Grievance	Means an oral or written expression of dissatisfaction about any matter other than an ABD, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or Contractor's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by Contractor to make an authorization decision.
Inquiry	An inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other

TERM	DEFINITION
	CHPIV processes
Resolution	Means that the Grievance has reached a conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the grievance system, including entities with delegated authority.
State Fair Hearing (SFH)	Means a hearing with a State Administrative Law Judge to resolve a member's dispute about an action taken by Contractor, its Network Providers, Subcontractors, or Downstream Subcontractors.

	Appeals Process	GA-002
Department	Health Services	
Functional Area	Grievances & Appeals	
Impacted Delegate	☒ Subcontractor ☐ NA	

DATES			
Policy Effective Date	6/12/2023	**Reviewed/Revised Date**	5/1/2024
Next Annual Review Due	5/1/2025	**Regulatory Approval**	

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

ATTACHMENTS
NA

AUTHORITIES/REFERENCES

- **Internal**
  - CHPIV, Delegation Oversight Policy and Procedure, CMP-002
- **Federal**
  - 42 CFR Sections 438.3, 438.400, 438.402, 438.406, 438.408, 438.410, 438.416, 438.420, 438.424, 18446
- **State**
  - California Health and Safety Code Sections ("H&S Code") 1367.01, 1367.042, 1368, 1368.015, 1368.016, 1368.02, 1368.2, 1370.2, 1374.31, 1374.34
  - California Welfare and Institutions Code Sections ("W&I Code") 10950
  - Title 22 California Code of Regulations Rules ("CCR") 51014.1, 51014.2, 53858
  - Title 28 CCR Rules 1300.68, 1300.68.01, 1300.74.30
  - 2024 DHCS Contract Exhibit A, Attachment III, 4.6 Member Grievance and Appeal System
  - DHCS All Plan Letters ("APL") 22-002, 21-011, 21-004, 20-020
- **Accreditation**
  - NCQA: Utilization Management (UM) 8, Element A, UM 9, Elements A-D, Member Experience (ME) 7, Element B, ME 7, Elements C-F

HISTORY

Revision Date	Description of Revision
6/12/2023	Policy creation
7/10/2023	Revised requirement around IMRs

	Added requirement HSC 1368.01(b) to immediately notify members of their right to notify DMHC of the appeal

I. OVERVIEW

A. This policy addresses Community Health Plan of Imperial Valley's ("CHPIV" or the "Plan") APPEALS requirements, policies, and procedures. The purpose of this policy is to establish an APPEAL Process pursuant to applicable statutory, regulatory, and contractual requirements.

II. POLICY

A. Standard APPEALS
   1. Pursuant to 42 CFR sections 438.228 and 438.400 - 424, CHPIV has an APPEAL process as required below to attempt to resolve MEMBER APPEALS before the MEMBER requests a STATE FAIR HEARING or an IMR. CHPIV may have only one level of APPEAL for MEMBERS. Upon a MEMBER's request, CHPIV must assist any MEMBER in preparing their APPEAL which includes assisting the MEMBER with navigating CHPIV's website, providing all documents that were relied on for its decision and providing the APPEAL form to the MEMBER.
   2. Following the receipt of a NOA, a MEMBER has 60 calendar days from the date on the NOA to file a request for an APPEAL either orally or in writing. The MEMBER, or a Provider or AUTHORIZED REPRESENTATIVE acting on behalf of the MEMBER and with the MEMBER's written consent, may request an APPEAL. Unless the MEMBER is requesting an expedited APPEAL, the date of the MEMBER's oral or written request for an APPEAL establishes the filing date for the APPEAL. The contractor must resolve the APPEAL within 30 calendar days of the MEMBER's oral or written request for an APPEAL.
   3. If CHPIV fails to send a written NOA within 30 calendar days or fails to comply with notice and language translation requirements in 42 CFR sections 438.10, 438.404, 438.408, W&I Code section 14029.91, 22 CCR section 53876 and Exhibit A, Attachment III, Section 5.1.3 (MEMBER Information), the MEMBER is deemed to have exhausted the internal APPEAL process and may request a STATE FAIR HEARING pursuant to 42 CFR section 438.402(c)(1)(i)(A). Deemed Exhaustion means the MEMBER has effectively exhausted Contractor's internal APPEAL because Contractor failed to timely resolve the APPEAL.
   4. CHPIV ensures the NOA informing the MEMBER of its NAR at a minimum, must indicate whether the decision on the APPEAL is upheld and the date of the decision on the APPEAL. For decisions not wholly in the MEMBER's favor, the NAR at a minimum, must include:
      a. MEMBER's right to request a STATE FAIR ~~HEARING;~~HEARING.
      b. How to request a STATE FAIR ~~HEARING;~~HEARING.
      c. That the MEMBER has a right to continuation of benefits during the STATE FAIR HEARING, and that Contractor is obligated to continue benefits as long as the requirements of 42 CFR section 438.420 are ~~met;~~met.

d. The right to request an IMR or a review of the decision by DMHC, if the MEMBER has not presented the disputed health care services for resolution by the Medi-Cal fair hearing process.
e. The IMR is not required for final STATE FAIR HEARING decision; and
f. The DHCS-approved "Your Rights" Attachment.

5. The timeframe to resolve an APPEAL may be extended by up to 14 calendar days if the MEMBER requests an extension or Contractor shows that there is a need for additional information. The contractor must maintain documentation to demonstrate to DHCS why the delay is in the MEMBER's interest. If the timeframe extension has not been requested by the MEMBER, CHPIV ensures the following:
   a. Make reasonable efforts to give the MEMBER prompt oral notice of the ~~delay;~~delay.
   b. Give the MEMBER a written notice of the reason to extend the timeframe within two calendar days, including information on the right to file an additional GRIEVANCE for the delay; and
   c. Resolve the APPEAL as expeditiously as the MEMBER's health condition requires and no later than the date the extension expires.
6. If the decision is reversed during the APPEAL, it must authorize or provide the disputed services promptly, and as expeditiously as the MEMBER's health condition requires, but no later than 72 hours from the date it reverses the ~~action, if~~action if the disputed services were not provided during the APPEAL.
7. CHPIV must pay for disputed services if the MEMBER received the disputed services while the APPEAL was pending.
8. The MEMBER must be given the opportunity before and during their APPEAL process to examine their case file. CHPIV ensures provision of, sufficiently in advance of the resolution timeframe and free of charge, the MEMBER's case file, including medical records, clinical criteria, guidelines and all documents and records relied on during the APPEAL process for its decision. CHPIV must assist any MEMBER who requires assistance preparing their APPEAL.

B. Expediated APPEALS
1. CHPIV ensures implementation and maintenance of a process resolve expedited APPEALS as described below. CHPIV ensures the expedited APPEAL process is followed when it determines or the requesting Provider indicates that taking the time for a standard resolution could seriously jeopardize the MEMBER's life, physical or mental health, or ability to attain, maintain, or regain maximum function.
2. A MEMBER, or a Provider or an AUTHORIZED REPRESENTATIVE, and with the MEMBER's written consent, may file an expedited APPEAL either orally or in writing. No additional follow-up from the MEMBER is required. CHPIV ensures that punitive action is not taken against a Provider who requests an expedited resolution or supports a MEMBER's APPEAL.
3. CHPIV must inform the MEMBER of the limited time available for the MEMBER to present evidence and allegations of fact or law, in person, by phone or in writing, sufficiently in advance of the resolution timeframe.

4. CHPIV ensures that the Member, or a provider or AUTHORIZED REPRESENTATIVES are immediately notified of their right to notify DMHC of the APPEAL.

~~3.~~5. CHPIV must provide a MEMBER notice, as quickly as the MEMBER's health condition requires, but no later than 72 hours from the day Contractor receives the request for an expedited APPEAL.

~~4.~~6. CHPIV may extend the timeframe to resolve an expedited APPEAL by up to 14 calendar days if the MEMBER requests an extension or if there is a need for additional information and how the delay is in the MEMBER's interest. If the extension was not requested by the MEMBER, CHPIV ensures reasonable efforts are made to give the MEMBER prompt oral notice of the delay, and within two calendar days provide the MEMBER with written notice that includes the reason the extension is needed. The notice must include information on the right to file a GRIEVANCE if the MEMBER disagrees that the extension is appropriate. CHPIV ensures that the APPEAL is resolved as expeditiously as the MEMBER's health condition requires and no later than the date the extension expires. CHPIV ensures documentation is maintained to demonstrate to the Department why the extension is necessary.

~~5.~~7. CHPIV ensures reasonable efforts are made to provide oral notice of an expedited APPEAL decision.

~~6.~~8. If a request for an expedited resolution of an APPEAL is denied, the request for an APPEAL must be processed in accordance with the standard APPEAL process timeframes for resolutions and extensions as required in Exhibit A, Attachment III, Subsection 4.6.4 (APPEAL Process).

~~7.~~9. A MEMBER, or a Provider or AUTHORIZED REPRESENTATIVE acting on behalf of the MEMBER, and with the MEMBER's written consent, has the right to file an APPEAL in the timeframes set forth in this Policy.

~~8.~~10. CHPIV ensures the APPEAL Process addresses the receipt, handling, and disposition of a MEMBER's APPEAL, in accordance with applicable statutory, regulatory, and contractual requirements.

~~9.~~11. CHPIV ensures assistance is provided to MEMBERS requiring assistance with filing an APPEAL, including, but not limited to, a MEMBER with limited English proficiency (LEP), disabilities, or cultural needs.

~~10.~~12. CHPIV ensures prompt review and investigation of an APPEAL.

~~11.~~13. CHPIV ensures referral of all APPEALS related to medical quality of care issues to the Quality Improvement (QI) Department for review by the Chief Medical Officer (CMO) or their Designee and any action deemed necessary under the quality review process.

~~12.~~14. CHPIV ensures MEMBERS are informed during the APPEAL Process of his or her right to request a State Hearing after the internal APPEAL Process has been exhausted or should have been exhausted, and of his or her right to Aid Paid Pending (i.e., continuation of benefits).

~~13.~~15. Continuation of Benefits Pending an APPEAL (i.e., Aid Paid Pending)

a. CHPIV ensures MEMBERS are advised and assisted with the provision of Aid Paid Pending, regardless of whether the MEMBER makes a separate request during the APPEAL process, if all of the following conditions are met:

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i. The MEMBER filed their APPEAL within the required timeframes for Aid Paid Pending (within ten (10) calendar days of when the Notice of ADVERSE BENEFIT DETERMINATION (ABD)/Notice of Action (NOA) was sent or before the intended effective date of the proposed action, whichever is later).
ii. The APPEAL involves the termination, suspension, or reduction of previously authorized Covered Services.
iii. The Covered Services were ordered by an authorized Provider; and
iv. The period covered by the original authorization has not expired.

b. A MEMBER shall continue to receive Aid Paid Pending while an APPEAL is pending until one (1) of the following occurs:
i. MEMBER withdraws the APPEAL.
ii. GRIEVANCE and APPEALS Resolution Services (GARS) issues an APPEAL decision adverse to the MEMBER; or
iii. The time period or service limits of a previously authorized service has been met.

~~14.~~16. CHPIV ensures payment for disputed Covered Services if the MEMBER received the disputed Covered Services while the APPEAL was pending.

~~15.~~17. CHPIV ensures that neither CHPIV, nor any of its Health Networks, Practitioners, or other Providers shall discriminate against a MEMBER, or a Provider or MEMBER's AUTHORIZED REPRESENTATIVE on the grounds that he or she filed an APPEAL.

~~16.~~18. A NABD/ NOA sent notifying a Provider or a MEMBER of a decision to delay, deny, modify, or recommend an alternative option to a requested service, shall inform a MEMBER of their right to file an APPEAL within sixty (60) calendar days of the date of the NABD/NOA.

~~17.~~19. CHPIV ensures communication of any changes to its GRIEVANCES and APPEALS Policies and Procedures to its Providers, Subcontractors and Downstream Subcontractors.

~~18.~~20. A Provider may request an APPEAL on his or her own behalf within sixty (60) calendar days after receipt of the denial for authorization or payment for services already received by the MEMBER.

~~19.~~21. A Provider, with the CHPIV MEMBER's written consent, may request an APPEAL on behalf of the MEMBER, for services rendered to that CHPIV MEMBER, by submitting a written request to CHPIV within sixty (60) calendar days from the date of the NABD/NOA, in accordance with the provisions of this Policy.

~~20.~~22. CHPIV ensures a MEMBER, or a Provider or AUTHORIZED REPRESENTATIVE acting on behalf of the MEMBER and with the MEMBER's written consent, are given a reasonable opportunity to present, in writing or in person, before the individual(s) resolving the APPEAL, evidence, testimony, facts, and law in support of the APPEAL.

~~21.~~23. CHPIV ensures MEMBERS, or a Provider or AUTHORIZED REPRESENTATIVE, acting on behalf of the MEMBER and with the MEMBER's written consent, are informed of the limited time available to present evidence sufficiently in advance of the resolution timeframes, including for expedited APPEALS.

~~22.~~24. CHPIV ensures the provision of culturally and linguistically appropriate notices of the APPEALS process to MEMBERS, including but not be limited to, Acknowledgement Letters and Notices of APPEAL Resolution.

a. CHPIV ensures assistance is provided to MEMBERS or a MEMBER's AUTHORIZED REPRESENTATIVE, with disabilities, limited English proficiency, vision disorders, or other communicative impairments, when completing APPEAL forms and other

procedural steps, including but not limited to, providing all documents relied on for the decision to the MEMBER, in addition to the following services:

i. Alternative formats (as set forth in All Plan Letter (APL) 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, And Language Assistance Services);
ii. Providing Auxiliary Aids and services upon request, such as interpreter services and a toll-free number with TTY/TDD and interpreter capability; and
iii. Assistance in the APPEAL Process, or to provide translation of APPEAL correspondence.

~~23.~~25. A MEMBER may be represented by anyone they choose during the APPEAL Process, including a legal representative.

~~24.~~26. The MEMBER has the right to request an APPEAL in the event a ABD/NOA is not issued within the required time frame, which shall be considered a denial and therefore constitutes an ADVERSE BENEFIT DETERMINATION.

~~25.~~27. CHPIV ensures the provision, upon request by the MEMBER, or a Provider or AUTHORIZED REPRESENTATIVE acting on behalf of the MEMBER and with the MEMBER's written consent, before and during the APPEALS Process, the opportunity to examine and/or obtain a copy of the MEMBER's case file, including Medical Records, and any other relevant documents and records considered during the APPEALS Process. CHPIV ensures the provision of records at no cost.

~~26.~~28. CHPIV ensures that the person reviewing the APPEAL was not involved in the initial determination and he or she is not the subordinate of any person involved in the initial determination.

~~27.~~29. CHPIV ensures that for APPEALS, the person making the final decision for the proposed resolution of an APPEAL has not participated in any prior decisions related to the APPEAL and is of the same or similar specialty, has clinical expertise in treating the MEMBER's condition or disease, and is able to treat complications that may result from the service or procedure, if deciding on any of the following:

a. An APPEAL of a denial based on lack of Medical Necessity or experimental/clinical investigation; and
b. Any APPEAL involving clinical issues.

~~28.~~30. Upon notice of the decision to deny an authorization request, a MEMBER, or a Provider or AUTHORIZED REPRESENTATIVE acting on behalf of the MEMBER, and with the MEMBER's written consent, may request an expedited APPEAL, when it is determined or the requesting Provider indicates that taking the time for a standard resolution could seriously jeopardize the MEMBER's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

~~29.~~31. All medical APPEALS are referred to the Chief Medical Officer (CMO) or to his or her Designee who has the authority to require CORRECTIVE ACTION and did not make the initial utilization management decision.

~~30.~~32. CHPIV ensures the provision of GRIEVANCE and APPEAL system requirements to subcontractors at the time they enter into a subcontract, on an annual basis, and when the relevant GRIEVANCE and APPEALS policies and procedures are updated.

~~31.~~33. CHPIV ensures language assistance is provided to MEMBERS, by plan staff or language line interpreter services, for Threshold Languages to register and resolve APPEALS.

~~32.~~34. In addition to any rights set forth in this Policy, a MEMBER or a MEMBER's AUTHORIZED REPRESENTATIVE shall also have the right to:
   a. Request a standard or expedited State Hearing with the Department of Social Services (DSS).
   b. CHPIV ensures MEMBERS are informed of such State Hearing rights annually, and in every Notice of APPEAL Resolution (NAR) letter.

~~33.~~35. If adequate notice is not provided to a MEMBER with a visual impairment or other disabilities requiring the provision of written materials in alternative formats, within applicable federal or state timeframes, then the MEMBER is deemed to have exhausted the internal APPEAL process and may immediately request a State Hearing.

~~34.~~36. CHPIV ensures APPEALS processes for pharmacy services rendered or requested before implementation of Medi-Cal Rx.

~~35.~~37. CHPIV ensures the maintenance of records of GRIEVANCES and APPEALS and must have policies and procedures in place governing the review of the information as part of its ongoing Quality Improvement System. CHPIV ensures the identification of systemic patterns of wrongful denials and impose CORRECTIVE ACTION as necessary. The records must be accurately maintained in a manner accessible to the State and available to CMS upon request. Records must include all required information set forth in 42 CFR section 438.416. ~~Contractor~~Contractors must ensure that all documents and records, whether in a written or electronic format generated or obtained are retained for at least 10 years pursuant to 42 CFR section 438.3(u).

III. PROCEDURE

A. CHPIV delegates the APPEAL 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
Adverse Benefit Determination ("ABD")	Means any of the following actions taken by Contractor: • The denial or limited authorization of a requested service, including determinations based on the type or level of a Covered Service, Medical Necessity,

TERM	DEFINITION
	appropriateness, setting, or effectiveness of a Covered ~~Service;~~Service. • The reduction, suspension, or termination of a previously authorized Covered Service. • The denial, in whole or in part, of payment for a Covered Service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of Clean Claim is not an Adverse Benefit Determination. • The failure to provide Covered Services in a timely manner. • The failure to act within the required timeframes for standard resolution of Grievances and Appeals. • The denial of the Member's request to obtain services out of Network when a Member is in an area with only one Medi-Cal managed care health plan; or • The denial of a Member's request to dispute financial liability.
Member	A beneficiary enrolled in a CHPIV program.
Appeal	Means a review by a Contractor of an ABD, which includes one of the following actions: • A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered ~~Service;~~Service. • A reduction, suspension, or termination of a previously authorized ~~service;~~service. • The denial, in whole or in part, of payment for a Covered Service, except payment denials based solely because the claim does not meet the definition of a Clean ~~Claim;~~Claim. • Failure to provide services in a timely manner; or • Failure to act within the timeframes provided in 42 CFR section 438.408(b).
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.

TERM	DEFINITION
Corrective Action	Means specific identifiable activities or undertakings of Contractor which address Contract deficiencies or noncompliance.
Grievance	Means an oral or written expression of dissatisfaction about any matter other than an ABD, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or Contractor's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by Contractor to make an authorization decision.
State Fair Hearing (SFH)	Means a hearing with a State Administrative Law Judge to resolve a member's dispute about an action taken by Contractor, its Network Providers, Subcontractors, or Downstream Subcontractors.

	Independent Medical Review (IMR)	GA-003
Department	Health Services	
Functional Area	Grievances & Appeals	
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 ☐ NA ☒ DMHC	
Title	Chief Medical Officer		

ATTACHMENTS

NA

AUTHORITIES/REFERENCES

- **Internal**
  - CHPIV, Delegation Oversight Policy and Procedure, CMP-002
- **Federal**
  - 45 Code of Federal Regulations ("CFR") Section 147.136,
  - 42 Code of Federal Regulations ("CFR") Section 438.420
- **State**
  - DHCS :2024 DHCS Contract Exhibit A, Attachment III Section 4.6.6
  - DMHC: DMHC All Plan Letter ("APL") 22-021
- **Accreditation**
  - NCQA: Utilization Management (UM) 4, Element F, UM 8, Element A

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") INDEPENDENT MEDICAL REVIEW (IMR) requirements, policies, and procedures. The purpose of this policy is to establish a comprehensive IMR process.

II. POLICY

A. CHPIV informs MEMBERS of the right to request an IMR of an action resulting in a MEMBER request for an Appeal, or the outcome of an Appeal.
B. An IMR must be requested by the MEMBER, Provider or AUTHORIZED REPRESENTATIVE, and with written authorization from the MEMBER, to act on the MEMBER's behalf. CHPIV will not require a MEMBER to request an IMR before, or use one as a deterrent to, requesting a State Fair Hearing.
C. CHPIV's IMRs must be conducted by the California DEPARTMENT OF MANAGED HEALTHCARE (DMHC) independently from either the MEMBER or CHPIV, and at no cost to the MEMBER.
D. CHPIV's IMRs do not extend any of the time frames stated in the 2024 DHCS Contract for Appeals, and do not disrupt the continuation of Covered Services per 42 CFR section 438.420.
E. CHPIV handles IMR requests and responds by the required timeframe indicated by the state.
F. CHPIV validates if an appeal was already addressed. If so, CHPIV will complete the Request for Health Plan Information (RHPI) form to submit back to the regulator.
G. Once the DMHC reviews and qualifies for IMR, CHPIV submits to MAXIMUS for review. CHPIV will receive the MAXIMUS outcome and work to ensure any required action occurs.

III. PROCEDURE

A. CHPIV delegates the IMR 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.
Authorized Representative	Means any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews, and in any other capacity, as specified by the Member or Potential Member.
Department of Managed Health Care (DMHC)	Means the California department responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.
Independent Medical Review (IMR)	Means a review of Contractor's denial of a member's request for health care service as not Medically Necessary, experimental, or investigational by an independent Physician(s) who is contracted with DMHC. The IMR decision is binding on Contractor but not the Member who may still request a State Fair Hearing after an IMR pursuant to H&S Code section 1374.30 and 28 CCR section 1300.74.30.
Maximus	The state of California's Independent Medical Review (IMR) organization.

	Public Policy Committee	CPR-001
Department	Executive Services	
Functional Area	Community & Public Relations	
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	Lawrence Lewis	☐ DHCS ☐ NA ☒ DMHC	
Title	Chief Executive Officer		

ATTACHMENTS

NA

AUTHORITIES/REFERENCES

- **Internal**
  - CHPIV, Delegation Oversight Policy and Procedure, CMP-002
- **State**
  - California Health and Safety Code Section ("H&S Code") 1369
  - Title 28 California Code of Regulations Rules ("CCR") Section 1300.69
  - Title 22 California Code of Regulations Rules ("CCR") Section 53876(c)
  - DHCS: DHCS 2024 Contract Exhibit A Attachment III Section 5.2.11

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") Public Policy Committee ("PPC") requirements, policy, and procedures.

II. POLICY

A. CHPIV provides PPC in compliance with all Legal Authority including but not limited to the following obligations:
   1. Establishment of policies and procedures describing the representation and participation of Medi-Cal Members on CHPIV's public policy advisory committee and
   2. Identification of the composition and meeting frequency of any committee participating in establishing CHPIV's public policy including the percent of patient/Member consumers, a description of CHPIV's Commission, including the percent of patient/Member consumers, the frequency of the committee's report submission to the Commission, and the Commission's process for handling reports and recommendations after receipt.

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

B. The following outlines the process for how CHPIV will organize its PPC:
   1. CHPIV ensures a diverse membership on the PPC that is reflective of the CHPIV 's services area(s) and includes adolescents and/or parents/caregivers of Members under 21 years of age, by publicizing the opportunity to serve widely in the county through community meetings, the plan website, local publications.
   2. CHPIV will support Member participation in the PPC by promoting the opportunity through the plan website and community forums.
   3. CHPIV ensures involvement of the PPC in appropriate policies and decision-making by bringing issues relating to quality, health equity, disparities, and health outcomes to the PPC for input.
   4. CHPIV will actively facilitate communication and connection between the PPC and CHPIV leadership by having plan leaders at the executive level.
   5. CHPIV ensures that one Member of the PPC participates in the DHCS Statewide Consumer Advisory Committee and how CHPIV will support Member's attendance and participation in that Committee.

C. CHPIV will have a diverse PPC pursuant to 22 CCR section 53876(c), comprised primarily of Members, as part of the CHPIV 's implementation and maintenance of Member and

community engagement with stakeholders, community advocates, traditional and Safety-Net Providers, and Members.

1. CHPIV will convene a PPC selection committee tasked with selecting the members of the PPC.
2. CHPIV will demonstrate a good faith effort to ensure that the PPC selection committee is comprised of a representative sample of each of the persons below to bring different perspectives, ideas, and views to the PPC:
    a. Persons who sit on CHPIV 's Commission, which should include representation in the following areas: Safety Net Providers including FQHCs, behavioral health, regional centers, local education authorities, dental Providers, IHS Facilities, and home and community-based service Providers; and
    b. Persons and community-based organizations who are representatives of each county within CHPIV 's Service Area adjusting for changes in membership diversity.
3. The Selection Committee ensures the PPC membership reflects the general Medi-Cal Member population in CHPIV 's Service Area, including representatives from IHS Providers, and adolescents and/or parents and/or caregivers of children, including foster youth, as appropriate and be modified as the population changes to ensure that CHPIV 's community is represented and engaged.
4. The selection committee will make good faith efforts to include representatives from diverse and hard-to-reach populations on the PPC, with a specific emphasis on persons who are representative of or serving populations that experience Health Disparities such as individuals with diverse racial and ethnic backgrounds, genders, gender identity, and sexual orientation and physical disabilities.
5. CHPIV 's selection committee will select all of its PPC members promptly no later than 180 calendar days from the effective date of this contract.
6. Should a PPC member resign, is asked to resign, or is otherwise unable to serve on the PPC, CHPIV will make its best effort to promptly replace the vacant seat within 60 calendar days of the PPC vacancy.
7. CHPIV will designate a coordinator and maintain a written job description detailing the PPC coordinator's responsibilities, which will include having responsibility for managing the operations of the PPC in compliance with all statutory, rule, and contract requirements, including, but not limited to:
    a. Ensuring committee meetings are scheduled and committee agendas are developed with the input of PPC members.
    b. Maintaining committee membership, including outreach, recruitment, and onboarding of new members, that is adequate to carry out the duties of the PPC
    c. Actively facilitating communications and connections between the PPC and CHPIV leadership, including ensuring PPC members are informed of CHPIV decisions relevant to the work of the PPC
    d. Ensuring that PPC meetings, including necessary facilities, materials, and other components, are accessible to all participants and that appropriate accommodations are provided to allow all attending the meeting, including, but not limited to, accessibility for individuals with a disability or LEP Members to effectively communicate and participate in PPC meetings;
    e. Ensuring compliance with all PPC reporting and public posting requirements; and vi. The PPC coordinator may be an employee of CHPIV or a downstream subcontractor

f. CHPIV will appoint one member of the PPC , selected by the PPC , or another CHPIV member designated by the PPC , to serve as the CHPIV 's representative to DHCS' Statewide Consumer Advisory Committee and consistent with Exhibit A, Attachment III, Subsection 5.2.11.D (Community Engagement).

8. CHPIV is responsible to compensate the PPC member representative for their time and participation on DHCS' Statewide Consumer Advisory Committee, including transportation expenses to appear in person.
9. PPC Meetings:
    a. CHPIV will hold its first regular PPC meeting promptly after all initial PPC members have been selected by the PPC selection committee and quarterly thereafter.
    b. CHPIV will make the regularly scheduled PPC meetings open to the public, posting meeting information publicly on CHPIV 's website in a centralized location 30 calendar days prior to the meeting, and in no event later than 72 hours prior to the meeting.
    c. CHPIV will provide a location for PPC meetings and all necessary tools and materials to run meetings, including, but not limited to, making the meeting accessible to all participants and providing accommodations to allow all individuals to attend and participate in the meetings.
    d. PPC will draft written minutes of each of its meetings and the associated discussions. All minutes will be posted on CHPIV 's website and submitted to DHCS no later than 45 calendar days after each meeting.
    e. CHPIV will retain the minutes for no less than 10 years and provided to DHCS, upon request

IV. DEFINITIONS

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

TERM	DEFINITION
Federally Qualified Health Center (FQHC)	Means an entity defined in 42 USC section 1396d(l)(2).
Oversight	Continual performance evaluation through auditing and monitoring consistent with CHPIV policy and contractual obligations.
Member	A beneficiary enrolled in a CHPIV program.
Department of Health Care Services (DHCS)	The State agency responsible for administration of the federal Medicaid (referred to as Medi-Cal in California) Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP) and other health related programs.

	After-Hours Communication	HR-004
Department	Human Resources	
Functional Area	Human Resources	
Impacted Delegate	☐ Subcontractor ☒ NA	

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

APPROVALS		
Internal		**Regulator**
Name	Michelle Stephanie Ortiz-Trujillo	☐ DHCS ☒ NA ☐ DMHC
Title	Senior Director of Human Resources & Community Relations	

ATTACHMENTS
NA

AUTHORITIES/REFERENCES
NA

HISTORY	
Revision Date	**Description of Revision**

I. OVERVIEW

A. The purpose of this policy is to promote work-life balance and respect employees' personal time by establishing guidelines for after-hours communication.
B. While we encourage flexible practices, it is essential to recognize that certain situations may require contacting employees outside of regular working hours.
C. Examples of business-critical or time-sensitive situations include security breaches, equipment breakdowns affecting operations, health and safety emergencies, and cybersecurity threats
D. This policy will protect all employees under management. Management will be able to work after-hours on a case by case basis, under emergency situations.

II. POLICY

A. Expectation
1. Reasonable expectation: We expect work -related communication after hours to be reasonable and necessary
2. Supervisors' Responsibility: Supervisors should be mindful when communicating with employees after stipulated working hours, regardless of the platform (phone calls, SMS, messaging apps).
3. Employee Leave: Employees on leave should not be contacted unless it is urgent, and no other options exist. Which should be extremely rare.

B. Guidelines for Communication
1. Urgent Matters: Only urgent matters warrant after-hours communication.
2. Respect Personal Time: Employees are entitled to uninterrupted personal time outside of work hours.
3. Setting Boundaries: Employees should set clear boundaries and communicate their availability to colleagues and supervisors.
4. Emergency Contacts: Maintain an emergency contact list for critical situations. This includes Larry Lewis (CEO) and Dr. Gordon Arakawa (CMO)

C. Human Resources Director's Responsibility
1. Education: HR managers should educate employees about this policy during onboarding.
2. Enforcement: Monitor compliance and address any violations promptly.
3. Feedback: Encourage feedback from employees regarding the effectiveness of the policy.

D. Pilot Period -Implementation
1. We will implement this policy on a trial basis for three months.
2. Gather feedback from employees and supervisors during this period.
3. Adjust the policy as needed based on feedback

III. PROCEDURE

A. Working Hours
1. All personnel are mandated to confine work-related requests to the designated business hours, specifically from 8:00 AM to 5:00 PM.

B. Reporting Violations

1. In the event of a perceived policy violation, the concerned employee is required to submit a formal report to the Human Resources (HR) department via email. This report should encompass:
    a. Incident Specifics: A comprehensive account of the incident, detailing the date, time, and nature of the perceived violation
    b. Supporting Evidence: Any corroborative evidence that substantiates the claim, such as copies of email correspondence, text messages, or other relevant communication.

C. Non-Compliance
1. Any personnel found to be non-compliant with this policy will be subject to disciplinary proceedings initiated by the Human Resources (HR) department.
    a. Initial Violation: The first instance of non-compliance will result in a verbal warning to the personnel involved, followed by an official email documenting the violation.
    b. Recurring Violations: In the event of subsequent non-compliance by the same personnel, a formal notice of disciplinary action will be issued.

D. Reporting Employees
1. Personnel who report violations of this policy will be safeguarded against any form of punitive action or retaliation. It is strictly prohibited for managers to harbor any prejudice against the reporting personnel.

E. Enforcement
1. This policy will be enforced by the HR department. All personnel are urged to report any perceived violations to HR.

IV. DEFINITIONS

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

TERM	DEFINITION
None	

	New Positions	HR-005
Department	Human Resources	
Functional Area	Human Resources	
Impacted Delegate	☐ Subcontractor ☒ NA	

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

APPROVALS		
Internal		**Regulator**
Name	Michelle Stephanie Ortiz-Trujillo	☐ DHCS ☒ NA ☐ DMHC
Title	Senior Director of Human Resources & Community Relations	

ATTACHMENTS
NA

AUTHORITIES/REFERENCES
NA

HISTORY	
Revision Date	**Description of Revision**

I. OVERVIEW

A. This policy applies to all departments and positions at all levels, including full-time regular, part-time regular and temporary positions.

II. POLICY

A. Clarity of Purpose: Define the need for the new position and articulate its purpose within the organization. Clearly align the role's responsibilities with organizational goals.
B. Strategic Alignment: Explain how the new position aligns with the overall strategic direction of the company. Highlight how it contributes to long-term success and growth.
C. Resource Justification: Provide a detailed breakdown of the costs associated with the new position. Justify the allocation of resources, including budget, personnel, and time.
D. Risk Assessment: Identify potential risks and challenges related to the new role. Briefly outline strategies for mitigating risks and addressing challenges.
E. Quantifiable Benefits: Present the benefits of the new position in comparison to the incurred costs. Decision-makers are interested in understanding the return on investment.

III. PROCEDURE

A. General Procedure
1. Managers must complete the requisition form, including all approval signatures, whenever a department has a need to:
   a. Create and fill a new position, or
   b. Refill an existing position when there is a termination of employment, or
   c. Hire or lease a temporary employee.
2. This policy explains the necessary forms and processes for these situations.

B. Approval Process
1. The hiring manager downloads the job requisition form from the HR folder and completes all applicable sections based on new position, refill position or temporary position.
2. The completed requisition form, including a copy of the current job description, must be submitted to the CEO as hard copy or electronically once all required approval signatures are obtained.
3. Once approved by the CEO, HR will review the request and ensure the job duties, requirements and pay grade are consistent with the position as described. If necessary, HR will recommend changes and work with the hiring manager to revise the request. If substantial changes made, a second round of approval signatures will be required.
4. Upon final approval of the requisition, the hiring manager will receive a confirmation e-mail of the open requisition and posting. It is the hiring manager's responsibility to check the information for accuracy and contact HR immediately if there are any discrepancies.
5. The recruiter assigned to the open requisition will contact the hiring manager within the first week of the open job requisition to coordinate the recruitment process.

C. New position
1. The budgeting process for new positions happens each year in September for the following calendar year. All new positions should go through the normal annual

budgeting process for planning and approval. In the event the business needs dictate hiring for a new position outside of this process, additional written business justifications and approvals will be needed on the job requisition form. HR may not start the candidate sourcing process for any position until all documents and signatures have been received.

D. Next Steps

1. Senior Leader and CEO approval of new positions with justification.
2. Senior Leader Submits a job description to CEO for review
3. Senior Leader submits new position request signed by CEO to HR along with job descriptions reviewed by CEO
4. Human Resources values the position with input from Senior Leader, Finance, Surveys, etc.
5. Post internally for 3 days (best practice is send the announcement to everyone internally when we're this size)
6. If no internal candidate meets the criteria, then post externally.

IV. DEFINITIONS

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

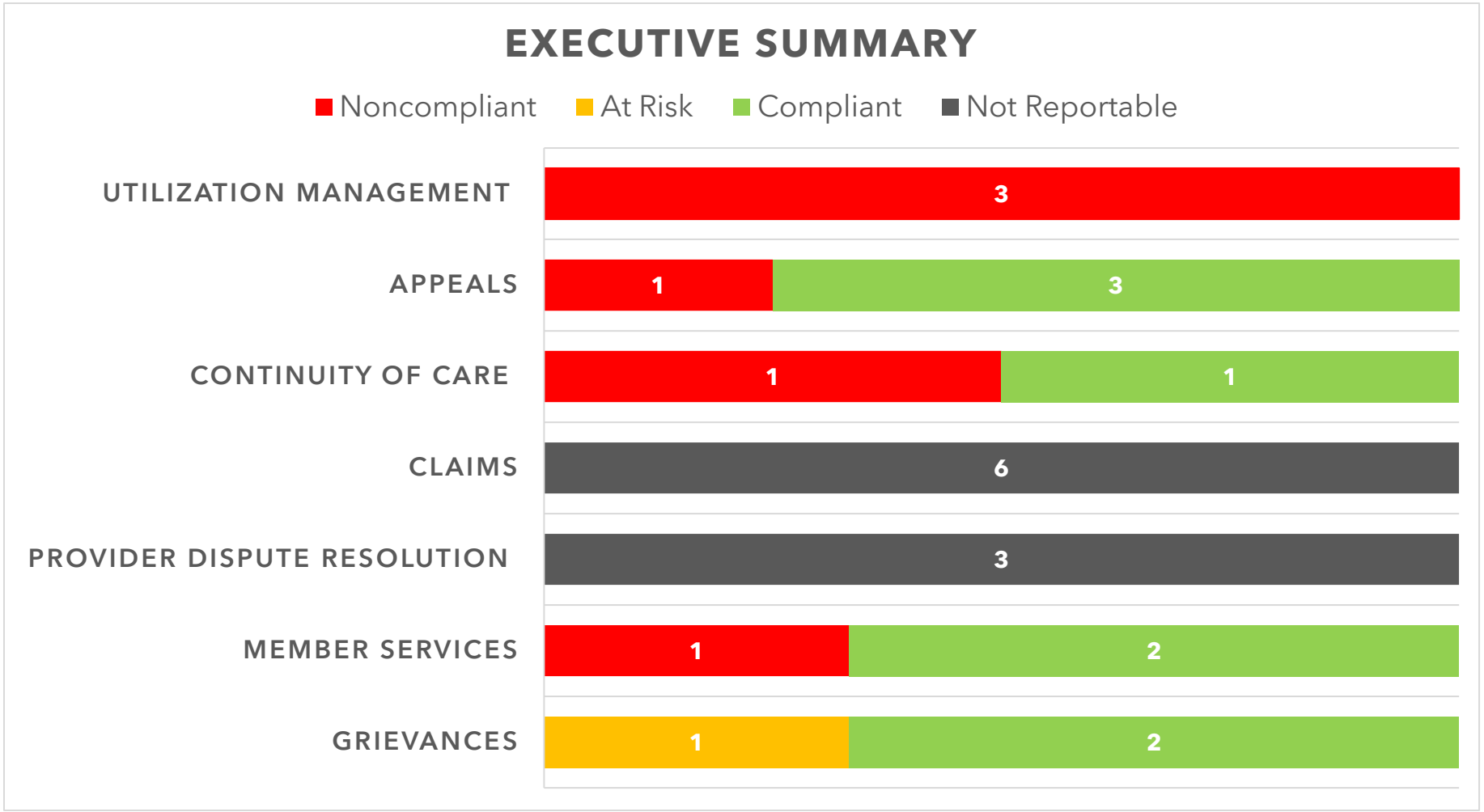
TERM	DEFINITION

DELEGATION OVERSIGHT

Health Net 2024 Quarter 1 Final Scorecard

Report Issued: July 11, 2024

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



DELEGATION OVERSIGHT

Health Net 2024 Quarter 1 Final Scorecard

Report Issued: July 11, 2024

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

HIGH PERFORMING AREAS

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

NON-COMPLIANT AREAS

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

NOT REPORTABLE

- Claims Log
- Provider Dispute Resolution Log

ACTIONS REQUIRED

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

DELEGATION OVERSIGHT

Health Net 2024 Quarter 1 Final Scorecard

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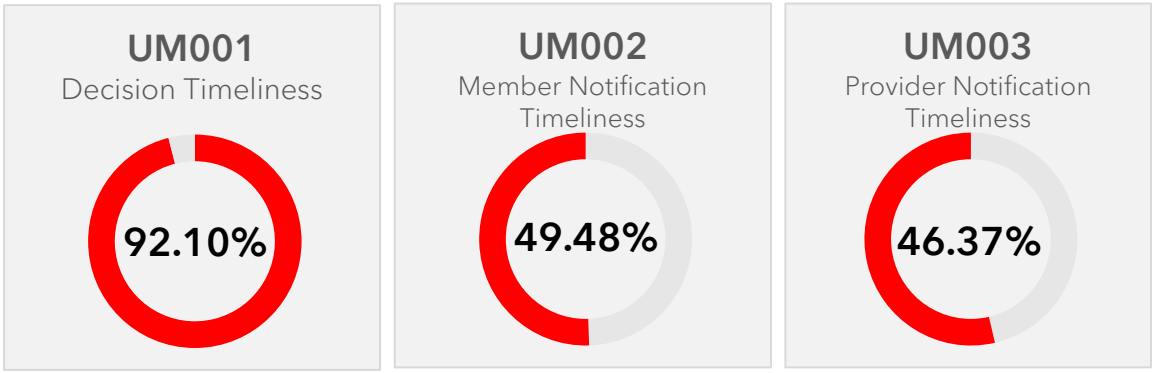
UTILIZATION MANAGEMENT



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

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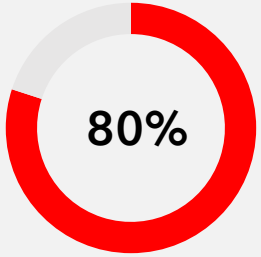
APPEALS

APPEAL001
Acknowledgement of Appeals Timeliness

APPEAL002
Decision of Appeals Timeliness

APPEAL003
Effectuation of Overturned Appeals Timeliness



APPEAL004
Member Notification Timeliness

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

DELEGATION OVERSIGHT

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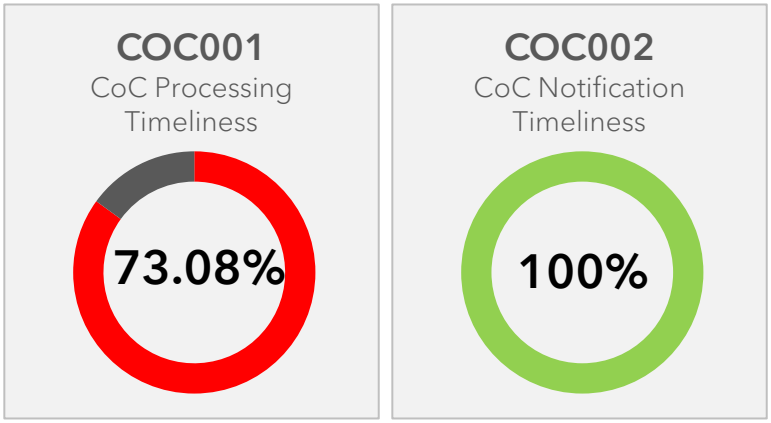
CONTINUITY OF CARE



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

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

BACKLOG	
CoC Member Notification	6

DELEGATION OVERSIGHT

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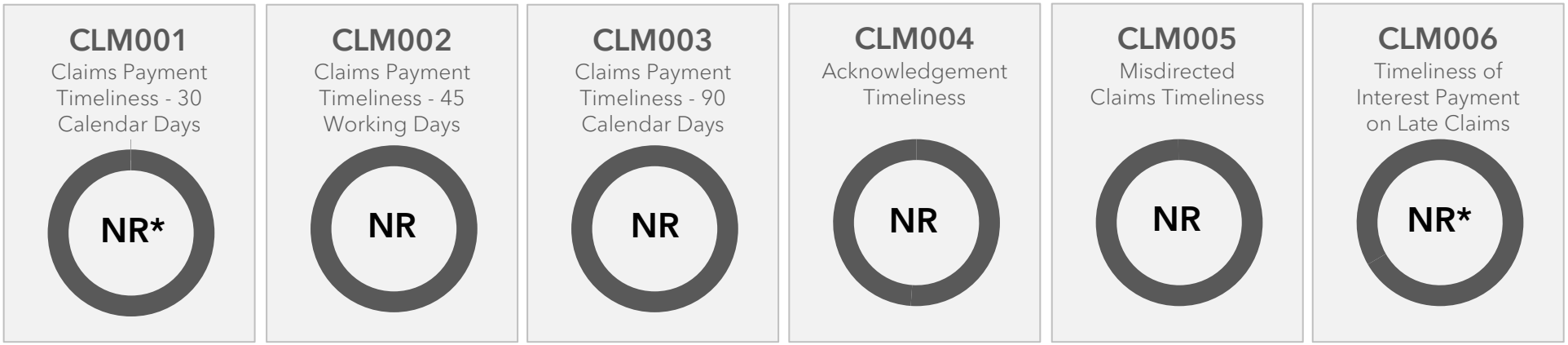
CLAIMS



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

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

DELEGATION OVERSIGHT

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PROVIDER DISPUTE RESOLUTION

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

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

DELEGATION OVERSIGHT

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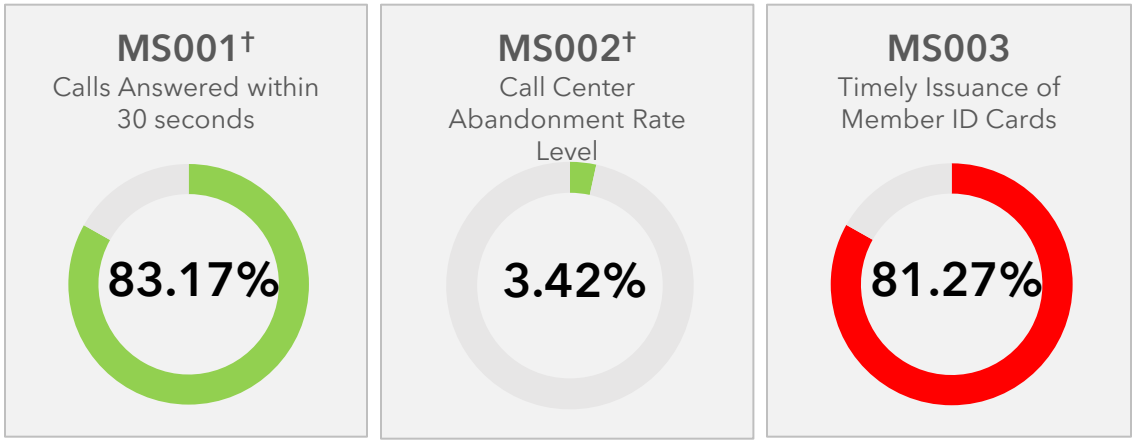
MEMBER SERVICES



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

† Self-reported compliance rate

DELEGATION OVERSIGHT

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GRIEVANCES

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

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Appendix 1 – KPI Details

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

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

DELEGATION OVERSIGHT

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

COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

Dear Health Net,

Letter of Non-Compliance: Q1 2024 Claims Log

This letter addresses your team's reporting issues, which have resulted in their inability to produce accurate logs in a timely manner. Despite our efforts to validate data and measure performance, your team's reporting deficiencies have significantly impacted our ability to do so accurately and efficiently. Reliable data is crucial for demonstrating compliance with regulatory requirements, and your team's inability to provide accurate logs limits our capacity to assess your performance.

Summary of Data Issues Identified

Issues
Incorrect dates for claims acknowledgement
Inability to pull RA/EOB mailed date

Actions Required

1. **Final Resubmission:** Review the identified errors, make necessary corrections to the entire Q1 2024 Log, and resubmit a revised log by **COB Friday, July 19, 2024**.

Failure to submit an accurate log by the final resubmission deadline will result in the formal issuance of a Corrective Action Plan (CAP).

Sincerely,

Elysse Tarabola
Chief Compliance Officer

COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

Dear Health Net,

Letter of Non-Compliance: Q1 2024 Provider Dispute Resolution (PDR) Log

This letter addresses your team's reporting issues, which have resulted in their inability to produce accurate logs in a timely manner. Despite our efforts to validate data and measure performance, your team's reporting deficiencies have significantly impacted our ability to do so accurately and efficiently. Reliable data is crucial for demonstrating compliance with regulatory requirements, and your team's inability to provide accurate logs limits our capacity to assess your performance.

Summary of Data Issues Identified

Issues
Incorrect reporting of dispute number
Incorrect reporting of dispute submission type
Incorrect reporting of dispute resolution date
Inability to pull RA/EOB and PDR determination letter mailed date

Actions Required

1. **Final Resubmission:** Review the identified errors, make necessary corrections to the entire Q1 2024 Log, and resubmit a revised log by **COB Friday, July 19, 2024**.

Failure to submit an accurate log by the final resubmission deadline will result in the formal issuance of a Corrective Action Plan (CAP).

Sincerely,

Elysse Tarabola
Chief Compliance Officer