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

AGENDA

Date/Time: November 12, 2024, 4:00 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: 843002905#) or clicking on the link below:

Click here to join the meeting
Meeting ID: 262 059 419 089
Passcode: sgCvs2

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	
David Wilson	Chief Financial Officer	
Julia Hutchins	Chief Operating Officer	
Michelle Ortiz-Trujillo	Head of Member Experience Development	
Jeanette Crenshaw	Executive Director of Health Services	
Chelsea Hardy	Senior Director of Compliance	
Jadira Alcaraz	Delegation Oversight Manager	
Rosa Sanchez	Compliance Manager	
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 August 12, 2024 — *Chair*

6. Approval of Minutes from October 1, 2024 ad hoc meeting

7. Chairperson's Report

8. Chief Compliance Officer Report — Elysse Tarabola, *Chief Compliance Officer*

   a. Approve Updated and New Policies & Procedures — Chelsea Hardy, *Senior Director of Compliance*; Dr. Gordon Arakawa, *Chief Medical Officer*; Michelle Ortiz-Trujillo, *Head of Member Experience Development*

   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: Updated Quarter 1 Results — Jadira Alcaraz, *Delegation Oversight Manager*

   g. Delegation Oversight Program: Quarter 2 Results — *Delegation Oversight Manager*

   h. Delegation Oversight Program: Corrective Action Plans — *Delegation Oversight Manager*

9. Adjourn to Closed Session — Dr. Allan Wu, *Chair*
   Pursuant to Welfare and Institutions Code § 14087.38 (m)

10. Reconvene in Open Session — *Chair*

11. Adjournment — *Chair*

Regulatory Compliance Oversight Committee (RCOC)

November 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 Meeting Minutes (August 12, 2024)
- Review and Approve RCOC Ad Hoc Meeting Minutes (October 1, 2024)
- Updated and New Policies and Procedures
- New All Plan Letters (APLs) Released and Status
- Regulatory Submissions
- Regulatory Member Issues
- Health Net Deliverables
- Delegation Oversight Program: Updated Quarter 1 Results
- Delegation Oversight Program: Quarter 2 Results
- Delegation Oversight Program: Corrective Action Plans

Review/Approve RCOC Minutes – August 12, 2024

See Exhibit A - 8/12/2024 LHA RCOC Meeting Minutes

Review/Approve RCOC Minutes – Ad Hoc Meeting October 1, 2024

See Exhibit B - 10/1/2024 LHA RCOC Ad Hoc Meeting Minutes

Updated and New Policies and Procedures

Updated and New P&Ps

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

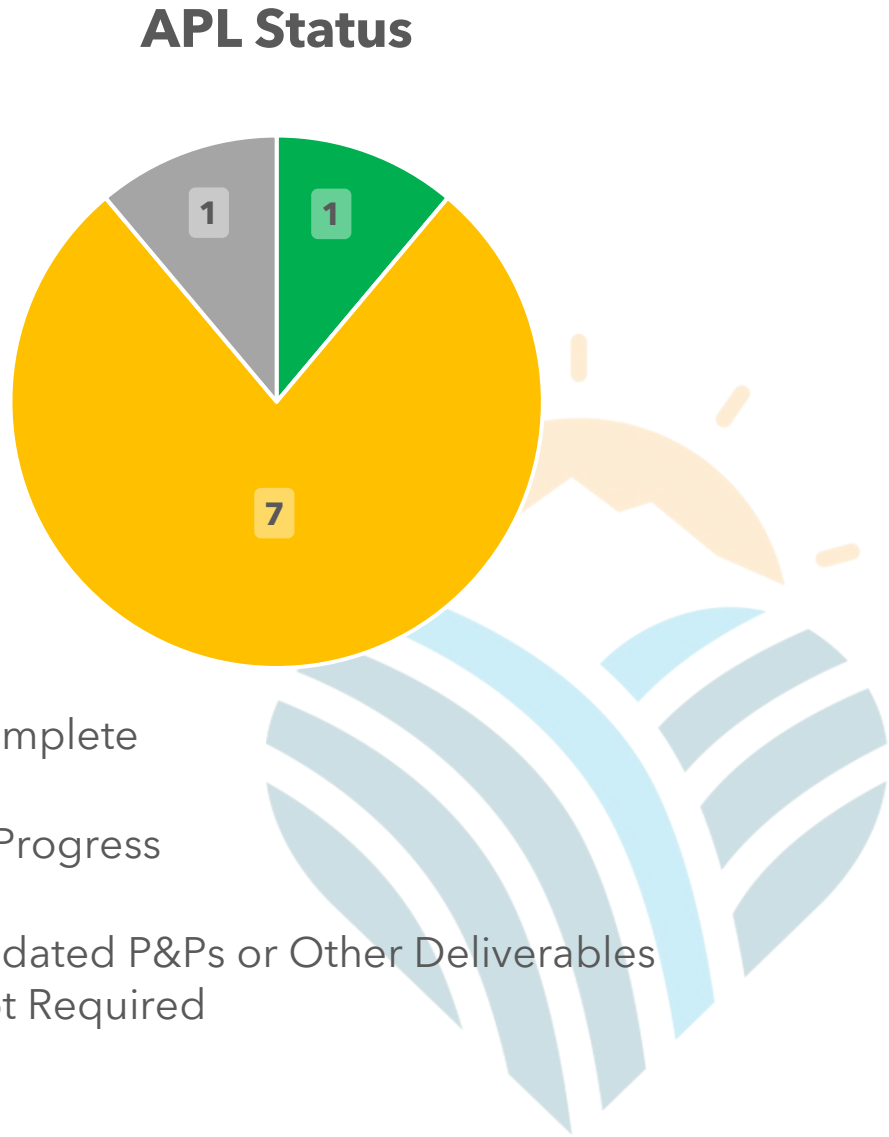
See Exhibit C – Policy Packet

New All Plan Letters (APLs) Released and Status

New APLs Released and Status

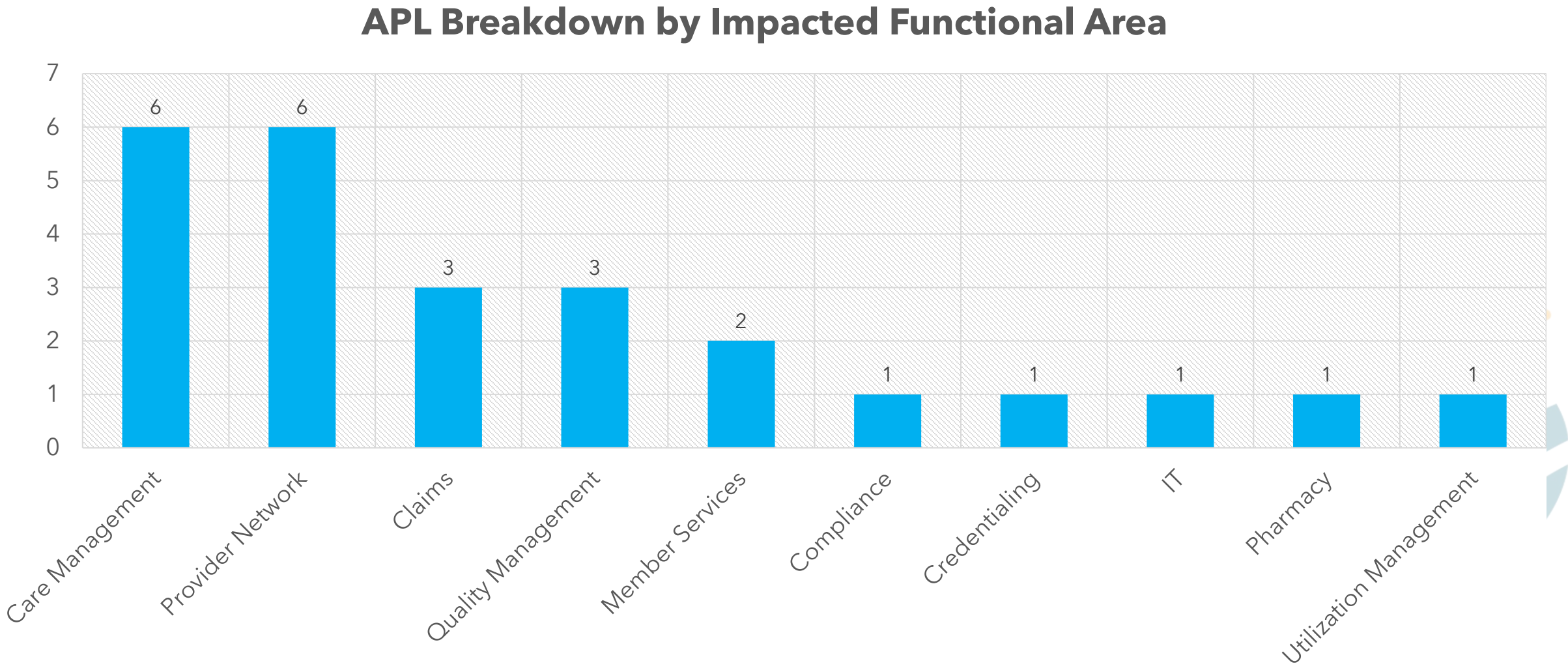
July 2024 – September 2024

- 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.
- 9 APLs released since our last meeting
  - 6 DHCS
  - 3 DMHC
  - 7 related to functions delegated to Health Net
  - 1 related to both delegated and in-house functions
  - 1 related to delegated in-house functions



New APLs released and Status

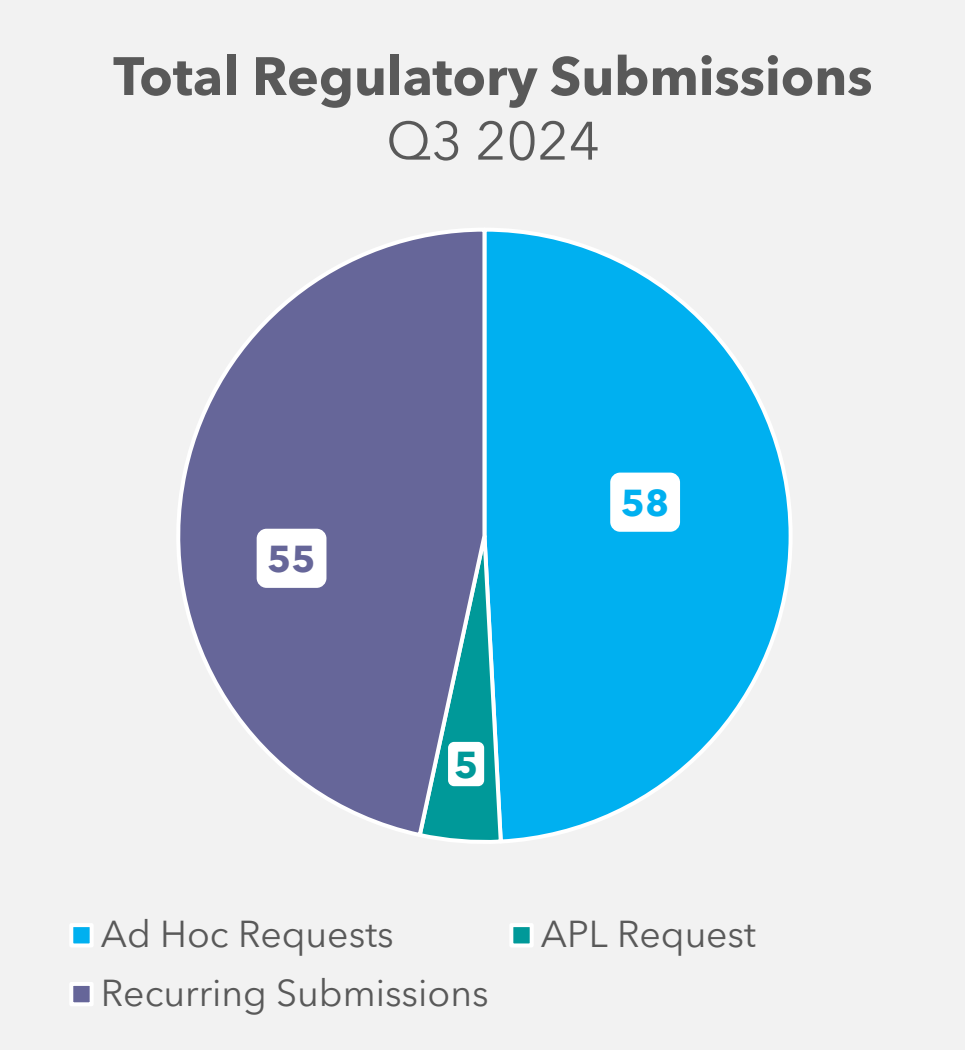
July 2024 – September 2024

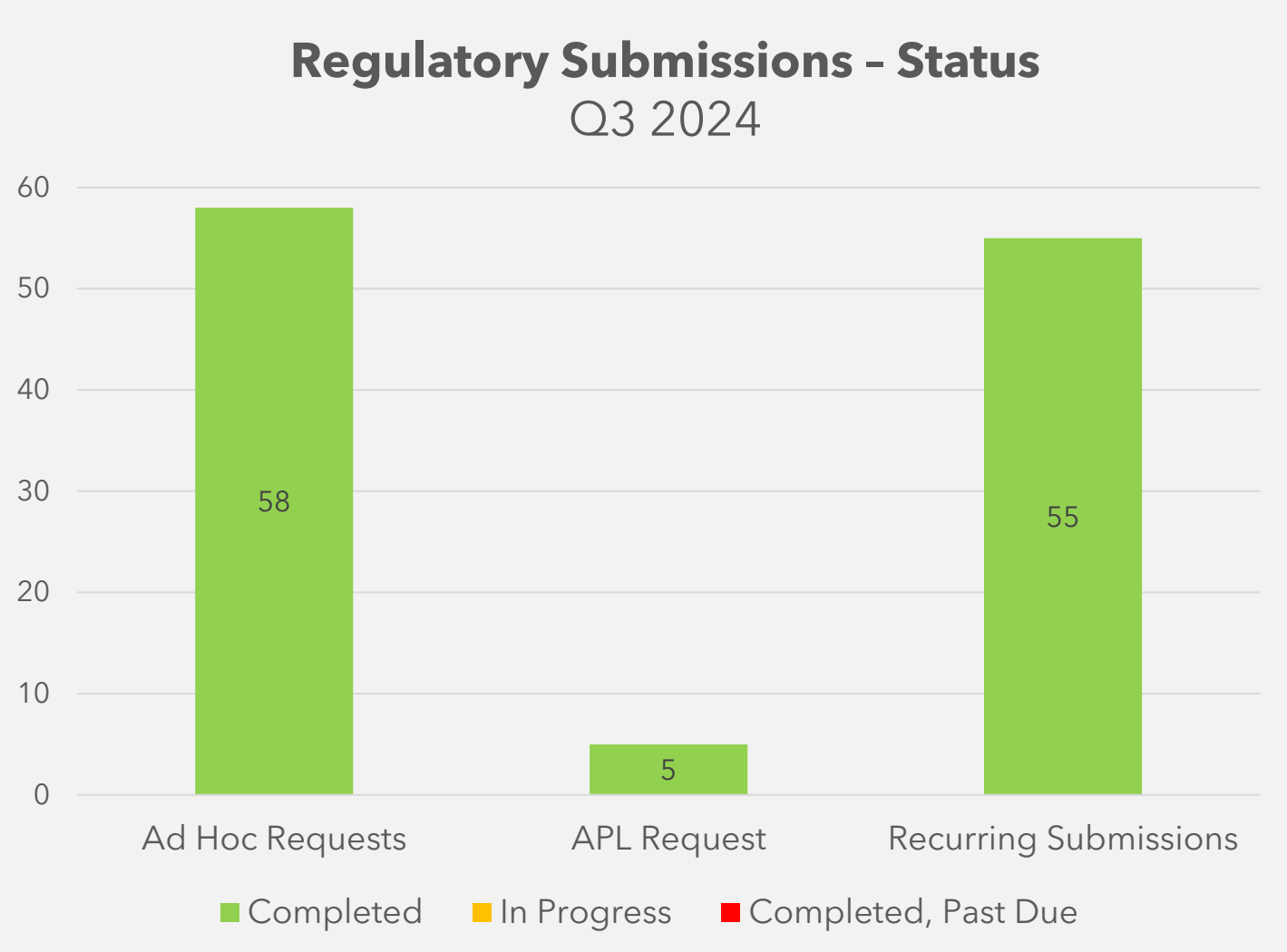


Regulatory Submissions

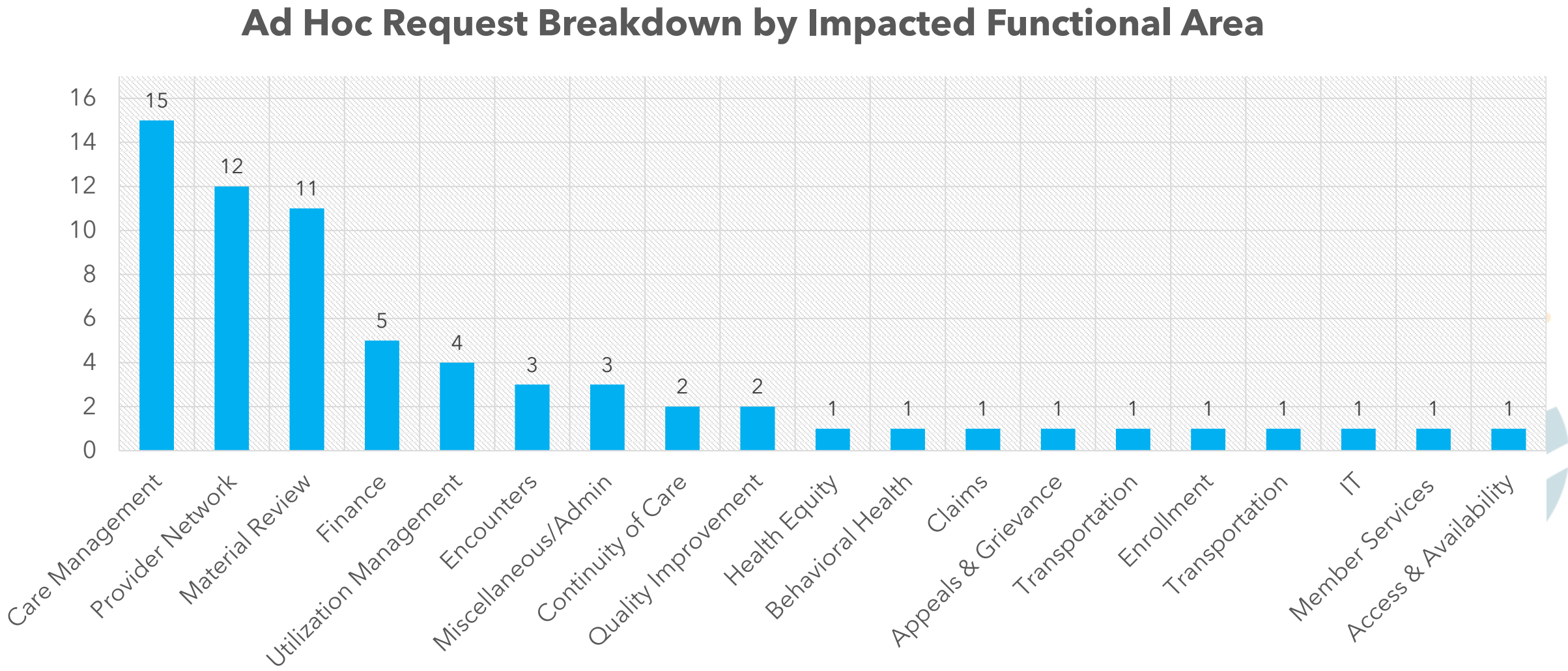
Regulatory Submissions – *Q3 2024*

Total Regulatory Submissions in Q3 2024: 118





Regulatory Submissions – *Q3 2024 (cont.)*



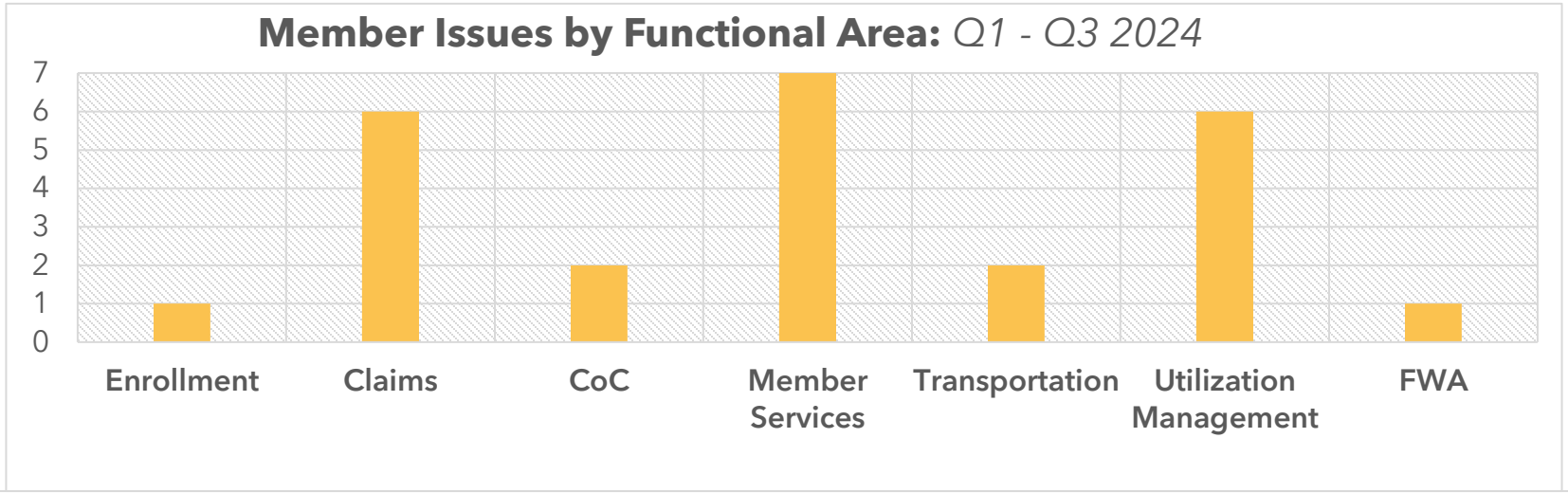
Regulatory Member Issues

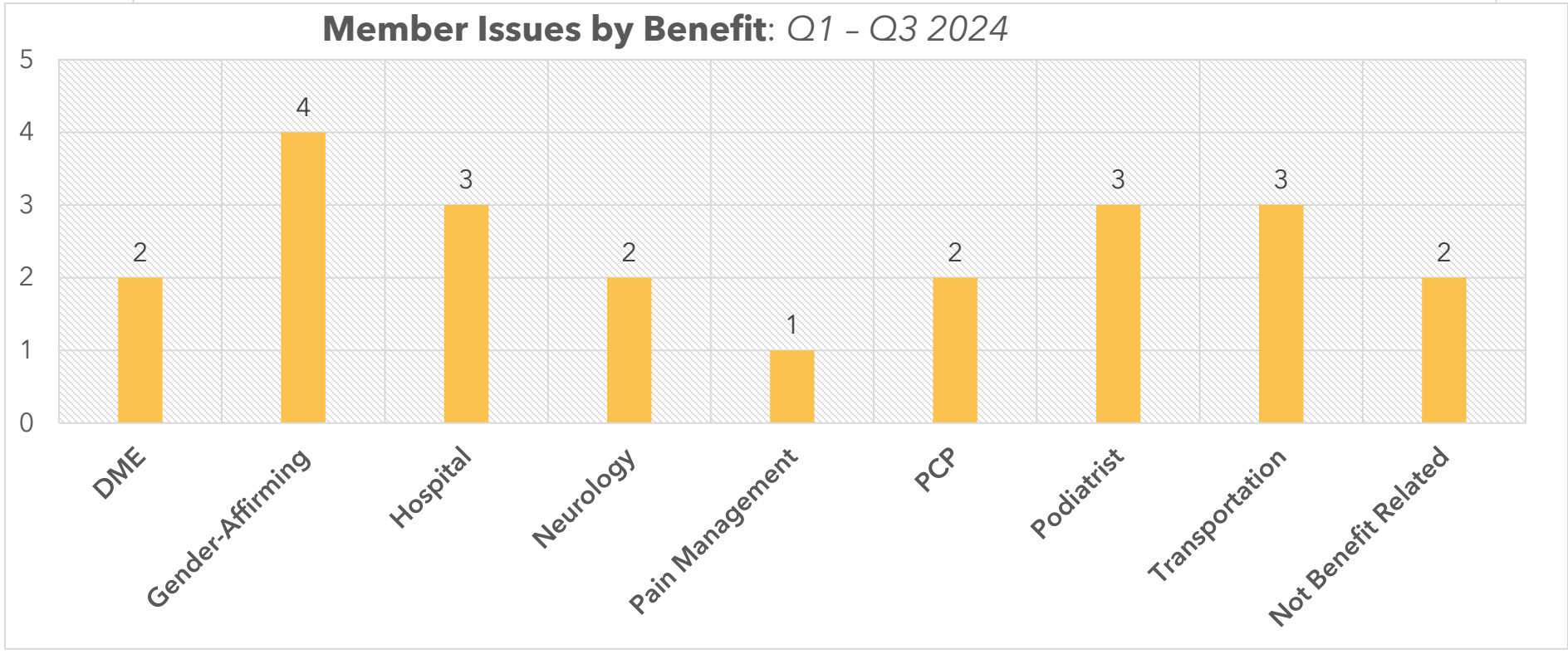
Regulatory Member Issues

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

- 10 total regulatory member issues in Q3 2024
  - 10 DMHC Complaint

No trends identified in Q1 – Q3 2024 that require corrective action

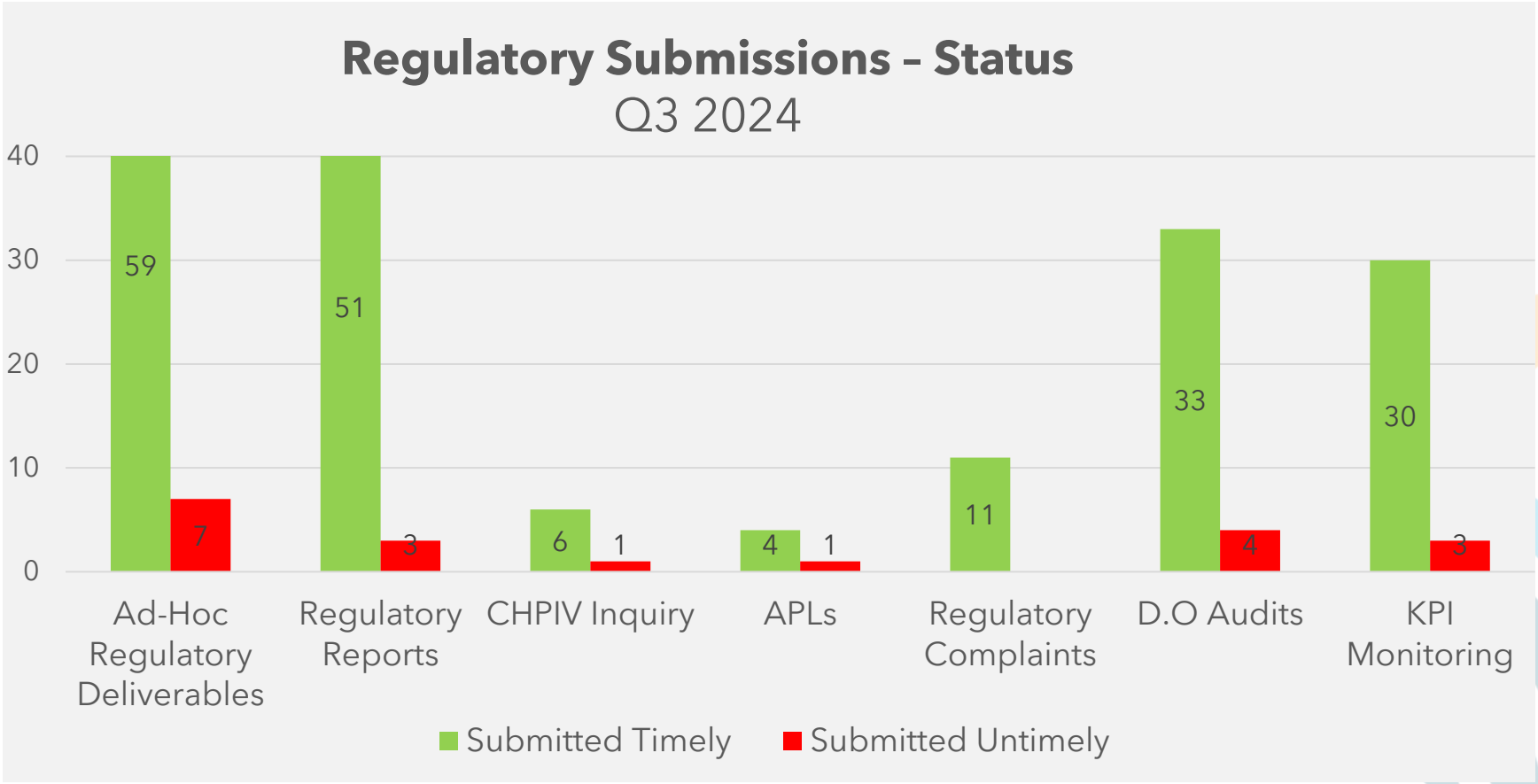




Health Net Deliverables

HN Deliverables Submissions

Total Deliverables Submissions in Q3 2024: 213



Health Net's untimely submissions in Q3 2024 resulted in CHPIV having to request an extension from our regulators.

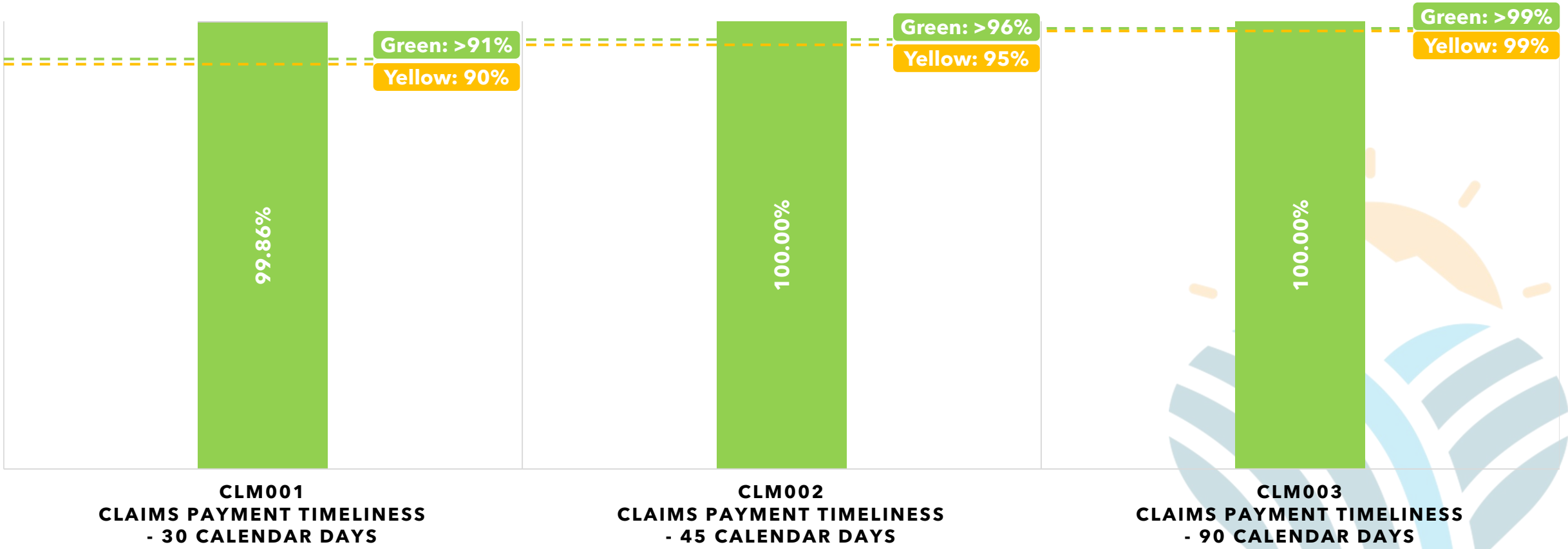
DO Monitoring Program: Quarter 1 Results

See Exhibit D – Delegation Oversight Program Updated Q1 Scorecard

Delegation Oversight Monitoring Program

Quarterly KPI Metrics (Q1 2024) – Results

CLAIMS

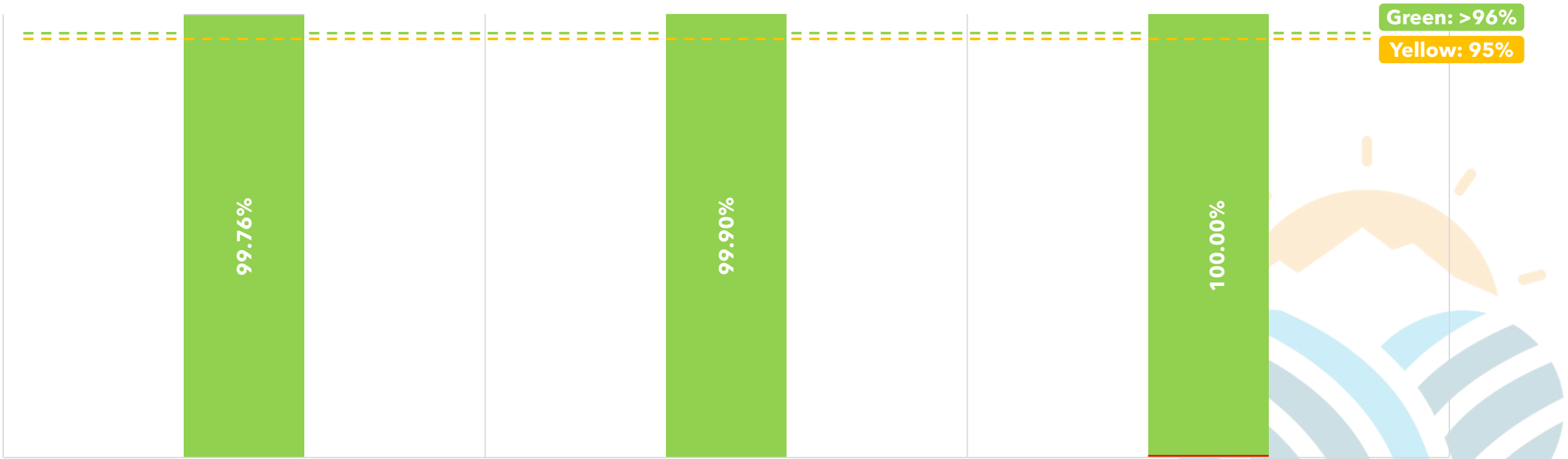


± Data did not pass data validation; pending resubmission of Claims log

Delegation Oversight Monitoring Program

Quarterly KPI Metrics (Q1 2024) – Results

CLAIMS



CLM004*
ACKNOWLEDGEMENT TIMELINESS

▸ Electronic	100%
▸ Paper	93.69%

CLM005
MISDIRECTED CLAIMS TIMELINESS

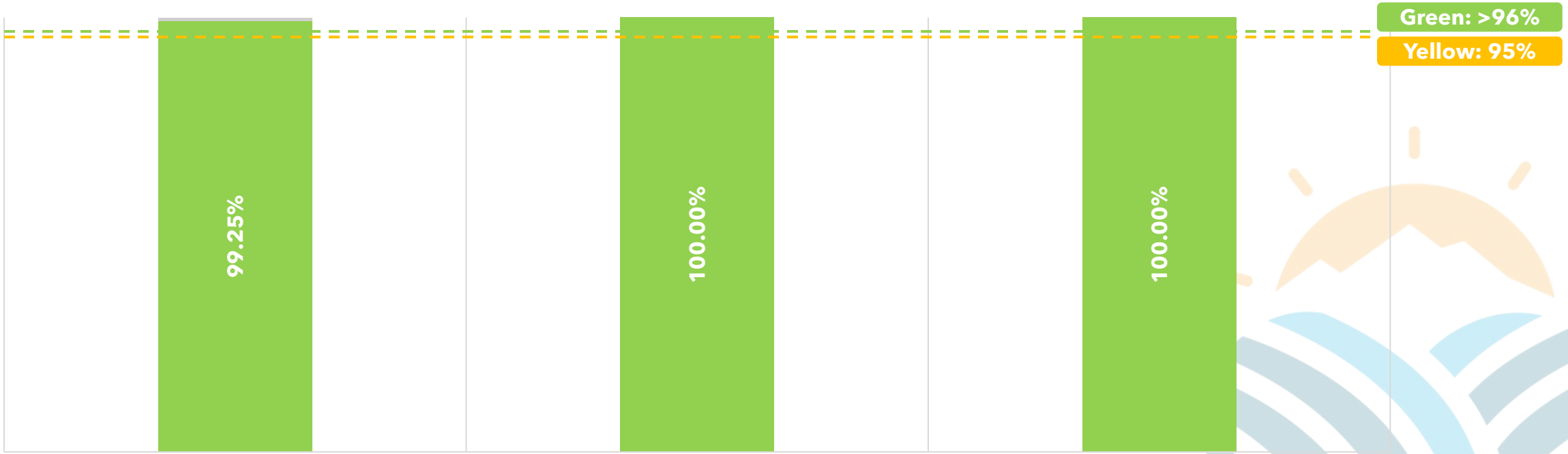
CLM006
TIMELINESS OF INTEREST PAYMENT ON LATE CLAIMS

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

Delegation Oversight Monitoring Program

Quarterly KPI Metrics (Q1 2024) - Results

PROVIDER DISPUTE RESOLUTION



▸ Electronic	No Cases
▸ Paper	99.25%

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

DO Monitoring Program: Quarter 2 Results

See Exhibit E – Delegation Oversight Program Q2 Scorecard

Q2 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
Claims	• Formatting issues (report specifications not followed in some columns) • Reporting logic issues for MHN claims is not in alignment with regulatory reporting guidelines	Not corrected
Provider Dispute Resolution (PDR)	• Formatting issues (report specifications not followed in some columns) • Incorrect date entries due to manual entries, not an automated process	Corrected
Utilization Management	• Formatting issues (report specifications not followed in some columns) • Date discrepancies (case reported decision date prior to received date) • Lacks critical data fields related to member and provider notification timeliness	Corrected

Q2 Data Validation Results

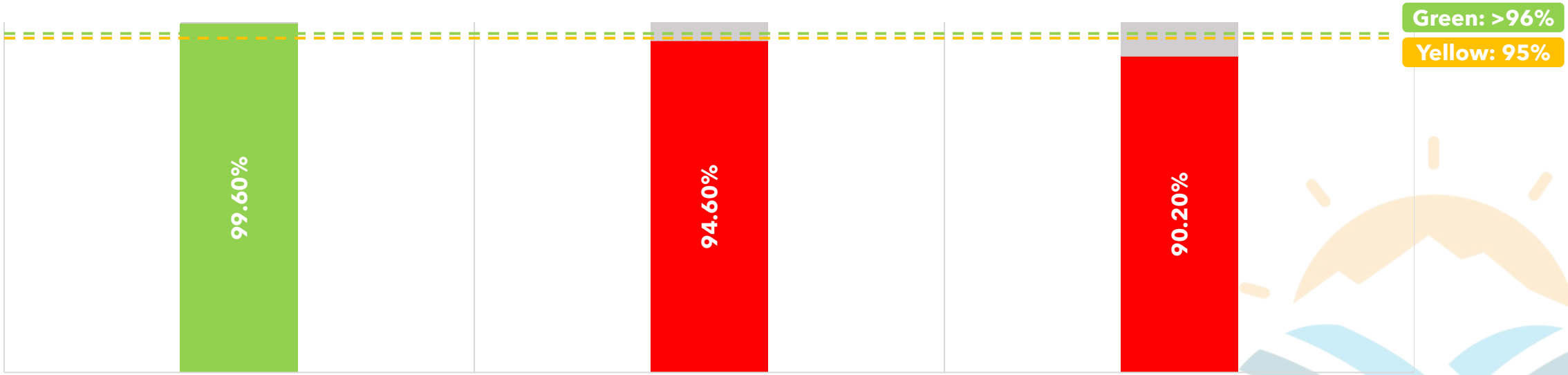
The purpose of data validation is to ensure the accuracy and integrity of the data logs submitted by Health Net. This process includes live webinars reviewing Health Net's systems and data sources to validate data points. Key performance indicators are measured through the logs and finalized only when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

Log	Pass/Fail
Appeals	Pass
Claims	Fail
Continuity of Care	Pass
Grievances	Pass
Member Services - ID Card	Pass
Provider Dispute Resolution (PDR)	Pass
Utilization Management	Pass

Delegation Oversight Monitoring Program

Quarterly KPI Metrics (Q2 2024) - Results

UTILIZATION MANAGEMENT



UM001*
DECISION TIMELINESS

Standard	98.3%
Expedited	100%
Concurrent	100%
Retrospective	100%
Post Stabilization	No Cases

UM002*
MEMBER NOTIFICATION TIMELINESS

Standard	98.3%
Expedited	66.7%
Concurrent	93.2%
Retrospective	100%

UM003*
PROVIDER NOTIFICATON TIMELINESS

Standard	100%
Expedited	100%
Concurrent	86.4%
Retrospective	100%

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

UM Provider Notification Timeliness
Corrective Action Plan Implementation Update

Key Performance Indicator (KPI)

UM003: Provider Notification Timeliness

Finding

Health Net failed to meet the compliance threshold of 95% for timely notification to providers for authorization services requests, with Q1 scores of **89.1%** and Q2 scores at **90.2%**

Current Status

Revised CAP submitted by Health Net was **approved** on 11/06/2024

Root Cause	Corrective Actions	Implementation Date
1. Training gap on deadline management for provider notification requirements for OB cases	1a. Training for relevant staff on notification timelines and OB admissions, implemented notification sending for OB cases, and creating KPI monitoring tools for timeliness and identifying any missed deadlines	1a. 10/11/2024

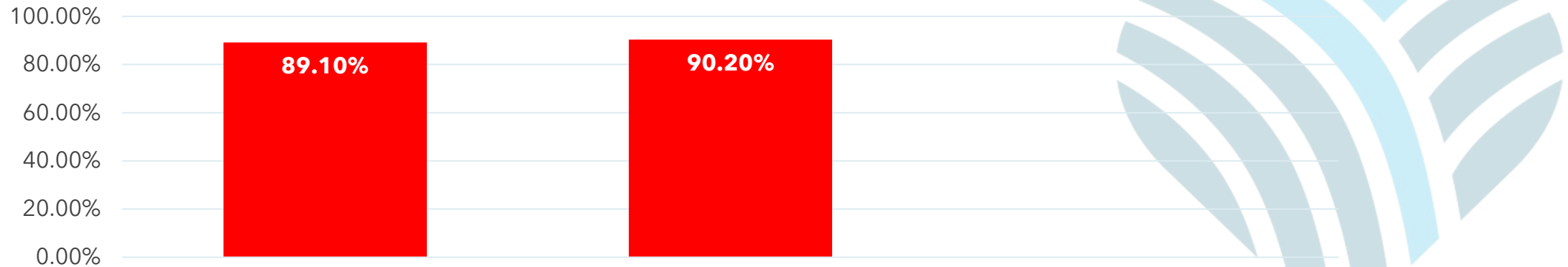
UM Provider Notification Timeliness
Corrective Action Plan Implementation Update

CAP Milestones

- All corrective action plans implemented as of 10/11/2024

Next Steps

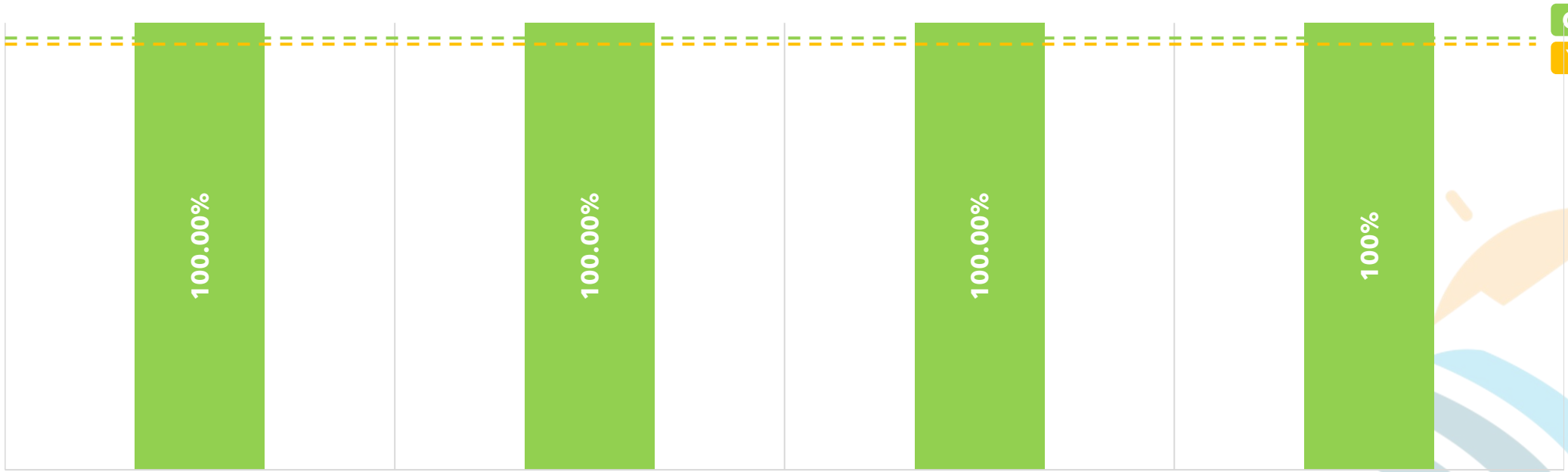
- Continuous monitoring for tracking implementation effectiveness
- Ongoing evaluation to assess compliance in timeliness requirements



Delegation Oversight Monitoring Program

Quarterly KPI Metrics (Q2 2024) - Results

APPEALS



APPEAL001 TIMELY ACKNOWLEDGEMENT OF APPEALS

APPEAL002* TIMELY DECISION OF APPEALS

Standard	100%
Expedited	100%

APPEAL003 EFFECTUATION OF OVERTURNED APPEALS TIMELINESS

APPEAL004* MEMBER NOTIFICATION TIMELINESS

Standard	100%
Expedited	100%

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

Delegation Oversight Monitoring Program

Quarterly KPI Metrics (Q2 2024) - Results

CONTINUITY OF CARE

COC001*
COC PROCESSING TIMELINESS

▸ **Non-Urgent**	80%
▸ **Immediate**	No Cases
▸ **Urgent**	No Cases

COC002*
COC NOTIFICATION TIMELINESS

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

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

DOMP: Continuity of Care CAP

Key Performance Indicator (KPI)

COC001: CoC Processing Timeliness

Finding

Health Net failed to meet the compliance threshold of 95% or above for 2 consecutive quarters in issuing timely notification to members for continuity of care requests outcomes

Current Status

- Revised CAP submitted by Health Net was approved on 10/31/2024

Root Cause	Corrective Actions	Implementation Date
1. Incorrect classification of COC requests by staff (i.e. Urgent / Non-urgent)	1a. Staff retraining on CoC requirements and timely processing of CoC requests 1b. Monthly staff meeting to review CoC timeliness performance	1a. 10/31/2024 1b. Ongoing
2. Lack of data field to capture classification of COC request in Assessment (HN's processing system)	2a. System updates implementation to reflect case categorization and facilitate monitoring against required timelines	2a. 09/20/2024

CoC Processing Timeliness

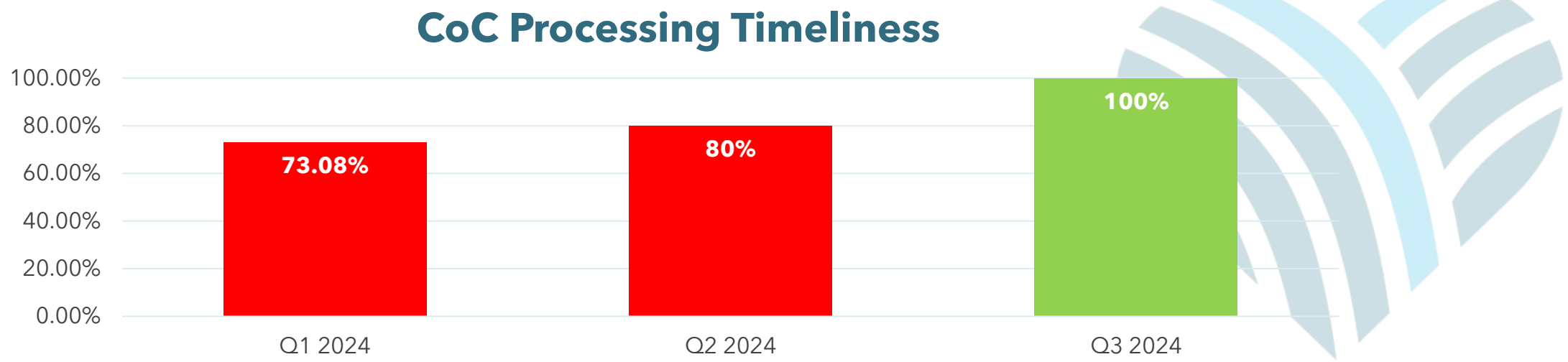
Corrective Action Plan Implementation Update

CAP Milestones

- All corrective action plans implemented as of 10/31/2024
- Q3 2024 preliminary CoC processing timeliness: 100%

Partnership Success

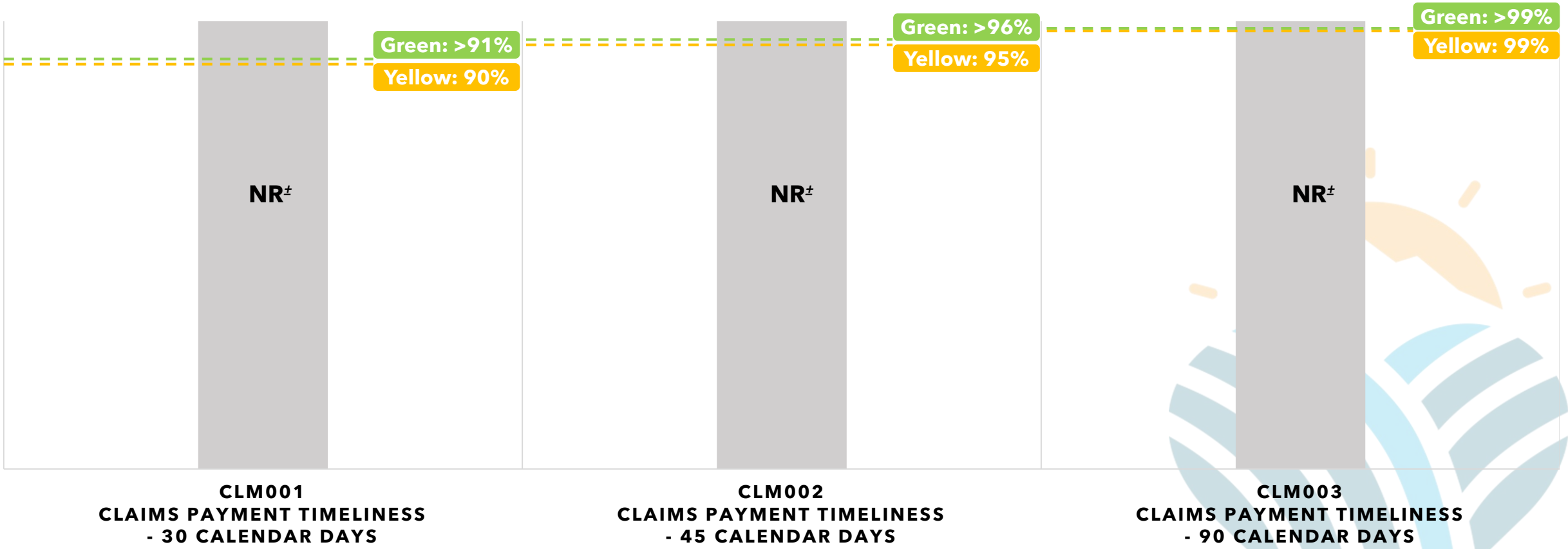
- Effective collaboration to identify and address non-compliance
- Proactive approach to improve processes
- Achieved 100% processing timeliness in Q3 2024



Delegation Oversight Monitoring Program

Quarterly KPI Metrics (Q2 2024) – Results

CLAIMS

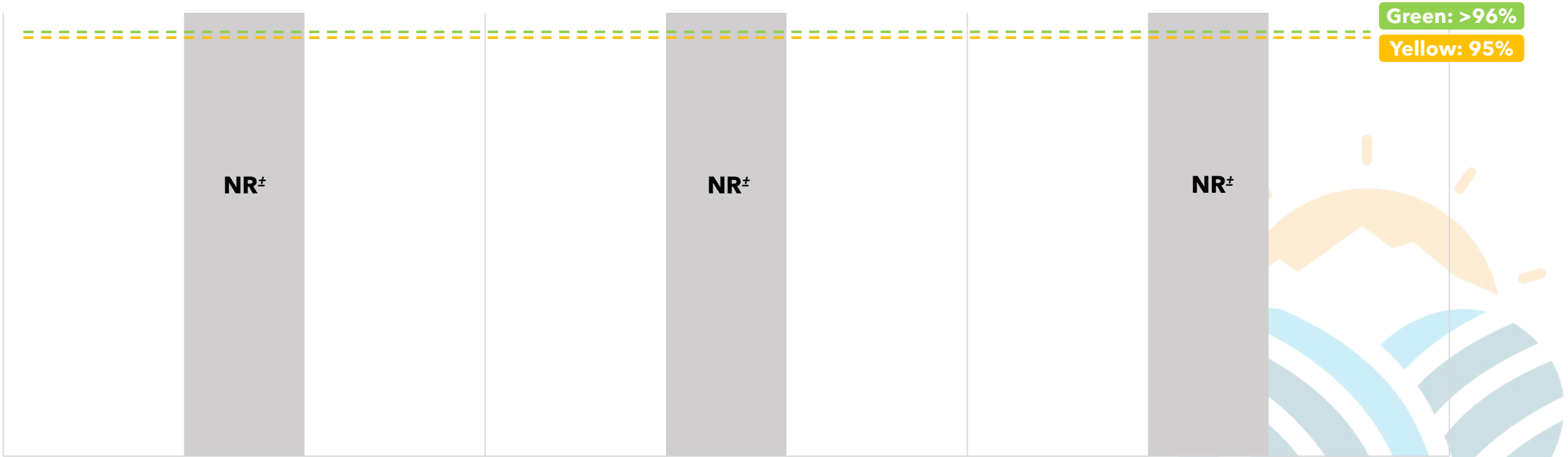


± Data did not pass data validation; pending resubmission of Claims log

Delegation Oversight Monitoring Program

Quarterly KPI Metrics (Q2 2024) – Results

CLAIMS



CLM004*
ACKNOWLEDGEMENT TIMELINESS

▸ Electronic	NR±
▸ Paper	NR±

CLM005
MISDIRECTED CLAIMS TIMELINESS

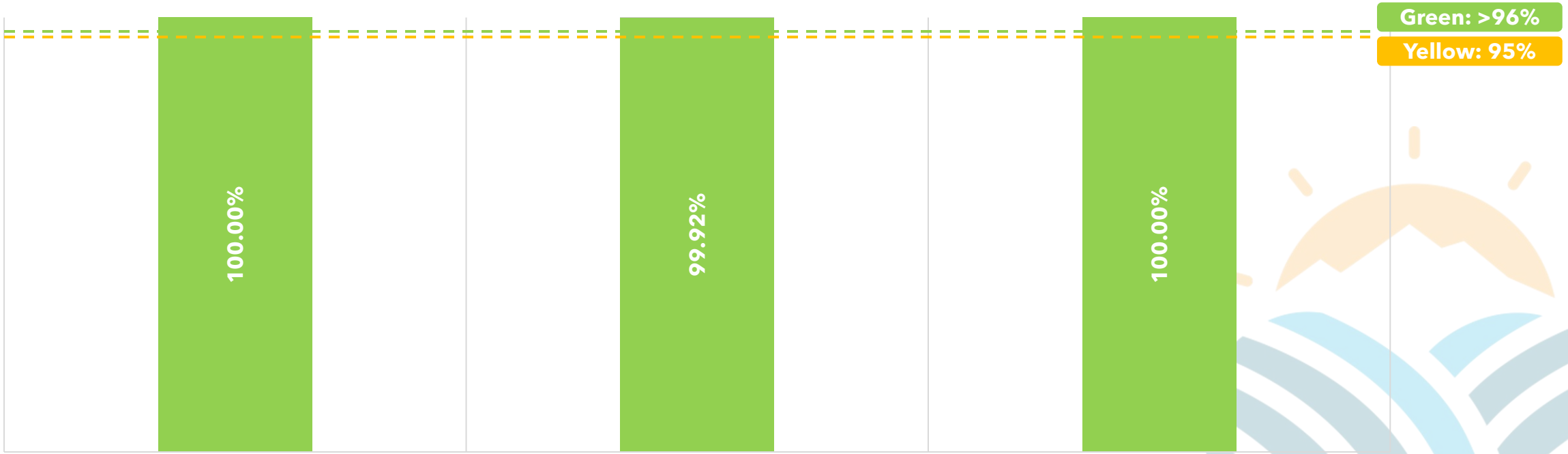
CLM006
TIMELINESS OF INTEREST PAYMENT ON LATE CLAIMS

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

Delegation Oversight Monitoring Program

Quarterly KPI Metrics (Q2 2024) - Results

PROVIDER DISPUTE RESOLUTION



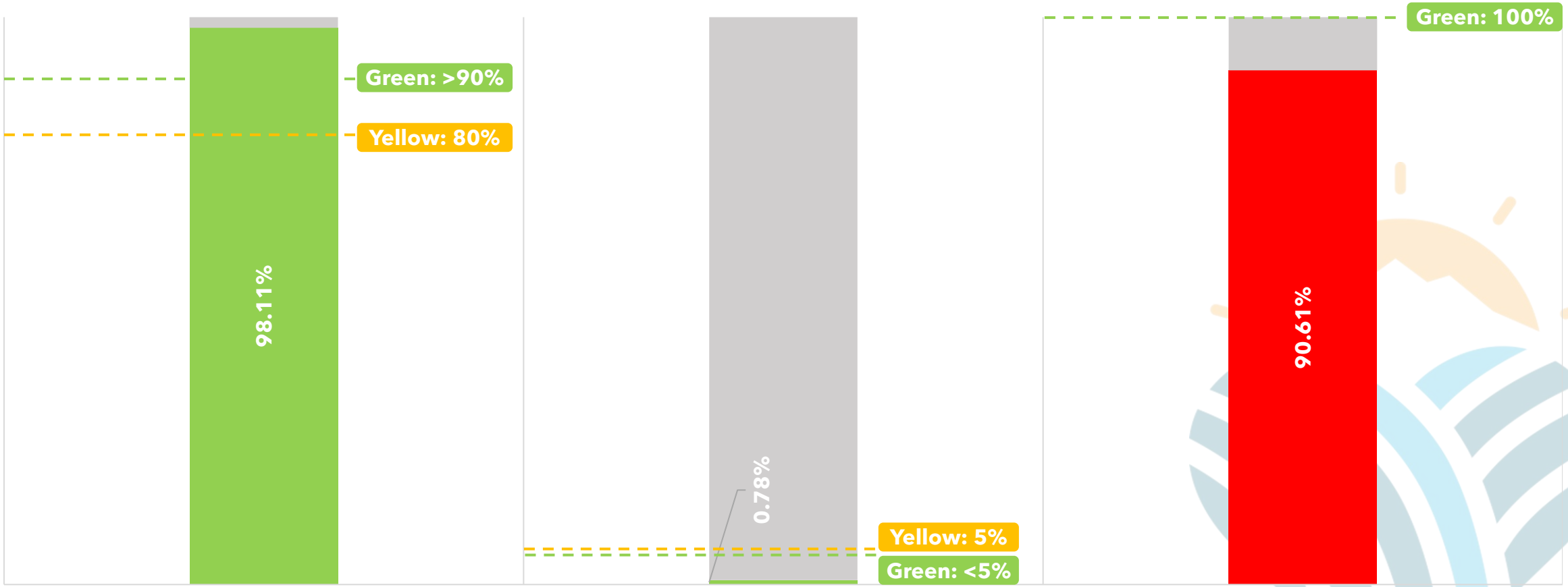
▸ Electronic	No Cases
▸ Paper	100%

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

Delegation Oversight Monitoring Program

Quarterly KPI Metrics (Q2 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.*

Member ID Card Issuance
Corrective Action Plan Implementation Update
Key Performance Indicator (KPI)

MS003: Timely Issuance of Member ID Cards

Finding

Health Net did not meet the **100%** compliance threshold for issuing member ID cards within 7 days of enrollment effective date, achieving scores of **81.27%** in Q1 and **90.61%** in Q2

Current Status

Revised CAP submitted by Health Net was **approved** on 11/06/2024

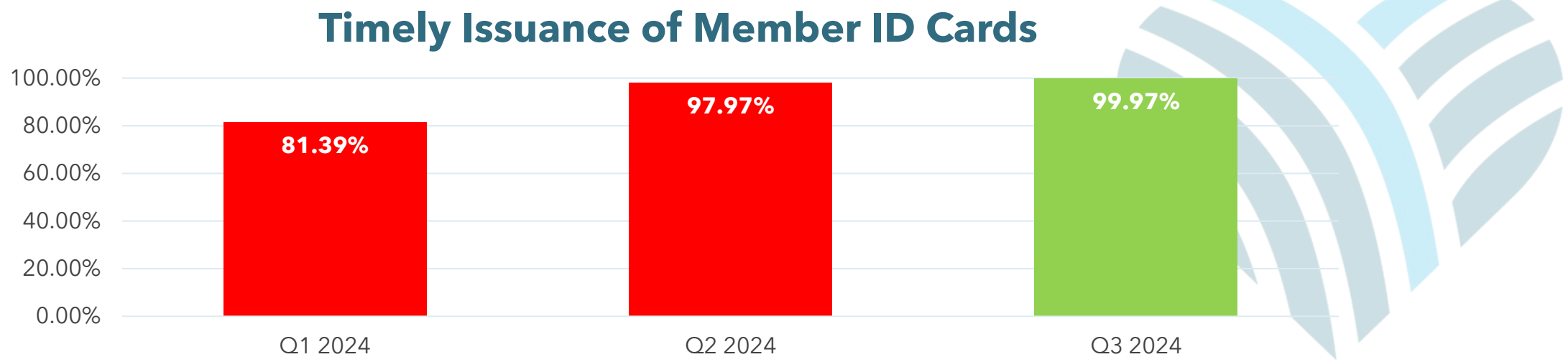
Root Cause	Corrective Actions	Implementation Date
1. Delayed EDI file processing for 01/01/2024 enrollments due to MCP transition	1a. Expedited mailing: - 29,826 late cards mailed by Jan 8 - Remaining 16,407 late cards mailed by Jan 11	1a. 01/11/2024
2. Member ID log template lacking EDI file dates therefore, retroactive enrollments processed within 7 days of receipt appear as late	2a. Enhanced Member ID log with EDI file dates for capturing accurate timeliness	2a. 10/15/2024

Member ID Card Issuance
Corrective Action Plan Implementation Update
CAP Milestones

- All corrective action plans implemented as of 10/15/2024
- Adding EDI File dates column reveals significant Q2 & Q3 improvements in ID card issuance

Next Steps

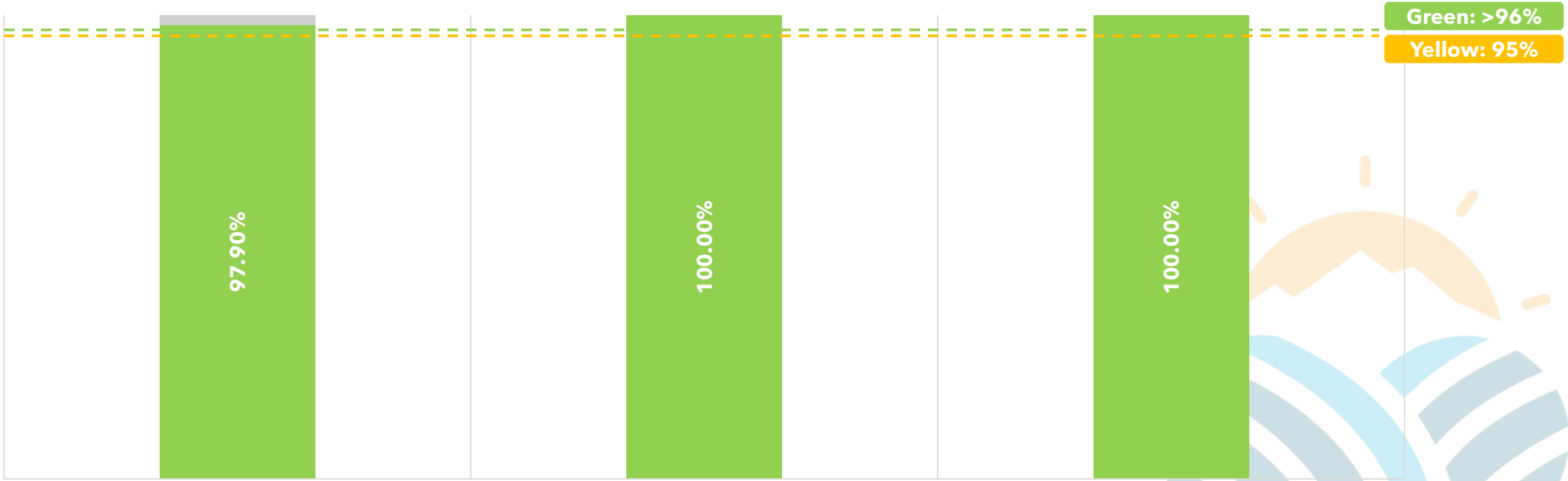
- Continue to discuss potential changes to the 100% KPI threshold. Objective is to identify systemic issues; Agree that 100% is not required to meet this objective. A slightly lower threshold can still effectively flag systemic issues.



Delegation Oversight Monitoring Program

Quarterly KPI Metrics (Q2 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 (Q2 2024) – Actions Required

FUNCTIONAL AREA	ACTION	DUE DATE
APPEALS	None	NA
CLAIMS	Submit Revised Log	NA
CONTINUITY OF CARE	Corrective Action Plan (CAP)	10/14/2024
GRIEVANCES	None	NA
MEMBER SERVICES	Corrective Action Plan (CAP)	10/14/2024
PROVIDER DISPUTE RESOLUTION	None	NA
UTILIZATION MANAGEMENT	Corrective Action Plan (CAP)	10/14/2024

DO Monitoring Program: Quarter 3

- **Q3 2024 Log Collection**
  - Health Net's Q3 2024 logs were submitted by October 29, 2024
- **Data Validation Audits**
  - Complete audits by November 22, 2024, or before which includes additional revalidation audits if needed
- **Scorecard Dissemination**
  - Disseminate Q3 2024 scorecard to Health Net by November 27, 2024

Questions

IMPERIAL COUNTY
Local Health Authority Commission

Regulatory Compliance Oversight Committee of the Commission

MEETING MINUTES

Date/Time: August 12, 2024, 12:00 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	☐
Jeanette Crenshaw	Senior Director of Healthcare Services	☒
Elysse Tarabola	Chief Compliance Officer	☐
Dr. Gordon Arakawa	Chief Medical Officer	☐
Michelle Ortiz-Trujillo	Senior Director of Human Resources and Community Relations	☒
Chelsea Hardy	Senior Director of Compliance	☒
Jadira Alcaraz	Delegation Oversight Manager	☒
Rosa Sanchez	Compliance Advisor	☒
Fernanda Ortega	Delegation Oversight Specialist	☒
Amanda Delgado	Compliance Coordinator	☒

IMPERIAL COUNTY
Local Health Authority Commission

Regulatory Compliance Oversight Committee of the Commission

Donna Ponce	Executive Assistant/Commission Clerk	☒

AGENDA ITEM/ PRESENTER	MOTION/MAJOR DISCUSSIONS	ACTIONS TAKEN
Call to Order Dr. Allan Wu, *Chair*	Meeting called to order: 12:34 p.m. Quorum was not achieved as Dr.Affue was unable to attend in person, resulting in insufficient physical presence of commission members.	
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	**No Objects/Comments**
Public Comment Dr. Allan Wu, *Chair*		**No Public Comment**
Chairperson's Report Dr. Allan Wu, *Chair*	No report given	
Chief Compliance Officer (Interim) Report Chelsea Hardy, Senior Director of Compliance Rosa Sanchez, Compliance Advisor	A. Approve Updated and New Policies & Procedures Chelsea Hardy presented the revised and new policies and procedures, highlighting changes are redlined for clarity. Two new HR policies were introduced, while some existing policies were reviewed without changes required. Approval is required but will be sought in the next meeting as this was an informational session. Dr. Wu asked if the policies and procedures were to ensure CHPIV's compliance with state regulations. Mrs. Hardy clarified that they guide CHPIV's operations,	

AGENDA ITEM/ PRESENTER	MOTION/MAJOR DISCUSSIONS	ACTIONS TAKEN
Jadira Alcaraz, Delegation Oversight Manager Fernanda Ortega, Delegation Oversight Specialist	many of them being functional areas delegated to Health Net and are reviewed annually for necessary updates. She also noted that the internal CHPIV team business owners made the modifications. B. New All Plan Letters (APLs) and Status Rosa Sanchez provided an overview of the latest APL releases and their statuses. She clarified that APLs are communications from DHCS and DMHC, offering updates and guidance on policy changes and procedures. Typically, Medi-Cal plans must submit updated policies or other deliverables as outlined in the APLs. In Q2, there were 13 APLs issued since the last meeting: 6 from DHCS, 7 from DMHC, 9 related to functions delegated to Health Net, and 4 related to both Health Net and in-house functions. Of these, 5 deliverables were completed, 5 are in progress, and 3 did not require deliverables. Mrs. Sanchez provided a detailed breakdown of the APLs by impacted functional areas, with a specific emphasis on claims and the provider network. Dr. Wu inquired about the nature of the APL claims, questioning whether they were related to lawsuits. Mrs. Hardy clarified that the Claims APLs pertained to provider claims and the requirements for processing payments. Pablo Velez asked if there were delays in paying the invoices. Mrs. Hardy explained that APLs could be issued for various reasons within the presented areas, including processing times and methods. She noted that the APLs	

AGENDA ITEM/ PRESENTER	MOTION/MAJOR DISCUSSIONS	ACTIONS TAKEN
	were categorized based on how they were being addressed and the regulatory focus and requirements. Mr. Velez reiterated his question, seeking clarification on whether the claims indicated non-compliance as pointed out by regulators. Mrs. Hardy further explained that the graph illustrated the number of APLs received from regulators concerning claims processes, not the number of claims themselves. She emphasized that APLs are notifications from regulators about regulatory changes. Dr. Wu suggested pulling the claims for review in the next meeting to gain a better understanding. C. Regulatory Submissions Mrs. Sanchez reported on the status of 81 regulatory submissions, which included 40 ad hoc requests, 5 APL implementations, and 36 recurring deliverables (bi-weekly or quarterly). Out of the ad hoc requests, 39 were submitted on time, with 1 being late. For the APL implementations, 4 were timely, and 1 was delayed due to Health Net. All recurring deliverables were submitted on schedule. D. Regulatory Member Issues Mrs. Sanchez outlined the process for handling regulatory member issues, which arise when members report concerns directly to regulators. In Q2 2024, there were 7 such issues: 5 related to DMHC complaints and 2 to DHCS complaints. No trends necessitating corrective action were identified in Q1 and Q2. E. Health Net Deliverables <u>Total Deliverable Submissions in Q2 2024</u>	

AGENDA ITEM/ PRESENTER	MOTION/MAJOR DISCUSSIONS	ACTIONS TAKEN
	Fernanda Ortega reviewed the table of deliverables, highlighting a total of 180. She noted that 54 ad-hoc regulatory deliverables were timely, while 6 were untimely. For regulator reports, 52 were timely and 9 were untimely. The CHPIV Inquiry had 11 deliverables. APLs included 7 timely and 1 untimely deliverable. There were 3 timely regulatory complaints and 1 untimely. DO Audits had 18 timely and 2 untimely deliverables, and KPI Monitoring had 13 timely and 3 untimely deliverables. Dr. Wu inquired about the late submissions. He wanted to know what the root cause of the late submission was. Fernanda then explained it is due to the fact that Kathleen is the liaison, and the deadlines are short and the SMEs have conflicting priorities. Sometimes extensions need to be granted. <u>Q1 2024 Data Log Issues</u> Mrs. Ortega presented the Data Log issues for the appeals, claims, Continuity of Care, grievances, member services call center, member services ID card, Provider Disputes Resolution, and utilization management logs. All data log issues have been corrected. <u>Q1 2024 Data Validation Results</u> Mrs. Ortega proceeded to discuss the Q1 data validation results. All areas passed except for Claims and Provider Dispute Resolution (PDR), which failed its Q1 data validation and was marked as “Not Reportable” due to an inability to provide a timely revised log. Consequently, CHPIV could not report their Q1 KPI results. <u>Utilization Management</u>	

AGENDA ITEM/ PRESENTER	MOTION/MAJOR DISCUSSIONS	ACTIONS TAKEN
	Ms. Alcaraz addressed Utilization Management (UM) KPIs, noting noncompliance in all three categories: 92.10% for decision timeliness, 49.48% for member notification timeliness, and 46.37% for provider notification timeliness. Dr. Wu inquired about how to read the graph and whether CHPIV is supposed to be below 81.03%. Ms. Alcaraz then clarified how the top scores were overall scores, the scores on the bottom were break down of categories and how the compliance threshold is 95%. <u>Appeals</u> Ms. Alcaraz then continues to explain the Appeals KPIs. Timely Acknowledgement of Appeals, Timely Decision of Appeals, and Member Notification Timeliness passed with an overall score of 100% while Effectuation of Overturned Appeals and time failed with an overall 80% score. <u>Continuity of Care</u> Ms. Alcaraz addressed Continuity of Care (COC), highlighting two monitored areas: COC processing timeliness and COC notification timeliness. Health Net was non-compliant in COC processing timeliness, scoring 73.08%, primarily due to a low score of 36.36% in urgent cases. However, COC notification timeliness was fully compliant with a score of 100%. <u>Claims</u> Ms. Alcaraz elaborated that the claims department was concentrating on meeting payment timelines for 30 calendar days, 45 working days, and 90 calendar days, acknowledgement timeliness, misdirected claims timeliness, timeliness of interest, payment on late claims. However, due to the inability to conduct data validation for Q1, the results were marked as Not Reportable (NR).	

AGENDA ITEM/ PRESENTER	MOTION/MAJOR DISCUSSIONS	ACTIONS TAKEN
	Provider Dispute Resolution Ms. Alcaraz explained they track acknowledgement timeliness, written determination timeliness, and timeliness of interest payment on late PDR's and how the same thing occurred with PDR as with Claims resulting in Not Reportable scores. Dr. Wu then inquired about PDR 003 needing to be continuously monitored. Ms. Alcaraz added that based on comments from the last meeting, DO created KPIs specific to Claims timeliness for ECRMC and PMH. Member Services Three key performance indicators (KPIs) are monitored: calls answered within 30 seconds, call center abandonment rate, and timely issuance of member ID cards. It was noted that these KPIs are not part of the data validation audit. Compliance was not achieved, there were some delays in the timely issuance of member ID cards. Grievances The monitoring of grievances includes Timely Acknowledgement Letters, Timely Grievance Resolution, and Timely Member Notification. Compliance was achieved in all three areas. However, Ms. Alcaraz highlighted that the Timely Acknowledgement Letter metric is marked as yellow (at risk), indicating it is borderline at 95% indicating there is a risk of becoming non-compliant. Quarterly KPI Metrics (Q1 2024) – Actions Required Ms. Alcaraz moved on to explain the actions required for Quarterly KPI Metrics in Q1 2024 and mentioned there were warning letters issued to departments that	

AGENDA ITEM/ PRESENTER	MOTION/MAJOR DISCUSSIONS	ACTIONS TAKEN
	were non-complaint. The notices of non-compliance were issued to Claims and PDR that required them to submit revised logs by 07/19. <u>Quarter 2 Updates</u> Ms. Alcaraz reported that Health Net's Q2 2024 logs were due on July 19, 2024. In addition, they are conducting data validations. DO is targeting to have data validations completed by August 23, 2024, or before which includes additional revalidation audits if needed and disseminate the Q2 2024 scorecard to Health Net by August 30, 2024	
	Mrs. Hardy presented slide 9 on page 11, sharing a DHCS APL to clarify its definition and appearance in regards to the functional area of claims. Dr. Wu emphasized that a high number of APL claims pertain to all Health Plans, not just CHPIV to which Mrs. Hardy agreed with.	
Adjourn to Closed Session Dr. Allan Wu, *Chair*	Nothing to be discussed in close session	
Reconvene in Open Session Dr. Allan Wu, *Chair*	No Comments Made	
Adjournment Dr. Allan Wu, *Chair*	Meeting adjourned at 1:14pm	

IMPERIAL COUNTY
Local Health Authority Commission

Regulatory Compliance Oversight Committee of the Commission

MEETING MINUTES

Date/Time: October 01, 2024, 1:00 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	☒
Jeanette Crenshaw	Senior Director of Healthcare Services	☒
Elysse Tarabola	Chief Compliance Officer	☐
Dr. Gordon Arakawa	Chief Medical Officer	☐
Michelle Ortiz-Trujillo	Senior Director of Human Resources and Community Relations	☐
Chelsea Hardy	Senior Director of Compliance	☒
Jadira Alcaraz	Delegation Oversight Manager	☐
Rosa Sanchez	Compliance Advisor	☒
Fernanda Ortega	Delegation Oversight Specialist	☐
Amanda Delgado	Compliance Coordinator	☒

IMPERIAL COUNTY
Local Health Authority Commission

Regulatory Compliance Oversight Committee of the Commission

Donna Ponce	Executive Assistant/Commission Clerk	☒

AGENDA ITEM/ PRESENTER	MOTION/MAJOR DISCUSSIONS	ACTIONS TAKEN
Call to Order Dr. Allan Wu, *Chair*	Meeting called to order: 1:06 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 Approve:** Pablo Velez **Second:** Dr.Wu
Public Comment Dr. Allan Wu, *Chair*		**No Public Comment**
Chairperson's Report Dr. Allan Wu, *Chair*	A. No Report Given	
Approval of Minutes Dr. Allan Wu, *Chair*	A. Approval of Minutes from April 23, 2024	**Motion Approve:** Pablo Velez **Second:** Dr.Wu
Chief Compliance Officer (Interim) Report	A. Approve Updated and New Policies & Procedures Chelsea Hardy presented the revised and new policies and procedures, highlighting the redlined changes for clarity. Two new HR policies were introduced, while some existing policies were reviewed without changes.	**Motion Approve:** Pablo Velez **Second:** Dr.Wu

IMPERIAL COUNTY
Local Health Authority Commission

Regulatory Compliance Oversight Committee of the Commission

AGENDA ITEM/ PRESENTER	MOTION/MAJOR DISCUSSIONS	ACTIONS TAKEN
Chelsea Hardy, Senior Director of Compliance	• CMP-002 Delegation Oversight • CMP-003 Corrective Action Plans • CMP-005 Confidentiality and Member Privacy • UM-001 Utilization Management • UM-002 Referrals • QM-001 Quality Management and Improvement • GA-001 Grievances Process • GA-002 Appeals Process • GA-003 Independent Medical Review (IMR) • CPR-001 Public Policy Committee • HR-004 After-Hours Communication • HR-005 New Positions	
Adjourn to Closed Session Dr. Allan Wu, *Chair*	Nothing to be discussed in close session	
Reconvene in Open Session Dr. Allan Wu, *Chair*	No Comments Made	
Adjournment Dr. Allan Wu, *Chair*	Meeting adjourned at 1:13pm	

	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**	10/01/2024
Next Annual Review Due	10/02/2025	**Regulator Approval**	7/02/2024

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
  - CHPIV, Notice of Privacy Practices, CMP-012
  - CHPIV, IT Policy and Procedure, IT-001
- **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**
  - ~~o~~ NCQA: Member Experience (ME) 3, Element B, Medicaid (MED) 4, Elements A-C
  - ~~Health Equity (HE), Element F-G~~

	Confidentiality and Member Privacy	CMP-005

HISTORY	
Revision Date	**Description of Revision**
6/12/2023	Policy creation
~~10/1~~5/17/2024	Annual review- revisions to align with AB 254 & AB 352 updated requirement & NCQA requirements
	Policy revision to align with NCQA requirements

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 PHI, PII, and data regarding race, ethnicity, language, gender identity, and sexual orientation.

II. POLICY

A. CHPIV ensures there are processes to protect the confidentiality of a subscriber's or enrollee's PHI, PII, and data regarding a Member's race, ethnicity, language, gender identity, and sexual orientation. 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.
   3. ~~Managing~~As outlined in IT-001, managing the use of PHI, PII, and data regarding a Member's race, ethnicity, language, gender identity, and sexual orientation through:

a. ~~Limiting~~Managing and limiting employee access to physical and electronic data sources, such as media, devices, and data storage, and
b. Delineating permissible and impermissible uses and disclosures of the data. In accordance with 45 C.F.R. §§ 164.502(a), 164.506(a)-(b), CHPIV may make the following permissible disclosure types:
    i. To the individual.
    ii. To the individual's PERSONAL REPRESENTATIVE.
    iii. With the individual's authorization.
    iv. By CHPIV for purposes of treatment, payment or health care operations in compliance with 45 C.F.R. § 164.502.
    v. To business associates of CHPIV.
    vi. To a plan sponsor.
    vii. To research organizations.
    viii. Additional uses and disclosures consistent with the Notice of Privacy Practices (see CMP-012) that are permitted or required by law.
    ix. CHPIV may not use race, ethnicity, language, gender identity, and sexual orientation data for underwriting, or to deny services, coverage and benefits.

B. CHPIV will not cooperate with any inquiry or investigation by or provide PHI, PII, or data regarding a Member's race, ethnicity, language, gender identity, and sexual orientation 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 PHI, PII, or data regarding a Member's race, ethnicity, language, gender identity, and sexual orientation is authorized under Civil Code Section 56.110.
C. CHPIV will not disclose, transmit, transfer, share or grant access to PHI, PII, or data regarding a Member's race, ethnicity, language, gender identity, and sexual orientation, or related sensitive health care services provided to a protected individual to the primary subscriber or any plan enrollees other than the protected individual receiving care, absent an express authorization of the protected individual. This includes PHI or PII 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 PHI and/or PII 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.

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 PHI and/or PII related to sensitive services only to those persons who are authorized to access specified PHI and/or PII.
    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.
    4. Provide the ability to automatically disable access to segregated Medical Information related to sensitive services by individuals and entities in another state.
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 enrollees of the status of implementation of the requests if the subscribers or enrollees contact the plan.
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.
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.
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).

K. CHPIV ensures there are policies and procedures in place to ensure Members' Rights to confidentiality of PHI, PI, and data regarding a Member's race, ethnicity, language, gender identity, and sexual orientation 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, data regarding a Member's race, ethnicity, language, gender identity, and sexual orientation, 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, PI, and data regarding a Member's race, ethnicity, language, gender identity, and sexual orientation. 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 any non-public information including but not limited to business plans, products, technical data, specifications, documentation, rules and procedures, contracts, presentations, know-how, product plans, business methods, product functionality, services, data, customers, markets, competitive analysis, databases, formats, methodologies, applications, developments, processes, payment, delivery and inspection procedures, algorithms, formulas, or information related to marketing, or finance.
Downstream Subcontractor	Means an individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A

TERM	DEFINITION
	Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.
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.
Personal Representative	Means any person who has the right and authority under state law to make health care decisions on behalf of the individual, including surrogates such as a court-appointed guardian, persons with power of attorney, and others acting on behalf of an adult or emancipated minor, and parents, guardians and persons acting in loco parentis for a minor. An executor, administrator or other person who has authority under state law to act on behalf of a deceased individual or the individual's estate is also a personal representative.
Protected Health Information (PHI)	Means information that identifies the individual or it is reasonably believed could identify the individual and is transmitted or maintained in any form or medium and: i. Is created or received by a health care provider, plan, or clearinghouse; and ii. Relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to the individual; or the past, present or future payment for the provision of health care to the individual.
Personally Identifiable Information (PII)	Means any personal information about an individual including, but not limited to, education, financial transactions, medical history and criminal or employment history, and information which can be used to distinguish or trace an individual's identity, such as their name, Social Security number, date and place of birth, mother's maiden name, biometric records and any other personal information, which is linked or linkable to an individual.
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.

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

DATES			
Policy Effective Date	10/9/2023	**Reviewed/Revised Date**	
Next Annual Review Due	10/9/2024	**Regulator Approval**	

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

ATTACHMENTS

- Attachment A – Member Notice of Privacy Practices

AUTHORITIES/REFERENCES

- CHPIV Contract with the Department of Health Care Services (DHCS) for Medi-Cal
- DHCS All Plan Letter (APL) 06-001: Notice of Privacy Practices and Notification of Breaches
- DHCS All Plan Letter (APL) 22-026: Interoperability and Patient Access Final Rule
- CHPIV Plan Compliance Plan
- Title 45, Code of Federal Regulations (C.F.R.), §160.202
- Title 45, Code of Federal Regulations (C.F.R.), §164.105(c)(2)
- Title 45, Code of Federal Regulations (C.F.R.), §164.504
- Title 45, Code of Federal Regulations (C.F.R.), §164.508(a)(2)-(a)(4)
- Title 45, Code of Federal Regulations (C.F.R.), §164.508(b)(5)
- Title 45, Code of Federal Regulations (C.F.R.), §164.520(b)(1)(ii)(A) or (B)
- Title 45, Code of Federal Regulations (C.F.R.), §164.530(g)
- Patient Protection and Affordable Care Act §1557
- NCQA Standard MED5 Privacy and Confidentiality: Element A: Adopting Written Policies, Factor 1-2107

HISTORY

Revision Date	Description of Revision
10/9/2023	Policy creation
	Revised to align with NCQA standards

I. OVERVIEW

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

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

C. CHPIV ensures its BUSINESS ASSOCIATE'S compliance with federal and state privacy and security requirements through ongoing monitoring and audits in accordance with this Policy and the BUSINESS ASSOCIATE AGREEMENT (BAA).

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

II. POLICY

A. CHPIV MEMBERS have the right to adequate notice of the USES and DISCLOSURES of PROTECTED HEALTH INFORMATION (PHI), PERSONALLY IDENTIFIABLE INFORMATION (PII), and data regarding a Member's race, ethnicity, language, gender identity, and sexual orientation ~~-~~that may be made by CHPIV and of the MEMBERS' rights and CHPIV's legal duties with respect to PHI.

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

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

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

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

III. PROCEDURE

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

1. Mandated header;
2. Description and one (1) example each, of the types of USE and DISCLOSURES that CHPIV is permitted under state and federal regulations for the purposes of TREATMENT, PAYMENT, and HEALTH CARE OPERATIONS. If a USE or DISCLOSURE for any purpose described in paragraphs (b)(1)(ii)(A) or (B) of Title 45, Code of Federal Regulations, Section 164.520 is prohibited or materially limited by other applicable law, the description of such USE or DISCLOSURE must reflect the more stringent law;

3. A description of the types of USES and DISCLOSURES that require an authorization under Section 164.508(a)(2)-(a)(4), a statement that other USE and DISCLOSURES not described in this notice will be made only with the Member's written authorization, and a statement that the MEMBER may revoke such authorization as provided by Section 164.508(b)(5);
4. Statement to describe the Member's rights concerning their ~~his or her~~ PHI, PII, and data regarding a MEMBER'S~~Member's~~ race, ethnicity, language, gender identity, and sexual orientation, how to exercise these rights, and restrictions on such rights, which shall include information on:
    a. Restrictions concerning certain USE and DISCLOSURES of PHI/PII and data regarding a ~~Member's~~MEMBER'S race, ethnicity, language, gender identity, and sexual orientation, and provision that CHPIV is not required to agree to those restrictions, except in case of a DISCLOSURE restricted under Section 164.522(a)(1)(vi);
    b. Right to receive confidential communications of ~~PHI~~PHI/PII and data regarding a ~~Member's~~MEMBER'S race, ethnicity, language, gender identity, and sexual orientation;
    c. Right to inspect and copy PHI/PII and data regarding a ~~Member's~~MEMBER'S race, ethnicity, language, gender identity, and sexual orientation ~~PHI~~;
    d. Right to request amendment to PHI/PII and data regarding a ~~Member's~~MEMBER'S race, ethnicity, language, gender identity, and sexual orientation ~~PHI~~;
    e. Right to receive accounting of DISCLOSURES, with certain exceptions; and
    f. Right to receive a paper copy of the NPP, in accordance with this Policy.
5. Statement specifically describing CHPIV's duties and rights under the privacy rule, including:
    a. A statement that CHPIV is ~~R~~required by ~~l~~Law to maintain the privacy of the MEMBER'S~~Member's~~ PHI/PII and data regarding a MEMBER'S~~Member's~~ race, ethnicity, language, gender identity, and sexual orientation, to provide individuals with notice of its legal duties and privacy practices with respect to ~~PHI~~the aforementioned information, and to notify affected MEMBERS following a breach of unsecured PHI/PII and data regarding a MEMBER'S~~Member's~~ race, ethnicity, language, gender identity, and sexual orientation~~PHI~~, and in accordance with CHPIV policies, which shall include processes to ensure internal protection of verbal (i.e., when talking to individuals on the telephone or in person about a Member), and written information;
    b. The responsibility to abide by the terms of the NPP currently in effect;
    c. Reserve CHPIV's right to make changes to the terms of the NPP when we make changes to our privacy practices; and
    d. A description of how CHPIV provides MEMBERS with a revised NPP.
6. Disclosure of CHPIV's policies and procedures for managing access to and use of race/ethnicity, language, gender identity and sexual orientation data, including:

a. Controls for physical and electronic access to the data (keeping office secure, training staff on privacy and security processes, using firewalls and antivirus)

~~a.~~b. Permissible and impermissible use of the data (sharing with providers in a need to know basis to provide benefits and services, not using this data for benefit or coverage decisions)~~:~~

~~6.~~7. Statement that the MEMBER may file a complaint as part of their privacy rights, and without retaliation, to CHPIV's Customer Service Department or Privacy Officer, the California Department of Health Care Services (DHCS), and/or the United States Department of Health and Human Services (HHS), if the MEMBER believes his or her privacy rights have been violated, and include contact title and telephone number for filing the complaint with CHPIV, or to get further information concerning the notice. The contact information should include:

a. Attn: Privacy Officer
CHPIV
512 west Aten Rd
Imperial, CA
Telephone: 760-332-6447

b. CHPIV Customer Service Department
Toll-free: 1-833-236-4141
TTY: 711

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

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

~~7.~~8. Effective date of the notice.

a. The NPP shall be made available to anyone, upon request, by calling or writing to the CHPIV Customer Service Department. CHPIV's Customer Service Department shall make the NPP available in THRESHOLD LANGUAGES to anyone by mail, in person, or through the CHPIV website. CHPIV shall distribute the NPP by:

i. Ensuring initial distribution by mail to all MEMBERS;

ii. Including copies in all new enrollment packets;

iii. Posting a copy in the Customer Service Department lobby in THRESHOLD LANGUAGES;

iv. Posting the NPP on the CHPIV website;

v. Providing a revised NPP, or information about the material change and how to obtain the revised NPP, in the next mailing to MEMBERS;

vi. Notifying all MEMBERS at least once every three (3) years that a copy of the NPP is available upon request or may be obtained on the CHPIV website at www.CHPIV.org; and

vii. Ensuring all mailings of the NPP comply with CHPIV's Cultural and Linguistic Services guidelines.

B. Documentation and Retention:

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

IV. DEFINITIONS

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

TERM	DEFINITION
Business Associate	Means a person or entity who creates, receives, maintains or transmits protected health information on behalf of Health Net, or who performs a function on behalf of CHPIV or provides a service to CHPIV involving the use or disclosure of protected health information.
Business Associate Agreement (BAA)	A written agreement or arrangement with the business associate that meets the following applicable requirements of 45 CFR § 164.504(e): i. A covered entity may disclose protected health information to a business associate and may allow a business associate to create, receive, maintain, or transmit protected health

TERM	DEFINITION
	information on its behalf, if the covered entity obtains satisfactory assurance that the business associate will appropriately safeguard the information. A covered entity is not required to obtain such satisfactory assurances from a business associate that is a subcontractor. ii. A business associate may disclose protected health information to a business associate that is a subcontractor and may allow the subcontractor to create, receive, maintain, or transmit protected health information on its behalf, if the business associate obtains satisfactory assurances, in accordance with § 164.504(e)(1)(i), that the subcontractor will appropriately safeguard the information.
Disclosure/Disclose	The release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information. (45 CFR § 160.103)
Health Care Operations	Includes without limitation in accordance with federal regulation, quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule. (45 CFR § 164.501)
Member	A beneficiary enrolled in a CHPIV Medi-Cal program.
Notice of Privacy Practices (NPP)	Notice provided to a Member that describes CHPIV's practices in the Use and Disclosure of Protected Health Information, Member rights, and CHPIV legal duties with respect to Protected Health Information.
Payment	Includes without limitation in accordance with federal regulation: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services. (45 CFR § 164.501)
Protected Health Information	Means information that identifies the individual or it is reasonably believed could identify the individual and is transmitted or maintained in any form or medium and:

TERM	DEFINITION
~~(PHI)Protected Health Information (PHI)~~	i. Is created or received by a health care provider, plan, or clearinghouse; and Relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to the individual; or the past, present or future payment for the provision of health care to the individual.~~Means information that identifies the individual or it is reasonably believed could identify the individual and is transmitted or maintained in any form or medium and:~~ ~~i. Is created or received by a health care provider, plan, or clearinghouse; and~~ ii. ~~Relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to the individual; or the past, present or future payment for the provision of health care to the individual.~~
Protected Health Information (PHI)	Means information that identifies the individual or it is reasonably believed could identify the individual and is transmitted or maintained in any form or medium and: i. Is created or received by a health care provider, plan, or clearinghouse; and ii. Relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to the individual; or the past, present or future payment for the provision of health care to the individual.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).
Treatment	The provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another. (45 CFR § 164.501)
Use	With respect to individually identifiable health information, means the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information. (45 CFR § 160.103)

Notice of Privacy Practices
Effective September 1, 2023

CHPIV offers you access to health care through the Medi-Cal program. We are required by state and federal law to protect your health information. After you become eligible and enroll in our health plan, Medi-Cal sends your information to us. We also get medical information from your doctors, clinics, labs and hospitals to approve and pay for your health care.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

YOUR RIGHTS
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. You must make this request in writing. You will be sent a form to fill out and we may charge a fair fee for the costs of copying and mailing records. • You must provide a valid form of ID to view or get a copy of your health records. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. • We may keep you from seeing certain parts of your records for reasons allowed by law. • CHPIV does not have complete copies of your medical records. If you want to look at, get a copy of, or change your medical records, please contact your doctor or clinic.
Ask us to correct health and claims records	• You have the right to send a written request to ask that information in your records be changed if it is not correct or complete. You must make your request in writing. • We may refuse your request if the information is not created or kept by CHPIV, or we believe it is correct and complete, but we will tell you why in writing within 60 days. • If we don't make the changes you ask, you may ask that we review our decision. You may also send a statement saying why you disagree with our records, and your statement will be kept with your records.
Request confidential communications	• You can ask us to contact you by your preferred method of contact (for example, home or work phone) or to send mail to a different address.

	• We will consider all fair requests. We must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment,payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
Use a self-pay restriction	• If you pay the whole bill for a service, you can ask your doctor not to share the information about that service with us. If you or your provider submits a claim to CHPIV, we do not have to agree to a restriction. If a law requires the disclosure, CHPIV does not have to agree to your restriction.
File a complaint if you feel your rights are violated	• If you feel we have violated your rights, you can complain by contacting us using the information in this notice. • We will not retaliate against you for filing a complaint.

Your Choices: For certain health information, you can tell us your choices about what we share. If you have a preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In most cases, if we use or share your Protected Health Information (PHI) outside of treatment, payment

or operations, we must get your written permission first. If you give us your permission, you may take it back in writing at any time. We can't take back what we used or shared when we had your written permission, but we will stop using or sharing your PHI in the future.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care. • Share information in a disaster relief situation. • Contact you for fundraising efforts. *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we never share your information unless you give us written permission:	• Psychotherapy Notes: We must obtain your authorization for any use or disclosure of psychotherapy notes, except to carry out certain treatment, payment or health care operations. • Marketing purposes, unless allowed by law or regulation. • Sale of your information.

Our Uses and Disclosures: Your information may be used or shared by CHPIV only for treatment, payment and health care operations related with the Medi-Cal program in which you are enrolled. We may use and share your information in health information exchanges with providers involved in the care you receive. The information we use and share includes, but is not limited to:

- Your name
- Address
- History of care and treatment given to you
- Cost or payment for care

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services. We will share information with doctors, hospitals and others in order to get you the care you need.*

Run our organization (health care operations)	• We can use and share your information to run our organization and contact you when necessary. • **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.**	**Example:** *We use health information about you to develop better services for you, which may include reviewing the quality of care and services you receive. We may also use this information in audits and fraud investigations.*
Pay for your health services	• We can use and share your health information as we pay for your health services.	***Example:*** *We share information with the doctors, clinics and others who bill us for your care. We may also forward bills to other health plans or organizations for payment.*
Administer your plan	• We may share your health information with the Department of Health Care Services (DHCS) or the Centers for Medicare & Medicaid Services (CMS) for plan administration.	***Example:*** *DHCS contracts with us to provide a health plan, and we provide DHCS with certain statistics.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medicines • Reporting suspected abuse, neglect or domestic violence • Preventing or reducing a serious threat to anyone's health or safety

Comply with the law	• We will share information about you if state or federal laws require it, including with the U.S. Department of Health and Human Services if it wants to see that we are complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner or funeral director when an individual dies.
Address workers' compensation, law enforcement and other government requests	We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions, such as military, national security and presidential protective services.
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.
Comply with special laws	• There are special laws that protect some types of health information, such as mental health services, treatment for substance use disorders, and HIV/AIDS testing and treatment. We will obey these laws when they are stricter than this notice. • There are also laws that limit our use and disclosure for reasons directly connected to the administration of CHPIV's programs.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: https://www.hhs.gov/hipaa/index.html.

Changes to the Terms of This Notice

CHPIV can change the terms of this notice, and the changes will apply to all information we have about you. If that happens, we will update the notice and notify you. We will also post the updated notice on our website.

How to Contact Us to Use Your Rights

If you want to use any of the privacy rights explained in this notice, please write us at:

Privacy Officer
Attn: CHPIV
512 west Aten Rd
Imperial, CA
Telephone: 760-332-6447
Or call CHPIV's Customer Service department at: **1-833-236-4141**
TTY: **711**

If you believe that we have not protected your privacy and wish to file a complaint or grievance, you may write or call CHPIV at the address and phone number above. You may also contact the agencies below:

California Department of Health Care Services
Privacy Officer
C/O: Office of HIPAA Compliance
Department of Health Care Services
P.O. Box 997413, MS 4722
Sacramento, CA 95899-7413
Email: privacyofficer@dhcs.ca.gov
Phone: 1-916-445-4646
Fax: 1-916-440-7680

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

Use Your Rights Without Fear

CHPIV cannot take away your health care benefits nor do anything to hurt you in any way if you choose to file a complaint or use any of the privacy rights in this notice. This notice applies to CHPIV's Medi-Cal health care program.

CHPIV's Medi-Cal program contracts with DHCS to provide benefits under the Medi-Cal program to its members. CHPIV complies with applicable federal civil rights laws and does not

discriminate on the basis of race, color, national origin, age, disability, or sex. Please call our Customer Service number at 1-833-236-4141, 24 hours a day, 7 days a week. TDD/TTY users can call 711.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-833-236-4141 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-833-236-4141 (TTY: 711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-833-236-4141 (TTY: 711).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-833-236-4141 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-833-236-4141 (TTY: 711)

Farsi: توجه :اگر بهِ زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. 1-833-236-4141 (TTY: 711) تماس بگیرید.

Arabic: ملحوظة :إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان .اتصل علي الرق م1- 833-236-4141 (TTY: 711)

	Key Personnel Disclosure	CMP-013
Department	Compliance	
Functional Area	Compliance	
Impacted Delegate	☐ Subcontractor ☒ NA	

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

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

ATTACHMENTS

N/A

AUTHORITIES/REFERENCES

- CHPIV Contract with Department of Healthcare Services (DHCS): Exhibit A, Attachment 1.1.8 (Key Personnel Changes)
- California Code, Health and Safety Code (HSC) 1352©
- 1300.51, 1300.52, 1300.52.2, 1300.52.4
- HSC 1352

HISTORY

Revision Date	Description of Revision

I. OVERVIEW

A. This policy addresses Community Health Plan of Imperial Valley's ("CHPIV" or the "Plan") key personnel change disclosure. The purpose of this policy is to establish a process to disclose to the Department of Healthcare Services (DHCS) and the Department of Managed Health Care (DMHC) changes in the status of the executive-level personnel.

II. POLICY

A. CHPIV must report within ten calendar days to DHCS Contract Manager any changes in the status of the executive-level personnel including, but not limited to:

1. CHIEF EXECUTIVE OFFICER
2. CHIEF FINANCIAL OFFICER
3. CHIEF OPERATING OFFICER
4. CHIEF MEDICAL OFFICER
5. CHIEF HEALTH EQUITY OFFICER
6. CHIEF COMPLIANCE OFFICER
7. GOVERNMENT RELATIONS PERSON

B. CHPIV must report within 20 calendar days to DHCS Contract Manager any changes in the status of the executive-level personnel for Fully Delegated SUBCONTRACTORS, Partially Delegated SUBCONTRACTORS, Downstream Fully Delegated SUBCONTRACTORS, and Downstream Partially Delegated SUBCONTRACTORS including, but not limited:

1. CHIEF EXECUTIVE OFFICER
2. CHIEF FINANCIAL OFFICER
3. CHIEF OPERATING OFFICER
4. CHIEF MEDICAL OFFICER
5. CHIEF HEALTH EQUITY OFFICER
6. CHEIF COMPLIANCE OFFICER
7. GOVERNMENT RELATIONS PERSON

C. CHPIV shall submit a personnel change filing with DMHC within 5 days of the change going into effect in accordance with the Health and Safety Code (HSC) 1352. Changes in key Plan personnel include (addition or deletion):

1. Directors;
2. Trustee;
3. Principal officer (president or CHIEF EXECUTIVE OFFICER (CEO), vice president, secretary, treasurer or CHIEF FINANCIAL OFFICER (CFO), or chairman of the board of a corporation, a sole proprietor, the managing general partner of a partnership;
4. General Partner;
5. General manager or principal management person;
6. Person occupying similar positions or performing similar functions; or
7. A substantial or material change in the duties of any such person.

III. PROCEDURE

A. DHCS Submission:

1. CHPIV shall submit artifact D.0002 Key Personnel Change in DHCS's Managed Care Operations Division-Managed Care Plan (MCOD-MCP) Submission Portal with an attached letter explaining the following:
    a. The names, titles, and dates of change for each addition and/or deletion of key personnel.
    b. The Plan's next steps to fill the vacant position and how the duties of the vacant position will be managed while it remains unfilled.

B. DMHC General Filing:
1. CHPIV shall submit a personnel change filing in DMHC's eFiling portal. DMHC will not review improperly filed Notices, Amendments, and Exhibits. CHPIV will be required to re-file and/or withdraw improperly filed Notices, Amendments, and Exhibits prior to review by DMHC.
2. CHPIV shall utilize the DMHC Checklist for Key Personnel/Business Administration Change to ensure all the necessary documentation within the required Exhibits are included in the filing. Required Exhibits:
    a. Exhibit E-1: eFiling Narrative
    b. Exhibit number format F-1: Business Information Documents
    c. Exhibit F-1-f: Individual Information Sheet
    d. Exhibit F-2: Creditor Information
    e. Exhibit L: Organization Chart
    f. Exhibits M: Key Personnel Narrative Information
    g. Exhibits HH-3-f-i: Measures to Maintain TNE
3. General Filing Information:
    a. Amendment Filing: File all changes to Key Personnel described in Section 1351 (C) and 1352 (C) as an Amendment Filing.
    b. Revised Exhibits: If CHPIV has revised documents previously approved by DMHC, CHPIV shall file the revised document as the proper Exhibit type and identify in Exhibit E-1 the eFiling number affiliated with the previously approved document. CHPIV shall identify changes via highlight or strikeout, in accordance with Rule 1300.52(d).

IV. DEFINITIONS

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

TERM	DEFINITION
Chief Executive Officer (CEO)	The Chief Executive Officer (CEO) of a Managed Care Plan is the highest-ranking executive, responsible for implementing organizational strategies, ensuring the achievement of overall objectives, and maintaining operational, legal, and financial integrity, all while being accountable to the Commission.

Chief Financial Officer (CFO)	The Chief Financial Officer (CFO) is an officer who is assigned to develop and initiate systems, policies and procedures for transacting financial matters, and ensure that the financial system is accurate, efficient, and in accordance with professional practices and governmental regulations.
Chief Operating Officer (COO)	The Chief Operating Officer (COO) is a key member of the management team, responsible for overseeing the day-to-day administrative and operational functions CHPIV departments.
Chief Medical Officer (CMO)	The Chief Medical Officer (CMO) is responsible to ensure CHPIV medical staff on board with administrative directives and leading any necessary changes in the organization's culture.
Chief Health Equity Officer	The Chief Health Equity Officer is responsible to ensure to provide CHPIV leadership in the design and implementation of CHPIV's strategies and programs to ensure Health Equity is prioritized and addressed. The Chief Health Equity Officer will ensure CHPIV's policy and procedures consider Health Inequities and are designed to promote Health Equity where possible and aimed at improving Health Equity and reducing Health Disparities.
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.
Government Relations Persons	Government Relations Persons responsible for directing and coordinating policy research and analysis on issues involving federal, state, and local governments and regulations. Develops strategies and promotes the system's position to government officials. Monitors potential legislative matters and develops action plans as appropriate

	Appropriate Professionals and Use of Board-Certified Physician Consultants in Utilization Management Decision Making	UM-004
Department	Health Services	
Functional Area	Utilization Management	
Impacted Delegate	☒ Subcontractor ☐ NA	

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

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

ATTACHMENTS

N/A

AUTHORITIES/REFERENCES

- Manual, Rev 105, Issued 04-20-2012, Section 40.1.1 California Knox Keene Act / H&S Code Section 1367.01 (e) (h) and (j)
- Knox Keene Act/ H&S Code Section 1367.63(b)
- CIC Section 10123.135(e)
- NCQA UM Standards UM 4
- Medicare Managed Care Manual, Chapter 4
- Title 22 CCR 51340 and 51340.1
- Title 42 USC Section 1396d (r)(5)
- NCQA UM Standard 4
- Medicare Managed Care Manual, Chapter 13,
- SB 1008 (Statutes of 2012, Chapter 33)
- DHCS Managed Care Contracts (Two Plan and Geographic Model, Exhibit A, Attachment 5.
- MMCD All Plan Letter 17- 006 "Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments"
- California Mental Health Parity Act
- Section 1374.721 of the Health and Safety Code
- Section 10144.5 to 10144.52 of the Health and Safety and Insurance Code
- Section 1374.72 and 1374.73 of the Health and Safety Code

HISTORY

	Appropriate Professionals and Use of Board-Certified Physician Consultants in Utilization Management Decision Making	UM-004

Revision Date	Description of Revision

I. OVERVIEW

A. This policy and related procedures apply to all individuals employed, contracted, or otherwise representing CHPIV and its subsidiaries who are responsible for providing Utilization Management for Plan Members.

II. POLICY

A. CHPIV will ensure that appropriately licensed professionals to make MEDICAL NECESSITY Utilization Management decisions. To achieve this the following procedures are followed:

1. Licensed Healthcare Professionals
    a. CHPIV will ensure that only appropriately licensed professionals make MEDICAL NECESSITY determinations.
    b. CHPIV will ensure that Qualified licensed healthcare professionals render or supervise all clinical review decisions. Under certain circumstances, non-clinical staff may authorize requests for coverage based on explicit instructions and coverage guidelines.
    c. CHPIV will ensure that Nurses may review and approve cases that are a covered benefit and meet MEDICAL NECESSITY criteria according to clinical guidelines as outlined in the Medical Policy Hierarchy. Cases not meeting MEDICAL NECESSITY criteria are forwarded to an appropriate physician for final decision. Medical directors provide oversight to nurses for consultation as needed.
    d. CHPIV will ensure that Nurses, at the discretion of the medical director, may approve requests for an Out of Network (OON) PROVIDER when MEDICAL NECESSITY criteria have been met.
    e. CHPIV will ensure that Nurses may make administrative denials based on lack of eligibility, or benefit exhaustions.
    f. CHPIV will ensure that non-clinical associates, under the supervision of appropriately licensed health professionals, collect data for preauthorization and CONCURRENT REVIEW and may approve requests for select services.
    g. CHPIV will ensure that written job descriptions on the Medical Management Intranet site, with qualifications for all practitioners who review potential denials of covered services based on MEDICAL NECESSITY.
    h. CHPIV will ensure that Qualifications include education, training, and/or professional experience in a medical or clinical practice, as well as a current license to practice without restriction.
    i. CHPIV will ensure that a contractual relationship with at least one external review organization. This organization is able to provide timely specialty opinions for all

recognized specialty types in the United States, usually within one business day. The panel of board-certified specialists can be consulted, when appropriate, to aid in the determination of MEDICAL NECESSITY for cases in which clinical judgement is needed for Utilization/Care Management decisions which are sufficiently specialized.

j. CHPIV will ensure that the Plan has entered into an agreement with a vendor to provide a panel of specialists. Credentialing of specialists included in a vendor panel has been delegated to the vendor in accordance with the Plan's Credentialing DELEGATION policies. The Plan contracted external review organizations are URAC accredited.

2. Utilization Management Decision-Making

a. CHPIV will ensure that Qualified licensed healthcare professionals render or supervise all clinical review decisions. Under certain circumstances, non-clinical staff may authorize requests for coverage based on explicit instructions and coverage guidelines.

b. These licensed health care professionals:

- Provide day-to-day supervision of assigned UM staff.
- Participate in staff training.
- Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision.
- Monitor documentation for adequacy.
- Are available to UM staff on site or by telephone.

~~a.~~c. CHPIV will ensure that Pharmacists may review cases for final decision.

~~b.~~d. CHPIV will ensure that Review of Behavioral health cases for denial of covered services are reviewed by physicians, psychiatrists, doctor-level clinical psychologists or certified addiction medicine specialists.

~~c.~~e. CHPIV will ensure that all utilization review decisions to deny coverage based on MEDICAL NECESSITY are made by APPROPRIATE PRACTITIONERS with the appropriate clinical expertise. For specialty areas, every effort is made to assure that the physician reviewing the case has the appropriate clinical expertise. Internal Plan Medical Directors, when available for the required specialty, will be the first contact for specialty consultations. When necessary, a same/similar specialist reviewer will evaluate the case and request service/item and provide recommendations regarding the MEDICAL NECESSITY of the requested service in accordance with The Plan's available clinical guidelines and medical policies used in making determinations as to whether a covered service is medically necessary.

3. Same/Similar Specialist Review

a. CHPIV will ensure that Guidelines for requesting same/similar specialist review or consultation include but are not limited to:

i. The case and or service/item under review request includes a complex medical procedure, a standard of care review, regulatory requirement, and/or specialist knowledge, or
ii. No Plan National Medical Advisory Committee Policy is available to clarify the MEDICAL NECESSITY decision-making process, or
iii. No INTERQUAL criteria are available, or
iv. The service/item under review request is outside the credentialed expertise of the reviewing The Plan's Medical Director.

4. Request for same/similar specialist review or consultation:

a. CHPIV will ensure that upon request for MEDICAL NECESSITY review, the Plan's Medical Director will either:
   i. Make the MEDICAL NECESSITY determination, or
   ii. Refer the case to a board-certified same/similar specialist for clinical review.
b. CHPIV will ensure that if the case requires same/similar specialist review or consultation:
   i. The Plan's Medical Director will contact or arrange for contact of the appropriate same/similar specialist, requesting consultation on the case and service/item under review generally within one (1) working day of receiving the case for review. The Plan's Medical Director will provide appropriate and available medical/clinical information, including the medical records, to the designated same/similar specialist and will request that a written opinion be received within a medically appropriate time frame, generally within one (1) working day.
   ii. Upon receipt of the Specialist's consultation, the Plan's Medical Director will review the same/similar specialist's written recommendation and will make a final determination. The written review is imaged into the online file.
c. CHPIV will ensure that the Plan's Medical Director, or his/her designee, notifies the requesting PROVIDER of the determination, and the determination is documented in the electronic medical management system.

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*:
   i. Ongoing monitoring
   ii. Performance reviews
   iii. Data analysis
   iv. Utilization of benchmarks, if available
   v. Annual desktop and on-site audits

IV. DEFINITIONS

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

TERM	DEFINITION
Appropriate Practitioners	May include but are not limited to Physicians, behavioral health practitioners, including psychiatrists, doctoral-level clinical psychologists or certified addition medicine specialists, chiropractors, dentists, and pharmacists.
Concurrent Review	Concurrent review is a member centric process that includes 3 essential components: -Medical Necessity Review -Discharge and Transitional Care Planning -Coordination of Care. Medical Management's focus is during the acute hospital event to support a smooth transition across the continuum.
Delegation	A formal process by which an entity is given the authority to perform certain functions on another's behalf.
InterQual	A set of measurable clinical indicators, diagnostic and therapeutic services reflecting the need for hospitalization. Criteria are based on the patient's level of illness and services required rather than on diagnosis.
Medical Necessity	Except where state or federal law or regulation requires a different definition, the Plan defines "Medical Necessary" or comparable term in each agreement with Physicians, Physicians Groups, and Physician Organizations and will not include in any such agreement a definition of Medical Necessity that is different from this definition.
Medically Necessary/Medical Necessity (Medi-cal)	For purposes of this Contract, the term "Medically Necessary" will include all Covered Services that are reasonable and necessary to protect life, prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity per Title 22 CCR Section 51303(a) and 42 CFR 438.210(a)(5).
National Medical Advisory Council (MAC)	The Medical Advisory Council (MAC) oversees the formal process for medical policy development, including medical necessity criteria, clinical practice guidelines and newly emerging technology.
Provider	The term provider includes providers contracted with the plan sponsor, non-contracted providers, and sub-contractors, including, but not limited to, pharmacists, pharmacies, physicians, hospitals, and long-term care facilities.

	Medical Necessity Criteria, Technology Assessment and Hierarchy of Resources	UM-005
Department	Health Services	
Functional Area	Utilization Management	
Impacted Delegate	☒ Subcontractor ☐ NA	

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

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

ATTACHMENTS

N/A

AUTHORITIES/REFERENCES

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- http://www.nationalacademies.org/hmd/~/media/8D03963CAEB24450947C1AEC0CAECD85.ashx
- Lembitz A, Clarke TJ. Clarifying "never events" and introducing "always events." Patient Saf Surg. 2009; 3:26.
- Change Healthcare InterQual® criteria.
- MCG (formerly Milliman Care Guidelines®) guidelines.
- National Committee for Quality Assurance. NCQA Standards and Guidelines for the Accreditation of Health Plans 2014.
- National Quality Forum. Serious reportable events in healthcare 2006 update: A consensus report.
- Steinberg, EP, Tunis, S, Shapiro, D. Insurance coverage for experimental technologies. Health Affairs, 1995 Vol. 14:4.
- California Senate Bill (SB) 855 Health Coverage Mental Health or Substance Use Disorders

HISTORY

Revision Date	Description of Revision

	Medical Necessity Criteria, Technology Assessment and Hierarchy of Resources	UM-005

I. OVERVIEW

A. MEDICAL NECESSITY criteria and related definitions.

II. POLICY

A. CHPIV will ensure that the Plan will use the following guidelines and uses criteria for determining medical appropriateness based on sound clinical evidence such as age, comorbidities, complications, progress of treatment, psychosocial situation, home environment, when applicable, are clearly documented, and include procedures for applying criteria based on the needs of individual patients and characteristics of the local delivery system.

~~A. to make MEDICAL NECESSITY decisions (listed in order of significance) on a case-by-case basis, based on the information provided on the member's health status:~~

1. Federal law (e.g., National Coverage Determinations (NCD), Local Coverage Determinations (LCD), and Medicare Coverage Articles for Federal programs such as Medicare).
2. State law/guidelines (e.g., when State requirements trump or exceed federal requirements).
    a. Note: Per Regulation SB 855, for Mental Health and Substance Abuse (MH/SA) the most recent versions of treatment criteria developed by the nonprofit professional agencies such as Level of Care Utilization System (LOCUS)/Child & Adolescent Level of Care Utilization System (CALOCUS) criteria, American Society of Addiction Medicine (ASAM), and Early Childhood Service Intensity Instrument (ECSII) shall be applied when contractually required. When no nonprofit professional association provides criteria for a clinical specialty, an external vendor such as InterQual or internally developed criteria may be used as long as they meet the "generally accepted standards of mental health and substance use disorder care."
3. Plan-specific clinical policy including plan-specific clinical policies in InterQual® as custom content and vendor specific criteria (such as eviCore, NIA).
4. Centene clinical policy (including Centene clinical policies in InterQual as custom content).
5. If no Plan- or Centene-specific clinical policy exists, then nationally recognized decision support tools such as Change Healthcare InterQual Clinical Decision Support Criteria or MCG (formerly Milliman Care Guidelines®) criteria are used.
6. In the case of no guidance from A-E, additional information that the applicable health plan Medical Director will consider, when available, includes:
    a. Reports from peer reviewed medical literature, from which a higher level of evidence and study quality is more strongly considered in determinations.
    b. Professional standards of safety and effectiveness recognized in the US for diagnosis, care, or treatment.

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c. Nationally recognized drug compendia resources such as Facts & Comparisons®, DRUGDEX®, and The National Comprehensive Cancer Network® (NCCN®) Guidelines
d. Medical association publications.
e. Government-funded or independent entities that assess and report on clinical care decisions and technology such as Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, National Institute for Health, and Care Excellence (NICE), etc.
f. Published expert opinions.
g. Opinion of health professionals in the area of specialty involved.
h. Opinion of attending provider in case at hand.

B. Availability of Criteria:
1. CHPIV will ensure that Clinical policies are posted internally for the health plan staff and are available to providers and members on the healthnet.com website.

2. CHPIV will ensure Communication of these policies is arranged by the Provider Communications Department through quarterly fast fax distribution.

C. Annual Review of Criteria:
1. CHPIV will ensure Corporate clinical policies, InterQual criteria updates and health plans specific policies are reviewed on an annual basis or more frequently as clinical literature dictates.

D. CHPIV will ensure Clinical policies that have been approved by the Corporate Clinical Policy Committee (see Centene's Clinical Policy Committee policy) and provided to the Plan for review and adoption.
E. CHPIV will ensure Clinical policies are reviewed at the Plan's Medical Advisory Council (MAC) (see the Plan's Medical Advisory Council Charter).
F. The Plan may choose to adopt, not adopt, or develop its own clinical policies based on business need. Clinical policies that developed by the Plan are reflective of current evidence based scientific research and critical thinking as the Centene clinical policies are reviewed on an annual basis by the MAC.

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
Medical necessary	Means all Covered Services that are reasonable and necessary to protect life, prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity per Title 22 CCR Section 51303(a) and 42 CFR 438.210(a)(5).When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and W & I Code Section 14132 (v). For individuals under 21 years of age, EPSDT service is considered medically necessary or a medical necessity when it is necessary to correct or ameliorate defects and physical and mental illnesses and conditions that are discovered by screening services. A service need not cure a condition in order to be covered under EPSDT. Services that maintain or improve the child's current health condition are also covered under EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. The common definition of "ameliorate" is to "make more tolerable." Additional services must be provided if determined to be medically necessary for an individual child

	Utilization Management System Controls	UM-006
Department	Health Services	
Functional Area	Utilization Management	
Impacted Delegate	☒ Subcontractor ☐ NA	

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

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

ATTACHMENTS
N/A

AUTHORITIES/REFERENCES

- **Internal**
  - IT Policies
- **Federal**
  - 42 CFR § 422.586 Opportunity to submit evidence
- **Accreditation**
  - NCQA UM 12 UM System Controls

HISTORY	
Revision Date	**Description of Revision**

I. OVERVIEW

A. The purpose of this policy is to ensure the organization has Utilization Management (UM) system controls in place that prevent and protect UM denial and APPEAL data and information from being altered outside of prescribed protocols.

II. POLICY

A. Policies and procedures are compliant with all NCQA, federal, and state regulatory requirements for system controls governing how UM denial and APPEAL information is stored, modified, and secured, to protect UM data from being altered outside of prescribed protocols. Contracts with external entities require information storage protocols to protect UM denial and APPEAL data from being altered outside of prescribed protocols. Audits are conducted to ensure all business units and delegated vendors that store, create, modify, or use UM denial or APPEAL data information have appropriate policies and processes in place to protect the security and integrity of UM data.

B. Denial and Appeals
   1. UM denial and APPEAL policies define the *date of request* as the date the request from the member or the member's authorized representative for the UM or APPEAL decision was received by the organization, even if not all necessary information was received at the time of the request and regardless of which business unit or department received the request except for Medicare urgent requests. The receipt date for Medicare urgent requests is the date that the appropriate department receives the request. Business units and departments have protocols for timely forwarding of all misdirected UM or APPEAL requests to the appropriate department responsible for the UM or APPEAL decision.
   2. UM denial and APPEAL policies define the *date of written notification* of a UM denial and/or APPEAL decision as the date included in the date field of the UM denial or APPEAL notification letter. When the organization uses electronic notification for denial or APPEAL determinations, the written notification date is the date the notification is entered into the electronic system.
   3. Staff who conduct UM activities document the UM DATE OF RECEIPT REQUEST, date of decision, and date of notification for all UM denials and appeals in the clinical documentation management system and/or appeals tracking database designated by their business units.
   4. Date of request is documented in the clinical system per the definition as noted above and in the Definitions section of this policy. All system entries are date and time stamped with the name of the individual staff completing the action.
      a. Requests received via the web are automatically stamped with the date/time of when the request was received, and the case is auto generated/created in the clinical documentation system.
      b. UM staff enter the date/time received into the requested date field for requests received via fax, and the fax is saved in the clinical documentation system.
      c. UM staff enter the date/time received into the requested date field for requests received telephonically and create a note documenting the content of the phone call.
   5. Date of written notification is auto generated in the clinical documentation system when the written notification (e.g., denial notice or APPEAL resolution letter) is created. No modifications to the date/time stamp can be made to this field under any circumstances, per system functionality.
   6. All business units conducting UM and/or APPEAL activities include training addressing the following:
      a. The process of recording dates of request, decision, and written notification in the clinical documentation management systems or appeals system.

b. The appropriate individuals who, and under what circumstances, the documented DATE OF RECEIPT REQUEST and/or date of written notification for a UM denial or APPEAL decision may be modified in the clinical management system or appeals tracking database.
   i. Staff who are authorized to modify dates includes: only authorized users with "write" access to the determination and appeals modules in the clinical documentation management systems. Staff are authorized to, when allowable by system limits and controls, modify information including dates in the respective documentation systems.
      A. Titles of frontline staff who manage *UM denials* and have "write" access to the clinical documentation system and thus can modify dates once initially recorded include Medical Director; Consultant Advisor; Clinical Pharmacist; Denial Coordinator; Concurrent Review Nurse (Senior/I/II), Service Coordinator (Lead/I/II); Referral Specialist (Lead/I/II); Clinical Pharmacist; Pharmacy Coordinator, Senior Pharmacy Specialist, Pharmacy Specialist. *Note: individual staff titles may vary by health plan or product in some instances.*
      B. Titles of frontline staff who manage *UM appeals* and have "write" access to the clinical documentation system and thus can modify dates once initially recorded include Medical Director, Consultant Advisor, Clinical Pharmacist, Clinical Appeals Coordinator, Appeals Nurse, Appeals Associate. *Note: individual staff titles may vary by health plan or product in some instances.*
      C. Titles of management/supervisory staff for *UM denials and appeals* and have "write" access and thus can modify dates once initially recorded include Vice President, Senior Director, Director, Senior Manager, Manager, or Supervisor of Population Health Clinical Operations, Utilization Management, Medical Management, or Pharmacy Operations; Manager or Supervisor Referral Services; Appeals Director, Manager, or Supervisor. *Note: individual staff titles may vary by health plan or product in some instances.*
      D. The clinical documentation system (e.g., TruCare, Care Central/Pega) *Role Matrix* specifies which job titles are assigned to each "Role" or "Access Group" which determines the level of access (i.e., read/write access or read only access), and type (e.g., access to which members/business unit, which modules [authorization determinations, appeals, UM and/or CM content, etc.]).
   ii. Circumstances when modification is appropriate include the following:
      A. A documentation error by UM and/or APPEAL staff was identified.
      B. A system generated date or record was in error.
      C. The recorded date was inconsistent with other documentation provided. In this case, the earliest provided date will be used for receipt date and the latest for notification date.
      D. Other circumstances as noted in the member record as appropriate reason for edits to dates or documentation.

C. Tracking Modified Dates
   1. User edits to documentation are tracked within the system, with each system entry date and time stamped with the name of the individual staff completing the action. Tracking

includes date modifications, when a date modification was made, staff who modified the date, and why the date was modified. Notes are utilized by users to provide the rationale for why edits were made to a record where there is not a rationale prompt.

2. System security controls are in place to protect data from unauthorized access and modification as described in the associated IT security policies and through the assignment of specific UM staff "roles" for system access. An ongoing review of appropriate access is conducted per IT security policies, including requirements for new system access requests for UM staff members changing roles or transferring to a new business unit, for example.

D. Monitoring of the UM Denial and Appeal Systems Control Process

1. Monitoring compliance with the definitions and processes identified in this policy and procedure is completed at least annually and appropriate action is taken when applicable.
    a. This policy is reviewed no less than annually and more often as needed (e.g., per updates to the NCQA standards) to ensure the definitions of date of receipt and date of written notification are consistent with NCQA requirements. Applicable revisions to the policy are made as needed to maintain consistency.
    b. Any significant change in system functionality is reflected in the policy and all associated policies, e.g., a change in the date of written notification auto-generated date/time stamp, which currently does not allow date modifications under any circumstances per system functionality.
    c. Audits of denial and appeals files with modifications are completed at least annually or more frequently as needed to ensure adherence to policies and procedures and includes analysis of date modifications that are not considered appropriate modifications, as described above. The monitoring of system modifications may occur via system event audit logs and/or individual record audits that identify modifications to the clinical systems data.
    b. Clinical documentation system reports are utilized to identify the file universe. The clinical documentation system reports for UM and appeals pulls the entire universe of files that includes files with and without modifications to calculate the sample of files for the monitoring period. The sample of files that are audited include only files with modifications.

2. A random sample of 5% or 50 files, whichever is less, for all products is selected for each Plan to review against the requirements for each applicable file type (i.e., UM denials and UM appeals).
3. The same clinical data management system is utilized to manage all product lines; therefore, a random sample is not generated by product line.

    a. PHCO and/or Quality auditing staff review each file to assess whether any modifications to the date of receipt have been made; this is assessed by comparing the date noted on the original request (i.e., web request, fax, or phone call) with the date populated in the request date field in the clinical documentation system. For each file reviewed, the auditor documents whether a modification was appropriate or not appropriate.

    b. PHCO leadership (e.g., UM Manager or Supervisor, Appeals Manager or Supervisor) provides process oversight and takes appropriate action if date modifications that are not deemed appropriate per this policy are identified during the auditing process. The

results of the audit for each health plan demonstrates monitoring compliance with the UM Denial and APPEAL controls through the following activities:

4. Identification of all modifications to receipt date for UM denials and appeals that did not meet policies and procedures for date modifications.
5. Analysis of all instances of date modifications that did not meet the policies and procedures for date modifications.
6. Implementation of interventions on all findings for performance improvement and the staff or department responsible for the follow-up actions.
7. Implementation of a quarterly monitoring process until the health plan demonstrates improvement for one finding over three consecutive quarters.
8. The process for documenting and reporting date modifications that do not meet this policy.
    a. Remediation of any findings may include individual or group training, loss of system access, or disciplinary action.

E. Vendor Management
1. The company contracts with external entities for storage of UM data. Policies and procedures are in place for monitoring vendors or delegated entities for compliance with processes to prevent unauthorized access to, or modification of, stored UM data. The Information Security Team works in alliance with the Privacy and Delegation Vendor Management/Oversight Teams as required when reviewing delegated vendors, including oversight and monitoring to ensure compliance to preserve UM data integrity and security.
2. Vendor Management is responsible for conducting the following activities:
    a. Pre-delegation audits, including policy review.
    b. Annual audits to include the delegate's specific programs that apply to the delegated functions, applicable policies and procedures, applicable file reviews, and review of meeting minutes for compliance with health plan, state, accreditation, CMS, or other applicable regulatory standards or contractual requirements, including monitoring the delegate's UM denial and APPEAL system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures.
    c. Audits may be twice annually, dependent on their identified risk level, and follow up corrective action in place as needed.

F. Information Technology/Information Security
1. The company has a robust security program that aligns with the NIST Cyber Security framework and maintains an ISO 27001 certification.
2. Controls are reviewed on an annual, semi-annual, and quarterly basis through the use of ISO 27000 series, NIST 800 series assessments, HIPAA assessment, SOC 2 audits, and other compliance reviews, as well as internal penetration tests and third-party penetration testing and vulnerability scans.
3. Policies and procedures are in place for user access management and the monitoring of user access management.

a. Information system accounts are managed through proper management approvals in its provisioning process, and the use of system authentication standards that control access to its systems. Multifactor authentication is used to protect local and network access to both privileged and non-privileged accounts.
b. Users requiring access to systems to perform their job functions must be registered in the Human Resource (HR) system of record. System access is then provisioned through the identity access management tool based on the HR record.
c. When a user transfers positions, his/her system access must be reviewed and updated in a timely manner to meet the needs of the newly assigned position. The user must submit a ticket to request the necessary access changes and the user's manager must also approve the access changes.
d. System users are only granted access as authorized by the appropriate level(s) of management. Access requests must be processed in accordance with standard access request procedures which includes specifying the permissions assigned to users.

4. System user password requirements include:
   a. A unique user ID;
   b. Strong passwords;
   c. Avoiding writing down passwords;
   d. Changing passwords periodically; and
   e. Notification to appropriate staff to disable or remove access of employees who leave the organization.

G. Information Security Audits
1. Audits of system controls and modifications are completed to ensure adherence to policies and procedures.
2. Independent third parties and internal resources are engaged to perform reviews of information security as appropriate, including but not limited to, SOC2 audits, HIPAA reviews, annual policy reviews, and capability assessments. The authoritative sources for these reviews are based on the NIST CSF and ISO 27001 Cybersecurity industry standard.
3. System controls related to access are ongoing and quarterly SOX audits assess all clinical system users, roles, and last access dates.
   a. On an ongoing basis, any user who has not logged into the system following a defined period of days will lose access to the clinical systems.
   b. Quarterly, during SOX audits, users are assessed for need and access is terminated for anyone found to no longer need access to perform daily work functions.

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
Appeal	An oral or written request for a Plan to change or reconsider a previous decision regarding an adverse determination, including adverse medical necessity and benefit decisions, adverse claim decision, an administrative action, etc. An appeal may be received from a member or the member's appointed/authorized representative and request that any initial determination be reconsidered based on the initial evidence and findings, or other evidence submitted or obtained by the parties, in accordance with 42 CFR § 422.586.
Date of Receipt of Request	Date the request from the member or the member's authorized representative, or provider is made for a covered member in accordance with reasonable filing procedures, regardless of whether the organization has all the information necessary to make the decision at the time of the request and regardless of which department in the organization received the request except for Medicare urgent requests. The receipt date for Medicare urgent requests is the date that the appropriate department receives the request. Time of receipt for urgent requests does not have to occur during normal business hours.

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

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

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

ATTACHMENTS
• Attachment A – Desktop Procedure

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

HISTORY	
Revision Date	**Description of Revision**

I. OVERVIEW

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

II. POLICY

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

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

C. Collection Process

1. Race/ETHNICITY data sources include data collected directly from MEMBERS and obtained through indirect methods. Raw race/ETHNICITY values are rolled-up to HEDIS/OMB race/ETHNICITY categories per NCQA document "Race and ETHNICITYStratification for Auditors: Resource Guide," 2022. Details of the roll-up logic are available in the resource "Document for REL Data Sources."

2. OMB Standards
    a. Ethnic Categories
        i. Hispanic or Latino
    b. Racial Categories
        i. American Indian or Alaska Native
        ii. Asian
        iii. Black or African American
        iv. Native Hawaiian or Other Pacific Islander
        v. White

3. Sexual Orientation and Gender Identity (SOGI) data collection is beginning in 2024. Collection processes are still being determined throughout the enterprise. Fields are finalized and follow industry standards. This Policy will be updated to reflect collection processes once finalized.
    a. Sexual Orientation Categories – Personal Identity Demographics
        i. Lesbian/gay/homosexual
        ii. Straight/heterosexual
        iii. Bisexual
        iv. Something else (e.g., Queer, Pansexual, Asexual)
        v. Don't Know
        vi. Decline to State
    b. Gender Identity Categories – Personal Identity Demographics
        i. Female
        ii. Male
        iii. Transgender Female
        iv. Transgender Male
        v. Neither exclusively female/male nonbinary
        vi. Declined to State

vii. Other

c. Sex Assigned at Birth Categories – Personal Identity Demographics
   i. Female
   ii. Male
   iii. Intersex
   iv. Declined to State
d. Pronoun
   i. He, him, his, himself
   ii. She, her, hers, herself
   iii. They, them, their, theirs, themselves
   iv. Something else, please specify

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

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

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

III. PROCEDURE

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

IV. DEFINITIONS

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

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

Policy UM-007
Attachment A – Desktop Procedure

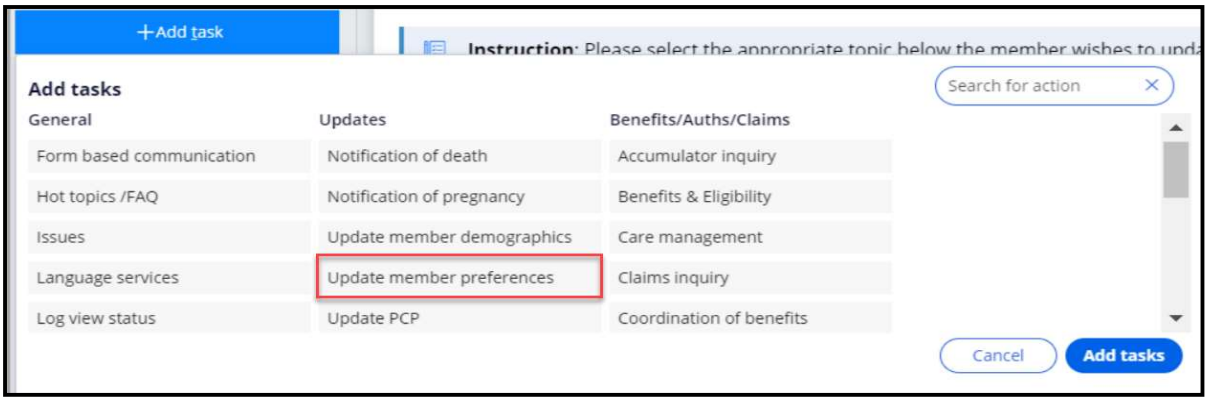
I. PROCEDURE

Spoken and Written Language, Race and Ethnicity:

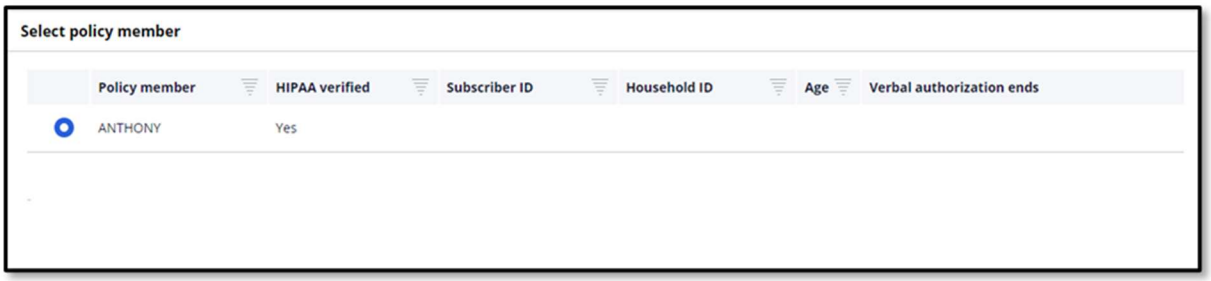
A. When a member contacts CHPIV regarding their own account, the CSA must verify that the member's spoken and written language preferences, race, and ethnicity are documented in OMNI by clicking the "Contact" tab in the Member 360 Interaction Driver Screen. The CSA must check the member's preferred Written & Spoken Languages, Race & Ethnicity and E-mail Address.

Note: If a member requests to update their gender identity and/or sexual orientation, the CSA will update the source system with the members preference. See "*Updating Gender and Sexual Orientation"* section.

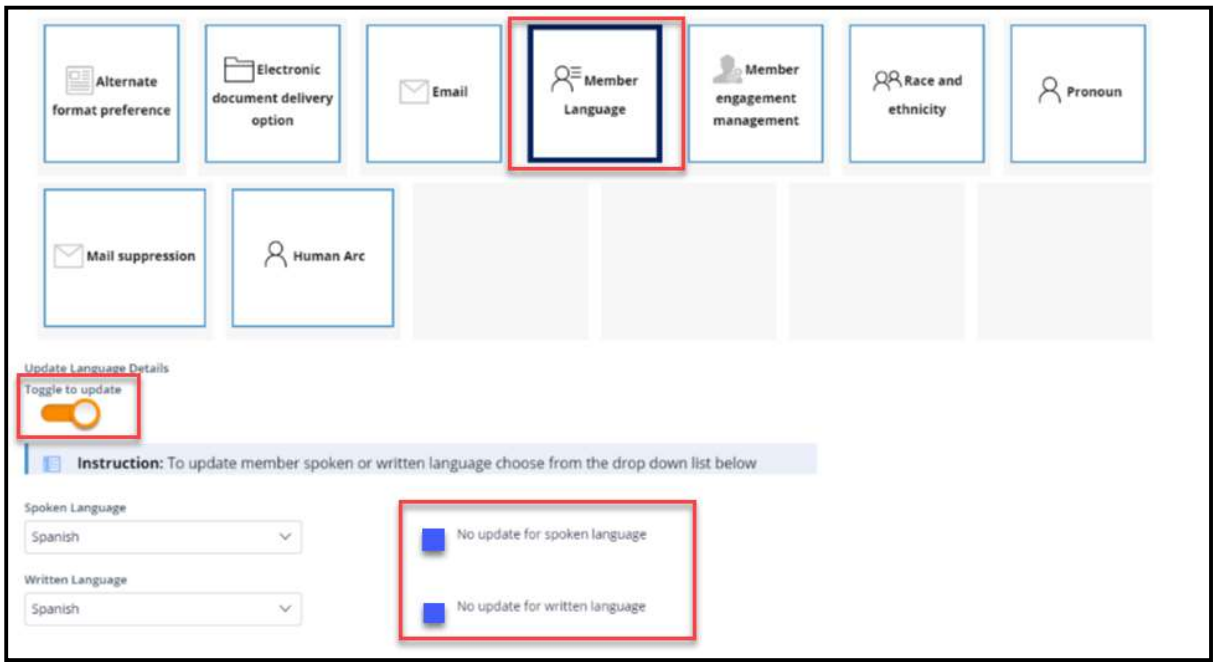
1) In OMNI, click "+Add Task" and double click "Update Member Preferences."



2) Select the appropriate member and click "Submit." To edit, select the appropriate category to update. Then click the Toggle to update. Enter the appropriate information and then select Submit.

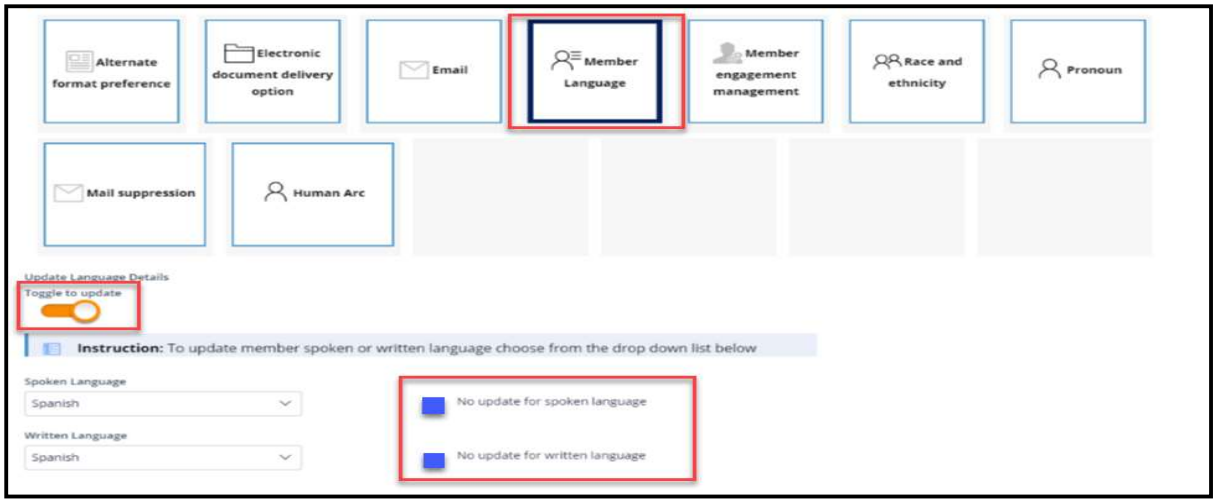


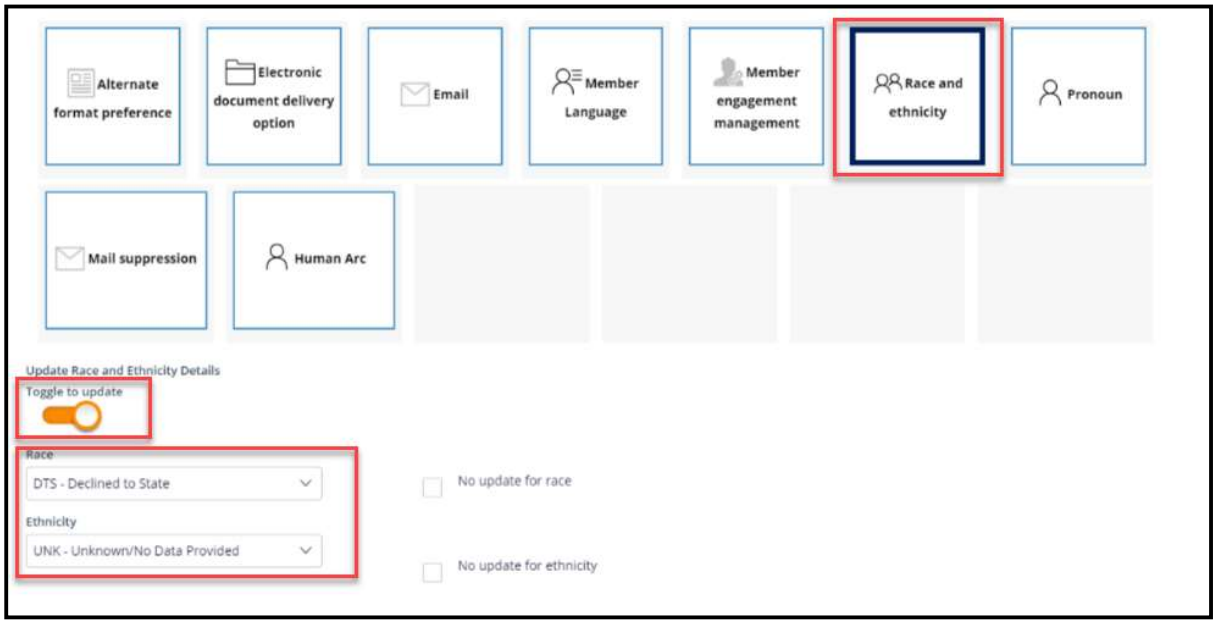
3) To edit, select the appropriate category to update. Then click the Toggle to update. Enter the appropriate information and then select Submit.



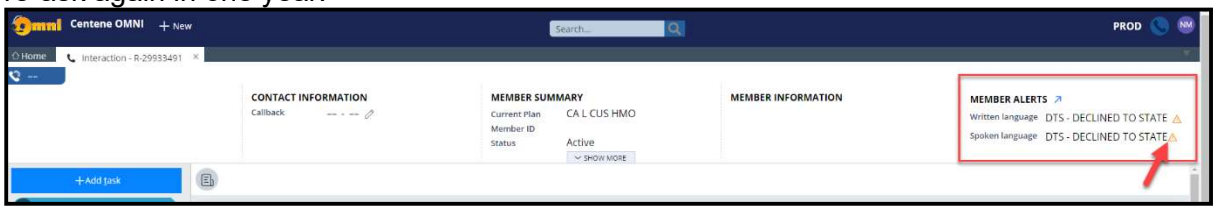
*It is **required** to obtain the written preference when it is displayed.

NOTE: If the member declines to provide their Spoken or Written Language, then check the box No update. In addition, if the member declines to provide their Race or Ethnicity preferences, please click on the DTS – Declined to State and UNK – Unknown/No Data Provided from the drop-down categories.





NOTE: If there is a DTS (Declined to State) or UNK (Unknown/No Data Provided), it means the Member has previously been asked and you do not need to ask the question again. There is a flag to re-ask again in one year.



Scripting and "If and then" Questions:

When a member contacts CHPIV, the CSA must use the following script:

"We are surveying our members, as required by state law, on their preferred spoken and written language preference, ethnicity, and race. Would you like to provide us this information today?"

Proceed with the following script if it helps to clarify *Senate Bill 853 (*SB853) or if the member requests additional information before answering:

"In response to the growing evidence of health care disparities, the California legislature enacted Senate Bill 853 (SB853). This new mandate requires that language services be provided for health-insured beneficiaries."

"This information will only be used for the purposes just discussed. CHPIV has strict policies to protect your information against inappropriate use and disclosure. This includes ethnicity, race and language preferences, and sexual orientation and gender identity information, Additionally, this data is prohibited for the use *of underwriting and denial of coverage and benefits."*

If…	Then…
The member complains or asks how answering	• Advise the collection of ethnicity and race information by health plans is now required by law

questions about their **ethnicity and race** helps them:	• It helps The Plan create projects for groups of people with similar cultures and similar health goals. • It will reduce cultural barriers to accessing CHPIV services and programs

If…	Then…
The member complains or asks how answering questions about their **spoken and written language** helps them:	• Advise The Plan can provide interpreter services in their preferred language • It helps The Plan know when additional language services should be added for all members. • It will reduce language barriers to accessing The Plan services and programs • It enables members to better manage their health and well-being through enhanced communication and increased benefit knowledge

EXCEPTIONS:
The Plan: If OMNI/ABS and UMV has already been updated or there is documentation the Member has already "Declined to State" or "Member Doesn't Know."

CHPIV OMNI Down

When a CSA receives information regarding a member's language and/or ethnicity and race preference, and OMNI is not available, the following procedures need to be followed to ensure The Plan's Membership Department can update the Member's information.

If…	Then…
The CSA cannot update OMNI to show the Member's requested preference:	• Using EXP, an ActionGram needs to be endorsed to Membership – *ES Medi-Cal • Include in the ActionGram "Remarks" section "OMNI unavailable" so Membership will not return the SF **Note**: The Service Form (SF) and ActionGram need to contain the same information
The CSA successfully sends an ActionGram to Membership:	• The Membership Department has five (5) business days to update the Member's information in the system • Please advise the Member of the five (5) day turnaround for Membership to process the request • Document in ABS notes that an ActionGram was endorsed to Membership for processing

B. Gender Identity Inquiries and Updates:

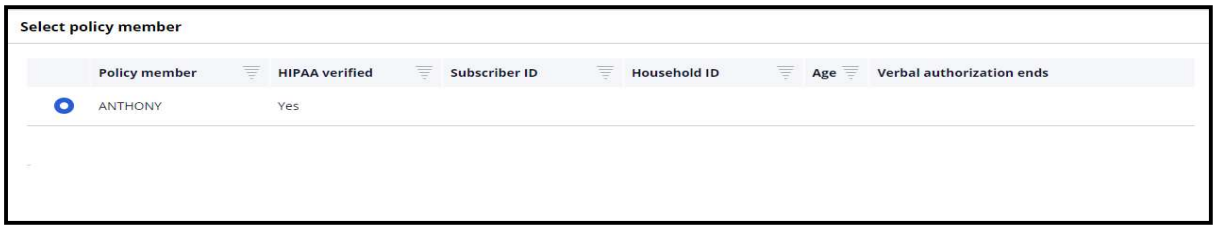
1. Member gender identity is collected on the enrollment form, or when a member contacts The Plan to verify or update the gender that is on file. The gender information can be found in OMNI by clicking the Member tab in the Member 360 Interaction Driver Screen.

   There are some instances when a member must make a gender identity change though their employer, the state local Department of Human Services, however if The Plan made an error in processing information received, CHPIV must take the steps to correct the information in our source system. For more information on updating members gender identity in OMNI, reference the applicable Centralpoint or Training & Development SharePoint articles:
   - Medi-Cal – from the Training & Development sharepoint - *Medi-Cal Address Different Call Scenarios*

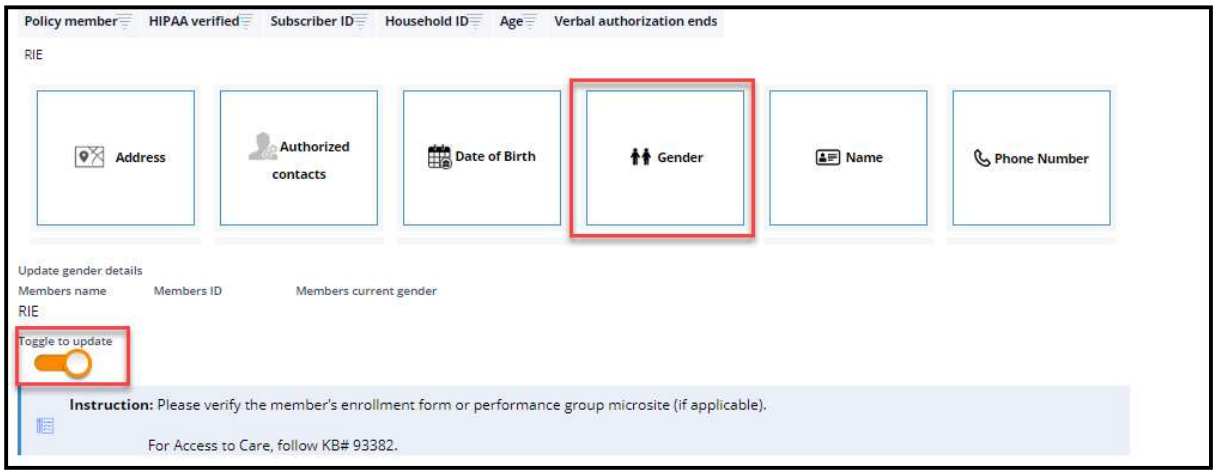
C. Updating Gender and Sexual Orientation:

1) In OMNI, click +Add Task and double click on Update member demographics

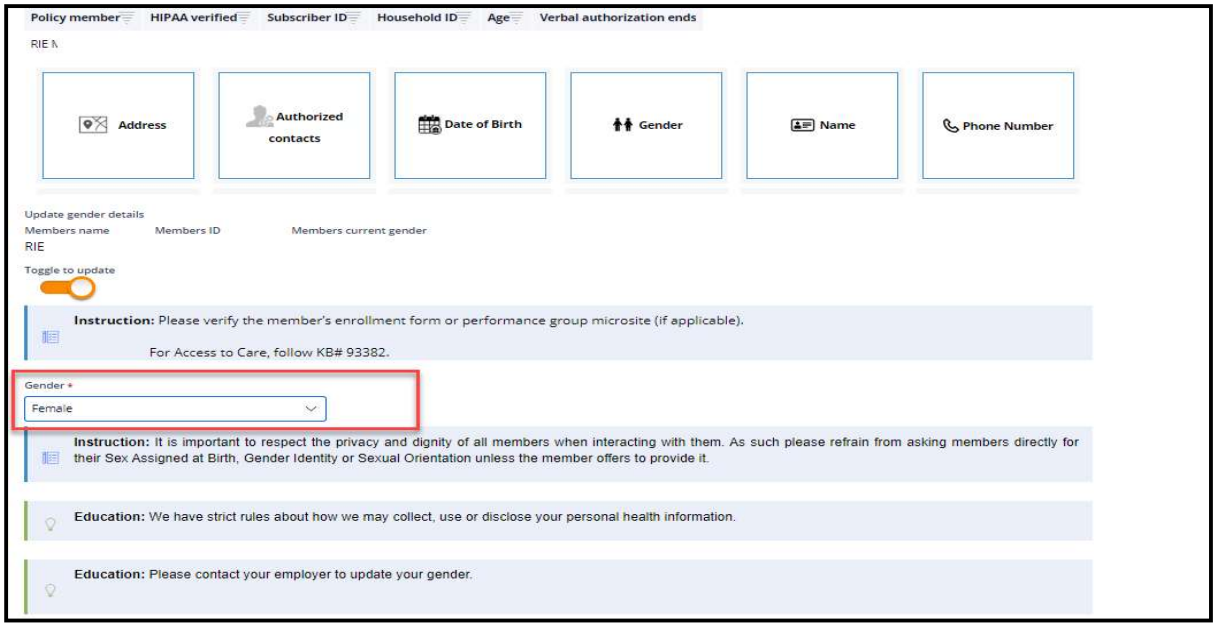
2) Select the appropriate member and select Submit



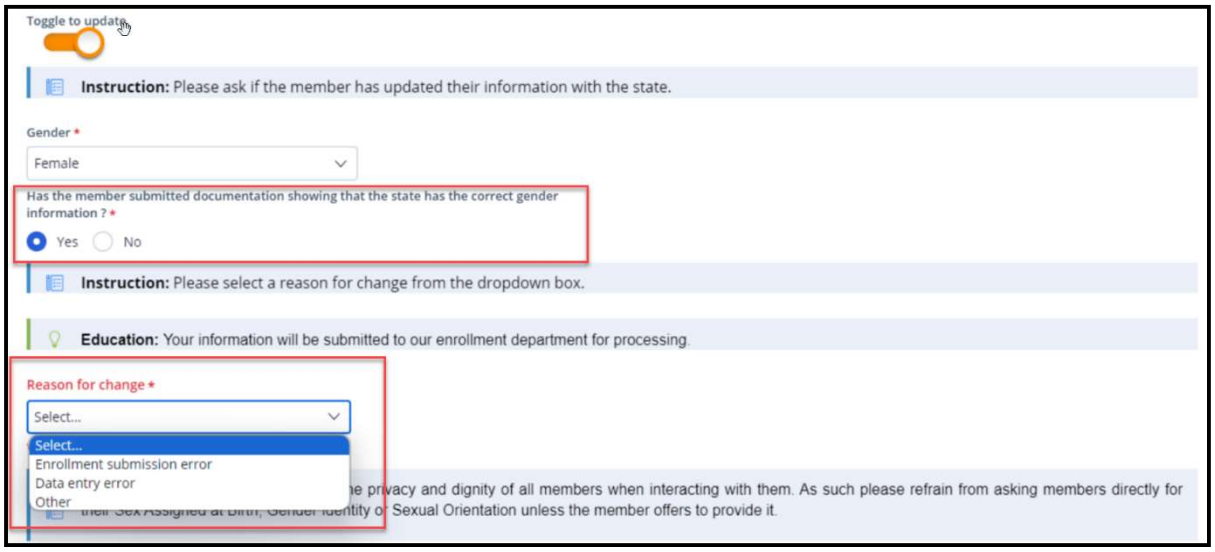
3) Select the Gender box and then Toggle to update



4) Select the member's gender from the drop down and complete the other necessary fields



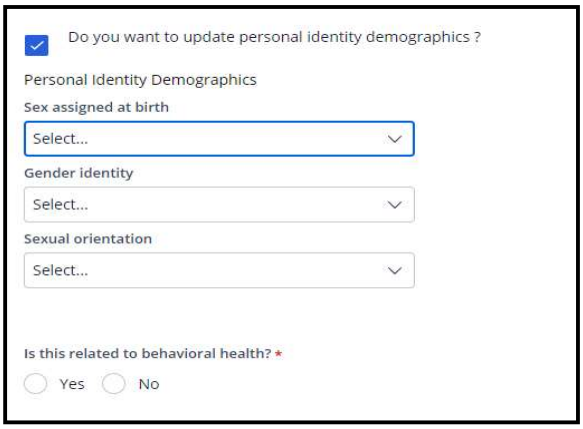
5) Answer the question "Has the member submitted documentation showing that the state has the correct gender information?" If you select "yes" Select the Reason for Change from the drop-down list, based on the information provided by the member.



6) To update the member's *Personal Identity Demographics, check the box before the question "*Do you want to update personal identity demographics?"

The following fields are available for updates in this section:

- Sex assigned at birth
- Gender identity
- Sexual orientation

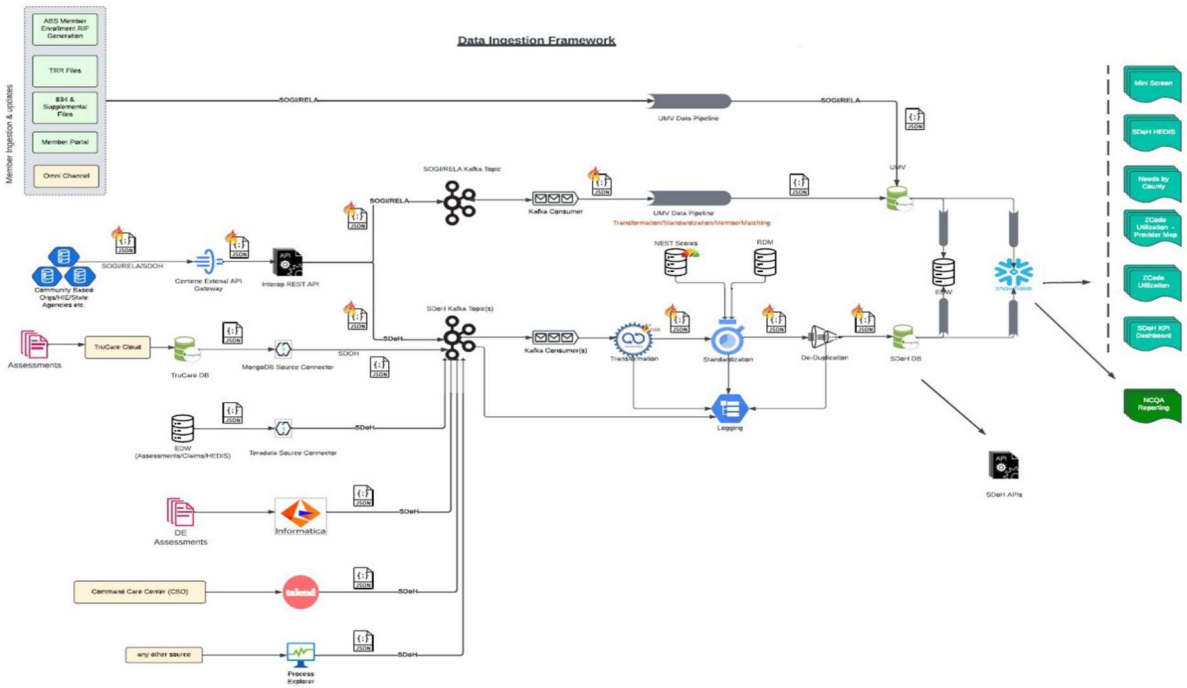


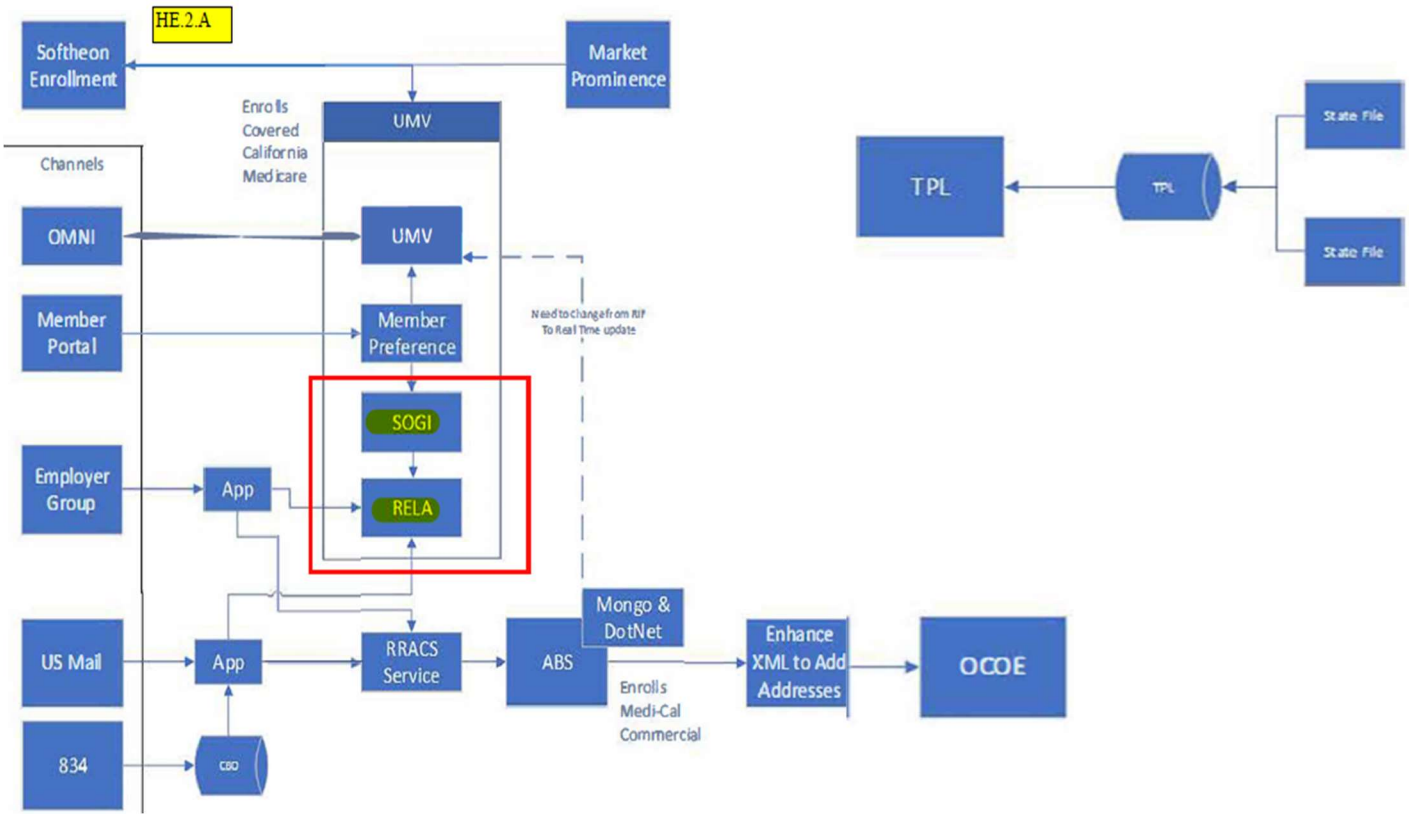
Mark "No" for the question "Is this related to behavioral health?"
Read the educational text below to the member and click submit.
"Your request has been submitted, please allow 3 to 5 business days for your request to be processed."

Note: The intent will route to the Enrollment Department. The Enrollment Department will review the request and return to the CSA, either completing the request, or providing information on why the request could not be completed.

D. <u>Standards for Member/Enrollee Assessment</u>

1. CHPIV will ensure The Plan has created a membership database to capture four fields to assess member demographic information including race, ethnicity, preferred spoken language and preferred written language.
2. CHPIV will ensure that Demographic Information is collected using several methods.
   a. Member language preference is requested when registering to use the HealthNet.com website/
   b. All call representatives will record member information when provided by the member.
   c. The most recent information provided directly by the member to The Plan is considered to be the most accurate and current member preference.




HE 2.A
Softheon Enrollment
Market Prominence
Enrolls Covered California Medicare
UMV
Channels
OMNI
UMV
Member Portal
Member Preference
Need to change from RIF To Real Time update
SOGI
Employer Group
App
RELA
US Mail
App
RRACS Service
ABS
Mongo & DotNet
Enhance XML to Add Addresses
OCOE
Enrolls Medi-Cal Commercial
834
CSO
TPL
TPL
State File
State File

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

DATES			
Policy Effective Date	6/12/2023	**Reviewed/Revised Date**	10/01/2024
Next Annual Review Due	10/02/2024	**Regulator Approval**	12/15/2023

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

ATTACHMENTS

AUTHORITIES/REFERENCES

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

HISTORY

Revision Date	Description of Revision

6/12/2023	Policy creation
7/10/2023	Added the requirements related to expedited grievances
10/01/2024	Annual review- no changes

I. OVERVIEW

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

II. POLICY

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

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

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

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

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

d. Who has authority to require corrective action.

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

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

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

B. Standard GRIEVANCES
1. CHPIV ensures GRIEVANCES are RESOLVED within the state's established timeframe of 30 calendar days.
2. "RESOLVED" means that the GRIEVANCE has reached a conclusion with respect to the MEMBER'S submitted GRIEVANCE as delineated in state regulations.
3. The written RESOLUTION must contain a clear and concise explanation of the MCP's decision.

4. If RESOLUTION of a standard GRIEVANCE is not reached within 30 calendar days as required, the MEMBER must be notified in writing of the status of the GRIEVANCE and the estimated date of RESOLUTION.

C. Expedited GRIEVANCES

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

D. Exempt GRIEVANCES

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

E. CHPIV ensures prompt review and investigation of MEMBER GRIEVANCES are conducted by the appropriate department and/or staff delegated the responsibility to handle CHPIV's internal GRIEVANCE operations.

F. CHPIV ensures that every GRIEVANCE submitted by a MEMBER, or a provider or AUTHORIZED REPRESENTATIVE acting on behalf of a MEMBER and with the MEMBER's written consent, is reported to an appropriate level within its network (i.e., quality of care versus quality of service).

G. CHPIV ensures the immediate referral of all medical quality of care issues to a MEDICAL DIRECTOR or Designee for review.

H. CHPIV ensures MEMBERS, MEMBER's AUTHORIZED REPRESENTATIVES, or providers are not discriminated against or retaliated against on grounds that he or she filed a GRIEVANCE as required by federal and State nondiscrimination law.

I. CHPIV ensures GRIEVANCES alleging discrimination are forwarded to the Department of Health Care Services (DHCS) Office of Civil Rights (OCR).

J. CHPIV GRIEVANCES processed for pharmacy services rendered or requested before implementation of Medi-Cal Rx.

K. CHPIV ensures the maintenance and availability for DHCS review, GRIEVANCE logs, including GRIEVANCE logs delineated by Subcontractor and Downstream Subcontractor. The record of each GRIEVANCE must contain, at a minimum, all the following information and must be accurately maintained in a manner accessible to the state and available upon request to CMS:

1. A general description of the reason for the GRIEVANCE.
2. The date received.
3. The date of each review or, if applicable, review meeting.
4. A description of the action taken by the plan or provider to investigate and resolve the GRIEVANCE.
5. RESOLUTION at each level of the GRIEVANCE, if applicable.
6. The name of the plan provider or staff person responsible for resolving the GRIEVANCE
7. Date of RESOLUTION at each level, if applicable.
8. Name of the covered person for whom the GRIEVANCE was filed.

L. CHPIV will ensure that The Plan has established a system that provides for the prompt receipt of DMHC contacts regarding urgent GRIEVANCESs and APPEALS twenty-four (24) hours a day, seven (7) days a week. During normal business hours, the system provides for The Plan to contact the DMHC within 30 minutes following the DMHC contact regarding an urgent issue [Title 28, CCR 1300.68.01(b)]. After normal business hours, on weekends or holidays, the system provides for The Plan to contact the DMHC within one (1) hour following the DMHC contact regarding an urgent issue. This system provides for the availability of The Plan's representative with authority on the plan's behalf to resolve urgent GRIEVANCES and authorize the provision of health care services covered under the MEMBER'S contract in a medically appropriate and timely manner. Such authority includes making financial decisions for expenditure of funds on behalf of The Plan without first having to obtain approval from supervisors or other superiors within the plan. Refer to compliance filing: Title 28, CCR Section 1300.68.01(b)(1).

M. CHPIV will ensure after either completing the GRIEVANCE process or participating in the process for at least 30 days, a subscriber or enrollee may submit the GRIEVANCE to the DMHC for review. In any case determined by DMHC to be a case involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, cancellations, rescissions, or the nonrenewal of a health care service plan contract, or in any other case where the department determines that an earlier review is warranted, a subscriber or enrollee shall not be required to complete the GRIEVANCE process or to participate in the process for at least 30 days before submitting a GRIEVANCE to the DMHC for review [1368(b)(1)(A)].

N. The Intake Specialist verifies that an urgent care issue does not exist according to the MEMBER'S perception, with support from the A&G CLIINICAL SPECIALIST II as necessary. This

is noted in the file documentation. CASE COORDINATOR shall immediately refer any clinically urgent care issues related to medical quality of care to a A&G CLIINICAL SPECIALIST II for the referral to the plan's Medical/Dental Director for decision or action and to arrange medical care for MEMBER, if required (see B. Procedure for Handling and Resolving Clinical GRIEVANCES).

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

N. Procedures for Handling and Resolving Clinical GRIEVANCES

1. A MEMBER'S concern is received orally or in writing by the health plan.
2. The Intake Specialist shall immediately refer any Clinically Urgent quality of care GRIEVANCE case to the A&G CLIINICAL SPECIALIST II (A&G Nurse) who will present the case immediately to the plan MEDICAL DIRECTOR to arrange medical care for the MEMBER (see Attachment 3) [Title 22 CCR Section 53858(e)(2)].
    a. All situations where the MEMBER has been determined to have a serious or imminent health risk and has voiced a concern about the quality of care that they are currently receiving, applicable alternative treatment arrangements will be made by the plan MEDICAL DIRECTOR, A&G CLIINICAL SPECIALIST II or PPG 72 hours based on the specific time and date of receipt of the GRIEVANCE [DHCS APL 21-011], depending upon the clinical urgency and applicability.
    b. Upon completion of the immediate actions and interventions, the case will then be handled via the process as outlined below. The actions and interventions taken will be documented in the file.
3. CASE COORDINATOR acknowledges receipt of the Clinical GRIEVANCE in writing to the MEMBER mailed and postmarked within five (5) calendar days [§ 438.406(a)(2)] [DHCS APL 21-011, Health & Safety Code, Section 1368(a)(4)(A); Title 28, CCR, Section 1300.68(d)(1)]. The acknowledgement advises the MEMBER that the GRIEVANCE has been received, the date of the receipt, and provides the name of the plan representative, telephone number and address of the plan representative who may be contacted about the GRIEVANCE [Title 28, CCR 1300.68(d)(1), 1368(a)(4)(A)]. Information is included informing the MEMBER of his or her right to request a DSS hearing or APPEAL to the DHCS or DMHC [Title 22 CCR Section 53858(e)(5)].
4. Written communications to MEMBERS s are provided in the threshold languages as defined by the DHCS [RR~~3.A.~~3. A.5]. Written communications shall also be provided in alternative formats (including Braille, large-size print font no smaller than 20-point, or audio format) and through auxiliary aids upon request and in a timely fashion appropriate for the format being requested and taking into consideration the special needs of MEMBERS with disabilities or LEP [Titles II and III of the Americans with Disabilities Act of 1990, section

1557 of the Affordable Care Act of 2010, sections 504 and 508 of the Rehabilitation Act of 1973, Government Code sections 11135 and 7405].

5. The case is then assigned to a CASE COORDINATOR for handling.
6. The CASE COORDINATOR determines the appropriate GRIEVANCE Type Code for entry into the on-line system according to requirements for tracking and reporting purposes. (See Attachment 2) The CASE COORDINATOR'S logging includes:
    a. A description of the MEMBER'S issue (MEMBER Issue)
    b. A description of the actions taken by the plan or provider to investigate the GRIEVANCE. (Action Taken).
    c. The proposed RESOLUTION by the plan or provider, (RESOLUTION Notes)
    d. The name of the person responsible for resolving the GRIEVANCE, and
    e. The date of the notification to the MEMBER.
7. The CASE COORDINATOR uses a Provider Information Request (PIR) to obtain the response, and any other pertinent information required for review, including medical records. The CASE COORDINATOR then creates a summary of the GRIEVANCE that provides specific information on the Provider(s), date of service and information needed with the PPG's written response. The CASE COORDINATOR sends the PIR to the appropriate PPG/Provider or hospital contact.
8. The PPG/Provider has seven (7) calendar days to respond to the request for information. If no response has been received, the CASE COORDINATOR contacts his/her manager for assistance. The plan may send a copy service for medical records.
9. Upon receipt of medical records, information and responses from the PPG, the CASE COORDINATOR forwards the case to the A&G CLIINICAL SPECIALIST II.
10. The A&G CLIINICAL SPECIALIST II verifies that all information has been received. The A& Clinical Specialist II summarizes the COMPLAINT and forwards all cases to the plan MEDICAL DIRECTOR for review. The summary includes the MEMBER'S perception with pertinent information along with the PPG's response and records, if applicable.
11. A determination is made as to the specialty required to review the case.
12. If needed the practitioner in a similar specialty that would typically treat the medical condition, performs the procedure or provides the treatment at issue, will be consulted and documentation of the consult will be included with the GRIEVANCE file.
13. The MEDICAL DIRECTOR may request that the case be referred to the plan's contracted third-party review organization for a similar specialty review. Refer to desktop protocol: A&G Department Protocol Consultation Review.
14. The plan MEDICAL DIRECTOR Review:
    a. The Plan's MEDICAL DIRECTOR conducts a peer review assessment of the care provided. The MEDICAL DIRECTOR conducting the review for the proposed RESOLUTION of the GRIEVANCE will not have participated in any prior decisions related to the GRIEVANCE. The MEDICAL DIRECTOR will code the peer review form with an appropriate severity outcome level code.
    b. The Plan's MEDICAL DIRECTOR, upon completion of the review of the case returns the case to the A&G CLIINICAL SPECIALIST II. The A&G CLIINICAL SPECIALIST II takes any appropriate follow-up action on behalf of the MEDICAL DIRECTOR. In any case where the MEDICAL DIRECTOR has severity outcome level coded the case to be a moderate or major quality of care event (e.g., severity outcome level code 3 and 4), the A&G CLIINICAL SPECIALIST II will refer the case to QI for intervention and next steps.

c. Corrective actions will be followed by the QI team to RESOLUTION [28 CCR sections 1300.70(b)(2)(H) and (c)].

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

III. PROCEDURE

A. CHPIV delegates the GRIEVANCE process to its Subcontractor, Health Net.

B. Delegation Oversight

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

IV. DEFINITIONS

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

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

	care or services provided, interpersonal relationships with a Provider or Contractor's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by Contractor to make an authorization decision.
Inquiry	An inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CHPIV processes.
Resolution	Means that the Grievance has reached a conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the grievance system, including entities with delegated authority.
State Fair Hearing (SFH)	Means a hearing with a State Administrative Law Judge to resolve a member's dispute about an action taken by Contractor, its Network Providers, Subcontractors, or Downstream Subcontractors.
Appeal	Is federally defined as a review by The Plan of an adverse benefit determination [42 CFR 438.400(b)]. While California regulations do not explicitly define the term "appeal," they do delineate specific requirements for certain types of grievances that would fall under the federal definition of appeal be-cause they involve the delay, modification, or denial of services based on medical necessity or a determination that the requested service is not a covered benefit [28 CCR 1300.68(d)(4)-(5)]. The Plan shall treat these grievances as appeals under federal regulations.
Notice Of Appeal Resolution (NAR)	A formal letter from The Plan informing a member of the outcome of the appeal of an adverse benefit determination [42 CFR 438.408(d)(2)]. The NAR informs the member whether The Plan has overturned or upheld its decision on the adverse benefit determination. The contents of the NAR shall meet all the language and accessibility standards including translation, font, and format requirements as set forth in DHCS APL 21-004 [Title 42 CFR section 438.10, 438.402(c)(1)(i)(A), 438.404, and 438.408(c)(3) and (i); WIC 14029.91 and 10951(b)(1)(A); and Title 45 CFR, Part 92].
A&G Clinical Specialist II	A Registered Nurse who provides clinical expertise in Clinical Grievance resolution and coordinates case as appropriate with the Medical/Dental Director, PPG/Provider and Third-Party Reviewer Organization.
Case Coordinator	A non-clinician knowledgeable associate involved in grievance resolution.
Complaint	is the same as "grievance."
Complainant	is the same as "grievant," and means the person who filed the grievance including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee.
Medical Director	A physician reviewer who is involved in grievance review and resolution.

Resolved	Means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the plan's grievance system, including entities with delegated authority.

	Provider Directory	PNM-002
Department	Operations	
Functional Area	Provider Network 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	Julia Hutchins	☐ DHCS ☐ NA ☒ DMHC
Title	Chief Operating Officer	

ATTACHMENTS

NA

AUTHORITIES/REFERENCES

- **Internal**
  - CHPIV, Delegation Oversight Policy and Procedure, CMP-002
- **Federal**
  - 42 CFR, Section 438.10
  - 42 CFR section 431.70
- **State**
  - California Health and Safety Code Section ("H&S Code") 1367.27
  - Department of Health Care Services (DHCS) APL 23-002
  - DHCS: DHCS Plan Contract (2024) Section 5.1.3
  - DHCS: All Plan Letter 22-026, "Interoperability and Patient Access Final Rule" (dated November 29, 2022)
  - DHCS: All Plan Letter 19-003, "
  - DMHC: All Plan Letter 23-015 (OPL), "Supplemental Provider Directory Annual Filling Requirements.
  - Medi-Cal Managed Care Division (MMCD) Policy Letter 00-002, Supersedes Policy Letter 97-09: Health Plan Provider Directory Policy, Guidelines, and Delivery Standards N. Medi-Cal Managed Care Division (MMCD) Policy Letter 11-009, Update to Policy Letter 00-002: Update to Health Plan Provider Directory Policy and Guidelines
- **Accreditation**
  - NCQA: Network Management (NET) 5, Elements A-J

HISTORY

Revision Date	Description of Revision
6/12/2023	Policy creation
5/13/2024	Policy revision to update the frequency on updating the electronic provider directory and add the requirements for providing the printed copy of the provider directory to members and potential members.
6/20/2024	Policy revision to add additional PAAS requirements outlined in DMHC APL 23-015

I. OVERVIEW

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

II. POLICY

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

pharmacies, and any other PROVIDERS who are credentialed and contracted with CHPIV for Medi-Cal services, or through a subcontracted agreement:

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

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

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

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

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

~~K.~~L. CHPIV ensures the PROVIDER DIRECTORY is updated in accordance with 1367.27(e) when PROVIDERS are found to be ineligible through the Provider Appointment Availability Survey (PAAS) administration.

~~L.~~M. CHPIV maintains a publicly accessible standards-based PROVIDER DIRECTORY API as described in 42 CFR section 431.70. Online PROVIDER DIRECTORY data is updated at least

weekly after the CHPIV receives the PROVIDER information or is notified of any information that affects the content or accuracy of the PROVIDER DIRECTORY.

1. CHPIV ensures its PROVIDER DIRECTORY API is updated in accordance with 42 CFR section 438.10(h)(3) and Health and Safety Code section 1367.27
2. CHPIV ensures accurate and complete information of reported data, screen the data for completeness, logic, and consistency, and collect service information in standardized formats to the extent feasible and appropriate. CHPIV makes all collected data available to DHCS and CMS, upon request.
3. CHPIV ensures there is routine testing and monitoring, and updates systems as appropriate, to ensure the APIs function properly, including conducting assessments to verify that the APIs are fully and successfully implementing required privacy and security features.

III. PROCEDURE

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

IV. DEFINITIONS

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

TERM	DEFINITION
Provider Directory	Contractor's listing of all Network Providers and that includes the Providers' contact information, whether the Provider is accepting new Members, the hours of operation, what languages are available in the Provider's office and whether the Provider's office has accommodations, including offices, exam rooms and equipment, for people with physical disabilities.
Delegated Provider Group	A physician group contracted with CHPIV or its downstream subcontractors to provide Covered Services to Members assigned to that Delegated Provider Group.
Facility	For purposes of this policy, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities.

TERM	DEFINITION
Member	A beneficiary enrolled in CHPIV's Medi-Cal plan.
Primary Care Provider	A physician who focuses his or her practice of medicine on general practice or who is a board verified or board eligible internist, pediatrician, obstetrician/gynecologist, or family practitioner. The PCP is responsible for supervising, coordinating, and providing initial and primary care to Members, initiating referrals, and maintaining the continuity of Member care.
Provider	For purposes of this Policy, any individual, entity, Health Network, or Delegated Provider Group that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
API	Application Programming Interface. A software intermediary enables two applications to communicate with each other.

	Credentialing and Recredentialing	CR-001
Department	Operations	
Functional Area	Provider Network Management	
Impacted Delegate	☒ Subcontractor ☐ NA	

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

APPROVALS			
Internal		**Regulator**	
Name	**Julia Hutchins**	☐ DHCS ☒ NA ☐ DMHC	
Title	Chief Operating Officer		

ATTACHMENTS

- Attachment A – Verification Tables
- Attachment B – Scope of Practitioners
- Attachment C – Credentialing System Controls

AUTHORITIES/REFERENCES

- Federal Title IV of public law 99-660, the Health Care Quality Improvement Act of 1986 ACA Section 1311 (c)(1)(D)-Benefit Exchange/Qualified Health Plans/Provider Credentialing
- Code of Federal Regulations: 42 CFR 422.112(a)(5), 422.152, 422.200, 422.202 (a)(3), 422.202(d)(1)(i)(ii)- and 422.202(d)(4)- 422.204(a), 422.204(b)(1)(i)(ii), 422.204(b)(2)(i)(ii)(iii), 422.204(b)(4), 422.205, 422.220
- Medicare Managed Care Manual Chapter 6 - Relationships with Providers: (Rev. 82, 04-27-07) Chapters 6 Sections 30.0, 50, 60.1, 60.2, 60.3, 60.4
- Medicaid Managed Care: 42CFR 438.206(b)(6), 438.214, 438.240, 438.610California Medi-Cal: California Code of Regulations, Title 22, Sections 51000.35 and 51200 California Code of Regulations, Title 22, Sections 53857 (Two Plan Model), Section 53912.5 (Geographic Model) and Medi-Cal Contract, Exhibit A, Attachment 1 Organization and Administration of the Plan, #6, Item B. California Code of Regulations, Title 22, Section 53856 (Two Plan Model), Section 53913 (Geographic Model), DHCS MMCD Policy Letter 02-02 and 10-016 and W&I Code 14182(b) (9) California Code of Regulations, Title 22, Section 53100 and 53280, DHCS MMCD Policy Plan Letter 17-019, Medi-Cal Contract, Exhibit A, Attachment 4, Quality Improvement System, #12. APL 19-004. Provider Credentialing/Recredentialing and Screening/Enrollment, Credentialing and Recredentialing, APL21-003 – Medi-Cal Network Provider and Subcontractor Terminations Nurse Practitioner - Title 16, CCR; B&P Code Sections 2834-2837 Certified Nurse Midwife - Title 16, CCR; B&P Code Sections 2505-2521 and 2746-2746.8 Clinical Nurse Specialist - Title 16, CCR; B&P Code Sections 2838-2838.4 Physician Assistant - Title 16,

Division 13.8 CCR; B&P Code, Div2, Chapter 7.7 28 CCR 1300.70 (a)(1)(2)(3)(4), 28 CCR 1300.70(b)(1), 28 CCR 1300.70(b)(2)(A-F) CA SB946. California Commercial H&S Code, Knox-Keen Act Section 1366.4(c0, 1374.96(d)(1) and (e)(1) California Code of Regulations, Title 28, Section 1300.70 & 1300.74.16(1)
• NCQA: CR1. A.1-A.12, CR1 B.1-B.3, CR1. C, CR2 A.2, A.3, CR3 A.1-A.6, CR3 B.1, B.2, CR3 C.1-C.6, CR4A, CR.5 A.1 – A.5. 8. Health Net/Centene Corporate Retention Policy: Record Retention Policy & Procedure

HISTORY	
Revision Date	**Description of Revision**

I. OVERVIEW

A. This policy applies to all practitioners outlined in Credentialing and Recredentialing, Attachment B – Scope of Practitioners, which may be modified based on network scope. This policy is not applicable to non-participating practitioners or practitioners who are not subject to credentialing. A practitioner's specialty type and scope of practice within the network are determined through the credential's verification process. A practitioner who employs a non-contracted practitioner to provide services to the Plan's member without becoming a contracted practitioner will be asked to follow the Plan's guidelines for hiring non-contracted providers. The Plan only recognizes practitioner specialties recognized by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American Nursing Certification Council (ANCC), American Board of Podiatric Surgery (ABPS), American Board of Podiatric Orthopedics & Primary Podiatric Medicine (ABPOPPM) (now doing business as the American Board of Podiatric Medicine [ABPM]), American Medical Association (AMA), American Dental Association (ADA) or the American Board of Oral & Maxillofacial Surgery (ABOMS).

II. POLICY

A. Community Health Plan of Imperial Valley (CHPIV) will ensure Prior to providing health care services to the Plan's members, all practitioners seeking admission to the Plan's network will undergo a comprehensive review and verification of professional credentials, qualifications, and other background checks. The Plan's, LLC. credentials and recredentials practitioners in accordance with state and federal regulatory requirements and accrediting entity standards. The Plan's credentialing process does not discriminate with respect to provider/practitioner participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law (PHSA Section 2706 42 USC 300gg-5 and 42 CFR 422.205). As a standard, the Plan expects all contracting practitioners and providers to abide by, adhere to and practice their respective profession in

accordance with provisions of professional conduct, including but not limited to a) California - California Business and Professions Code b) Title 42: CFR, Section 438.602 (b)(2)

B. CHPIV will ensure the Plan's Credentialing Department will follow the procedures outlined below in the credentialing and recredentialing process for all non-delegated practitioners. Although credentialing procedures employed by delegated IPAs/medical groups may vary from those outlined herein, such procedures shall at all times be consistent with the Plan's participation requirements. When delegating credentialing activities, the Plan and the delegate shall follow the Delegation of Quality Improvement Activities established in the contract.

1. Application Process
    a. Practitioner completes a Plan approved application, and forwards it, along with requested supporting documentation, as instructed.
    b. Signature and date of application will not exceed 180 days at the time of Credentialing Committee or Chairperson review and/or approval.
    c. By completing and signing the credentialing application, the practitioner:
        i. affirms the completeness and truthfulness of representations made in the application.
        ii. indicates a willingness to provide additional information for the credentials process.
        iii. authorizes the Plan to obtain information regarding the applicant's qualifications, competence, or other information relevant to the credentialing review, and
        iv. releases the Plan and its independent contractors, agents and employees from any liability connected with the credentialing review.
2. Practitioners' Right of Review/Request for Current Network Status:
    a. A practitioner has the right to review information obtained by the Plan for the purpose of evaluating his/her credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards or the National Practitioner Data Bank [NPDB]), but does not extend to review of information, references or recommendations protected by law from disclosure. A practitioner has the right to request his/her status within the Plan's network. Upon written request, the Plan's Credentialing Department will provide details of his/her current status in the credentialing or recredentialing process.
3. Right of Review:
    a. A practitioner may request to review such information at any time by sending a written request via letter, email, or fax to the Credentialing Department Manager/Supervisor. The Manager/Supervisor of Credentialing will notify the practitioner within 72 hours of the date and time when such information will be available for review at the Plan's Credentialing Department.
4. Notification of Discrepancy:
    a. Practitioners will be notified in writing, via letter, email, or fax, when information obtained by primary sources varies from information provided on the practitioner's application. Documented telephone contact with a practitioner's office is also acceptable. Examples of information at substantial variance include reports of a practitioner's malpractice claim history, actions taken against a practitioner's license/certificate, suspension or termination of hospital privileges or board certification expiration when one or more of these examples have not been self-

reported by the practitioner on his/her application form. Practitioners will be notified of the discrepancy at the time of primary source verification. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

5. Correction of Erroneous Information:
   a. If a practitioner believes erroneous information has been supplied to the Plan by primary sources, the practitioner may dispute such information by submitting written notification to the Credentialing Department. Failure to dispute the accuracy of any discrepancy in primary source information as provided in this section shall be deemed an acceptance by the practitioner of the information provided by the primary source and shall constitute a waiver of subsequent objections to that information. Practitioners who wish to dispute the accuracy of information provided by a primary source must submit written notice via letter, email, or fax, along with a detailed explanation, to the Manager/ Supervisor of Credentialing. Notification to the Plan must occur within five business days of the Plan's notification to the practitioner of a discrepancy or within 24 hours of a practitioner's review of his/her credentialing file. Upon receipt of notification from the practitioner, the Plan will re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the practitioner's credentialing file. The practitioner will be notified in writing, via letter, email, or fax, that the correction has been made to his/her file. If upon re-review the primary source information remains inconsistent with the information provided by the practitioner, the Credentialing Department will notify the practitioner via letter, email, or fax. The practitioner may then provide proof of correction by the primary source body to the Plan's Credentialing Department via letter, email, or fax within 10 business days. The Credentialing Department will repeat re-verification of primary source information if such documentation is provided.
   b. If after 10 business days the primary source information remains in dispute, the practitioner will be subject to action under up to and including administrative denial/termination.
   c. Practitioner rights information contained within this policy is distributed as written to contracting and participating network practitioners with initial credentialing and recredentialing mailings and all Credentialing Committee approval notification letters. The Plan's practitioner rights are also posted on the Plan's website, www.healthnet.com.

C. Provider Selection and Criteria for Initial Network Participation:

1. CHPIV will ensure that all practitioners participating in the Plan's network must comply with the following the Plan's standards for participation in order to receive or maintain credentialing. Only licensed, qualified practitioners meeting these standards and participation requirements are accepted or retained in the Plan's network.
   a. The practitioner must complete all items on the Plan's approved application and submit all requested supporting documentation. The verification time limit for the Plan approved application is 180 days.
   b. The practitioner will answer all confidential questions and provide explanations in writing for any questions answered adversely, including but not limited to:
      i. Present illegal drug use
      ii. History of loss of license or certification

iii. History of criminal/felony convictions
iv. History of loss or limitation of privileges or disciplinary actions with any health care entity.
v. Any inability to perform all essential functions of the contracted specialty(ies), with or without accommodation, according to criteria of professional performance.
vi. Current malpractice insurance coverage

c. The practitioner will attest to the completeness and truthfulness of all elements of the application.
d. Information submitted on the application by the practitioner must be supported by verifiable sources.
e. The practitioner must provide a continuous work history for the previous five years. The verification time limit is 180 days.

2. CHPIV will ensure any gaps exceeding six (6) months will be reviewed and clarified either verbally or in writing. All verbal communication will be documented in the file. Any gap(s) in work history that exceeds one year must be clarified in writing.
   a. The practitioner must possess a current, valid license or certificate issued by the state in which the practitioner is applying to practice. The verification time limit is 180 days.
   b. Licenses that are limited, suspended, restricted, showing an accusation, on probation or no practice restriction are, administratively denied
   c. The practitioner must possess adequate and appropriate education and training. The board certification verification time limit is 180 days; verification of medical school/residency/fellowship completion is valid indefinitely.
   d. The practitioner for whom hospital care is an essential component of their practice must possess admitting privileges with at least one of the Plan's participating hospital or freestanding surgery center that is currently credentialed. A documented coverage arrangement with the Plan's credentialed and contracted practitioner of a like specialty is a requirement in lieu of admitting privileges. Hospital privileges that have been impacted for quality-of-care reasons will be acted upon
   e. The practitioner must possess a valid, current Drug Enforcement Administration (DEA) and/or Controlled Dangerous [or Drug] Substance (CDS) certificate, if applicable.
      i. The document must be current at the time of the Credentialing Committee decision.
      ii. The Plan verifies a DEA or CDS certificate in each state in which the practitioner is contracted to provide care to its members.
      iii. If a practitioner does not have a DEA or CDS certificate, the Plan obtains an explanation that includes arrangements for the practitioner's patients who need prescriptions requiring DEA certification.
   f. The practitioner will possess malpractice insurance coverage that meets the Plan's standards. This information must be documented on the application or submitted as a face sheet. The document must be current at the time of the Credentialing Committee decision. Exceptions may be granted for post-dated malpractice insurance coverage to meet network needs. The amounts of coverage required are defined in Attachment A – Verification Tables.
   g. The practitioner will assist the Plan in investigating professional liability claims history for the previous five years.

h. The practitioner must be in good standing and absent from the Medicare/Medicaid Cumulative Sanction Report if treating members under the Medicare or a Medicaid line of business. The verification time limit is 180 days. Practitioners with identified sanctions will be denied or terminated from the Medicare and Medi-Cal (Medicaid) line of business
i. The practitioner must be absent from the Medicare Opt-Out Report if treating members under the Medicare line of business. The verification time limit is 180 days.
j. The practitioner must be in good standing and absent from the Medi-Cal Suspended and Ineligible List. The verification time limit is 180 days (California only). Practitioners with identified sanctions will be denied or terminated from the Medi-Cal (Medicaid) line of business according to the leveling guidelines
k. The practitioner must be absent from the Federal Employee Health Benefits Program Debarment Report if treating federal members. The verification time limit is 180 days. Practitioners with identified sanctions will be denied or terminated from the FEHBP according to the leveling guidelines established by Policy/Procedure.

D. Credentialing Files and Verification Process

1. CHPIV will ensure the Credentialing Department completes a review of each practitioner's credentialing file and conducts primary source verification as outlined in Attachment A – Verification Tables.
2. CHPIV will ensure a roster of applicants meeting all the Plan's participation criteria, without adverse actions, is prepared for presentation to the Credentialing Committee.
3. CHPIV will ensure that the Plan incorporates performance data as part of the reapplication or lost delegation decision-making process.
4. CHPIV will ensure Practitioners with current or prior adverse actions will be further reviewed by the Adverse Action staff. The Adverse Action staff will investigate and prepare an individual case summary outlining the nature of the adverse action(s), including supporting documentation. The complete case summary packet will be presented to the Credentialing Committee Chairperson and/or Credentialing Committee.
5. CHPIV will ensure A roster of practitioners who are administratively noncompliant with the Plan's credentialing criteria is presented to the Credentialing Committee for consideration and decision-making.
6. CHPIV will ensure Practitioners who have been administratively denied are eligible to reapply for network participation as soon as the administrative matter is resolved.
7. CHPIV will ensure Practitioners no longer affiliated with a delegated group will be treated as an initial credentialing applicant within 180-days of the status/network change.

E. Recredentialing Process

1. CHPIV will ensure the Credentialing Department has established a recredentialing cycle through which each non-delegated practitioner's recredentialing materials are processed at least every 36 months.
2. CHPIV will ensure the Credentialing Department forwards a recredentialing package/notification to the practitioner and/or IPA/medical group approximately six (6) months in advance of the scheduled reappointment date. Practitioners with current Council for Affordable Quality Healthcare (CAQH) on-line credentialing/recredentialing applications do not receive recredentialing notices.
   a. By completing and signing the recredentialing application, the practitioner:
      i. affirms the completeness and truthfulness of representations made in the application.

ii. indicates a willingness to provide additional information for the credentials process.
iii. authorizes the Plan to obtain information regarding the applicant's qualifications, competence, or other information relevant to the credentialing review, and
iv. releases the Plan and its independent contractors, agents and employees from any liability connected with the credentialing review.

b. The practitioner will answer all confidential questions and provide explanations in writing for any questions answered adversely, including but not limited to:
i. Present illegal drug use
ii. History of loss of license or certification
iii. History of criminal/felony convictions
iv. History of loss or limitation of privileges or disciplinary actions with any health care entity
v. Any inability to perform all essential functions of the contracted specialty(ies), with or without accommodation, according to criteria of professional performance.
vi. The Credentialing Department completes a review of the practitioner's recredentialing file and conducts primary source verification as outlined in the Primary Source Verification Tables specified for recredentialing (see Attachment A – Verification Tables).

F. Ongoing Monitoring

1. CHPIV will ensure on an ongoing basis, the Credentialing Department reviews the following reports within 30 days of release:
a. Member complaints and quality of care and service tracking and trending issues are reviewed on an ongoing basis in accordance with criteria established in the Plan's policy
b. Practitioners who are identified as having been sanctioned by Medicare/Medicaid are administratively terminated from the applicable line of business and may be subject to further investigation.
c. Federal Debarment Report: Practitioners who are identified as having been debarred from the Federal Employees Health Benefits Program (FEHBP) are administratively terminated from this program affiliation.
d. Medicare Opt-Out Report: Practitioners who are identified as having opted out of the Medicare program are administratively terminated from the Medicare line of business.
e. OIG/LEIE: The Office of Inspector General listing of excluded Medicare providers. Provider/Practitioners identified are administratively terminated from the Medicare line of business.
f. Medicare Preclusion Listing: Practitioners who are identified as having been disciplined from participating in the Medicare program are administratively terminated from the Medicare line of business.
g. State medical board disciplinary/non-disciplinary action reports: Practitioners subject to state licensing board disciplinary/non-disciplinary action and/or other adverse events are investigated by the Plan
h. Medi-Cal Suspended & Ineligible Practitioners list: Practitioners appearing on this list are administratively terminated from the Medi-Cal (Medicaid) and the Plan Community Solutions, line of business.

i. Restricted Provider Database (RPD): Exclusion listing by the state, barring participation in the Medi-Cal program. Practitioners who are identified as having been disciplined from participating in the Medic-Cal (Medicaid) program are administratively terminated from the Medi-Cal and the Plan's Community Solutions lines of business.
j. Ongoing Office Monitoring: Practitioners with three (3) or more office complaints regarding physical appearance, accessibility, or adequacy of waiting/examining room space within a rolling six (6) month period will be subject to an office site evaluation

2. CHPIV will ensure upon identifying an exclusionary status for an active participating practitioner, notification will be sent to the impacted departments such as but not limited to: Provider Network Management, Provider Data Management, Compliance, Claims and Special Investigations Unit to take the appropriate actions.
3. CHPIV will ensure upon identifying an exclusionary status for an active participating practitioner, notification will be sent to the impacted practitioner advising them that they are not to treat membership associated with the excluded line of business.

G. Internal Credentialing & Directory Database Integrity Review

1. CHPIV will ensure the Plan's Credentialing Department will conduct an internal review, ensuring the listings within practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty.
2. CHPIV will ensure the Plan will conduct this review quarterly, and the National Credentialing Department will review results at least annually. Inter-departmental training will be provided if deemed appropriate. Senior leadership will be notified of all identified process improvement opportunities.
3. CHPIV will ensure adverse findings may result in internal or external corrective action plan(s) (CAPs) to address/correct noted deficiencies.

H. Antidiscrimination Practices in Credentialing

1. CHPIV will ensure all the Plan's Credentialing Committee members sign a confidentiality/conflict of interest statement annually, attesting to their adherence to the Plan's nondiscriminatory credentialing practices. The Plan will not make credentialing decisions based on an applicant's race, ethnic/national identity, gender, age or sexual orientation, or patient (e.g., Medicaid) in which the practitioner specializes.
2. CHPIV will ensure pertinent clauses from the confidentiality/conflict of interest statement are included on Credentialing Committee sign-in sheets that are distributed and signed by all voting members of the committee, its chairperson and attending staff prior to commencement of each committee meeting.
3. CHPIV will ensure any time the Credentialing Committee is asked to make administrative participation decisions (i.e., credentialing/recredentialing approval, denial, or termination) the decisions are based on review of standardized criteria for participation that are defined by federal and state regulators and accrediting entities. Administrative decisions rendered by the Credentialing Committee cannot be modified, reversed, or appealed.
4. CHPIV will ensure the only demographic information housed in the credentialing database is that which is essential to conducting the credentialing/recredentialing process. Nonessential data, including but not limited to race, ethnicity/national identity, languages spoken, and sexual orientation are not reviewed by staff or stored within the credentialing database.
5. CHPIV will ensure the uniform execution of credentials file-processing standards is monitored by a Credentialing Manager or Supervisor on an ongoing basis via internal

database reporting, outreach tracking logs or standardized termination/documentation forms.

6. CHPIV will ensure Credentialing Specialists are subject to individual monthly file quality oversight audits to ensure work completed within the department is unvarying. The Credentialing Department also conducts quarterly file standardization audits.
7. CHPIV will ensure unless required for legal reasons or demonstration of compliance during a regulatory or accreditation audit, the only information released internally or externally about adverse action case decisions are the outcomes and origination source (i.e., medical licensing board, Medicare/Medicaid sanction reports, National Practitioner Data Bank, etc.).
8. CHPIV will ensure the Plan will not refuse to credential a health care provider who is an employee or contractor of a county, local supervisory authority, or detention facility on the basis that the employee or contractor provides the services in a facility operated by the local supervisory authority or in a detention facility.
    a. The denial or termination of an employee, contractor of the county will be communicated to the provider, explaining the reason(s) for the refusal.

I. Approval/Denial Notification

1. CHPIV will ensure Practitioners are notified of the Credentialing Committee's decision within 60 calendar days of the decision.

J. Credentialing Committee Process

1. CHPIV will ensure the Credentialing Committee or its Chairperson/Medical Director reviews and signs or initials the roster of practitioners meeting the Plan's criteria and makes the determination as to admission or retention as participants in the Plan's network.
2. CHPIV will ensure the Credentialing Committee reviews non-compliant initial and recredentialing practitioner files and makes the determination as to their administrative denial or termination from network participation. The committee's discussion is documented in the meeting minutes.
3. CHPIV will ensure the Credentialing Committee reviews all adverse action cases meeting Level IV investigatory criteria. Upon review of each adverse action case, the committee renders a network participation decision, which may include, but is not limited to, network admittance, continued participation, denial, or termination. The committee's discussion is documented in the meeting minutes.

K. Change Notifications

1. CHPIV will ensure This policy is updated when necessary to reflect substantive changes in regulatory and/or accrediting entity standards. Substantive changes will be communicated to delegates, before going into effect, via the Plan's Scope of Work & Performance Standards.

L. Confidentiality

1. CHPIV will ensure all credentialing and peer review activities will be protected under all applicable state and federal laws.
2. CHPIV will ensure the Credentialing Department maintains the credentialing and recredentialing files in secure locations. Unauthorized personnel are restricted from access to the files.
3. CHPIV will ensure Credentialing files are organized and maintained according to written desktop procedures.
4. CHPIV will ensure all Credentialing Committee minutes will be maintained in a secure area.

M. Reporting
1. Refer to the Credentialing Department Reports tracking tool for relevant reporting related to this policy.

N. Credentialing System Controls
1. CHPIV will ensure only Credentialing Department staff are authorized to view credentialing documentation and electronic records.
2. CHPIV will ensure only Credentialing Department staff are authorized to amend credentialing documentation and electronic records when necessary to accurately assess/represent and publish practitioner qualifications.

O. Emergency Provisional Credentialing
1. CHPIV will ensure should a national, regional disaster or emergency occur, and a government emergency declaration is declared the Plan may invoke Business Continuity Planning or Emergency Protocols and adopt Provisional Credentialing proceedings as recognized by the National Committee for Quality Assurance (NCQA).
2. CHPIV will ensure Practitioners will have an expedited review of pertinent documentation and allow to participate in network with Credentialing Chairperson or Medical Director approval, should all criteria be met.
3. CHPIV will ensure upon approval and inclusion to our network, the practitioner will have all credentialing primary source verifications completed, in accordance with the requirements for initial credentialing as outlined in this policy, within 60 calendar days.

P. Criteria for Provisional approval. The practitioner must have:
1. Application: CHPIV will ensure the Practitioner completes the Plan approved application and forwards it, along with requested supporting documentation, as instructed. Signature and date of application will not exceed 180 days at the time of Credentialing Committee or Chairperson review and/or approval.
    a. affirms the completeness and truthfulness of representations made in the application.
    b. indicates a willingness to provide additional information for the credentials process.
    c. authorizes the Plan to obtain information regarding the applicant's qualifications, competence, or other information relevant to the credentialing review, and
    d. releases the Plan and its independent contractors, agents and employees from any liability connected with the credentialing review.
2. An approved application, completed and attested to within 180 days
    a. Present illegal drug use
    b. History of loss of license or certification
    c. History of criminal/felony convictions
    d. History of loss or limitation of privileges or disciplinary actions with any health care entity
    e. Any inability to perform all essential functions of the contracted specialty(ies), with or without accommodation, according to criteria of professional performance
    f. Current malpractice insurance coverage.
        i. The practitioner will attest to the completeness and truthfulness of all elements of the application.
        ii. Information submitted on the application by the practitioner must be supported by verifiable sources.
        iii. The practitioner must provide a continuous work history for the previous five years. The verification time limit is 180 days.

g. Any gaps exceeding six (6) months will be reviewed and clarified either verbally or in writing. All verbal communication will be documented in the file. Any gap(s) in work history that exceeds one year must be clarified in writing.

3. License
   a. The practitioner must possess a current, valid license or certificate issued by the state in which the practitioner is applying to practice. The verification time limit is 180 days.
   b. Licenses that are limited, suspended, restricted, showing an accusation, on probation or no practice restriction are, administratively denied
4. Malpractice Claims History and Medicare-Medicaid Sanctions
   a. CHPIV will ensure the practitioner will be assessed with a National Practitioner Databank Report (NPDB). The verification time limit is 180 days.
   b. Licenses that are limited, suspended, restricted, showing an accusation, on probation or no practice restriction are, administratively denied

III. PROCEDURE

A. CHPIV delegates the Credentialing and Recredentialing 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
N/A	

Policy CR-001 – Attachment A

Regulatory & Accreditation Requirement Verification Source Tables

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Section I: Regulatory & Accreditation Requirement Verification Tables

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Section II: Regulatory & Accreditation Requirement

Primary Source Verification /Not Required/Application is Deemed the Source

All Practitioners: Required Documentation – Primary Source Verification Not Required							
Items Requiring Validation for Credentialing and Recredentialing	**Sources of Verification (~~who~~Who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (~~how~~How verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
Application/profile complete (demographics)	• Practitioner	• Application (180 days)	• Completed application/profile in file (180 days)	☒	☒	☒	1,2,3,4,5,6
Questionnaire complete	• Practitioner	• Application (180 days)	• Completed questionnaire in file	☒	☒	☒	1,2,3,4,5,6

All Practitioners: Required Documentation – Primary Source Verification Not Required							
Items Requiring Validation for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
Attestation signed/dated • Inability to perform essential functions; illegal drug use • History of actions, including, but not limited to: Loss of license/privileges or felony convictions • Current malpractice coverage • Correctness and completeness	• Practitioner	• Application (180 days)	• Signed/dated in file (stamped signature is not acceptable) • Electronic Signatures are acceptable (CAQH) •	☒	☒	☒	1,2,3,4,5,6
Work history – 5 years (gaps of 6 to 12 months explained [verbal confirmation allowed]; gaps of more than 12 months explained in writing)	• Staff (up to one year) • Practitioner (exceeds one-year gap)	• Application (180 days) or • Curriculum vitae or • Work-history form	• Document(s) in file, including signature or initials of staff who reviewed the work history and the date of review	☒	☒	☐	1,2,3,4,5,6
Malpractice ~~claim~~claims history explanation(s), if applicable	Practitioner	• Application (180 days) or • Liability explanation form or • Written explanation/letter or • Malpractice worksheet	Document(s) in file	☒	☒	☒	1,2,3,4,5,6

All Practitioners: Required Documentation – Primary Source Verification Not Required							
Items Requiring Validation for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
Malpractice insurance coverage *$1 million per Occurrence/$3 million Aggregate are ~~Health Net~~CHPIV minimal requirements.*	• Practitioner or • Malpractice policy face sheet	• Application (180 days) or • Malpractice policy face sheet (current at time of committee decision)	Document(s) in file	☒	☒	☒	1,2,3,4,5,6
Affiliated hospital admitting privileges or approved coverage arrangement as defined in the body of ~~Health Net~~CHPIV's Credentialing/ Recredentialing policy *Telemedicine practitioners are exempt from this requirement*	• Practitioner • Coverage Arrangement or • Corporate Transfer Agreement	• Attestation (180 days) or • Oral/written verification* from hospital medical staff office • *The applicant must identify a ~~Health Net~~CHPIV or CHPIV Subcontractor contracted practitioner to admit or identify an acceptable practice to admit (Example: Hospitalist Panel.)* • *N/A if the practice location is Nevada only*	• Application (180 days) or • Oral/written verification* from hospital medical staff office in file or • Admit plan signed or attested to by the practitioner	☒	☒	☒	1,2,3,4,5,6

Section III: Regulatory & Accreditation Requirement Verification Tables

Primary Source Verification is Required for All Practitioner Types

All Practitioners: Regulatory Reporting - Required Primary Source Verification							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
Verify Type 1 NPI	• NPPES NPI Registry	• Screen print from NPPES NPI Registry	• Document in file (180 days)	☒	☒	☒	3, 6
Social Security Death Master File Applicant is absent from report	• Social Security Death Master File	• Screen print from Social Security Death Master File	• Document in file (180 days)	☒	☒	☒	3, 6
Medicare Certification (SAM)	• Individual Provider listing at cms.gov	• Screen print from cms.gov	• Document in file (180 days) • log or checklist - Date of report - Date of review - Findings of review Initials or signature of reviewer	☒	☒	☒	2,6
Debarment from Federal Employee Health Benefits Program (FEHBP)	• Federal debarment report from U.S. Office of Personnel Management (OPM)	• Written verification from OPM or • Screen print from FEHBP Report	• Document in file (180 days) • log or checklist - Date of report - Date of review - Findings of review Initials or signature of reviewer	☒	☒	☒	3,5,6
Medicare/Medicaid Sanction Activity	• NPDB • Office of Inspector General (OIG)	• Medicare/Medicaid Sanctions and Reinstatement Report or • OIG website or • Screen print from NPDB	• Document in file (180 days) • log or checklist - Date of report - Date of review - Findings of review • Initials or signature of reviewer	☒	☒	☒	1,2,3,5,6

All Practitioners: Regulatory Reporting - Required Primary Source Verification							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
Medicare Opt-Out (Medicare/ Medicaid)	Regional Medicare/ Medicaid Opt-Out Report (released quarterly)	• Regional Medicare/ Medicaid Opt-Out Report	• Document in file (180 days) • log or checklist - Date of report - Date of review - Findings of review • Initials or signature of reviewer	☒	☒	☒	2,3,5,6
Medi-Cal (Medicaid) Exclusion Report	Suspended and Ineligible Provider Listing (SIPL)	• Screen print from SIPL Report	• Document in file (180 days) • log or checklist - Date of report - Date of review - Findings of review • Initials or signature of reviewer	☒	☒	☒	2,3,5,6
Medicare Preclusion Listing	CMS Medicare Provider Enrollment and Certification	• Screen print from Medicare Preclusion Report	• Document in file (180 days) • log or checklist - Date of report - Date of review - Findings of review • Initials or signature of reviewer	☒	☒	☒	2
Performance Data *This category is applicable only to recredentialing and lost delegation files Additional verifications may apply to practitioners that were reinstated or through a special ~~project.~~ project.*	Reports from departments including, but not limited to: • Quality Improvement Department and/or • Grievance/Appeals Department and/or • Utilization Management Department and/or • Provider Network Management Department	• Departmental databases and/or • Spreadsheets and/or • Performance data forms	• Profile in file and/or • Audit tool in file and/or • Data form(s) in file	☐	☒	☒	1,2,3,4,5,6

All Practitioners: Regulatory Reporting - Required Primary Source Verification							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
HIV/AIDS Specialty Designation	• AAHIVM registry • American Board of Medical Specialties (ABMS) • American Osteopathic Association profile (AOA) or • American Medical Association (AMA) Master profile or • Residency program or • Fellowship and/or • Medical school • Practitioner	• Board Certified in Infectious Diseases, screen print from ABMS or • Attestation to the completion of one or more of the following requirements: • The practitioner is currently a member of the American Academy of HIV Medicine, • Board certified in Infectious Disease and in the past 12 months has treated 25 HIV patients and completed 15 hours of category 1 CME in HIV medicine, five-hours of which was related to antiretroviral therapy, • In the past 24 months has provided continuous and direct treatment to 20 HIV patients and in the past 12 months have completed board certification in Infectious Disease, • In the past 24 months has provided continuous and direct treatment to 20 HIV patients and in the past 12 months have completed 30 hours of category 1 CME in HIV medicine, • In the past 24 months has provided continuous and direct treatment to 20 HIV patients and in the past 12 months have completed 15 hours of category 1 CME in HIV medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine. • Qualifying Education Verification through the state licensure board	• Document in file • Oral/written, evidenced by: – Applicant name – ABMS Board – AAHIVM membership/credentialing status – Staff member initials or signature of reviewer – Date of report – Findings of review – Date of review • Attestation	☒	☒	☐	4, 6

All Practitioners: Regulatory Reporting - Required Primary Source Verification							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
HIV/AIDS Specialty Designation	• American Board of Medical Specialties (ABMS)/CD-ROM • American Osteopathic Association profile (AOA) • Medical Board of applicable state • Osteopathic Medical Board of applicable state (OMC) • DEA or • National Technical Information Service (NTIS)	• Board Certified in Infectious • For MDs, screen print state medical board website • State medical board disciplinary reports monthly • For DOs, oral/ written verification* from OMB • Copy DEA certificate(s) or • Screen print from query of NTIS or • Oral/written verification* through the DEA	• Documents in file – Received date – Staff member initials – Expiration Date •	☐	☐	☒	4, 6
Qualified Autism Service Provider Specialty Designation **Applicable to:** Behavior Analyst Certification Board - BCBA = Masters Certification Behavior Analyst Certification Board - BCBA-D = Doctoral Certification Behavior Analyst Certification Board - BCaBA = Assistant	• American Board of Medical Specialties (ABMS) • American Osteopathic Association profile (AOA) or • American Medical Association (AMA) Master profile or • Residency program or • Behavior Analyst Certification Board	• For MDs, screen print from ABMS BoardCertifiedDocs • Oral/written/Internet verification* from an ABMS specialty board • For DOs, written/printed verification from current AOA directory or ABMS BoardCertifiedDocs • For residency/ fellowship/medical education, oral/written/ Internet verification* from AMA; or AMA in combination with web site profile or oral/written/Internet verification* from residency/fellowship program and/or medical school • For all other provider types, ~~Qualifying~~qualifying medical education verification through the state medical licensing board (oral, written or Internet) as applicable • Screen print from the BACB website	• Document in file • Oral/written, evidenced by: – Applicant name – ABMS Board – Behavior Analyst Certification Board membership/credentialing status – Staff member initials or signature of reviewer – Date of report – Findings of review – Date of review • Attestation	☒	☒	☒	4, 6

Section IV: Regulatory & Accreditation Requirement Verification Source Tables

Primary Source Verification (PSV) Requirements for Network Specialties by Type

Medical Doctors (MDs) and Osteopathic Physicians (DOs) Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
License	• State licensing board	• Screen print from state licensing board website • Verbal verification* from state medical licensing board	• Document in file or • Oral, written or printed verification* from licensing board evidenced by: – Received or print date – Staff member initials – Expiration date of license	☒	☒	☒	1,2,3,4,5,6
Sanctions or Limitations on Licensure	• State medical licensing board or • National Practitioner Data Bank (NPDB)	• Screen print from state medical licensing board website • Verbal verification* from state medical licensing board • Electronic query (printout) from NPDB	• Document in file • Oral, written or printed verification* from medical board evidenced by: – Received or print date – Staff member initials – Expiration date of license	☒	☒	☒	1,2,3,4,5,6

Medical Doctors (MDs) and Osteopathic Physicians (DOs) Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
Drug Enforcement Administration (DEA) *Verification must be completed for each state in which a practitioner sees ~~Health Net~~CHPIV members* *If a practitioner does not have a DEA or CDS certificate, ~~Health Net~~CHPIV obtains a written explanation from the practitioner that includes arrangements for the practitioner's patients who need prescriptions requiring DEA certification* *A DEA or CDS certificate may not be required within the scope of services provided*	• DEA or • National Technical Information Service (NTIS) or • U.S. Department of Justice/ DEA Duplicate Certificate Site	• Copy of DEA certificate(s) or • Screen print from query to NTIS or • Screen print from USDOJ DEA duplicate or • Oral/written verification* from the DEA	• Document in file or • Screen print from query to NTIS or • Oral/written verification* from the DEA in file	☒	☒	☒	1,2,3,4,5,6
Controlled Dangerous [or Drug] Substance (CDS) certificate, as applicable *Nevada Required* *Verification must be completed for each state in which a practitioner sees ~~Health Net~~CHPIV members* *A DEA or CDS certificate may not be required within the scope of services provided*	• Applicable state website/contact/agency or state board of pharmacy	• Copy of CDS certificate or • Oral/written/Internet verification* from state CDS/board of pharmacy	• Oral/written/Internet verification* from CDS/state board of pharmacy – Received or print date – Staff member initials – Expiration date of certificate	☒	☒	☒	1,2,3,4,5,6

Medical Doctors (MDs) and Osteopathic Physicians (DOs) Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
Education	• American Osteopathic Association profile (AOA) or • American Medical Association (AMA) Master Profile or • Completed Residency program or • Completed Fellowship and/or • Medical school or • State medical licensing board (if issue date of license follows graduation date and if state conducts verification of education prior to licensure)	• For MDs, screen print from ABMS BoardCertifiedDocs • Oral/written/Internet verification* from an ABMS specialty board • For DOs, written/printed verification from current AOA directory or ABMS BoardCertifiedDocs • For residency/ fellowship/medical education, oral/written/ Internet verification* from AMA; or AMA in combination with web site profile or oral/written/Internet verification* from residency/fellowship program and/or medical school • Qualifying medical education verification through the state medical licensing board (oral, written or Internet)	• Document in file • Oral/written/Internet verification*	☒	☒	☐	1,2,3,4,5,6

Medical Doctors (MDs) and Osteopathic Physicians (DOs) Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
Board certification	• American Board of Medical Specialties (ABMS) BoardCertifiedDocs (~~180 day~~180-day verification limit) • American Osteopathic Association profile (AOA) (180 day verification limit) or • American Medical Association (AMA) Master Profile (~~180 day~~180-day verification limit) •	• For MDs, screen print from ABMS BoardCertifiedDocs • Oral/written/Internet verification* from an ABMS specialty board • For DOs, written/printed verification from current AOA directory or ABMS BoardCertifiedDocs •	• Document in file Oral/written/Internet verification*	☒	☒	☒	1,2,3,4,5,6
Professional Liability Claim History	• Malpractice insurance carrier or • National Practitioner Data ~~Bank~~(Bank (NPDB)	• Written verification of the following from the malpractice insurance carrier: • Five (5) years professional liability claim history (initial credentialing) • Three (3) years professional liability claim history (recredentialing)	• Document in file or • Audit tool in file	☒	☒	☒	1,2,3,4,5,6

Doctor of Podiatric Medicine (DPMs) Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
License	• State licensing board	• Screen print from state licensing board website • Verbal verification* from state medical licensing board	• Document in file or • Oral, written or printed verification* from licensing board evidenced by: – Received or print date – Staff member initials – Expiration date of license	☒	☒	☒	1,2,3,4,5,6
Sanctions or Limitations on Licensure	• State licensing board or • National Practitioner Data Bank (NPDB)	• Screen print from state licensing board website • Verbal verification* from state medical licensing board • Electronic query (printout) from NPDB	• Document in file • Oral, written or printed verification* from medical board evidenced by: – Received or print date – Staff member initials – Expiration date of license	☒	☒	☒	1,2,3,4,5,6
Drug Enforcement Administration (DEA) *Verification must be completed for each state in which a practitioner ~~sees~~sees ~~Health Net~~CHPIV members* *Written explanation required in absence of DEA/CDS* *A DEA certificate may not be required within the scope of services provided*	• DEA or • National Technical Information Service (NTIS) or • U.S. Department of Justice/ DEA Duplicate Certificate Site	• Copy of DEA certificate(s) or • Screen print from query to NTIS/DOJ Duplication Site or • Oral/written verification* from the DEA	• Document in file or • Screen print from query to NTIS or • Oral/written verification* from the DEA in file	☒	☒	☒	1,2,3,4,5,6

Doctor of Podiatric Medicine (DPMs) Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
Controlled Dangerous [or Drug] Substance (CDS) certificate, as applicable *Nevada Required* *Verification must be completed for each state in which a practitioner sees ~~Health Net~~CHPIV members* *A CDS certificate may not be required within the scope of services provided*	• Applicable state website/contact/agency or state board of pharmacy	• Copy of CDS certificate or • Oral/written/Internet verification* from state CDS/board of pharmacy	• Oral/written/Internet verification* from CDS/state board of pharmacy – Received or print date – Staff member initials – Expiration date of certificate	☒	☒	☒	1,2,3,4,5,6
Education	• American Board of Podiatric Medicine (ABPM) or American Board of Foot and Ankle Surgery (ABFAS) or American Board of Podiatric Medicine (ABPMED) or • State board of podiatry (if issue date of the license follows the graduation date, and if the state conducts verification of education prior to licensure) or • Other applicable state licensing board (if issue date of the license follows the graduation date, and if the state conducts verification of education prior to licensure)	• Oral/written verification* from American Board of Podiatric Surgery Directory of Members or • State medical board issued license verifies practitioner education or • Qualifying medical education verification* through the state licensing board (oral, written or Internet)	• Document in file • Oral*/written/Internet	☒	☒	☐	1,2,3,4,5,6

Doctor of Podiatric Medicine (DPMs) Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
Board certification	• American Board of Podiatric Medicine (ABPM) • or • American Board of Foot and Ankle Surgery (ABFAS) • or • American Board of Podiatric Medicine (ABPMED)	• Screen print from ABMS BoardCertifiedDocs • Oral/written/Internet verification* from ABPS or ABPOPPM	• Document in file • Oral/written/Internet verification*	☒	☒	☒	1,2,3,4,5,6
Professional Liability Claim History	• Malpractice insurance carrier or • NPDB	• Written verification of the following from the malpractice insurance carrier: • Five (5) years professional liability claim history (initial credentialing) • Three (3) years professional liability claim history at recredentialing or • Printout from NPDB	• Document in file or • Audit tool in file	☒	☒	☒	1,2,3,4,5,6

Acupuncturists (ACs) Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
License	• State licensing board	• Screen print from state licensing board website • Verbal verification* from state medical licensing board	• Document in file • Oral, written or printed verification* from medical board, evidenced by: – Received or print date – Staff member initials – Expiration date of license	☒	☒	☒	1,2,3,4,5,6
Sanctions or Limitations on Licensure	• State licensing board or • NPDB	• Screen print from state licensing board website • Verbal verification* from state medical licensing board • Electronic query (printout) from NDPB	• Document in file • Oral, written or printed verification* from medical board, evidenced by: – Received or print date – Staff member initials – Expiration date of license	☒	☒	☒	1,2,3,4,5,6
Education	• State licensing board (if issue date of license follows graduation date and if state conducts verification of education prior to licensure) or • Educational institution	• Oral/written verification* from institution or • Qualifying education verification* through the state licensing board (oral, written or Internet)	• Document in file • Oral/written/ Internet	☒	☒	☐	1,2,3,4,5,6
Professional Liability Claim History	• Malpractice insurance carrier or • NPDB	• Written verification of the following from the malpractice insurance carrier: • Five (5) years professional liability claim history (initial credentialing) • Three (3) years professional liability claim history at recredentialing or • Printout from NPDB	• Document in file or • Audit tool in file	☒	☒	☒	1,2,3,4,5,6

Audiologists (AUDs) Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
License	• State licensing board	• Screen print from state licensing board website or • Verbal verification* from state licensing board	• Document in file • Oral, written or printed verification from medical board evidenced by: – Received or print date – Staff member initials – Expiration date of license	☒	☒	☒	1,2,3,4,5,6
Sanctions or Limitations on Licensure	• State licensing board or • NPDB	• Screen print from state licensing board website • Verbal verification* from state licensing board • Electronic query (printout) from NPDB	• Document in file • Oral, written or printed verification* from medical board, evidenced by: – Received or print date – Staff member initials – Expiration date of license	☒	☒	☒	1,2,3,4,5,6
Education	• Training institution or • State licensing board (if issue date of license follows graduation date and if state conducts verification of education prior to licensure)	• Oral/written verification* from training institution or • Qualifying medical education verification* through the state licensing board (oral, written or Internet)	• Document in file • Oral/written/ Internet	☒	☒	☐	1,2,3,4,5,6

Audiologists (AUDs) Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**

Professional Liability Claim History	• Malpractice insurance carrier
	or
	• NPDB
		• Written verification of the following from the malpractice insurance carrier:
		  • Five (5) years professional liability claim history (initial credentialing)
		  • Three (3) years professional liability claim history at recredentialing
		or
		• Printout from NPDB
			• Document in file
			or
			• Audit tool in file
				☒	☒	☒	1,2,3,4,5,6

Dentists; Oral & Maxillofacial Surgeons (DDSs / DMDs) Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
License	• State board of medical or dental examiners	• Screen print from state medical or dental licensing board website • Verbal verification* from state medical or dental licensing board website	• Document in file • Oral, written or printed verification* from licensing board or evidenced by: – Received or print date – Staff member initials – Expiration date of license	☒	☒	☒	1,2,3,4,5,6
Sanctions or Limitations on Licensure	• State medical or dental licensing board or • NPDB	• Screen print from state medical licensing board website • Verbal verification* from state medical licensing board • Electronic query (printout) from NPDB	• Document in file • Oral, written or printed verification* from medical or dental board, evidenced by: - Received or print date - Staff member initials - Expiration date of license	☒	☒	☒	1,2,3,4,5,6
Drug Enforcement Administration (DEA) *Verification must be completed for each state in which a practitioner ~~seesees~~ ~~Health Net~~CHPIV members* *Written explanation required in absence of DEA/CDS* *A DEA certificate may not be required within the scope of services provided*	• DEA or • National Technical Information Service (NTIS) or • U.S. Department of Justice/ DEA Duplicate Certificate Site	• Copy of DEA certificate(s) or • Screen print from query to NTIS/DOJ Duplication Site or • Oral/written verification* from the DEA	• Document in file or • Screen print from query to NTIS or • Oral/written verification* from the DEA in file	☒	☒	☒	1,2,3,4,5,6

Dentists; Oral & Maxillofacial Surgeons (DDSs / DMDs) Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
Controlled Dangerous [or Drug] Substance (CDS) certificate, as applicable *Nevada Required* *Verification must be completed for each state in which a practitioner sees ~~Health Net~~CHPIV members* *A CDS certificate may not be required within the scope of services provided*	• Applicable state website/contact/agency or state board of pharmacy	• Copy of CDS certificate or • Oral/written/Internet verification* from state CDS/board of pharmacy	• Oral/written/Internet verification* from CDS/state board of pharmacy – Received or print date – Staff member initials – Expiration date of certificate	☒	☒	☒	1,2,3,4,5,6
Education	• American Board of Maxillofacial Surgeons or • Residency program or dental school or • State medical or dental licensing board (if issue date of license follows graduation date and if state conducts verification of education prior to licensure)	• Oral/written/Internet verification* from specialty board or • Oral/written verification* from residency program or • Qualifying dental/medical education verification through the state licensing board (oral, written or Internet)	• Document in file – Oral/written/ Internet	☒	☒	☐	1,2,3,4,5,6

Dentists; Oral & Maxillofacial Surgeons (DDSs / DMDs) Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
Board certification	• American Board of Oral & Maxillofacial Surgeons • American Dental Association (ADA) • American Board of Endodontics or • American Board of Orthodontics or • American Board of Periodontology or • American Board of Prosthodontics	• Screen print from ABOMS • Oral/written/Internet verification* from an ABMS specialty board • Oral/written/Internet verification* from the ADA	• Document in file • Oral/written/ Internet verification*	☒	☒	☒	1,2,3,4,5,6
Professional Liability Claim History	• Malpractice insurance carrier or • NPDB	• Written verification of the following from the malpractice insurance carrier: • Five (5) years professional liability claim history (initial credentialing) • Three (3) years professional liability claim history at recredentialing or • Printout from NPDB	• Document in file or • Audit tool in file	☒	☒	☒	1,2,3,4,5,6

	Doctor of Chiropractic Medicine (DCs) Primary Source Verification Requirements						
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with~~ with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
License	• State Board of Chiropractic Examiners	• Screen print from state licensing board website • Verbal verification* from state medical licensing board	• Document in file or • Oral, written or printed verification* from licensing board evidenced by: – Received or print date – Staff member initials – Expiration date of license	☒	☒	☒	1,2,3,4,5,6
Sanctions or Limitations on Licensure	• State Board of Chiropractic Examiners or • NPDB	• Screen print from state licensing board website • Verbal verification* from state licensing board • Electronic query (printout) from NPDB	• Document in file or • Oral, written or printed verification* from medical board evidenced by – Received or print date – Staff member initials – Expiration date of license	☒	☒	☒	1,2,3,4,5,6
Education	• State Board of Chiropractic Examiners (if issue date of the license follows the graduation date, and if the state conducts verification of education prior to licensure)	• Oral/written/Internet verification* from applicable licensing board or • Qualifying medical education verification* through the state licensing board (oral, written or Internet)	• Document in file • Oral/written/Internet	☒	☒	☐	1,2,3,4,5,6

	Doctor of Chiropractic Medicine (DCs) Primary Source Verification Requirements						
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**

Professional Liability Claim History	• Malpractice insurance carrier
	or
	• NPDB
		• Written verification of the following from the malpractice insurance carrier:
		  • Five (5) years professional liability claim history (initial credentialing)
		  • Three (3) years professional liability claim history at recredentialing
		or
		• Printout from NPDB
			• Document in file
			or
			• Audit tool in file
				☒	☒	☒	1,2,3,4,5,6

Doctors of Naturopathic Medicine (NDs) Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
License	• State licensing board	• Screen print from state licensing board • Verbal verification from state licensing board	• Document in file • Oral, written or printed verification from licensing board, evidenced by: -- Received or print date -- Staff member initials -- Expiration date of license	☒	☒	☒	1,2,3,4,5,6
Sanctions or Limitations on Licensure	• State licensing board or • National Practitioner Data Bank (NPDB)	• Screen print from state licensing board • Verbal verification from state licensing board • Electronic query (printout) from NPDB	• Document in file • Oral, written or printed verification from licensing board, evidenced by: -- Received or print date -- Staff member initials -- Expiration date of license	☒	☒	☒	1,2,3,4,5,6

Doctors of Naturopathic Medicine (NDs) Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
Education	• State licensing board or • Educational institution	• Screen print from state licensing board • Verbal verification from state licensing board	• Document in file • Oral, written or printed verification from licensing board, evidenced by: -- Received or print date -- Staff member initials -- Expiration date of license	☒	☒	☐	1,2,3,4,5,6
Professional Liability Claim History	• Malpractice insurance carrier or • National Practitioner Data Bank (NPDB)	• Written verification of the following from the malpractice insurance carrier: • Five (5) years professional liability claim history (initial credentialing) • Three (3) years professional liability claim history (recredentialing) or • Printout from NPDB	• Document in file or • Audit tool in file	☒	☒	☒	1,2,3,4,5,6

Licensed Clinical Social Workers (LCSWs); Marriage & Family Therapists (MFTs); Marriage, Family & Child Counselors (MFCCs), and Mental Health Counselors (MHCs) Primary Source Verification Requirements

Items Requiring Verification for Credentialing and Recredentialing	Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)	Methods of Verification (how verified: copy of document, Oral/written, etc.)	Evidence of Verification	Cred	Lost Delegation	Recred	Regulatory Standards
License	• State board of behavioral health or behavioral sciences	• Screen print from state licensing board website • or • Verbal verification* from state medical licensing board	• Document in file • Oral, written or printed verification* from medical board evidenced by: – Received or print date – Staff member initials – Expiration date of license	☒	☒	☒	1,2,3,4,5,6
Sanctions or Limitations on Licensure	• State licensing board or • NPDB	• Screen print from state licensing board website • Verbal verification* from state licensing board • Electronic query (printout) from NPDB	• Document in file • Oral, written or printed verification* from medical board evidenced by: – Received or print date – Staff member initials – Expiration date of license	☒	☒	☒	1,2,3,4,5,6
Education	• State licensing board (if issue date of license follows graduation date and if state conducts verification of education prior to licensure) or • Educational institution	• Oral/written verification* from institution or • Qualifying education verification* through the state licensing board (oral, written or Internet)	• Document in file • Oral/written/Internet	☒	☒	☐	1,2,3,4,5,6

Licensed Clinical Social Workers (LCSWs); Marriage & Family Therapists (MFTs); Marriage, Family & Child Counselors (MFCCs), and Mental Health Counselors (MHCs) Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**

Professional Liability Claim History	• Malpractice insurance carrier
	or
	• NPDB
		• Written verification of the following from the malpractice insurance carrier:
		  • Five (5) years professional liability claim history (initial credentialing)
		  • Three (3) years professional liability claim history at recredentialing
		or
		• Printout from NPDB
			• Document in file
			or
			• Audit tool in file
				☒	☒	☒	1,2,3,4,5,6

Optometrists (ODs) Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
License	• State licensing (optometry) board	• Screen print from state licensing board • Verbal verification* from state licensing board	• Document in file • Oral, written or printed verification* from medical board or NPDB evidenced by: – Received or print date – Staff member initials – Expiration date of license	☒	☒	☒	1,2,3,4,5,6
Sanctions or Limitations on Licensure	• State licensing (optometry) board or • NPDB	• Screen print from state licensing board • Verbal verification* from state licensing board • Electronic query (printout) from NPDB	• Document in file • Oral, written or printed verification* from medical board or NPDB evidenced by: – Received or print date – Staff member initials – Expiration date of license	☒	☒	☒	1,2,3,4,5,6
Drug Enforcement Administration (DEA) *Verification must be completed for each state in which a practitioner ~~sees~~sees ~~Health Net~~CHPIV members* *Written explanation required in absence of DEA/CDS* *A DEA certificate may not be required within the scope of services provided*	• DEA or • National Technical Information Service (NTIS) or • U.S. Department of Justice/ DEA Duplicate Certificate Site	• Copy of DEA certificate(s) or • Screen print from query to NTIS/DOJ Duplication Site or • Oral/written verification* from the DEA	• Document in file or • Screen print from query to NTIS or • Oral/written verification* from the DEA in file •	☒	☒	☒	1,2,3,4,5,6

Optometrists (ODs) Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
Controlled Dangerous [or Drug] Substance (CDS) certificate, as applicable *Nevada Required* *Verification must be completed for each state in which a practitioner sees ~~Health Net~~CHPIV members* *A CDS certificate may not be required within the scope of services provided*	• Applicable state website/contact/agency or state board of pharmacy	• Copy of CDS certificate or • Oral/written/Internet verification* from state CDS/board of pharmacy	• Oral/written/Internet verification* from CDS/state board of pharmacy – Received or print date – Staff member initials – Expiration date of certificate •	☒	☒	☒	1,2,3,4,5,6
Education	• State licensing board (if issue date of license follows graduation date and if state conducts verification of education prior to licensure) or • Educational institution	• Oral/written verification* from institution or • Qualifying education verification* through the state licensing board (oral, written or Internet)	• Document in file • Oral/written/ Internet	☒	☒	☐	1,2,3,4,5,6
Professional Liability Claim History	• Malpractice insurance carrier or • NPDB	• Written verification of the following from the malpractice insurance carrier: • Five (5) years professional liability claim history (initial credentialing) • Three (3) years professional liability claim history at recredentialing or • Printout from NPDB	• Document in file or • Audit tool in file	☒	☒	☒	1,2,3,4,5,6

Physical & Occupational Therapists (PTs/OTs) Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
License	• State licensing board	• Screen print from state licensing board website • Verbal verification* from state licensing board	• Document in file • Oral, written or printed verification* from licensing board, evidenced by: – Received or print date – Staff member initials – Expiration date of license	☒	☒	☒	1,2,3,4,5,6
Sanctions or Limitations on Licensure	• State licensing board or • NPDB	• Screen print from state licensing board website • Verbal verification* from state licensing board • Electronic query (printout) from NPDB	• Document in file • Oral, written or printed verification* from licensing board, evidenced by: – Received or print date – Staff member initials – Expiration date of license	☒	☒	☒	1,2,3,4,5,6
Education	• State licensing board (if issue date of license follows graduation date and if state conducts verification of education prior to licensure) or • Educational institution	• Oral/written verification* from institution or • Qualifying education verification* through the state licensing board (oral, written or Internet)	• Document in file • Oral/written/ Internet	☒	☒	☐	1,2,3,4,5,6

Physical & Occupational Therapists (PTs/OTs) Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**

Professional Liability Claim History	• Malpractice insurance carrier
	or
	• NPDB
		• Written verification of the following from the malpractice insurance carrier:
		  • Five (5) years professional liability claim history (initial credentialing)
		  • Three (3) years professional liability claim history at recredentialing
		  or
		• Printout from NPDB
			• Document in file
			or
			• Audit tool in file
				☒	☒	☒	1,2,3,4,5,6

Physician Assistants (PAs) Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
License	• State medical licensing board	• Screen print from state medical licensing board website • Verbal verification* from state medical licensing board	• Document in file • Oral, written or printed verification* from medical board or NPDB evidenced by: – Received or print date – Staff member initials – Expiration date of license	☒	☒	☒	1,2,3,4,5,6
Sanctions or Limitations on Licensure	• State medical licensing board or • NPDB	• Screen print from state medical licensing board website • Verbal verification* from state medical licensing board • Electronic query (printout) from NPDB	• Document in file • Oral, written or printed verification* from medical board or NPDB evidenced by: – Received or print date – Staff member initials – Expiration date of license	☒	☒	☒	1,2,3,4,5,6
Drug Enforcement Administration (DEA) *Verification must be completed for each state in which a practitioner ~~seesees Health Net~~CHPIV members* *Written explanation required in absence of DEA/CDS* *A DEA certificate may not be required within the scope of services provided*	• DEA or • National Technical Information Service (NTIS) or • U.S. Department of Justice/ DEA Duplicate Certificate Site	• Copy of DEA certificate(s) or • Screen print from query to NTIS/DOJ Duplication Site or • Oral/written verification* from the DEA	• Document in file or • Screen print from query to NTIS or • Oral/written verification* from the DEA in file	☒	☒	☒	1,2,3,4,5,6

Physician Assistants (PAs) Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
Controlled Dangerous [or Drug] Substance (CDS) certificate, as applicable *Nevada Required* *Verification must be completed for each state in which a practitioner sees ~~Health Net~~CHPIV members* *A CDS certificate may not be required within the scope of services provided*	• Applicable state website/contact/agency or state board of pharmacy	• Copy of CDS certificate or • Oral/written/Internet verification* from state CDS/board of pharmacy	• Oral/written/ Internet verification* from CDS/state board of pharmacy – Received or print date – Staff member initials – Expiration date of certificate	☒	☒	☒	1,2,3,4,5,6
Education	• State licensing board (if issue date of license follows graduation date and if state conducts verification of education prior to licensure) or • Educational institution	• Oral/written verification* from institution or • Qualifying education verification* through the state licensing board (oral, written or Internet)	• Document in file • Oral/written/ Internet	☒	☒	☐	1,2,3,4,5,6

Professional Liability Claim History	• Malpractice insurance carrier
	or
	• NPDB
		• Written verification of the following from the malpractice insurance carrier:
		  • Five (5) years professional liability claim history (initial credentialing)
		  • Three (3) years professional liability claim history at recredentialing
		or
		• Printout from NPDB
			• Document in file
			or
			• Audit tool in file
				☒	☒	☒	1,2,3,4,5,6

Psychologists (PSYCHs) Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
License	• State licensing board	• Screen print from state licensing board website or • Verbal verification* from state licensing board	• Document in file • Oral, written or printed verification* from licensing board, evidenced by: – Received or print date – Staff member initials – Expiration date of license	☒	☒	☒	1,2,3,4,5,6
Sanctions or Limitations on Licensure	• State licensing board or • NPDB	• Screen print from state licensing board website • Verbal verification* from state medical licensing board • Electronic query (printout) from NPDB	• Document in file • Oral, written or printed verification* from licensing board, evidenced by: – Received or print date – Staff member initials – Expiration date of license	☒	☒	☒	1,2,3,4,5,6
Education	• State licensing board (if issue date of license follows graduation date and if state conducts verification of education prior to licensure) or • Educational institution	• Oral/written verification* from institution or • Qualifying education verification* through the state licensing board (oral, written or Internet)	• Document in file • Oral/written/ Internet	☒	☒	☐	1,2,3,4,5,6

Psychologists (PSYCHs) Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**

Professional Liability Claim History	• Malpractice insurance carrier
	or
	• NPDB
		• Written verification of the following from the malpractice insurance carrier:
		  • Five (5) years professional liability claim history (initial credentialing)
		  • Three (3) years professional liability claim history at recredentialing
		  or
		• Printout from NPDB
			• Document in file
			or
			• Audit tool in file
				☒	☒	☒	1,2,3,4,5,6

Registered Dental Hygienists (RDHs) Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
License	• State licensing board	• Screen print from state licensing board • Verbal* verification from state licensing board	• Document in file • Oral, written or printed verification* from licensing board, evidenced by: -- Received or print date -- Staff member initials -- Expiration date of license	☒	☒	☒	1,2,3,4,5,6
Sanctions or Limitations on Licensure	• State licensing board or • National Practitioner Data Bank (NPDB)	• Screen print from state licensing board • Verbal* verification from state licensing board • Electronic query (printout) from NPDB	• Document in file • Oral, written or printed verification* from licensing board, evidenced by: -- Received or print date -- Staff member initials -- Expiration date of license	☒	☒	☒	1,2,3,4,5,6

Registered Dental Hygienists (RDHs) Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
Education	• State licensing board	• Screen print from state licensing board • Verbal* verification from state licensing board	• Document in file • Oral, written or printed verification* from licensing board, evidenced by: -- Received or print date -- Staff member initials -- Expiration date of license	☒	☒	☐	1,2,3,4,5,6
Medicare Opt-Out (Medicare/ Medicaid)	• Regional Medicare/ Medicaid Opt-Out Report (released quarterly)	Regional Medicare/ Medicaid Opt-Out Report	• Document on file checklist or log: - Date of report - Date of review - Findings of review - Initials or signature of reviewer	☒	☒	☒	2,3,5,6
Medicare Certification	• Individual Provider listing at cms.gov	• Screen print from cms.gov	• Document on file checklist or log: - Date of report - Date of review - Findings of review - Initials or signature of reviewer	☒	☒	☒	2,6

Registered Nurse Anesthetists (RNAs), Nurse Practitioners (NPs) and Certified Nurse Midwives (CNMs) Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
License	• State licensing (nursing) board	• Screen print from state licensing (nursing) board website • Verbal verification* from state licensing (nursing) board	• Document in file • Oral, written or printed verification* from nursing board, evidenced by: – Received or print date – Staff member initials – Expiration date of license	☒	☒	☒	1,2,3,4,5,6
Sanctions or Limitations on Licensure	• State licensing (nursing) board or • NPDB	• Screen print from state licensing (nursing) board website • Verbal verification* from state licensing (nursing) board • Electronic query (printout) from NPDB	• Document in file • Oral, written or printed verification* from nursing board, evidenced by: – Received or print date – Staff member initials – Expiration date of license	☒	☒	☒	1,2,3,4,5,6
Drug Enforcement Administration (DEA) *Verification must be completed for each state in which a practitioner ~~sees~~sees ~~Health Net~~CHPIV members* *Written explanation required in absence of DEA/CDS.* *A DEA certificate may not be required within the scope of services provided*	• DEA or • National Technical Information Service (NTIS) or • U.S. Department of Justice/ DEA Duplicate Certificate Site	• Copy of DEA certificate(s) or • Screen print from query to NTIS/DOJ Duplication Site or Oral/written verification* from the DEA	• Document in file or • Screen print from query to NTIS or • Oral/written verification* from the DEA in file •	☒	☒	☒	1,2,3,4,5,6

Registered Nurse Anesthetists (RNAs), Nurse Practitioners (NPs) and Certified Nurse Midwives (CNMs) Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
Controlled Dangerous [or Drug] Substance (CDS) certificate, as applicable *Nevada Required* *Verification must be completed for each state in which a practitioner sees ~~Health Net~~CHPIV members* *A CDS certificate may not be required within the scope of services provided*	• Applicable state website/contact/ agency or state board of pharmacy	• Copy of CDS certificate or • Oral/written/Internet verification* from state CDS/board of pharmacy	• Oral/written/Internet verification* from CDS/state board of pharmacy – Received or print date – Staff member initials – Expiration date of certificate	☒	☒	☒	1,2,3,4,5,6
Education	• State licensing board (if issue date of license follows graduation date and if state conducts verification of education prior to licensure) or • Educational institution	• Oral/written verification* from institution or • Qualifying education verification* through the state licensing board (oral, written or Internet)	• Document in file • Oral/written/Internet	☒	☒	☐	1,2,3,4,5,6

Professional Liability Claim History	• Malpractice insurance carrier
	or
	• NPDB
		• Written verification of the following from the malpractice insurance carrier:
		  • Five (5) years professional liability claim history (initial credentialing)
		  • Three (3) years professional liability claim history at recredentialing
		or
		• Printout from NPDB
			• Document in file
			or
			• Audit tool in file
				☒	☒	☒	1,2,3,4,5,6

State Licensed Mid-Wife (Non-Physician Medical Practitioner)							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
License	• State Medical Board http://www.mbc.ca.gov/Licensees/Midwives/	• Screen print from state licensing (nursing) board website • Verbal verification* from state licensing (nursing) board	• Document in file • Oral, written or printed verification* from Medical Board, evidenced by: – Received or print date – Staff member initials – Expiration date of license	☒	☒	☒	3, 4
Sanctions or Limitations on Licensure	• State Medical Board http://www.mbc.ca.gov/Licensees/Midwives/ or • NPDB	• Screen print from state licensing (nursing) board website • Verbal verification* from state licensing (nursing) board • Electronic query (printout) from NPDB	• Document in file • Oral, written or printed verification* from Medical Board, evidenced by: – Received or print date – Staff member initials – Expiration date of license	☒	☒	☒	3, 4
Education	• State issued certificate http://www.mbc.ca.gov/Licensees/Midwives/	• Qualifying education verification* through the state issued licensing board (oral, written or Internet)	• Document in file • Oral/written/Internet	☒	☒	☐	3, 4

Professional Liability Claim History	• Malpractice insurance carrier
	or
	• NPDB
		• Written verification of the following from the malpractice insurance carrier:
		  • Five (5) years professional liability claim history (initial credentialing)
		  • Three (3) years professional liability claim history at recredentialing
		or
		• Printout from NPDB
			• Document in file
			or
			• Audit tool in file
				☒	☒	☒	3, 4

Speech Therapists (STs) and Speech Pathologists (SPs) Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost**	**Recred**	**Regulatory Standards**
License	• State licensing board	• Screen print from state licensing board website • Verbal verification* from state licensing board	• Document in file • Oral, written or printed verification* from medical board, evidenced by: – Received or print date – Staff member initials – Expiration date of license	☒	☒	☒	1,2,3,4,5,6
Sanctions or Limitations on Licensure	• State medical licensing board or • NPDB	• Screen print from state medical licensing board website • Verbal verification* from state medical licensing board • Electronic query (printout) from NPDB	• Document in file • Oral, written or printed verification* from medical board, evidenced by: – Received or print date – Staff member initials – Expiration date of license	☒	☒	☒	1,2,3,4,5,6
Education	• State licensing board (if issue date of license follows graduation date and if state conducts verification of education prior to licensure) or • Educational institution	• Oral/written verification* from institution or • Qualifying education verification* through the state licensing board (oral, written or Internet)	• Document in file • Oral/written/ Internet	☒	☒	☐	1,2,3,4,5,6

Speech Therapists (STs) and Speech Pathologists (SPs) Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost**	**Recred**	**Regulatory Standards**

Professional Liability Claim History	• Malpractice insurance carrier
	or
	• NPDB
		• Written verification of the following from the malpractice insurance carrier:
		  • Five (5) years professional liability claim history (initial credentialing)
		  • Three (3) years professional liability claim history at recredentialing
		or
		• Printout from NPDB
			• Document in file
			or
			• Audit tool in file
				☒	☒	☒	1,2,3,4,5,6

Clinical Pharmacist Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
License	• State licensing board	• Screen print from state licensing board website • Verbal verification* from state medical licensing board	• Document in file or • Oral, written or printed verification* from licensing board evidenced by: – Received or print date – Staff member initials – Expiration date of license	☒	☒	☒	2,3,4,6
Sanctions or Limitations on Licensure	• State licensing board or • National Practitioner Data Bank (NPDB)	• Screen print from state licensing board website • Verbal verification* from state medical licensing board • Electronic query (printout) from NPDB	• Document in file • Oral, written or printed verification* from medical board evidenced by: – Received or print date – Staff member initials – Expiration date of license	☒	☒	☒	2,3,4,6
Education	• State licensing board	• Screen print from state licensing board website • Verbal verification* from state medical licensing board	• Document in file or • Oral, written or printed verification* from licensing board evidenced by: – Received or print date – Staff member initials – Expiration date of license	☒	☒	☐	2,3,4,6

Clinical Pharmacist Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
Professional Liability Claim History	• Malpractice insurance carrier or • NPDB	• Written verification of the following from the malpractice insurance carrier: • Five (5) years professional liability claim history (initial credentialing) • Three (3) years professional liability claim history at recredentialing or • Printout from NPDB	• Document in file or • Audit tool in file	☒	☒	☒	1,2,3,4,5,6
Drug Enforcement Administration (DEA) *Verification must be completed for each state in which a practitioner ~~see~~sees ~~Health Net~~CHPIV members* *Written explanation required in absence of DEA/CDS.* *A DEA or CDS certificate may not be required within the scope of services provided*	• DEA or • National Technical Information Service (NTIS) or • U.S. Department of Justice/ DEA Duplicate Certificate Site	• Copy of DEA certificate(s) or • Screen print from query to NTIS/DOJ Duplication Site or • Oral/written verification* from the DEA	• Document in file or • Screen print from query to NTIS or • Oral/written verification* from the DEA in file	☒	☒	☒	1,2,3,4,5,6

Tele Medicine Practitioner Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
Drug Enforcement Administration (DEA) *Verification must be completed for each state in which a practitioner ~~see~~sees ~~Health Net~~CHPIV members* *Written explanation required in absence of DEA/CDS.* *A DEA certificate may not be required within the scope of services provided*	• DEA or • National Technical Information Service (NTIS) or • U.S. Department of Justice/ DEA Duplicate Certificate Site	• Copy of DEA certificate(s) or • Screen print from query to NTIS/DOJ Duplication Site or • Oral/written verification* from the DEA	• Document in file or • Screen print from query to NTIS or • Oral/written verification* from the DEA in file	☒	☒	☒	1,2,3,4,5,6
Sanctions or Limitations on Licensure	• State licensing board or • NPDB	• Screen print from state licensing board website • Verbal verification* from state medical licensing board • Electronic query (printout) from NDPB	• Document in file • Oral, written or printed verification* from medical board, evidenced by: – Received or print date – Staff member initials – Expiration date of license	☒	☒	☒	1,2,6

Tele Medicine Practitioner Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**
Education	• American Osteopathic Association profile (AOA) or • American Medical Association (AMA) Master Profile or • Residency program or • Fellowship program and/or • Medical school or State medical licensing board (if issue date of license follows graduation date and if state conducts verification of education prior to licensure)	• For MDs, screen print from ABMS BoardCertifiedDocs • Oral/written/Internet verification* from an ABMS specialty board • For DOs, written/printed verification from current AOA directory or ABMS BoardCertifiedDocs • For residency/ fellowship/medical education, oral/written/ Internet verification* from AMA; or AMA in combination with web site profile or oral/written/Internet verification* from residency/fellowship program and/or medical school • Qualifying medical education verification through the state medical licensing board (oral, written or Internet)	• Document in file • Oral*/written/Internet Should the asterix be after Internet, line in the methods column?	☒	☒	☐	1,2,6
Board certification	• American Board of Medical Specialties (ABMS) BoardCertifiedDocs (~~180 day~~180-day verification limit) • American Osteopathic Association profile (AOA) (180 day verification limit) or • American Medical Association (AMA) Master Profile (~~180 day~~180-day verification limit) •	• For MDs, screen print from ABMS BoardCertifiedDocs • Oral/written/Internet verification* from an ABMS specialty board • For DOs, written/printed verification from current AOA directory or ABMS BoardCertifiedDocs •	• Document in file • Oral/written/Internet verification*	☒	☒	☒	1,2,6

Tele Medicine Practitioner Primary Source Verification Requirements							
Items Requiring Verification for Credentialing and Recredentialing	**Sources of Verification (who verified ~~with:~~with agency name, organization, etc.)**	**Methods of Verification (how verified: copy of document, Oral/written, etc.)**	**Evidence of Verification**	**Cred**	**Lost Delegation**	**Recred**	**Regulatory Standards**

Professional Liability Claim History	• Malpractice insurance carrier
	or
	• NPDB
		• Written verification of the following from the malpractice insurance carrier:
		  • Five (5) years professional liability claim history (initial credentialing)
		  • Three (3) years professional liability claim history at recredentialing
		  or
		• Printout from NPDB
			• Document in file
			or
			• Audit tool in file
				☒	☒	☒	1,2,6

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Policy CR-001

Attachment B – Scope of Included Practitioners

Credentialing standards apply to all licensed independent practitioners or groups of practitioners who provide medically covered benefits/care to Community Health Plan of Imperial Valley (CHPIV) members. CHPIV's or CHPIV's SUBCONCTRATOR credentials all practitioners in accordance with CHPIV standards for participation requirements, state and federal regulatory requirements and accrediting entity standards. Additional regulatory requirements may apply based on the product line(s) associated with the practitioner.

PRACTITIONERS WHO MUST BE CREDENTIALED:

Practitioners who have an independent relationship with CHPIV or CHPIV's SUBCONTRACTOR must be credentialed. An independent relationship exists when CHPIV or CHPIV's SUBCONTRACTOR selects and directs its members to see a specific practitioner or group of practitioners. This includes all practitioners whom members can select as a primary care practitioner (PCP).

A "yes" answer to any of the following questions means a practitioner must be credentialed:

1. Can the member specifically select the practitioner by name, using a CHPIV directory or website, and schedule an appointment?

2. Does the practitioner treat CHPIV members in the inpatient facility setting (hospital, freestanding/ambulatory surgery center, etc.) and have an additional contractual relationship(s) that allows him/her to treat CHPIV members in a private or group setting that is not connected to the facility and whom members can select via directory or referral?

3. Is the practitioner hospital-based but can see CHPIV members as a result of an independent relationship with CHPIV or CHPIV's SUBCONTRACTOR? (Example: Anesthesiologists with pain management practices.)

4. Is the practitioner a dentist who provides care under CHPIV medical benefits? If dental and medical benefits are not differentiated, then services or care must be identified as if they were. Identify only care services associated with medically necessary medical or surgical procedures that occur within or adjacent to the oral cavity or sinuses. (Example: Oral/maxillofacial surgery.)

5. Is the practitioner a dental care practitioner who provides general dental care under a CHPIV Medicare, Medicaid or state health plan?

6. Is this a non-physician practitioner who has an independent relationship with CHPIV or CHPIV'S SUBCONTRACTOR (see definition above) and who provides care under CHPIV medical benefits (i.e., nurse practitioners, midwives or physician assistants)?

7. Is this a CHPIV Medical Director or Chief Medical Officer?

8. Is the practitioner affiliated with a medical group that is not licensed as a home health agency but is contracted/contracting to provide care to CHPIV members in the in-home setting?

9. Is the practitioner a covering practitioner (e.g., locum tenens) who has an independent relationship with the organization serving in this capacity for more than 90 calendar days?

10. Is the practitioner contracting/contracted to provide telemedicine services to members?

PRACTITIONERS NOT REQUIRING CREDENTIALING:

A "yes" answer to any of the following means a practitioner does not have to be credentialed:

1. Does the practitioner practice within the inpatient setting and provide care for CHPIV members only as a result of members being directed to the hospital, inpatient or other facility setting? (Examples: Pathologists, radiologists, hospitalists without office practices and emergency room physicians or staff employed only through a facility setting as in an ambulatory surgery center.)

2. Is the practitioner a dentist who provides primary dental care only under a commercial dental plan or rider?

3. Is the practitioner a pharmacist employed by a pharmacy benefits management organization to which the organization delegates utilization management functions?

4. Is the practitioner a consultant/medical advisor who does not provide services to members in a treatment setting?

5. Does the practitioner practice exclusively within freestanding facilities and provide care for CHPIV members only as a result of members being directed to the facility?

6. Is the practitioner a covering practitioner (less than 90 days)?

7. Is the practitioner currently credentialed by CHPIV or CHPIV's delegated entity?

PRACTITIONERS WHO MUST BE CREDENTIALED (IF MEET DEFINITION OF 'INDEPENDENT RELATIONSHIP' AS DEFINED ABOVE):

1. Medical Doctors (MDs)

2. Osteopathic Physicians (DOs)
3. HIV/AIDS Specialists (California only)
4. Doctor of Podiatric Medicine (DPMs)
5. Acupuncturists (ACs)
6. Audiologists (AUDs)
7. Dentists; Oral & Maxillofacial Surgeons (DDS / DMDs)
8. Doctor of Chiropractic Medicine (DCs)
9. Doctors of Naturopathic Medicine (NDs)
10. Licensed Clinical Social Workers (LCSWs)
11. Marriage & Family Therapists (MFTs)
12. Marriage, Family & Child Counselors (MFCCs)
13. Mental Health Counselors (MHCs)
14. Optometrists (ODs)
15. Physical & Occupational Therapists (PTs/OTs)
16. Physician Assistants (PAs)
17. Psychologists (PSYCHs)
18. Registered Dental Hygienists (RDHs)
19. Registered Nurse Anesthetists (RNAs)
20. Nurse Practitioners (NPs)
21. Certified Nurse Midwives (CNMs)
22. Licensed Midwife (LMW)
23. Certified Nurse Specialist
24. Speech Therapists (STs)
25. Speech Pathologists (SPs)
26. Qualified Autism Service Providers (QASPs) - any contracted discipline

The above practitioner types will be credentialed in accordance with federal, state and accrediting entity requirements.

Attachment C – Credentialing System Controls

Standard	Criteria
Primary Source Verification	Credentialing completes Primary Source Information, and the acceptable sources as identified in policy: *P&P CR-001 ATTACHMENT A – VERIFICATION TABLES.* • The sources of information may include oral, written and/or internet sources. Any sources approved by NCQA are accepted. • Query images and other documentation reviewed (including those retrieved via oral sources) during PSV are saved, date stamped, initialed, and placed in the applicant's file prior to the credentialing decision. **Non-CAQH Files:** • Documentation (Primary Source Verification) is the source of truth for all credentialing files. The primary source documentation from the applicable source is date stamped/initiated or signed off as evidence of completion on a checklist as evidence of compliance. • The source of the PSV verification is identified in the Credentialing Database and records the Credentialing Specialist (I/II) and thew date that verification was completed. • If a correction, modification, or update is required, documentation received is used to replace or supplement the information in accordance with *P&P CR-001 ATTACHMENT A – VERIFICATION TABLES* from the applicable source agency. • A checklist is completed to assess that all primary source verifications are present, compliant, and complete. • The database and checklist identify who completed the verifications, when the verification was completed and the source of that verification. • This documentation is stored as a PDF in a secure share drive folder with the affiliated practitioner name. **CAQH VeriFide Files:** • Documentation from CAQH/VeriFide is the source of truth for all credentialing CAQH Vendor files. The primary source documentation from the applicable source is date stamped/initialed or signed off as evidence of completion on a checklist as evidence of compliance. • The credentialing database is updated with the source of the verification, who completed the verifications, when the verification was completed. • If a correction, modification, or update is required, documentation received is used to replace or supplement the information in accordance with *P&P CR-001 ATTACHMENT A – VERIFICATION TABLES* from the applicable source. • A checklist is completed to assess that all primary source verifications are present, compliant, and complete. • The database and checklist identifies whom completed the verifications, when the verification was completed and the source of that verification.

Attachment C – Credentialing System Controls

	• This documentation is stored as a PDF in a secure share drive folder with the affiliated practitioner name. **<u>All Relevant Documentation</u>:** • Documentation (Facsimiles, Mail/Correspondence, Email, Internet) utilized to complete or assess the credentialing processes are printed, date stamped and initialed by the user assessing the information. • Assessment of the NPDB or any other electronically reproduced report is assessed by an actual screen copy from the Primary Source Issuing body and a reference to that report is noted on a checklist and credentialing. • Printed materials are treated in the same manner as electronic records. The documentation must be date stamped and validated in advance of the committee decision. • Information relevant to the completion of the credentialing file is documented in the credentialing database notes section, with the user id, date/time stamp. • All materials are stored in a secured common share folder and reviewed/audited to ensure integrity and measure associate quality. • Hardcopy materials are secured in a locked desk, locked file room, or scanned to be made electronic. • Temporary documentation or documentation not of use is deposited in a secured shred bin for destruction.

Modifications, Supplemental and Removal of Primary Source Verification	Modifications made to either; update new information, correct erroneous information, or supplement existing information, needed to assess the applicant/re-applicant's qualification in accordance with *P&P CR-001 ATTACHMENT A – VERIFICATION TABLES*.
	• The Credentialing Specialists (I/II) are authorized to make electronic demographic changes to the practitioner record if the information is necessary to accurately assess and expedite the practitioner credentialing process.
	  ○ Includes erroneous information from a primary source
	  ○ Requests from the applicant
	  ○ The Credentialing Specialist (I/II) will note in the file and credentialing database, the change, the reason(s) for the change, the approved sources of the change and note the date and sources(s) used to complete these actions.
	• Credentialing management is alerted to discrepancies found between the practitioner, applications, or database via the Credentialing Specialist (I/II)
	  ○ Credentialing management will conduct a review of the discrepancy notification and evaluate the processes and documentation
	  ○ Ensure the discrepancy was addressed, corrected and applicable parties notified (applicant, Provider Network Management, Provider Data Management, CAQH VeriFide or Other).
	• The Credentialing Specialists (I/II) will supplement any documentation submitted by CAQH VeriFide, if the information is necessary to accurately

Attachment C – Credentialing System Controls

	assess the practitioner's qualifications. • The Credentialing Specialists (I/II) will request an electronic change to the record to Provider Data Management (PDM) if the information is necessary to accurately reflect the practitioner demographics. • Changes to data within the credentialing database maybe requested by staff, via an electronic submission/application service form, that would require the immediate supervisors review and approval. • All changes and requests for changes become a part of the scanned file to be included in MACESS and stored at Iron Mountain for the duration of the retention policy, unless subjected to a Legal Hold. • Printed materials are treated in the same manner as electronic records. The documentation must be date stamped and validated in advance of the committee decision. • Removal of practitioner electronic information is authorized by • credentialing management. These types of occurrences are generally approved when; a system-generated error is found or a business need is required to archive old data elements, to begin a new credentialing or recredentialing event (the original paper file is still maintained in MACESS and Iron Mountain).

Authorized Staff	Only Credentialing Department staff (Credentialing Specialists I/II), Document Retention Specialists, Adverse Action Coordinators, CHPIV Peer Review Staff and Credentialing Management) are authorized to access credentialing documentation and electronic records.
	• Credentialing Specialists (I/II) and Credentialing Management can write data into the credentialing database.
	  ▪ Adverse Action Coordinator can only enter data in the Adverse Action Module – All other data is Read Only.
	  ○ Anyone other authorized user will have Read Only access
	• Modifications to electronic records can only be completed by Credentialing IT with the authorization and approval from Credentialing management.
	• Physical documentation is date stamped/initialed or signed and scanned to MACESS to finalize the credentialing record and cannot be altered.
	  ○ Only the document retention specialist, Credentialing Management and Credentialing Specialists (I/II) have access to this documentation.
	• Share Drive electronic documentation is saved as a PDF and cannot be altered.
	  ○ Only the Credentialing Management and Credentialing Specialists (I/II) have access to this documentation.
	• Only Credentialing Department staff have access to the secured file room.

Credentialing Storage **Attachment C – Credentialing System Controls**

- All credentialing files are scanned and stored within a secure imaging platform (MACESS) or Share drive/SharePoint folder.

Attachment C – Credentialing System Controls

	• Hardcopy files- will be retained in a secure file room, authorized to credentialing staff only. After scanning, each credentialing file is archived and sent to Iron Mountain for storage in accordance with the company retention policy (10 years) unless a Legal Hold is applied. • NPDBs are stored in the Provider – Practitioner Credentialing Database (PPCS) for historic reference. There is no expiration date or retention value placed on this documentation.

Access to Credentialing Information	To minimize the loss or unauthorized access of disclosure of credentialing information: Physical and Electronic Access Controls limit staff to authorized credentialing department personnel only to perform credentialing operations.
	• The access to the credentialing system is inclusive of corporate password usage, change schedule and security policies.
	• Each associate has his/her own unique system Login
	• Staff are educated to ensure passwords are not written down/to be compromised.
	• The use of strong passwords is required
	• Associate log on passwords is changed/terminated:
	  ○ 60-day intervals
	  ○ When access has been compromised (accidental or intentional)
	  ○ When an associate reports a lost/stolen password
	  ○ The staff member is no longer employed by the company
	• Associate desktops/working spaces are secured - documentation is locked, desktop screensavers are set to 5 minutes and the staff adhere to all corporate policies in regard to; Ethics, Cybersecurity, HIPPA and PII protections. The staff are required, annually, to train in these areas.
	• System/Network controls are in place to disable remote printing.
	• Online credentialing documentation is only stored in a secure Share Drive/Share Point Authorized to assigned credentialing department staff.
	• Credentialing paper files are stored in a secure, locked room, with access by Credentialing Management and the Document Retention Staff only (key entry control).
	• The credentialing database access is controlled by IT, with the granting of, removal of privileges, authorized by Credentialing Management only.
	• The electronic file imaging system (MACESS) access is controlled by IT,
	• with the granting of, removal of privileges, authorized by Credentialing Management only.
	• Credentialing Share-points/Share-drives access is controlled by IT, with the granting of, removal of privileges, authorized by Credentialing Management only.
	
	Management is responsible for:
	• Establishing a standard process, distributing guidance, and providing the means for management to appropriate access reviews
	• Ensuring user access modifications are requested and processed per access termination/modification policies.
	• The access review of personnel that require viewing of credentialing

Attachment C – Credentialing System Controls

	related materials ○ Monthly, Credentialing Management will review credentialing database and share drive/share point access to ensure that only the authorized staff have access to required documentation, systems, and reports. • Ensuring training is completed in Credentialing Policy Review, Ethics and Cyber Security for new hires and annually thereafter.
Audits	**Quarterly** – File Reviews • The file review will consist of the Checklist, Credentialing Database and Primary Source Verification Materials to identify discrepancies. ○ Discrepancies are investigated ○ Discrepancies are corrected ○ Discrepancies are noted in the database notes ○ Discrepancies are noted in the credentialing file, with the applicable documentation will be turned into a PDF into the share-drive or MACESS record ○ Discrepancies are scored for quality and will impact the associates overall annual performance score ○ The source of truth is the credentialing documentation on file and is scored/measured against regulations and standards. Any discrepancies identified with CAQH PSV will be discussed during the CHPIV/CAQH VeriFide Monthly meetings to: ○ Identify root cause issues ○ Provide a resolution to the issue(s) ○ Correct erroneous information **Annually** – An assessment and report summary are completed by Credentialing Management. • A selection of 5% or 25 files (whichever is less) for Credentialing and Recredentialing are selected and assessed for reporting. The quarterly file review audit is conducted with the review of: ○ Accuracy of data ○ Validity of data (Presented and noted as compliant to meet the time it was verified and presented timely in advance of the committee decision). ○ Review of any data changes that were initiated by the applicant, staff, Provider Network Management or Provider Data Management, to ensure procedural processing. ○ Review of any document changes that were initiated by the applicant, staff, Provider Network Management or Provider Data Management. ○ The collection of appropriate documentation ○ The correct storage of documentation ○ All items will be reviewed and resolved by credentialing management

Attachment C – Credentialing System Controls

	○ Performance trends are tracked and trended for training purposes. ○ Implementation of a Corrective Action Plan and Performance Monitoring for any breaches in policy. • Occurrences or negative findings are reported to the Director of Clinical Support Services and the Vice President of Quality Improvement for further directions and action. • Corporate IT will force users to reset passwords every 60 days to ensure overall compliance with Corporate IT security policy. **Annually –** Corporate Compliance will review policies, files, reports, documentation to ensure all NCQA standards, CMS and DHCS regulations are met and report findings to plan and corporate leadership. CAQH Verified will provide an annual report of Credentialing Database Integrity findings and report this information to the Credentialing Committee, when made available.
Credentialing Data and Document Access Appendix A	Appendix identifying the roles and responsibilities of the Credentialing IT Department in PPCS Access Controls.
Policy Violations	Severe occurrences of data corruption, suspected breaches, or violations of the use of credentialing data will be reported to; Help Desk/Cred ITG, the Corporate Ethics Department, Human Resources and Cyber Security for direction (within 24 hours of an occurrence). • Service Desk: 1(866) 675-8852 • Ethics & Compliance Hotline 1(800) 345-1642 • Ask HR: 1(866) 462-7547 • Cyber Security Hotline: 1(833) 342-9237

	Credentialing Appeals Process	CR-002
Department	Operations	
Functional Area	Credentialing	
Impacted Delegate	☒ Subcontractor ☐ NA	

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

APPROVALS		
Internal		**Regulator**
Name	**Julia Hutchins**	☐ DHCS ☒ NA ☐ DMHC
Title	Chief Operating Officer	

ATTACHMENTS
• Attachment A – Scope of Practitioners

AUTHORITIES/REFERENCES
• CMS: Code of Federal Regulations 42 CFR 422.112(a)(5), 422.202 (a)(1)(2)(3)(4), 422.202(b)(2), 422.202 (d)(1)(i)(ii)(2)(3) Medicare Managed Care Manual Chapter 6 - Relationships with Providers (Rev. 82, 04-27-07) Sections 30, 60.1, 60.4 • California DMHC: 28 CCR 1300.70 (a) (1); 28 CCR 1300.70 (b) (2) (C-E) • NCQA : CR1 A.9, CR7 A.2 - A.4, CR7 B, MA8. A.1, MA8. A.3, MA8 B

HISTORY	
Revision Date	**Description of Revision**

I. OVERVIEW

A. This policy applies to all delegated and non-delegated practitioners outlined in Attachment A – Scope of Practitioners. "This policy is not applicable to non-participating practitioners, practitioners who are not subject to credentialing or organizational providers.

II. POLICY

A. CHPIV ensures Practitioners whose participation in The Plan's network has been denied, reduced, suspended, or terminated for quality of care/medical disciplinary causes or reasons will be provided notice and opportunity to participate in an appeals process in accordance with this policy. This policy does not apply to practitioners who are administratively denied admittance to, or administratively terminated from The Plan's network.

B. Practitioner Notification and Grounds for an Appeal:

1. CHPIV will ensure when the Plan has made an adverse determination regarding network participation, the affected practitioner will be afforded due process and appeal rights that will allow for a full and impartial investigation of the facts and one level of reconsideration that involves a reexamination of the issues by those involved in the initial adverse determination.
2. CHPIV will ensure after investigation, and on the basis of a quality of care/medical cause or reason (not administrative reasons), the Credentialing Committee may vote to take one of the actions
   listed below. (The practitioner subject to that action will be entitled to notification within 60 calendar days of the effective date ("Notice of Final Action"). This provides a timeline for the Credentialing and/or Peer Review committee decision, legal counsel review and final Credentialing and/or Peer Review committee determination. This notification will document the effective date of the Credentialing and/or Peer Review committee decision, reason(s) for the decision, and will also serve as notice to the practitioner of his/her right to appeal rights in accordance with this policy. These procedural rights are limited to Credentialing or Peer Review committee decisions to:
   a. Deny or terminate the practitioner's participation in CHPIV's or CHPIV's Subcontractor network,
   b. Reduce or restrict the practitioner's network participation privileges for more than 30 calendar days in any 12-month period, or
   c. Summarily suspend the practitioner for more than 14 consecutive calendar days.
3. CHPIV will ensure that the Notice provided to the practitioner in accordance with the above guidelines will include the following essential elements of this process:
   a. An action against the practitioner has been proposed by the Credentialing and/or Peer Review committee, which, if adopted, will be reported to the appropriate state medical licensing board, the National Practitioner Data Bank (NPDB) pursuant to the Health Care Quality Improvement Act (HCQIA) of 1986, and to such other state or federal agencies as may be required by law or warranted by the circumstances to protect the health and safety of patients.
   b. The practitioner has the right to file a written request for a reconsideration or fair hearing on the committee's final action. Facsimile or e-mail requests are acceptable initially; however, the request must still be received by CHPIV's Subcontractor Credentialing Department ("Department") Manager/Supervisor or designee, post-marked no later than 30 calendar days from the date of the Notice.

c. The practitioner may bypass the reconsideration process and request a fair hearing.
    a. A notice is not an automatic termination, suspension, restriction or limitation from the Plan's current network participation and/or activities. However, the Plan reserves the right to take immediate action if and when patient risk is identified. Any such action will be reported to the NPDB pursuant to the HCQIA, and to such other state or federal agencies as may be required by law.
    b. Unless patient risk is identified, the Plan will not take action against a practitioner's license while the appeal process is being arranged or executed.

C. Request for Reconsideration or Fair Hearing & Acknowledgement of Appeal

1. The practitioner must request a reconsideration or fair hearing in writing. The Department will notify the practitioner in writing of:
    a. The reason(s) for the action taken, including the act(s) or omission(s) with which the practitioner is accused,
    b. The time, place, and date of the reconsideration of fair hearing,
    c. The Plan's policies and procedures that led to the committee's adverse determination and
    d. Instructions for submittal of evidentiary documents.
    e. Unless the Credentialing Committee and practitioner agree in writing, the requested reconsideration or fair hearing will take place no more than 60 days from the date the practitioner's request for appeal is received by the Department. If after the reconsideration date is approved the impacted practitioner or committee member(s) have cause to postpone the reconsideration, a one-time postponement may be granted, based on circumstances and committee members' availability. During the postponement timeframe, if the impacted practitioner is identified with additional adverse actions (i.e., member complaints, license, license status changes, NPDB filings, etc.) committee members will be provided with this information without benefit of the practitioner's response. The new information may be included for reference during the reconsideration only if applicable to the committee's original network status determination.
2. Reconsideration Review Process and/or Fair Hearing not requested.
    a. If a request for a reconsideration or fair hearing is not requested by the practitioner by the 30th calendar day of the notice, the practitioner will be notified via correspondence of the Plan's immediate action to process his/her denial/termination from the provider network on the basis of the identified quality of care concern(s) and due to his/her failure to request an appeal Upon the expiration of the 30-day time limit provided by the notice, the denial/termination will be reported to the state licensing board and the National Practitioner Data Bank (NPDB) pursuant to the Health Quality Improvement Act of 1986 and to such other State or federal agency as may be required by law.
3. Reconsideration (Informal) Review Process
    a. CHPIV will ensure that the following persons will participate in the reconsideration review process.
        i. At least 50 percent of the participating members of the Credentialing Committee who made the decision to deny/terminate the practitioner for cause.

I. The reconsideration review process will be postponed if the requisite number of voting committee members is not present. Determinations regarding network participation status require a majority vote. A committee member may be excused from the proceedings due to semblance of competition or personal knowledge of, or relationship with, the affected practitioner.

ii. Adequate personnel to record minutes of the proceedings.

iii. The affected practitioner, who may elect to submit additional evidentiary documents in advance of the reconsideration, must submit them as soon as practicable but no later than 10 calendar days prior to the reconsideration. Documents must be submitted in hard copy format and should be organized and numbered in the order that they are to be reviewed by the panel. Electronic materials, digital media (i.e., diskettes, CD's weblinks, etc.) will not be accepted, downloaded, or distributed to the panel members. All hard copy materials must be received at the Plan's corporate offices on or before the established deadline. Documents postmarked or received after the deadline will not be provided to the reconsideration panel.

II. CHPIV will ensure that the Plan will make reasonable effort to ensure the affected practitioner is able to attend his or her reconsideration in person. The practitioner may, however, opt to participate via teleconference or waive the right to participate and only submit documentation for the committee to review in reconsidering its network participation determination. The Plan will make every attempt to reasonably accommodate the affected practitioner.

iv. Neither the Plan nor the affected practitioner may have an attorney, advisor, or witnesses present during a reconsideration review. The practitioner does, however, have the right to retain legal counsel during preparation for the reconsideration.

v. If the practitioner elects to participate in the reconsideration via teleconference, he/she will be asked to sign an attestation confirming no other parties or individuals will be physically or telephonically present with the practitioner during any or all portions of the proceeding and that the proceedings will not be recorded. Failure to return or abide by this attestation will automatically render the committee's network participation decision final and without opportunity for further appeal.

4. The panel of practitioners participating in the reconsideration review process has the authority to:
    a. Uphold the original determination; if the committee upholds its adverse determination, the practitioner may request a fair hearing as described in section C, above.
    b. Modify the original determination by implementing one or more of the following:
        i. A corrective action plan (CAP) that may include, but not be limited to, continuing medical education or other training, and medical evaluations.
        ii. Practitioner monitoring or other forms of review, such as interim (<36 months) credentialing and/or conduct medical chart reviews, for a specified period of time, or as long as the practitioner remains a participant in the Plan's network.

iii. Overturn the original determination.
iv. After the reconsideration review process is concluded, the Plan will make good faith best efforts to notify the practitioner of the committee's decision in writing within fifteen (15) calendar days.

5. Fair Hearing-Rules for participation
    a. Fair hearing panel
        i. CHPIV will ensure that the Credentialing Committee Chairperson or designee will appoint a fair hearing panel of at least three practitioners and one alternate who participates in the Plan's network. To be eligible to serve in this capacity, prospective panel members shall:
            I. not have prejudged the matter (i.e., shall be unbiased),
            II. gain no direct financial benefit from the outcome of the matter, and
            III. not have previously acted as an accuser, investigator, factfinder, or initial decision-maker in this matter (i.e., shall not have served as a voting member of the Credentialing or Peer Review committee at the time the adverse determination was rendered).
            IV. The fair hearing panel will include a majority of individuals who are peers of the affected practitioner. A peer is an appropriately trained and licensed practitioner in a practice and specialty similar to that of the affected practitioner.
            V. All fair hearing panel members and the affected practitioner must attend the fair hearing in person.
            VI. Employment by the Plan, or any subsidiary or affiliate, or an independent contract with the Plan or any subsidiary or affiliate, will not disqualify an individual from participation as a hearing panel member, provided such individual meets all other conditions for panel member or hearing officer status.
    b. In the event that a state fair hearing panel quorum is not met, the fair hearing officer may opt to grant a continuance within-(30) to sixty-(60) calendar days from the date of the scheduled hearing.
    c. In addition to appointing the fair hearing panel, duties of the Credentialing Committee Chairperson, a non-voting fair hearing panel member, include:
        i. Presenting a summary of evidence supporting the proposed action against the practitioner.
        ii. Answering the question if the affected practitioner or fair hearing panel pose any.

III. PROCEDURE

A. CHPIV delegates the Credentialing 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*:
    d. Ongoing monitoring
    e. Performance reviews

f. Data analysis
g. Utilization of benchmarks, if available
h. 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
	N/A
N/A	

Policy CR-002

Attachment A – Scope of Included Practitioners

Credentialing standards apply to all licensed independent practitioners or groups of practitioners who provide medically covered benefits/care to Community Health Plan of Imperial Valley (CHPIV) members. CHPIV's or CHPIV's SUBCONCTRATOR credentials all practitioners in accordance with CHPIV standards for participation requirements, state and federal regulatory requirements and accrediting entity standards. Additional regulatory requirements may apply based on the product line(s) associated with the practitioner.

PRACTITIONERS WHO MUST BE CREDENTIALED:

Practitioners who have an independent relationship with CHPIV or CHPIV's SUBCONTRACTOR must be credentialed. An independent relationship exists when CHPIV or CHPIV's SUBCONTRACTOR selects and directs its members to see a specific practitioner or group of practitioners. This includes all practitioners whom members can select as a primary care practitioner (PCP).

A "yes" answer to any of the following questions means a practitioner must be credentialed:

1. Can the member specifically select the practitioner by name, using a CHPIV directory or website, and schedule an appointment?

2. Does the practitioner treat CHPIV members in the inpatient facility setting (hospital, freestanding/ambulatory surgery center, etc.) and have an additional contractual relationship(s) that allows him/her to treat CHPIV members in a private or group setting that is not connected to the facility and whom members can select via directory or referral?

3. Is the practitioner hospital-based but can see CHPIV members as a result of an independent relationship with CHPIV or CHPIV's SUBCONTRACTOR? (Example: Anesthesiologists with pain management practices.)

4. Is the practitioner a dentist who provides care under CHPIV medical benefits? If dental and medical benefits are not differentiated, then services or care must be identified as if they were. Identify only care services associated with medically necessary medical or surgical procedures that occur within or adjacent to the oral cavity or sinuses. (Example: Oral/maxillofacial surgery.)

5. Is the practitioner a dental care practitioner who provides general dental care under a CHPIV Medicare, Medicaid or state health plan?

6. Is this a non-physician practitioner who has an independent relationship with CHPIV or CHPIV'S SUBCONTRACTOR (see definition above) and who provides care under CHPIV medical benefits (i.e., nurse practitioners, midwives or physician assistants)?

7. Is this a CHPIV Medical Director or Chief Medical Officer?

8. Is the practitioner affiliated with a medical group that is not licensed as a home health agency but is contracted/contracting to provide care to CHPIV members in the in-home setting?

9. Is the practitioner a covering practitioner (e.g., locum tenens) who has an independent relationship with the organization serving in this capacity for more than 90 calendar days?

10. Is the practitioner contracting/contracted to provide telemedicine services to members?

PRACTITIONERS NOT REQUIRING CREDENTIALING:

A "yes" answer to any of the following means a practitioner does not have to be credentialed:

1. Does the practitioner practice within the inpatient setting and provide care for CHPIV members only as a result of members being directed to the hospital, inpatient or other facility setting? (Examples: Pathologists, radiologists, hospitalists without office practices and emergency room physicians or staff employed only through a facility setting as in an ambulatory surgery center.)

2. Is the practitioner a dentist who provides primary dental care only under a commercial dental plan or rider?

3. Is the practitioner a pharmacist employed by a pharmacy benefits management organization to which the organization delegates utilization management functions?

4. Is the practitioner a consultant/medical advisor who does not provide services to members in a treatment setting?

5. Does the practitioner practice exclusively within freestanding facilities and provide care for CHPIV members only as a result of members being directed to the facility?

6. Is the practitioner a covering practitioner (less than 90 days)?

7. Is the practitioner currently credentialed by CHPIV or CHPIV's delegated entity?

PRACTITIONERS WHO MUST BE CREDENTIALED (IF MEET DEFINITION OF 'INDEPENDENT RELATIONSHIP' AS DEFINED ABOVE):

1. Medical Doctors (MDs)

2. Osteopathic Physicians (DOs)
3. HIV/AIDS Specialists (California only)
4. Doctor of Podiatric Medicine (DPMs)
5. Acupuncturists (ACs)
6. Audiologists (AUDs)
7. Dentists; Oral & Maxillofacial Surgeons (DDS / DMDs)
8. Doctor of Chiropractic Medicine (DCs)
9. Doctors of Naturopathic Medicine (NDs)
10. Licensed Clinical Social Workers (LCSWs)
11. Marriage & Family Therapists (MFTs)
12. Marriage, Family & Child Counselors (MFCCs)
13. Mental Health Counselors (MHCs)
14. Optometrists (ODs)
15. Physical & Occupational Therapists (PTs/OTs)
16. Physician Assistants (PAs)
17. Psychologists (PSYCHs)
18. Registered Dental Hygienists (RDHs)
19. Registered Nurse Anesthetists (RNAs)
20. Nurse Practitioners (NPs)
21. Certified Nurse Midwives (CNMs)
22. Licensed Midwife (LMW)
23. Certified Nurse Specialist
24. Speech Therapists (STs)
25. Speech Pathologists (SPs)
26. Qualified Autism Service Providers (QASPs) - any contracted discipline

The above practitioner types will be credentialed in accordance with federal, state and accrediting entity requirements.

	Language Assistance Program	MS-001
Department	Operations	
Functional Area	Member Services	
Impacted Delegate	☒ Subcontractor ☐ NA	

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

APPROVALS		
Internal		**Regulator**
Name	Julia Hutchins	☐ DHCS ☒ NA ☐ DMHC
Title	Chief Operating Officer	

ATTACHMENTS

N/A

AUTHORITIES/REFERENCES

- Health and Safety Code, 10 CCR § 2538, 28 CCR § 1300.67.04; Subsection 1367.04 and 1363, [and additional regulatory and contractual references pertaining to California State Health Programs] as well as 45 CFR and H.R. 3590 under Health Care Reform
- California Insurance Code Title 22 CCR Section 53853 (c); Section 10133.10. s2538.3 and Section 10603 Section 10133.8 and 10133.9 of the California Insurance Code
- 45 CFR Part 92, subsection 92.4, 92.8, 98.201; Affordable Care Act, Section 1557
- 45 CFR 155.205 (c) Consumer Assistance tools and programs of an Exchange
- 45CFR Part 147.1436
- Medi-Cal 2 Plan Contract, Exhibit A, Attachment 9; GMC Contract, Exhibit A, Attachment 9, Access and Availability, 14. Linguistics Services, C.2 & D.1 &2
- MMCD Policy Letters 99-03; APL 21-2004; APL 210-011; Dental APL 21-001
- CMS 2018 Medicare Marketing Guidelines, section 30.5 and 30.7
- CMS 2018 MMP Guidelines Section 30.5 and 30.7; 3-way contract (Sections 2.11.4.5.2, 2.15.2.1, and 2.17.2.3)
- CMS-42 CFR § 422.112(a)(8).
- Title 22 CCR Section 538583(c)

HISTORY

Revision Date	Description of Revision

I. OVERVIEW

A. The purpose of this policy is to inform members and PROVIDERS of the availability of the Language Assistance Program (LAP), which offers language assistance services at no cost to members, including how to access the services and their rights to file grievances, in compliance with legal, contractual, regulatory and oversight agencies guidelines.

II. POLICY

A. Language Assistance Program (LAP)
   1. Community Health Plan of Imperial Valley (CHPIV) that the plan will provide equal access as required by applicable law and regulations to services for members with limited English proficiency through its Language Assistance Program (LAP).
   2. The plan's LAP includes four main elements (A-D):

B. Standard for Member/Enrollee Assessment
   1. CHPIV will ensure the plan maintains a membership database to capture four fields to assess member demographic information including race, ethnicity, preferred spoken language, and preferred written language.
   2. Members may be informed of the LAP and the need to collect the demographic information through newsletters, annual membership mailings, targeted mailings, and Customer Contact Center contact script.
      a. Notices sent to members requesting the member's language preference will be translated into languages that meet the threshold criteria.
   3. A demographic analysis of member composition by race, ethnicity, spoken language and written language will be conducted annually.
   4. Demographic information is collected using several methods.
      a. The Commercial Customer Contact Center has scripts in place prompting the CSR to request spoken and written language preference, race, and ethnicity. The member's information is recorded in the membership database.
      b. Member language preference is requested when registering to use the plan's website.
      c. All call center representatives will record member information when provided by the member.
      d. The most current information provided directly by the members to the plan is considered the most accurate and current member preference.
      e. REL data received from other sources, not directly to the plan (ex. HEDIS care gap calls, vendor outreach calls, etc.) will not overwrite data that has been directly provided to the plan by the member.
         i. Direct member contact includes calls to the customer contact center and member profile on the health plan website.
   5. CHPIV will ensure the plan will protect the confidentiality of member language, race, and ethnicity information. The plan has developed a Notice of Privacy Practices that describes ways in which it may collect, use, and disclose member protected health information (PHI), such as demographic information, and describes member rights

concerning their PHI. The relevant demographic information will be made available to California DMHC for regulatory purposes.

a. The plan will request that data shared with the California Department of Managed Health Care (CA DMHC) be held in confidence as part of the submission process.

C. Standards for providing language assistance services

1. Interpreter Services
    a. Interpreter services are a means of facilitating communication between members with limited English proficiency (LEP), the plan's associates, or members with LEP and contracted PROVIDERS. Interpreter services are compliant with all state and federal rules, regulations, and contracts.
    b. A member, plan associate, or contracted PROVIDER may request interpreter services, at no cost to the patient, to promote communication between the member, associate, and/or PROVIDER.
    c. The Customer Contact Center (CCU), Centralized Unit (CU) will coordinate the process of scheduling interpreters for all plan members and all POINTS OF CONTACT.
        i. The CU will prepare a monthly tracking report for interpreter requests made by members. The tracking report will include: the length of time it took the request to move from the CSR to the CU, the length of time it took the CU to send the interpreter request to an interpreter to the member and/or PROVIDER.
    d. All interpreter services (face to face in person, video, or telephone) can be made available during a member's scheduled appointment with a PROVIDER or other POINTS OF CONTACT with at least 5 days advance notice.
    e. A member may request an oral translation of any written information received from the health plan or its contracted PROVIDER groups during business hours.
    f. Standards for interpreter quality are included in interpreter vendor contracts. Interpreter quality standards are compliant with 45 CFR 92.
    g. Interpreter quality is monitored through complaints and grievances.
2. Translation Services
    a. CHPIV will ensure the plan's translation services are guided by a translation P&P to ensure and promote consistent and quality translations.
    b. Translation services included: quality standards for translations, quality standards for translators, a style guide, a glossary of common terms in each THRESHOLD LANGUAGE, and a process to monitor translations for accuracy and quality.
    c. CHPIV will ensure documents will be made available in THRESHOLD LANGUAGES as required by regulations or contract. See translation P&P for a list of documents that will be translated by line of business.
    d. The plan's departments that produce member informational materials will have a process in place to identify and determine if the document is required

to be translated in compliance with existing state or federal regulations or contracts.

e. Each department that produces materials for Medi-Cal and Cal MediConnect lines of business will have a process in place to provide standing requests for translated documents for members that have a standing request on record.
f. All documents required to be translated will adhere to the translation process established in the translation P&P
g. Members may request translation of documents by calling the toll-free number listed on their membership identification card.
    i. The Customer Costumer Contact Center will coordinate the translation of written materials through the CU.
    ii. The CU will implement procedures to facilitate the translation request process withing the twenty-one (21) daytime frame.
    iii. The CU will prepare monthly reports to track documents that have been translated during the reporting period and will have, at a minimum, the following: whether an oral and/or print translation was requested, into what language they were translated, fulfillment time, and whether the document produced was by the plan, a PROVIDER group, or subcontractor produced.
h. Oral translations will be made available for non- THRESHOLD LANGUAGES of VITAL DOCUMENTS upon request from the member.

3. Linguistic Services
4. CHPIV will ensure that the plan's Equity Department provides linguistic services to internal departments to help create culturally inclusive and linguistically appropriate member-informing materials.
5. Linguistic services may include, but are not limited to,
    a. Review of materials for cultural appropriateness and literacy standards, review of English materials in preparation for translation, PROVIDER workshops on cultural and language issues that impact the access to health, and Community Advisory Committee (CAC) which includes community input on cultural and linguistic barriers to accessing health care services.
    b. All staff that use a non-English language to communicate with members will have their language skills assessed to assure that they have “health care versed” vocabulary skills.

D. Standards for Staff Training
    1. CHPIV will ensure that the plan’s staff that have direct contact with members are informed and trained in the requirements established by the LAP.
    2. CHPIV will endure the plan’s staff will be trained on a yearly basis on elements of the LAP including:
        a. How to access and promote services in support of and to work effectively with members with LEP and potential members
        b. How to facilitate the collection of data by members including race, ethnicity, written and spoken language preference.

c. The tracking of cultural and linguistic related complaints and grievances, including steps for corrective actions that may be necessary following a grievance.
d. How language services are monitored for quality and utilization
e. The available on-going education and support bilingual associates.
f. Understanding and accommodating members' and potential members' cultural diversity, being culturally sensitive to different perspectives of health care delivery and interpreter services as specified in Exhibit A, Attachment III, Subsection 5.2.11 (Culturally and Linguistic Programs and Committees).
g. The process for reviewing all relevant policies and procedures for language assistance services on an ongoing basis.

E. Standards for Compliance and Monitoring
1. CHPIV will ensure the plan's operational departments have their own policies and procedures that are related to the LAP.
2. The plan will ensure that tracking and compliance mechanisms are in place and are reviewed annually for the following:
    a. Member and PROVIDER communication promoting the LAP
    b. Bilingual staff assessment
    c. Utilization of interpreter services
    d. Monitoring of translations
    e. Cultural and linguistic related grievances
3. CHPIV will ensure that internal and external sources are subject to and part of the plan's compliance and monitoring strategy, including:
    a. Internal:
        i. Centralized Unit (CU) monthly tracking of interpreter requests and processes
        ii. CU monthly tracking of translation requests and processes
        iii. Quarterly metrics reviewing the monthly CU tracking
    b. External:
        i. Language vendor PROVIDER reports provided monthly
        ii. Joint Operating Committee (JOC) meetings coordinated by Vendor Management Department with each language vendor, biannually or quarterly, depending on the level of utilization
        iii. Language vendor audits annually for quality by Vendor Management Department
4. The plan will ensure that all contractors, physicians, health care PROVIDER groups, and networks are informed of the LAP annually.
5. Monitoring the LAP may include member satisfaction surveys, performance reviews, or quarterly reviews of grievances and member complaints, including steps for corrective events.
6. CHPIV will ensure the plan's Health Equity Department will work closely with the Appeals and Grievance Department and the Customer Contact Center to ensure that complaints and grievances related to cultural and/or linguistic issues are addressed promptly.

7. The Health Equity Department will ensure A&G staff are trained on the identification of C&L issues and grievances.
8. CHPIV will ensure that the plan's Customer Contact Center will take a grievance or complaint from a member in any language.
    a. The plan will provide members with access to grievance forms in THRESHOLD LANGUAGES, located on the plan's website.
    b. The plan will accept a grievance letter submitted in any language or an oral grievance via telephone to Member Services.
9. Appeals and Grievance (A&G) staff will forward all cultural and linguistic related complaints or grievances to the Health Equity Department for investigation and steps toward corrective action.
    a. The Health Equity Department will track, monitor, and develop corrective action as needed, in a timely manner for C&L related grievances. Resolution of a language complaint may include linguistic support for the physician's office, identification of further educational training needs for physician and staff, and/or reassignment to a physician that is more linguistically sensitive.
    b. The plan will provide a semi-annual report on all grievances to the applicable Quality Committee. The committee will make recommendations for any further corrective action steps.

F. Communication and Support
    1. Member Communication
        a. CHPIV will ensure that plan informs all new and renewing members about the no-cost LAP including interpreter services, translation services, and supporting linguistic services, through various communication types including, but are not limited to, Evidence of Coverage, newsletters, mailings, and Customer Contact Center messages to inform members of the availability of language services.
        b. The plans Customer Contact Center staff will be trained on the LAP and will be an additional resource and means of informing members about the LAP.
        c. Written notice of availability of LAP will be included in English and in THRESHOLD LANGUAGES in annual mailing at minimum.
        d. The following information will be included in member communications:
            i. The interpreter and translation services available by the plan
            ii. Instructions on how to access LAP services
            iii. LAP services are available at no cost to the member
            iv. Access to INTERPRETING services is available at all applicable POINTS OF CONTACT
            v. The right to file a grievance if language needs are not met
        e. CHPIV will ensure the plan includes a Non-Discrimination Notice with all significant communications sent to members. The significant communication will include all Non-Discrimination elements required by federal rules or regulations.

f. All significant communications that include Non-Discrimination information will also include a notice advising the member of the availability of language assistance services (aka TAGLINES or NOLA)

2. PROVIDER Group Communication and Support
   a. CHPIV will ensure the plan informs PROVIDER groups and physicians of the availability and how to access the Language Assistance Program at no cost to members.
   b. Methods of communication to PROVIDER groups and physicians include the plan's PROVIDER Operations Manual, PROVIDER updates, faxed bulletins, flyers, or onsite visits to PROVIDER locations.
   c. The plan's PROVIDER groups and physicians will be advised of the following:
      i. PROVIDER s must give members access to INTERPRETING services at all medical POINTS OF CONTACT
      ii. The hours that interpreter services are available
      iii. Timely access requirements for interpreter services
      iv. The specifications on the use of bilingual staff and the patient's family, friends or minors as interpreters found 45 CFR 92
      v. Interpreter services are offered at no cost to the members
   d. CHPIV will ensure the plan supports PROVIDER groups and physicians through trainings (both formal and informal) and printed resources including:
      i. Culturally specific topic such as culture and diabetes management
      ii. Customized trainings in cultural competency
      iii. Trainings on how to access interpreter services, including services and relay services for the deaf
   e. CHPIV will ensure the plan gives contracted PROVIDER groups and physicians information that explains how enrollees may contact their health plan, file a complaint with their plan, obtain assistance from the CA DMHC and seek an independent medical review.
      i. Forms to request an independent medical review are transplanted and are available in non-English languages through DMHC websitewww.hmohelp.ca.gov
   f. The plan will distribute monthly eligibility reports that include member language preference and alternate format preference to contracted PROVIDER groups.
      i. Individual physicians may also request member language information by submitting a request through the PROVIDER portal website or by calling either PROVIDER or member services center.
   g. CHPIV will ensure the plan releases a yearly PROVIDER article focusing on collaborating effectively with interpreters in person and through video, telephone, and other media. The article will include information such as:
      i. What to do at the beginning of the session, including the purpose, type of information to be covered and how to facilitate the conversation with the interpreter.

ii. Helpful tips during the session, including how the PROVIDER should continue to speak in the first person and speak slightly slower than normal speed of talking.
iii. How to navigate through a longer conversation and how to end the session successfully.

III. PROCEDURE

A. CHPIV delegates the Language Assistance Program to its Subcontractor, The Plan.
B. Delegation Oversight
   1. CHPIV shall provide oversight and continually assess the delegated functions, responsibilities, processes, and performance of The Plan. CHPIV will ensure The Plan'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
Points of Contact	Instances in which a member accesses the services covered under a plan contract, health insurer's policy or certificate, including administrative and clinical services., telephonic and in-person contacts where the need for language assistance may be anticipated.
Interpreting or Interpretation	The process of understanding and analyzing a spoke or signed message and re-expressing that message faithfully, accurately, and objectively in another spoken or signed language, taking cultural and social context into account.
Provider	An institution or organization that provides services for health plan members. Examples of providers include hospitals and home health agencies. NCQA uses the term practitioner to refer to the professionals who provide he4alth care services but recognizes that a "provider directory" includes both providers and practitioners and the inclusive definition is the more common use of the word.
Taglines	Brief statements that advise members of the availability of language assistance services and how to access these services. Taglines are also referred to as a Notice of Language Assistance or NOLA.

Threshold Language	A language spoken by a minimum number or percentage of members, as required by state or federal regulations or contract. These are product line specific.
Vital Document	Documents that defined by DMHC and CDI for California commercial lines of business only.

	Device Tracking and Management Using Microsoft Intune	IT-001
	Department	Finance, Network & Informatics
	Functional Area	Information Technology
	Impacted Delegate	☐ Subcontractor ☒ NA

DATES			
Policy Effective Date	10/15/2024	**Reviewed/Revised Date**	
Next Annual Review Due		**Regulator Approval**	

APPROVALS			
Internal		**Regulator**	
Name	David Wilson	☐ DHCS ☒ NA ☐ DMHC	
Title	Chief Financial Officer		

ATTACHMENTS
N/A

AUTHORITIES/REFERENCES
N/A

HISTORY	
Revision Date	**Description of Revision**
10/15/2024	Policy creation

Device Tracking and Management Using Microsoft Intune

I. **OVERVIEW**

A. This policy outlines the procedures for receipt, tracking, removing, and accessing devices, including bring your own devices (BYOD), using Microsoft Intune. The goal is to ensure the security, integrity, and proper use of company assets.

II. **POLICY**

A. This policy applies to all employees who have access to a company device, including BYOD.

III. PROCEDURE

A. **Device Tracking:**
   1. **Device Enrollment:** All devices, including BYOD, must be enrolled in Microsoft Intune by IT upon issuance.
   2. **Device Inventory:** A comprehensive inventory of all enrolled devices will be maintained in Microsoft Intune, including device type, serial number, and assigned user.

B. **Device Removal:**
   1. **Separation of Employment:** Upon termination of employment or contract, the employee or contractor must return all company-owned devices.
   2. **Device Deactivation:** IT will leverage Microsoft Intune to remotely disable the device, thereby preventing unauthorized access to company data.
   3. **Device Recovery:** In the event of a lost or stolen device, the device data will be automatically wiped when it reconnects to the internet. Sensitive data is encrypted at rest to enhance security.

C. **Device Access:**
   1. **Authorized Users:** Only authorized employees may access company-owned devices using their credentials.
   2. **Password Management:** Strong, unique passwords must be used for all device accounts.
   3. **Data Encryption:** Sensitive data stored on company devices (or BYOD if applicable) must be encrypted.

D. **Policy Violations:**
   1. **Data Access**: Access to data will be restricted to locations within the United States. Any attempt to access data from outside the country will be considered a violation of company policy.
   2. **Consequences:** Failure to comply with this policy may result in disciplinary action, including termination of employment or contract.
   3. **Reporting:** Any suspected violations of this policy must be reported to the IT department immediately.

IT Policy: Physical Access ControlI.

I. OVERVIEW

A. This policy outlines the procedures for granting and revoking physical access to company premises using badge cards. The goal is to ensure the security and safety of the workplace.

II. POLICY

A. This policy applies to all employees who require access to company premises.

III. PROCEDURE

A. **Badge Card Issuance:**

1. **HR Request:** All requests for badge cards must be submitted to the Human Resources department.
2. **Vendor Coordination:** HR will coordinate with the designated external vendor to process the badge card request. HR is responsible for managing and keeping track of the badge inventory.
3. **Card Activation:** The vendor will activate the badge card upon receipt of the request.

B. **Badge Card Deactivation:**

1. **Termination or Change of Status:** When an employee's employment is terminated or their status changes, HR will notify the vendor to deactivate their badge card.
2. **Lost or Stolen Cards:** If a badge card is lost or stolen, the cardholder must report it to HR immediately. HR will coordinate with the vendor to deactivate the card and issue a replacement.

C. **Access Control Procedures:**

1. **Badge Card Presentation:** All individuals entering the building must tap their badge card into the security system.
2. **Access Granting:** The security system will verify the badge card and grant access if authorized.
3. **Visitor Access:** Visitors must be accompanied by an authorized employee and may be issued temporary visitor badges.

D. **Security Measures:**

1. **Regular Reviews:** Access privileges will be reviewed periodically to ensure they remain appropriate.
2. **Security Cameras:** Security cameras are installed in key areas to monitor access points and deter unauthorized entry.
3. **Emergency Procedures:** Emergency procedures for building evacuation and lockdown will be in place.

E. **Policy Violations:**

1. **Consequences:** Unauthorized access to company premises may result in disciplinary action, including termination of employment or contract.
2. **Reporting:** Any suspected violations of this policy must be reported to HR immediately.

IT Policy: Device Disposal and Reuse

I. OVERVIEW

A. This policy outlines the procedures for the disposal and reuse of company-owned devices. The goal is to ensure that devices are disposed of in a responsible and environmentally friendly manner while protecting sensitive company data.

II. POLICY

A. This policy applies to all company-owned devices, including computers, laptops, tablets, smartphones, and peripherals.

III. PROCEDURE

A. **Device Disposal:**

1. **Data Erasure:** Prior to device disposal or reuse, all data must be permanently erased using secure methods that render the data unrecoverable.
2. **Data Destruction:** For highly sensitive data, physical destruction of storage media may be required.

B. **Device Reuse:**

1. **Internal Reuse:** If a device is still functional and meets company standards, it may be repurposed for internal use within the organization.
2. **Asset Management:** A record of all devices disposed of or reused must be maintained in the company's asset management file.

C. **Disposal Methods:**

1. **Data Security:** Vendors must provide assurances that data will be securely erased or destroyed during the disposal process.

D. **To install applications or software not currently available on company computers, staff must follow these steps:**

1. **Request approval:** Staff need to submit an email request to their supervisor, specifying the desired **application** or software.
2. **Supervisor approval:** If the supervisor approves the request, they will forward the email to ifranco@chpiv.org for purchase and/or installation.
3. **Important note:** Due to security restrictions, users cannot directly install software on their computers.

Microsoft Entra User Account Policy

I. OVERVIEW

A. This policy outlines the guidelines for managing user accounts within the Microsoft Entra environment. It establishes centralized control over user roles and responsibilities, ensuring consistency and security across the organization.

II. POLICY

A. This policy applies to all user accounts created within the Microsoft Entra ID environment.

III. PROCEDURE

A. **Centralized Account Management:**

1. **Role Assignment:** All user roles and permissions will be managed centrally through Microsoft Entra. This includes assigning appropriate access levels based on the user's job function and responsibilities.
2. **Account Lifecycle Management:** Microsoft Entra will be used to manage the entire lifecycle of user accounts, including creation, modification, and deactivation.
3. **Two-Factor Authentication:** Users require two-factor authentication (2FA) for all Microsoft Entra accounts, adding an extra layer of protection for the user account.

B. **Account Deactivation Procedure:** When a user leaves the company, the following procedure will be followed:

1. **Notification:** The HR department will notify the IT department of the employee's departure.
2. **Account Deactivation:** The user's account will be deactivated within Microsoft Entra.
    a. **Example of Two-Factor Authentication:** When John Doe logs in to a corporate device for the first time or if the Microsoft ecosystem detects unusual activity on his account, he will be prompted to enter a verification code from the Microsoft Authenticator app.
    b. **Example of Account Deactivation:** If John Doe, a sales representative, leaves the company, his account will be deactivated as follows:
        i. **Account Deactivation:** John's account will be marked as "Disabled" in Microsoft Entra, preventing him from logging in.

C. **Sign-In Logging:**

1. **Activity Tracking:** Microsoft Intune will record detailed information about user sign-in attempts, including:
    a. **Date and Time:** The exact time of the sign-in attempt.
    b. **Location:** The geographical IP location from which the sign-in was attempted.
    c. **Operating System:** The operating system of the device used for the sign-in.

d. **Success or Failure:** Whether the sign-in attempt was successful or failed.

e. **Reason for Failure:** If the sign-in failed, the reason for the failure (e.g., incorrect password, account lockout).

D. **Data Retention:** Sign-in logs will be retained for 30 days.

E. **Email Access:**

1. **Assigned Email Accounts:** Users will be granted access to their assigned email accounts using their Microsoft Entra account, which will be provisioned based on their job function and responsibilities.
2. **Email Retention:** Email messages will be retained for at least three months.
3. **Email Security:** Users are responsible for following email security best practices, such as:

   a. Avoiding phishing scams.

   b. Not clicking on suspicious links or attachments.

   c. Reporting any suspicious email activity to the IT department.

F. **File Resource Access:**

1. **Assigned File Resources:** Users will be granted access to the file resources they need to perform their job duties, using their Microsoft Entra account. Access will be based on their role and responsibilities within the organization.
2. **File Sharing:** Users may be granted permission to share files with other authorized users, as necessary.
3. **File Security:** Users are responsible for following file security best practices, such as:

   a. Using strong passwords to protect their accounts.

   b. Avoiding unauthorized file sharing.

   c. Reporting any suspicious file activity to the IT department.

G. **Access Restrictions:**

1. **Unauthorized Access:** Users are prohibited from accessing resources that are not assigned to them.
2. **Data Privacy:** Users must comply with all applicable data privacy laws and regulations when accessing and handling company data.

H. **Account Deactivation:**

1. **Upon Termination:** When a user's employment is terminated, their account access will be revoked.

I. **Policy Enforcement:**

2. **Regular Reviews:** The IT department will conduct regular reviews of user accounts to ensure compliance with this policy and identify any potential security risks.
3. **Training:** All employees will receive training on the importance of following this policy and the consequences of unauthorized access or misuse of user accounts.
4. **Auditing:** Microsoft Entra's auditing capabilities will be used to monitor user activity and detect any suspicious behavior.

Email Encryption Policy

I. Overview

A. This policy outlines the organization's commitment to protecting the confidentiality of email communications by ensuring that all emails are sent using encryption in transit.

II. Policy

A. This policy applies to all email communications sent and received by the organization.

III. Procedure

A. Encryption in Transit:

1. **Secure Protocols:** The organization will use secure protocols, such as Transport Layer Security (TLS), to encrypt email communications during transmission. All emails sent from our organization are automatically encrypted in transit using secure protocols. If the recipient's email server does not support encrypted connections, the email will not be sent.
2. **Certificate Management:** The organization will maintain and manage appropriate digital certificates to enable secure TLS connections.
3. **Regular Updates:** Encryption protocols and certificates will be regularly updated to ensure compatibility with evolving security standards.

Antivirus Software Usage

I. Overview

A. To ensure the security and integrity of corporate computer systems and data by mandating the use of antivirus software on all corporate devices and BYOD.

II. Policy

A. This policy applies to all employees and authorized users who have access to computer devices, including laptops, desktops, and servers.

III. Procedure

A. Antivirus Installation and Maintenance:

1. All corporate devices must have up-to-date antivirus software installed and activated.
2. The antivirus software performs automatic scans at regular intervals and scans all files downloaded or accessed from external sources.
3. Antivirus software definitions are updated automatically to protect against the latest threats.

B. User Conduct:

1. Users are unable to disable antivirus due to profile restrictions on their corporate devices.
2. Users must report any suspicious activity or suspected malware infections to the IT department immediately.
3. Users must exercise caution when opening attachments from unknown sources or clicking on links in emails.

C. IT Department Responsibilities:

1. The IT department will select and deploy approved antivirus software.
2. The IT department will monitor antivirus software performance and update definitions as needed.
3. The IT department will investigate and address any malware infections promptly.

D. Consequences of Non-Compliance: Failure to comply with this policy may result in disciplinary action, including termination of employment.

E. Exceptions: Exceptions to this policy may be granted by the IT department in specific cases, such as for testing purposes or when compliance is impractical.

External Storage Device Restrictions

I. Overview

A. To protect the security and integrity of corporate data by restricting the use of external storage devices.

II. Policy

A. This policy applies to all employees and authorized users who have access to computer devices including BYOD.

III. Procedure

A. External Storage Device Restrictions:

1. **Unrecognized Devices:** Corporate devices will not recognize or interact with external storage devices that are not explicitly approved by the IT department.

2. **Data Transfer Restrictions:** Data transfer between corporate devices and external storage devices will be strictly controlled and monitored.

B. Approved Devices:

1. **List of Approved Devices:** The IT department will maintain a list of approved external storage devices under the Asset Management file. External USB storage, including flash drives and CD/DVD drives, is exclusively for backing up server files and updating computers. Data stored on these devices will be encrypted with industry-standard encryption.
2. **Device Approval Process:** Users must obtain prior approval from their supervisor before connecting any external storage device to a corporate device.

C. Data Transfer Procedures:

1. **Secure Transfer Methods:** Data transfer between corporate devices and approved external storage devices must be conducted using secure methods, such as encrypted files or secure cloud storage.
2. **Data Backup:** Regular backups of sensitive data should be performed to ensure data integrity and recoverability.
3. For security reasons, all users are prohibited from using external USB storage devices. To share files, please use SharePoint or email. These methods employ encryption both in transit and at rest. Shared file activities will be logged in your Microsoft Entra account.

D. Example of Unrecognizable Device: If an employee connects a personal USB drive to a corporate laptop, the laptop may not display the drive in the file explorer. This is because the device is not on the approved list and is therefore unrecognized by the corporate device's security settings. For security purposes, any device attempting to read or write data to an external USB device will be blocked.

E. Consequences of Non-Compliance: Failure to comply with this policy may result in disciplinary action, including termination of employment.

Bring Your Own Device (BYOD) Program

I. Overview

A. To establish guidelines for employees who wish to use their personal devices for work purposes.

II. Policy

A. This policy applies to all employees who wish to enroll their personal devices in the company's BYOD program.

III. Procedure

A. Device Enrollment:

1. Employees who wish to participate in the BYOD program must enroll their personal devices in Microsoft Intune.
2. Enrollment will enable remote control and device encryption capabilities.

B. Device Management:

1. The company reserves the right to remotely manage and control enrolled devices for security and compliance purposes.
2. This includes the ability to remotely wipe the device if necessary.

C. Device Encryption:

1. All enrolled devices must have data encryption enabled to protect sensitive company information.
2. The company will enforce encryption policies to ensure data security.

D. Device Ownership:

1. The employee remains the owner of the personal device.
2. The company does not assume responsibility for the device's physical condition or performance.

E. Device Removal:

1. If an employee leaves the company or wishes to unenroll their personal device, the device will be remotely wiped to remove all company data.
2. The employee is responsible for ensuring that any personal data is backed up before unenrollment.

F. Acceptable Use:

1. Employees must comply with all company policies and procedures when using their personal devices for work purposes.
2. This includes adhering to company security standards and avoiding unauthorized access to company systems.

File Resources and Monitoring

I. Overview

A. To establish guidelines for the use of company file resources and to outline the monitoring practices in place to ensure security and compliance.

II. Policy

A. This policy applies to all employees, and authorized users who have access to company file resources such as company network(s), secure portals, data systems and applications.

III. Procedure

A. File Resource Access:

1. Access to company file resources will be granted based on job role and responsibilities.
2. Users must only access files that are relevant to their work duties.
3. Unauthorized access to files is strictly prohibited.

B. File Storage and Management:

1. All company files will be stored on Microsoft Office 365 cloud storage.
2. The company will implement appropriate security measures to protect file resources, including access controls, encryption, and regular backups.

C. File Activity Monitoring:

1. All activities related to file resources will be monitored under Microsoft Azure.
2. This includes receipt of, tracking, and managing file access, creation, modification, and deletion.
3. Monitoring will be conducted to detect and prevent unauthorized access, data breaches, and other security threats.

D. Data Retention and Deletion:

1. The company will retain files for a specified period, as determined by legal and regulatory requirements.
2. Files that are no longer required will be securely deleted in accordance with data retention policies.

E. Data Privacy and Confidentiality:

1. Employees must handle all company files with the utmost care and confidentiality.
2. Sensitive data must be protected in accordance with applicable data privacy laws and regulations.

Geographic Access Restrictions

I. Overview

A. To establish guidelines for restricting access to our resources within the United States.

II. Policy

A. This policy applies to all users accessing our network, systems, and data.

III. Procedure

A. Geographic Restriction: All access to our internal resources will be automatically restricted to within the United States.

B. Access Denial: Attempts to access our internal resources from outside the United States will be denied.

1. **Example:**
    a. **User:** A user located in Canada attempts to log in to our internal network.
    b. **System:** The system detects the user's IP address as being outside the United States.
    c. **Result:** The user is denied access and receives a message indicating that their location is not authorized.

C. Enforcement:

1. **Monitoring:** Network traffic will be monitored to identify and block unauthorized access attempts.
2. **Logging:** Access attempts, both successful and unsuccessful, will be logged for auditing purposes under Microsoft Entra.
3. **Consequences:** Violations of this policy may result in disciplinary action, including termination of employment.

	Diversity Equity & Inclusion	HR-006
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	**Shannon Long**	☐ DHCS ☐ NA ☐ DMHC
Title	Human Resources Consultant	

ATTACHMENTS
NA

AUTHORITIES/REFERENCES
NA

HISTORY	
Revision Date	**Description of Revision**

I. OVERVIEW

A. Community Health Plan of Imperial Valley is committed to fostering, cultivating, and preserving a culture of DIVERSITY, EQUITY, and INCLUSION.
B. Our human capital is the most valuable asset we have. The collective sum of the individual differences, life experiences, knowledge, inventiveness, innovation, self-expression, unique capabilities, and talent that our employees invest in their work represents a significant part of not only our culture, but our reputation and company's achievement as well.
C. We embrace and encourage our employees' differences in age, color, disability, ethnicity, family or marital status, gender identity or expression, language, national origin, physical and mental ability, political affiliation, race, religion, sexual orientation, socio-economic status, veteran status, and other characteristics that make our employees unique.
D. To ensure a work environment that provides commitment to equal employment opportunities for all CHPIV employees and applicants. All employment decisions, including recruiting, hiring, training opportunities, promotions, discipline, termination, are made on the basis of qualifications and merit.

II. POLICY

A. All employees of Community Health Plan of Imperial Valley have a responsibility to treat others with dignity and respect at all times. All employees are expected to exhibit conduct that reflects INCLUSION during work, at work functions on or off the work site, and at all other company-sponsored and participative events. All employees are also required to attend and complete annual DIVERSITY awareness training to enhance their knowledge to fulfill this responsibility.
B. Any employee found to have exhibited any inappropriate conduct or behavior against others may be subject to disciplinary action.
C. Employees who believe they have been subjected to any kind of discrimination that conflicts with the company's DIVERSITY policy and initiatives should seek assistance from a supervisor or an HR representative.

III. PROCEDURE

A. All CHPIV Staff will take part in training in DIVERSITY, EQUITY & INCLUSION to ensure we have a staff properly educated on the boundaries that should be respected at work.
B. Ensuring a diverse, equitable, and inclusive (DEI) hiring process involves several key steps. Here is a comprehensive procedure to guide Human Resources:
   1. Job Description and Requisition
      a. Review and Revise: Ensure job descriptions are free from biased language and focus on essential qualifications. Use gender-neutral language and consider competencies and transferable skills.
      b. Commitment to DEI: Include a statement about the organization's commitment to DIVERSITY, EQUITY, and INCLUSION in all job postings.
   2. Recruitment Strategy
      a. Diverse Outreach: Develop a strategic recruitment plan that includes outreach to diverse groups. Utilize platforms and networks that cater to underrepresented communities.

   b. Inclusive Advertising: Allocate budget for advertising in channels that reach diverse candidates.
3. Training and Education
   a. Bias Training: Provide training for hiring managers and interviewers on unconscious bias and inclusive hiring practices.
   b. Interview Preparation: Train interviewers on legal and appropriate interview questions, focusing on assessing candidates' commitment to DEI.
4. Candidate Sourcing
   a. Broad Networks: Partner with organizations that support underrepresented groups and attend DIVERSITY-focused job fairs.
   b. Employee Resource Groups: Leverage internal employee resource groups to share job postings within their networks.
5. Interview Process
   a. Structured Interviews: Use structured interview questions and evaluation rubrics to ensure fairness.
   b. Diverse Panels: Include diverse members in the interview panel to provide varied perspectives.
6. Selection and Hiring
   a. Holistic Evaluation: Assess candidates holistically, considering their skills, experiences, and potential contributions to DEI.
   b. Fair Policies: Implement fair hiring policies that do not automatically disqualify candidates with non-traditional backgrounds.
7. Committees and Governing Bodies
   a. CHPIV utilizes its QIHEC committee to ensure appropriate processes are followed for recruiting and hiring personnel with diverse backgrounds.
   b. At a minimum CHPIV will.
      i. Assess committee membership composition and ensure alignment with its membership composition.
      ii. Include practitioners/providers and members of the community in the committee.
      iii. Complete process improvement measures as outlined in section E. Performance Measures, Analysis and Reporting.
8. Continuous Improvement
   a. Feedback and Review: Regularly review and assess hiring practices for inclusivity and effectiveness. Seek feedback from candidates and employees to identify areas for improvement.
9. Performance Measures, Analysis and Reporting
   a. To monitor its hiring and recruiting processes, and create opportunities for improvement in recruiting and hiring diverse staff, CHPIV will assess the performance of these measures utilizing the following;
   b. To identify opportunities, CHPIV will;
      i. Annually gather (through surveys or other engagement activities) and report on staff feedback on and satisfaction with the organization's promotion of DIVERSITY, EQUITY, INCLUSION, and cultural humility.
      ii. Survey staff to identify the primary barriers to maintain employment, to reduce turnover rates for traditionally marginalized, disenfranchised, or disempowered groups.

iii. Compare the DIVERSITY of the organization's workforce with groups or subgroups of the community or population that the organization serves (e.g., racial/ethnic, preferred language, gender identity, sexual orientation) and with the available pool of candidates in the labor market where the organization operates.

c. To act on opportunities, CHPIV will:
   i. Annually share the data with the QIHEC committee to vote on opportunities to improve recruitment and hiring of diverse staff and annually share with the committee how performance in this area has improved or declined.
   ii. Build DIVERSITY, EQUITY, INCLUSION and cultural humility performance metrics into all management and leadership job descriptions and goals.
   iii. Suggest staff share pronouns in introductions and/or email signatures.
   iv. Design workspaces to better accommodate staff of differing mobility.
   v. Host, offer or promote events (e.g., webinars, speaker series, brown bag sessions) that foster DIVERSITY, EQUITY, INCLUSION, and cultural humility and highlight traditionally marginalized, disenfranchised, or disempowered groups.
   vi. Create temporary or permanent positions, departments, councils, or committees focused on highlighting underrepresented groups.

C. By following these steps, HR can create a more inclusive hiring process that attracts and retains a diverse workforce.

IV. DEFINITIONS

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

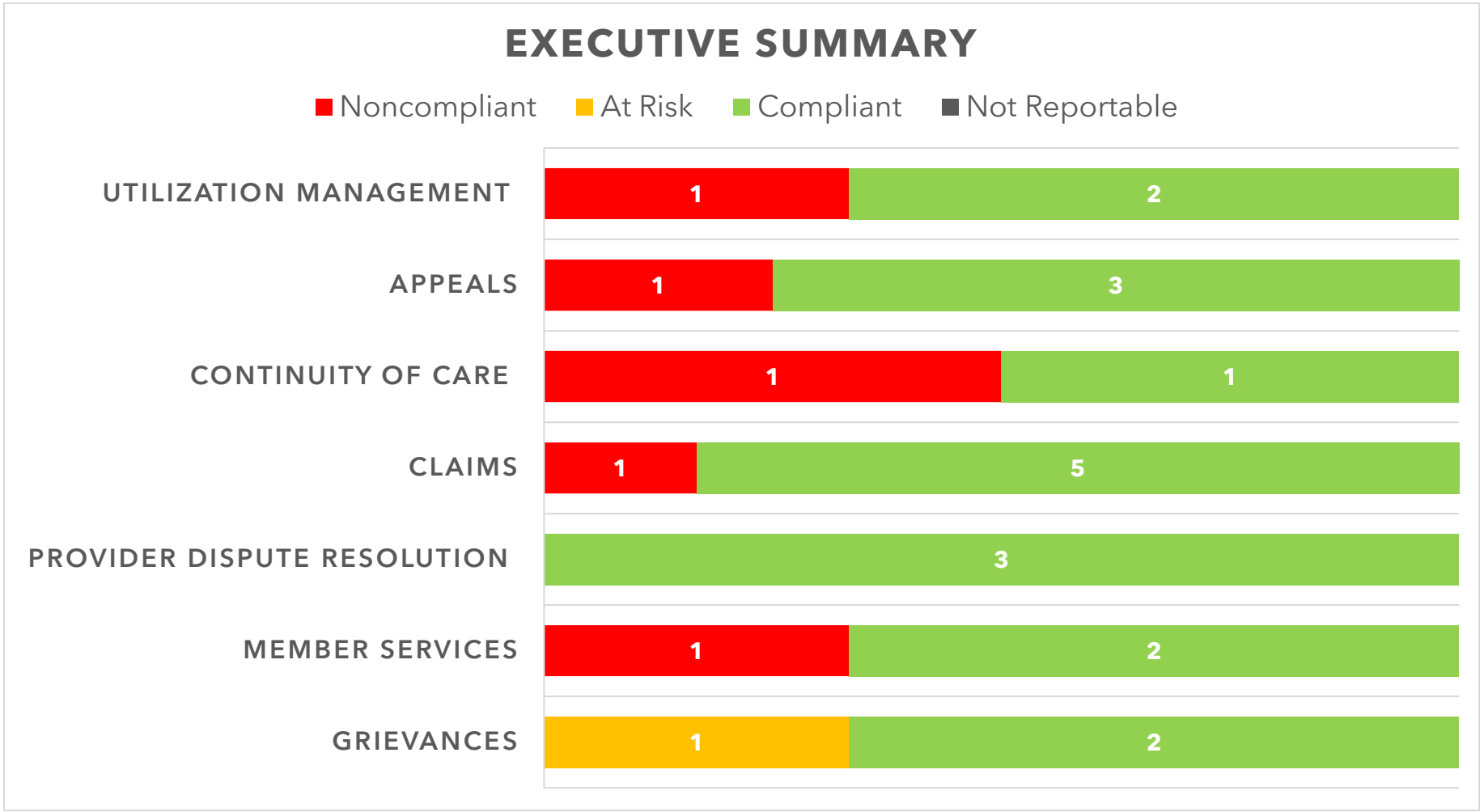
TERM	DEFINITION
Diversity	The practice or quality of including or involving people from a range of different social and ethnic backgrounds and of different genders, sexual orientations, etc.
Equity	The quality of being fair and impartial.
Inclusion	The practice or policy of providing equal access to opportunities and resources for people who might otherwise be excluded or marginalized, such as those who have physical or intellectual disabilities and members of other minority groups.

DELEGATION OVERSIGHT

Health Net 2024 Quarter 1 Final Scorecard

Report Re-Issued: September 13, 2024

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



DELEGATION OVERSIGHT

Health Net 2024 Quarter 1 Final Scorecard

Report Re-Issued: September 13, 2024

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

HIGH PERFORMING AREAS

- ✓ 100% Appeals 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
- ✓ 99.25% PDR Acknowledgement Timeliness
- ✓ 100% PDR Written Determination Timeliness and Timeliness of Interest Payment on Late PDRs
- ✓ 99.86% Claims Payment Timeliness - 30 Calendar Days
- ✓ 100% Claims Payment Timeliness – 45 Working Days and 90 Calendar Days
- ✓ 99.76% Claims Acknowledgement Timeliness
- ✓ 99.9% Misdirected Claims Timeliness
- ✓ 98.3% UM Decision Timeliness
- ✓ 96% UM Member Notification Timeliness

NON-COMPLIANT AREAS

- ☒ 80% Effectuation of Overturned Appeals
- ☒ 81.27% Timely Issuance of Member ID Cards
- ☒ 89.1% UM Provider Notification Timeliness
- ☒ 73.08% Continuity of Care Processing Timeliness
- ☒ 0% Timely Interest Payment on Late Claims

ACTIONS REQUIRED

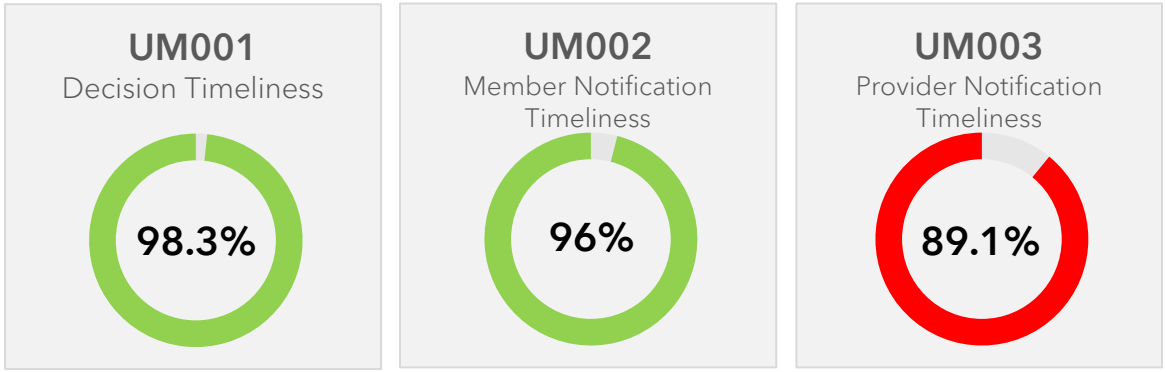
FUNCTIONAL AREA	ACTION	DUE DATE
UTILIZATION MANAGEMENT	Warning Letter	NA
APPEALS	Warning Letter	NA
CONTINUITY OF CARE	Warning Letter	NA
CLAIMS	Warning Letter	NA
PROVIDER DISPUTE RESOLUTION	None	NA
MEMBER SERVICES	Warning Letter	NA
GRIEVANCES	None	NA

DELEGATION OVERSIGHT

Health Net 2024 Quarter 1 Final Scorecard

Report Re-Issued: September 13, 2024

UTILIZATION MANAGEMENT



BACKLOG - Overdue	
Member Notification	4
Provider Notification	26

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

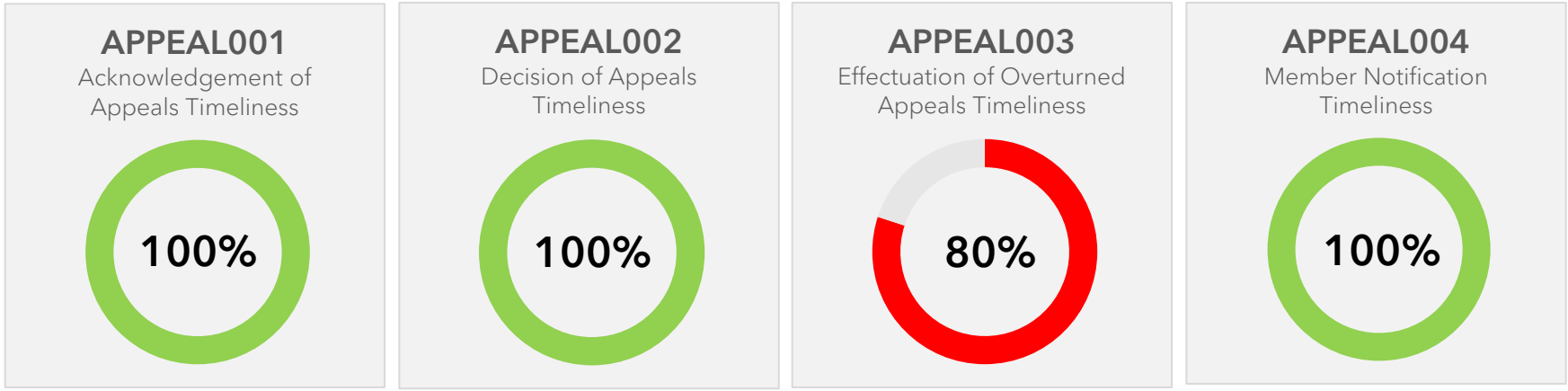
*Percentage does not include the backlog of cases that have not been completed/processed and have passed the required timeframe

DELEGATION OVERSIGHT

Health Net 2024 Quarter 1 Final Scorecard

Report Re-Issued: September 13, 2024

APPEALS



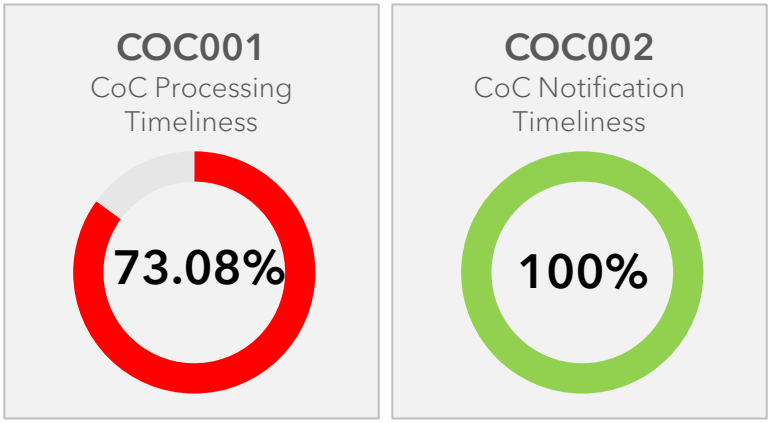
KPI #	KPI	Quarter 1	Quarter 2	Quarter 3	Quarter 4
APPEAL001	**Acknowledgement of Appeals Timeliness**	**100%**			
APPEAL002	**Decision of Appeals Timeliness**	**100%**			
APPEAL002S	▸ Standard	100%			
APPEAL002E	▸ Expedited	No cases			
APPEAL003	**Effectuation of Overturned Appeals Timeliness**	**80%**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

DELEGATION OVERSIGHT

Health Net 2024 Quarter 1 Final Scorecard

Report Re-Issued: September 13, 2024

CONTINUITY OF CARE



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

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

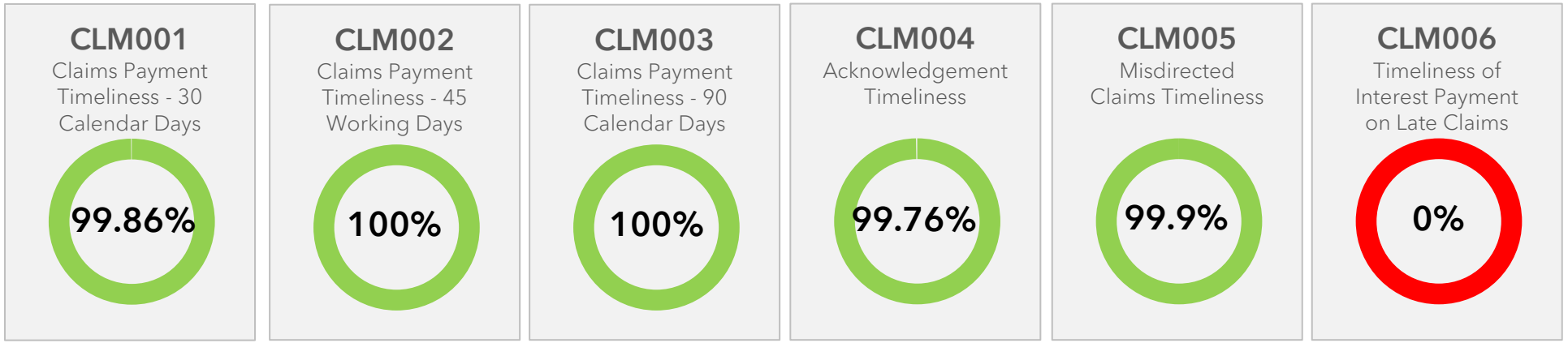
BACKLOG	
CoC Member Notification	6

DELEGATION OVERSIGHT

Health Net 2024 Quarter 1 Final Scorecard

Report Re-Issued: September 13, 2024

CLAIMS



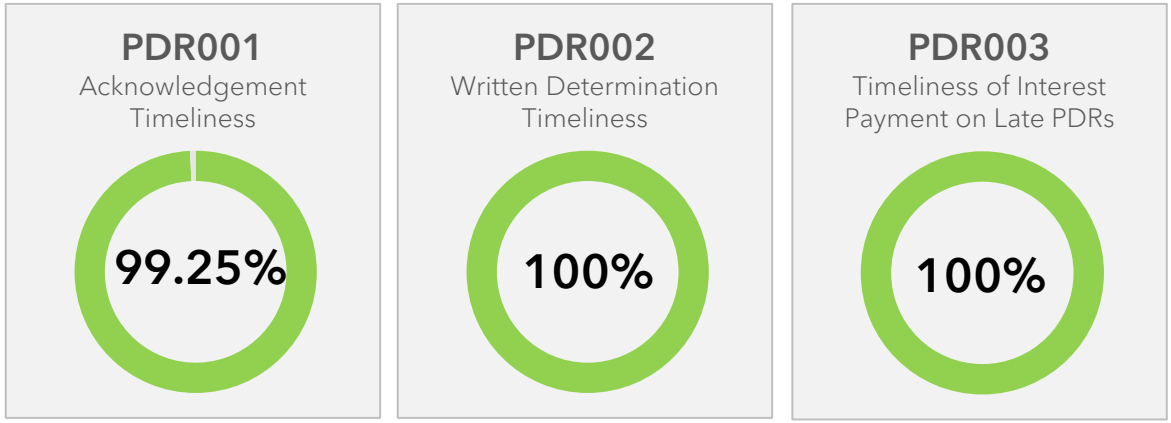
KPI #	KPI	Quarter 1	Quarter 2	Quarter 3	Quarter 4
CLM001	**Claims Payment Timeliness - 30 Calendar Days**	**99.86%**			
CLM002	**Claims Payment Timeliness - 45 Working Days**	**100%**			
CLM003	**Claims Payment Timeliness - 90 Calendar Days**	**100%**			
CLM004	**Acknowledgement Timeliness**	**99.76%**			
CLM004E	▸ Acknowledgement Timeliness - Electronic	100%			
CLM004P	▸ Acknowledgement Timeliness - Paper	93.69%			
CLM005	**Misdirected Claims Timeliness**	**99.9%**			
CLM006	**Timeliness of Interest Payment on Late Claims**	**0%**			

DELEGATION OVERSIGHT

Health Net 2024 Quarter 1 Final Scorecard

Report Re-Issued: September 13, 2024

PROVIDER DISPUTE RESOLUTION



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

DELEGATION OVERSIGHT

Health Net 2024 Quarter 1 Final Scorecard

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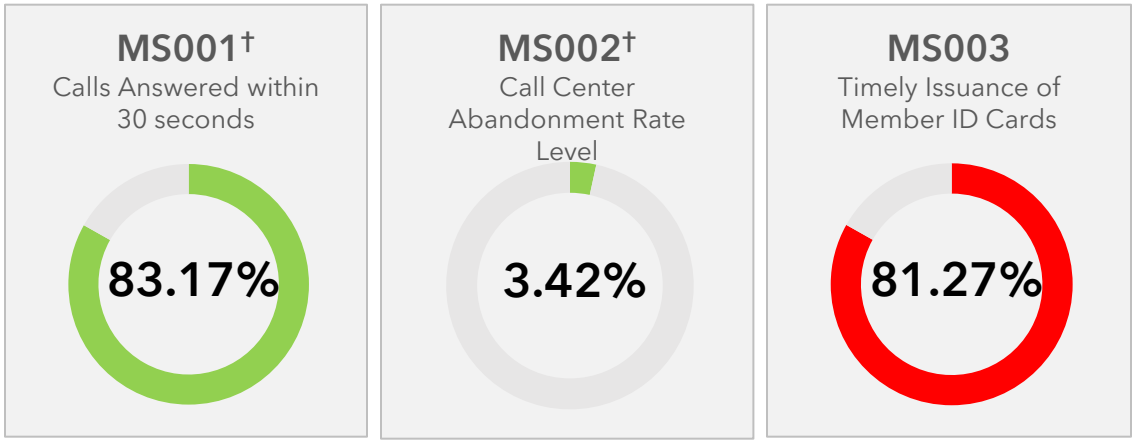
MEMBER SERVICES



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%			

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

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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

DELEGATION OVERSIGHT

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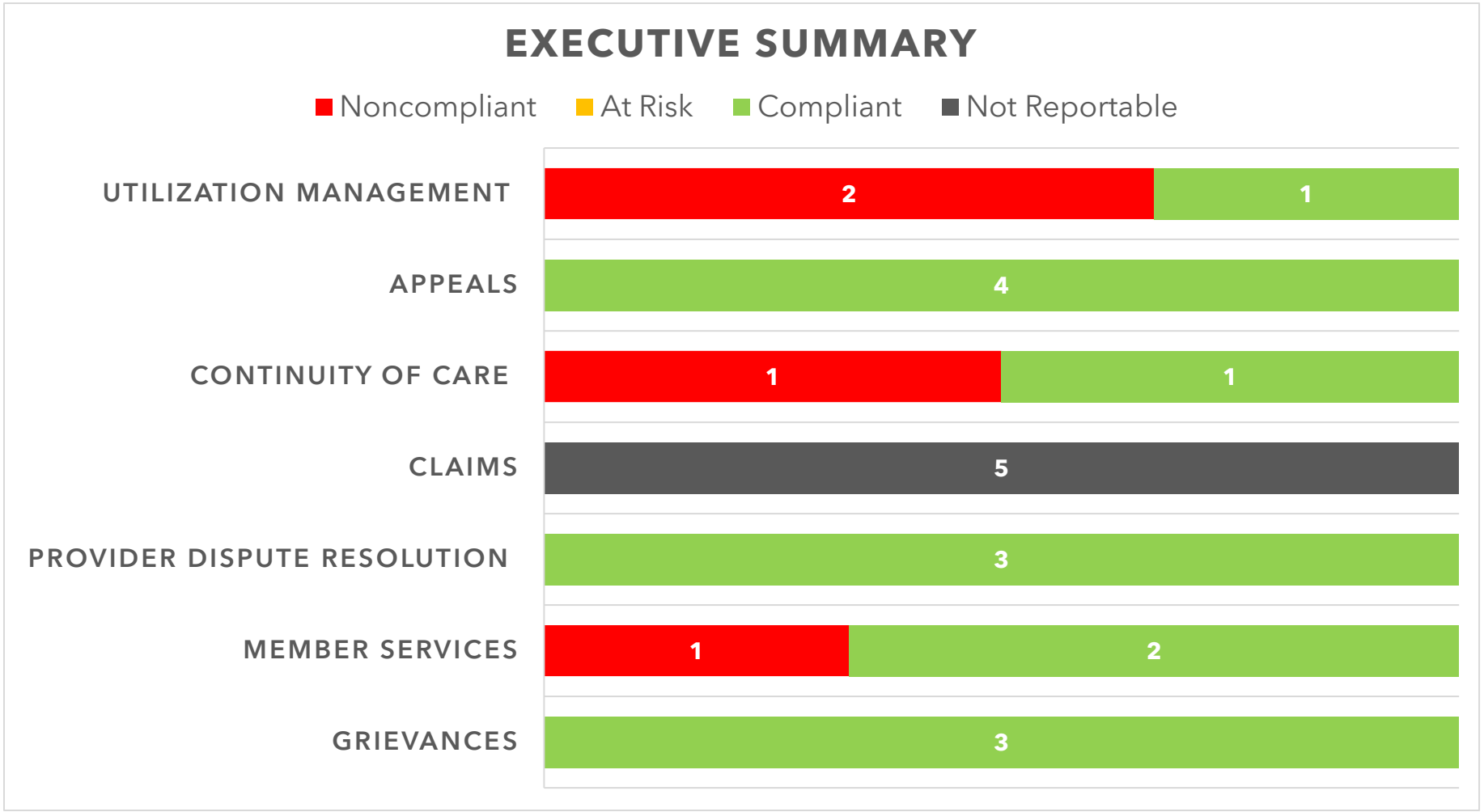
The CHPIV Delegation Oversight Monitoring Program ensures continuous oversight of high-risk and critical delegated activities that have high member impact and regulatory focus. The Executive Summary provides a concise overview of the performance metrics and categorizes each area into compliant (green),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



DELEGATION OVERSIGHT

Health Net 2024 Quarter 2 Final Scorecard

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

HIGH PERFORMING AREAS

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

NON-COMPLIANT AREAS

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

NOT REPORTABLE

- Claims Log

ACTIONS REQUIRED

FUNCTIONAL AREA	ACTION	DUE DATE
UTILIZATION MANAGEMENT	Corrective Action Plan (CAP)	10/14/2024
APPEALS	None	NA
CONTINUITY OF CARE	Corrective Action Plan (CAP)	10/14/2024
CLAIMS	Submit Revised Log	NA
PROVIDER DISPUTE RESOLUTION	None	NA
MEMBER SERVICES	Corrective Action Plan (CAP)	10/14/2024
GRIEVANCES	None	NA

DELEGATION OVERSIGHT

Health Net 2024 Quarter 2 Final Scorecard

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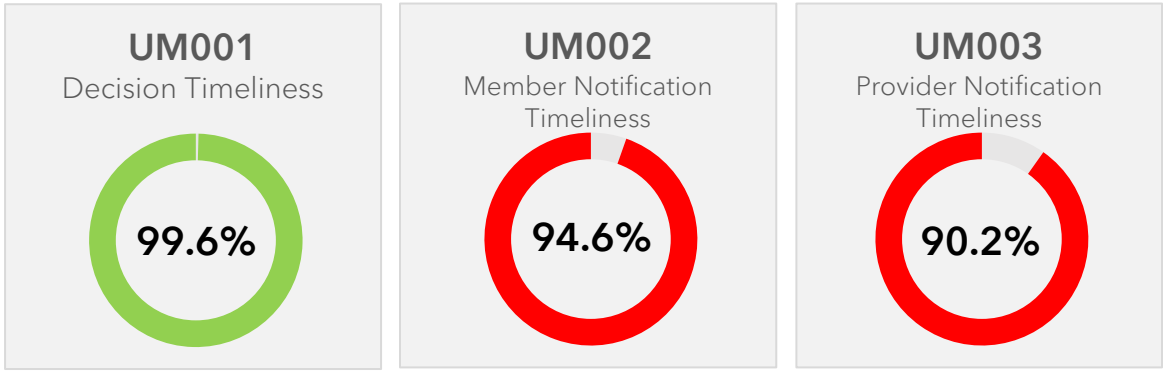
UTILIZATION MANAGEMENT



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

DELEGATION OVERSIGHT

Health Net 2024 Quarter 2 Final Scorecard

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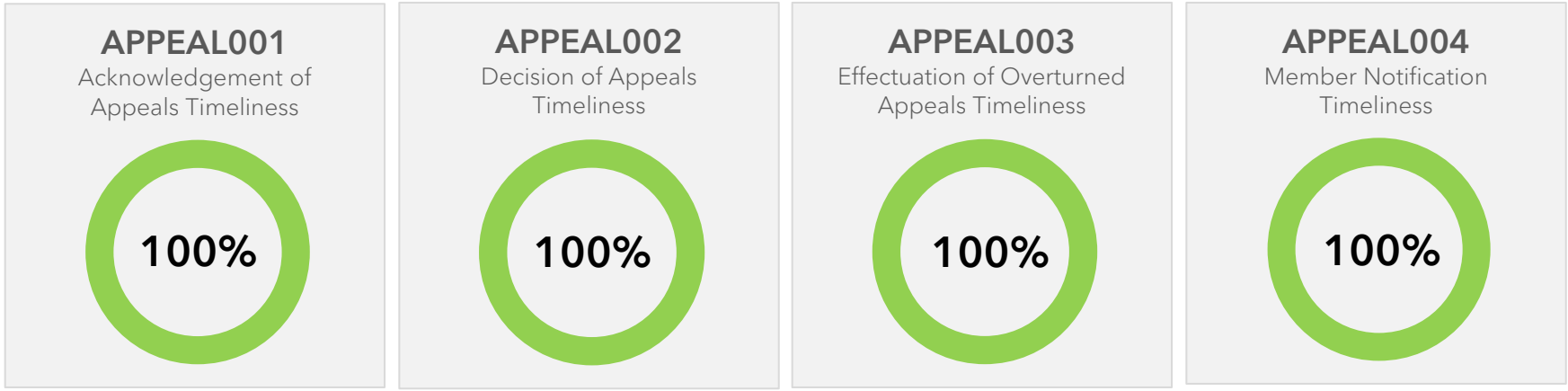
APPEALS



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

DELEGATION OVERSIGHT

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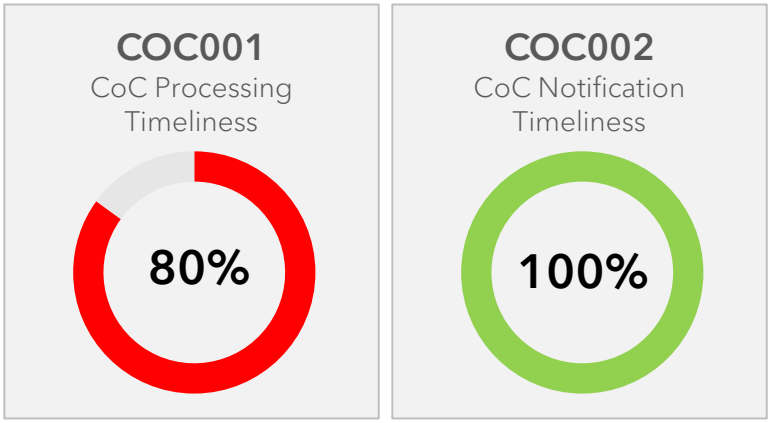
CONTINUITY OF CARE



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

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

DELEGATION OVERSIGHT

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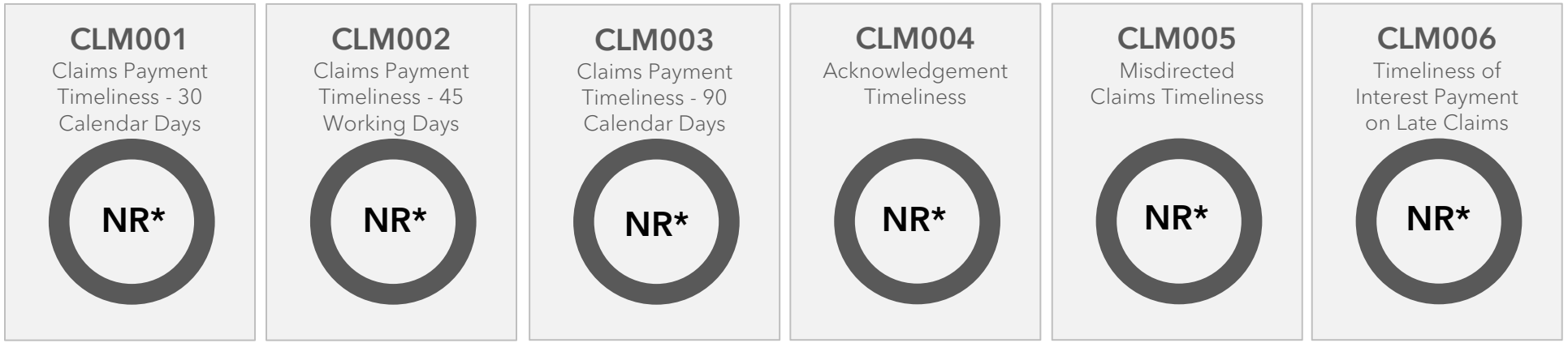
CLAIMS



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

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

DELEGATION OVERSIGHT

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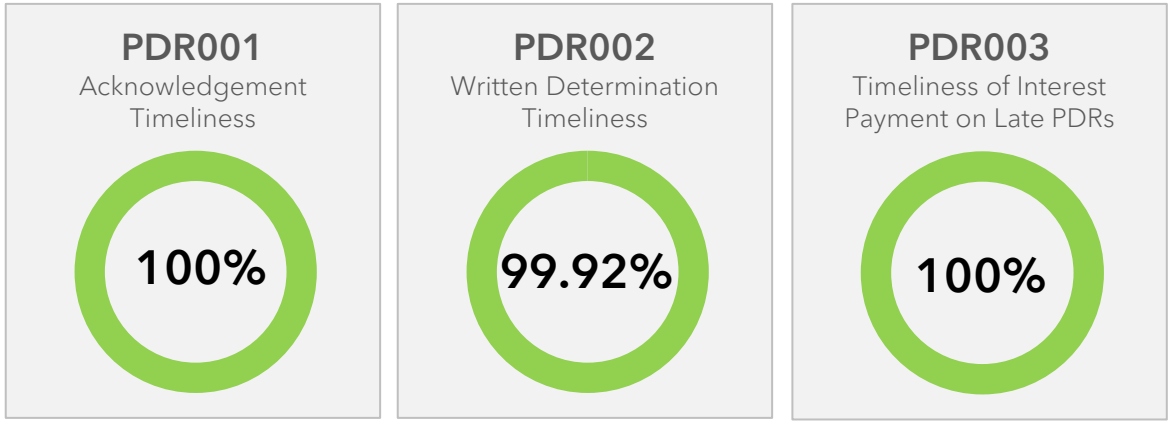
PROVIDER DISPUTE RESOLUTION



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

DELEGATION OVERSIGHT

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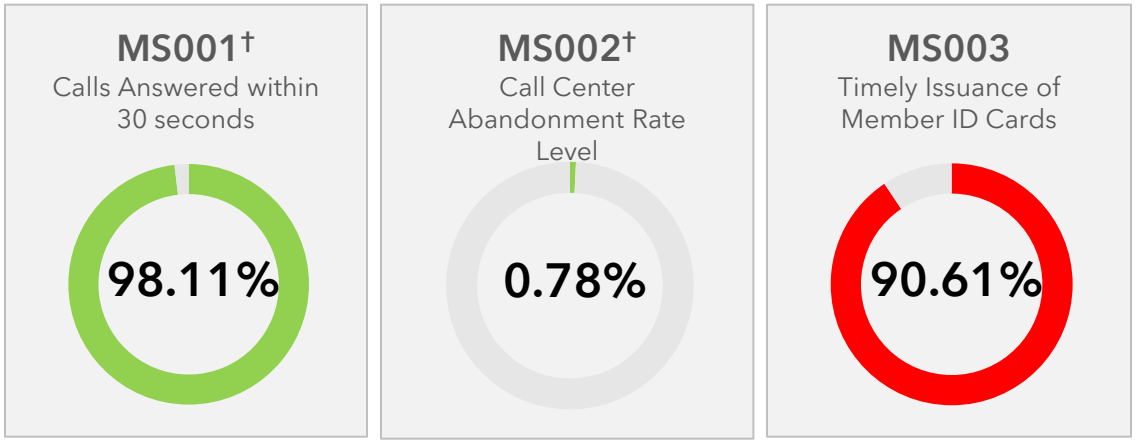
MEMBER SERVICES



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

† Self-reported compliance rate

DELEGATION OVERSIGHT

Health Net 2024 Quarter 2 Final Scorecard

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GRIEVANCES

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

Appendix 1 – KPI Details

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

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

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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