San Joaquin County Health Commission
dba Health Plan of San Joaquin
and
Mountain Valley Health Plan
2024 Compliance Program Plan

The San Joaquin County Health Commission 2024 Compliance Plan has been approved by:

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Contents

1. Overview of the Compliance Program

The San Joaquin County Health Commission ("Commission" operating and doing business as Health Plan of San Joaquin in San Joaquin and Stanislaus counties and Mountain Valley Health Plan in El Dorado and Alpine counties ("Health Plan"), is committed to conducting its operations in compliance with ethical standards, contractual obligations, and all applicable statutes, regulations, and rules, including those pertaining to CalAIM, Medi-Cal, Seniors and Persons with Disabilities (SPD).

The Health Plan's compliance commitment encompasses its own internal operations, as well as its oversight and monitoring responsibilities related to the Health Plan's network providers, covered entities, subcontractors, and downstream subcontractors such as, physician groups, participating providers, suppliers, Pharmacy Benefit Manager (PBM), and consultants. The term First Tier, Downstream, and Related Entity (FDR) is used in this document to refer to the Health Plan's delegated subcontractors which perform administrative functions and/or provide health care services that the Health Plan is required to perform and maintains responsibility for under its state contract with the Department of Health Care Services (DHCS). Such persons/entities, referred to as FDR herein, include those that directly contract with the Health Plan and those that subcontract (Downstream or Related Entities) with the Health Plan's First Tier Entities.

The Health Plan has developed a comprehensive Compliance Program which incorporates all elements of an effective compliance program as recommended by the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) and required by the Centers for Medicare and Medicaid Services (CMS). The Compliance Program is continually evolving and may be modified and enhanced based on compliance monitoring and identification of new areas of operations, regulatory, or legal risk. The Health Plan requires that the Health Plan Commission, employees, and FDRs conduct themselves in accordance with the requirements of the Health Plan Compliance Program. Our goal as an organization is to ensure that our commitment to compliance is reflected throughout our systems and processes, as well as our culture.

2. The Compliance Plan

This Compliance Plan sets forth the Health Plan's commitment to legal and ethical conduct by establishing compliance activities, along with the Health Plan principles and standards, to efficiently monitor adherence to all applicable laws, regulations, and guidelines. The Compliance Plan addresses the fundamental elements of an effective compliance program and identifies how the Health

Plan is implementing each of the fundamental elements of an effective compliance program in its operations to meet its contractual, legal, and regulatory obligations, including guarding against fraud, waste, and abuse. Moreover, the Compliance Plan is designed to provide guidance and to ensure that the Health Plan's operations and practices of its Commission Members, employees, and FDRs comply with contractual requirements, ethical standards, and applicable law.

This Compliance Plan is adopted annually by the Commission. It was developed and is managed by the Chief Compliance Officer (Compliance Officer) with the Compliance Committee. The Compliance Plan may be revised and updated regularly to adapt to the continually changing regulatory environment in which we operate.

Commission Members, employees, and FDRs are expected to review and adhere to the requirements and standards set forth in the Compliance Plan, the Code of Conduct, and all related policies and procedures. Furthermore, Commission Members, employees, and FDRs are expected to be familiar with the contractual, legal, and regulatory requirements pertinent to do their respective roles and responsibilities. If a Commission Member, employee, and/or FDR has/have any questions about the application, or implementation of this Compliance Plan, or questions related to the Code of Conduct or the Health Plan policies and procedures, they should seek guidance from the Compliance Officer and/or the Health Plan Office of Compliance (Compliance).

3. Elements of the Compliance Plan

The purpose of this Compliance Program is to prevent, detect, and correct issues of non-compliance and mitigate areas of compliance risk to the organization. To ensure the Health Plan's Compliance Program is effective, the Health Plan has implemented the following seven elements:

Element 1: Written Policies, Procedures, and Standards of Conduct

Element 2: Compliance Officer, Compliance Committee, and High-Level Oversight

Element 3: Effective Training and Education

Element 4: Effective Lines of Communication

Element 5: Well-Publicized Disciplinary Standards

Element 6: Routine Monitoring, Auditing, and Identification of Compliance Risks

Element 7: Procedures and System for Prompt Response to Compliance Issues

3.1 Written Standards

To demonstrate the Health Plan's commitment to complying with all applicable federal and state laws and regulations and to ensure a shared understanding of what ethical and legal standards and requirements are expected of Commission Members, employees, and FDRs, the Health Plan develops, maintains, and distributes its written standards in the form of this Compliance Plan, a separate Code of Conduct, and written policies and procedures.

a. Compliance Plan

As noted above, the Compliance Plan outlines how contractual and legal standards are reviewed and implemented throughout the organization and communicated to the Health Plan Commission Members, employees, and FDRs. This Compliance Plan also includes the fraud prevention program; articulating the Health Plan's commitment to preventing Fraud, Waste, and Abuse (FWA), and setting forth guidelines and procedures designed to detect, prevent, and remediate FWA in the administration of the Health Plan programs. The Compliance Plan is available on the Health Plan's external website for Commission Members and FDRs, as well as on the Health Plan's intranet site, referred to as the San Joaquin Health Plan Team site, accessible to all employees.

b. Policies and Procedures

The Health Plan also developed written policies and procedures to address specific areas of the Health Plan's operations, compliance activities, and FWA prevention, detection, and remediation to ensure the Health Plan can efficiently monitor adherence to all applicable laws, regulations, and guidelines. These policies and procedures are designed to provide guidance to Commission Members, employees, and FDRs concerning compliance expectations and outline processes on how to identify, report, investigate, and/or resolve suspected, detected, or reported compliance issues. Commission Members, employees, and FDRs are expected to be familiar with the policies and procedures pertinent to their respective roles and responsibilities and are expected to perform their duties in compliance with ethical standards, contractual obligations, and applicable law. The Compliance Officer or their designee will ensure that Commission Members, employees, and FDRs are informed of applicable policy requirements, and that such dissemination of information is documented and retained, in accordance with applicable record retention requirements.

The policies and procedures are reviewed annually and updated as needed, depending on state and federal regulatory changes and/or operational improvements to address identified risk factors. Changes to the Health Plan's policies and procedures are reviewed and approved by the Health Plan's internal Policy Review Committee. The Policy Review Committee, comprised of executive officers and key management staff, meets regularly to review and approve proposed changes and additions to the Health Plan's policies and procedures. Policies and procedures are available on the Health Plan's website and SAI360, a separate web portal accessible to Commission Members, employees, and FDRs. Commission Members, employees, and FDRs receive notice when policies and procedures are updated via a memorandum.

c. Code of Conduct

The Code of Conduct is the Health Plan's foundational document detailing fundamental principles, values, and the framework for business practices within and applicable to the Health Plan. The objective of The Code is to articulate compliance expectations and broad principles that guide the Health Plan Commission Members, employees, and FDRs in conducting their business activities in a professional, ethical, and lawful manner. The Code of Conduct is approved by the Commission and distributed to Commission Members, employees, and FDRs upon appointment, hire, or the commencement of the contract, and annually thereafter. New Commission Members, employees, and FDRs are required to sign an attestation acknowledging receipt and review of the Code of Conduct within thirty (30) calendar days of hire, or commencement of the contract, and annually thereafter.

3.2 Oversight

The successful implementation of the Compliance Program requires dedicated commitment and diligent oversight throughout the Health Plan's operations, including but not limited to, key roles and responsibilities by the Commission, the Compliance Officer, the Compliance Committee, the Delegation Oversight Committee, and Executive Team.

a. Governing Body

The Health Plan Commission, as the Governing Body, is responsible for approving, implementing, and monitoring the Compliance Program. The Commission delegates the Compliance Program Oversight to the Compliance Officer, who handles compliance oversight and activities full-time. The Compliance Officer, in conjunction with the Compliance Committee, are both accountable for the oversight and reporting

roles and responsibilities as set forth in this Compliance Plan. However, the Health Plan Commission remains accountable for ensuring the effectiveness of the Compliance Program to ensure its efficient and successful implementation.

b. Chief Compliance Officer

The Chief Compliance Officer serves as the Compliance Officer, the Privacy Officer, and the Fraud Prevention Officer who coordinates and communicates all assigned compliance activities and programs, as well as plans, implements, monitors the day-to-day activities of the Compliance Program. The Compliance Officer reports directly to the Chief Executive Officer (CEO) and the Health Plan Commission on the activities and status of the Compliance Program. The Compliance Officer has authority to report matters directly to the Health Plan Commission at any time. Furthermore, the Compliance Officer ensures that the Health Plan meets all state and federal regulatory and contractual requirements.

The Compliance Officer interacts with the Health Plan Commission, CEO, Executive Team, Management, FDRs, legal counsel, state and federal representatives, and others as required. In addition, the Compliance Officer supervises Compliance, which includes compliance professionals with expertise and responsibilities for the following areas: Medi-Cal Regulatory Affairs & Compliance, Policies and Procedures, Special Investigations, Privacy, FWA, internal and FDR Audit & Oversight, and training on compliance activities.

c. Compliance Committee

The Compliance Committee, chaired by the Compliance Officer, is composed of the Health Plan's Executive Team and management. The members of the Compliance Committee serve at the discretion of the CEO and may be removed or added at any time. The role of the Compliance Committee is to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The Compliance Committee meets at least on a quarterly basis, or more frequently as necessary, to enable reasonable oversight of the Compliance Program.

The Compliance Committee responsibilities include, but are not limited to the following:

i. Maintain and update the Code of Conduct consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the Commission;

ii. Maintain written notes, records, correspondence, or minutes of Compliance meetings reflecting reports made to the Compliance Committee and the decisions on issues raised;
iii. Review and monitor the effectiveness of the Compliance Program, including monitoring key performance reports and metrics, evaluating business and administrative operations, and overseeing the creation, implementation, and development of corrective and preventive action(s) to ensure they are prompt and effective;
iv. Analyze applicable federal and state program requirements, including contractual, legal, and regulatory requirements, along with areas of risk, and coordinate with the Compliance Officer to ensure the adequacy of the Compliance Program;
v. Review, approve, and/or update policies and procedures to ensure the successful implementation and effectiveness of the Compliance Program consistent with regulatory, legal, and contractual requirements;
vi. Recommend and monitor the development of internal systems and controls to implement the Health Plan's standards and policies and procedures as part of its daily operations;
vii. Determine the appropriate strategy and/or approach to promote compliance and detect potential violations and advise the Compliance Officer accordingly;
viii. Develop and maintain a reporting system to solicit, evaluate, and respond to complaints and problems;
ix. Review and address reports of monitoring and auditing of areas in which the Health Plan is at risk of program non-compliance and/or potential FWA, and ensure Corrective Action Plans (CAPs), and Immediate Action Plans (ICAPS) are implemented and monitored to avoid recurrence;
x. Suggest and implement all appropriate and necessary actions to ensure all operations are in compliance with applicable laws, regulations, and contractual obligations; and
xi. Provide regular and ad-hoc status reports of compliance with recommendations to the Health Plan Commission.

3.3 Training

Education and training are critical elements of the Compliance Program. The Health Plan requires that all Commission Members, employees, and FDRs complete training upon appointment, hire, or commencement of contract and annually thereafter. Required courses cover the Health Plan's Code of Conduct, compliance obligations, relevant laws, HIPAA, FWA, and cultural

competency as applicable. Specialized education courses are assigned to individuals based on their respective roles or positions.

The Health Plan utilizes web-based training courses that emphasize the Health Plan's commitment to the Compliance Program, and which courses are updated regularly to ensure that employees are kept fully informed about any changes in procedures, regulations, and requirements. The Compliance Officer, or their designee, is responsible for coordinating compliance education and training programs, and ensuring that records evidencing an individual's completion of training requirements are documented and maintained, such as sign-in sheets, attestations, or electronic certifications, as required by law. The Compliance Officer and the Executive Team are responsible for ensuring that Commission Members, employees, and FDRs complete training annually.

a. **Code of Conduct, Conflict of Interest, and Confidentiality Statement** The Health Plan's Code of Conduct, Conflict of Interest, and Confidentiality Statement is distributed to Commission Members, employees, and FDRs. Commission Members, employees, and FDRs are required to sign an attestation acknowledging their receipt, review, and understanding of the Code of Conduct within thirty (30) calendar days of their appointment, employment, or contract. Signed attestations are maintained in each individual's personal file as required by law.

b. **Mandatory Training Courses (Compliance Oversight, FWA, and HIPAA)** The Health Plan requires Commission Members, employees, and FDRs, regardless of role or position with the Health Plan, to complete mandatory compliance training courses. Mandatory courses may include but are not limited to: The Fundamentals of the Compliance Program; FWA Training; HIPAA; Overview of the Medi-Cal Program; False Claims Act (FCA); Whistleblower Protections, reporting methods including the reporting Hotline. Employees must complete the required compliance training courses within thirty (30) calendar days of hire, and annually thereafter and shall be a condition of continued employment and a factor in the annual performance evaluation of each employee. Commission Members and FDRs are required to complete the mandatory compliance training courses within thirty (30) days of appointment or commencement of contract and annually thereafter. (Some FDRs may be exempt or deemed to have met the HIPAA or FWA training and education requirements if the FDR's training complies with CMS requirements and attests to completing the training.) FDRs are required to disseminate copies of the Code of Conduct and policies and procedures to their employees, agents,

and/or Downstream Entities. Completion of the training courses are documented electronically, and records of completion are maintained for each individual as required by law.

c. Additional Training

Compliance may provide additional training opportunities throughout the year focused on essential elements of the Compliance Program if issues arise through an audit or issuance of new laws, rules or regulations to Commission Members, employees, and/or FDRs. Compliance will coordinate with impacted business areas, Commission Members, and FDRs to disseminate the appropriate training and educational materials.

3.4 Lines of Communication and Reporting

a. General Compliance Communication

The Health Plan regularly communicates the requirements of the Compliance Program and the importance of performing individual roles and responsibilities in compliance with applicable laws, contractual obligations, and ethical standards. The Health Plan utilizes various methods and forms to communicate general information, statutory or regulatory updates, process changes, updates to policies and procedures, contact information for the Compliance Officer, relevant federal and state fraud alerts, policy letters, pending/new legislation reports, and advisory bulletins from the Compliance Officer to the Health Plan Commission Members, employees, FDRs, and members, including but not limited to: presentations, meeting updates, SAI360 (policies and procedures portal), electronic mail, intranet website, Compliance intranet webpage, written reports to the Commission and Compliance Committee, and direct contact with the Compliance Officer.

b. Reporting Mechanisms

The Health Plan Commission Members, employees, and FDRs have an affirmative duty and are directed in the Health Plan's Code of Conduct and policies and procedures to report compliance concerns, questionable conduct, or practices, suspected to actual violations immediately upon discovery. (FDRs also have contractual obligations to report FWA and Privacy incidents to the Health Plan). As a result, the Health Plan has established multiple reporting mechanisms to receive, record, and respond to compliance questions, potential non-compliance issues, and Privacy and/or FWA incidents from State and/or Federal Agencies, Commission Members, employees, FDRs, members, and other community members. These reporting systems

provide for anonymity and confidentiality to the extent permitted by applicable law and circumstances. The Health Plan maintains and supports a **non-retaliation policy** governing good faith reports of suspected or actual non-compliance.

Upon receipt of a report, the Compliance Officer, or their designee, shall follow appropriate policies and procedures to promptly review, investigate, and resolve such matters. The Compliance Officer shall monitor the process for follow-up communications to persons submitting reports or disclosures through these reporting mechanisms and shall ensure documentation concerning such report is maintained according to all applicable legal and contractual requirements.

i. Report Directly to Management or Executive Staff

The Health Plan employees are encouraged to contact their immediate supervisor when non-compliant activity is suspected or observed. A report should be made immediately upon or identifying the potential or suspected non-compliance, or violation. Supervisors or management staff who receive such reports will promptly escalate the report to the Compliance Officer for further investigation and reporting to the Compliance Committee. If an employee is concerned that their immediate supervisor did not adequately address their report or complaint, the employee may go directly to the Compliance Officer.

ii. Call the Compliance and Ethics Hotline

The Health Plan maintains an easily accessible Compliance and Ethics Hotline, available twenty-four (24) hours a day, seven (7) days a week, with multilingual support, in which the Health Plan may receive anonymous issues on a confidential basis. Members are encouraged to call the Compliance and Ethics Hotline if they have identified potential non-compliance activity, or FWA issues. The Compliance and Ethics Hotline information is as follows:

Toll Free: 1-855-400-6002

Calls or issues reported through the Compliance and Ethics Hotline are received, logged into a database, and investigated by the Compliance Department. No disciplinary action will be taken against individuals making good faith reports. Every effort will be made to keep reports confidential to the extent permitted by law. The process for reporting suspected violations to the Compliance and Ethics Hotline is part of the education and training for all Commission Members, employees, and FDRs. Members also have

access to the Compliance Officer through the Compliance and Ethics Hotline.

iii. Report online through Syntrio Anonymous Reporting System

The Health Plan maintains a confidential and anonymous 24/7 online reporting system available through both the external and internal website for employees, members, Commission Members, and FDRs. Syntrio is a vendor who collects the information electronically and forwards to the Compliance Officer or their designee. Every effort will be made to maintain confidentiality of the reporting to the extent permitted by law. Online reporting is available in English and Spanish, the threshold languages for the Health Plan counties. Reporters wishing to remain anonymous are issued a PIN that enables them to follow up or get the status of an existing report through the Syntrio system.

iv. Report Directly to the Compliance Officer

The Compliance Officer is available to receive reports of suspected or actual compliance violations, or FWA issues, on a confidential basis, to the extent possible as permitted by law, from Commission Members, employees, FDRs, and members. The Compliance Officer may be contacted by telephone, written correspondence, email or by a face-to-face appointment.

v. Report Directly to the Office of Compliance

Reports may be made directly to the Health Plan's Office of Compliance via mail, email, or through the Compliance and Ethics Hotline for confidential reporting. Emails can be sent to (PIU@hpsj.com).

Mail can be sent to:

Health Plan
ATTN: Compliance Officer
7751 S. Manthey Rd
French Camp, CA 95231

vi. Confidentiality and Non-Retaliation

Every effort will be made to keep reports confidential to the extent permitted by law[1], but there may be instances where the identity of the individual making the report will have to be disclosed. As a

[1] In accordance with DHCS PIU program, the Health Plan acknowledges and considers referrals of FWA from other health plans, state and federal agencies as confidential (Exhibit A,3.1.3.2,D,6)

result, the Health Plan has implemented and enforces a non-retaliation policy to protect individuals who report suspected or actual non-compliance, or FWA issues in good faith. This non-retaliation policy is communicated along with reporting instructions by posting information on the Health Plan intranet and website, as well as sending periodic member notifications. The Health Plan also takes violations of the non-retaliation policy seriously, and the Compliance Officer will review and enforce disciplinary and/or other violations, as appropriate, with the approval of the Compliance Committee.

3.5 Enforcement and Disciplinary Standards

a. Conduct Subject to Enforcement and Discipline

Commission Members, employees, and FDRs are subject to appropriate disciplinary action and/or corrective actions if they have violated the Health Plan's standards, policies, or applicable laws. Commission Members, employees, and FDRs may be disciplined or sanctioned as appropriate for failing to adhere to the Health Plan's Compliance Program and/or violating standards, regulatory requirements, and/or applicable laws, including but not limited to:

i. Conduct that leads to the filing of false or improper claim in violation of federal or state laws and/or contractual requirements;
ii. Conduct that results in a violation, or violations of any other federal or state laws or contractual requirements relating to participation in federal or state health care programs;
iii. Failure to perform any required obligation relating to the Compliance Program, applicable laws, or to report suspected or known FWA issues to an appropriate person through one of the reporting mechanisms; or
iv. Conduct that violates HIPAA or other privacy laws, and/or the Health Plan privacy and security policies including actions that harm the privacy of members or the Health Plan information systems that store member data.

b. Enforcement and Discipline

The Health Plan maintains a "zero tolerance" policy towards any illegal, or unethical conduct that impacts the operation, mission, or image of the Health Plan. The standards established in the Compliance Program shall be enforced consistently through appropriate disciplinary actions. Individuals or entities may be disciplined by way of reprimand, suspension, financial penalty,

reduced responsibilities, and/or termination, depending on the nature and severity of the conduct, or behavior. Commission Members may be subject to removal of appointment. Employees are subject to disciplinary action up to and including termination. FDRs may incur financial penalties, and/or be subject to contract termination.

Violations of applicable laws and regulations, even unintentional, could subject individuals, entities, or the Health Plan to civil, criminal, or administrative sanctions and/or penalties. Further violations could lead to suspension, preclusion, or exclusion from participation in federal or state health care programs.

The Health Plan employees shall be evaluated annually based on their compliance with the Health Plan's Compliance Program. Where appropriate, the Health Plan shall promptly initiate education and training to correct identified problems or behaviors.

3.6 Auditing and Monitoring

The Health Plan has an established system for routine monitoring and identification of compliance risks. The system includes internal monitoring and audit, and, as appropriate, external audits, to evaluate internal operations and FDRs compliance with applicable laws and regulations, and overall effectiveness of the Compliance Program. The Health Plan's system of ongoing monitoring and auditing is reflective of its size, risks, and resources to assess performance in areas identified as being at risk. Identified risks are incorporated into a monitoring and auditing work plan, known as the Compliance Work Plan, which is coordinated and overseen by the Compliance Officer and Compliance Committee. The Compliance Officer receives regular reports from the Compliance Staff who are conducting the audits regarding the results of auditing and monitoring, and the status and effectiveness of corrective actions taken. It is the responsibility of the Compliance Officer or their designee to provide updates on monitoring and auditing results to the Compliance Committee, CEO, Executive Team, and Commission.

a. Risk Assessment

The Compliance Officer, or their designee, shall conduct a formal baseline assessment of the Health Plan's major compliance and FWA risk areas through an annual risk assessment. The risk assessment shall consider all business operational areas, including FDRs. Each operational area shall be assessed for the types and levels of risks the area presents to the organization. Factors considered in determining risks associated with each area include but are not limited to:

i. Size of department or operational area;
ii. Complexity of work;
iii. Amount of training that has taken place;
iv. Past compliance issues; and
v. Budget

Risks identified by the risk assessment are evaluated based on the potential probability of occurrence and the severity of occurrence to determine which risk areas will have the greatest impact on the organization and are prioritized accordingly. Risks change and evolve with changes in law, regulations, requirements, and operational matters. Therefore, the Health Plan conducts ongoing review of potential risks of non-compliance and FWA and periodically re-evaluates identified risks and overall risk scores. Risk areas identified through external audits and oversight, as well as through internal monitoring, audits, and investigations are priority risks. The results of the risk assessment inform the development of monitoring and audit work plan.

b. Monitoring and Auditing Work Plan

Once the risk assessment has been completed, a monitoring and auditing work plan is developed. The Compliance Officer or designee may coordinate with each operational department or FDR to develop a monitoring and auditing work plan based upon the results of the risk assessment. The work plan may include:

i. The audits to be performed;
ii. Audit schedules, including start and end dates;
iii. Announced or unannounced audits;
iv. Audit methodology;
v. Necessary resources;
vi. Types of Audits: desk or onsite;
vii. Person(s) responsible;
viii. Final audit report due date to compliance officer; and
ix. Follow-up activities from findings.

The Health Plan includes in their work plans a process for responding to all monitoring and auditing results and for conducting follow-up review of areas found to be non-compliant to determine if the implemented corrective actions have fully addressed the underlying issue.

The Health Plan ensures that auditors are independent and do not engage in self-policing. Operations staff may assist in audit activities provided the assistance is compatible with the independence of the audit function. Operations staff may be asked to gather data for samples requested by the auditor and may provide other types of information to

auditors. The Compliance Officer works with the Executive Team and management to ensure the audit staff have access to the relevant personnel, information, records, and areas of operation under review, including the operational areas at the plan and FDR level.

c. Oversight of Delegated Activities
To ensure the terms and conditions of statutory and contractual obligations to CMS, DHCS, and DMHC are adhered to, the Health Plan has a comprehensive Delegation Oversight Program to oversee, monitor and audit FDRs. The Health Plan Delegation Oversight Program Description describes all oversight activities in detail.

3.7 Response and Remediation

Compliance shall promptly respond to compliance issues as they are raised. Compliance is responsible for investigating potential compliance problems as identified during self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensuring ongoing compliance with applicable laws and regulations.

If the Health Plan discovers evidence of misconduct related to payment or delivery of items or services, Compliance shall conduct a timely and reasonable investigation into that conduct in accordance with policy CMP01 Response and Prevention of Compliance Violations. The Health Plan shall conduct appropriate corrective actions (for example, repayment of overpayments, disciplinary actions against responsible individuals) in response to the potential violation. The Health Plan shall voluntarily self-report potential fraud or misconduct related to the Medi-Cal program to DHCS.

a. Timely and Reasonable Inquiry
The Health Plan Compliance Department shall conduct a timely and well-documented reasonable inquiry into any compliance incident or issue involving potential non-compliance or potential FWA. Non-compliance and FWA may be discovered through the Compliance and Ethics Hotline, Syntrio online reporting, email, member complaint, routine monitoring, self-assessment, internal audit, or by regulatory authorities. The Compliance Department shall complete a reasonable inquiry as quickly as possible, but no later than ten (10) working days after the date the potential non-compliance or potential FWA was identified.

A reasonable inquiry includes a preliminary investigation of the matter by the Compliance Officer or their designee. If the issue appears to involve potential FWA, the issue is referred to the DHCS Program Integrity Unit

(PIU) within ten (10) working days of the date the FWA is identified. Should serious FWA occur the Compliance Officer shall report the instance to the DHHS OIG and/or law enforcement.

In accordance with 42 CFR section 438.608(a)(7), the DHCS PIU Program, the Health Plan will:

i. File a preliminary report with DHCS's PIU detailing any suspected Fraud, Waste, or Abuse identified by or reported to the Health Plan, our Subcontractors, Downstream Subcontractors, and/or Network Providers within ten (10) working days of discovery or notice of FWA.
ii. The Health Plan will file within ten (10) working days of completing the FWA investigation (including regulator-initiated referrals), a completed report to DHCS's PIU. This report includes findings, actions taken, and include all documentation necessary to support any action taken and as required by state and federal agencies.

b. Corrective Action

The Health Plan shall undertake appropriate corrective actions in response to non-compliance or FWA. Corrective actions are designed to correct the underlying problem that results in program violations and to prevent future non-compliance. As part of the corrective action design process, the Compliance Officer or their designee shall conduct a root cause analysis to determine what caused or allowed the FWA, problem or deficiency to occur. Each corrective action is tailored to address the instance of FWA or non-compliance identified and shall include timeframes and specific and measurable goals. Corrective actions are documented and regularly reviewed by the Compliance Committee. Should any party fail to satisfactorily implement corrective actions as specified, the Office of Compliance shall enforce disciplinary action, including termination of employment or contract.

c. Providers with a History of Complaints

The Health Plan shall maintain files for a period of ten (10) years on both in-network and out-of-network providers who have been subject to complaints, investigations, violations, and prosecutions. This includes member complaints, DHCS and DMHC audit and investigation referrals, OIG and/or Department of Justice (DOJ) investigations, prosecutions, and any other civil, criminal, or administrative action for violations of federal and state health care program requirements. The Health Plan shall also maintain files that contain documented warnings (i.e., Fraud Alerts) and educational contacts, the results of previous investigations,

and copies of complaints resulting in investigations. The Health Plan shall comply with requests by law enforcement, CMS, DHCS, and/or DMHC regarding monitoring activities which have been identified as potential FWA.

Appendix A – Program Integrity Unit (PIU)

1. Fraud Prevention Program

The prevention detection and remediation of Fraud, Waste, and Abuse (FWA) are components of the Health Plan's compliance program. FWA activities are implemented and overseen by the Chief Compliance Officer or his/her designee, the Fraud Prevention Officer and his/her designee, and in coordination with other compliance activities. Investigations are performed according to policy CMP05 - Fraud, Waste, and Abuse and overseen by the Program Integrity Unit (PIU), an internal investigative unit with the Health Plan's Compliance Department responsible for FWA investigations. The Chief Compliance Officer or his/her designee shall attend quarterly CADOJ/DMFEA Program Integrity meetings. The Chief Compliance Officer or his/her designee with the Fraud Prevention Officer or his/her designee reports FWA activities to the Program Integrity Committee, Compliance Committee, Executive Leadership, and the Health Plan's Commissioners. Additionally, the Health Plan fully cooperates with the Office of California Attorney General, DMFEA, and/or USDOJ on investigations.

The Health Plan utilizes various resources to detect, prevent, and remediate FWA. In addition, the Health Plan promptly investigates suspected FWA issues, and reports them within ten (10) business days to DHCS credible allegation of fraud. Additionally, the Health Plan may implement disciplinary or corrective action to avoid occurrence of FWA issues. The objective of the anti-fraud, waste, and abuse plan is to ensure that the scope of the benefits covered by the Health Plan is appropriately delivered to members and the resources are effectively utilized in accordance with state and federal guidelines.

2. Provider Screening, Enrolling, and Credentialing/ Recredentialing

The Health Plan Credentialing Department is part of the Quality Improvement Department and oversees provider screening, enrolling, and credentialing/recredentialing as defined in policy QM43 – Credentialing and Re-Credentialing of Practitioners, and policy QM44 – Credentialing Corrective Action and Practitioner Appeal. The Health Plan Provider Services department oversees provider contracting as defined in policy CONT01 – Review and Execution of Provider Contracts. These policies define how the Health Plan implements 42 CFR section 438.602(b), and APL 19-004. The Health Plan delegates credentialing to a number of organizations that are part of the network. The credentialing department monitors performance of these organizations through review of reports and annual audits. The Health Plan has a robust credentialing process that includes

collaborating with the Quality Improvement staff to obtain Grievances, Facility Site Review, and Medical Record audit scores at the time of the initial credentialing and re-credentialing. The Department monitors sanctions and exclusion lists on an ongoing basis to improve the quality of the network. The Credentialing Department also manages the Peer Review process under the direction of the Medical Director/ Chief Medical Officer. The Health Plan Provider Services Department, per policy CONT13 – Contract Termination, promptly notifies DHCS about a change in a network provider's subcontractors, or downstream subcontractor's circumstances that may affect the network provider's subcontractors, or downstream subcontractor's eligibility to participate in the Medi-Cal managed care program per state and federal law, 42 CFR section 438.608(a)(4), and APL 21-003.

3. Suspended, Excluded, and Ineligible Providers

The ongoing monitoring, after initial enrollment of network providers, subcontractors, and downstream subcontractors for exclusions from federal and state funded health care programs is administered by the Program Integrity Unit. Through process defined in policy CMP20 – Exclusion and Ineligibility Monitoring, the Health Plan prohibits employing, paying, contracting, or maintaining a Medi-Cal contract with providers that ae excluded, suspended, or ineligible to participate, either directly or indirectly, in the Medicare or Medi-Cal programs, per 42 CFR § 438.610(a), and APL 21-003.

4. Treatment of Overpayment Recoveries

The Health Plan Program Integrity Unit, in conjunction with the Health Plan Claims department, per APLs 15-026, 17-003 and 23-011, and as defined in policy CLMS14 – Overpayment of Service Recovery and policy CMP05 – Fraud, Waste, and Abuse identifies overpayments and recoups improper payments from subcontractors, downstream subcontractors, and network providers. The Health Plan notifies DHCS within ten (10) business days of identification of an overpayment that results from FWA, and reports overpayments to DHCS as required annually per 42 CFR § 438.608(d)(3). The Health Plan will also report and return any overpayment to DHCS within 60 calendar days of when it has identified capitation of payments or other payments it has received or paid in excess of amounts as specified in policy CLMS05 – Overpayment of Service Recover.

5. Federal False Claims Act Compliance and Support

The Health Plan abides by the Federal False Claims Act (FCA) 42 USC section 1396a(a)(68) by training on reporting allegations of FWA and maintaining a retaliation free workplace, as outlined in policy CMP24 – Compliance Program Training and Education, and policy CMP05- Fraud, Wase, and Abuse, which requires all its employees, subcontractors, downstream subcontractors, and network

providers to train annually on False Claims Act and other federal and state laws, including information about the rights of employees to be protected as whistleblowers. The Health Plan also maintains a nonretaliatory policy for reporting FWA and/or FCA claims as outlined in policy CMP12- Non-Retaliation for Reporting Violations.