



Mountain Valley
Health Plan

San Joaquin County Health Commission
dba Health Plan of San Joaquin
and
Mountain Valley Health Plan
2026 Compliance Program Plan

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I. Compliance Program Overview

The San Joaquin County Health Commission ("Commission"), dba Health Plan of San Joaquin and Mountain Valley Health Plan ("Health Plan"), is a licensed health care services plan under the Knox-Keene Health Care Service Plan Act of 1975 ("Knox-Keene Act"). Health Plan operates as Health Plan of San Joaquin in San Joaquin and Stanislaus counties and as Mountain Valley Health Plan in El Dorado and Alpine counties. Health Plan is regulated by Department of Managed Health Care ("DMHC") and has contracts with the Department of Health Care Services ("DHCS") and the Centers for Medicare & Medicaid Services ("CMS"). Health Plan is also accredited by the National Committee for Quality Assurance ("NCQA").

Health Plan is committed to conducting its operations in compliance with ethical standards, contractual requirements, and all applicable statutes, regulations, and rules, including those pertaining to Medi-Cal, Medicare Advantage (Part C) and Prescription Drug (Part D) Plan, and other Health Plan programs.

In addition to the contractual requirements with DHCS and CMS, the Health Plan's Compliance Program contains eight elements, which are modeled after the Health and Human Services, Office of the Inspector General (HHS-OIG) for an effective compliance program. The Health Plan's compliance program also addresses concerns as outlined in the Deficit Reduction Act ("DRA"), which requires the Health Plan to establish written policies and procedures to inform employees and others about certain federal and state false claims and whistleblower laws. Health Plan's Compliance Program has the following elements.

- 1) Written policies and procedures and Code of Conduct
- 2) Designation of a Compliance Officer/Committee
- 3) Training and education programs
- 4) Open lines of communication to the responsible compliance position
- 5) Disciplinary policies to encourage good faith participation
- 6) A system for routine identification of compliance risk areas
- 7) A system for responding to compliance issues
- 8) A policy of non-intimidation and non-retaliation for good faith participation in the compliance program

Health Plan's Compliance Program governs internal operations, as well as oversight and monitoring responsibilities related to Health Plan's Commissioners, Workforce, which includes employees, contractors, Commissioners, and Third-Parties which includes First Tier, Downstream, and Related Entities ("FDRs"),

Delegates, Vendors, Contractors, Subcontractors, providers, and Business Associates for all lines of business and Health Plan programs.

Health Plan's Compliance Program is communicated to our Commissioners, Workforce and Third Parties through our Compliance Program Plan. This Compliance Plan is adopted at least annually by the Commission. It is developed and managed by the Chief Regulatory Affairs & Compliance Officer ("CRACO") along with the Compliance Committee. The Compliance Plan may also be revised and updated regularly to adapt to the continually changing regulatory environment in which we operate.

Health Plan's Commissioners, Workforce and Third Parties are expected to review and adhere to the requirements and standards set forth in the Compliance Program Plan, the Code of Conduct, and all related policies and procedures. Furthermore, they are expected to be familiar with the contractual, legal, and regulatory requirements pertinent to do their respective roles and responsibilities. If a member of Health Plan's Commission, Workforce or a Third Party has 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 CRACO and/or Health Plan's Compliance Department ("Compliance").

II. Written Policies and Procedures and Code of Conduct

To demonstrate 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 our Workforce and Third Parties, Health Plan develops, maintains, and distributes its written standards in the form of this Compliance Program Plan, a separate Code of Conduct, and written policies and procedures.

A. Compliance Program Plan

As noted earlier, the Compliance Program Plan outlines how contractual and legal standards are reviewed and implemented throughout the organization and communicated to the Workforce and Third Parties. The Compliance Program 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 Program Plan is available on Health Plan's Intranet for Workforce members, and is published to the public web site (<https://www.hpsj.com> or <https://hpsj-mvhp.org>) for Third-Parties, members, and general public.

B. Policies and Procedures

Health Plan has developed written Policies and Procedures (P&Ps) describing operations and compliance activities designed to prevent fraud, waste and abuse, and ensure adherence to all applicable laws, regulations, and guidelines. Health Plan's Workforce and Third-Parties are bound to act in an ethical manner in accordance with the organization's policies and values as outlined within the Health Plan's Code of Conduct and Business Ethics policy. The Health Plan Workforce and Third-Parties are expected to be familiar with the P&Ps pertinent to their roles and responsibilities and are expected to perform in compliance with ethical standards, contractual obligations and applicable law. The CRACO, or his/her Designee, is responsible for ensuring that all Workforce, Commissioners, and Third-Parties are informed of applicable policy requirements. The accounting of the information dissemination is documented and retained in accordance with applicable record retention standards.

Applicable P&Ps are reviewed annually and updated, or as needed, based on state and federal regulatory changes and/or operational enhancements to maintain compliance and address identified risk factors. P&Ps are reviewed and approved by Health Plan's Compliance Committee. All P&Ps are available on the Health Plan's Intranet, and select P&Ps are published to the public web site (<https://www.hpsj.com> or <https://hpsj-mvhp.org>) for Third-Parties, members, and general public.

C. Code of Conduct

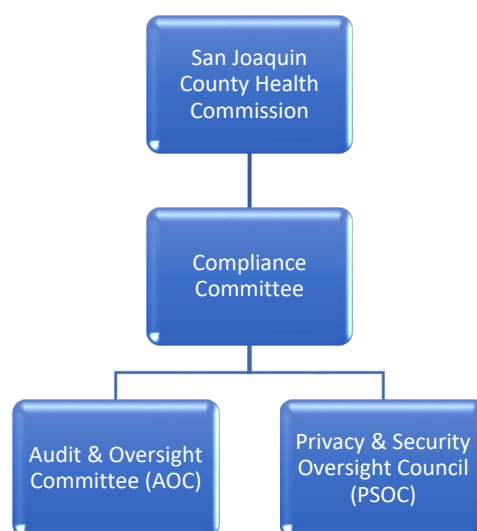
The Code of Conduct and Business Ethics ("Code of Conduct") describes the general principles that guide Health Plan business activities. The Code of Conduct is developed based on the laws, regulations, and other rules that apply to the Workforce. The Code of Conduct is approved by the Compliance Committee and Health Commission. The Commissioners, Workforce and Third-Parties are required to attest to the receipt of and review within thirty (30) calendar days of appointment, hire, execution of the contract and annually thereafter.

III. 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 CRACO, the Compliance Committee ("CC"), the Audit & Oversight Committee ("AOC"), and Executive Team.

A. Governing Body

San Joaquin County's Health Commission, as the Governing Body, is responsible for approving, implementing, and monitoring a Compliance Program governing the Health Plan's operations. The Commission delegates the Compliance Program oversight and day-to-day compliance activities to the CRACO. The CRACO, in conjunction with the CC, promotes understanding and adherence to the Health Plan's Compliance Program as well as the development and implementation of the Program. The Commission remains accountable for ensuring the effectiveness of the Compliance Program and compliance with contractual requirements, state and federal laws. The Compliance Program Plan is reviewed by the CC on an annual basis. The CC convenes at least quarterly to enable oversight activities, including but not limited to measures that prevent and detect, and correct fraud, waste and abuse, or other incidents of non-compliance. The reporting relationship between the Commission and CC including its staff-supported sub-committees are described below.



B. Designation of a Compliance Officer, Fraud Prevention Officer, Privacy Officer and Security Officer

Health Plan designates the Chief CRACO as both the Compliance Officer and Fraud Prevention Officer. The CRACO is responsible for developing, implementing, and ensuring compliance with contractual requirements, state and federal laws and the Health Plan's Fraud prevention program. The CRACO reports directly to the Chief Executive Officer ("CEO") with a dotted line to the Health Commission. The CRACO is an independent full-time employee vested in

the day-to-day operations of the compliance program and does not serve in an operational role. The CRACO is knowledgeable about the content and operation of the compliance program and exercises reasonable oversight with respect to the implementation and effectiveness of the compliance program. The CRACO has the authority to report matters directly to Commission at any time.

The CRACO is also the designated Privacy Officer and the Director, Technology Operations & Security is the designated Security Officer. They are both responsible for developing and managing the Health Plan's privacy and security policies, measures and activities pertaining to member's Protected Health Information (PHI), Personal Identifiable Information (PII), and confidential information whether they are electronic or hard copies. The Security Officer is also responsible for the ongoing management of information security policies, procedures, and technical systems to ensure the confidentiality, integrity, and availability of all electronic healthcare information systems are maintained. Both the Privacy and Security Officers shall do this in accordance with state and federal laws, contractual obligations and HIPAA regulations.

C. Compliance Committee

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

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

- Maintain and update the Code of Conduct consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the Commission;
- Maintain written notes, records, correspondence, or minutes of Compliance meetings reflecting reports made to the Compliance Committee and the decisions on issues raised;
- 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;

- 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;
- 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;
- 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;
- Determine the appropriate strategy and/or approach to promote compliance and detect potential violations and advise the Compliance Officer accordingly;
- Develop and maintain a reporting system to solicit, evaluate, and respond to Compliance-related complaints and problems;
- 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 Corrective Action Plans ("ICAPS") are implemented and monitored to avoid recurrence;
- Suggest and implement all appropriate and necessary actions to ensure all operations are in compliance with applicable laws, regulations, and contractual obligations; and
- Provide regular and ad-hoc status reports of compliance with recommendations to the Commission.

IV. Conducting Effective Training and Education

Health Plan requires and ensures the completion of training and education to the Commissioners, Workforce, and applicable Third Parties in compliance with federal and state requirements. These trainings are required within ninety (90) days upon appointment, hire, or commencement of contract and annually thereafter, completion is verified through a certification or attestation. Timely completion is a condition of continued appointment, employment, or contract. Third Parties are to complete required trainings through their own internal compliance program or by using training materials supplied by Health Plan.

Health Plan's Compliance Program delivers training to the Workforce through its Learning Management System ("LMS"). Workforce trainings and education include the overall Compliance Program, prevention of fraud, waste and abuse, privacy and security, and code of conduct in accordance with contractual

requirements, state and federal laws. Workforce members are educated on assisting Members with disabilities, chronic conditions, and components of health equity in compliance with DHCS and CMS contractual requirements.

Health Plan's management team are responsible for ensuring the Workforce receives training on P&Ps related to compliance with specific job functions through department level training materials and resources.

Health Plan's Compliance Department, in conjunction with the Provider Relations Department, ensures Network Providers and applicable Third Parties complete the required Initial and ongoing trainings with established timeframes in accordance with the DHCS and CMS contractual requirements. The Compliance Department ensures that records evidencing Commissioners, Workforce and Third Parties' completion of the training requirements are documented and maintained, such as sign-in sheets, attestations, or electronic certifications.

V. Lines of Communication and Reporting

A. General Compliance Communication

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. Health Plan utilizes various methods and forms to communicate how to report compliance concerns, general information, statutory or regulatory updates, process changes, updates to policies and procedures, contact information for the CRACO, relevant federal and state fraud alerts, policy letters, pending/new legislation reports, and advisory bulletins from CRACO to Health Plan Commissioners, Workforce, and Third Parties, including but not limited to: presentations, meeting updates, P&Ps, electronic mail, intranet website, Compliance intranet webpage, written reports to the Commission and Compliance Committee, and direct contact with the Compliance Officer. Health Plan also ensures communications and reporting mechanisms are meet state and federal accessibility requirements.

B. Reporting Mechanisms

Health Plan Commissioners, Workforce, and Third Parties have an affirmative duty and are directed in 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. (Third Parties also have contractual obligations to report FWA and Privacy incidents to Health Plan). As a result, 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, Commissioners, Members, Workforce, Third Parties, and 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 CRACO, or their designee, shall follow appropriate policies and procedures to promptly review, investigate, and resolve such matters. The CRACO 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.

1. Report Directly to Management or Executive Staff

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 suspecting 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 CRACO for further investigation and reporting to the CC. If an employee is concerned that their immediate supervisor did not adequately address their report or compliance complaints, the employee may go directly to the CRACO.

2. Call the Compliance and Ethics Hotline

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 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-compliant 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 Commissioner, Workforce, and Third Parties. Members also have access to the CRACO through the Compliance and Ethics Hotline.

3. Report online through Anonymous Reporting System

Health Plan maintains a confidential and anonymous 24/7 online reporting system available through both the external website and intranet website for Workforce, members, Commissioners, Workforce and Third Parties. Our Anonymous Reporting vendor collects the information electronically and forwards it to the CRACO. Every effort will be made to maintain confidentiality of the report to the extent permitted by law. Online reporting is available in English and Spanish, and 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 anonymous reporting system.

4. Report Directly to the Compliance Officer

The CRACO 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 CRACO may be contacted by telephone, written correspondence, email, or by a face-to-face appointment.

5. Report Directly to the Compliance Department

Reports may be made directly to The Health Plan's Compliance Department 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 of San Joaquin

ATTN: Compliance Officer

7751 S Manthey Rd

French Camp, CA 95231

6. Confidentiality and Non-Retaliation

Every effort will be made to keep reports confidential to the extent permitted by law¹, but there may be instances where the identity of the individual making the report will have to be disclosed. As a result, 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 Health Plan intranet and website, as well as sending periodic member notifications. Health Plan also takes violations of the non-retaliation policy seriously, and the CRACO will review and enforce disciplinary and/or other violations, as appropriate, with the approval of the CC.

VI. Conducting Internal Monitoring and Auditing

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 Third Parties compliance with applicable laws and regulations, and overall effectiveness of the Compliance Program. 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 CRACO and CC. The CRACO 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 CRACO or their designee to provide updates on monitoring and auditing results to the CC, CEO, Executive Team, and Commission.

A. Risk Assessment

The CRACO, or their designee, shall conduct a formal baseline assessment of Health Plan's major compliance and FWA risk areas through an annual risk assessment. The risk assessment shall consider all business operational areas, including Third Parties. 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 limited to:

- Size of department or operational area;

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)

- Complexity of work;
- Amount of training that has taken place;
- Past compliance issues; and
- 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, 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 annually. The CRACO 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:

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

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 work plan is overseen by the CRACO. The work plan includes a schedule that lists all the monitoring and auditing activities for the calendar year, organized by quarter. This annual workplan is developed and based on ad hoc and annual risk assessment results that identify and analyze risks associated with failure to comply with CMS and DHCS compliance and operational

performance standards. The work plan is reviewed and approved annually by AOC and presented to the CC, as well as the Commission.

C. Oversight of Third Party Activities

To ensure the terms and conditions of statutory and contractual obligations to CMS, DHCS, and DMHC are adhered to, Health Plan has a comprehensive Audit & Oversight Program to oversee, monitor and audit Third Parties. Health Plan Audit & Oversight Program Description describes all oversight activities in detail and methods and strategies used to evaluate and ensure compliance.

VII. Enforcing Standards through Well-Publicized Disciplinary Guidelines

Health Plan has well-publicized disciplinary guidelines within the policies. The Health Plan applies appropriate sanctions to Workforce members failing to comply with policies, state and federal regulations. The Health Plan educates and trains the Workforce and subcontractors to report suspected or actual non-compliance with applicable laws, regulations, and the Health Plan's P&Ps. The reporters are free from fear of retaliation for reporting violations or seek guidance related to suspected or actual non-compliance. Health Plan's Human Resources (HR) enforces disciplinary guidelines with the Workforce and maintains records of disciplinary actions in compliance with state and federal laws. Commissioners, Workforce and Third Parties may be disciplined or sanctioned as appropriate for failing to adhere to Health Plan's Compliance Program and/or violating standards, regulatory requirements, and/or applicable laws, including but not limited to:

- Conduct that leads to the filing of false or improper claim in violation of federal or state laws and/or contractual requirements;
- Conduct those 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;
- 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
- 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.

Health Plan maintains a "zero tolerance" policy towards any illegal, or unethical conduct that impacts the operation, mission, or image of 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. Commissioners may be subject to removal of appointment. Workforce is subject to disciplinary action up to and including termination. Third Parties 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.
- Health Plan Workforce shall be evaluated annually based on their compliance with Health Plan's Compliance Program. Where appropriate, The Health Plan shall promptly initiate education and training to correct identified problems, or behaviors.

VIII. Responding Promptly to Detected Offenses and Undertaking Corrective Action

Health Plan is dedicated to a culture that promotes compliance with the Compliance Program, which includes, but is not limited to, addressing issues of non-compliance. The Workforce, Third-Parties, members and public may report non-compliance using the various avenues as previously outlined. Such reports are promptly investigated and addressed.

Upon receipt of a report of non-compliance or suspected violations of Health Plan policies, the CRACO or his/her designee reviews and verifies the reported incident and regularly report to the CC, as appropriate. The CRACO or designee conduct a comprehensive investigation and provide recommended actions or next steps to correct or mitigate the violation. Credible Fraud, Waste and Abuse cases and Privacy/Security Incidents are also reported to both the DOJ and/or DHCS/DMHC, and Federal government when applicable, promptly per the contractual or regulatory filing requirements.

Health Plan shall undertake appropriate corrective actions in response to non-compliance or FWA (e.g., repayment of overpayments and disciplinary actions against responsible individuals). 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 CRACO 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 CC. Should any party fail to satisfactorily implement corrective actions as specified, Compliance shall enforce disciplinary action, including termination of employment or contract.

IX. Record Retention and Management

Health Plan retains contracts, books, documents, records, financial statements, and other data, as defined in Title 42, Code of Federal Regulations, Sections 438.5(c), 438.8(k), 438.604, 606, 608, and 610, for a minimum of ten (10) years from the final date of the Phaseout Period of the state or federal contract or from the date of completion of any audit, whichever is later, in accordance with 42 CFR sections 438.3(h) and (u) and 438.230(c), except for privileged documents which shall be retained until the issue raised in the documentation has been resolved, or longer if necessary.

In accordance with Health Plan policies, state and federal regulations, Health Plan maintains the documentation required by HIPAA for at least ten (10) years from the date of its creation or the final date of the Phaseout Period of the state or federal contract or from the date of completion of any audit, whichever is later. This includes the following: (i) Policies and Procedures (and changes thereto) designed to comply with the standards, implementation specifications or other designated requirements; (ii) writings, or electronic copies, of communications required by HIPAA; (iii) writings, or electronic copies, of actions, activities, or designations required to be documented under HIPAA; and (iv) documentation to meet its burden of proof related to identification of breaches under Title 45, Code of Federal Regulations, § 164.414(b).

The CC provides oversight and decision making for the Record Retention Management Plan ("RRMP") to ensure compliance with the Health Plan's policies, and state and federal regulatory guidelines, and will meet quarterly to review and, if necessary, update the RRMP to align with any changes to business practices and systems, or any new or amended laws or regulations. Any changes to the RRMP must be approved in writing by PIC. The PIU reviews the RRMP and any policies and procedures annually to ensure it follows regulatory requirements and reports to the CC regularly. Any changes will be distributed to relevant Workforce personnel.