KERN HEALTH SYSTEMS

GOVERNANCE AND COMPLIANCE COMMITTEE MEETING

Wednesday, January 24, 2024
at
9:00 a.m.

Kern Health Systems
2900 Buck Owens Blvd.
1st Floor – Board Room
Bakersfield, CA 93308

For more information, call (661) 664-5000

AGENDA

GOVERNANCE AND COMPLIANCE COMMITTEE MEETING

KERN HEALTH SYSTEMS
2900 Buck Owens Boulevard
Bakersfield, California 93308

Wednesday, January 24, 2024

9:00 A.M.

All agenda item supporting documentation is available for public review at Kern Health Systems in the Administration Department, 2900 Buck Owens Boulevard, Bakersfield, CA 93308 during regular business hours, 8:00 a.m. – 5:00 p.m., Monday through Friday, following the posting of the agenda. Any supporting documentation that relates to an agenda item for an open session of any regular meeting that is distributed after the agenda is posted and prior to the meeting will also be available for review at the same location.

PLEASE REMEMBER TO TURN OFF ALL CELL PHONES OR ELECTRONIC DEVICES DURING MEETING.

COMMITTEE TO RECONVENE

Members: Acharya, Hoffmann, Meave, Turnipseed
ROLL CALL:

CONSENT AGENDA/OPPORTUNITY FOR PUBLIC COMMENT: ALL ITEMS LISTED WITH A "CA" ARE CONSIDERED TO BE ROUTINE AND NON-CONTROVERSIAL BY KERN HEALTH SYSTEMS STAFF. THE "CA" REPRESENTS THE CONSENT AGENDA. CONSENT ITEMS WILL BE CONSIDERED FIRST AND MAY BE APPROVED BY ONE MOTION IF NO MEMBER OF THE COMMITTEE OR AUDIENCE WISHES TO COMMENT OR ASK QUESTIONS. IF COMMENT OR DISCUSSION IS DESIRED BY ANYONE, THE ITEM WILL BE REMOVED FROM THE CONSENT AGENDA AND WILL BE CONSIDERED IN LISTED SEQUENCE WITH AN OPPORTUNITY FOR ANY MEMBER OF THE PUBLIC TO ADDRESS THE COMMITTEE CONCERNING THE ITEM BEFORE ACTION IS TAKEN.

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

1) This portion of the meeting is reserved for persons to address the Committee on any matter not on this agenda but under the jurisdiction of the Committee. Committee members may respond briefly to statements made or questions posed. They may ask a question for clarification, make a referral to staff for factual information or request staff to report back to the Committee at a later meeting. Also, the Committee may take action to direct the staff to place a matter of business on a future agenda. SPEAKERS ARE LIMITED TO TWO MINUTES. PLEASE STATE AND SPELL YOUR NAME BEFORE MAKING YOUR PRESENTATION. THANK YOU!

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

2) On their own initiative, Committee members may make an announcement or a report on their own activities. They may ask a question for clarification, make a referral to staff or take action to have staff place a matter of business on a future agenda (Government Code Section 54954.2(a)(2))

3) Report on Governance and Compliance Committee Charter (Fiscal Impact: None) – RECEIVE AND FILE; REFER TO KHS BOARD OF DIRECTORS

4) Report on Officer Priorities and Program Shifts (Fiscal Impact: None) – RECEIVE AND FILE; REFER TO KHS BOARD OF DIRECTORS

5) Report on 2024 Compliance Program Description (Fiscal Impact: None) – RECEIVE AND FILE; REFER TO KHS BOARD OF DIRECTORS

6) Report on Final 2023 Compliance Work Plan Review and Proposed 2024 Work Plan Review (Fiscal Impact: None) –
RECEIVE AND FILE; REFER TO KHS BOARD OF DIRECTORS

ADJOURN

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

The meeting facilities at Kern Health Systems are accessible to persons with disabilities. Disabled individuals who need special assistance to attend or participate in a meeting of the KHS Finance Committee may request assistance at the Kern Health Systems office, 2900 Buck Owens Boulevard, Bakersfield, California 93308 or by calling (661) 664-5000. Every effort will be made to reasonably accommodate individuals with disabilities by making meeting material available in alternative formats. Requests for assistance should be made five (5) working days in advance of a meeting whenever possible.

Kern Health Systems Governance & Compliance Committee Charter

The Governance and Compliance Committee (Committee) has the fiduciary responsibility to oversee Kern Heath System's (KHS) regulatory Compliance Program and shall ensure the establishment and maintenance of an effective compliance and ethics program by assuring compliance activities are reasonably designed, implemented, and generally effective in preventing and detecting risks or compliance violations. Specifically, the Committee shall be primarily responsible for overseeing, monitoring and evaluating KHS's compliance with all regulatory (federal, state and local), as applicable and contractual obligations of KHS.

This Committee assists the Board to improve its functioning, structure, and infrastructure. The Committee reviews and makes recommendations regarding KHS's Bylaws and Governance Structure, including Board composition.

Among its authority and responsibilities, the Governance and Compliance Committee shall:

- Be knowledgeable about the content and operation of KHS's overall compliance program and collaborate on the development, review, evaluation, implementation and effectiveness of the Compliance program activities.

- Ensure KHS Board stays abreast of significant developments relating to the compliance expectations from federal and state legislators, regulators, and/or enforcement officials.

- Review and approve the policies and procedures impacting the Compliance Program. These polices provide guidance and promote KHS workforce members and affiliates awareness of, and compliance with, all applicable laws, regulations, guidance, and contractual obligations.

- Receive, review, and act upon reports and recommendations from the Compliance Officer, subcommittees, and work groups regarding compliance and/or ethics issues generated through internal and external audits, monitoring, and individual reporting or referrals. As such, overseeing implementation and adherence with corrective actions.

- Assist the Compliance Officer by participating in discussions aimed at identifying, prioritizing, mitigating and remediating organizational risk related to compliance and regulatory requirements. This may include but is not limited to reviewing the effectiveness of open lines of communication between staff and compliance leadership; assuring disciplinary guidelines are well publicized; and ensuring the compliance programs acts independently from operational programs.

- Review the Fraud Prevention program on an annual basis and approve

quarterly reporting.

- Receives the Delegation Reporting Compliance Plan and reviews the delegation audits and outcomes of monitoring during the applicable time period.

- Biannually review and approve trainings for Network Providers and KHS staff which may include, but is not limited to, HIPAA; Fraud, Waste, and Abuse; Provider Trainings mandated by DHCS; and Diversity, Equity, and Inclusion.

- Annually review and approve KHS's Code of Conduct and Compliance Plan.

- Annually review KHS Bylaws and recommend necessary changes to the KHS Board.

- Regularly review KHS Board membership to monitor participation in governance and diverse representation of the communities we serve.

- Annually review Board Committees' membership to encourage participation from KHS's Board members and other stakeholders as appropriate.

- Annually review of KHS Board Committee charters.

- Perform other functions as reasonably necessary to assist the Compliance Officer in fulfilling the intent and purpose of the Compliance Program.

GOVERNANCE, STRUCTURE AND ORGANIZATION
The Chair of the Governance and Compliance Committee shall be a member of the KHS Board of Directors. The Chair, in consultation with other members of the Committee, will determine the frequency and duration of the meetings of the Committee and the agenda of items to be addressed at each meeting. This Committee shall meet no less than four (4) times a year.

This Committee shall have no less than four (4) members from the Board of Directors, with board member representation from different districts.

KHS Governance & Compliance Committee Standing Staff Invites

- Chief Compliance and Fraud Prevention Officer
- Chief Executive Officer
- Chief Operating Officer (optional)
- Chief Information Officer (optional)

- Chief Financial Officer (optional)
- Chief Medical Officer (optional)
- Chief Health Equity Officer (optional)
- Executive Services Coordinator


Legal & Compliance Risk Management
Compliance Program Management
Gartner Priorities Navigator™
for Chief Compliance Officers
2023
Compliance Function Strategy, Structure & Metrics
Identify and measure department goals, and allocate resources effectively
Code & Policy Management
Create a compelling and comprehensive code of conduct and set of policies
Compliance Training & Communications
Create tailored and engaging compliance training and communications
Compliance Risk Response Strategies
Identify and mitigate key compliance risks
Third-Party Risk Management
Manage and monitor the compliance risks of the organization's extended enterprise
Risk Identification & Assessment
Assess and prioritize compliance risks
Risk Mitigation & Monitoring
Create risk mitigation plans and develop key risk indicators
Risk Reporting & Coordination
Develop risk reporting dashboards to communicate key issues
Risk Coordination
Align with other assurance functions to avoid gaps, overlaps and other inefficiencies in risk coverage to present one consistent view of the risk landscape
Enterprise Risk Management
Emerging Technologies & Vendors
Identify and evaluate new technologies that support compliance department effectiveness
Technology Roadmaps & Planning
Build a roadmap for investment in technology and ensure proper implementation
L&C Technology Planning & Strategy
Privacy Risk Mitigation Strategies
Uncover potential privacy risks within your business, and create strategies to monitor and mitigate them
Privacy Strategy, Structure & Metrics
Build an effective privacy program to appropriately spot and manage privacy-related risks
Allegations Reporting & Investigations
Set up an effective reporting and investigations process
Culture of Compliance & Ethics
Establish a strong culture of integrity and reduce misconduct
Corporate Ethics and Integrity
Information Governance & Management
Create, maintain, and enforce standards and processes to govern information collection, use, sharing, and retention to mitigate privacy risk
Privacy Program Management
Gartner
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10 key program shifts to make by 2030

There are 10 shifts compliance leaders must make to program elements to adopt data-driven risk management and personal compliance touchpoints.

Data-Driven Risk Management

1. Risk assessment and monitoring

From **High-Level**
To **Granular**

2. Policy management

From **One-Size-Fits-All**
To **Tailored**

3. Third-party management

From **Manual**
To **Shared**

4. Program improvement, testing and review

From **Intermittent**
To **Continuous**

5. Analysis and remediation of underlying misconduct

From **Backward-Looking**
To **Predictive**

Personalized Touchpoints

6. Speak-up culture and reporting structure

From **Company-Centric**
To **Employee-Centric**

7. Training and communications

From **Burdensome**
To **Embedded**

8. Compliance staff and liaisons

From **Central**
To **Local**

9. Compensation structures and consequence management

From **Narrow**
To **Companywide**

10. Investigation of misconduct

From **Process-Oriented**
To **Trust-Oriented**

Kern Family Health Care™

Kern Health Systems

2900 Buck Owens Blvd
Bakersfield CA 93308
661/664-5000

2024 CORPORATE COMPLIANCE PROGRAM

Table of Contents

COMPLIANCE PROGRAM

Executive Summary

Why Have a Compliance Program

Kern Health System's Compliance Program is necessary because it:

- Stops fraud.
- Protects patient privacy.
- Nurtures an ethical culture.
- Prevents conflicts of interest.
- Ensures proper credentialing.
- Identifies and prevents waste.
- Furthers accurate billing and coding.
- Assists in obeying state and federal laws.
- Maintains and promotes high quality care; and
- Strives to promote the use of best practices in management and board governance.

Kern Health System Health's Compliance Program applies to:

- Vendors
- Contractors
- Consultants
- All staff no matter the title or position
- Board of Directors

What you must do:

- Act fairly.
- Act ethically.
- Act honestly.
- Act as a team.
- Report a conflict of interest that you may have.
- Treat patients and one another with respect at all times.
- Identify ways to do things better in your department and act; and
- Report problems immediately to your supervisor, directly to the Compliance Director and/or the Chief Compliance and Fraud Prevention Officer or take advantage of our anonymous compliance hotline options.

COMPLIANCE PROGRAM

I. INTRODUCTION

Kern Health System (KHS) d.b.a. Kern Family Health Care (KFHC) is the Local Initiative for the arrangement of medical, social, and behavioral health care for Medi-Cal enrollees in Kern County. KHS is a public agency formed under Section 14087.38 of the California Welfare and Institutions Code. KHS began full operations on September 1, 1996, under the Kern County Board of Supervisors. KHS serves more than 365,000 Medi-Cal participants in Kern County. Medi-Cal is a jointly funded, Federal-State health insurance program for certain low-income beneficiaries. KHS is committed to the mission of improving the health of members with an emphasis on prevention and access to quality healthcare services. KHS strives to be a leader in developing innovative partnerships with the safety net and community providers to elevate the health status of all community members. with a commitment to health equity, diversity, and inclusion. We are strongly committed to and have a longstanding reputation for lawful and ethical conduct. We take pride in earning the trust of those we serve, government regulators and one another.

The Department of Health Care Services (DHCS), Department of Managed Health Care, and Knox Keene License, requires organizations that participate as California Med-Cal plan, to have a formal compliance program. The Unites States Department of Health and Human Services, Office of the Inspector General (OIG) requires Medi-Cal providers to have a compliance program as well. Additionally, in response to the many laws, rules and regulations governing healthcare, e.g., federal and state false claims and whistleblower laws, KHS has established a comprehensive compliance program to help the organization achieve our commitment to adhere to the highest ethical standards of conduct in all business practices.

One goal of KHS's compliance program is to prevent fraud, waste, and abuse while at the same time advancing the mission of providing affordable and extraordinary primary and specialty care. Our compliance efforts are aimed at prevention, detection, and resolution of variances.

The eight elements of the KHS's Compliance Plan are:

1. Designation of a Compliance Officer/Committee
2. Written policies and procedures, including Standards of Conduct
3. Training and education programs
4. Open lines of communication to the responsible compliance position
5. Disciplinary enforcement policies/standards to encourage good faith participation

6. A system for routine identification of compliance risk areas and responding to issues identified

~~7. A system for responding to compliance issues~~

~~8.~~7. A policy of non-intimidation and non-retaliation for good faith participation in the compliance program

Our Compliance Program further supports KHS' overall commitment to ensure we have the organizational capacity, leadership, financial well-being, commitment to invest in our communities, and demonstrated ability to ensure program integrity and compliance with all applicable federal and state requirements and the standards under the DHCS Contract.

II. COMPLIANCE STRUCTURE

KHS's compliance program starts with its Board of Directors, who must assure the organization operates in compliance with applicable Federal, state, and local laws and regulations. The Board of Directors provide direction to our CEO, who sets the tone for the organization's compliance activities.

The Chief Compliance and Fraud Prevention Officer works to ensure the organization has the appropriate policies, procedures, and processes in place to minimize its risk and further the organization's mission to provide a holistic approach to services offerings while promoting equitable and timely access. In addition to the Chief Compliance and Fraud Prevention Officer, the Compliance Team consists of the Director of Compliance, a Compliance Manager, a Compliance Manager of Audits and Investigations, Compliance Analyst(s), Compliance Auditor, and Compliance Specialist. On a quarterly basis, the Chief Compliance and Fraud Prevention Officer and the Director of Compliance meet with the Compliance Committee and provide updates on the department's current and future activities.

KHS recognizes the importance of fostering a culture of compliance. As a result, KHS maintains and supports a Compliance ~~Organizational~~ organizational ~~Structure~~ structure that allows the Compliance Program to act independently of operational and program areas without fear of repercussions for uncovering deficiencies or areas of noncompliance.

How KHS's Compliance Program Aligns to OIG Standards

Eight Steps of Compliance							
Written Policies and Procedures	**Designation of a Compliance Officer/ Committee**	**Training and Education Programs**	**Open Lines of Communication**	**Disciplinary policies to encourage good faith participation**	**A system for routine identification of compliance risk areas**	**A system for responding to compliance issues**	**A policy of non-intimidation and non-retaliation**
• Fraud, Waste & Abuse, Anti-Kickback Statute, False Claims Act and Stark Law policies • Whistle Blower/ Non-retaliation policy • Clinical policies • HIPAA • Conflict of Interest • Exclusion screening	• Compliance Officer job description • Compliance Committee Chair • Oversight responsibility of the Program • Prepare an Annual Compliance Report	• Annual compliance training • Compliance on-boarding training • Monthly Spotlight • Department training events • Training at periodic all Staff meetings • Ad Hoc training informs and train on recent events	• Open door policy • Compliance Hotline: allows individuals to report perceived compliance issues anonymously either online, through email, fax or mail	• All members of organization are required to comply with applicable standards, laws, and procedures. • Supervisors and/or Managers are account-able for the foreseeable compliance failures of their subordinates	• Annual identification of top risks • Ongoing audit and monitoring activities • Ad hoc audits • Monthly exclusion screening • Maintain anonymous outside Hotline. • Annual risk assessment • Credentialing and peer review	• Internal investigations and reporting • Review of an Annual Conflict of Interest Disclosure Forms • Process for reporting and resolving incidents	• Whistleblower/ non-retaliation policy

III. WRITTEN POLICIES AND PROCEDURES

The written compliance policies and procedures provide a clear explanation of the organization's compliance and quality goals and provide clear and understandable mechanisms and procedures designed to achieve those goals in compliance with Federal, state, and other program requirements and standards. The organization has specific, individual policies for an array of matters ranging from proper documentation of services to whistle blower protections. In addition, the Compliance Policies describe how we implement and operationalize the Compliance Program. KHS' policies and procedures are available online at the KHS's company site.

A. Code of Conduct

The KHS Code of Conduct is a foundational statement of our governing principles and clearly articulates KHS' commitment to comply with all applicable regulatory requirements, including the DHCS contract, and all applicable state and federal laws. The Code of Conduct describes KHS expectation that all employees act ethically and have a responsibility for ensuring compliance. The full Board of Directors will approve the Code of Conduct. The Code of Conduct is part of the training provided upon hire and annually thereafter. It is also reviewed during the New Hire Orientation and available on the KHS Intranet.

B. Conflict of Interest Policy and Disclosure Statement

KHS is required to ensure that it adheres to the highest standards of ethical conduct by identifying instances which an independent observer might reasonably conclude that the potential for individual or institutional conflict could influence decision making or carrying out responsibilities. KHS has a ~~conflict of interest~~conflict-of-interest policy that is based upon full disclosure and appropriate management of any possible conflict of interest. The policy requires staff to conduct their business according to the highest ethical standards of conduct and to comply with all applicable laws.

KHS requires individuals to complete the annual conflict of interest disclosure form to assist in identifying and evaluating potential conflicts of interests. Individuals also are required to disclose any actual, potential, or perceived conflicts as they arise during their affiliation or employment with KHS. The forms are reviewed on an annual basis or when the need to complete the statement arises (new hires or changed circumstances). It is the responsibility of everyone to have a working knowledge of these policies and procedures and refer to them.

KHS does not utilize any state officer, employee in state civil service, other appointed state official, or intermittent state employee, or contracting consultant for DHCS, unless the employment, activity, or enterprise is required as a condition of the officer's or employee's regular state employment.

C. Other Written Policies and Procedures

Annual Work Plan

Every year, the Chief Compliance and Fraud Prevention Officer will prepare a Work Plan after reviewing the latest Department of Health Care Services (DHCS) and Department of Managed Care (DMHC) priorities, recent enforcement activities, recent internal and external audit findings and other relevant topics that necessitate additional scrutiny. Additionally, the Chief Compliance and Fraud Prevention Officer will obtain input from the Chief Executive Officer, the Director of Compliance, the Compliance Committee, and various departments.

Additionally, the Work Plan includes a list of areas that the Compliance Department will audit and monitor. The Compliance Department may add additional monitoring audits to its duties in response to new and emerging risks. The Compliance Department and audited departments will review the audit findings and develop audit responses to address findings. The parties will develop remediation plans and associated timelines. The Compliance Department will conduct follow-up on remediation activities and report progress to the Chief Executive Officer and the Chief Compliance and Fraud Prevention Officer. Additionally, the Compliance Department will coordinate external audits from state and other regulatory oversight organizations.

D. Ad Hoc Policy and Procedure Development

From time to time, the Compliance Department will work with other departments to develop and revise policies and procedures to reflect new legal requirements and new concerns that may arise.

IV. DESIGNATION OF A COMPLIANCE OFFICER AND/OR A COMPLIANCE COMMITTEE

DHCS requires KHS to designate a compliance officer to carry out and enforce compliance activities. The compliance officer functions as an independent and objective person that reviews and evaluates organizational compliance and privacy/confidentiality issues and concerns. The compliance officer's main duties include coordination and communication of the compliance plan; this involves planning, implementing, and monitoring the program. The Chief Compliance and Fraud Prevention Officer is a full-time employee, reporting directly to the Chief Executive Officer (CEO) and the Board of Directors. The CCO reports to the Compliance Committee on the activities and status of the Compliance Program and has the authority to report matters directly to the Board of Directors at any time. The Chief Compliance Officer is an independent employee of KHS and does not serve in any operational capacity.

COMPLIANCE PROGRAM

A. Chief Compliance Officer

The responsibilities of the Chief Compliance Officer include:

- ~~developing~~Developing, implementing, and ensuring compliance with the requirements and standards under the DHCS contract.
- Chair the Compliance Committee and serve as a spokesperson for the Committee.
- Oversee and monitor the implementation of the compliance program.
- Report periodically to the Compliance Committee, the Chief Executive Officer, and the Board of Directors on the progress of implementation of compliance initiatives, corrective actions, and recommendations to reduce the vulnerability to allegations of fraud, waste, and abuse.
- Develop and distribute all written compliance policies and procedures to all affected employees.
- Periodically revise the program in light of changes in the needs of the organization and in the law, and changes in policies and procedures of government payer health plans and emerging threats.
- Develop, coordinate, and participate in a multifaceted educational and training program that focuses on the elements of the compliance program and seeks to ensure that all employees are knowledgeable of, and comply with, pertinent federal and state payer standards.
- Ensure that employees, vendors, and Board of Directors do not appear on any of the Federal or State “excluded, debarred or suspended” listings published by Medicare and Medicaid.
- Ensure that all Providers/Staff are informed of compliance program standards with respect to coding, billing, documentation, and marketing, etc.
- Assist in coordinating internal compliance review and monitoring activities, including annual or whenever necessary reviews of policies.
- Review the results of compliance audits, including internal reviews of compliance, independent reviews, and external compliance audits.
- Independently investigate and act on matters related to compliance, including the flexibility to design and coordinate internal investigations.
- Develop policies and programs that encourage managers and employees to report suspected fraud and other improprieties without fear of retaliation. (See Whistleblower Policy)
- Interact with external legal counsel to discuss the Organization’s initiatives on regulatory compliance.
- Handle inquiries by employees, affiliates, members, and family members regarding compliance issues.

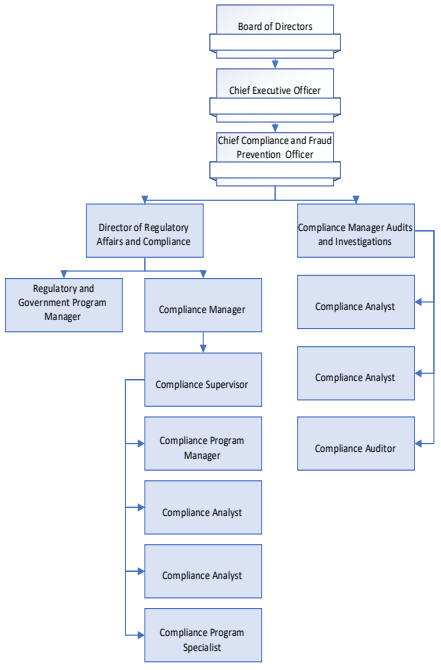
The Chief Compliance and Fraud Prevention Officer has the authority to review all documents and other information relative to compliance activities, including, but not limited to Human Resources/Personnel records, requisition forms, billing

information, claims information, and records concerning marketing efforts and arrangements with vendors.

B. Compliance Department Organizational Structure

The Chief Compliance and Fraud Prevention Officer supervises the Director of Compliance. The Director of Compliance and Regulatory Affairs supervises the Compliance Manager. The Compliance Manager oversees the Compliance Program Manager, Compliance Analyst(s), Compliance Auditor, and compliance Specialist, and other positions which may be added based on the department's identified operational needs.

Because the Chief Compliance and Fraud Prevention Officer is responsible for compliance oversight for all other departments of the organization, this position reports directly to the Chief Executive Officer to mitigate risk.



Field Code Changed

C. Compliance Committee

KHS has established a regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the Compliance Program and compliance with the state and federal requirements, and the DHCS contract. The Compliance Committee will advise the Chief Compliance and Fraud Prevention Officer and assist in the implementation of the compliance program as needed. The Compliance Committee will consist of at least the Executive Officers and Departmental leadership. The Chief Compliance and Fraud Prevention Officer will also select designees representing other departments as needed.

The functions of the Compliance Committee are to:

- Analyze the organization's regulatory environment, the legal requirements with which it must comply, and specific risk areas.
- Assess existing policies and procedures that address risk areas for possible incorporation into the Compliance Program.
- Work within the organization's standards of conduct, policies, and procedures to promote compliance.
- Recommend and monitor the development of internal systems and controls to implement standards, policies, and procedures as part of the daily operations.
- Determine the appropriate strategy/approach to promote compliance with the program and detection of any potential problems or violations.
- Develop a system to solicit, evaluate, and respond to complaints and problems.
- Monitor Corrective Action Plans
- Review and approve the Compliance Program at least ~~biennually~~annually.

D. Governance and Compliance Committee

Newly created in 2024, The Governance and Compliance Committee has the fiduciary responsibility to oversee the KHS regulatory Compliance Program to ensure an effective and ethical program through its design, implementation, and monitoring in the prevention and detection of risks or compliance violations. Specifically, for evaluating KHS's compliance with all regulatory (federal, state, and local) as applicable and contractual obligations for all internal and delegated activities.

This Committee assists the Board to improve its functioning, structure, and infrastructure. The Committee reviews and makes recommendations regarding

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KHS's Bylaws and Governance Structure, including committee composition, auditing and investigative practices.

V. CONDUCTING EFFECTIVE TRAINING AND EDUCATION

An effective Compliance Program is rooted in an active and adaptive education and training program. Active education and training are designed to teach each individual how to carry out their responsibilities effectively, efficiently and in compliance with statutory and regulatory compliance requirements. Adaptive education and training are designed to be responsive to the educational needs of the organization's workforce identified through internal and/or external reviews, audits, or compliance assessments or by government notices, alerts, and/or other advisory statements. KHS has established a system for training and educating the compliance officer, senior management, and employees on federal and State standards and requirements of the DHCS contract.

KHS utilizes a variety of training methods including but not limited to web-based training courses and in-person training. Compliance trainings must be verified such as through a certification or attestation upon training completion and review of the standard of conduct, compliance program, and compliance policies and procedures.

Inadequate training significantly increases the risks of compliance issues and possible violations of the applicable statutes and regulations. KHS requires all employees, contractors, and volunteers to attend specific training upon hire and on an annual and as needed basis thereafter. This will include training in federal and state statutes, regulations, program requirements, policies, code of conduct and corporate ethics. The training emphasizes KHS's commitment to compliance with these legal requirements and policies.

The training programs will include sessions highlighting KHS's Compliance Program, summaries of fraud and abuse laws, HIPAA regulations, policy and procedures that reflect current legal and program standards.

The Chief Compliance and Fraud Prevention Officer or other designated staff member will document the attendees, the subjects covered, and any materials distributed at the training sessions.

Basic training will include:

- Overview of the organization's regulatory environment
- Examples of fraud, waste, and abuse.
- Recent enforcement activities
- KHS's compliance structure
- Eight elements of compliance
- Location of compliance plan and policies and procedures on the KHS's SharePoint site and company website

- Key laws and regulations
- KHS's commitment to non-retaliation
- Compliance hotline information for making anonymous complaints
- Duty to report misconduct.

The Compliance Program will be posted to the KHS Intranet and website.

VI. DEVELOPING EFFECTIVE AND OPEN LINES OF COMMUNICATION

A. Open Lines of Communication

Open lines of communication encourage everyone to express their compliance, quality, and other concerns and/or suggestions for improvement without fear of retaliation. Open communication is essential to maintaining an effective Compliance Program and enables the organization to learn about issues that may arise, generating faster responses and quicker fixes. Additionally, open communications allow KHS to address small problems before they become big ones.

Any potential problem or questionable practice which is, or is reasonably likely to be, in violation of, or inconsistent with, federal or state laws, rules, regulations, or directives or the organization rules or policies relative to the delivery of healthcare services, or the billing and collection of revenue derived from such services, and any associated requirements regarding documentation, coding, supervision, and other professional or business practices must be reported to the Chief Compliance and Fraud Prevention Officer.

Any person who has reason to believe that a potential problem or questionable practice is or may be in existence should report the circumstance to the Chief Compliance and Fraud Prevention Officer. Such reports may be made verbally or in writing and may be made on an anonymous basis. KHS utilizes an external vendor, Ethics Point, so that employees may anonymously report violations though the following mediums:

Online:	www.kernfamilyhealthcare.com FraudTeam@khs-net.com HIPAATeam@khs-net.com Compliance@khs-net.com
Phone:	Ethics Hotline 1 (833) 607-6589
Mail:	Kern Health System Health c/o Chief Compliance and Fraud Prevention Officer, 2900 Buck Owens Blvd, Bakersfield CA 93308.

The Chief Compliance and Fraud Prevention Officer or designee will promptly document and investigate reported matters that suggest substantial violations of policies, regulations, statutes, or program requirements to determine their veracity.

The Chief Compliance and Fraud Prevention Officer will work closely with legal counsel who can provide guidance regarding complex legal and management issues.

B. Exit Interviews

VII. DISCIPLINARY GUIDELINES

All employees of KHS will be held accountable for failing to comply with applicable standards, laws, and procedures. Directors, Manages, and/or Supervisors will be held accountable for the foreseeable compliance failures of their subordinates.

The Director, Manager, or Supervisor will be responsible for taking appropriate disciplinary actions in the event an employee fails to comply with applicable regulations or policies. The disciplinary process for violations of compliance programs will be administered according to KHS protocols (generally oral warning, written warning, suspension without pay, and may lead to termination) depending upon the seriousness of the violation. The Chief Compliance and Fraud Prevention Officer is to be consulted and may consult legal counsel in determining the seriousness of the violation. However, the Chief Compliance and Fraud Prevention Officer should never be involved in imposing discipline.

If the deviation occurred due to legitimate, explainable reasons, the Chief Compliance and Fraud Prevention Officer and director/manager/supervisor may want to limit disciplinary action or take no action. If the deviation occurred because of improper procedures, misunderstanding of rules, including systemic problems, KHS should take immediate action to correct the problem.

When disciplinary action is warranted, it should be prompt and imposed according to written standards of disciplinary action established and defined within the Human Resources Personnel Manual.

Within thirty (30) working days after receipt of an investigative report, the Director/Manager/Supervisor and/or Chief Human Resources Officer or their designee shall determine the action to be taken upon the matter and refer to the CEO for final recommendations. The action may include, without limitation, one or more of the following:

1) Dismissal of the matter.
2) Verbal counseling.

3) Issuing a warning, a letter of admonition, or a letter of reprimand.
4) Entering and monitoring of a formal corrective action plan. The corrective action plan may include requirements for individual or group remedial education and training, consultation, proctoring, and/or concurrent review.
5) Reduction, suspension, or revocation of clinical/assigned privileges.
6) Suspension or termination of employment.
7) Modification of assigned duties.
8) Reduction in the amount of salary compensation in parallel with demotion.

The CEO shall have the authority to, at any time, suspend summarily the involved employee or contractor's privileges or to summarily impose consultation, concurrent review, proctoring, or other conditions or restrictions on the assigned duties of the involved party in order to reduce the substantial likelihood of violation of standards of conduct.

VIII. AUDITING AND MONITORING

The Chief Compliance and Fraud Prevention Officer will conduct ongoing evaluations of compliance processes involving thorough monitoring and regular reporting to the KHS Executive leadership/officers.

The Chief Compliance and Fraud Prevention Officer will develop an annual audit plan that is designed to address KHS's key compliance risks, including but not limited to the Department of Health Care Services contract and the Department of Managed Care Knox-Keen license requirements. The audit work program steps will inquire into compliance with specific rules and policies that have been the focus of Medi-Cal regulatory agencies.

The Chief Compliance and Fraud Prevention Officer should be aware of patterns and trends in deviations identified by the audit that may indicate a systemic problem.

IX. RESPONDING TO DETECTED OFFENSES AND DEVELOPING CORRECTIVE ACTION INITIATIVES

Violations of the organization's compliance program, failure to comply with applicable state or federal law, and other requirements of government health plans, and other types of misconduct may threaten KHS's status as a reliable, honest, and trustworthy provider, capable of participating in federal and state healthcare programs. Detected, but uncorrected, misconduct may seriously endanger the mission, reputation, and legal status of the organization. Consequently, upon reports or reasonable indications of suspected noncompliance, the Chief Compliance and Fraud Prevention Officer must initiate an investigation to

determine whether a material violation of applicable laws or requirements has occurred.

The steps in the internal investigation may include interviews and a review of relevant documentation. Records of the investigation should contain documentation of the alleged violation, a description of the investigative process, copies of interview notes and key documents, a log of witnesses interviewed, and the documents reviewed, results of the investigation, and the corrective actions implemented.

Additionally, the Chief Compliance and Fraud Prevention Officer must take appropriate steps to secure or prevent the destruction of documents or other evidence relevant to the investigation.

If the results of the internal investigation identify a problem, the response may be immediate referral to criminal and/or civil law enforcement authorities, development of a corrective action plan, a report to the government, and submission of any overpayments, if applicable. If potential fraud or violations of the False Claims Act are involved, the Chief Compliance and Fraud Prevention Officer should report the potential violation to the Office of the Inspector General or the Department of Justice.

The CEO shall have the authority and responsibility to direct repayment to payers and the reporting of misconduct to enforcement authorities as is determined, in consultation with legal counsel, to be appropriate or required by applicable laws and rules.

If the CEO discovers credible evidence of misconduct and has reason to believe that the misconduct may violate criminal, civil, or administrative law, then the Chief Compliance and Fraud Prevention Officer will promptly report the matter to the appropriate government authority within the required timeframe after determining that there is credible evidence of a violation.

When reporting misconduct to the government, the Chief Compliance and Fraud Prevention Officer should provide all evidence relevant to the potential violation of applicable federal or state laws and the potential cost impact.

X. NON-INTIMIDATION AND NON-RETALIATION POLICIES

The organization will protect whistle-blowers from retaliation. KHS will not retaliate against employees who, in good faith, have raised a complaint against some practice of the organization, or of another individual or entity with whom KHS has a business relationship, on the basis of a reasonable belief that the practice is in violation of law, or a clear mandate of public policy.

Staff, vendors, interns, contractors, and Board Members are obligated to report to the Chief Compliance and Fraud Prevention Officer any activity he or she believes to be inconsistent with KHS's policies or state and federal law. KHS has a Whistleblower policy which is intended to encourage and enable employees and others to raise serious concerns within the organization, prior to seeking resolution outside of the organization. The policy protects employees who in good faith reports an ethics violation from harassment, retaliation, or adverse employment consequence. Any employee who retaliates against someone who has reported a violation in good faith is subject to discipline up to and including termination of employment.

Reports of violations or suspected violations will be kept confidential to the extent possible, consistent with the need to conduct an adequate investigation. The Chief Compliance and Fraud Prevention Officer will notify the sender and acknowledge receipt of the reported violation or suspected violation within the required timeframes. All reports will be promptly investigated, and appropriate corrective action will be taken if warranted by the investigation.

XI. KERN HEALTH SYSTEM'S COMMITMENT TO COMPLIANCE

A. Standards of Conduct

KHS's employees are bound to comply, in all official acts and duties, with all applicable laws, rules, regulations, standards of conduct, including, but not limited to laws, rules, regulations, and directives of the federal government and the state of California, including KHS's rules, policies, and procedures. These current and future standards of conduct are incorporated by reference in this Compliance ~~Plan~~Program.

All candidates for employment shall undergo a reasonable and prudent background investigation, including a reference and criminal background check. Due diligence will be used in the recruitment and hiring process to prevent the appointment to positions with substantial discretionary authority, persons whose record (professional licensure, credentials, prior employment, criminal record or specific "exclusion" from Medi-Cal funded programs) gives reasonable cause to believe the individual has a propensity to fail to adhere to applicable standards of conduct.

All new employees will receive orientation and training in compliance policies and procedures. Participation in required training is a condition of employment. Failure to participate in required training may result in disciplinary actions, up to and including, termination of employment.

Every employee is asked to attest that they have received, read, and understood the contents of the compliance plan.

COMPLIANCE PROGRAM

Every employee will receive an initial compliance orientation and periodic training updates in compliance protocols as they relate to the employee's individual duties.

Non-compliance with the plan or violations will result in sanctioning of the involved employee(s) up to, and including, termination of employment.

B. Member Rights

We treat our members with respect and dignity and provide care that is both necessary and appropriate. No distinction is made in the admission, transfer, discharge, or care of individuals on the basis of race, creed, religion, national origin, gender, gender expression, sexual orientation, or disability. Clinical care is provided based on identified healthcare needs and Care Management is provided based on needs identified through a uniform assessment tool, and no treatment or action is undertaken without the informed consent of the patient or an authorized representative. Members are provided with a written statement of rights which conforms to all applicable laws, and ensure their autonomy and privacy are respected.

Employees involved in member's care are expected to know and comply with all applicable laws and regulations and our policies and procedures governing their particular program.

C. Personal Health Information/HIPAA

KHS collects and aggregates personal health information about our members to provide the best possible care. We realize the sensitive nature of this information and are committed to safeguarding our member's privacy.

The Chief Compliance and Fraud Prevention Officer is responsible for development and implementation of policies, procedures and educational programs that will ensure that KHS will continue to be compliant with the Privacy regulations and will also ensure that protected health information is secure.

To ensure that confidentiality is maintained, employees and their representatives must adhere to the following rules:

- Do not discuss protected health information (PHI)/ client information in public areas such as elevators, hallways, common gathering areas.
- Limit release of PHI/client information to the minimum reasonably necessary for the purpose of the disclosure.
- Do not disclose PHI without an appropriate consent signed by the member unless it is related to the person's care, payment of care, or health care operations of the organization. In an emergency, a member's consent may

not be required when a healthcare provider treating the patient requests information, but the name and affiliation of the person requesting the information must be confirmed and documented in the medical record.
- Honor any restrictions on uses or disclosure of information placed by the member.
- Make sure PHI/member information stored in the computer system is properly secured.
- Be familiar with and comply with special confidentiality rules governing the disclosure of sensitive health care conditions, alcohol and substance abuse and behavioral/mental health treatment.

KHS maintains a Chief Information Officer who is responsible for the development and implementation of the policies and procedures required by the Security Rule.

The Chief Information Officer is responsible for ensuring Kern Health System engages in the following activities:

- Maintain appropriate security measures to ensure the confidentiality, integrity, and availability of patients' electronic protected health information (EPHI).
- Adhere to applicable federal and state security laws and standards.
- Provide security training and orientation to all employees, volunteers, medical and professional staff.
- Comply with Security Policies including periodic risk assessments.
- Monitor access controls to EPHI to ensure appropriate access to authorized personnel.
- Maintain hardware and software with the appropriate patches and updates.
- Maintain a validation of compliance with the Data Security Standards, a set of security controls that businesses are required to implement to protect data.

D. Medical Necessity

KHS will take reasonable measures to ensure that only claims for services that are reasonable and necessary, given the member's condition/ client's needs are billed.

Documentation will support the determinations of medical necessity/member need when providing services.

KHS is aware that DHCS will only pay for services that meet the coverage criteria and are reasonable and necessary to treat or diagnose a suspected condition. Therefore, KHS's Providers will use prudent ordering practices.

In requesting diagnostic procedures or tests, KHS's Providers will make an independent medical necessity decision with regard a treatment plan. Documentation of findings and diagnoses will support the medical necessity of the service.

KHS's Providers understand that there may be limitations on services; therefore, the prior authorization process will be followed.

E. Billing

All claims for services submitted will correctly identify the services ordered.
Only those services that are performed and that meet payer criteria will be billed.

Intentionally or knowingly up coding (the selection of a code to maximize reimbursement when such code is not the most appropriate descriptor of the service offered) may result in disciplinary. KHS's providers must provide documentation to support services provided and billed based on clinical and behavioral findings and diagnoses.

Immediate disciplinary action, up to and including termination will be implemented for instances of intentional misrepresentation of any service if results in over billing.

All individuals who provide billing information and billing department employees who prepare or submit billing statements must comply with all applicable laws, rules and regulations and the organization's policies.

KHS will promptly return to payers any payments which we determine do not conform to our policies and applicable laws.

As healthcare providers, KHS's business involves reimbursement under government programs which require submission of certain reports of our costs of operations. KHS complies with all federal and state laws and regulations relating to cost reports, which define what costs are allowable and describe the appropriate methodologies to claim reimbursement for the cost of services provided to program beneficiaries. Given the complexity of this area, all issues related to the completion and settlement of cost reports must be communicated through or coordinated with the Chief Financial Officer.

F. Compliance with Applicable Fraud Alerts

The Chief Compliance and Fraud Prevention Officer will review the Medi-Cal/Medicare Fraud Alerts. KHS has an established Fraud, Waste and Abuse Committee that assists as a consolidation point for monitoring of FWA activities within the health plan. The committee also serves as a forum for the exchange of ideas and make recommendations for remediation.

The Chief Compliance and Fraud Prevention Officer will ensure that any conduct disparaged by the Fraud Alert is immediately ceased, implement corrective actions, and take reasonable actions to ensure that future violations do not occur.

KHS has a Fraud Plan that is submitted to the regulators on an annual basis that outlines the internal process for mitigating the implication of fraudulent activities. Fraud Risk Management demonstrates the commitment to high integrity, control, and ethical values of the organization.

G. Marketing

KHS will promote only honest, straightforward, fully informative, and non-deceptive marketing. We use marketing to educate the public, increase awareness of our services and recruit employees. All marketing materials must accurately describe our services and programs. To ensure that no incorrect information is disseminated, employees must coordinate all marketing materials with and direct all media requests to the CEO or designee. KHS will only use and/or disclose any member protected health information for marketing activities if a written prior authorization is obtained.

Marketing materials, including health education information, is subject to DHCS review and approval before using with community events or member education.

H. Anti-Kickback/Inducements

KHS will not participate in nor condone the provision of inducements or receipt of kickbacks to gain business or influence referrals. KHS's Providers will consider the member's interests in offering referral for treatment, diagnostic, or service options.

Federal and state laws prohibit any form of kickback, bribe, or rebate, either directly or in directly, in cash or in kind, to induce the purchase or referral of goods, services or items paid for by Medicare or Medi-Cal.

Self-referral laws prohibit a Provider from referring a patient for certain types of health services to an entity with which the Provider or members of his or her immediate family has a financial relationship unless there is an applicable exception under the self-referral law.

Since violations of these laws may subject both KHS and the individual involved to civil and criminal penalties and exclusion from government-funded healthcare programs, all proposed transactions with healthcare providers must be reviewed with legal counsel.

Any employee involved in promoting or accepting kickbacks or offering inducements may be terminated immediately.

COMPLIANCE PROGRAM

I. Relationships with Subcontractors, Vendors and Suppliers

KHS is committed to employing the highest ethical standards in its relationships with subcontractors, vendors, and suppliers with respect to source selection, negotiation, determination of contract awards, and administration of purchasing activities. All subcontractors, vendors, and suppliers are to be selected solely based on objective criteria; personal relationships and friendships will play no part in the selection process. KHS does not knowingly contract or do business with a subcontractor, or vendor that has been excluded from a government-funded healthcare program. Any subcontractor, vendor, or suppler who has access to the organization's PHI and is not a covered entity, will be required to enter into a Business Associate Agreement to comply with applicable federal and state confidentiality and data protections rules, including HIPAA and 42 C.F.R. KHS will maintain a subcontractor review program for selecting and assessing the appropriate safeguards and security controls for key vendors.

J. Delegation Reporting and Compliance Plan

KHS will provide the Department of Health Care Services (DHCS) with a delegation reporting and compliance plan describing, all contractual relationships with Subcontractors and Downstream Subcontractors; KHS's oversight responsibilities for all delegated obligations; and how KHS will oversee all delegated activities, including, but not limited to, details regarding key personnel who will be overseeing such delegated functions. This reporting is provided to DHCS in the format and frequency requested and outlined in KHS policies and procedures.

KHS maintains a Delegation Oversight Committee to ensure adequate oversight and enforcement of all regulatory, contractual, and policy requirements under which KHS is accountable to contractually to our regulatory agencies. This oversight entails the entire spectrum from pre-delegation auditing to annual compliance audits, both internally and externally, conducted by Department heads and staff with coordination through the Compliance department.

K. Retention of Records/Documentation/Destruction

KHS will ensure that all records required by federal and/or state law are created and maintained. All records will be maintained as required under specific laws.

Documentation of compliance efforts will include staff meeting and committee minutes, audit reports, memoranda concerning compliance protocols, problems

identified, and corrective actions taken, the results of any investigations, and documentation supportive of assessment findings, diagnoses, treatments, and plan of care.

Hard copy data that is not necessary or which the organization is no longer required to retain will be shredded and disposed of according to KHS policies.

L. Medical Record Documentation

Timely, accurate and complete documentation is important to clinical care. This documentation not only facilitates high quality care, but also serves to verify that billing is accurate as submitted.

KHS requires that Providers follow these documentation guidelines:

- The medical record is complete and organized.
- Documentation is timely
- The documentation of each encounter includes the reason for the encounter, any relevant history, physical examination findings, prior diagnostic test results, assessment, clinical impression or diagnosis, plan of care, and date and legible identity of the observer.
- CPT and ICD-10 codes used for claims submission are supported by documentation in the medical record.
- Appropriate health risk factors are identified. The patient's progress, his or her response to treatment.
- Care management encounters will be documented

KHS will maintain a process for identifying and reviewing its billing and coding to ensure compliance with applicable state and federal requirements.

~~This plan~~KHS ~~has attempted~~strives to provide the foundation for the development and sustainment of an effective and cost-efficient compliance program. By fostering a true cultural shift for the organization from "following" risk management to "living" risk management, KHS is poised to strengthen its enterprise-wide ~~-~~governance, risk, and compliance, now and in the future.

KERN HEALTH SYSTEMS
2023
Compliance Program
Compliance Plan

2023 Compliance Plan

Last Updated: 8/1/2023

Pause/Delay
Barrier
Complete

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	Q1 COMMENTS	Q2 COMMENTS	Q3 COMMENTS	Q4 COMMENTS
Compliance Plan									
A. Annual Review/Update of Compliance Documents and Written Policies and Procedures									
1. 2023 Compliance Plan	Create 2023 Compliance Plan and for Executive approval	3/31/2023	Director of Compliance		Complete	Draft submitted to CCO 03/29/2023			
1a. Obtain Board Approval	Obtain Board Approval of Compliance Plan	4/16/2023	Chief Compliance Officer		Complete		BOD approval on 4/16/2023		
2. Review/Update and Approval of Compliance Code of Conduct	Update Code of Conduct to align with 2024 DHCS Contract and obtain Board approval	8/22/2023	Director of Compliance		Complete		Updated Code of Conduct to incorporate 2024 language; approved by DHCS on 06/14/2023; will be reviewed by CEO/CCO to determine if additional updates are needed.		
2a. Obtain Board Approval of Compliance Code of Conduct	Obtain Board Approval of Compliance Code of Conduct	11/15/2023	Chief Compliance Officer		In Progress				Moved to Q1 2024 for Governance and Compliance Committee review and approval and forward to BOD in 2024
3. Review/Update and Approval of Compliance Guide	Update Code of Conduct to align with 2024 DHCS Contract and obtain Board approval	11/15/2023	Director of Compliance		In Progress				Moved to Q1 2024 for Governance and Compliance Committee review and approval and forward to BOD in 2024
3a. Obtain Compliance Committee Approval of Compliance Guide	Obtain Compliance Committee Approval of Compliance Guide	11/15/2023	Chief Compliance Officer		In Progress				Moved to Q1 2024 for Governance and Compliance Committee review and approval and forward to BOD in 2024
4. Create 2023 Compliance Program	Create 2023 Compliance Program description and obtain Board approval	5/22/2023	Director of Compliance						
4a. Obtain Compliance Committee Approval of Compliance Program	Obtain Compliance Committee Approval of Compliance Program	11/15/2023	Chief Compliance Officer		Complete	Many reviews/updates underway as part of 2024 contract readiness	Updated to incorporate 2024 language; approved by DHCS on 06/14/2023; will be reviewed by CEO/CCO to determine if additional updates are needed.		
5. Coordinate Departmental Review/Update of all Policy and Procedures	Create schedule & ensure all policies	12/31/2023	Compliance Manager Compliance Analyst Compliance Specialist		Pause/Delay	Many reviews/updates underway as part of 2024 contract readiness	Currently reconciling policies updated through 2024 contract readiness activities vs. policy updates for other regulatory efforts.		Policies that were not impacted by revisions for 2024 contract review will extend into 2024 effort
5a. Create schedule and distribute to stakeholders	Create schedule for policy reviews and distribute	8/15/2023	Compliance Manager		Complete		In progress and on track	Tasks created and distributed accroding to regulatory requirements	
5b. Track to completion	All policies to be reviewed by end of year	12/31/2023	Compliance Manager Compliance Analyst Compliance Specialist		In Progress			Policy reconciilation ongoing	Departments notfied of policies needing updates. Several have been revised for 2024 contract and will be placed on new template as part of 2024 initiative.
5c. Report Policy Review Status in Compliance Committee Meetings	Provide quarterly update to Compliance Committee (number reviewed/to be reviewed by department)	3Q 2023 forward	Compliance Manager Compliance Analyst Compliance Specialist		In Progress		Updated to begin reporting in Compliance Committee in the third quarter meeting	Reconciling policies for 2024 contract, NCQA, and APL alginment ongoing	Q4 2023 Compliance meeting will be held in Q1 2024
6. Review/Update Compliance Policy & Procedures	Review/Update all Compliance owned policy and procedures	12/31/2023	Director of Compliance Compliance Manager		Complete		Several policies updated through 2024 Contract Readiness deliverables; remaining policies will be reviewed by target date	Reconciling policies for 2024 contract, NCQA, and APL alginment ongoing	Updates completed
6a. Create Public versions of policies where needed (e.g. FWA, HIPAA)	Create public facing versions of identified policies (e.g. HIPAA; FWA; etc)	10/31/2023	Director of Compliance Compliance Analyst		Complete		Updated for 2024 DHCS Contract Readiness; public-facing policies created, will be sent internally for review and then filed with regulators for approvals by 08/31/2023	Updated due date to 10/31/2023; HIPAA policies being revamped to separate into multiple new policies for multiple subjects (access; amendment, verification of authority, etc.). On track to be completed by10/31/2023	Updates completed

KERN HEALTH SYSTEMS
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ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	Q1 COMMENTS	Q2 COMMENTS	Q3 COMMENTS	Q4 COMMENTS
6b. Finalize New HIPAA Privacy policies and procedures	Create missing privacy-related policies and procedures	10/31/2023	Director of Compliance Compliance Manager		In Progress		Updated for 2024 DHCS Contract Readiness. Gaps also identified for Federal HIPAA requirements and additional policies being created. In progress; will be sent internally for review and then filed with regulators for approvals by 08/31/2023	Updated due date to 10/31/2023; HIPAA policies being revamped to separate into multiple new policies for multiple subjects (access; amendment, verification of authority, etc.). On track to be completed by10/31/2023	NCQA accreditation updates needed for finalization
B. Compliance Committee and Oversight									
1. Conduct Committee Meetings at least quarterly									
1a. Conduct Compliance Committee meetings at least quarterly	Create agenda, minutes and action items, related reporting and documents for review and hold meeting quarterly	Quarterly	Director of Compliance Compliance Manager		Complete	Q1 Meetiing held 03/27/2023	Q2 Meeting held 07/10/2023	Q3 Meeting held 10/9/2023	Q4 Meeting to be held in 2024
1b. Conduct Fraud, Waste, and Abuse Committee at least quarterly	Create agenda, minutes and action items, related reporting and documents for review and hold meeting quarterly	Quarterly	Director of Compliance Compliance Manager		Complete	Q1 Meeting held 04/17/2023	Q2 Meeting held 07/25/2023	Q3 meeting held 10/10/2023	Q4 Meeting to be held in 2024
1c. Conduct Delegation Oversight Committee at least quarterly	Create agenda, minutes and action items, related reporting and documents for review and hold meeting quarterly	Quarterly	Director of Compliance Compliance Manager		Complete	Q1 Meeting held 03/24/2023	Q2 Meeting held 07/26/2023	Q3 meeting scheduled 10/17/2023	Q4 Meeting to be held in 2024
2. Review/update Committee Charters at least annually	Review/Update Charters and obtain Committee Approvals								
2a. Compliance Committee	Review/Update Charter	11/30/2023	Chief Compliance Officer		Complete			Will schedule review/approval to align with 2024 contract implementation	No updates were made in 2023
2a.1 Obtain Committee Approval	Obtain Committee Approval on updated Charter	11/30/2023	Chief Compliance Officer		Complete			Will schedule review/approval to align with 2024 contract implementation	No updates were made in 2023
2b. FWA Committee	Review/Update Charter	11/30/2023	Chief Compliance Officer		Complete			Will schedule review/approval to align with 2024 contract implementation	No updates were made in 2023
2a.1 Obtain Committee Approval	Obtain Committee Approval on updated Charter	11/30/2023	Chief Compliance Officer		Complete			Will schedule review/approval to align with 2024 contract implementation	No updates were made in 2023
2c. Delegation Oversight Committee	Review/Update Charter	11/30/2023	Chief Compliance Officer		Complete			Will schedule review/approval to align with 2024 contract implementation	No updates were made in 2024
2c.1 Obtain Committee Approval	Obtain Committee Approval on updated Charter	11/30/2023	Chief Compliance Officer						
3. Provide regular Compliance Updates to the Board of Directors	Distribute monthly Compliance Corner email communication by th 10th of each month	Bi-Monthly BOD Meetings	Chief Compliance and Fraud Prevention Officer/Director of Compliance		Complete	02/16/2023 BOD Update	Due to agenda, update not provided	8/16/2023 BOD update, including recommendatin for new format and Board and Compliance Governance Committee, oending final apporval	Compliance report is inlcuded in each bi-monthly BOD meeting with verbal updates at least quarterly
C. Effective Training and Education									
1. In coordination with HR, review/update Corporate Compliance Training for calendar year 2024									
1a. Compliance Training	Review/update Compliance Training	11/30/2023	Director of Compliance		Complete	In progress	Reviewed for 2023, but additional enhancements to be created for 2024 training.		
1b. Fraud, Waste, and Abuse Training	Review/Update FWA Training	11/30/2023	Director of Compliance		Complete		Reviewed for 2023, but additional enhancements to be created for 2024 training.		
1c. HIPAA/Privacy Training	Review/Update HIPAA/Privacy Training	11/30/2023	Director of Compliance		Complete		Reviewed for 2023, but additional enhancements to be created for 2024 training.		
2. In coordination with HR, track/report on completion of mandatory training (Compliance, FWA, HIPAA)	Track annual training to completion	12/30/2023	Director of Compliance (HR resource TBD)		Complete		Working with 2024 DHCS Contract Project team to develop Compliance Dashboard to include this		
2a. Report training status in quarterly Compliance Committee Meetings	Report status of training completions, by department, in quarterly Compliance Committee Meetings	Quarterly	Director of Compliance (HR resource TBD)		Complete		Report in October Compliance Committee Meeting and moving forward	Report reviewed in 10/09/2023 Compliance Committee Meeting and moving forward	
3. Review/Update New Hire Orientation Overview	Review/Update Compliance New Hire Orientation Overview	5/15/2023	Director of Compliance		Complete		Updated and completed monthly by Chief Compliance Officer with new hires	Completed monthly by Chief Compliance Officer with new hires	

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ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	Q1 COMMENTS	Q2 COMMENTS	Q3 COMMENTS	Q4 COMMENTS
4. Compliance & Ethics Week	Plan and Execute activities for annual Compliance & Ethics Week	11/15/2023	Compliance Manager Compliance Team Members		Complete				Compliance week completed successfully with several KHS staff participating with Kern Buck awards
5. Establish Compliance Training for Subcontractors	Establish content and method for delegated entity/subcontractor Compliance training	10/31/2023	Compliance Manager Director of Compliance		In Progress				Continued in 2024 as requried in 2024 contract
5a. Idenitfy Delegated Entities/Subcontractors to receive training	Identify subcontractors to which Compliance Training applies	8/31/2023	Compliance Manager Director of Compliance		Complete		Stria no longer a business partner with KHS	KP, VSP, Health Dialog, Language Line, and AL are identified as delegated entities	KP contract ended 12/31/2023
5b. Implement Compliance Training for Subcontractors	Implement delegated entity/identified subcontractor training	12/31/2023	Compliance Manager Director of Compliance		In Progress				Continued in 2024 as requried in 2024 contract
6. Review and provide feedback on content of Provider Manual	Review and continually expand upon content of Provider Manual for Compliance-related topics	Quarterly	Compliance Manager Director of Compliance		Complete	Compliance Manager Completed Review Director to review and submit to PNM	Provided feedback to PNM for updating FWA section in Q2 On track to provide additional information to include regarding HIPAA for Q3 review		Provided feedback to PNM for updating HIPAA/FWA section in Q4
7. Compliance distributes notifications to key stakeholders of any DHCS-related meeting/webinar/presentations	Receive, review, distribute regulatory updates regarding trainings, webinars, meetings to relevant stakeholders	Ongoing	Compliance Manager		Complete				
8. 2024 DHCS Contract Readiness Activities	Compliance coordinates with project team and key stakeholders on deliverables, AIRs, and implementation readiness	Ongoing	Director of Compliance Compliance Analyst		Complete		196 deliverables submitted to date and 190 approved by DHCS; 5 items still under DHCS review and 1 on hold by DHCS. 55 deliverables with future due dates remain and are on target for submission.	To date, 254 total deliverables with 218 approved by DHCS. KHS received approval from DHCS to move forward with 2024 contract based on deliverables to date. Remaining MOU work will continue through mid 2024.	All deliverables completed with MOU and reporting templates ongoing for execution and status reports as required by DHCS for Q1-Q2 2024
9. Compliance key personnel attend regulatory-focused meetings:	Attend calls and report relevant updates to key stakeholders								
9a. LHPC call (weekly)		Weekly	Director of Compliance		Complete		Compliance attends weekly calls	Compliance attends weekly calls	Compliance attends weekly calls
9b. CAHPS meeting (weekly)		Weekly	Manager of Compliance		Complete		Compliance attends weekly calls	Compliance attends weekly calls	Compliance attends weekly calls
9c. DHCS Plan Call (including Payment Call) (weekly)		Weekly	Director of Compliance		Complete		Compliance attends weekly calls	Compliance attends weekly calls	Compliance attends weekly calls
9d. DHCS topic-specific webinars/meetings (ad hoc)		As scheduled	Director of Compliance Compliance Manager		Complete		Compliance attends weekly calls topic-specific and webinars as scheduled by DHCS	Compliance attends weekly calls	Compliance attends weekly calls
9e. DMHC Roundtable Meetings (quarterly)		Quarterly	Director of Compliance		Complete		Compliance Director attends quarterly	Compliance attends weekly calls	Compliance attends weekly calls
9f. LHPC Compliance Officer Meetings (monthly)		Monthly	Chief Compliance Officer Director of Compliance		Complete		Compliance attends monthly	Compliance attends weekly calls	Compliance attends weekly calls
9g. LHPC Compliance Officer Contract Readiness (bi-monthly)		Bi-Monthly	Chief Compliance Officer Director of Compliance		Complete		This meeting ended in Q1 and conversation rolled into 9f above.	N/A	N/A
D. Effective Lines of Communication									
1. Distribute Monthly "Compliance Capsule" email communications	Distribute monthly Compliance Capsule email communication by th 15th of each month	05/15/2023 - 12/15/2023	Compliance Manager Compliance Analysts		Complete		Began sending out monthly Compliance Capsule and posting to Ceridian: May Compliance Capsule: HIPAA June Compliance Capsule: FWA	July Compliance Capsule: DMHC vs DHCS Education August Capsule: Communication iwth Compliance September Capsule: Conflict of Interest	October Capsule: Delegation and Oversight November Capsule: Compliance and Ethics Week activities December Capsule: Regulatory Calendar
2. Conduct Compliance Awareness Survey	Compliance will implement a compliance survey to obtain feedback from employees regarding various compliance topics such as training, retaliation, HIPAA, and the Compliance HelpLine. Such surveys evaluate how well the compliance program is functioning and identify areas that can be strengthened.	11/30/2023	Compliance Manager / Director of Compliance		Pause/ Delay			Updated due date to `11/30/2023 to conduct survey following completion of Compliance Week activities in early November.	Drafted for execution in 2024
4. Focus at least one monthly Compliance Capsule email on methods for communication with Compliance		8/15/2023	Director of Compliance		Complete		Compliance Capsule posted each months Q2	Compliance Capsule posted each months Q3-August focused on communication	Compliance Capsule posted each months Q4 with excception in November for Compliance Week activities
5. Compliance Updates			Chief Compliance Officer Director of Compliance						

KERN HEALTH SYSTEMS
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Compliance Program

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	Q1 COMMENTS	Q2 COMMENTS	Q3 COMMENTS	Q4 COMMENTS
5a. Compliance provide updates at monthly in Executive Officers Meeting		Monthly	Chief Compliance Officer Director of Compliance		Complete	Updates on Compliance issues provided during monthly ELT meetings 2/28/23; 3/28/23.	Updates on Compliance issues provided during monthly ELT meetings 4/11/23; 5/2/23; 5/23/23; 6/6/23; 6/20/2023.	Updates on Compliance issues provided during monthly ELT meetings 8/1/23; 9/11/23	Updates on Compliance issues provided during monthly ELT meetings 11/7/23; 12/5/23
5b. Compliance provides updates at least every-other-month in Operations Meeting		Ad hoc	Chief Compliance Officer Director of Compliance		Complete	Regulatory audits	Sanctions	Operational readiness	Regulatory audits
6. Compliance continues to coordinate communication and hold meetings as needed regarding regulatory updates (APLs, emails, DHCS weekly meetings, etc.)		Ongoing	Compliance Manager Director of Compliance		Complete	Daily, weekly, monthly	Daily, weekly, monthly	Daily, weekly, monthly	Daily, weekly, monthly
7. Participate in weekly Grievance & Appeals review meetings	review materials, attend meetings, request updates, provide education in weekly meetings	weekly	Director of Compliance		Complete	Compliance Director has participated and provided feedback in each weekly meeting	Compliance Director has participated and provided feedback in each weekly meeting	Compliance Director has participated and provided feedback in each weekly meeting	Compliance Director has participated and provided feedback in each weekly meeting
8, Participate in weekly Discriminations review meetings	review materials, attend meetings, request updates, provide education in weekly meetings	weekly	Director of Compliance		Complete	Compliance Director has participated and provided feedback in each weekly meeting	Compliance Director has participated and provided feedback in each weekly meeting	Compliance Director has participated and provided feedback in each weekly meeting	Compliance Director has participated and provided feedback in each weekly meeting
E. Well Publicized Disciplinary Standards									
1. In coordination with HR, ensure review of new hires against exclusionary databases and report out in Compliance Committee		10/30/2023	Director of Compliance		Complete			Confirmed with HR on recent new hires for review of exclusionary database cross reference in October 2023	
2. Incorporate further emphasis on disciplinary standards into Compliance materials, trainings, policies, and new hire orientation		11/30/2023	Director of Compliance		Complete			Add information to new hire orientation presentation at onboarding 10/9/2023	
F. Routine Monitoring and Identification of Compliance Risks									
1. Complete Risk Assessments and incorporate into Compliance Auditing/Monitoring Plan for 2024		8/30/2023	Director of Compliance						
1a. 2022 APLs		8/30/2023	Director of Compliance		Complete		Compliance completed risk assessment of 2022 APLs and prioritized for retrospective reviews	Prioritized APL retrospective reviews (10) for completion	
1b. 2022 DHCS Medical Survey Findings		8/30/2023	Director of Compliance		Complete			CAP review and discussion	(1) outstanding finding open R/T tertiary faciilty owneship and disclousre documents not received
1c. 2023 DMHC Medical Survey Findings		8/30/2023	Director of Compliance		Pause/Delay		Remediations based on potential issues		Still pending notification from DMHC
1d. Prior Regulatory Audits		8/30/2023	Director of Compliance		Complete		Exclusion criteria for credentialing	IHA, UM NOA, AA and Gold Card	
4. Establish Routine monthly Operational Reporting for Monitoring/Oversight/Identification of Potential Compliance Issues (e.g. Grievance timeliness)		04/30/2023	Director of Compliance		In Progress	Has been added to 2024 Readiness project as acceptance criteria	Defined requirements and currently working with 2024 DHCS Contract Readiness Project Team to develop Compliance Dashboard On Track for Grievance team to provide independent timeliness reporting in Q3 Compliance Committee Meeting		Dashboard under development continues in 2024
5. Based on final monitoring plan, report on items being monitored in quarterly Compliance Committee Meeting		10/31/2023	Director of Compliance		In Progress		On track to report out in 10/9/2023 Compliance Committee Meeting		Report Q4 in Q1 2024
6. Based on final internal auditing plan, conduct and report out on all audits in the Compliance Committee Meeting (# TBD)		Q3 2023	Director of Compliance		Complete			(10) Internal retrospective audit began in 7/2023- Q3 Compliance committee	
G. Procedures and Systems for Prompt Response to Compliance Issues									
1. Create Compliance Issues Tracking Log		2/1/2023	Director of Compliance		Complete	Log created and 2023 items being tracked			
1a. Report on status of Compliance Issues in quarterly Compliance Committee Meetings		Q3, Q4 meetings	Director of Compliance Manager of Compliance		In Progress		Log implemented; Compliance Committee Reporting will begin with 10/09/2023 Compliance Committee Meeting		Review of departmental reports to identify gaps for remediation-Q4 report in Q1 2024

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ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	Q1 COMMENTS	Q2 COMMENTS	Q3 COMMENTS	Q4 COMMENTS
2. Create Compliance Policy for Prompt Response to compliance Issues (include tracking mechanism, reporting, CAP process)		06/30/2023	Director of Compliance		Complete		Draft policy completed		
2a. Create Corrective Action Plan template for CAPs (internal/external)		11/30/2023	Director of Compliance		Complete		Began compiling options for actual template	Q3 completion	
2b. Report on status of CAPS in quarterly Compliance Committee Meetings		Q2, Q3, Q4 meetings	Director of Compliance		Complete		No Corrective Action Plans issued	CAPs in draft and will be reported in Compliance Committee Meeting on 10/09/2023: * Kaiser Audit * VSP access & availability * Provider potential FWA	CAPs issued to KP, VSP and provider FWA
H. Fraud, Waste, and Abuse (FWA)									
1. Attend Annual and Quarterly DOJ FWA Trainings		12/31/2023	Director of Compliance Chief Compliance Officer Compliance Analyst		Complete	Director of Compliance and Compliance Analyst attended in February	CCO attended 5/9/23 in San Francisco	KHS did not attend August meetng--DOJ omitted invite	KHS attended DOJ meeting in LA November 28, 2023
2. Review/Update Annual FWA Plan	Review, update, and submit annual FWA plan to DMHC	12/31/2023	Director of Compliance		Complete			FWA subgroup chaired by CCO to review process for monitoring/oversight	
3. Facilitate FWA Data Mining Workgroup at least every other month	Facilitate workgroup meetings and prioritize	Ongoing	Director of Compliance		Complete		Meeting held 6/12/23	Meeting held 9/11/2023	Meeting held 12/11/2023
3b. Identify and assess at least one FWA Data Mining Initiative per quarter		Ongoing	Director of Compliance / Compliance Analyst Data Mining Workgroup		Complete	* Impossible Visits and high-level E&M currently underway * Data refresh for transportation requested for 2nd quarter initiative	Transportation (ghost/duplicate trips)	Lab tests and telehealth reviewed for overutilization	
4. Conduct investigations regarding potential FWA and provide Updated FWA Reporting to FWA Committee		Ongoing	Director of Compliance / Compliance Analyst		Complete		Investigations ongoing; 104 cases received in 2023 through June 30, 2023; 80 complete. Status reported in 04/17/2023 FWA Committee	Investigations ongoing; 64 cases received in 2023 Q3 2023. Total of 100 cases reported to DHCS for further investigations through Q3 2023	Investigations ongoing; 46 cases received trhough November 2023 KHS submitted total of 126 609 forms to DHCS.
I. Delegation Oversight						Part of Compliance Audit/Monitoring Plan			
1. Schedule & Coordinate Annual Delegation Oversight Audits									
1a. Kaiser		9/30/2023	PNM		Complete		KP requesting to delay until August/September 2023 due to other scheduled audits. On track to complete by end of Q3	Completed in Spetember 2023-final report to KP October 11, 2023	CAP issued to KP
1b. VSP		10/31/2023	PNM/UM		Pause/ Delay	Claims and Credentialing completed	On track to complete by end of Q3	Planned for October 2023	VSP issued CAP for Provider Access
1c. Stria		8/31/2023	Robin Dow-Morales - monthly Stria quality audit Director of Compliance		Complete		Stria/Bitwise business furloughed/closed May 2023-services no longer utilized/delegated. Claims completed monthly Audits through March.	N/A	N/A
1d. American Logistics (AL)		11/30/2023	Member Services Marketing		Pause/ Delay			Planned for November 2023	Moved to Q1 2024
1e. Health Dialog		10/31/2023	UM		Pause/ Delay	Identify additional elements that need to be audited (in progress)		Planned for October 2023	Moved to Q1 2024
2. Determine additional Subcontractors to be audited (e.g. Interpreter; Health Education vendors; etc.) and develop schedule		8/30/2023	Director of Compliance (w/ Director of C&L/HE)		In progress		Language line oversight implemented		Moved to Q1 2024
3. Participate in quarterly delegated subcontractor joint operating meetings (JOM)									

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ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	Q1 COMMENTS	Q2 COMMENTS	Q3 COMMENTS	Q4 COMMENTS
3a. Kaiser		Ongoing	Director of Compliance		Complete	Director of Compliance participated in 03/22/2023 JOM and 2/27/2023 Transition plan	Director of Compliance participated in 06/29/2023 JOM	Director of Compliance participated in 06/23/2023 JOM	Director of Compliance participated in 12/15/2023 JOM/Transition Plan
3b. VSP		Ongoing	Director of Compliance		Complete	Director of Compliance participated in 02/01/2023 JOM	Director of Compliance participated in 05/10/2023 JOM	Director of Compliance participated in Q3 2023 JOM	Director of Compliance participated in Q4 2023 JOM
3c. AL		Ongoing	Director of Compliance		Complete		Director of Compliance added to distribution and participated in 05/25/2023 JOM	Director of Compliance participated in 8/17/2023 JOM	Director of Compliance participated in 11/28/2023 JOM
3d. Health Dialog		Ongoing	Director of Compliance		Complete		Director of Compliance added to distribution and participated in 05/11/2023 JOM	Director of Compliance participated in 8/24/2023 JOM	Director of Compliance participated in 11/20/2023 JOM
4. Create delegation reporting and compliance plan in accordance with 2024 contract readiness requirements			Director of Compliance		Complete		Delegation reporting and compliance plan was drafted and submitted to DHCS for approval on 06/14/2023		
4a. Delegation Function Matrix		6/30/2023	Director of Compliance		Complete		Delegation Function Matrix was drafted and submitted to DHCS for approval on 06/14/2023		
4b. Delegation Justification and Plan		6/30/2023	Director of Compliance		Complete		Delegation justification and plan was drafted and submitted to DHCS for approval on 06/14/2023		
4c. Contract Requirements Grid		6/30/2023	Director of Compliance		Complete		Delegation reporting and compliance plan was drafted and submitted to DHCS for approval on 06/14/2023		
5. Track Delegated Entity Compliance with APLs through APL grid attestation at least quarterly	Distribute APL grid to Kaiser and VSP; follow up as needed with subcontractors to complete; report out on status in Delegation Oversight Committee quarterly	Send by the 15th of the month following each quarter	Compliance Manager		In progress	2022 Grid distributed and responses received	Q1 distributed to Kaiser and VSP 04/03/2023	Q2 distributed to Kaiser and VSP 07/17/2023	Q3 distributed to Kaiser and VSP
5a. Report status of Delegates APL compliance quarterly	Report status in Delegation Oversight Committee meeting quarterly	Meeting schedule	Compliance Manager		In progress		Review in 07/26/2023 Delegation Oversight Committee Meeting		Q3 reported in Q! 2024
5b. Determine if/how to incorporate other subcontractors and which subcontractors and begin distribution/tracking	Distribute APL grid and track to ensure responses received	Meeting schedule	Compliance Manager		In progress				

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ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	Q1 COMMENTS	Q2 COMMENTS	Q3 COMMENTS	Q4 COMMENTS
Compliance Plan									
A. Annual Review/Update of Compliance Documents and Written Policies and Procedures									
1. 2024 Compliance Work Plan	Create 2024 Compliance Plan		Chief Compliance Officer Director of Compliance						
1a. Obtain Board Approval	Obtain Board Approval of Compliance Work Plan	2/15/2024	Chief Compliance Officer		**In Progress**				
2. Review/Update and Approval of Compliance Code of Conduct	Update Code of Conduct to align with 2024 DHCS Contract and obtain Board approval		Chief Compliance Officer Director of Compliance						
2a. Obtain Board Approval of Compliance Code of Conduct	Obtain Board Approval of Compliance Code of Conduct	4/11/2024	Chief Compliance Officer		**In Progress**				
3. Review/Update and Approval of Compliance Guide	Update Code of Conduct and obtain Board approval		Chief Compliance Officer Director of Compliance						
3a. Obtain Compliance Committee Approval of Compliance Guide	Obtain Compliance Committee Approval of Compliance Guide	2/1/2024	Chief Compliance Officer		**In Progress**				
3b. Obtain Board approval of Compliance Guide	Obtain Board approval of Compliance Guide	4/11/2024	Chief Compliance Officer		**In Progress**				
4. Create 2024 Compliance Program	Create 2024 Compliance Program		Chief Compliance Officer Director of Compliance						
4a. Obtain Compliance Committee Approval of Compliance Program	Obtain Compliance Committee Approval of Compliance Program	2/1/2024	Chief Compliance Officer		**In Progress**				
4b. Obtain Board approval of Compliance Program	Obtain Board approval of Compliance Program	2/15/2024	Chief Compliance Officer		**In Progress**				
5. Coordinate Departmental Review/Update of all Policy and Procedures	Create schedule & ensure all policies		Compliance Manager Compliance Analyst Compliance Specialist						
5a. Create schedule and distribute to stakeholders	Create schedule for policy reviews and distribute	3/1/2024	Compliance Manager		**In Progress**				
5b. Track to completion	All policies to be reviewed by end of year	12/31/2024	Compliance Manager Compliance Analyst Compliance Specialist		**In Progress**				
5c. Report Policy Review Status in Compliance Committee Meetings	Provide quarterly update to Compliance Committee (number reviewed/to be reviewed by department)	Quarterly	Compliance Manager Compliance Analyst Compliance Specialist		**In Progress**				
6. Review/Update Compliance Policy & Procedures	Review/Update all Compliance owned policy and procedures		Director of Compliance Compliance Manager						
6a. Create Public versions of policies where needed (e.g. FWA, HIPAA)	Create public facing versions of identified policies (e.g. HIPAA; FWA; etc)	6/1/2024	Director of Compliance Compliance Analyst		**In Progress**				
B. Compliance Committee and Oversight									
1. Conduct Committee Meetings at least quarterly									
1a. Conduct Compliance Committee meetings at least quarterly	Create agenda, minutes and action items, related reporting and documents for review and hold meeting quarterly	Quarterly	Director of Compliance Compliance Manager		**In Progress**				
1b. Conduct Fraud, Waste, and Abuse Committee at least quarterly	Create agenda, minutes and action items, related reporting and documents for review and hold meeting quarterly	Quarterly	Director of Compliance Compliance Manager		**In Progress**				
1c. Conduct Delegation Oversight Committee at least quarterly	Create agenda, minutes and action items, related reporting and documents for review and hold meeting quarterly	Quarterly	Director of Compliance Compliance Manager		**In Progress**				
2. Review/update Committee Charters at least annually	Review/Update Charters and obtain Committee Approvals								
2a. Compliance Committee	Review/Update Charter	3/1/2024	Chief Compliance Officer						
2a.1 Obtain Committee Approval	Obtain Committee Approval on updated Charter	Q2 2024	Chief Compliance Officer						
2b. FWA Committee	Review/Update Charter	3/1/2024	Chief Compliance Officer						
2a.1 Obtain Committee Approval	Obtain Committee Approval on updated Charter	Q2 2024	Chief Compliance Officer						
2c. Delegation Oversight Committee	Review/Update Charter	3/1/2024	Chief Compliance Officer						
2c.1 Obtain Committee Approval	Obtain Committee Approval on updated Charter	Q2 2024	Chief Compliance Officer						
3. Provide regular Compliance Updates to the Board of Directors		Bi-Monthly BOD Meetings	Chief Compliance and Fraud Prevention Officer						
C. Effective Training and Education									

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ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	Q1 COMMENTS	Q2 COMMENTS	Q3 COMMENTS	Q4 COMMENTS
1. In coordination with HR, review/update Corporate Compliance Training for calendar year 2024									
1a. Compliance Training	Review/update Compliance Training	4/1/2024	Director of Compliance						
1b. Fraud, Waste, and Abuse Training	Review/Update FWA Training	4/1/2024	Director of Compliance						
1c. HIPAA/Privacy Training	Review/Update HIPAA/Privacy Training	4/1/2024	Director of Compliance						
2. In coordination with HR, track/report on completion of mandatory training (Compliance, FWA, HIPAA)	Track annual training to completion		Director of Compliance (HR resource TBD)						
2a. Report training status in quarterly Compliance Committee Meetings	Report status of training completions, by department, in quarterly Compliance Committee Meetings	Quarterly	Director of Compliance (HR resource TBD)		In Progress				
3. Review/Update New Hire Orientation Overview	Review/Update Compliance New Hire Orientation Overview	1/1/2024	Chief Compliance and Fraud Prevention Officer		Complete	Updated for 2024 in HR scheduled onboarding			
4. Compliance & Ethics Week	Plan and Execute activities for annual Compliance & Ethics Week	11/15/2024	Compliance Manager Compliance Team Members						
5. Establish Compliance Training for Subcontractors	Establish content and method for delegated entity/subcontractor Compliance training	3/1/2024	Compliance Manager Director of Compliance						
5a. Idenitfy Delegated Entities/Subcontractors to receive training	Identify subcontractors to which Compliance Training applies	3/1/2024	Compliance Manager Director of Compliance						
5b. Implement Compliance Training for Subcontractors	Implement delegated entity/identified subcontractor training	4/1/2024	Compliance Manager Director of Compliance						
6. Review and provide feedback on content of Provider Manual	Review and continually expand upon content of Provider Manual for Compliance-related topics	Quarterly	Compliance Manager Director of Compliance		In Progress				
7. Compliance distributes notifications to key stakeholders of any DHCS-related meeting/webinar/presentations	Receive, review, distribute regulatory updates regarding trainings, webinars, meetings to relevant stakeholders	Ongoing	Compliance Manager		In Progress				
8. 2024 DHCS Contract Monitoring Activities	Compliance coordinates with project team and key stakeholders	Ongoing	Director of Compliance Compliance Analyst		In Progress				
9. Compliance key personnel attend regulatory-focused meetings:	Attend calls and report relevant updates to key stakeholders								
9a. LHPC call (weekly)		Weekly	Director of Compliance		In Progress				
9b. CAHPS meeting (weekly)		Weekly	Manager of Compliance		In Progress				
9c. DHCS Plan Call (including Payment Call) (weekly)		Weekly	Director of Compliance		In Progress				
9d. DHCS topic-specific webinars/meetings (ad hoc)		As scheduled	Director of Compliance Compliance Manager		In Progress				
9e. DMHC Roundtable Meetings (quarterly)		Quarterly	Director of Compliance		In Progress				
9f. LHPC Compliance Officer Meetings (monthly)		Monthly	Chief Compliance Officer Director of Compliance		In Progress				
9g. LHPC Compliance Officer Contract Readiness (bi-monthly)		Bi-Monthly	Chief Compliance Officer Director of Compliance		In Progress				
D. Effective Lines of Communication									
1. Distribute Monthly "Compliance Capsule" email communications	Distribute monthly Compliance Capsule email communication by th 15th of each month	1/15/2024-12/15/2024	Compliance Manager Compliance Analysts		In Progress				
2. Conduct Compliance Awareness Survey	Compliance will implement a compliance survey to obtain feedback from employees to evaluate how well the compliance program is functioning and identify areas that can be strengthened.	3/1/2024	Compliance Manager / Director of Compliance						
3. Focus at least one monthly Compliance Capsule email on methods for communication with Compliance		6/1/2024	Director of Compliance						
4. Compliance Updates									

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ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	Q1 COMMENTS	Q2 COMMENTS	Q3 COMMENTS	Q4 COMMENTS
4a. Compliance provide updates at monthly in Executive Officers Meeting		Monthly	Chief Compliance Officer		In Progress				
4b. Compliance provides updates at least every-other-month in Operations Meeting		Ad hoc	Chief Compliance Officer Director of Compliance		In Progress				
4c. Compliance provide updates at BI-monthly Board meetings		Bi-monthly	Chief Compliance Officer		In Progress				
5. Compliance continues to coordinate communication and hold meetings as needed regarding regulatory updates (APLs, emails, DHCS weekly meetings, etc.)		Ongoing	Compliance Manager Director of Compliance		In Progress				
6. Participate in weekly Grievance & Appeals review meetings	review materials, attend meetings, request updates, provide education in weekly meetings	weekly	Director of Compliance		In Progress				
7, Participate in weekly Discriminations review meetings	review materials, attend meetings, request updates, provide education in weekly meetings	weekly	Director of Compliance		In Progress				
E. Well Publicized Disciplinary Standards									
1. In coordination with HR, ensure review of new hires against exclusionary databases and report out in Compliance Committee		Ongoing	Director of Compliance		In Progress				
2. Incorporate further emphasis on disciplinary standards into Compliance materials, trainings, policies, and new hire orientation		Ongoing	Director of Compliance		In Progress				
F. Routine Monitoring and Identification of Compliance Risks									
1. Complete Risk Assessments and incorporate into Compliance Auditing/Monitoring Plan for 2025			Director of Compliance						
1a. 2023 APLs		8/30/2024	Director of Compliance						
1b. 2023 DHCS Medical Survey Findings		8/30/2024	Director of Compliance						
1c. 2023 DMHC Medical Survey Findings		8/30/2024	Director of Compliance						
1d. Prior Regulatory Audits		8/30/2024	Director of Compliance						
3. Establish Routine monthly Operational Reporting for Monitoring/Oversight/Identification of Potential Compliance Issues (e.g. Grievance timeliness)		4/30/2024	Director of Compliance						
4. Report on items being monitored in quarterly Compliance Committee Meeting		Quarterly	Director of Compliance		In Progress				
5. Conduct and report out on all audits in the Compliance Committee Meeting (# TBD)		Q3 2024	Director of Compliance						
G. Procedures and Systems for Prompt Response to Compliance Issues									
1. Create Compliance Issues Tracking Log			Director of Compliance						
1a. Report on status of Compliance Issues in quarterly Compliance Committee Meetings		Quarterly	Director of Compliance Manager of Compliance		In Progress				
2. Create Compliance Policy for Prompt Response to compliance Issues (include tracking mechanism, reporting, CAP process)			Director of Compliance						
2b. Report on status of CAPS in quarterly Compliance Committee Meetings		Quarterly	Director of Compliance		In Progress				
H. Fraud, Waste, and Abuse (FWA)									
1. Attend DOJ FWA Trainings		Quarterly/ Annual	Director of Compliance Chief Compliance Officer Compliance Analyst		In Progress				

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ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	Q1 COMMENTS	Q2 COMMENTS	Q3 COMMENTS	Q4 COMMENTS
2. Review/Update Annual FWA Plan	Review, update, and submit annual FWA plan to DMHC	4/1/2024	Director of Compliance						
3. Facilitate FWA Data Mining Workgroup at least every other month	Facilitate workgroup meetings and prioritize	Ongoing	Chief Compliance and Fraud Prevention Officer Director of Compliance		**In Progress**				
3b. Identify and assess at least one FWA Data Mining Initiative per quarter		Ongoing	Director of Compliance / Compliance Analyst Data Mining Workgroup		**In Progress**				
4. Conduct investigations regarding potential FWA and provide Updated FWA Reporting to FWA Committee		Ongoing	Director of Compliance / Compliance Analyst		**In Progress**				
I. Delegation Oversight									
1. Schedule & Coordinate Annual Delegation Oversight Audits									
1a. VSP		4/1/2024	Compliance/PNM/UM						
1b. American Logistics (AL)		3/1/2024	Compliance/Member Services Marketing						
1c. Health Dialog		3/1/2024	UM						
1d. Language Line		4/1/2024	Compliance/Cultural and Linguistics Health Equity						
2. Participate in quarterly delegated subcontractor joint operating meetings (JOM)									
3a. Kaiser		Ongoing	Director of Compliance		**In Progress**				
3b. VSP		Ongoing	Director of Compliance		**In Progress**				
3c. AL		Ongoing	Director of Compliance		**In Progress**				
3d. Health Dialog		Ongoing	Director of Compliance		**In Progress**				
3e. Language Line		Ongoing	Director of Compliance		**In Progress**				
4. Create delegation reporting and compliance plan			Director of Compliance						
4a. Delegation Function Matrix Updates		4/1/2024	Director of Compliance						
4b. Delegation Justification and Plan		4/1/2024	Director of Compliance						
4c. Contract Requirements Grid		4/1/2024	Director of Compliance						
5. Track Delegated Entity Compliance with APLs through APL grid attestation at least quarterly	Distribute APL grid and follow up as needed with subcontractors to complete; report out on status in Delegation Oversight Committee quarterly	5th of the month following each quarter	Compliance Manager						
5a. Report status of Delegates APL compliance quarterly	Report status in Delegation Oversight Committee meeting quarterly	Quarterly	Compliance Manager		**In Progress**				
5b. Determine if/how to incorporate other subcontractors and which subcontractors and begin distribution/tracking	Distribute APL grid and track to ensure responses received	Quarterly	Compliance Manager		**In Progress**				