KERN HEALTH SYSTEMS

GOVERNANCE AND COMPLIANCE COMMITTEE MEETING

Friday, February 7, 2025
at
8:30 a.m.

Kern Health Systems
2900 Buck Owens Blvd.
4th floor – Kern River Room
Bakersfield, CA 93308

For more information, call (661) 664-5000

AGENDA

GOVERNANCE AND COMPLIANCE COMMITTEE MEETING

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Bakersfield, California 93308

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8:30 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 SILENT CELL PHONES AND OTHER ELECTRONIC DEVICES DURING THE MEETING

COMMITTEE TO RECONVENE

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

ADJOURN TO CLOSED SESSION

CLOSED SESSION

1) CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION
(Government Code § 54956.9 (e)(3).) Number of cases: Two (2)
Significant exposure to litigation in the opinion of the Board of Directors on the advice of legal counsel, based on the receipt of a claim pursuant to the Government Claims Act or some other written communication from a potential plaintiff threatening litigation, which non-exempt claim or communication is available for public inspection.

2) CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION
(Government Code § 54956.9 (d)(2).) Number of cases: One (1)
Significant exposure to litigation in the opinion of the Board of Directors on the advice of legal counsel, based on facts and circumstances that might result in litigation against Kern Health Systems but which Kern Health Systems believes are not yet known to a potential plaintiff or plaintiffs, which facts and circumstances need not be disclosed. (Government Code § 54956.9 (e) (1).)

8:15 A.M.

COMMITTEE TO RECONVENE

REPORT ON ACTIONS TAKEN IN CLOSED SESSION

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

3) 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

4) 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))

COMMITTEE MATTERS

5) Report on Kern Health Systems 2025 Compliance Program MCAL (Fiscal Impact: None) –
RECEIVE AND FILE

6) Report on Kern Health Systems 2025 Code of Conduct (Fiscal Impact: None) –
RECEIVE AND FILE

7) Report on Kern Health Systems 2025 Compliance Guide (Fiscal Impact: None) –
RECEIVE AND FILE

8) Report on Kern Health Systems 2025 Anti-Fraud Plan (Fiscal Impact: None) –
RECEIVE AND FILE

9) Report on Kern Health Systems 2024 Compliance Workplan Q4 update (Fiscal Impact: None) –
RECEIVE AND FILE

10) Report on Kern Health Systems 2025 Compliance Workplan (Fiscal Impact: None) –
RECEIVE AND FILE

ADJOURN TO THURSDAY, MARCH 27, 2025 AT 8:30 A.M.

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

MEMORANDUM

TO: Kern Health Systems Governance and Compliance Committee

FROM: Deborah Murr, Chief Compliance and Fraud Prevention Officer

SUBJECT: 2025 Compliance Program Description

DATE: February 7, 2025

BACKGROUND

The Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC), requires organizations that participate as a California Med-Cal plan, to have a formal compliance program. 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.

The focus 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 that adheres and aligns with to the regulatory requirements under the office of Inspector General (OIG). Our overall compliance efforts are aimed at prevention, detection, and resolution of variances through audits and monitoring activities to identify new or emerging risk.

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.

REQUESTED ACTION

Receive and File; Refer to KHS Board of Directors.

Kern Family Health Care™

Kern Health Systems

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

2025 CORPORATE COMPLIANCE PROGRAM

COMPLIANCE PROGRAM

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COMPLIANCE PROGRAM

Executive Summary

Why Have a Compliance Program?

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

- Prevents, detects, and corrects non-compliance and fraud, waste, and abuse (FWA).
- 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 400,000 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.

The health care industry is heavily regulated by federal and state agencies responsible for ensuring health care organizations operate in compliance with contractual and regulatory obligations. KHS will be regulated by the Centers for Medicare & Medicaid Services (CMS) with the implementation of a Dual Special Needs Medicare Advantage Plan in 2026, the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC).

The Centers for Medicare & Medicaid Services (CMS)

CMS is an agency within the U.S. Department of Health & Human Services responsible for administration of several key federal health care programs. CMS oversees Medicare (the federal health insurance program for seniors and persons with disabilities) and Medicaid (the federal needs-based program).

COMPLIANCE PROGRAM

The Department of Health Care Services (DHCS)

DHCS is one of thirteen departments within the California Health and Human Services Agency (CHHS) that provides a range of health care services, social services, mental health services, alcohol and drug treatment services, income assistance and public health services to Californians. DHCS administers publicly financed health insurance and safety net programs and works to effectively use federal and state funds to operate the Medi-Cal program. DHCS ensures that high-quality, efficient health care services are delivered to more than 13 million Californians (or one in three Californians).KHS maintains contracts with DHCS to operate Medi-Cal managed care services.

The Department of Managed Health Care (DMHC)

DMHC regulates health care service plans that deliver health, dental, vision and behavioral health care benefits. DMHC protects the rights of approximately 20 million enrollees, educates consumers about their rights and responsibilities, ensures financial stability of the managed health care system and assists Californians in navigating the changing health care landscape. DMHC reviews all aspects of the plan's operations to ensure compliance with California law. KHS maintains one Knox-Keene Licenses with DMHC to operate in California.

KHS is committed to the highest standards of ethics, integrity and professionalism throughout every aspect of our business. We are firmly committed to ensuring full compliance with all federal and state health care program requirements. Our compliance efforts are aimed at prevention, detection, and resolution of variances.

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

1. Written policies and procedures
2. Compliance Leadership and Oversight
3. Training and education
4. Effective lines of communication
5. Enforcement Standards: Consequences and Incentives
6. Risk Assessment, Auditing and Monitoring
7. Responding to Detected Offenses and Developing Corrective Action Initiatives

COMPLIANCE PROGRAM

The information contained within the program applies to all– the KHS Governing Board Members, our Chief Officers, the KHS Leadership team, staff, and KHS's business associates – and it should be reviewed and referenced often. Our shared commitment to honesty, integrity, transparency and accountability helps develop the trust of our members and our providers. It also helps us establish good working relationships with our federal and state regulators. The Compliance Program supports this commitment by helping to understand how KHS must comply with laws and regulations that govern health care to ensure KHS maintains a reputation of excellence.

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.

KHS's Compliance Program Alignment with OIG Standards

Written Policies and Procedures	**Chief Compliance and Fraud Prevention Officer Compliance Leadership and Oversight**	**Training and Education**	**Effective Lines of Communication with Chief Compliance and Fraud Prevention Officer and Disclosure Programs**	**Enforcement Standards: Consequence and Incentive**	**Risk Assessment, Auditing and Monitoring**	**Responding to Detected Offenses and Developing Corrective Action Initiatives**
• Fraud, Waste & Abuse, Anti-Kickback Statute, False Claims Act and Stark Law policies • Whistle Blower/ Non-retaliation policy • Clinical policies • HIPAA • Conflict of Interest	• Chief Compliance and Fraud Prevention Officer job description • Compliance Committee • Oversight of the Program • Annual Compliance Report	• Annual compliance training/on-boarding training • Monthly Spotlight • Periodic training at staff meetings • Ad Hoc training informs and train	• Open door policy • Ethics Hotline • Exclusion screening	• Comply with applicable standards, laws, and procedures • Supervisor and/or Managers oversight of process failures	• Annual risk review • Ongoing audit and oversight activities • Ad hoc audits • Monthly exclusion screening • Maintain anonymous. • Annual risk assess-ment • Credential and peer review	• Internal investi-gations and reporting • Review Annual Conflict of Interest Disclosure Forms • Process for reporting and resolving incidents

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.

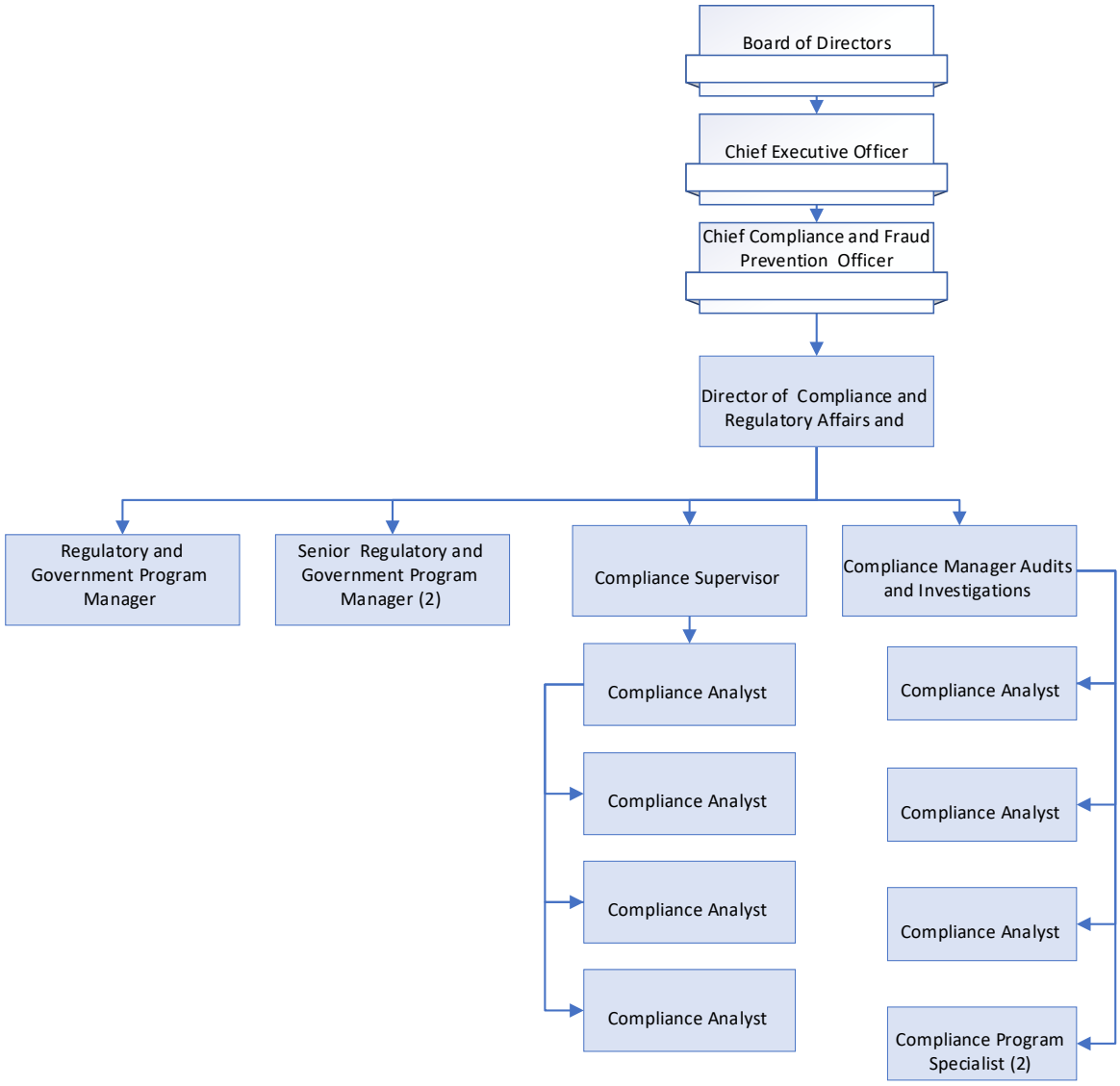
The Chief Compliance and Fraud Prevention Officer (CCFPO) provides oversight and supervision to the Compliance department. Positions may be added or revised based on the department's identified operational needs.

Because the Chief Compliance and Fraud Prevention Officer is responsible for compliance oversight for all other department activities of the organization, this position reports directly to the Chief Executive Officer to mitigate risk. The Chief Compliance and Fraud Prevention Officer is responsible for implementing a Compliance Program that includes and addresses quality and patient safety compliance risks just as they do for any other compliance risk area integral to KHS's Board of Directors, staff, members, providers, and community.

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

KHS recognizes the importance of fostering a culture of compliance. As a result, KHS maintains and supports a Compliance organizational 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.

COMPLIANCE PROGRAM



III. ELEMENT 1 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. Access to policies and procedure include relevant individuals such as employees, contractors, members, customers, subcontractors, agents, or people in other roles, or a subset of the above. KHS' policies and procedures are available online at the KHS's company site www.kernfamilyhealthcare.com.

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.

These six fundamental values: **EQUITY, EXCELLENCE, COMPASSION, COLLABORATION, INNOVATION, and INTEGRITY**, remind us that preserving an ethical workplace is critical to our long-term success as an organization. The Code articulates the standards of behavior that each one of us is expected to observe while performing our jobs, as well as our commitment to complying with all regulatory requirements, state, and federal laws.

As employees, we are all required to ensure compliance and report any potential issues, ethical concerns, or violations of this Code of Conduct in accordance with policies and procedures. For additional information please refer to the Compliance Program Description, Compliance Guide, Employee Handbook, and Policies and Procedures located on the KHS Intranet website.

COMPLIANCE PROGRAM

KERN HEALTH SYSTEMS CORE VALUES

Equity

- We take action to create a culture of fairness and inclusion that fits all members and employees, regardless of zip code, race, ethnicity, preferred language, cultural preferences, or personal history.
- Equity matters because people matter. We recognize that everyone is beautifully diverse, and we are better as an organization and a community when every individual is able to thrive and contribute their unique gifts.

Excellence

- We continually strive for outstanding results by maintaining high standards, community relevance, and working to improve ourselves and our programs.
- Excellence translates to quality outcomes, and a stronger, healthier community. We take pride in our work and invest the necessary effort to grow and ensure a meaningful, measurable impact for those we serve and work with.

Compassion

- We seek to see through the eyes of someone else's experience and extend empathy and care.
- Compassion is at the core of who we are. It is something that we give to others and ourselves, recognizing each person's inherent value and worth. When we understand and care for each other, we can design a better solution and response more productively to those is need.

KERN HEALTH SYSTEMS CORE VALUES

Collaboration

- We leverage each other's experience and expertise to solve problems and accomplish shared outcomes in support of a common mission.
- We recognize that we are most effective when we collaborate. Bringing together different strengths and perspectives promotes greater creativity, and makes for more sustainable, impactful solutions and results.

Innovation

- We create novel methods, solutions or systems that expand what is possible and deepen our potential impact.
- We value experimentation and out-of-the-box thinking as keys to finding new opportunities, improving efficiency, and producing a greater output and value. We are informed by the changing world that we work in, and constantly looking for ways to better serve our members and ourselves.

Integrity

- We do the right thing, even when its not the easy thing.
- Integrity is essential to creating the foundation for trust, workability and performance. Being true to our word and each other is what gives us the best possible chance to succeed and make a lasting difference.

B. Conflict of Interest (COI) Policy and Disclosure Statement

Workplace business decisions must be made with objectivity and fairness. A Conflict of Interest (COI), or even the appearance of one, should be avoided. A COI presents itself in the form of a personal or financial gain for an individual or entity that could possibly corrupt the motivation of that individual or entity.

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 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.

Examples of COI include, but are not limited to:

- Accepting concurrent employment with, acting for, or rendering services to any business or endeavor, with or without compensation, which competes with or conducts business with KHS
- Selling products directly or indirectly in competition with KHS financial interest or business involvement with an outside concern which conducts business with or is a competitor of KHS
- Representing KHS in any transaction in which a personal interest exists
- Accepting gifts in excess of $150 or any substantial materials or supplies, from an outside company that does business with or is seeking to do business with KHS. The annual gift limit is adjusted biennially and subject to change based on the Consumer Price Index. Designated employees may not accept a gift that is worth more than the financial thresholds set forth in FPPC regulation 2 CCR§ 18730, sections 7-9.5. $590.001 (2023-2024 limit amounts) in a twelve (12) month period.

KHS Board members, Chief Executives, and all management staff should avoid any business, activity or situation, which may possibly constitute a COI between their personal interests and the interests of KHS. Immediate disclosures are required if any potential situation may involve a COI.

KHS requires certain identified 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). If KHS has a potential, suspected, and/or actual conflict of interest, KHS will provide a description of the

relationship and a Conflict Avoidance Plan to ensure that such a relationship will not adversely affect DHCS, DMHC, other Managed Care Plans, or Medi-Cal Members. 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. 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.

IV. ELEMENT 2 DESIGNATION OF A CHIEF COMPLIANCE AND FRAUD PREVENTION OFFICER AND/OR A COMPLIANCE COMMITTEE

An effective Compliance Program reduces and mitigates risk, provides patients safe and high-quality care, and saves costs. DHCS requires KHS to designate a Chief Compliance and Fraud Prevention Officer to carry out and enforce compliance activities. The Chief Compliance and Fraud Prevention Officer functions as an independent and objective person that reviews and evaluates organizational compliance and privacy/confidentiality issues and concerns. The Chief Compliance and Fraud Prevention Officer’s main duties include coordination and communication of the compliance plan; this involves planning, implementing, and monitoring the program.

COMPLIANCE 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 and Fraud Prevention Officer is an independent employee of KHS and does not serve in any operational capacity.

A. Chief Compliance and Fraud Prevention Officer

The responsibilities of the Chief Compliance and Fraud Prevention Officer as defined in the Department of Health Care Services contract include:

- 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. Coordinate with Human Resources to ensure that all directors, officers, employees, and contractors, if applicable, are screened before appointment or engagement and monthly thereafter against any applicable State Medicaid program exclusion lists
- 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.
- 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.

Coordination and communication are the Chief Compliance and Fraud Prevention Officer's key tools for planning, implementing, and monitoring an effective Compliance Program. The Chief Compliance and Fraud Prevention Officer should strive to develop, and promote, productive working relationships with organizational leaders. Coordinating work and sharing information with leaders of other support functions, including (as applicable), Legal, Internal Audit, Information Technology, Human Resources, Quality, Risk Management, and Security will enhance the strength and success of the Compliance Program.

B. Compliance Committee

Actively leading the Compliance Committee and its meetings is an important and integral function of the Chief Compliance and Fraud Prevention Officer. As the Compliance Committee chair, the Chief Compliance and Fraud Prevention Officer should establish and facilitate committee discussion and encourage active participation by all committee members.

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.
- Assessing education and training needs and effectiveness, and regularly reviewing required training
- Monitor Corrective Action Plans
- Develop. review and approve the Compliance Program and Workplan at least annually.
-

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.

C. Governance and Compliance Committee

Newly created in 2024, the Governance and Compliance Committee has the regulatory and fiduciary responsibility to oversee the KHS 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 KHS's Bylaws and Governance Structure, including committee composition, auditing and investigative practices. The Chief Compliance and Fraud Prevention Officer periodically provides a report to the board assessing the Compliance Committee's performance. This report compares KHS's expectations of the committee's performance with its actual performance. As part of the assessment, the Chief Compliance and Fraud Prevention Officer seeks input from the members of the Compliance Committee, the CEO, and the board.

D. Board Compliance Oversight

The United States Sentencing Commission's Guidelines require that a governing authority shall be knowledgeable about the content and operation of the

compliance program and shall exercise reasonable oversight with respect to the implementation and effectiveness of the compliance and ethics program. The board should have access to sufficient knowledge and resources to allow it to fulfill its compliance-related obligations competently. Oversight of the Chief Compliance and Fraud Prevention Officer is a critical component of the board's compliance role. The board should ensure that the Chief Compliance and Fraud Prevention Officer has sufficient power, independence, and resources to implement, maintain, and monitor the Compliance Program and advise the board about compliance operations and risk.

V. ELEMENT 3 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 KHS Board of Directors, Chief Compliance and Fraud Prevention Officer, Senior management, and employees on federal and State standards and requirements.

KHS requires First Tier Entities to provide Compliance Training to their employees and Downstream Entities within 90 days of hire, assignment or appointment and annually thereafter. First Tier Entity is any party that enters into a written arrangement with KHS to provide administrative services or health care services to a KHS member. Downstream Entity is any party that enters into a written arrangement with persons or entities below the level of the arrangement between KHS and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

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
- Seven 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. ELEMENT 4 EFFECTIVE LINES OF COMMUNICATION WITH THE CHIEF COMPLIANCE AND FRAUD PREVENTION OFFICER AND DISCLOSURE PROGRAMS

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 to allow employees to anonymously report violations, including other reporting 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. Disclosure Programs

All disclosures of compliance concerns, including potential violations of policies or Federal or State requirements, should be recorded in a log maintained by the Chief Compliance and Fraud Prevention Officer or their designee. All disclosures should be logged regardless of how they are made. whether made directly to the Chief Compliance and Fraud Prevention Officer or other compliance personnel, to another organizational leader, or through the anonymous reporting mechanism,

The Chief Compliance and Fraud Prevention Officer may take responsibility for reviewing some reported concerns, some reported concerns may be referred to other leaders or departments, for example, Human Resources, and some reports, such as those involving substantial legal violations, may be referred to counsel or law enforcement. The Chief Compliance and Fraud Prevention Officer should remain involved in all health care compliance investigations in which counsel takes the lead.

VII. ELEMENT 5 ENFORCING STANDARDS: CONSEQUENCES AND INCENTIVES

a. Consequences

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 and/or any law or regulation 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 and has responsibility for monitoring the consistency of the discipline. 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.

b. Incentives

KHS has developed appropriate incentives to encourage participation in the Compliance Program. The Chief Compliance and Fraud Prevention Officer, Compliance Committee, and other leaders consider the compliance performance or activities to incentivize, both across the organization and within specific departments or positions. Excellent compliance performance or significant contributions to the Compliance Program could be the basis for, significant recognition, or other, smaller forms of encouragement.
Behaviors that KHS could incentivize include:

- Achievement of compliance goals that are specific to a department or a specific position description.
- Achievements that reduce compliance risk (e.g., a team that develops a process that reduces compliance risk or enhances compliant outcomes, or an individual who suggests a method of attaining a strategic goal with less risk); or
- Performance of compliance activities outside of the individual's job description (e.g., mentoring of colleagues in compliant performance or performing as a compliance representative within their department or team).

Achievements in compliance should be treated commensurately with achievements in other areas valued by the organization. Through the thoughtful and deliberate use of incentives, KHS acts to reduce its compliance risk, enhance adherence to the Compliance Program, and develop a positive association with KHS's compliance culture.

VIII. ELEMENT 6 RISK ASSESSMENT, AUDITING AND MONITORING

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

A. Risk Assessment

Risk assessment, auditing, and monitoring each play a role in identifying and quantifying compliance risk. Although identifying and addressing risk have always been at the core of Compliance Programs, in recent years, compliance leaders have come to recognize and place increasing emphasis upon the importance of a formal compliance risk assessment process as part of the Compliance Program.

Risk assessment is a process for identifying, analyzing, and responding to risk. A compliance risk assessment is a risk assessment process that looks at risk to the organization stemming from violations of law, regulations, or other legal requirements. In organizations affected by government health care programs, a compliance risk assessment focuses on risks stemming from violations of government health care program requirements and other actions (or failures to act) that may adversely affect KHS's ability to comply with those requirements. Risk assessments are an integral part of the fiscal internal control process and to enterprise risk management and are essential for state and federal monetary funding.

B. Auditing and Monitoring

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 compliance work plan also should contain insight to organizational capacity to monitor the effectiveness of controls and risk remediation.

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. ELEMENT 7 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. Therefore, monitoring of hotlines, program integrity, and other operational activities is essential in detecting, noncompliance. 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.

A. Investigations of Violations

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.

B. Reporting to the Government

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 or legal counsel should report the potential violation not more than 60 days after the determination that credible evidence of a violation exists to the Office of the Inspector General, Department of Justice, Centers of Medicare and Medicaid Services (CMS), or other appropriate Government authority.

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.

C. Implementing Corrective Actions Initiatives

Once KHS has gathered sufficient credible information to determine the nature of the misconduct, steps for prompt corrective action are taken, including:

- Refunding of overpayments.
- Enforcing disciplinary policies and procedures; and
- Making any policy or procedure changes necessary to prevent a recurrence of the misconduct.

Throughout any investigation of any noncompliant conduct the Chief Compliance and Fraud Prevention Officer should gather information to aid them in determining

the root causes of the conduct. Additionally, the Chief Compliance and Fraud Prevention Officer should also determine whether the conduct exposed any compliance weaknesses that could place the entity at risk for other, unrelated misconduct.

X. NON-INTIMIDATION AND NON-RETALIATION POLICIES

The organization will protect whistle-blowers from retaliation. KHS maintains a zero tolerance for retaliation 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 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.

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. A member’s protected health information (PHI) is protected by the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act and state confidentiality laws.

COMPLIANCE PROGRAM

The Security Standards for the Protection of Electronic Protected Health Information, known as the Security Rule, was also promulgated pursuant to HIPAA. It specifies a series of administrative, physical, and technical safeguards for covered entities and their business associates to ensure, among other provisions, the confidentiality, integrity, and security of electronic PHI. Covered entities and their business associates can consider their organization and capabilities, as well as costs, in designing their security plans and procedures to comply with Security Rule requirements.

If a staff member discovers a potential privacy incident or breach, they are required to report the issue immediately to the Compliance Department . When a breach of PHI is discovered, KHS must report it to the DHCS Privacy Office, DHCS Contract Manager and DHCS Information Security Officer within twenty-four hours of discovery and to the Office for Civil Rights (OCR) under the Department of Health and Human Services (HHS) within the required time frames. A failure to report according to our regulated time frames may result in monetary penalties and/or sanctions against KHS.

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.

COMPLIANCE PROGRAM

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). Examples of member information that is protected by these regulations includes but is not limited to:

- 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.

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.

D. 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 (FWA) 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.

The Federal False Claims Act and similar state laws make it a crime to submit false claim to the government for payment. False claims include but are not limited to billing for treatment not rendered; upcoding to bill for higher reimbursement; and falsifying records to support billed amounts. Under the Federal False Claims Act, whistleblowers may bring a civil lawsuit against the company on behalf of the U.S. Government and, if the suit is successful, they may be awarded a percentage of the funds recovered. There is a provision in the Federal False Claims Act that protects a whistleblower from retaliation by an employer. Actions such as suspension, threats, harassment, or discrimination could be considered retaliatory. By statute, different categories of conduct result in different penalty amounts. For example, false claims may result in penalties of up to $20,000 per item or service falsely claimed, and improper kickback conduct results in penalties of up to $100,000 per violation.

KHS will not tolerate retaliation against any person who has suspected fraudulent activity and reported those suspicions in compliance with KHS policy.

E. 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. If KHS staff are approached or contacted by the media to discuss KHS, staff are required to refer them to the Senior Director of Marketing and Member Engagement.

All co-branded (KHS and other companies or vendors) and other marketing materials created by other companies or vendors must be approved by the Marketing Department prior to distribution. Marketing materials, including health education information, is subject to DHCS review and approval before using with community events or member education.

F. 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.

Violation of the Federal anti-kickback statute constitutes a felony punishable by a maximum fine of $100,000, imprisonment up to 10 years, or both. Conviction also will lead to mandatory exclusion from Federal health care programs, including Medicare and Medicaid. Liability under the Federal anti-kickback statute is determined separately for each party involved.

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

G. 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.

In addition, KHS has entered new arenas in support of its membership. For example, new technology such as Artificial Intelligence and organizations providing non-traditional services in health care settings (such as social services, food delivery, housing support, and care coordination services). While these organizations may be familiar with compliance risks applicable to their current business, KHS will need to evaluate and familiarize the potential for new risk areas associated with new and different lines of health care businesses and technology.

H. 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 remains fully responsible for the performance of all duties and obligations it delegates to Subcontractors and Downstream Subcontractors. Regardless of the relationship KHS has with a Subcontractor, whether direct or indirect through additional layers of contracting or delegation, KHS has the ultimate responsibility for adhering to, and fully complying with, all terms and conditions of the DHCS Contract, and all state and federal regulations.

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.

Responsibilities include:

- Ensure KHS Departments which delegate functions establish performance and reporting deliverables for departmental business needs designed to assess the effectiveness of health care delivery to members in compliance with regulatory requirements.
- Assist Departments with establishing effective departmental auditing tools designed to measure and report delegated entity performance in order to ensure compliance with regulatory requirements.
- Oversee all audits of delegated entities and assure that departments perform all necessary audits of delegated entities which are responsible for those functions delegated as set forth in the written delegation agreement on behalf of KHS. Audits and review of monthly and quarterly reports to be completed on a timely basis.
- Review and evaluate delegated entity's performance including identifying opportunities for performance improvement, recommending and/or issue corrective action plans when a deficiency has been identified.
- Distribute information to the Delegation Oversight Committee regarding findings, recommended changes to contracts and policies, and requested initiatives or project updates by the delegate entity.
- Make recommendations to the Quality Improvement Committee, the Chief Medical Officer, and the Chief Compliance and Fraud Prevention Officer/Director of Compliance regarding the compliance status of the delegated entity as it relates to DHCS contract, DHCS and DMHC All Plan Letters, and CMS and other documented requirements.
- Outstanding issues from the Committee could be advanced to the Kern Health Systems Board of Directors as identified.

KHS will not delegate the following contractual elements, as specified in the DHCS contract:

- Chief Health Equity Officer
- Medical Loss Ratio (MLR)
- Compliance Program
- NCQA Accreditation
- Duty to Ensure Subcontractor, Downstream Contractor, and Network Provider Compliance
- Delegation of Authority
- Conflict of Interest Avoidance

An effective Compliance Program is critical to meeting internal operational goals; decreasing errors; improving the quality of patient care and patient safety; and preventing, detecting, and addressing fraud, waste, and abuse. KHS 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

MEMORANDUM

TO: Kern Health Systems Governance and Compliance Committee

FROM: Deborah Murr, Chief Compliance and Fraud Prevention Officer

SUBJECT: Compliance Code of Conduct

DATE: February 7, 2025

BACKGROUND

Kern Health Systems (KHS) is required to implement an effective Compliance Program that meets the regulatory requirements set forth in both the Department of Health Care Services (DHCS) contract and the Department of Managed Health Care (DMHC) Knox-Keene license.

The Governance and Compliance 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.

Kern Health System's Code of Conduct articulates the standards of behavior that is demonstrated by all KHS employees and Board Members This Committee assists the Board to improve its functioning, structure, and infrastructure. Adherence to the Code of Conduct demonstrates the organizational commitment to comply with all regulatory requirements, state, and federal laws.

As a core function of the KHS's Governance and Compliance Committee, advancing transparency of all Compliance related activities, serves to mitigate risk to the organization through a centrally comprised oversight committee.

REQUESTED ACTION

Receive and File; Refer to KHS Board of Directors.

KERN HEALTH SYSTEMS

Code of Conduct

2025

Table of Contents

Executive Summary

Kern Health Systems, dba Kern Family Health Care, is committed to conducting its business operations in compliance with regulatory and contractual obligations while also delivering high quality and accessible health care services. Kern Health Systems' Compliance Program, Compliance Work Plan, and Code of Conduct together form the core components of the organization's Compliance Program. Kern Health Systems' Compliance Program and Code of Conduct reinforces the organization's purpose and values which support our commitment to integrity and ethical business conduct.

At Kern Health Systems (KHS), compliance and ethical conduct mean doing the right thing while serving the community. The Code of Conduct is a valuable guide to help us choose wisely when faced with an ethical dilemma. All employees, including members of the KHS Board of Directors, are required to perform consistently as outlined in the KHS Code of Conduct.

These six fundamental values: **EQUITY, EXCELLENCE, COMPASSION, COLLABORATION, INNOVATION, and INTEGRITY**, remind us that preserving an ethical workplace is critical to our long-term success as an organization. The Code articulates the standards of behavior that each one of us is expected to observe while performing our jobs, as well as our commitment to complying with all regulatory requirements, state, and federal laws.

As employees, we are all required to ensure compliance and report any potential issues, ethical concerns, or violations of this Code of Conduct in accordance with policies and procedures. For additional information please refer to the Compliance Program Description, Compliance Guide, Employee Handbook, and Policies and Procedures located on the KHS Intranet website.

Emily Duran

Chief Executive Officer

CORE VALUES


KHS CORE VALUES
EXCELLENCE
INTEGRITY
COLLABORATION
EQUITY
INNOVATION
COMPASSION

KERN HEALTH SYSTEMS CORE VALUES

Equity

- We take action to create a culture of fairness and inclusion that fits all members and employees, regardless of zip code, race, ethnicity, preferred language, cultural preferences, or personal history.
- Equity matters because people matter. We recognize that everyone is beautifully diverse, and we are better as an organization and a community when every individual is able to thrive and contribute their unique gifts.

Excellence

- We continually strive for outstanding results by maintaining high standards, community relevance, and working to improve ourselves and our programs.
- Excellence translates to quality outcomes, and a stronger, healthier community. We take pride in our work and invest the necessary effort to grow and ensure a meaningful, measurable impact for those we serve and work with.

Compassion

- We seek to see through the eyes of someone else's experience and extend empathy and care.
- Compassion is at the core of who we are. It is something that we give to others and ourselves, recognizing each person's inherent value and worth. When we understand and care for each other, we can design a better solution and response more productively to those is need.

KERN HEALTH SYSTEMS CORE VALUES

Collaboration

- We leverage each other's experience and expertise to solve problems and accomplish shared outcomes in support of a common mission.
- We recognize that we are most effective when we collaborate. Bringing together different strengths and perspectives promotes greater creativity, and makes for more sustainable, impactful solutions and results.

Innovation

- We create novel methods, solutions or systems that expand what is possible and deepen our potential impact.
- We value experimentation and out-of-the-box thinking as keys to finding new opportunities, improving efficiency, and producing a greater output and value. We are informed by the changing world that we work in, and constantly looking for ways to better serve our members and ourselves.

Integrity

- We do the right thing, even when its not the easy thing.
- Integrity is essential to creating the foundation for trust, workability and performance. Being true to our word and each other is what gives us the best possible chance to succeed and make a lasting difference.

KERN HEALTH SYSTEMS PURPOSE STATEMENT

Health and Equity for All!

It's in everything we do and everything we are. It's our rally cry! It's what brings us together and propels us forward. When we say for all, we mean for ***all***. Our members, our community, our providers and our employees at KHS.

At KHS we invest. We invest in what's possible. We equip our community, members, providers, and people to go beyond health and care of the body, to include the health of family, home, work, and relationships.

Our members are the heartbeat of our work. Each day is about serving them, empowering them, and caring for them. Care with the kind of quality that raises people up, breaks the cycle of poverty and opens doors to opportunity.

Employees are not just coming to work; they come to make a difference. They come to KHS as the place to express their full and best gifts, grow as leaders, and leave the community a better place.

When we level up, our community levels up.

Health and Equity for All is about more than healthcare; it's about fostering a community of care. This means people-care, member-care, community-care, and provider-care – each facet integral, every individual valued.

Our Values

Equity

Excellence

Compassion

Collaboration

Innovation

Integrity

CODE OF CONDUCT PRINCIPLES

KHS 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 rules, policies, and procedures.

All candidates for employment 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 employment or appointment to positions with substantial discretionary authority, of 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.

Every employee will receive an initial compliance orientation and periodic training updates regarding compliance protocols as they relate to the employee's individual duties. Non-compliance or violations will result in sanctioning of the involved employee(s) up to, and including, termination of employment. Disciplinary action will be taken in accordance with Kern Health System Human Resources policies and Employee Handbook.

Employees are required to read, acknowledge, and attest to completion of training on Kern Health Systems' Code of Conduct, annually. Employees understand and agree their attestation certifies the employee has received, read, agrees with, and will abide by, the Code of Conduct and all Kern Health System policies.

Conduct

Anti-Discrimination/Anti-Harassment. Employees will not unlawfully discriminate or engage in unlawful harassment against anyone on account of age, disability, marital status, national origin, race, religion, sexual orientation, or gender identity in hiring or other employment practices. Employees are responsible for supporting Kern Health System in its endeavor to protect others from such harassments and to assist affected employees in support and preventative action.

Honesty. Employees must not make false or misleading statements to any members and/or persons doing business with Kern Health System or about products or services offered by Kern Health System. Intentional acts of dishonesty are subject to strict disciplinary action, up to and including termination. Suspected violations should be promptly reported to the Compliance team at **FraudTeam@khs-net.com**.

Professionalism. Personal and professional behavior must conform to the standards expected of persons in their positions and within their responsibilities to ensure no misrepresentation of facts.

Duty to Safeguard. Employees must safeguard the identity, eligibility, individually identifiable health information, and other confidential information in accordance with Kern Health System policies and applicable legal requirements. Suspected violations should be promptly reported to the Compliance team at **HIPAATeam@khs-net.com**.

Proprietary Information. Employees will safeguard confidential proprietary information, which includes, but is not limited to contractor information, proprietary systems and software, research studies, and reports.

Ethics

Kern Health Systems maintains a strong commitment to comply with all applicable Federal and State requirements and standards under its contract and licensure with the State Regulatory agencies. KHS's organizational expectation requires all employees, Executive officers, Board of Directors, Network Providers, Subcontractors, and Downstream Contractors to act ethically and have a responsibility in ensuring compliance.

Compliance with the Law. Employees will not lie, cheat, steal, or violate any law in connection with their employment with Kern Health System. Employees cannot be suspended, terminated, debarred or otherwise ineligible to participate in any Federal or State health care program. Employees must act ethically, and all employees have a responsibility for ensuring compliance.

Compliance Program and Reporting. Employees are required to promptly report suspected violations of any Federal and/or State statute, regulation, or guideline, or Kern Health Systems policies. Employees must report any non-compliance or misconduct to a supervisor, the Chief Compliance and Fraud Prevention Officer, Director of Compliance and Regulatory Affairs and/or anonymously to the Compliance **Ethics Hotline 1-833-607-6589**.

Regulatory Reporting. Employees must notify the Chief Compliance and Fraud Prevention Officer and/or the Director of Compliance and Regulatory Affairs immediately upon the receipt of an inquiry, or other government request for information from an external body. Employees will not take action with regulatory bodies that is false or misleading and will communicate with regulatory agencies in a direct, open, and honest manner.

Accurate Books and Records. Financial reports, accounting records, expense accounts, timesheets, regulatory reporting, and other documents must be prompt and accurately represent the facts or true nature of the transaction(s). Improper or fraudulent documentation or reporting will violate this policy and may violate the law. Employees are to report inaccuracies promptly.

Preservation of Documentation and Records. Employees will not destroy or alter information or documents in anticipation of, or in response to, a request for documents by any governmental agency or court with jurisdiction.

Protection of Company Property. Employees are responsible for protecting and taking reasonable steps to prevent the misuse, theft, or damage of Kern Health System assets. Kern Health System property may not be converted to personal use.

Conflicts of Interest

Avoiding Conflict. Employees are expected to avoid, and not engage in, situations or business practices that conflict with the interests of the company. If under any circumstance, employee interests' conflict with those of Kern Health Systems, the employee must seek advice from the Chief Compliance and Fraud Prevention Officer and their senior management.

Business Relationships. Offering, giving, soliciting, or accepting any form of bribe or other improper payment is expressly prohibited. Kern Health Systems' business must be executed in a manner designed to further the interests of Kern Health Systems, rather than the interests of an individual.

Gifts. Employees will not accept or solicit personal gratuities, gifts, favors, services, entertainment, or any other things of value from any person or organization unless specifically permitted by Kern Health Systems.

Meals. Employees may not accept cash or cash equivalents. Perishable or consumable gifts given to a department are not subject to any specific limitation. Business meetings at which a meal is served are not prohibited from being provided by Kern Health Systems to a partner, or by a partner to Kern Health Systems.

Use of Funds. Kern Health Systems and its employees will not make gifts of public funds or assets or lend credit to private persons without adequate consideration unless such actions clearly serve a public purpose and are approved by the Legal Department.

The Code of Conduct is a living document that will be reviewed on an annual basis and updated as necessary to reflect the needs of the organization. A copy can be downloaded from the KHS Intranet as well as our website- **kernfamilyhealthcare.com**.

Without programs to prevent, detect, and correct non-compliance, risk is created for potential harm to members, such as delayed services, denial of benefits, difficulty in using providers of choice and other hurdles to care or loss of contracts or licensures.

If anyone has questions regarding the Code of Conduct, our Compliance Program, or are unsure if something is non-compliant or in violation, please reach out to the Chief Compliance and Fraud Prevention Officer via email at **deborah.murr@khs-net.com** or phone at 661-664-5541, and/or the Director of Compliance and Regulatory Affairs via email @ **jane.macadam@khs-net.com** or phone at 661-664-5016 or the Compliance team via email at **Compliance@khs-net.com.**

Compliance is your partner, advocate, and confidante; ready to assist with all compliance related issues.

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Governance and Compliance Committee

FROM: Deborah Murr, Chief Compliance and Fraud Prevention Officer

SUBJECT: Compliance Guide

DATE: February 7, 2025

BACKGROUND

Kern Health Systems (KHS) is required to implement an effective Compliance Program that meets the regulatory requirements set forth in both the Department of Health Care Services (DHCS) contract and the Department of Managed Health Care (DMHC) Knox-Keene license.

The Governance and Compliance Committee ensures 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.

Kern Health System's Compliance Guide offers a self-study reference guide in support of KHS's commitment to acting ethically and responsibly in a culture of compliance, ethics, and integrity. Additional resources are available in the KHS Employee Handbook and policies and procedures.

Educational support to all staff and Board Members for managing organizational risks related to Fraud, Waste, and Abuse (FWA) and Privacy and Security issues under the Health Insurance Portability and Accountability Act (HIPAA) ensures the organization is provided the necessary tools to protect KHS members' personal health information and KHS's proprietary activities.

As a core function of the KHS's Governance and Compliance Committee, advancing transparency of all Compliance related activities, serves to mitigate risk to the organization through a centrally comprised oversight committee.

REQUESTED ACTION

Receive and File; Refer to KHS Board of Directors.

KERN HEALTH SYSTEMS

Self-Study Employee Guide

HIPAA Fraud, Waste, or Abuse Code of Conduct Core Values

2025

KHS Self-Study Employee Guide

HIPAA Fraud, Waste, or Abuse Code of Conduct

Table of Contents

A message from the Compliance Department

At Kern Health Systems we are deeply committed to acting ethically and responsibly in a culture of compliance, ethics, and integrity. To support that commitment, we have created this Self-Study Employee Guide that will cover general information regarding HIPAA, Fraud, Waste, or Abuse, and the KHS Code of Conduct.

Additional information can be found in the Employee Handbook as well as polices and procedures located on the KHS Intranet. Should you have questions regarding any of the topics in this guide, please contact the Compliance Department.

Methods for contacting Compliance and reporting concerns:

FraudTeam@khs-net.com
HIPAATeam@khs-net.com
Compliance@khs-net.com
Director of Compliance and Regulatory Affairs: jane.macadam@khs-net.com
Chief Compliance and Fraud Prevention Officer: deborah.murr@khs-net.com

KHS employees can also report suspected ethical abuses and fraud by calling the Ethics Hotline at:

1-833-607-6589

Available 24/7. All calls are strictly confidential.

HIPAA

What does it mean to you?

At Kern Health Systems every employee is responsible for the health records of over 400,000 Members. It's important to understand the state and federal laws that regulate the privacy and protection of Member information, as necessary to carry out KHS workforce functions.

HEALTH
I NSURANCE
P ORTABILITY
ACCOUNTABILITY
ACT

WHAT DOES THE LAW SAY?

The Health Insurance Portability and Accountability Act of 1996 or (HIPAA) is a federal law designed to protect a subset of sensitive information known as protected health information or (PHI) shared with health plans, doctors, hospitals and others who provide and pay for healthcare. In 2009, HIPAA was expanded and strengthened by the HITECH Act (Health Information Technology for Economic and Clinical Health).

What is PHI, ePHI, and PI?

The HIPAA Privacy Rule protects the privacy of individually identifiable health information, called protected health information (PHI).

PHI (Protected Health Information) is any information that can be used to identify a Member, whether living or deceased - that relates to the patient's past, present, or future physical or mental health or condition.

The HIPAA Security Rule protects information which is individually identifiable health information received, maintained or transmitted in electronic form. The Security Rule calls this information “electronic protected health information” (e-PHI).

PI (Personal Information) is any information that is not public and maintained by an agency that identifies or describes an individual. This may include two or more pieces of information such as first and last name with a social security number and or date of birth.

Examples of PI

- Name (first and last)
- Social Security Number
- Physical Description
- Home Address
- Home Telephone Number
- Education
- Financial Matters
- Medical or Employment History
- Statements made by or attributed to the individual

Employees may access Member PHI, ePHI or PI ONLY when necessary to perform their job-related duties.

HIPAATeam@khs-net.com

You must take immediate action and report all potential privacy breaches or unauthorized disclosures to your Supervisor and the *HIPAATeam@khs-net.com* or the Chief Compliance Officer

A privacy breach is an unauthorized disclosure of PHI, ePHI, or PI in any manner (paper, electronic or verbal) that violates either Federal or State laws.

TYPES OF BREACHES

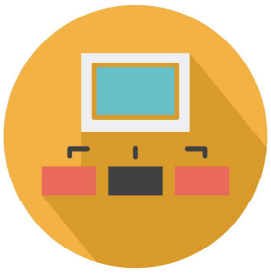
Paper Breach
Misdirected paper faxes with PHI outside of KHS, loss or theft of paper documents containing PHI, mailings with PHI to incorrect providers or members.

Electronic Breach
Stolen, unencrypted laptops, hard drives, PCs with ePHI, stolen unencrypted USB devices (memory sticks, thumb drive, etc.), misdirected e-fax to an unauthorized party.

Verbal Breach
Sharing PHI with friends or family outside of work, over the phone to a person not authorized by law or permission.

Privacy & Security Tips

Protect PHI and ePHI at all times – your job and reputation may depend on it.



- Cover, turn over, or lock up PHI and lock your computer screen when you're away from your workstation.
- Use encryption for emails containing ePHI.
- Do not discuss PHI outside of work under any circumstances.
- Protect PHI on computers, laptops, copy machines, or other electronic devices.
- When faxing member information, double check the recipient's number.
- Promptly pick up your copies containing PHI from copy machines.
- Report accidental or willful disclosures of PHI and security violations to your Supervisor and the KHS Privacy Officer by using the HIPAA Team email node - HIPAATeam@khs-net.com.
- Do not leave your passwords exposed.
- Use confidential shredding bins to dispose of PHI.

Accessing or disclosing Member's PHI is only permitted when it pertains to the employee's job duties.

Penalties for Breaches

Breaches of the HIPAA Privacy and Security Rules have serious ramifications that may result in civil and criminal penalties.

CIVIL

HIPAA civil financial penalties apply to covered entities and its employees which may include: $141-$2,134,831 in fines or more for single violation up to $1.5 million for multiple violations in 1 year. Additional separate penalties can be assessed by the Attorney General of $100 to $25,000 per violation category.

CRIMINAL

Criminal penalties for knowingly obtaining, using or disclosing PHI in violation of HIPAA may include fines up to $50,000 to $250,000 and up to 10 years in prison.

Sources: 45 C.F. R. § 160.404,
42 U.S. Code § 1320d-6

Violations of KHS policies may also result in disciplinary action, up to and including termination of employment.

Minimum Necessary

Provide only the information that is necessary in order to minimize risk to the security of a member's PHI.

Follow minimum necessary principles for using confidential information:

- If you don't need confidential information to complete a task, don't access it.
- If specific information is requested, such as a list of specific members or a person's name, send only that.
- If you need to reply to or forward an email or text message, remove all non - essential PHI and recipients from the message before you send it.
- Leave minimal information necessary on voicemail or answering machines.

HIPAA requirements state that when you access, use, or disclose PHI, only access, use, or disclose the minimum necessary information to accomplish the intended purpose.

Sources: 45 C.F. R. § 164.502(b), 45 C.F.R. 164.514(d)

We are ALL responsible for reporting suspected cases of FWA.

Fraud, Waste, or Abuse

What is FRAUD?

An intentional deception or misrepresentation made by persons with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person and includes any act that constitutes Fraud under applicable federal or State law, including 42 CFR section 455.2 and W&I section 14043.1(i).

WASTE?

The over utilization or inappropriate utilization of services and misuse of resources.

or ABUSE?

Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program.

WHAT DOES THE LAW SAY?

The False Claims Act (FCA) (31 U.S.C. §3729-3733), protects the government from being overcharged or sold substandard goods or services. The FCA imposes liability on any person who submits a claim to the federal government that he or she knows is false.

Examples of
Fraud, Waste, or Abuse

Provider FWA

- Billing for services not rendered
- Sending Members a bill after the plan has made payment
- Coding a New Patient Visit instead of an Established Patient Visit
- Soliciting or receiving kickbacks
- Questionable prescribing practices

Member FWA

- Ambulance abuse and overuse of Emergency Rooms
- Sharing ID card, benefit sharing
- Illegal doctor shopping & drug-seeking behavior
- Deliberately providing misinformation to retrieve services
- Selling and forging prescriptions

Report FWA

Speak Up!

Report suspicious activities to your Supervisor and the Director of Compliance by using the Fraud Team email node. You can also make anonymous reports by calling the Ethics Hotline at 1-833-607-6589, available 24/7. All calls to the hotline are strictly confidential.

Do the right thing

Anyone with information about possible fraud, waste, or abuse can make a confidential report.

Kern Health Systems does NOT allow or tolerate retaliation against those who, in good faith, report potential Fraud, Waste, or Abuse (FWA) to the Compliance Department.

Report FWA concerns:

- To your Supervisor or Management Team
- Email the Fraud Team at FraudTeam@khs-net.com
- In person to the Compliance Team
- Call the Ethics Hotline 1-833-607-6589

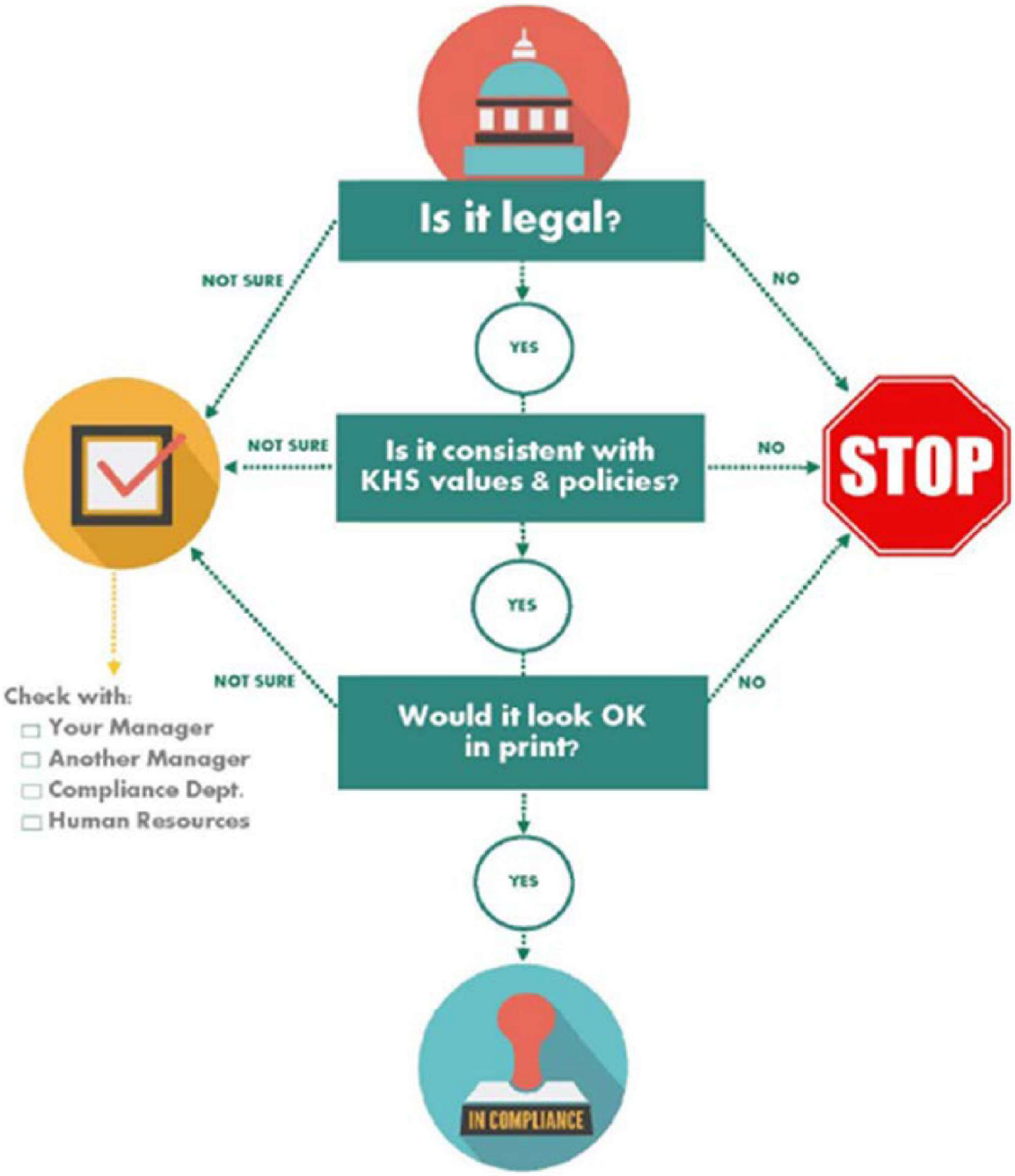
When you report, you're protected.

KHS employees can report suspected ethical abuses and fraud by calling the Ethics Hotline at:

1-833-607-6589

Available 24/7. All calls are strictly confidential.

HEADLINE TEST



Do the right thing while serving the community.

Code of Conduct

At Kern Health Systems (KHS), compliance and ethical conduct mean doing the right thing while serving the community.

The KHS' Code of Conduct is a set of values outlining the responsibilities for you as an employee and KHS as an organization.

These **SIX** fundamental values: **EXCELLENCE, EQUITY, INTEGRITY, INNOVATION, COLLABORATION, AND COMPASSION**, remind us that preserving an ethical workplace is critical to our long-term success as an organization. The Code articulates the standards of behavior that each one of us is expected to observe while performing our jobs.

KHS maintains a non-retaliation policy. As employees we are required to, in good faith, report compliance issues, ethical concerns, or violations of this Code of Conduct in accordance with KHS policies.

KERN HEALTH SYSTEMS

Potential compliance concerns should be reported to the Director of Compliance, Chief Compliance Officer, or Compliance@khs-net.com.

Kern Health Systems is committed to advancing our values by designing our services and benefits that meet the needs of diverse patient populations

When you hear

Code of Conduct

think

6

The Code of Conduct is a cornerstone of the Kern Health Systems Compliance Program and articulates the standards of behavior that each one of us is expected to observe while performing our jobs.

KERN HEALTH SYSTMS CORE VALUES

Equity

- We take action to create a culture of fairness and inclusion that fits all members and employees, regardless of zip code, race, ethnicity, preferred language, cultural preferences, or personal history.
- Equity matters because people matter. We recognize that everyone is beautifully diverse, and we are better as an organization and a community when every individual is able to thrive and contribute their unique gifts.

Excellence

- We continually strive for outstanding results by maintaining high standards, community relevance, and working to improve ourselves and our programs.
- Excellence translates to quality outcomes, and a stronger, healthier community. We take pride in our work and invest the necessary effort to grow and ensure a meaningful, measurable impact for those we serve and work with.

Compassion

- We seek to see through the eyes of someone else's experience and extend empathy and care.
- Compassion is at the core of who we are. It is something that we give to others and ourselves, recognizing each person's inherent value and worth. When we understand and care for each other, we can design a better solution and response more productively to those is need.

Collaboration

- We leverage each other's experience and expertise to solve problems and accomplish shared outcomes in support of a common mission.
- We recognize that we are most effective when we collaborate. Bringing together different strengths and perspectives promotes greater creativity, and makes for more sustainable, impactful solutions and results.

Innovation

- We create novel methods, solutions or systems that expand what is possible and deepen our potential impact.
- We value experimentation and out-of-the-box thinking as keys to finding new opportunities, improving efficiency, and producing a greater output and value. We are informed by the changing world that we work in, and constantly looking for ways to better serve our members and ourselves.

Integrity

- We do the right thing, even when its not the easy thing.
- Integrity is essential to creating the foundation for trust, workability and performance. Being true to our word and each other is what gives us the best possible chance to succeed and make a lasting difference.

KERN HEALTH SYSTEMS PURPOSE STATEMENT

Health and Equity for All!

It's in everything we do and everything we are. It's our rally cry! It's what brings us together and propels us forward. When we say for all, we mean for *all*. Our members, our community, our providers and our employees at KHS.

At KHS we invest. We invest in what's possible. We equip our community, members, providers, and people to go beyond health and care of the body, to include the health of family, home, work, and relationships.

Our members are the heartbeat of our work. Each day is about serving them, empowering them, and caring for them. Care with the kind of quality that raises people up, breaks the cycle of poverty and opens doors to opportunity.

Employees are not just coming to work; they come to make a difference. They come to KHS as the place to express their full and best gifts, grow as leaders, and leave the community a better place.

When we level up, our community levels up.

Health and Equity for All is about more than healthcare; it's about fostering a community of care. This means people-care, member-care, community-care, and provider-care – each facet integral, every individual valued.

Our Values

Equity

Excellence

Compassion

Collaboration

Innovation

Integrity

The Chief Compliance and Fraud Prevention Officer and the entire Compliance Department are valuable resources available to partner with you in all aspects of ensuring compliance. Compliance is everyone's responsibility.

- Answer questions
- Clarify requirements, regulations, and reporting obligations.
- Provide guidance or training on compliance or regulatory topics.
- Investigate and resolve any concerns or potential violations.
- Provide guidance on implementing new requirements or corrective actions for any potential areas of non-compliance.

An effective compliance program is critical to meeting internal operational goals; decreasing errors; improving the quality of patient care and patient safety; and preventing, detecting, and addressing fraud, waste, and abuse. KHS 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

MEMORANDUM

TO: Kern Health Systems Governance and Compliance Committee

FROM: Deborah Murr, Chief Compliance and Fraud Prevention Officer

SUBJECT: Anti-Fraud Plan

DATE: February 7, 2025

BACKGROUND

In accordance with California Health and Safety Code Section 1348, Kern Health Systems (KHS) establishes and maintains an antifraud plan. The purpose of the antifraud plan outlines KHS strategies and efforts to identify and reduce costs to the plan, providers, subscribers, enrollees, and others caused by fraudulent activities, and to protect consumers in the delivery of health care services through the timely detection, investigation, and prosecution of suspected fraud.

The Governance and Compliance Committee ensures 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.

The KHS Compliance Department regularly reviews strategies to strengthen its Anti-Fraud Plan. Key elements include ensuring enhanced fraud risk awareness and facilitating increased coordination and collaboration across the organization are essential to improving its fraud risk assessment processes.

KHS provides an effective training program for all KHS employees and Board of Directors. Providers, vendors, subcontractors, and enrollees also receive information to educate and improve their awareness of various forms of fraud, waste, or abuse and how they can detect, prevent, and report suspected fraud, waste, or abuse. This training highlights KHS' commitment to compliance with federal and state regulations regarding fraud, waste, or abuse.

REQUESTED ACTION

Receive and File; Refer to KHS Board of Directors.

KERN HEALTH SYSTEMS

ANTI-FRAUD PLAN

In accordance with California Health and Safety Code Section 1348, Kern Health Systems (KHS) establishes and maintains an antifraud plan. The purpose of the antifraud plan outlines KHS strategies and efforts to identify and reduce costs to the plan, providers, subscribers, enrollees, and others caused by fraudulent activities, and to protect consumers in the delivery of health care services through the timely detection, investigation, and prosecution of suspected fraud.

1. **Definitions:**

   - **Abuse** is defined as practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program.

   - **Fraud** is defined as an intentional deception or misrepresentation made by persons with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person and includes any act that constitutes Fraud under applicable federal or State law, including 42 CFR section 455.2 and W&I section 14043.1(i).

   - **Waste** includes the overutilization or inappropriate utilization of services and misuse of resources.

2. **Structure:**

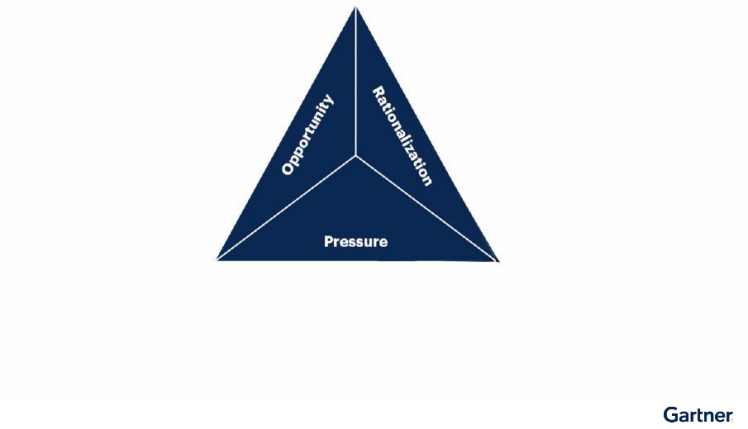
   Under the leadership of the Chief Compliance and Fraud Prevention Officer (CCFPO), the KHS Compliance Department is responsible for implementation of the Anti-Fraud Plan (AFP). The Compliance Department is responsible for Anti-Fraud Plan oversight, and it has full authority to review all documents and other information that are relevant to the exercise of position duties. In addition, the Chief Compliance and Fraud Prevention Officer is copied on internal reports and work with Directors to identify opportunities for process improvement. The Chief Compliance and Fraud Prevention Officer annually reviews and updates the Anti-Fraud Plan as necessary to address KHS operational, legislation, or federal/state policies changes.

   The Chief Compliance and Fraud Prevention Officer reports to the Chief Executive Officer and has access KHS legal counsel, and dotted reporting authority to the KHS Board of

Directors. The attached Fraud Reporting Structure[i] demonstrates the relationship of the Compliance Department to senior management and KHS Board of Directors (see attachment A).

- KHS employees, providers, members, vendors, and sub-contractors shall abide by all parts of this plan.
- KHS serves Medi-Cal beneficiaries and coordinates care with local programs.
- KHS does not delegate program integrity and compliance plan functions to any Subcontractor or Downstream Contractor.

The KHS Compliance Department regularly reviews strategies to strengthen its Anti-Fraud Plan[1]. Key elements include ensuring enhanced fraud risk awareness and facilitating increased coordination and collaboration across the organization are essential to improving its fraud risk assessment processes.



Fraud, Waste, and Abuse (FWA) Committee:

The Compliance Department chairs a Fraud, Waste, and Abuse Committee, which reviews and discusses potential fraud, waste, and abuse activities. The Committee meets at least quarterly, and more often as needed based on FWA activities and investigations.

3. Policies and Procedures:

KHS maintains an anti-fraud strategy to identify fraud, waste, or abuse and reduce costs associated with such activities. This includes the protection of the members during the delivery of health care services by providers.

The Compliance Department is responsible for the development and implementation of policies and procedures to prevent and detect fraud, waste, or abuse, which address specific areas of suspected fraud, waste, or abuse and the initiation of corrective action to prevent similar offenses. KHS has an established policy, *14.04-P Preventing, Detecting, and*

Reporting Fraud, Waste, or Abuse, which is submitted and approved by both the Department of Healthcare Services (DHCS) and the Department of Managed Health Care (DMHC) (see Attachment B).

In accordance with 42 USC section 1396b(i)(2), KHS will not pay any amount for any services or items, other than Emergency Services, to an Excluded Provider as defined in Exhibit A, Attachment III, Subsection 1.3.4.A, (*Tracking Suspended, Excluded, and Ineligible Providers*) of DHCS Contract. This prohibition applies to non-emergent services furnished by a Provider at the medical direction or prescribed by an Excluded Provider when the Provider knew or had a reason to know of the exclusion or prescribed by an Excluded Provider to whom DHCS has failed to suspend payment while pending an investigation of a credible allegation of Fraud.

- Compliance with the Anti-Fraud Plan and related policies and procedures may be a factor in evaluating the performance of employees. KHS may take disciplinary action, up to and including termination, for violation of these requirements.

- Contracted providers are by virtue of their contract are obligated to adhere to all KHS' policies and procedures including regulatory requirements related to Fraud, Waste, or Abuse. Providers access relevant policy and procedures via KHS' website. Additionally, contracted providers periodically receive provider awareness bulletins.

4. **Anti-Fraud Awareness Training Program:**

Noncompliance and misconduct stem from many factors, and organizational culture remains a leading cause of both. Fraud-awareness training creates a culture of fraud awareness, helping prevent fraud and increase the likelihood of incident reporting. Comprehensive fraud-awareness training programs help address the conditions that lead to fraud — rationalization, pressure, and opportunity — by educating employees about common fraud scenarios and communicating consequences for fraudulent activity and behavior. A strong code of conduct provides the foundation for a fraud-aware culture.

KHS provides an effective training program for all KHS employees and Board of Directors. Providers, vendors, subcontractors, and enrollees also receive information to educate and improve their awareness of various forms of fraud, waste, or abuse and how they can detect, prevent, and report suspected fraud, waste, or abuse. This training highlights KHS' commitment to compliance with federal and state regulations regarding fraud, waste, or abuse.

- New employees receive Anti-Fraud Awareness training as part of the New Employee Orientation Program within 90 days from their hire date.

- FWA training is also conducted for all employees annually, which requires all employees to participate in the training and pass quizzes presented throughout the training.

- Employee attendance and participation in training programs are a condition of continued

employment, and failure to comply with training requirements may result in disciplinary action, up to and including termination.

- The Compliance Department maintains adequate training records, including attendance logs and material distributed during the training sessions.

- If an employee is unclear as to their obligations regarding anti-fraud matters, the employee may seek clarification from the Fraud Team, Director of Compliance, or the Chief Compliance and Fraud Prevention Officer.

- The Chief Compliance and Fraud Prevention Officer, Director of Compliance and members of the Compliance Department attend anti-fraud training, workshops, and seminars to enhance their knowledge and awareness of fraud investigation, detection, and prevention.

- New providers contracting with Kern Health Systems (KHS) are educated through our new provider orientation training, which includes a specific section on fraud, waste, and abuse.

5. Communication:

Employees may report suspected fraud, waste, or abuse or any anti-fraud compliance issue to the Anti-Fraud Team, Chief Compliance and Fraud Prevention Officer or designee, or by calling the Ethics Hotline. After making the report, the employee should refrain from additional discussion of the matter, except with the Chief Compliance and Fraud Prevention Officer or designee. All reports directed to the Compliance Department will be reviewed within the standards set by contract or law.

KHS acknowledges that information shared by DHCS, other State and federal agencies, and other Medi-Cal managed care plans in connection with any Fraud, Waste, or Abuse referral must be considered confidential, until formal criminal proceedings are made public. All reports of suspected fraud, waste, or abuse will be treated confidentially. However, contingent upon circumstances, KHS may be required to reveal such information to comply with governmental authorities or law enforcement.

In accordance with Policy 14.04-P *Preventing, Detecting, and Reporting Fraud, Waste, or Abuse Prohibition of Retaliation*, KHS prohibits retaliation against any employee who makes a good faith report of suspected fraud, waste, or abuse. No employee will be subject to disciplinary action solely because they reported what they reasonably believe to be an act of wrongdoing. However, an employee whose report of wrongdoing contains an admission of personal wrongdoing cannot be guaranteed protection against disciplinary action. The fact that the employee volunteered the information will be considered as a favorable act in any disciplinary action concerning that employee. An employee may be subject to discipline if KHS determines they knowingly fabricated, in whole or in part, a report of wrongdoing.

In addition to published policies and training, KHS supports ongoing communication and resources related to fraud, waste, and abuse, some of which are outlined below:

- The Compliance Department hosts an annual company-wide Compliance Awareness week event during the month of November. Materials are created internally and cover a variety of Compliance-related topics, including fraud, waste, and abuse.

- The KHS Code of Conduct also provides education on fraud, waste, and abuse. The code of Conduct is reviewed during New Employee Orientation and is also referenced during Compliance Week Activities. It is also available on the website (internal and external) for reference as needed.

- Additional provider education and resources include our Provider Manual and policies, which includes information on detection and reporting of fraud, waste, and abuse.

- The Member Handbook (Evidence of Coverage) describes examples of fraud, waste, and abuse and encourages members to report any allegations of fraud related to providers or members suspected of misusing his or her benefits or the benefits of others.

- The KHS website provides instructions for reporting fraud. A KHS FWA Reporting Form is available online at the KHS website for providers, members, and the public to use to report suspected fraud.

- Reports of suspected fraud, including those provided anonymously, are also accepted orally by telephone, via email to a dedicated Fraud Team email address, in person, or in writing from any source including employees, members, subcontractors, downstream subcontractors, providers and the public.

- The annual FWA training includes reminders on the internal processes for referring potential FWA to Compliance and the importance of timely referrals, including job aids and tutorials.

- The Compliance Team issues a monthly Compliance Capsule on a variety of topics, with at least one monthly capsule dedicated to potential fraud, waste, and abuse. The Compliance Capsule is distributed to all employees via email and also posted to the KHS internal employee dayforce hub.

- The Anti-Fraud Plan is submitted annually to the KHS Board of Directors (BOD). Regular reporting on the KHS FWA activities is also reported to the BOD.

6. Fraud Investigations:

The Chief Compliance and Fraud Prevention Officer, in collaboration with the Director of Compliance, oversees fraud, waste, or abuse investigations. The Compliance Manager of Audits and Investigations assists in managing the day-to-day operations regarding fraud, waste, and abuse.

The Compliance Department has dedicated team members responsible for researching and gathering information, including supporting documentation, for allegations of fraud, waste, or abuse received by the department.

Allegations may be identified and/or received from enrollees, providers, KHS employees, subcontractors, government regulatory agents, the public, or a variety of other sources.

The Compliance department also serves as the primary point of contact in the coordination of KHS resources in response to external auditor, regulator, or law enforcement requests, including but not limited to the California Department of Justice Special Investigators and DHCS Medi-Cal investigators.

Compliance Department activities may involve the submission of the results of the preliminary investigation to the Department of Health Care Services (DHCS) Program Integrity Unit, and possibly law enforcement. KHS is committed to comply with any investigation or a prosecution conducted by the Division of Medi-Cal Fraud and Elder Abuse (DMFEA) and/or the United States Department of Justice (US DOJ), including communicating requirements with Subcontractors and Downstream Subcontractors.

- All allegations or suspicions of potential fraud, waste, and abuse received or identified are submitted to the Compliance Department for investigation.

- All allegations of fraud, waste, or abuse are entered in a Fraud Log to control and track the status of investigations.

- Compliance conducts investigations, which may include, but are not limited to reviews and/or analysis of claims, medical records, accounting records, and utilization management prior authorizations; telephone interviews; provider responses; and/or other applicable investigation techniques.

- Cases may be determined to be unsubstantiated if the act committed was due to an honest and unintentional mistake, and/or where there is no evidence of potential fraud, waste, and abuse upon the completion of the investigation.

- Actions taken as a result of investigations may include but are not limited to: referring to criminal and/or civi11aw enforcement authorities as appropriate; education; issuing formal corrective action plans and monitoring through closure; disciplinary action, provider termination, or no additional action being taken, dependent on the nature of the allegation and outcome of the investigation.

- All investigations are documented utilizing an internal investigation form, with the allegation, investigation form, reporting, and all communications maintained in individual case files.

- The Director of Compliance, Manager of Audits and Investigations, Compliance Auditor, and Compliance Analysts meet weekly to review newly received cases, the status of open cases, and determine next steps.

- The CCFPO meets with the Director of Compliance, Manager of Audits & Investigations, and lead Compliance Analyst bi-weekly for oversight and additional direction on specific cases as needed.

- The FWA Committee also provides oversight and direction related to the FWA investigations.

- Compliance submits credible allegations of potential fraud, waste, or abuse to the Department of Health Care Services (DHCS) Program Integrity Unit, and law enforcement as required and outlined within our policies.

7. Auditing and Monitoring:

- The Compliance Department submits an Annual Audit and Monitoring Plan to the Chief Executive Officer and Board of Directors for review and approval annually. The Annual Audit Plan contains intended areas of focus and outlines audit objectives for a calendar year. KHS regularly audits and monitors its internal departments, providers, subcontractors, and vendors.

- Compliance coordinates internal reviews and monitoring activities, including periodic reviews of departments based upon the annual audit plan or requests for a special audits, which may be triggered through other monitoring activities or reviews.

- The Claims Department also conducts ad hoc audits related to potential fraud, waste, and abuse, reporting results up to Compliance and the Fraud, Waste, and Abuse Committee.

- In addition to the FWA specific investigations, additional monitoring activities occur to detect possible provider or member fraud. Some examples are outlined at a high level below and reported up through the FWA Committee:

Monitoring Activity	Description	Department
Verification of Services	Quarterly mailing to at least 150 members to validate claims processed by KHS were actually received by the member	Compliance
Transportation Misuse	Member Transportation reports are reviewed for potential misuse; members found to be abusing the use of the transportation services may be restricted in the types of transportation services provided	Member Services

Monitoring Activity	Description	Department
Grievance	Report of possible fraud when a member has filed a grievance is investigated.	Member Services
Provider Monitoring	Monthly review of multiple ineligible provider and suspensions lists (OIG, DHCS, etc).	Provider Credentialing

8. Reporting:

KHS complies with all reporting requirements as outlined within the DHCS contract and state and federal requirements.

- KHS reports FWA activity status regularly to the KHS Board of Directors and the quarterly FWA Committee.
- KHS reports relevant allegations to the DHCS Program Integrity Unit within ten (10) business days of initial identification and within ten (10) business days of completion.
- KHS provides a quarterly states report on FWA investigations to the DHCS Program Integrity unit within ten (10) calendar days of the end of each reporting quarter.
- KHS reports to other agencies and/or law enforcement as required based on the individual investigation.
- KHS provides an annual anti-fraud report to the Department of Managed Health Care Services by 12/31 of each year.
- KHS complies with the DHCS Contract, State and Federal laws, and the guidelines issued by DHCS pertaining to reporting and retention policies for the treatment of recoveries of all Overpayments to Providers, including for the treatment of recoveries of overpayments due to Fraud, Waste, and Abuse, as outlined in KHS Policy 6.01-P, Claims Submission and Reimbursement.

References:

i Attachment A – Fraud Reporting Structure
ii Attachment B – KHS Policy *14.04-P, Preventing, Detecting, and Reporting Fraud, Waste, or Abuse*
[1] 2022 Gartner Audit Key Priorities and Risks Survey.

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Governance and Compliance Committee

FROM: Deborah Murr, Chief Compliance and Fraud Prevention Officer

SUBJECT: 2024 Compliance Work Plan Quarter 4 2024 Update

DATE: February 7, 2025

BACKGROUND

The Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC), requires organizations that participate as a California Med-Cal plan, to have a formal compliance program. 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 an annual work plan to help the organization achieve our commitment to adhere to the highest ethical standards of conduct in all business practices.

The U.S. Health and Human Services Office of Inspector General (OIG) outlines a structure for implementing an ongoing evaluation process which is critical to a successful compliance program. Through annual review and renewal, KHS can adjust the work plan accordingly to align with the changing healthcare landscape and regulatory requirements.

KHS prepares a Compliance workplan after reviewing the latest Department of Health Care Services (DHCS) and Department of Managed Care (DMHC) priorities, recent enforcement activities, previous internal and external audit findings and other relevant topics that necessitate additional scrutiny. Additionally, the workplan includes a list of areas that the Compliance Department will audit and monitor as a risk mitigation strategy for ongoing compliance under KHS's contract and licensure.

The 2024 Quarter 4 Workplan update provides a summary review of activities that were scheduled for 2024 and the status of those activities.

REQUESTED ACTION

Receive and File; Refer to the KHS Board of Directors.

KERN HEALTH SYSTEMS
2024
Compliance Program

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		**Complete**	BOD approval Februay 2024			
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	12/17/2024	Chief Compliance Officer		**Complete**	Awaiting corporate updates to pillars to update Code of Conduct further.	Six (6) new pillars have been adopted an approved July 2024. Final revision to Code of Conduct in progress.	Code of Conduct finalized with new values and purpose. Reviewed by CLHRO for use.	Code of Conduct submitted to DHCS and approved
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	11/20/2024	Chief Compliance Officer		**Complete**		Six (6) new pillars have been adopted an approved July 2024. Final revision to Code of Conduct in progress.	Compliance guide finalized and under internal review with leadership. Compliance meeting scheudled for 11/20/2024.	Reviewed and ready for review by GCC and BOD 1/2025
3b. Obtain Board approval of Compliance Guide	Obtain Board approval of Compliance Guide	12/17/2024	Chief Compliance Officer		**Complete**		Six (6) new pillars have been adopted an approved July 2024. Final revision to Code of Conduct in progress.		Reviewed and ready for review by GCC and BOD 1/2025
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	3/29/2024	Chief Compliance Officer		**Complete**	Committee approval February 2024			
4b. Obtain Board approval of Compliance Program	Obtain Board approval of Compliance Program	2/15/2024	Chief Compliance Officer		**Complete**	BOD approval Feburay 2024			
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	6/1/2024	Compliance Manager		**Complete**	Reconciliaton work in progress; policies identified that were not updated over past year for APLs/2024 Contract Readiness, which will be the initial focus for review.	7/5/2024 Notifications sent to department leadership/executives for annual policy review updates process.		
5b. Track to completion	All policies to be reviewed by end of year	12/31/2024	Compliance Manager Compliance Analyst Compliance Specialist		**Complete**		Ongoing monitoring for completed reivews and submissions for final approvals.	Ongoing monitoring for completed reivews and submissions for final approvals.	Ongoing monitoring for completed reivews and submissions for final approvals.
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		**Complete**	Reconciliation being finalized for NCQA, APL, 2024 DHCS Contract updates. Reporting will begin in Q2 Compliance Committee Meeting	Held August 14, 2024	Held August 26, 2024	Held November 20, 2024
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)	12/31/2024	Director of Compliance Compliance Analyst		**Complete**	On track for publication by target date of 06/01/2024	Updated versions of HIPAA and FWA policies pending posting on website.	Policy revisions or new added as completed	Policy revisions or new added as completed
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**	Held February 29, 2024	Held May 8, 2024	Held August 26, 2024	Held November 20, 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**	Held February 9, 2024	Held May 6, 2024	Held August 5, 2024	Held November 4, 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**	Held February 26, 2024	Held May 7, 2024	Held July 30, 2024	Held October 28, 2024

KERN HEALTH SYSTEMS
2024
Compliance Program

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	Q1 COMMENTS	Q2 COMMENTS	Q3 COMMENTS	Q4 COMMENTS
2. Review/update Committee Charters at least annually	Review/Update Charters and obtain Committee Approvals								
2a. Compliance Committee	Review/Update Charter	6/1/2024	Chief Compliance Officer		Complete		Delayed Q3		Reviewed with no revisions
2a.1 Obtain Committee Approval	Obtain Committee Approval on updated Charter	Q3 2024	Chief Compliance Officer		Complete		Delayed Q3		Reviewed with no revisions
2b. FWA Committee	Review/Update Charter	6/1/2024	Chief Compliance Officer		Complete		Delayed Q3		Reviewed with no revisions
2a.1 Obtain Committee Approval	Obtain Committee Approval on updated Charter	Q3 2024	Chief Compliance Officer		Complete		Delayed Q3		Reviewed with no revisions
2c. Delegation Oversight Committee	Review/Update Charter	6/1/2024	Chief Compliance Officer		Complete		Delayed Q3		Reviewed with no revisions
2c.1 Obtain Committee Approval	Obtain Committee Approval on updated Charter	Q3 2024	Chief Compliance Officer		Complete		Delayed Q3		Reviewed with no revisions
3. Provide regular Compliance Updates to the Board of Directors		Bi-Monthly BOD Meetings	Chief Compliance and Fraud Prevention Officer		Complete	Held February 15, 2024	Held April 18, 2024	Held August 15, 2024	Held October 17, 2024
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	4/1/2024	Director of Compliance		Complete	Compliance working with Human Resources Learning and Development team to revise/refresh content and delivery of training	2024 FWA, HIPAA trainings updated and will be assigned to staff in August 2024	Follow up and closure of open trainings for organization by Compliance and Learning/Development staff	Follow up and closure of open trainings for organization by Compliance and Learning/Development staff
1b. Fraud, Waste, and Abuse Training	Review/Update FWA Training	4/1/2024	Director of Compliance		Complete	Compliance working with Human Resources Learning and Development team to revise/refresh content and delivery of training	2024 FWA, HIPAA trainings updated and will be assigned to staff in August 2024	Follow up and closure of open trainings for organization by Compliance and Learning/Development staff	Follow up and closure of open trainings for organization by Compliance and Learning/Development staff
1c. HIPAA/Privacy Training	Review/Update HIPAA/Privacy Training	4/1/2024	Director of Compliance		Complete	Compliance working with Human Resources Learning and Development team to revise/refresh content and delivery of training	2024 FWA, HIPAA trainings updated and will be assigned to staff in August 2024	Follow up and closure of open trainings for organization by Compliance and Learning/Development staff	Follow up and closure of open trainings for organization by Compliance and Learning/Development staff
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)		Compliance	Reported out in Compliance Committee Meeting 02/29/2024; will also be Q2 agenda item	Reported out in Compliance Committee Meeting 05/08/2024 and will continue to be an agenda item for each meeting.	Reported out in Compliance Committee Meeting and will continue to be an agenda item for each meeting.	Reported out in Compliance Committee Meeting and will continue to be an agenda item for each meeting.
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		Complete			Planning begins in September/October.Scheduled for November 4-8, 2024	
5. Establish Compliance Training for Subcontractors	Establish content and method for delegated entity/subcontractor Compliance training	9/1/2024	Compliance Manager Director of Compliance		Complete	Moved target date due to resource constraints related to regulatory audits	Parntering with Delegation Oversight team to complete with contracting/pre-delegation audit	New subcontractors attest to compliance topic training at contracting	New subcontractors attest to compliance topic training at contracting
5a. Identify Delegated Entities/Subcontractors to receive training	Identify subcontractors to which Compliance Training applies	9/1/2024	Compliance Manager Director of Compliance		Complete	American Logistics VSP Health Dialog Language Line	Addtionally delegated entities/vendors identified--- All Med Cotiviti Hall Letter Harte Hanks LIfeSigns SPH Analytics Web MD Ignite (Health Wise) Zelis (PaySpan)		
5b. Implement Compliance Training for Subcontractors	Implement delegated entity/identified subcontractor training	9/1/2024	Compliance Manager Director of Compliance		Complete	Initial discussions with HR on potential use of new training platform. Currently re-reviewing DHCS contract to determine topics for delegate training.	Reviewing required topics for delegate training referencing increased number of identified delegates.	New subcontractors attest to compliance topic training at contracting	New subcontractors attest to compliance topic training at contracting
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	Director of Compliance added HIPAA/FWA language	Language added as identified	Language added as identified	
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	Emails, webinar invitations, etc.	Emails, webinar invitations, etc.	Emails, webinar invitations, etc.	Emails, webinar invitations, etc.

KERN HEALTH SYSTEMS
2024
Compliance Program

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	Q1 COMMENTS	Q2 COMMENTS	Q3 COMMENTS	Q4 COMMENTS
8. 2024 DHCS Contract Monitoring Activities	Compliance coordinates with project team and key stakeholders	Ongoing	Director of Compliance Compliance Analyst		Complete	DHCS submissions/AIR completion Compliance Dashboard Health Equity Dashboard Reports for PHM, UM, WP, PNM QNXT Config Updates MOU Status Reporting & Execution	DHCS submissions/AIR completion Compliance Dashboard Health Equity Dashboard Reports for PHM, UM, WP, PNM QNXT Config Updates MOU Status Reporting & Execution	DHCS submissions/AIR completion Compliance Dashboard Health Equity Dashboard Reports for PHM, UM, WP, PNM QNXT Config Updates MOU Status Reporting & Execution	DHCS submissions/AIR completion Compliance Dashboard Health Equity Dashboard Reports for PHM, UM, WP, PNM QNXT Config Updates MOU Status Reporting & Execution
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	Attended by Director of Compliance and CCO	Attended by Director of Compliance and CCO	Attended by Director of Compliance and CCO	Attended by Director of Compliance and CCO
9b. CAHPS meeting (weekly)		Weekly	Manager of Compliance		Complete	Attended by Director of Compliance and CCO	Attended by Director of Compliance and CCO	Attended by Director of Compliance and CCO	Attended by Director of Compliance and CCO
9c. DHCS Plan Call (including Payment Call) (weekly)		Weekly	Director of Compliance		Complete	Attended by Director of Compliance and CCO	Attended by Director of Compliance and CCO	Attended by Director of Compliance and CCO	Attended by Director of Compliance and CCO
9d. DHCS topic-specific webinars/meetings (ad hoc)		As scheduled	Director of Compliance Compliance Manager		Complete	Attended by Director of Compliance and CCO	Attended by Director of Compliance and CCO	Attended by Director of Compliance and CCO	Attended by Director of Compliance and CCO
9e. DMHC Roundtable Meetings (quarterly)		Quarterly	Director of Compliance		Complete	Attended by Director of Compliance and CCO	Attended by Director of Compliance and CCO	Attended by Director of Compliance and CCO	Attended by Director of Compliance and CCO
9f. LHPC Compliance Officer Meetings (monthly)		Monthly	Chief Compliance Officer Director of Compliance		Complete	Attended by Director of Compliance and CCO	Attended by Director of Compliance and CCO	Attended by Director of Compliance and CCO	Attended by Director of Compliance and CCO
D. Effective Lines of Communication									
1. Distribute Monthly "Compliance Capsule" email communications	Distribute monthly Compliance Capsule email communication by the 15th of each month	Monthly	Compliance Manager Compliance Analysts		Complete	January 29, 2024-Remote Work and Member Privacy February 26, 2024-Privacy Protections/Permissions March 25, 2024 - FWA	April 24, 2024 - Enforcement May 28, 2024-Office of Inspector General (OIG) June 21, 2024- Centers for Medicare and Medicaid (CMS)	July 28, 2024- Anti-Kickback and Stark Law August 28, 2024-Artificial Intelligence and Machine Learning September 26, 2024- DSNP and Medicare	October 23, 2024- DHCS/DMHC Filing requirements November 21, 2024-DHCS/DMHC Regulatory Audits December 17, 2024-Code of Conduct
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		Complete	Conducted 3/4/2024 (255 respondents)			
3. Focus at least one monthly Compliance Capsule email on methods for communication with Compliance		12/312024	Director of Compliance		Complete	Q1 Privacy protections	Q2 Enforcemnt	Q3 Anit-Kickback and Stark Law	Q4- Code of Conduct
4. Compliance Updates									
4a. Compliance provide updates in Executive Officers Meeting		Ad hoc	Chief Compliance Officer		Complete	January 16, 2024-APL ownership/oversight February 27, 2024-Change Healthcare Breach	June 2, 2024-DMHC 2023 audit July 2, 2024-DSNP Strategy and filing	August 13, 2024-Enterprise Risk Assessment; APL ownership	October 8, 2024-2024 DHCS audit scheduled for 12/8-12/20/2024
4b. Compliance provides updates in Operations Meeting		Ad hoc	Chief Compliance Officer Director of Compliance		Complete	Regulatory Calendar Process	Compliance Training Process	Timely filing regulations	DHCS Audit 12/9/2024
4c. Compliance provide updates at BI-monthly Board meetings		Bi-montlhy	Chief Compliance Officer		Complete	BOD February 15, 2024	BOD April 18, 2024	BOD August 18, 2024	BOD October 17, 2024
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		Complete	DHCS APL 24-001, 002, 003	DHCS APL 24-004, 005, 006, 007, 008	DHCS APL 24-009, 010, 011, 012, 013, 014	DHCS APL 24-015, 016, 017, 018, 019
6. Participate in weekly Grievance & Appeals review meetings	review materials, attend meetings, request updates, provide education in weekly meetings	weekly	Director of Compliance Compliance Auditor		Complete	Director of Compliance attended weekly and provided feedback; transition to review of agenda by Compliance Auditor with oversight from Director of Compliance	Director of Compliance attended weekly and provided feedback; transition to review of agenda by Compliance Auditor with oversight from Director of Compliance	Director of Compliance attended weekly and provided feedback; transition to review of agenda by Compliance Auditor with oversight from Director of Compliance	Director of Compliance attended weekly and provided feedback; transition to review of agenda by Compliance Auditor with oversight from Director of Compliance
7, Participate in weekly Discriminations review meetings	review materials, attend meetings, request updates, provide education in weekly meetings	weekly	Director of Compliance		Complete	Director of Compliance attended weekly meeting and responded to additional email reviews as needed.	Director of Compliance attended weekly meeting and responded to additional email reviews as needed.	Director of Compliance attended weekly meeting and responded to additional email reviews as needed.	Director of Compliance attended weekly meeting and responded to additional email reviews as needed.
E. Well Publicized Disciplinary Standards									

KERN HEALTH SYSTEMS
2024
Compliance Program

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	Q1 COMMENTS	Q2 COMMENTS	Q3 COMMENTS	Q4 COMMENTS
1. In coordination with HR, ensure review of new hires against exclusionary databases and report out in Compliance Committee		Ongoing	Director of Compliance		Complete	New hire onboarding includes review of exclusionary databases	New hire training completed by Leaerning/Develoment team	New hire training completed by Leaerning/Develoment team	New hire training completed by Leaerning/Develoment team
2. Incorporate further emphasis on disciplinary standards into Compliance materials, trainings, policies, and new hire orientation		Ongoing	Director of Compliance		Complete	Updated Compliance program to outline disciplinary standards	Working with HR Learning and Development for process for accountability for addressing late or incomplete trainings	Video for compliance week Incentivize completion to staff HR provides weekly reporting during the 60 days and thereafter once a month	Updated Code of Conduct and Compliance Guide
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. 2023-2024 APLs		Ongoing	Director of Compliance		Complete		Retrospecitve audits and internal audits inlcuded as part of monitoring plan	Retrospecitve audits and internal audits inlcuded as part of monitoring plan	Retrospecitve audits and internal audits inlcuded as part of monitoring plan
1b. 2023 DHCS Medical Survey Findings		8/30/2024	Director of Compliance		Complete		Retrospecitve audits and internal audits inlcuded as part of monitoring plan	DHCS audit findings/CAP closed	
1c. 2023 DMHC Medical Survey Findings		9/30/2024	Director of Compliance		Complete		Retrospecitve audits and internal audits inlcuded as part of monitoring plan	DMHC audit findings/CAP in progress	Submissions for CAP activites filed as required-remaining CAP activities will be followed in 2025
1d. Prior Regulatory Audits		Ongoing	Director of Compliance		Complete		Retrospecitve audits and internal audits inlcuded as part of monitoring plan	Retrospecitve audits and internal audits inlcuded as part of monitoring plan	Retrospecitve audits and internal audits inlcuded as part of monitoring plan
3. Establish Routine monthly Operational Reporting for Monitoring/Oversight/Identification of Potential Compliance Issues (e.g. Grievance timeliness)		9/30/2024	Director of Compliance		Complete	Currently working on development of Compliance Dashboard and identifying additional reports to be included in Q2 Compliance Committee	Dashboard development delayed - still testing the first measures.	KPI established for Compliance Dashboard in Production-- addtional KPI identified for implementation	Compliancf Dashboard initial KPIs in production
4. Report on items being monitored in quarterly Compliance Committee Meeting		Quarterly	Director of Compliance		Complete	Currently working on development of Compliance Dashboard and identifying additional reports to be included in Q2 Compliance Committee	Dashboard development moving delayed - still testing the first measures.	Reports on department KPIs discussed/completed	Reports on department KPIs discussed/completed
5. Conduct and report out on all audits in the Compliance Committee Meeting (# TBD)		Q3 2024	Director of Compliance		Complete	Results of grievance audit reported in 02/29/2024 Meeting	Results of two additional grievance audits and three utilization management activities underway and draft reporting in 05/08/2024 meeting.	Clalims process audit completed 10/2024 Population Health Management internal audit planned for Q3 2024	Claiim process audit completed PHM audit for compliance to contract requirements ongoing
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		Complete	Tracking Log has been created and will be reported upon in 1st quarter 2024 Compliance Committee Meeting (April/May)	Delayed until August meeting due to resource constraints and receipt of audit reports	Tracking Log reported upon in quarterly Compliance Committee Meeting	Tracking Log reported upon in quarterly Compliance Committee Meeting
2. Create Compliance Policy for Prompt Response to compliance Issues (include tracking mechanism, reporting, CAP process)			Director of Compliance		Complete	Policy drafted	Routed for signatures	Completed	
2b. Report on status of CAPS in quarterly Compliance Committee Meetings		Quarterly	Director of Compliance		Complete	VSP Cap discussed in 4th Quarter Delegation Oversight Committee meeting held 02/26/2024 FWA CAP discussed in FWA Subcommittee 02/09/2024	Continued reporting out in Delegation Oversight meeting 05/07/2024 and FWA Committee meeting on 05/08/2024	VSP (vision) CAP closed with ongoing monitoring of access and availabilty of vision services. American Logistics (transportation) FWA remediation with member/providers in progress	
H. Fraud, Waste, and Abuse (FWA)									

KERN HEALTH SYSTEMS
2024
Compliance Program

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	Q1 COMMENTS	Q2 COMMENTS	Q3 COMMENTS	Q4 COMMENTS
1. Attend DOJ FWA Trainings		Quarterly/ Annual	Director of Compliance Chief Compliance Officer Compliance Analyst		Complete	Q1 meeting schedule 3/26/2024-FWA/SIU and Manager Audits and Investigations attending	Q2 meeting held 05/07/2024 and attended by CCO, Manager of Audits & Investigations, and Lead SIU Compliance Analyst	Q3 Meeting scheduled 8/13/2024-Manager Audits/Investigations and Lead SIU COmpliance Analyst to attend	Q3 Meeting scheduled 11/5/2024-Manager Audits/Investigations and Lead SIU COmpliance Analyst to attend
2. Review/Update Annual FWA Plan	Review, update, and submit annual FWA plan to DMHC	12/31/2024	Director of Compliance		Complete	Began review and on track to submit to DMHC by target date	Ongoing	FInalizing for Q4 BOD review	Submitted to DMHC for approval and then BOD in February 2025
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		Complete	Bi-weekly FWA CAP meeeting held with compliance leadership and Lead SIU compliance analyst	Bi-weekly FWA CAP meeeting held with compliance leadership and Lead SIU compliance analyst	Bi-weekly FWA CAP meeeting held with compliance leadership and Lead SIU compliance analyst	Bi-weekly FWA CAP meeeting held with compliance leadership and Lead SIU compliance analyst
3b. Faciiltate FWA Workgroup monthly/quarterly focused on complicated/high risk/Corrective Action Plans		Ongoing	Director of Compliance / Compliance Analyst FWA/CAP Workgroup		Complete	Meetings held to review and obtain consensus on approach to suspected FWA	Internal compliance FWA workgroup meetings bi-weekly to address high risk	Various provider CAPs in progress resulting from data mining/reporting/DHCS/DOJ requests	Various provider CAPs in progress resulting from data mining/reporting/DHCS/DOJ requests
4. Conduct investigations regarding potential FWA and provide Updated FWA Reporting to FWA Committee		Ongoing	Director of Compliance / Compliance Analyst		Complete	Updates reported in 02/09/2024 FWA Subcommittee Meeting	Updates reported in 05/06/2024 FWA Subcommittee Meeting Status reporting submitted to DHCS on 04/30/2024 in alignment with 2024 contract.	Held August 5, 2024	Held November 4, 2024
I. Delegation Oversight									
1. Schedule & Coordinate Annual Delegation Oversight Audits									
1a. VSP		6/1/2024	Compliance/PNM/UM		Complete	Audit Entrance Letter finalized and provided to VSP; finalizing dates of audit	Pre-Audit deliverables due June with completion targeted by mid-July	Joint operations meeting minutes and performance reivew 7/30/2024	Completed Q4 2024
1b. American Logistics (AL)		6/1/2024	Compliance/Member Services Marketing		Complete	Unannounced portion of audit (required by 2024 DHCS Contract) scheduled for 03/21/2024. Audit letter drafted	Results of unannounced portion discussed in Delegation Oversight meeting 05/07/2024; Final announced audit letter on target to be sent by mid-May for audit in June/July.	Joint operations meeting minutes and performance reivew 7/30/2024	Completed Q4 2024
1c. Health Dialog		6/1/2024	UM		Complete		Finalized list of requests on 05/07/2024 and will be communicated to Health Dialogue by mid-May	Health Dialogue acquired by Care Net for Nurse Advice Line services with KHS. Pre-delegation audit in progress. Q2 JOM held 8/22/2024	Completed Q4 2024
1d. Language Line		6/1/2024	Compliance/Cultural and Linguistics Health Equity		Complete	Cultural Linguistics reported out on oversight in 02/08/2024 Meeting	Cultural Linguistics reported out on oversight in 05/07/2024 Delegation Oversight Committee Meeting	Joint operations meeting minutes and performance reivew 7/30/2024	Completed Q4 2024
2. Participate in quarterly delegated subcontractor joint operating meetings (JOM)									
3a. Kaiser		Ongoing	Director of Compliance		Complete	Kaiser JOM no longer occurring due to termination of contract effective 12/31/2023			
3b. VSP		Ongoing	Director of Compliance		Complete	Director of Compliance attended Q1 meeting 02/01/2024	Director of Compliance attended Q1 meeting 05/02/2024 Q2 meeting 08/07/2024	Director of Compliance attended Q4 JOM scheduled 11/6/2024	Director of Compliance attended Q4 JOM scheduled 1/7/2025 due to holiday
3c. AL		Ongoing	Director of Compliance		Complete	Director of Compliance attended Q1 meeting 02/29/2024	CCO attended meeting 6/27/2024	Q3 meeting held 8/29/2024	Q3 meeting held 11/22/2024
3d. Health Dialog		Ongoing	Director of Compliance		Complete	Director of Compliance attended Q1 meeting 02/22/2024	Held 8/22/2024	Q3 JOM scheuduled 11/20/2024	Director of Compliance attended Q4 JOM scheduled 1/9/2025 due to holiday
3e. Language Line		Ongoing	Director of Compliance		Complete			Q3 meeting held 9/4/2024	Q3 meeting held 12/4/2024
4. Create delegation reporting and compliance plan			Director of Compliance						
4a. Delegation Function Matrix Updates		6/1/2024	Director of Compliance		Complete	Completed as part of 2024 DHCS Contract Readiness and published to website; will be updated as needed if new delegates identified			

KERN HEALTH SYSTEMS
2024
Compliance Program

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	Q1 COMMENTS	Q2 COMMENTS	Q3 COMMENTS	Q4 COMMENTS
4b. Delegation Justification and Plan		6/1/2024	Director of Compliance		Complete	Completed as part of 2024 DHCS Contract Readiness and published to website; will be updated as needed if new delegates identified			
4c. Contract Requirements Grid		6/1/2024	Director of Compliance		Complete	Completed as part of 2024 DHCS Contract Readiness and published to website; will be updated as needed if new delegates identified			
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	Delegation Oversight/Director of Compliance						
5a. Report status of Delegates APL compliance quarterly	Report status in Delegation Oversight Committee meeting quarterly	Quarterly	Delegation Oversight/Director of Compliance		Compliance		Reported in 05/07/2024 Delegation Oversight Committee Meeting; grid for Q1 sent to VSP		
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	Delegation Oversight/Director of Compliance		Compliance				

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Governance and Compliance Committee

FROM: Deborah Murr, Chief Compliance and Fraud Prevention Officer

SUBJECT: 2025 Compliance Work Plan

DATE: February 7, 2025

BACKGROUND

The Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC), requires organizations that participate as a California Med-Cal plan, to have a formal compliance program. 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 an annual work plan to help the organization achieve our commitment to adhere to the highest ethical standards of conduct in all business practices.

The U.S. Health and Human Services Office of Inspector General (OIG) outlines a structure for implementing an ongoing evaluation process which is critical to a successful compliance program. Through annual review and renewal, KHS can adjust the work plan accordingly to align with the changing healthcare landscape and regulatory requirements.

KHS prepares a Compliance workplan after reviewing the latest DHCS and DMHC priorities, recent enforcement activities, previous internal and external audit findings and other relevant topics that necessitate additional scrutiny. Additionally, the workplan includes a list of areas that the Compliance Department will audit and monitor as a risk mitigation strategy for ongoing compliance under KHS's contract and licensure.

The 2025 Compliance Workplan update provides a summary review of activities scheduled for 2025, including revisions for new requirements under DHCS, DMHC, and Center for Medicare and Medicaid Services (CMS).

REQUESTED ACTION

Receive and File; Refer to the KHS Board of Directors.

DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	Q1 COMMENTS	Q2 COMMENTS	Q3 COMMENTS	Q4 COMMENTS
Create 2025 Compliance Plan								
Obtain Governance and Compliance Committee Approval	2/7/2025	Chief Compliance Officer Director of Compliance		In Progress				
Obtain Board Approval of Compliance Work Plan	2/20/2025	Chief Compliance Officer		In Progress				
Update Code of Conduct to align with 2025 DHCS Contract and obtain Board approval								
3a. Obtain Governance and Compliance Committe Approval	2/7/2025	Chief Compliance Officer		In Progress				
Obtain Board Approval of Compliance Code of Conduct	2/20/2025	Chief Compliance Officer		In Progress				
Update Code of Conduct and obtain Board approval								
3a. Obtain Governance and Compliance Committe Approval	2/7/2025	Chief Compliance Officer Director of Compliance		In Progress				
Obtain Compliance Committee Approval of Compliance Guide	2/12/2025	Chief Compliance Officer		In Progress				
Obtain Board approval of Compliance Guide	2/20/2025	Chief Compliance Officer		In Progress				
Create 2025 Compliance Program								
4a. Obtain Governance and Compliance Committe Approval	2/7/2025	Chief Compliance Officer		In Progress				
Obtain Compliance Committee Approval of Compliance Program	2/12/2025	Chief Compliance Officer		In Progress				
Obtain Board approval of Compliance Program	2/20/2025	Chief Compliance Officer		In Progress				
Create schedule & ensure all policies								
Create schedule for policy reviews and distribute	3/3/2025	Compliance Manager		In Progress				
All policies to be reviewed by end of year	12/31/2025	Compliance Manager Compliance Analyst Compliance Specialist		In Progress				
Provide quarterly update to Compliance Committee (number reviewed/to be reviewed by department)	Quarterly	Compliance Manager Compliance Analyst Compliance Specialist		In Progress				
Review/Update all Compliance owned policy and procedures								
Create public facing versions of identified policies (e.g. HIPAA; FWA; etc)	12/31/2025	Director of Compliance Compliance Analyst		In Progress				
Create agenda, minutes and action items, related reporting and documents for review and hold meeting quarterly	Quarterly	Director of Compliance Compliance Manager		In Progress				
Create agenda, minutes and action items, related reporting and documents for review and hold meeting quarterly	Quarterly	Director of Compliance Compliance Manager		In Progress				
Create agenda, minutes and action items, related reporting and documents for review and hold meeting quarterly	Quarterly	Director of Compliance Compliance Manager		In Progress				
Review/Update Charters and obtain Committee Approvals								
Review/Update Charter	4/1/2025	Chief Compliance Officer		In Progress				
Obtain Committee Approval on updated Charter	Q22025	Chief Compliance Officer		In Progress				
Review/Update Charter	4/1/2025	Chief Compliance Officer		In Progress				
Obtain Committee Approval on updated Charter	Q2 2025	Chief Compliance Officer		In Progress				
Review/Update Charter	4/1/2025	Chief Compliance Officer		In Progress				
Obtain Committee Approval on updated Charter	Q2 2025	Chief Compliance Officer		In Progress				
	Bi-Monthly BOD Meetings	Chief Compliance and Fraud Prevention Officer		In Progress				
	Monthly	Chief Compliance and Fraud Prevention Officer		In Progress				
Review/Update Compliance Training	4/1/2025	Director of Compliance		In Progress				
Review/Update FWA Training	4/1/2025	Director of Compliance		In Progress				
Review/Update HIPAA/Privacy Training	4/1/2025	Director of Compliance		In Progress				

DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	Q1 COMMENTS	Q2 COMMENTS	Q3 COMMENTS	Q4 COMMENTS
Report status of training completions, by department, in quarterly Compliance Committee Meetings	Quarterly	Director of Compliance/Human Resources/Leaerning and Development		In Progress				
Plan and Execute activities for annual Compliance & Ethics Week	11/10/2025	Compliance Manager Compliance Team Members		In Progress				
Identify subcontractors to which Compliance Training applies Establish content and method of delegate training	4/3/2025	Compliance Manager Director of Compliance		In Progress				
Implement delegated entity/identified subcontractor training	Quarterly	Compliance Manager Director of Compliance		In Progress				
Review and continually expand upon content of Provider Manual for Compliance-related topics	Ongoing	Compliance Manager/Designee		In Progress				
Receive, review, distribute regulatory updates regarding trainings, webinars, meetings to relevant stakeholders	Ongoing	Director of Compliance Compliance Analyst(s) Program Manager(s)		In Progress				
Attend calls and report relevant updates to key stakeholder				In Progress				
Attend calls and report relevant updates to key stakeholder	Weekly	Chief Compliance Officer Director of Compliance		In Progress				
Attend calls and report relevant updates to key stakeholder	Weekly	Chief Compliance Officer Director of Compliance		In Progress				
Attend calls and report relevant updates to key stakeholder	As scheduled	Chief Compliance Officer Director of Compliance		In Progress				
Attend calls and report relevant updates to key stakeholder	Quarterly	Chief Compliance Officer Director of Compliance		In Progress				
Attend calls and report relevant updates to key stakeholder	Monthly	Chief Compliance Officer Director of Compliance		In Progress				
Attend calls and report relevant updates to key stakeholder	Monthly	Chief Compliance Officer Director of Compliance		In Progress				
Post Compliance Capsule to Ceridian Hub for staff visibility	Monthly	Chief Compliance Officer/Compliance Manager		In Progress				
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.	3/1/2025	Director of Compliance/Compliance Program Manager		In Progress				
Distribute monthly Compliance Capsule email communication by the 15th of each month	12/312025	Director of Compliance/Compliance Program Manager		In Progress				
Activites/Reporting/Findings	Ad hoc	Chief Compliance Officer Director of Compliance		In Progress				
Activites/Reporting/Findings	Bi-montlhy	Chief Compliance Officer/Director of Compliance		In Progress				
Activites/Reporting/Findings	Ongoing	Chief Compliance Officer		In Progress				
Review materials, attend meetings, request updates, provide education in weekly meetings	Weekly	Director of Compliance Compliance Auditor		In Progress				
Review materials, attend meetings, request updates, provide education in weekly meetings	Weekly	Compliance Manager Compliance Analyst		In Progress				
Review materials, attend meetings, request updates, provide education in weekly meetings	Weekly	Director of Compliance		In Progress				

DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	Q1 COMMENTS	Q2 COMMENTS	Q3 COMMENTS	Q4 COMMENTS
	Ongoing	Director of Compliance		In Progress				
	Ongoing	Director of Compliance		In Progress				
	Ongoing	Director of Compliance		In Progress				
	Ongoing	Director of Compliance		In Progress				
	Ongoing	Director of Compliance		In Progress				
	3/1/2025	Director of Compliance		In Progress				
	Quarterly	Director of Compliance		In Progress				
	Quarterly	Director of Compliance		In Progress				
	Quarterly	Director of Compliance		In Progress				
	Quarterly	Director of Compliance Manager of Compliance		In Progress				
	Quarterly	Director of Compliance		In Progress				
DOJ trainings varioius CA locations	Quarterly/ Annual	Director of Compliance Chief Compliance Officer Compliance Manager		In Progress				
Review, update, and submit annual FWA plan to DMHC	Ongoing	Director of Compliance Chief Compliance Officer Compliance Manager		In Progress				
Claims, internal/external notfiications	Ongoing	Director of Compliance / Compliance Manager FWA/CAP Workgroup		In Progress				
Facilitate workgroup meetings and prioritize	Ongoing	Director of Compliance / Compliance Analyst		In Progress				
Develop Corrective Action Plans for resolution	Ongoing	Director of Compliance / Compliance Analyst		In Progress				
Conduct annual audit for compliance and identify any key performance indicator variances	Ad hoc	Delegation Oversight/Compliance		In Progress				
Conduct annual audit for compliance and identify any key performance indicator variances	Ad hoc	Delegation Oversight/Compliance		In Progress				
Conduct annual audit for compliance and identify any key performance indicator variances	Ad hoc	Delegation Oversight/Compliance		In Progress				
Conduct annual audit for compliance and identify any key performance indicator variances				In Progress				
Conduct annual audit for compliance and identify any key performance indicator variances	Ad hoc	Delegation Oversight/Compliance		In Progress				
Conduct annual audit for compliance and identify any key performance indicator variances	Ad hoc	Delegation Oversight/Compliance		In Progress				
Conduct annual audit for compliance and identify any key performance indicator variances	Ad hoc	Delegation Oversight/Compliance		In Progress				
Conduct annual audit for compliance and identify any key performance indicator variances	Ad hoc	Delegation Oversight/Compliance		In Progress				
Conduct annual audit for compliance and identify any key performance indicator variances	Ad hoc	Delegation Oversight/Compliance		In Progress				
Conduct annual audit for compliance and identify any key performance indicator variances	Ad hoc	Delegation Oversight/Compliance		In Progress				

DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	Q1 COMMENTS	Q2 COMMENTS	Q3 COMMENTS	Q4 COMMENTS
Conduct annual audit for compliance and identify any key performance indicator variances	Ad hoc	Delegation Oversight/Compliance		In Progress				
Process/ Contract/Reporting updates	Quarterly	Delegtion Oversight/Director of Compliance		In Progress				
Process/ Contract/Reporting updates	Quarterly	Delegtion Oversight/Director of Compliance		In Progress				
Process/ Contract/Reporting updates	Quarterly	Delegtion Oversight/Director of Compliance		In Progress				
Process/ Contract/Reporting updates	Quarterly	Delegtion Oversight/Director of Compliance		In Progress				
Process/ Contract/Reporting updates	Quarterly	Delegtion Oversight/Director of Compliance		In Progress				
Process/ Contract/Reporting updates	Quarterly	Delegtion Oversight/Director of Compliance		In Progress				
Process/ Contract/Reporting updates	Quarterly	Delegtion Oversight/Director of Compliance		In Progress				
Process/ Contract/Reporting updates	Quarterly	Delegtion Oversight/Director of Compliance		In Progress				
Process/ Contract/Reporting updates	Quarterly	Delegtion Oversight/Director of Compliance		In Progress				
Process/ Contract/Reporting updates	Quarterly	Delegtion Oversight/Director of Compliance		In Progress				
Process/ Contract/Reporting updates	Quarterly	Delegtion Oversight/Director of Compliance		In Progress				
	3/1/2025	Delegtion Oversight/Director of Compliance		In Progress				
	3/1/2025	Delegtion Oversight/Director of Compliance		In Progress				
	3/2/2025	Delegtion Oversight/Director of Compliance		In Progress				
Report status in Delegation Oversight Committee meeting quarterly	Quarterly	Compliance Manager/Senior Program Manager		In Progress				
Distribute APL grid and track to ensure responses received	Quarterly	Compliance Manager/Senior Program Manager		In Progress				
Review and approval for DMHC/DHCS	Ongoing							

DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	Q1 COMMENTS	Q2 COMMENTS	Q3 COMMENTS	Q4 COMMENTS
	1/27/2025	Delegtion Oversight/Director of Compliance		In Progress				
	1/10/2025	Delegtion Oversight/Director of Compliance		In Progress				
	2/7/2025	Delegtion Oversight/Director of Compliance		In Progress				
	2/7/2025	Delegtion Oversight/Director of Compliance		In Progress				
	2/7/2025	Delegtion Oversight/Director of Compliance		In Progress				
	2/7/2025	Delegtion Oversight/Director of Compliance		In Progress				
	2/7/2025	Delegtion Oversight/Director of Compliance		In Progress				
	6/3/2025	Delegtion Oversight/Director of Compliance		In Progress				
	7/3/2025	Delegtion Oversight/Director of Compliance		In Progress				
	9/1/2025	Delegtion Oversight/Director of Compliance		In Progress				
	10/1/2025	Delegtion Oversight/Marketing		In Progress				
	10/15/2025	Delegtion Oversight/Marketing/ Enrollment		In Progress				
Coordinate with Project Management to implement new Policy Management Platform to improve efficiency	1/1/2025	Director of Compliance Project Management Office Program Manager		In Progress				
Design and implement 2nd module for compliance activity monitoring to include NCQA and Date Governance	2/1/2025	Director of Compliance Officer Project Management Office Program Manager		In Progress				
Review/evaluate vendors	6/1/2025	Chief Compliance Officer Learning and Development Program Manager		In Progress				
Purchase content for organizational wide distribution for education/training	6/1/2025	Chief Compliance Officer Learning and Development Program Manager		In Progress				
Outline corporate structures Establish Risk Committee Policy and Procedure Development/Revisions Begin Organization Risk discussions/interviews	1/2025-3/31/2025	Chief Compliance Officer Director of Compliance Program Manager(s) Operational Stakeholders		In Progress				

DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	Q1 COMMENTS	Q2 COMMENTS	Q3 COMMENTS	Q4 COMMENTS
Training Development Outline and document Risk Governance structure Identify ERM leadership Identify and frame risk tolerance and risk exposure	4/1/2025- 7/31/2025	Chief Compliance Officer Director of Compliance Program Manager(s) Operational Stakeholders		In Progress				
Perform Enterprise Wide Risk Assessment	7/31/2025- 9/1/2025	Chief Compliance Officer Director of Compliance Program Manager(s) Operational Stakeholders		In Progress				
Risk Strategy/Remediation Planning/Monitoring Roadmap Plan for 2026 Project for Risk Mitigation	9/1/2025- 12/31/2025	Chief Compliance Officer Director of Compliance Program Manager(s) Operational Stakeholders		In Progress				
		Chief Compliance Officer Director of Compliance Compliance Manager Program Manager(s) Operational Stakeholders						
Timely submission of pre-audit deliverables Responses to ongoing requests from regulators following pre-audit deliverable submission Responses to Preliminary Audit Reports Corrective Action Plans for Final Report	01/27/2025 - 12/31/2025	Chief Compliance Officer Director of Compliance Compliance Manager Program Manager(s) Operational Stakeholders		In Progress				
Timely submission of pre-audit deliverables Responses to ongoing requests from regulators following pre-audit deliverable submission Responses to Preliminary Audit Reports Corrective Action Plans for Final Report	10/01/2025 - 12/31/2025	Chief Compliance Officer Director of Compliance Compliance Manager Program Manager(s) Operational Stakeholders		In Progress				
Timely submission of pre-audit deliverables Responses to ongoing requests from regulators following pre-audit deliverable submission Responses to Preliminary Audit Reports Corrective Action Plans for Final Report	10/01/2025 - 12/31/2025	Chief Compliance Officer Director of Compliance Compliance Manager Program Manager(s) Operational Stakeholders		In Progress				
Timely submission of pre-audit deliverables Responses to ongoing requests from regulators following pre-audit deliverable submission Responses to Preliminary Audit Reports Corrective Action Plans for Final Report	07/01/2025 - 10/15/2025	Chief Compliance Officer Director of Compliance Compliance Manager Program Manager(s) Operational Stakeholders		In Progress				