For a Regular Meeting of the

Santa Clara County Health Authority

Compliance Committee

Monday, March 2, 2020
11:30 AM – 1:00 PM
Board Room
6201 San Ignacio Ave
San Jose CA 95119

AGENDA

1.	**Roll Call**	Ms. Yamashita	1:00	5 min
2.	**Public Comment** Members of the public may speak to any item not on the agenda; two minutes per speaker. The Compliance Committee reserves the right to limit the duration of the public comment period to 30 minutes.	Ms. Yamashita	1:05	5 min
3.	**Approve Minutes of the November 14, 2019 Regular Compliance Committee Meeting** **Possible Action:** Approve November 14, 2020 Compliance Committee Minutes	Ms. Yamashita	1:10	5 min
4.	**Compliance Staffing Update** Review changes to Compliance team staff.	Ms. Yamashita	1:15	5 min
5.	**CMS Program and Validation Audits** Discuss status of CMS Program Audit and next steps.	Ms. Yamashita	1:20	10 min
6.	**Compliance and Oversight Activity Report** a. State Regulatory Audits b. Internal Audits and Corrective Action Plans c. Oversight Committee Report i. Review Minutes of Oversight Committee Meetings ii. Review Delegate Corrective Action Plans **Possible Action:** Accept Compliance and Oversight Activity Report	Team	1:30	20 min
7.	**Compliance Policies and Procedures** Review and discuss HIPAA Policies and Procedures HI.01 – HI.53. **Possible Action**: Approve HIPAA Policies and Procedures	Ms. Yamashita	1:50	10 min

8.	**CMC Contract Management Team (CMT) HRA PIP** Discuss status of HRA PIP.	Ms. Yamashita	2:00	5 min
9.	**Review CMC and Medi-Cal Compliance Dashboard and Work Plans** **Possible Action:** Accept Dashboard Report and Work Plans	Ms. Nguyen	2:05	15 min
10.	**Fraud, Waste, and Abuse Report** Discuss any credible FWA cases and recovery efforts. **Possible Action:** Accept Fraud, Waste, and Abuse Report	Ms. Yamashita	2:20	5 min
11.	**Adjournment**	Ms. Yamashita	2:25	

Notice to the Public—Meeting Procedures

- Persons wishing to address the Committee on any item on the agenda are requested to advise the Recorder so that the Chairperson can call on them when the item comes up for discussion.
- In compliance with the Americans with Disabilities Act, those requiring accommodations in this meeting should notify Rita Zambrano 48 hours prior to the meeting at 408-874-1842.
- To obtain a copy of any supporting document that is available, contact Rita Zambrano at 408-874-1842. Agenda materials distributed less than 72 hours before a meeting can be inspected at the Santa Clara Family Health Plan offices at 6201 San Ignacio Ave., San Jose, CA 95119.
- This agenda and meeting documents are available at www.scfhp.com

Santa Clara Family Health Plan

Regular Meeting of the Santa Clara County Health Authority Compliance Committee

Thursday, November 14, 2019
1:30 PM – 3:30 PM
6201 San Ignacio Ave.
San Jose, CA 95119

Minutes

Members Present
Linda Williams, Board Member
Christine M. Tomcala, Chief Executive Officer
Robin Larmer, Chief Compliance and Regulatory Affairs Officer
Neal Jarecki, Controller, Finance
Chris Turner, Chief Operating Officer
Laura Watkins, VP Marketing and Enrollment
Jonathan Tamayo, Chief Information Officer
Jordan Yamashita, Director, Compliance

Staff Present
Mai Phuong Nguyen, Oversight Manager
Leanne Kelly, Delegation Oversight Analyst

1. **Roll Call**

   Ms. Larmer called the meeting to order at 1:45pm. Roll call was taken and a quorum established.

2. **Public Comment**

   There were no public comments.

3. **Approve Minutes of the May 23, Regular Compliance Committee Meeting**

   Minutes of the August 22, 2019 regular Compliance Committee meeting were approved as presented.

4. **Compliance Program**

   Ms. Larmer presented the proposed Compliance Program for 2020 with red-line changes from the 2018-2019 version of the Compliance Program. Ms. Larmer explained that the changes are mostly grammatical and not material. There were updates made to information regarding the Compliance Hotline.

A **motion** was made to approve the 2020 Compliance Program; the motion was **seconded and unanimously approved.**

5. **CMS Program Audit**

Ms. Larmer provided an update on the Independent Validation Audit (IVA) to validate the Plan's correction of the Conditions cited in the Centers for Medicare and Medicaid (CMS) Program Audit report. Ms. Larmer stated that CMS declined to close the audit based on the IVA Report, which indicated that 5 of the 31 Conditions were not fully remediated, because 3 of the 5 non-remediated Conditions impacted more than 50 members. Corrective Action Plans (CAPs) have been submitted for the 5 conditions. CMS has accepted the CAPs, and indicated that the Plan will have to have a second IVA to validate full remediation. The Plan will submit a draft IVA Work Plan for CMS' review and approval next week, and anticipates submission of the IVA Report to CMS in June 2020. There is some potential for an additional fine based on the failure to fully remediate all 31 Conditions.

6. **Compliance Activity and Audit Report**

   a. The Plan received DMHC's Report from the 2019 full-scope Audit. The Report noted only 4 deficiencies, and shows a marked improvement over the Plan's performance in the last full-scope Audit, which cited 32 deficiencies.
   b. Ms. Kelly and Ms. Nguyen reviewed the status of the current delegation audits.
   c. Corrective Action Plans (CAPs): Ms. Nguyen reported that there are 4 active CAPs issued to the delegates: Language Line, VHP, PMG and CHME.

A **motion** was made to accept the Compliance Activity and Audit Report; the motion was **seconded and unanimously approved.**

7. **CMC Contract Management Team HRA PIP**

CMS notified the Plan that CA's performance on HRA completion and related tasks is materially below the national average. As a result, most CA MMP's, including the Plan, have been directed to submit Performance Improvement Plans (PIPs). Through its PIP, the Plan must demonstrate how it will improve performance in the next 6 months.

8. **Review CMC and Medi-Cal Compliance Dashboard and Work Plans**

Ms. Nguyen stated that operational measures will be removed from the Dashboard and new compliance measures will be added due to findings from recent regulatory audits. Customer Services CAPs were closed as they provided evidence of training on the new work flow for handling off cases to G&A. CM and IT continues to work on the extraction of the data for the reporting of SPD HRA completion. G&A has 2 CAPs, both are related to the acknowledgement within 5 days. Due to the system (QNXT) upgrade in July, UM only reported partial data. UM's complete data will be available by the end of October.

A **motion** was made to approve the Compliance Dashboard; the motion was **seconded and unanimously approved.**

9. **Oversight Committee Report**

Ms. Yamashita explained that regulators have been focusing heavily on delegation oversight. The Oversight Committee has been reinstated and reports up to the Governing Board through the Compliance Committee. Meetings are on a monthly basis and provide an opportunity for the Plan to present issues staff has identified with delegates. The Committee also discusses internal oversight, including internal audits and monitoring and resulting CAPs. The Committee is used as a functioning work group to look at and collaboratively resolve issues. The meeting minutes for the 9.19.19 meeting were reviewed.

A **motion** was made to approve the Oversight Committee Report; the motion was **seconded and unanimously approved.**

10. **Fraud, Waste and Abuse Report**

The Fraud, Waste, and Abuse (FWA) Vendor, T&M Protection Resources, continues to data mine to look for possible fraud cases. CMS announced a new 5 pillar program on FWA prevention. The program focuses on paying the right amount and shifting from a "pay and chase" model to a more proactive focus on fraud prevention. Audits will need to demonstrate strong prevention methods which leverage technology.

Ms. Yamashita reported that upon reviewing records obtained during a Physical Therapy practice investigation, the Plan discovered that that the practice provided electronic records created after the notice of audit was sent, not contemporaneous with provision of services. The claims value of the services at issue is roughly $6000. Ms. Williams noted that, in general, if a medical service is not properly recorded, it is to be considered not done. Ms. Turner and Ms. Larmer discussed adding language to provider training about fraudulent charting.

The group addressed the recoupment period for instances of suspected, but not definitively established, fraud (CA law allows for an extension of the one-year period for recoupment of payments to providers where fraud was a factor in the overpayment). Ms. Yamashita noted that in general, most CA Health Plans attempt to recoup outside the one-year limitations period only where the DOJ has definitively concluded fraud has occurred. The Plan will adopt a similar policy.

A **motion** was made to approve the Fraud, Waste, and Abuse Report; the motion was **seconded and unanimously approved.**

11. **Adjournment**

The meeting was adjourned at 2:49pm.

POLICY

Policy Title:	**Privacy Officer Assignment and Responsibilities**	**Policy No.:**	HI.01 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To assure the assignment of a Privacy Officer for the purpose of overseeing Santa Clara Family Health Plan's (SCFHP) obligations to maintain the privacy of Protected Health Information (PHI) in accordance with state and federal privacy laws and the HIPAA Regulations.

II. Policy

SCFHP assigns a Privacy Officer responsible for all SCFHP's privacy matters including Privacy and Breach Notification Policies and Procedures and for assuring that all SCFHP's workforce members comply with such requirements.

III. Responsibilities

All SCFHP Employees, Temporary Staff, and Consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.530
Omnibus Final Rule

Santa Clara Family Health Plan™

POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager Date	Jordan Yamashita Compliance Director & Privacy Officer Date	Robin Larmer Chief Compliance & Regulatory Affairs Officer Date

Version Number	**Change (Original/ Reviewed/ Revised)**	**Reviewing Committee (if applicable)**	**Committee Action/Date (Recommend or Approve)**	**Board Action/Date (Approve or Ratify)**
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Assignment of Privacy Officer and Responsibilities**	**Procedure No.:**	HI.01.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the assignment and responsibilities of the Santa Clara Family Health Plan (SCFHP) Privacy Officer.

II. Procedure

A. Appointment of Privacy Officer

SCFHP will maintain a Privacy Office and appoint a Privacy Officer to be responsible for ensuring compliance with privacy requirements throughout SCFHP. The Privacy Officer is appointed by the Chief Compliance Officer, with approval from the Compliance Committee.

B. Responsibilities of Privacy Officer

1. Develop SCFHP's Privacy and Breach Notification Policies and Procedures in coordination with SCFHP management.
2. Investigate and maintain a log of all reported incidents and follow-up related to SCFHP and/or SCFHP's Business Associates.
3. Monitor and communicate changes in privacy and breach notification laws and regulations and assuring that any necessary revisions are made to SCFHP's Privacy and Breach Notification Policies and Procedures in a timely manner.
4. Conduct periodic assessments of compliance with SCFHP's Privacy and Breach Notification Policies and Procedures, and making SCFHP management aware of any known or potential problems that will be addressed.
5. Participate in the identification of subcontractors that handle PHI on behalf of SCFHP and ensuring that appropriate agreements and safeguards are implemented and maintained between SCFHP and its vendors and subcontractors.
6. Investigate and follow-up, as appropriate, on requests for PHI disclosures.
7. Determine whether a charge for an accounting of disclosures is appropriate, and, if so, the amount of such charge.
8. Maintain, or ensure the maintenance of, all documentation required by the HIPAA Privacy and Breach Notification Rules as outlined in SCFHP's Privacy and Breach Notification Policies and Procedures.

PROCEDURE

9. Ensure the development and provision of SCFHP's initial and ongoing privacy training for employees, including orientation for new staff, temporary help and consultants and regular, periodic updates for current staff and when necessary.
10. Respond to an individual's concerns and complaints regarding SCFHP's Privacy Policies and Procedures.
11. Respond to and coordinate SCFHP's response to privacy audits by regulatory agencies and working with SCFHP's management to assure that appropriate actions are taken to resolve any problems.
12. Collaborate with SCFHP's Security Officer and facilities departments and assist in the development of appropriate administrative, physical and technical safeguards for the protection of PHI in SCFHP's care.
13. Develop appropriate disciplinary measures when SCFHP staff violates SCFHP's Privacy Policies and Procedures.
14. Cooperate with state and federal agencies, including the DHHS Office for Civil Rights, in any and all compliance reviews or investigations.

C. Contacting the Privacy Office

The Privacy Office can be contacted via SCFHP email at privacyandsecurityofficers@scfhp.com twenty-four (24) hours a day, seven (7) days a week. Incident and disclosure reports must be immediately completed and submitted to the Compliance Department by using the online form located on ICAT, under "Library", "Privacy and Security" folder and the Incident Report Form. Upon completion of the form, submit it to the Compliance Department at Compliance@scfhp.com.

D. Documentation

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.01 Privacy Officer Assignment and Responsibilities
HI.02 Privacy Training Requirements
HI.04 Reporting Violations Mitigation and Sanctions
HI.05 Required and Permissible Uses and Disclosures
HI.06 Request for Access
HI.07 Amendments to Protected Health Information
HI.08 Accounting of Disclosures
HI.09 Authorization to Use or Disclose Protected Health Information
HI.10 Uses by and Disclosures to Business Associates and Third Parties
HI.16 Reporting and Responding to Privacy Complaints
HI.18 Safeguards

PROCEDURE

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer and Compliance Director Date

POLICY

Policy Title:	**Privacy Training Requirements**	**Policy No.:**	HI.02 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒CMC	

I. Purpose

To define Santa Clara Family Health Plan (SCFHP) privacy training requirements for SCFHP staff, temporary help, consultants, providers/delegates and vendors in keeping with SCFHP's obligations to maintain the privacy of Protected Health Information (PHI) in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to ensure appropriate privacy training for all SCFHP staff, temporary help, consultants, providers/delegates and vendors to assure that they understand the privacy requirements established under state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, consultants, providers/delegates and vendors must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.530(b)
Omnibus Final Rule

POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager Date	Jordan Yamashita Compliance Director & Privacy Officer Date	Robin Larmer Chief Compliance & Regulatory Affairs Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Privacy Training Requirements**	**Procedure No.:**	HI.02.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe Santa Clara Family Health Plan's (SCFHP) privacy training requirements for all SCFHP staff, temporary help, consultants, providers/delegates and vendors, in keeping with SCFHP's obligations to maintain the privacy of Protected Health Information (PHI) in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. Development of Privacy Training Program

The Privacy Officer or designee, is responsible for developing or arranging for privacy training for all SCFHP staff, temporary help, and consultants upon hire and periodically thereafter, but no less frequently than annually. The Privacy Officer, or designee, is also responsible for providing updates following significant regulatory changes or other material changes to SCFHP's Privacy Policies and Procedures that impact any job functions or responsibilities.

B. Privacy Training Method

Privacy training will be conducted in a manner that ensures that all SCFHP staff, temporary help, providers and consultants, with common duties and responsibilities, and/or access levels and security clearance, receives similar training so that more attention may be devoted to specific responsibilities and the privacy requirements related to such responsibilities.

SCFHP collects annual attestations from its delegates and vendors that they have conducted similar training.

C. Privacy Training for New SCFHP staff, Temporary Help, Consultants, Providers/Delegates and Vendors

New SCFHP staff, temporary help, consultants, and providers will receive initial privacy training on SCFHP's Privacy Policies and Procedures within a reasonable period of time after joining SCFHP, and will not be allowed to access, use or disclose PHI until they have received appropriate training.

PROCEDURE

D. Content

The initial privacy training will cover, at a minimum, the following basic matters:

1. The history and purpose of federal privacy laws, including the HIPAA Regulations and the legal responsibilities of SCFHP and health care providers.

2. Individual privacy rights, including access and inspection, amendments, accountings of disclosures, requests for restrictions, and confidential communications; specific procedures will not be covered unless the Workforce member will be responsible for assisting individuals or Customer's with exercising these rights or are likely to receive request from individuals.

3. Allowable internal uses and disclosures for Treatment, Payment, and Health Care Operations.

4. "Minimum necessary" requirements for uses, disclosures and requests.

5. Internal safeguards within SCFHP, including administrative, physical, and technical safeguards to protect the security and integrity of PHI. Special attention will be given to the measures that will be taken by the all SCFHP staff, temporary help, and consultants, with respect to their own duties and responsibilities.

6. An introduction to SCFHP's Privacy Policies and Procedures(P&Ps), with special attention given to those policies that may be needed by the all SCFHP staff, temporary help, and consultants, when carrying out their duties. Relevant SCFHP Privacy P&Ps are shared with providers.

7. Procedures for obtaining clarification of privacy requirements and for notifying the Privacy Officer or other appropriate persons in the event of a possible privacy breach.

8. The penalties and consequences to SCFHP and SCFHP's Business Associates for violations of the HIPAA Regulations.

9. Disciplinary sanctions that will be imposed on an employee, temporary help, and contractors by SCFHP for non-compliance with the Privacy Policies and Procedures which may range from receiving a warning to being terminated.

E. Privacy Training Documentation

SCFHP's Privacy Officer or designee maintains documentation of all SCFHP Privacy training and the staff who have participated in privacy training. Failure by a staff member to participate in privacy training may result in disciplinary actions ranging from system revocation, verbal and/or written warnings and up to termination.

Further, SCFHP has incorporated compliance standards in to its annual performance evaluations. Failure to meet SCFHP and/or regulatory training requirements may result in negative performance evaluations.

F. Collaboration

The Privacy Officer is responsible for oversight of privacy training through collaboration with business unit managers and trainers.

G. Document Retention

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.02 Privacy Training Requirements
HI.04 Reporting Violations Mitigation and Sanctions

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Minimum Necessary Standards**	**Policy No.:**	HI.03 v2
Replaces Policy Title (if applicable):	Minimum Necessary Access to and Use of PHI	**Replaces Policy No. (if applicable):**	CP016.02
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒CMC	

I. Purpose

To define the circumstances under which the minimum necessary amount of Protected Health Information (PHI) will be used, disclosed or requested in accordance with state and federal privacy laws and the HIPAA Regulations.

II. Policy

It is the policy of Santa Clara Family Health Plan (SCFHP) to protect PHI by developing and implementing policies and procedures to reasonably limit used, disclosures and requests of PHI to the minimum necessary to carry out the purpose of the use, disclosure, or request.

III. Responsibilities

All SCFHP employees, temporary help, consultants, providers/delegates and vendors must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.502(b)
45 C.F.R. §164.514(d)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong	Jordan Yamashita	Robin Larmer

POLICY

Compliance Manager	Compliance Director & Privacy Officer	Chief Compliance & Regulatory Affairs Officer
Date	Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v2	Revised	Compliance Committee		

PROCEDURE

Procedure Title:	**Minimum Necessary: Uses, Disclosures and Requests**	**Procedure No.:**	HI.03.01 v2
Replaces Procedure Title (if applicable):	Minimum Necessary Access to and Use of PHI	**Replaces Procedure No. (if applicable):**	CP016.02
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the circumstances under which the minimum necessary amount of Protected Health Information (PHI) will be used, disclosed or requested in accordance with state and federal privacy laws and the HIPAA Regulations.

II. Procedure

A. Minimum Necessary Information

Unless an exception applies (see Section B below), uses, disclosures of, and requests for PHI will be limited to information consisting of the minimum amount of information to meet the intended purpose. This means that reasonable efforts will be made to not use, disclose, or request information that is not relevant, exceeds the amount requested, or is not needed to accomplish the purpose of the contemplated use or disclosure.

B. Exceptions

The "minimum necessary" limitations do NOT apply to PHI being requested by or disclosed to any of the following:

1. A Health Care Provider for Treatment,
2. The individual or the individual's authorized representative,
3. A person or entity named in a valid Authorization;
4. The Secretary of the DHHS (or designee), or
5. An official or agency as required by law.

C. Access by Santa Clara Family Health Plan (SCFHP) Employees, Temporary Help, and Consultants

PROCEDURE

SCFHP employees, temporary help, and consultants will only be allowed access to those portions of an individual's PHI reasonably needed in order to perform their job functions.

1. The Privacy Officer, in conjunction with the human resources department will assign Data Classifications to certain PHI (electronic and paper) taking into account specific job responsibilities and sensitivity of the health information.

2. If a SCFHP employees, temporary help, or consultant performs functions within SCFHP that require access to all PHI, access may be granted to perform their own duties and responsibilities.

3. To the extent reasonably practicable, SCFHP will use technological controls to limit access to PHI to the amount necessary for SCFHP employees, temporary help, or consultants to perform their job functions.

4. The human resources department, in conjunction with the Information System program manager, will identify SCFHP employees, temporary help, or consultant that require access to PHI, classify the level of access required for assigned responsibilities, assign an access code for authorized levels of access, and assign those access codes. A documented process for changing access levels or for changing responsibilities (for promotions, demotions, new hires, or terminations) will be developed and implemented by the human resources department to ensure prompt reclassification as necessary to protect PHI.

5. Especially sensitive information, such as mental health information or test results for sexually transmitted diseases, will be stored, maintained and transmitted separately from the rest of the PHI in an individual's medical record in order to limit unauthorized access.

6. Supervisors are responsible for assigning appropriate access to PHI to each employees, temporary help, or consultant and submitting a signed change in responsibility form to the designated IT manager whenever a SCFHP employees, temporary help, or consultant is newly hired, changes job responsibilities or is terminated.

7. The designated IT manager is responsible for ensuring that appropriate and timely changes are made for any and all employees who experience a change in responsibility in order to ensure that appropriate access to PHI is maintained.

8. Licensed practitioners who are involved in an individual's Treatment may be given access to all portions of the individual's medical record.

D. Routine Requests and Disclosures by Others

SCFHP's Privacy Officer will identify those person and entities to which routine disclosures are made, and determine the categories of PHI reasonably needed to carry out the purpose for which the disclosure is made.

PROCEDURE

E. Routine Requests for Information by SCFHP

If SCFHP routinely requests PHI from other entities, SCFHP will request only the minimum amount of information necessary to carry out the purposes for which the information is requested. SCFHP's Privacy Office will identify types of routine requests and the categories of PHI reasonably needed for SCFHP to carry out the purpose of each type of request.

F. Non-Routine Requests and Disclosures by Others

Non-routine requests for, and disclosures of, PHI (i.e. those that are not made on a recurring basis and for which SCFHP has not established policies and procedures) will be reviewed on a case-by-case basis by the SCFHP's Privacy Office to determine the minimum necessary amount of information that may be disclosed. In making this determination, the Privacy Office will consider, among other things, the following criteria:

1. The purpose of the request or disclosure,
2. The relevance of the information being requested or disclosed,
3. The importance of the request or disclosure, including the likelihood that harm could occur if the information were not disclosed, and
4. The potential for accomplishing the purpose using de-identified information.

G. Non-Routine Requests and Disclosures by SCFHP

If a SCFHP employees, temporary help, or consultant requests PHI from other entities, he/she will request only the minimum amount of information necessary to carry out the purposes for which the information is requested. Non-routine requests will be approved by the Privacy Office to assure that only the minimum necessary information is requested based on the criteria listed under section F above and is provided to an employees with the appropriate access to PHI.

H. Reliance on Certain Requests for Disclosure

Unless otherwise indicated by the circumstances, SCFHP's Privacy Office may assume that the PHI requested for any of the following purposes has been limited to the minimum necessary for the stated purpose:

1. Disclosures requested by public officials for public health purposes, health oversight, law enforcement, or other permitted disclosures, if the requesting officials represent that the information requested is the minimum necessary for the stated purpose,
2. Disclosures requested by a professional who is either:

a. SCFHP employees, temporary help, or consultant with appropriate access to PHI, or

b. Business Associate providing profession services and who has executed a valid Business Associate Agreement or addendum that includes representations that he or she will only request the minimum necessary information required for the professional to provide such services, and

3. Disclosures for research purposes to a person or entity that provides appropriate documentation.

I. Complete Record

Unless specifically justified as being the minimum amount necessary for the purpose, an individual's complete medical record will not be requested or disclosed.

J. Document Retention

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.03 Minimum Necessary Standards
HI.05 Required and Permissible Uses and Disclosures
HI.06 Request for Access
HI.13 Requests for Restrictions on Uses and Disclosures
HI.14 Request for Confidential Communications
HI.16 Reporting and Responding to Privacy Complaints
HI.18 Safeguards

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Reporting Violations Mitigation and Sanctions**	**Policy No.:**	HI.04 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒CMC	

I. Purpose

To define the processes associated with reporting violations of Santa Clara Family Health Plan's (SCFHP) Privacy Policies and Procedures, follow-on activities of such violations to remediate and mitigate future harm, and the circumstances under which sanctions may be imposed against a SCFHP staff, temporary help, or consultant who violates the Privacy Policies and Procedures in keeping with SCFHP's obligations to maintain the privacy of Protected Health Information (PHI) in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP that violations of its Privacy Policies and Procedures are identified and addressed promptly, that appropriate measures are taken to mitigate any further impermissible use or disclosure and/or any unauthorized modification or destruction of PHI in order to reduce the possibility of harm or re-occurrence and that appropriate sections are imposed.

III. Responsibilities

All SCFHP staff, temporary help, consultants, providers/delegates and vendors must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.530(e)
45 C.F.R. §164.502(j)
Omnibus Final Rule

V. Approval/Revision History

Santa Clara Family Health Plan™

POLICY

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager Date	Jordan Yamashita Compliance Director & Privacy Officer Date	Robin Larmer Chief Compliance & Regulatory Affairs Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Reporting Violations, Mitigation and Sanctions**	**Procedure No.:**	HI.04.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the processes associated with reporting violations of Santa Clara Family Health Plan's (SCFHP) Privacy Policies and Procedures, follow-on activities of such violations to remediate and mitigate future harm, and the circumstances under which sanctions may be imposed against a SCFHP staff, temporary help, or consultant who violates the Privacy Policies and Procedures in keeping with SCFHP's obligations to maintain the privacy of Protected Health Information (PHI) in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. Responsibility for Reporting Suspected or Confirmed Incidents of Impermissible Use or Disclosure of PHI

When one of SCFHP's staff, temporary staff, consultants, providers/delegates and vendors suspects that PHI may have been impermissibly used or disclosed in violation of state or federal laws, HIPAA Regulations or SCFHP's Privacy Policies or Procedures must immediately notify a supervisor and/or the Privacy Office.

1. Examples of impermissible uses or disclosures of PHI that must be reported may include, but not limited to, the following:

    a. Sharing PHI for purposes other than delivery of SCFHP's services.
    b. Unauthorized access to PHI by SCFHP employee, temporary employees, consultants, providers/delegates or vendors
    c. More than the minimum necessary use or disclosure for the intended purpose,
    d. Disclosure of PHI to individuals without permission,
    e. Emails containing PHI sent to the wrong recipient,
    f. Emails containing PHI sent to the correct recipient via an unsecure route,
    g. Fulfillment errors resulting in PHI being sent to the wrong recipient, and
    h. Fax errors resulting in PHI being sent to the wrong recipient.

2. Any SCFHP staff member receiving such a report will submit an incident report immediately to the Privacy Office by accessing and completing the incident report form located at http://icat/Pages/Default.aspx . If the disclosure involves a breach of security as outlined in SCFHP's

Security Policies and Procedures, SCFHP's Privacy Officer or designee within the Compliance department will forward the report to the SCFHP Security Officer.

3. The SCFHP Privacy Officer will follow-up and/or investigate each suspected or confirmed incident reported on an incident report form in a manner that complies with SCFHP's internal standard operating procedures on investigation and reporting.

B. Responsibility of the SCFHP Privacy Officer or Designee

Upon receipt of notice of a potential impermissible use or disclosure, the Privacy Officer will:

1. Immediately notify the Security Office if the potential impermissible use or disclosure pertains to a Security Incident (as outlined in SCFHP's Security Policies and Procedures).

2. Conduct, or oversee the conduct of, a detailed investigation of the circumstances associated with the use or disclosure.

3. Implement activities to mitigate any harm associated with future impermissible use or disclosure of the PHI, such as verification of destruction or return of the PHI and take measures to:

   a. Ensure proper and thorough investigation of any suspected or confirmed incident, report of non-compliance with the HIPAA Privacy Rule, or complaint.
   b. Take reasonable steps to ensure no further use or disclosure of any unsecured PHI,
   c. Oversee the development and implementation of any required corrective action plan(s) to avoid a reoccurrence,
   d. Monitor mitigation and remediation plans to ensure effectiveness,
   e. Determine with legal counsel the "probability of compromise" with respect to SCFHP's breach risk assessment policy, and
   f. Document the details and resolution of a reported suspected or confirmed incident or violation.

4. If the terms of a Business Associate Agreement have been violated, the Privacy Officer, in consultation with legal counsel, will comply with the requirements set forth.

5. Ensure the development and implementation of a remediation plan that may include changes to facility access, data access, policies and procedures, training material, and/or suspension or termination.

6. In consultation with SCFHP's legal counsel:

   a. Determine whether the use or disclosure is a violation of the HIPAA Regulations of SCFHP's Privacy or Security Policies and Procedures, and
   b. If notification is required, the Privacy Officer or designee will follow the requirements for notification outlined in SCFHP's Breach Notification Policies and Procedures and by federal or state laws and the HIPAA Regulations.

7. Maintain a file of all impermissible uses or disclosures and other violations.

PROCEDURE

B. Sanctions

1. SCFHP's human resources department, in consultation with the Privacy Officer, will establish a range of sanctions that may be imposed if SCFHP's Privacy Policies and Procedures are violated.

2. Disciplinary action will be commensurate with the severity of the violation, the intent (accidental, intentional, malicious), the existence of previous violations and the degree of potential harm.

3. Sanctions may range from warnings and further training in the event the staff member was not aware of policy requirements, to immediate termination in the event of an intentional violation.

4. All SCFHP's staff, temporary help, and consultants will be made aware of the disciplinary actions and sanctions that may be imposed. Additionally, federal privacy laws impose civil and criminal penalties including fines and imprisonment for violations of the law.

C. No Sanctions Based on Whistleblowing or Complaints

1. It is not a violation of SCFHP's Privacy Policies and Procedures for a staff member to disclosure PHI to a health oversight agency, public health authority, or other appropriate entity in the good faith belief that SCFHP has engaged in unlawful conduct, violated professional or clinical standards, or potentially endangered individuals, workers, or the public. Sanctions will not be imposed based on such disclosures.

2. It is not a violation of SCFHP's Privacy Policies and Procedures for a staff member to file a complaint with the Secretary of DHHS, testify, assist, or participate in an investigation or compliance review of SCFHP's Privacy Policies and Procedures, or oppose any act made unlawful by HIPAA Regulations, provided the staff member has a good faith belief that SCFHP's action being opposed is unlawful, and the manner of the opposition is reasonable and does not involve a disclosure of PHI in violation of the HIPAA Privacy Rule. Sanctions will not be imposed based on such actions.

3. It is not a violation of SCFHP's Privacy Policies and Procedures for a staff member who is the victim of a criminal act to disclose information about the suspected perpetrator to the law enforcement agency, as long as the officer or agency's identity and authority has been verified and documented and the "Minimum necessary" information to carry out the purpose is disclosed. Sanctions will not be imposed on such actions.

E. Accounting of Disclosure

All unauthorized disclosures of PHI must be included in the Accounting of Disclosures.

F. Documents Retention

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

PROCEDURE

III. Policy Reference

HI.02 Privacy Training Requirements
HI.03 Minimum Necessary Standards
HI.08 Accounting of Disclosures
HI.10 Uses by and Disclosures to Business Associates and Third Parties
HI.14 Request for Confidential Communications
HI.16 Reporting and Responding to Privacy Complaints
HI.18 Safeguards

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Required and Permissible Uses and Disclosures**	**Policy No.:**	HI.05 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To define how Santa Clara Family Health Plan (SCFHP) will respond to requests for Protected Health Information (PHI), in keeping with SCFHP's obligations to maintain the privacy of PHI, in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP that requests for access to PHI are investigated to determine the need and Authorization from the individual or his/her Personal Representative. If the use or disclosure is either required or permissible without an Authorization, SCFHP will verify the requestor's identity and approved authority, to ensure that the information, if approved, includes only the minimum necessary for the purpose intended, and that all efforts are undertaken to mitigate any impermissible access, use, disclosure, modification or destruction of PHI in order to reduce the possibility of harm.

III. Responsibilities

All SCFHP staff, temporary staff, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.502(a)
45 C.F.R. §164.506
45 C.F.R. §164.510
45 C.F.R. §164.512
Omnibus Final Rule

V. Approval/Revision History

POLICY

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager Date	Jordan Yamashita Compliance Director & Privacy Officer Date	Robin Larmer Chief Compliance & Regulatory Affairs Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Required and Permissible Uses and Disclosures**	**Procedure No.:**	HI.05.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe how Santa Clara Family Health Plan (SCFHP) will respond to requests for Protected Health Information (PHI), in keeping with SCFHP's obligations to maintain the privacy of PHI, in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. Requests Made by an Individual

1. Only the Privacy Officer and those SCFHP staff, temporary staff, or consultants specifically identified and documented by the SCFHP's Privacy Officer have the authority to disclose PHI.

2. Prior to making a disclosure of PHI to a third party that is permitted by these Privacy Policies and Procedures, a SCFHP staff member will verify the recipient's identity and authority to receive the PHI.

    a. Written Communications. SCFHP's staff verifies that the communication is signed by the individual or if an email, contains the individual's name in the email address.
    b. Telephone Calls. SCFHP's staff verifies the caller's identity by obtaining from the caller the following:

        i. The individual's name,
        ii. The individual's date of birth,
        iii. The individual's home address, and
        iv. The individual's telephone number.

B. Requests Made by the Individual's Personal Representative

1. SCFHP will accept written or verbal communication from the individual notifying SCFHP of the designation of the Personal Representative who has the authority under state law, by advance directive, health care proxy, or otherwise, to make health care decisions.

PROCEDURE

2. SCFHP will accept written notification from a Personal Representative, if valid, legal documentation is provided indicating designation of a Personal Representative who has the authority under state law, by advance directive, health care proxy, or otherwise, to make health care decisions.

3. Upon notification of designation of a Personal Representative, a SCFHP staff member documents the following:

    a. Personal Representative's name,
    b. Personal Representative's address (street, city, state),
    c. Date of Personal Representative's authority; and
    d. Signature of Personal Representative.

C. Requests Made by Others

If SCFHP's staff receives requests from others not covered in this Privacy Policy, the request will be forwarded to the Privacy Officer or designee who will use the following procedures to verify authority and identity:

1. Verification of Identity of Public Officials. When a government agency or public officials requests PHI, the Privacy Officer may rely upon the following to verify their identity, if reliance is reasonable under the circumstances:

    a. For in-person requests: the official's presentation of an agency identification badge, other official credentials or other proof of government status,
    b. For written requests: the request, if it is on appropriate government letterhead,
    c. For requests made by someone acting on behalf of a government official: evidence or documentation that establishes that the person is acting on behalf of the public official, such as a written statement on appropriate government letterhead that the person is acting under the government's authority, a contract for services, a memorandum of understanding, or a purchase order.

2. Verification of Authority of Public Officials: When a government agency or public officials requests PHI, the Privacy Officer may rely upon the following to verify their authority, if reliance is reasonable under the circumstances:

    a. A written statement of the legal authority under which the information is requested,
    b. If a written statement is not practical, an oral statement of the legal authority under which the information is requested, or
    c. A copy of a warrant, subpoena, order or other legal process issued by a grand jury or a judicial or administrative tribunal is presumed to constitute legal authority.

D. Inability to Verify

If SCFHP's staff is unable to verify a requestor's identity and authority, the PHI may not be disclosed. The request will be forwarded to the Privacy Officer to assist in verifying authority and identity.

PROCEDURE

E. Scope of Disclosure

If the authority and identity of the party requesting PHI has been verified, SCFHP staff may disclose PHI to the requestor, but only the amount of PHI permitted by the applicable Privacy Policies and Procedures that permit the disclosure.

F. Documentation Prior to Disclosure

If these Privacy Policies and Procedures require any documentation, statements or representations from the intended recipient (such as a subpoena) as the basis for or condition of allowing a disclosure, SCFHP will obtain such documentation, statements or representations prior to making the disclosure.

G. Reliance on Documentation

If reasonable under the circumstances, SCFHP's staff may rely on documentation, statements or representations that, on their face, meet the requirements for disclosure. Examples of such documentation include signed authorization forms.

H. Document Retention

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.03 Minimum Necessary Standards
HI.04 Reporting Violations Mitigation and Sanctions
HI.05 Required and Permissible Uses and Disclosures
HI.06 Request for Access
HI.08 Accounting of Disclosures
HI.10 Uses by and Disclosures to Business Associates and Third Parties
HI.12 Uses and Disclosures of Limited Data Sets
HI.21 Disclosures to Family, Caregivers, and Friends
HI.23 Disclosures Related to Individuals with Mental Incapacities
HI.24 Communications with Minors
HI.26 Uses and Disclosures for Treatment Purposes
HI.27 Uses and Disclosures for Health Care Operations
HI.28 Uses and Disclosures for Payment
HI.29 Uses and Disclosures for Marketing
HI.31 Uses and Disclosures Required by Law
HI.32 Uses and Disclosures for Law Enforcement Purposes
HI.33 Uses and Disclosures for Public Health Activities
HI.34 Uses and Disclosures about Decedents
HI.35 Disclosures for Suspected or Confirmed Abuse, Neglect or Domestic Violence
HI.36 Uses and Disclosures for Research Purposes

PROCEDURE

HI.37 Uses and Disclosures for Specialized Government Functions
HI.38 Disclosures for Workers Compensation
HI.39 Verification of Identity and Authority
HI.40 Uses and Disclosures for Cadaveric Organ, Eye or Tissue Donation Purposes
HI.41 Uses and Disclosures for Health Oversight Activities
HI.42 Uses and Disclosures for Disaster Relief Purposes
HI.43 Uses and Disclosures to Avert a Serious Threat to Health or Safety

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Request for Access**	**Policy No.:**	HI.06 v2
Replaces Policy Title (if applicable):	Member Rights to Access and Amend PHI	**Replaces Policy No. (if applicable):**	CP011.02
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To define the circumstances under which an individual is entitled to inspect and obtain copies of their Protected Health Information (PHI) maintained by Santa Clara Family Health Plan (SCFHP) and how SCFHP will respond to requests for access in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to allow individuals to inspect and obtain copies of their PHI in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.524
Omnibus Final Rule

Santa Clara Family Health Plan™

POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager Date	Jordan Yamashita Compliance Director & Privacy Officer Date	Robin Larmer Chief Compliance & Regulatory Affairs Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v2	Revised	Compliance Committee		

PROCEDURE

Procedure Title:	**Request for Access**	**Procedure No.:**	HI.06.01 v2
Replaces Procedure Title (if applicable):	Member Rights to Access and Amend PHI	**Replaces Procedure No. (if applicable):**	CP011_02
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the circumstances under which an individual is entitled to inspect and obtain copies of their Protected Health Information (PHI) maintained by Santa Clara Family Health Plan (SCFHP) and how SCFHP will respond to requests for access in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. Right to Inspect PHI

Individuals generally have the right to inspect and obtain copies of their PHI maintained in a Designated Record Set, except for:

1. Psychotherapy notes; and

2. Information complied in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.

B. Responsibility for Access Determinations

1. The SCFHP Privacy Office is responsible for granting or denying access requests. The Privacy Officer may inform the individual that requests for access must be in writing.

2. Any SCFHP employee who receives a notice or a request to provide PHI to an individual will forward the notice or request immediately to SCFHP's Privacy Office, which will oversee the response.

C. Denial of access

1. Obligations of the Privacy Office: If SCFHP's Privacy Office, in consultation with legal counsel, denies access to the requested PHI as described in the Policy, in whole or in part, then the SCFHP Privacy Officer must ensure the following:

   a. To the extent possible, the individual is given access to any other PHI requested, after excluding the PHI for which access has been denied,

b. Provide a timely, written denial to the individual in plain language that contains:
   i. The basis for the denial,
   ii. If applicable, a statement of the individual's review rights, including a description of how the individual may exercise such review rights, and
   iii. A description of how the individual may complain to SCFHP or to the Secretary of DHHS, including the name, or title, and telephone number of the contact person or office.
   iv. If SCFHP does not maintain the requested PHI but knows where the requested information is maintained, the Privacy Officer must inform the individual where to direct the request for access.

2. Unreviewable Grounds for Denial: The SCFHP Privacy Officer, in consultation with legal counsel, may deny access without providing the individual an opportunity for review, in the following circumstances:

   a. The access request is for psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding,
   b. Obtaining such copy would jeopardize the health, safety, security, custody, or rehabilitation of the individual or of other inmates of a correctional institution, or the safety of any officer, employee, or other person at the correctional institution or responsible for the transporting of the individual and/or inmates,
   c. The individual is participating in research related to treatment which is still in progress and has agreed to the denial of access until the completion of the research,
   d. The denial of access relates to records that are subject to the Privacy Act of 1974, as amended at 5 U.S.C. 552a, if the denial meets the requirements of that law, or
   e. The PHI was obtained from someone other than a Health Care Provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

3. Reviewable Grounds for Denial: The SCFHP Privacy Officer, in consultation with legal counsel, may deny access provided that the individual is given a right to have such denial reviewed in the following circumstances:

   a. A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person,
   b. The PHI makes reference to another person (unless such other person is a Health Care Provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person, or
   c. The request for access is made by the individual's Personal Representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such Personal Representative is reasonably likely to cause substantial harm to the individual or another person.

4. Review of a denial of access: If access is denied on a ground permitted under Section 3(c) above, the individual has the right to have the denial reviewed by a licensed health care professional

designated by SCFHP to act as a reviewing official, who did not participate in the original decision to deny. The SCFHP Privacy Officer must:

a. Refer a request for review to such designated reviewing official,
b. Ensure that the designated reviewing official determines, within a reasonable period of time, whether or not to deny the access,
c. Promptly provide written notice to the individual of the determination of the reviewing official.

D. Provision of access

If SCFHP's Privacy Office approves the provision of access of PHI to the individual, in whole or in part, the Privacy Officer will ensure that:

1. The access provided is that which was requested by the individual, including inspection or obtaining a copy, or both, in Designated Record Sets. If the PHI requested is maintained in more than one Designated Record Set or at more than one location, SCFHP need only produce the PHI once in response to a request for access.

2. The PHI is in the form or format requested by the individual, if it is readily producible in such form or format; or, if not, in a readable hard copy form or such other form or format as agreed by SCFHP and the individual.

3. If agreed in advance by the individual, SCFHP may provide the individual with a summary or an explanation of the PHI requested, in lieu of providing access. The individual must also agree in advance to any fees imposed for such summary or explanation.

4. The access as requested by the individual is provided within thirty (30) days of the request including arranging with the individual for a convenient time and place to inspect or obtain a copy of the PHI, or mailing the copy of PHI at the individual's request.

5. If the PHI requested is maintained in one or more Designated Record Sets electronically and if the individual requests an electronic copy of such information, SCFHP must provide the individual with access to the PHI in the electronic form and format requested, if it is readily producible in such form and format, or, if not, SCFHP must provide a copy of the PHI directly to another person designated by the individual. The individual's request must be in writing, signed by the individual, and clearly identify the designated person and where to send the copy of the PHI.

6. Appropriate and reasonable cost-based fees are charged to the individual for copies, or for a summary or explanation agreed to in advance (see Section 4(c) above), for supplies and labor for copying (whether in paper or electronic form), postage if requested to be mailed, and, if applicable, preparation of an explanation or summary of the PHI.

E. Documentation and Retention

SCFHP must document the following and retain the documentation as described below:

PROCEDURE

1. The Designated Record Sets that are subject to access by individuals; and

2. The titles of the persons or offices responsible for receiving and processing requests for access by individuals.

F. Documentation

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.06 Request for Access
HI.16 Reporting and Responding to Privacy Complaints

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Amendments to Protected Health Information**	**Policy No.:**	HI.07 v2
Replaces Policy Title (if applicable):	Member Rights to Access and Amend PHI	**Replaces Policy No. (if applicable):**	CP011.02
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To define the circumstances under which an individual is entitled to amend their Protected Health Information (PHI) and how Santa Clara Family Health Plan (SCFHP) will respond to, and implement, amendment requests in accordance with state and federal privacy laws, and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to allow amendments to be made to an individual's PHI in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary staff, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.526
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager	Jordan Yamashita Compliance Director & Privacy Officer	Robin Larmer Chief Compliance & Regulatory Affairs Officer

Santa Clara Family Health Plan™

POLICY

Date	Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v2	Revised	Compliance Committee		

PROCEDURE

Procedure Title:	**Amendments to Protected Health Information**	**Procedure No.:**	HI.07.01 v2
Replaces Procedure Title (if applicable):	Member Rights to Access and Amend PHI	**Replaces Procedure No. (if applicable):**	CP011_02
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the circumstances under which an individual is entitled to amend their Protected Health Information (PHI) and how Santa Clara Family Health Plan (SCFHP) will respond to, and implement, amendment requests in accordance with state and federal privacy laws, and HIPAA Regulations.

II. Procedure

A. Individual's Right to Amend

All individuals have the right to request an amendment of their PHI or a record about the individual which is in a Designated Record Set.

B. Who May Request

Only the individual or the individual's Personal Representative may request an amendment.

C. Responsibility for Amendment Determinations

1. SCFHP's Privacy Office is responsible for granting or denying amendment requests.

2. Any SCFHP employee that receives a notice from an individual requesting SCFHP to amend his or her PHI will forward the notice to SCFHP's Privacy Office, which will oversee responding to or handling the notice.

3. Any SCFHP employee, temporary staff, or consultant that receives a notice from another Covered Entity requesting SCFHP to amend PHI or to assist in evaluating an amendment request will forward the notice to the SCFHP's Privacy Office, which will oversee responding to or handling the notice.

4. SCFHP Privacy Office may require individuals to make requests for amendment in writing and to provide a reason to support a requested amendment, provided that it informs the individual in advance.

D. Request for Amendment

PROCEDURE

Upon receipt of a request for amendment, the SCFHP Privacy Officer must act on the individual's request no later than 60 days of receipt.

E. Denial of Amendment

1. SCFHP's Privacy Office, in consultation with legal counsel, may deny an individual's request for amendment if it determines that the PHI or record that is the subject of the request:

    a. Was not created by SCFHP, unless the individual provides a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment,
    b. Is not part of the Designated Record Set,
    c. Would not be available for inspection under rights of access, or
    d. Is accurate and complete.

2. If a request for amendment is denied, the SCFHP Privacy Officer must ensure:

    a. That the individual is provided with a written denial, to include:
        i. The basis for the denial,
        ii. The individual's right to submit a written statement disagreeing with the denial and how the individual may file such a statement:
            (1) SCFHP's Privacy Officer may reasonably limit the length of a statement of disagreement, and
            (2) The SCFHP Privacy Officer may prepare a written rebuttal to the individual's statement of disagreement; whenever such a rebuttal is prepared, the Privacy Officer must provide a copy to the individual who submitted the statement of disagreement.
        iii. A statement that, if the individual does not submit a statement of disagreement, the individual may request that SCFHP provide the individual's request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment; and
        iv. A description of how the individual may complain to SCFHP pursuant to the complaint procedure; the description must include the name, or title, and telephone number of the contact person or office.

    b. That SCFHP responds within the required time, or if SCFHP cannot act on the amendment within the required time, the SCFHP Privacy Officer may extend the period, one time only, by no more than 30 days, if the individual is provided with a written statement of the reasons for the delay and the date by which SCFHP will complete its action on the request.

    c. The SCFHP Privacy Officer will communicate the information to its Privacy Office designee who will identify the record or PHI in the Designated Record Set that is the subject of the disputed amendment and append or otherwise link the individual's request for an amendment, the denial of the request, the individual's statement of disagreement, if any, and SCFHP's rebuttal, if any, to the Designated Record Set.

    d. Future Disclosures:

i. If a statement of disagreement has been submitted by an individual, SCFHP's Privacy Office designee will include the material appended in accordance with Section E.2.c above, or at the election of SCFHP, an accurate summary of any such information, with any subsequent disclosure of the PHI to which the disagreement relates.
ii. If the individual has not submitted a written statement of disagreement, SCFHP's Privacy Office designee will include the individual's request for amendment and its denial, or an accurate summary of such information, with any subsequent disclosure of the PHI only if the individual has requested such action.
iii. When a subsequent disclosure is made using a standard transaction under the Administrative Simplification provisions of the HIPAA Regulations at 45 C.F.R. §162 that does not permit the additional material to be included with the disclosure, the Privacy Office designee may separately transmit the required material, as applicable, to the recipient of the standard transaction.

F. Accepting the Amendment

If SCFHP's Privacy Office accepts the requested amendment, in whole or in part, then:

1. The Privacy Officer will communicate, in writing, the amendment to the Privacy Office designee responsible for such authorized amendments.

2. Upon making the requested change in the individual's Designated Record Set, the Privacy Office designee will additionally:

   a. Document the amendment as required, but at a minimum will document the titles of the person or offices responsible for receiving and processing requests for amendments and retain the documentation as required by the SCFHP's Privacy Policies and Procedures, and
   b. Notify the SCFHP's Privacy Officer that the amendment has been documented as required.

3. Upon receiving notification from the Privacy Office designee, the Privacy Officer will:

   a. Inform the individual in the time required, that the amendment is accepted and obtain the individual's identification of an agreement to have the Privacy Officer notify the relevant persons with which the amendment needs to be shared.
   b. Inform the individual if any others, including SCFHP's Business Associates that have the PHI and may have relied, or could foreseeably rely, on such information to the detriment of the individual.
   c. Make reasonable efforts to inform others and provide the amendment within a reasonable time to:
      i. Persons identified by the individual as having received PHI about the individual and needing the amendment; and
      ii. Persons, including Business Associates, that SCFHP knows have the PHI that is subject of the amendment and that may have relied, or could foreseeably rely, on such information to the detriment of the individual.

G. Actions on Notices of Amendment

PROCEDURE

Upon receiving a notice of amendment to an individual's PHI from another Covered Entity, the SCFHP Privacy Officer, in consultation with legal counsel, will ensure the amendment of the PHI in Designated Record Sets as provided in this Policy.

H. Document Retention

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year form the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.06 Request for Access
HI.07 Amendments to Protected Health Information
HI.16 Reporting and Responding to Privacy Complaints

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V2	Revised	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Accounting of Disclosures**	**Policy No.:**	HI.08 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To define the circumstances under which an individual may obtain an Accounting of Disclosures of their Protected Health Information (PHI) in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of Santa Clara Family Health Plan (SCFHP) to provide an Accounting of Disclosures of an individual's PHI when requested by the individual in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary staff, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.528
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager	Jordan Yamashita Compliance Director & Privacy Officer	Robin Larmer Chief Compliance & Regulatory Affairs Officer

Santa Clara Family Health Plan™

POLICY

Date	Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Accounting of Disclosures**	**Procedure No.:**	HI.08.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the circumstances under which an individual may obtain an Accounting of Disclosures of their Protected Health Information (PHI) in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. Right to Accounting of Disclosures

Individuals have the right to receive an Accounting of Disclosures of their PHI.

1. The Accounting of Disclosures does not have to include disclosures made for the following purposes or to the following recipients:

    a. For Treatment, Payment, or Health Care Options
    b. To the individual or the individual's Personal Representative
    c. Authorized by the individual or the individual's Personal Representative
    d. To notify families of individuals or to assist families or and other persons involved in the individual's care
    e. For national security intelligence,
    f. To correctional institutions or to law enforcement authorities that have custody of the individual,
    g. As part of a Limited Data Set,
    h. Occurring prior to April, 14, 2003, or
    i. Incident to a use or disclosure otherwise permitted or required by these policies.

2. Examples of accountable disclosures include:

    a. Impermissible disclosures known to any SCFHP employee,
    b. Disclosures to government agencies performing licensure surveys, etc.,
    c. Disclosures made pursuant to a court order or subpoena,
    d. Disclosures to law enforcement not involved in custodial care, and
    e. Disclosures about victims of abuse, neglect or domestic violence.

PROCEDURE

3. SCFHP must temporarily suspend an individual's right to receive an Accounting of Disclosures if it receives a written statement from a health oversight agency or law enforcement official that such an Accounting to that individual would be reasonably likely to impede the agency's or official's activities. The time frame for such a suspension is required.

4. The Accounting of Disclosures will not include disclosures occurring prior to the shorter of:

    a. The period specified by the individual,
    b. April 14, 2003, or
    c. The date six (6) years prior to the individual's request.

B. Who May Obtain Accounting

Only the individual or the individual's Personal Representative may obtain an Accounting of Disclosures of the individual's PHI.

C. Requests Made Directly to SCFHP

Upon receiving a request for an Accounting of Disclosures of PHI directly from an individual or an individual's Personal Representative, the SCFHP employee will:

1. Refer the individual or individual's Personal Representative to SCFHP's customer service department, and

2. Notify SCFHP's Privacy Office of the request.

D. Responsibility for Responding to Requests

SCFHP's Privacy Office is responsible for making determinations regarding requests for Accounting of Disclosures.

E. Record Retention

1. SCFHP's Privacy Office will, for a period of six (6) years from the date of a PHI disclosure, provide an Accounting of Disclosures upon request of the individual or his/her designated Personal Representative.

2. A similar record will be kept by all SCFHP's Business Associates that disclose PHI.

F. Charges

1. SCFHP may not charge for the first Accounting of Disclosure request, but may charge a reasonable fee based on SCFHP's costs, for any additional Accounting requests received within a twelve (12) month period.

2. For disclosure of PHI maintained in an Electronic Health Record, the charge for disclosure may not exceed labor costs.

3. SCFHP's Privacy Office will determine if a charge is appropriate.

G. Provision of Accounting

1. SCFHP's Privacy Office will provide to the requesting individual an Accounting of Disclosures within sixty (60) days of receiving an authorized request.

2. The SCFHP Privacy Officer will provide the individual the Accounting of Disclosure that includes the following information:

   a. A brief description of the event including the date of the disclosure,
   b. A description of the types of PHI disclosed,
   c. Name of entity or person who received the PHI and address if known,
   d. The purpose of the disclosure (if applicable),
   e. If the disclosure was unauthorized or impermissible, a brief description of efforts to investigate the disclosure, to mitigate losses and to protect against further PHI disclosures,
   f. In addition to the Accounting of Disclosures, other information that may be required by applicable legal requirements such as contact procedures for individuals to ask questions or learn additional information which may include a toll-free telephone number, an email address, website or postal address.

H. Documents Retention

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or date when last in effect, whichever is later.

III. Policy Reference

HI.08 Accounting of Disclosures
HI.09 Amendments to Protected Health Information
HI.10 Uses by and Disclosures to Business Associates and Third Parties
HI.12 Uses and Disclosures of Limited Data Sets
HI.20 Personal Representatives
HI.21 Disclosures to Family, Caregivers, and Friends
HI.26 Uses and Disclosures for Treatment Purposes
HI.27 Uses and Disclosures for Health Care Operations
HI.28 Uses and Disclosures for Payment

PROCEDURE

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Authorization to Use or Disclose Protected Health Information**	**Policy No.:**	HI.09 v2
Replaces Policy Title (if applicable):	Determining Whether an Authorization is Valid	**Replaces Policy No. (if applicable):**	CP025.01
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To define the procedures for using or disclosing an individual's Protected Health Information (PHI) in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of Santa Clara Family Health Plan (SCFHP) to protect PHI and to use or disclose PHI only in accordance with a valid Authorization, when required and in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP employees, temporary staff, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.508
45 C.F.R. §164.502
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager	Jordan Yamashita Compliance Director & Privacy	Robin Larmer Chief Compliance & Regulatory Affairs

POLICY

	Officer	Officer
Date	Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v2	Revised	Compliance Committee		

PROCEDURE

Procedure Title:	**Authorization to Use or Disclose Protected Health Information**	**Procedure No.:**	HI.09.01 v2
Replaces Procedure Title (if applicable):	Determining Whether an Authorization is Valid	**Replaces Procedure No. (if applicable):**	CP025.01
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the procedures for using or disclosing an individual's Protected Health Information (PHI) in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. When Authorization is Not Required

Please refer to SCFHP Policy HI.05 Required and Permissible Uses and Disclosures.

B. When Authorization is Required

Written Authorization will be obtained before using or disclosing an individual's PHI for any of the following purposes:

1. Psychotherapy Notes: Generally, Psychotherapy Notes may not be used or disclosed without an Authorization except for use by the originator of the Notes and for other limited purposes.

2. Marketing: With some exceptions, PHI may not be used for Marketing unless an Authorization is obtained; the Authorization must state that SCFHP is receiving financial remuneration for the communication.

3. Sale of PHI: With some exceptions, SCFHP must obtain an Authorization for any disclosure of PHI for which SCFHP receives direct or indirect remuneration from, or on behalf of, the recipient of the information; the SCFHP Privacy Officer, in conjunction with legal counsel, will make the determination of the need for an Authorization in this situation.

4. Employers: PHI may not be disclosed to employers or persons acting on behalf of employers unless Authorization has been obtained.

5. Life Insurance Companies: PHI may not be disclosed to life insurance companies, or persons acting on their behalf, unless Authorization has been obtained.

PROCEDURE

6. Pharmaceutical Companies: PHI may not be disclosed for marketing purposes to pharmaceutical companies, or persons acting on their behalf, unless Authorization has been obtained.

7. Research: PHI may not be disclosed for research purposes without an Authorization unless an alteration or waiver of Authorization satisfies specific criteria.

8. Any other Purpose.

C. Authorization for Use or Disclosure

If an Authorization is required by the HIPAA Privacy Rule, the individual or the individual's Personal Representative may authorize the use or disclosure of the individual's PHI.

D. Requests Made Directly to SCFHP

When SCFHP receives a request to release PHI from an individual or any third party, SCFHP will:

1. Instruct the individual or other third party to make the request directly to the applicable customer service department; and

2. Advise SCFHP's Privacy Office of the request.

E. Implementing an Authorization

1. All Authorizations received or obtained by SCFHP will be forwarded to the SCFHP's Privacy Office to confirm that the requirements of this policy have been met and to oversee the response to the Authorization.

2. Prior to using or disclosing PHI pursuant to an Authorization that has not already been reviewed and verified by, SCFHP's Privacy Office will make reasonable efforts to verify the identity of the individual or the identity and authority of the Personal Representative, if applicable, who signed the Authorization form consistent with verification procedures outlined in HI.05 Required and Permissible Uses and Disclosures and HI.39 Verification of Identity and Authority.

F. Minimum Necessary

Only the information specified in an Authorization may be used or disclosed and the terms of the Authorization must be followed. If the Authorization appears vague or overly broad, the SCFHP Privacy Officer will review the Authorization and may contact the individual to determine the appropriate amount of PHI to be used or disclosed.

G. Defective Authorizations

An Authorization cannot be accepted if it has any of the following defects:

PROCEDURE

1. The expiration date has passed, or the Authorization specifies a particular expiration event that is known to have occurred.

2. The Authorization:

   a. Does not include all of the required core elements (see, Attachment 1 - SCFHP Request for Personal Health Information Form) or has not been filled out completely,
   b. Has not been signed and dated by the individual or an authorized Personal Representative, or
   c. Is for a limited or specific purpose and the anticipated disclosure of PHI would exceed the limitation or specific use.

3. The Authorization is known to have been revoked even if SCFHP has not yet received a copy of the written revocation.

4. The Authorization has been combined with other documents or types of permissions. See regulatory exceptions for Psychotherapy Notes and Research at 45 C.F.R. §164.508(b)(3).

H. Revocation

The individual or the individual's Personal Representative may revoke an Authorization at any time. The revocation will be in writing and will be signed by the individual or the Personal Representative. The revocation does not affect any uses or disclosures made by SCFHP prior to the revocation.

I. Revoked or Expired Authorization

1. Upon revocation or expiration of an Authorization, the Authorization form will be clearly marked to show that it is no longer valid. SCFHP's Privacy Office will communicate, in writing, the revocation or expiration of the Authorization, to the designated Privacy Office designee who will mark all related records, including the Health Profile and the appropriate clinical and Electronic Health Records to show that the Authorization is no longer valid.

2. Upon completion of the marking of related records, the designated Privacy Office designee will so notify SCFHP's Privacy Office who will notify SCFHP's Business Associates who might otherwise rely on the Authorization that it has expired or been revoked.

J. No Denial of Treatment or Enrollment in a Health Plan or Eligibility for Benefits

Treatment, enrollment in a Health Plan, or eligibility for benefits will not be denied solely because an individual refuses to sign an Authorization. See 45 C.F.R. §164.508(b) (4) for certain exceptions related to research or situations where an employer or insurer has requested and is paying for physicals or screenings.

K. Possible Exemptions from Authorization Requirements

SCFHP's Privacy Office is responsible for making determinations of possible exemptions from Authorization requirements.

PROCEDURE

1. If a use or disclosure of the information is for any of the following purposes, it may be exempted from the Authorization requirements. Refer to the following SCFHP Privacy Policies and Procedures to determine the circumstances under which the information may be released without Authorization from the individual:

    a. HI.10 Uses By and Disclosures to Subcontractors and Third Parties,
    b. HI.11 De-Identification of Health Information, and
    c. HI.12 Uses and Disclosures of Limited Data Sets.

2. If a use or disclosure of the information is for any of the following purposes, it may be exempted from the Authorization requirements. Refer such uses and disclosures to SCFHP's Privacy Officer to determine the circumstances under which the information may be released without Authorization from the individual:

    a. Family, Caregivers and Friends,
    b. Treatment Purposes,
    c. Health Care Operations,
    d. Payment Purposes,
    e. Court Orders and Subpoenas,
    f. Required by Law,
    g. Law Enforcement Purposes, and
    h. Suspected or Confirmed Abuse, Neglect or Domestic Violence.

3. SCFHP may make the following disclosures, provided the Privacy Office, after conferring with legal counsel, has approved the disclosure in advance, and determined that the regulatory requirement for the applicable exception to the requirement for an Authorization has been met:

    a. Disaster Relief Purposes,
    b. Public Health Activities,
    c. Health Oversight Activities,
    d. Decedents,
    e. Communications with Minors,
    f. Cadaveric Organ, Eye, or Tissue Donation Purposes,
    g. Research Purposes,
    h. Specialized Government Functions, and
    i. Worker's Compensation.

III. Policy Reference

HI.05 Required and Permissible Uses and Disclosures
HI.09 Authorization to Use or Disclose Protected Health Information
HI.10 Uses by and Disclosures to Business Associates and Third Parties
HI.11 De-Identification of Health Information
HI.12 Uses and Disclosures of Limited Data Sets
HI.20 Personal Representatives

PROCEDURE

HI.21 Disclosures to Family, Caregivers, and Friends
HI.24 Communications with Minors
HI.26 Uses and Disclosures for Treatment Purposes
HI.27 Uses and Disclosures for Health Care Operations
HI.28 Uses and Disclosures for Payment
HI.29 Uses and Disclosures for Marketing
HI.30 Uses and Disclosures for Court Orders and Subpoenas
HI.31 Uses and Disclosures Required by Law
HI.32 Uses and Disclosures for Law Enforcement Purposes
HI.33 Uses and Disclosures for Public Health Activities
HI.34 Uses and Disclosures about Decedents
HI.35 Disclosures for Suspected or Confirmed Abuse, Neglect or Domestic Violence
HI.36 Uses and Disclosures for Research Purposes
HI.37 Uses and Disclosures for Specialized Government Functions
HI.38 Disclosures for Workers Compensation
HI.39 Verification of Identity and Authority
HI.40 Uses and Disclosures for Cadaveric Organ, Eye or Tissue Donation Purposes
HI.41 Uses and Disclosures for Health Oversight Activities
HI.42 Uses and Disclosures for Disaster Relief Purposes
HI.43 Uses and Disclosures to Avert a Serious Threat to Health or Safety
HI.48 Sale of Protected Health Information

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V2	Revised	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

PROCEDURE

Attachment 1 - SCFHP Request for Personal Health Information Form

POLICY

Policy Title:	**Uses by and Disclosures to Business Associates and Third Parties**	**Policy No.:**	HI.10 v2
Replaces Policy Title (if applicable):	Business Associate Agreements	**Replaces Policy No. (if applicable):**	CP012.04
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To define the relationship and respective commitments, responsibilities and obligations of Santa Clara Family Health Plan (SCFHP) and any Business Associates of SCFHP who use or disclose Protected Health Information (PHI) on behalf of SCFHP in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and to require Business Associates and other third parties who use or disclose PHI on behalf of SCFHP to provide satisfactory assurance that they will protect PHI which will be documented through a written Business Associate Agreement or other agreement that meets the requirements of state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary staff, consultants, providers/delegates and vendors must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §160.103
45 C.F.R. §164.500(a) and (c)
45 C.F.R. §164.502(a), (b) and (e)
45 C.F.R. § 164.504(e)
45 C.F.R. §164.532(a), (b) and (d)
Omnibus Final Rule

V. Approval/Revision History

POLICY

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager Date	Jordan Yamashita Compliance Director & Privacy Officer Date	Robin Larmer Chief Compliance & Regulatory Affairs Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v2	Revised	Compliance Committee		

PROCEDURE

Procedure Title:	**Uses by and Disclosures to Business Associates and Third Parties**	**Procedure No.:**	HI.10.01 v2
Replaces Procedure Title (if applicable):	Business Associate Agreements	**Replaces Procedure No. (if applicable):**	CP012.04
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the relationship and respective commitments, responsibilities and obligations of Santa Clara Family Health Plan (SCFHP) and any Business Associates of SCFHP who use or disclose Protected Health Information (PHI) on behalf of SCFHP in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. Identify Business Associates

SCFHP's contracting designee, in conjunction with the Privacy Office, will identify all of its Business Associates that handle PHI. Business Associates do not include persons or entities that would not, in the normal course of their activities, use or disclose PHI but who may inadvertently come into contact with such information. SCFHP's contracting designee, in conjunction with the Privacy Office, will ensure that those persons or entities sign a confidentiality agreement but are otherwise not covered by this policy.

B. Disclosures to Business Associates

SCFHP may disclose PHI to a Business Associate and may allow the Business Associate to create, receive, maintain, or transmit PHI on its behalf, if SCFHP obtains satisfactory assurances, in accordance with contractual requirements outlined in the HIPAA Privacy Rule, that the Business Associate will appropriately safeguard the PHI.

C. Subcontractors

The contractual requirements of the Privacy Rule apply to any contract or other arrangement between a Business Associate and a subcontractor in the same manner as such requirements apply to contracts or other arrangements between a Covered Entity and Business Associate. A Business Associate may disclose PHI to a subcontractor and may allow the subcontractor to create, receive, maintain, or transmit PHI on its behalf, if the Business Associate obtains satisfactory assurances, in accordance with contractual requirements outlined in the Privacy Rule, that the subcontractor will appropriately safeguard the information.

PROCEDURE

D. Business Associate Agreements (BAA)

All Business Associate Agreements will be reviewed, approved, including legal approval, and signed under the SCFHP's policies and procedures for contracting, procurement and/or sourcing. SCFHP's contracting designee, in collaboration with the Privacy Officer and legal counsel, will ensure the following:

1. All Business Associate Agreements covered by this policy will include appropriate language regarding SCFHP's duties and obligations as a Covered Entity.

2. Whenever possible, the attached form (Attachment 1 – SCFHP Business Associate Agreement Template) is utilized. Exceptions require consultation with the SCFHP's legal counsel.

3. SCFHP's legal counsel must be consulted if the Business Associate wishes to add or change any of the terms, to assure that the changes meet legal and regulatory requirements and do not adversely affect SCFHP.

4. Business Associates are required to use SCFHP's Business Associate Agreement Template.

E. Business Associate Obligation under the Business Associate Agreement

Prior to entering into a Business Associate Agreement, the Business Associate must be able to demonstrate to SCFHP's Privacy Office that it has policies and procedures in place to ensure that it will adequately safeguard PHI. The terms of the Business Associate Agreement will:

1. Establish the permitted and required uses and disclosures of PHI by the Business Associate; the BAA may not authorize the Business Associate to use or further disclose PHI in a manner that would violate the requirements of the HIPAA Privacy Rule if done by SCFHP except that:

    a. The BAA may permit the Business Associate to use and disclose PHI for the proper management and administration of its affairs, and
    b. The BAA may permit the Business Associate to provide Data Aggregation services relating to the Health Care Operations of SCFHP.

2. Provide that the Business Associate will:

    a. Not use or further disclose the PHI other than as permitted or required by the BAA or as required by law,
    b. Use appropriate safeguards and comply, where applicable, with the HIPAA Security Rule with respect to electronic PHI to prevent use or disclosure of the information other than as provided for by its BAA,
    c. Report to SCFHP any use or disclosure of PHI not provided for by its BAA of which it becomes aware, including breaches of unsecured PHI,

d. Ensure that any Subcontractors (e.g. vendors) that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree to the same restrictions and conditions that apply to the Business Associate with respect to such PHI,
e. To the extent the Business Associate is to carry out SCFHP's obligation under the HIPAA Privacy Rule, comply with those regulations that apply to SCFHP in the performance of such obligation,
f. Make its internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of, SCFHP available to the Secretary of DHHS for purposes of determining compliance with the HIPAA Privacy Rule,
g. Provide that, at termination of the contract, if feasible, return or destroy PHI received from, or created or maintained by the Business Associate from or on behalf of SCFHP; if such return or destruction is not feasible, it will agree to extend the protections of the BAA to the PHI and limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible, and
h. Authorize the Business Associate to terminate a BAA with Subcontractor if it determines that the Subcontractor has violated a material term of the BAA.

5. Require the Business Associate to assist SCFHP in a timely manner if a request for PHI is received, including investigating the validity of the request and, if valid:

   a. Providing the individual with copies or access to the PHI upon the request of SCFHP,
   b. Amending the information upon request from SCFHP,
   c. Maintaining an Accounting of all Disclosures for purposes other than Treatment or Payment purposes or Health Care Operations or other purposes excluded from the accounting obligation, and provide the accounting to SCFHP upon request (see, HI.08: Accounting of Disclosures), and
   d. Complying with all SCFHP's requests regarding confidential communications and restrictions on the use and disclosure of PHI. See, HI.13: Requests for Restrictions of Uses and Disclosures and HI.14 Requests for Confidential Communications.

F. Notifications to Business Associates

SCFHP's Privacy Office will:

1. Provide its Business Associates with copies of SCFHP's Notice of Privacy Practices,

2. Notify its Business Associates when it changes its Notice of Privacy Practices in a manner that affects the Business Associate, and

3. Document the name of the person notified as well as the date(s) when the Business Associate was initially notified and when notified of any change.

G. Minimum Necessary Disclosures

All disclosures to Business Associates will be limited to the minimum amount of PHI needed for the Business Associate to carry out its functions on behalf of SCFHP. Business Associates are subject to the same "minimum necessary" limitations as SCFHP, as outlined in HI.03 Minimum Necessary: Uses, Disclosures and Requests.

PROCEDURE

H. Violations by Business Associates

1. Any SCFHP staff, temporary help, or consultant who learns, or has reason to believe, that a Business Associate is in any way jeopardizing the privacy and confidentiality of PHI provided by SCFHP, will notify SCFHP's Privacy Office immediately.

2. SCFHP's Privacy Office will notify the Business Associate immediately to cease such activities and will work with the Business Associate on mitigating any harmful effect that may result from the violation.

3. If the violation is not remedied with the Business Associate, the BAA with the Subcontractor may be terminated. The Privacy Officer, in consultation with legal counsel, may determine if a reasonable cure period may be allowed.

4. If termination is not feasible because the Business Associate is the only qualified and available person or entity for such services, the SCFHP Privacy Officer will appropriately document the reason for no termination.

I. Termination of a Business Associate Agreement

If the Business Associate Agreement with your Business Associate is terminated for any reason, SCFHP will stop disclosing any PHI to the Business Associate and require the Business Associate to do the following:

1. Return all PHI in its possession or ensure that the PHI is properly destroyed in a manner that protects the confidentiality of the PHI; the Business Associate will be required to provide a certificate of destruction showing that the PHI has been properly destroyed.

2. If any of the PHI cannot be returned or destroyed (for example, because the Business Associate is required to maintain certain information for inspection by regulatory agencies), the Business Associate may retain the PHI as long as it continues to protect the PHI in accordance with the terms of the Business Associate Agreement and to use the information only for the purposes that make return or destruction infeasible.

J. Accounting of Disclosures to Business Associates

It is not necessary to include disclosures to SCFHP's Business Associates in an Accounting of Disclosures. However, Business Associates are required to maintain a record of their disclosures to the same extent as SCFHP is required to do so. See, HI.08 Accounting of Disclosures.

K. Uses and Disclosures to Third Parties for Certain Legal Responsibilities, Management and Administration

1. SCFHP's Privacy Office may approve the disclosure of PHI to third parties for purposes of SCFHP's fulfillment of legal responsibilities, management and administration.

2. In such instances, contracts must be executed with the third party containing at least the following:

   a. An obligation to hold the PHI confidentially and use it or further disclose it only as required by law or for the purpose for which it was disclosed; and
   b. An obligation to notify the SCFHP's Privacy Office of any instances in which the confidentiality of the PHI has been compromised.

L. Document Retention

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.10 Uses by and Disclosures to Business Associates and Third Parties
HI.03 Minimum Necessary Standards
HI.08 Accounting of Disclosures
HI.13 Requests for Restrictions on Uses and Disclosures
HI.14 Request for Confidential Communications

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V2	Revised	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

PROCEDURE

Attachment 1 – SCFHP Business Associate Agreement Template

POLICY

Policy Title:	**De-Identification of Health Information**	**Policy No.:**	HI.11 v2
Replaces Policy Title (if applicable):	Health Information Privacy - De-Identified Information	**Replaces Policy No. (if applicable):**	CP023.02
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

The define the circumstances under which Santa Clara Family Health Plan (SCFHP) may create and use or disclose De-identified Health Information in accordance with state and federal laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to ensure that any De-identified Health Information used or disclosed on its behalf meets the requirements of this policy and is in accordance with state and federal privacy laws and HIPAA Regulations. When reasonably practical, SCFHP will use and disclose de-identified health information, rather than Protected Health Information (PHI).

III. Responsibilities

All SCFHP staff, temporary help, consultants, providers/delegates and vendors must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.502(d)
45 C.F.R. §164.514
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong	Jordan Yamashita	Robin Larmer

Santa Clara Family Health Plan™

POLICY

Compliance Manager	Compliance Director & Privacy Officer	Chief Compliance & Regulatory Affairs Officer
Date	Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v2	Revised	Compliance Committee		

PROCEDURE

Procedure Title:	**De-Identification of Health Information**	**Procedure No.:**	HI.11.01 v2
Replaces Procedure Title (if applicable):	Health Information Privacy – De-Identified Information	**Replaces Procedure No. (if applicable):**	CP023.02
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the circumstances under which Santa Clara Family Health Plan (SCFHP) may create and use or disclose De-identified Health Information in accordance with state and federal laws and HIPAA Regulations.

II. Procedure

A. Creation of De-Identified Health Information

SCFHP may create De-identified Health Information from individual PHI, in accordance with this policy. SCFHP may allow a Business Associate to create De-identified Health Information on its behalf as long as the Business Associate has executed a Business Associate Agreement or appropriate addendum, as described in HI.10 Uses By and Disclosures to Business Associates and Third Parties. The SCFHP Privacy Officer is responsible for ensuring the validity of De-Identified Health Information that is being used or disclosed on a routine or non-routine basis.

B. De-Identification Procedures

PHI is deemed to be de-identified if it meets either of the following qualifications:

1. SCFHP has obtained a written determination by a qualified statistician that there is very little risk that the information could be used, alone or in combination with other reasonably available information, to identify the individual. The statistician's analysis methods and results will be documented.

2. All of the identifiers listed in the attached De-Identification Checklist (Attachment 1) at the end of this policy have been removed.

C. Re-Identification Codes

SCFHP may assign a re-identification code to De-identified Health Information, which is not derived from or related to information of the individual and will not be shared with any third party other than Business Associates that have signed a Business Associate Agreement, as described in HI.10 Uses By and Disclosures to Business Associates and Third Parties.

D. Other Methods of Not Revealing Identity

In order to prevent identification of an individual's PHI when generating aggregate reports, the reports must address a minimum of fifty individual participant responses. If the aggregate report contains less than fifty individual participant responses it must be sent only to the SCFHP's Privacy Office.

E. Accounting of Disclosures

Recording of De-identified Health Information disclosures is not required. Any disclosure of the individual's Re-identification Code to a recipient of the applicable De-identified Health Information pursuant to HI.08 Accounting of Disclosures must be recorded in accordance with that policy.

F. Document Retention

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.08 Accounting of Disclosures
HI.10 Uses by and Disclosures to Business Associates and Third Parties
HI.11 De-Identification of Health Information

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V2	Revised	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

PROCEDURE

Attachment 1 - De-Identification Checklist

An individual's PHI is deemed to be de-identified if SCFHP does not have actual knowledge that the information could be used alone or in combination with other information to identify the individual, and all of the following elements have been removed with regard to (1) the individual, (2) the individual's relatives, (3) the individual's employer, and (4) the individual's household Individuals:

a. Names,

b. All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

   i. The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and

   ii. The initial three (3) digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

c. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;

   i. Telephone numbers,

   ii. Fax numbers,

   iii. Electronic mail addresses,

   iv. Social security numbers,

   v. Medical record numbers,

   vi. Health Plan or Customer beneficiary numbers,

   vii. Account numbers,

   viii. Certificate/license numbers,

   ix. Vehicle identifiers and serial numbers,

   x. Device identifiers and serial numbers,

   xi. Web Universal Resource Locators (URLs),

   xii. Internet Protocol (IP) address numbers,

   xiii. Biometric identifiers, including finger and voice prints,

   xiv. Full face photographic images and any comparable images, and

PROCEDURE

xv. Any other unique identifying number, characteristic or code.

POLICY

Policy Title:	**Uses and Disclosures of Limited Data Sets**	**Policy No.:**	HI.12 v2
Replaces Policy Title (if applicable):	Health Information Privacy – Limited Data Set	**Replaces Policy No. (if applicable):**	CP022.02
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To define how Santa Clara Family Health Plan (SCFHP) may create and use disclosure Limited Data Sets as set forth in this policy and in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to use and disclose Limited Data Sets for Research, public health, and Health Care Operations in accordance with state and federal privacy laws and HIPAA Regulations.

SCFHP will only use or disclose a Limited Data Set if SCFHP obtains satisfactory assurance in the form of a Data Use Agreement or Business Associate Agreement, that the recipient will only use or disclose the Protected Health Information (PHI) for limited purposes.

III. Responsibilities

All SCFHP staff, temporary help, consultants, providers/delegates and vendors must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.514(e)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval

POLICY

Anna Vuong Compliance Manager Date	Jordan Yamashita Compliance Director & Privacy Officer Date	Robin Larmer Chief Compliance & Regulatory Affairs Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v2	Revised	Compliance Committee		

PROCEDURE

Procedure Title:	**Uses and Disclosures of Limited Data Sets**	**Procedure No.:**	HI.12.01 v2
Replaces Procedure Title (if applicable):	Health Information Privacy – Limited Data Set	**Replaces Procedure No. (if applicable):**	CP022.02
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

The describe how Santa Clara Family Health Plan (SCFHP) may create and use or disclose Limited Data Sets as set forth in this policy and in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. Creation of Limited Data Sets

SCFHP or its Business Associates may create and disclose Limited Data Sets in accordance with this policy. All of the identifiers listed in the Limited Data Set Checklist (included herein) must be removed before the information is deemed to qualify as a Limited Data Set.

B. Purpose of Disclosure

Limited Data Sets may be disclosed only for the purposes of Research, public health, or Health Care Operations.

C. Recipients of Limited Data Sets

Information in a Limited Data Set may be disclosed only to a recipient, approved by SCFHP in consultation with the Privacy Office, which has given satisfactory assurance, by signing a Data Use Agreement.

1. If SCFHP becomes aware that the recipient is violating the Data Use Agreement, the SCFHP Privacy Officer will take one of the following actions:

    a. Terminate the Data Use Agreement (immediately or after giving the recipient an opportunity to cure, consistent with the terms of the Data Use Agreement); and/or
    b. Report the problem to SCFHP's legal counsel.

D. Accounting of Disclosures

PROCEDURE

Disclosures of information in a Limited Data Set do not have to be included in the Accounting of Disclosures. See, HI.08 Accounting of Disclosures.

E. Document Retention

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.08 Accounting of Disclosures
HI.12 Uses and Disclosures of Limited Data Sets

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V2	Revised	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date
V3	Revised	[Name of Approver] Date	[Name of Approver] Date

POLICY

Policy Title:	**Requests for Restrictions on Uses and Disclosures**	**Policy No.:**	HI.13 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To define the circumstances under which an individual has the right to request restrictions on uses or disclosures of their Protected Health Information (PHI) and how Santa Clara Family Health Plan (SCFHP) will consider and implement restriction requests in accordance with state and federal laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and to consider requested restrictions on the use or disclosure of an individual's PHI and, if those restrictions are approved, to comply with the individual's request in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.522(a)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong	Jordan Yamashita	Robin Larmer

Santa Clara Family Health Plan™

POLICY

Compliance Manager	Compliance Director & Privacy Officer	Chief Compliance & Regulatory Affairs Officer
Date	Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Request for Restrictions on Uses and Disclosures**	**Procedure No.:**	HI.13.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the circumstances under which an individual has the right to request restrictions on uses or disclosures of their Protected Health Information (PHI) and how Santa Clara Family Health Plan (SCFHP) will consider and implement restriction requests in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. Right to Request Restrictions

Individuals have the right to request restrictions on how their PHI is used or disclosed for Treatment or Payment purposes or Health Care Operations. (See SCFHP policies referenced in Section III below). They also have the right to request restrictions on notifying or disclosing information to family, caregivers, friends, or others involved in their care.

B. Who May Request

Only the individual or the individual's Personal Representative may request a restriction.

C. Requests for Restriction

1. If an individual requests to restrict use of their PHI, SCFHP's Privacy Office, in consultation with legal counsel, is responsible for determining whether or not to grant the restriction. SCFHP is not required to agree to a restriction except restriction requests from self-pay patients (see Section C.2. below).

2. SCFHP must agree to the request of an individual to restrict disclosure to a Health Plan if:

   a. The disclosure is for Payment purposes or Health Care Operations and is not otherwise required by law, and
   b. The PHI pertains solely to a health care item or service for which the individual, or a person, other than the Health Plan, acting on behalf of the individual, has paid for the health care item or service in full.

PROCEDURE

3. Any SCFHP staff, temporary help or consultant that receives a notice from an individual or their Personal Representative requesting SCFHP to implement a restriction request will forward the request to the SCFHP's Privacy Office.

4. SCFHP's Privacy Office will ensure that the request does not restrict permitted or required uses and disclosures that are not subject to a restriction. See, HI.05 Required and Permissible Uses and Disclosures.

5. If the SCFHP Privacy Officer agrees to grant the restriction request, the Privacy Officer will:

   a. Communicate the restriction, in writing, to the quality manager who will ensure that the restriction is documented in the individual's Health Profile, and
   b. Ensure that, if the individual who requested the restriction is in need of emergency treatment and the restricted PHI is needed to provide the emergency treatment, SCFHP will release the restricted PHI to a Health Care Provider to provide Treatment to the individual, and request that the Health Care Provider not further use or disclose the PHI.

D. Terminating a Restriction

If an individual requests a termination to a restriction, the Privacy Officer will:

1. Ensure that the individual agrees to or requests the termination in writing or, if oral, that the oral agreement is documented in the individual's Health Profile, and
2. Notify the quality manager to remove the restriction and provide the date that the individual will be or has been informed so that the restriction termination is only effective with respect to PHI created or received after the date the individual has been informed.
3. Ensure that the individual is informed that the restriction is terminated effective on the date of notification.

E. Documentation

The SCFHP Privacy Officer with ensure that documentation associated with a restriction that has been granted includes:

1. Communication and documentation, and
2. Any action, activity or designation related to the granting or terminating of a restriction request.

F. Document Retention

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.05 Required and Permissible Uses and Disclosures

PROCEDURE

HI.13 Requests for Restrictions on Uses and Disclosures
HI.21 Disclosures to Family, Caregivers, and Friends
HI.26 Uses and Disclosures for Treatment Purposes
HI.27 Uses and Disclosures for Health Care Operations
HI.28 Uses and Disclosures for Payment

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date
V2	Revised	[Name of Approver] Date	[Name of Approver] Date

POLICY

Policy Title:	**Request for Confidential Communications**	**Policy No.:**	HI.14 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To define the circumstances under which an individual has the right to request changes in the method of communications of their Protected Health Information (PHI) and how Santa Clara Family Health Plan (SCFHP) will grant and implement confidential communication requests in accordance with state and federal privacy laws and HIPAA.

II. Policy

A. It is the SCFHP policy to permit individuals to request that communications of protected health information be directed to alternative locations or delivered by alternative means.

B. As a Health Plan, SCFHP must accommodate reasonable requests to receive communications of PHI from the Health Plan by alternative means or at alternative locations, if the individual clearly states that the disclosure of all or part of that information could endanger the individual.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.522(b)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval

Santa Clara Family Health Plan™

POLICY

Anna Vuong Compliance Manager Date	Jordan Yamashita Compliance Director & Privacy Officer Date	Robin Larmer Chief Compliance & Regulatory Affairs Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Request for Confidential Communications**	**Procedure No.:**	HI.14.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the circumstances under which an individual has the right to request changes in the method of communications of their Protected Health Information (PHI) and how Santa Clara Family Health Plan (SCFHP) will grant and implement confidential communication requests in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. Right to Request Confidential Communications

Individuals have the right to request that communications from SCFHP be delivered by alternative means or at alternative locations (such as postal address, email address, telephone number).

B. Who May Request

Only the individual or the individual's Personal Representative may request confidential communications. See, HI.20 Personal Representatives.

C. Method of Request

To facilitate record keeping, SCFHP will require the request be in writing.

1. The request must include details that describe where or how the individual will receive future communications (the physical or mailing address, the phone number, or the email address to be used).

2. If the individual requests communications via email, SCFHP ensures that all electronic responses are encrypted.

3. SCFHP will not require an explanation from the individual as to the basis for the request, except that a health plan may request a statement that disclosure of all or part of the information to which the requests pertains could endanger the individual.

PROCEDURE

D. Responding to a Request

If an individual submits a request to SCFHP to change the means or location of confidential communications of their PHI, SCFHP staff, temporary help, or consultants will:

1. Refer the individual to SCFHP's customer service department to initiate the request;

2. Notify SCFHP's Privacy Officer;

3. The Privacy Officer will review the request to determine if it can be met and is reasonable. If the request is granted, the SCFHP Privacy Officer will:

   a. Notify the individual that the request is accepted.
   b. Where appropriate, inform the individual as to how payment, if any, will be handled.
   c. Oversee implementing the necessary procedures to comply with the granted request and communicate the change to any internal departments who may communicate with the individual.
   d. Direct the Enrollment and Eligibility Department to document the request in the individual's Health Profile.

E. Document Retention

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.14 Request for Confidential Communications
HI.20 Personal Representatives

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Reporting Impermissible Uses and Disclosures**	**Policy No.:**	HI.15 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To define the circumstances under which Santa Clara Family Health Plan (SCFHP) reports all impermissible uses and disclosures of Protected Health Information (PHI) that violates state of federal privacy laws or the HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and to report any suspected or confirmed impermissible uses or disclosures of PHI that violate state or federal privacy laws or the HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, consultants, providers/delegates and vendors must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.530(f)
45 C.F.R. § 164.414(b)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager	Jordan Yamashita Compliance Director & Privacy	Robin Larmer Chief Compliance & Regulatory Affairs

Santa Clara Family Health Plan™

POLICY

	Officer	Officer
Date	Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Reporting Impermissible Users and Disclosures**	**Procedure No.:**	HI.15.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the circumstances under which Santa Clara Family Health Plan (SCFHP) reports all impermissible uses and disclosures of Protected Health Information (PHI) that violates state or federal privacy laws or the HIPAA Regulations.

II. Procedure

A. Examples of Impermissible Use or Disclosure of PHI

Examples of impermissible uses or disclosures of PHI that must be reported include, but are not limited to, the following:

1. Sharing PHI for purposes other than delivery of SCFHP's services,
2. Disclosure of PHI to individuals or SCFHP staff, temporary help, consultants, providers/delegates and vendors without permission,
3. Emails containing PHI sent to an incorrect recipient,
4. Emails containing PHI sent to the correct recipient via an unsecure route,
5. Fulfillment errors resulting in PHI sent to an unintended recipient,
6. Fulfillment reports lost or missing in the mail (including U.S. Mail, Fed-Ex, UPS, etc.),
7. Facsimile errors resulting in PHI sent to an unintended recipient,
8. Voice mails containing PHI on a phone without permission,
9. Lost or stolen portable media containing PHI, such as laptops, flash drives, iPads or iPhones, or
10. Lost or stolen unsecured PHI, such as in paper faxes, records, notes, prescriptions, patient logs, visitor sign-in logs that include patient names.

B. Responsibilities of Workforce Members

1. When a SCFHP staff, temporary help, consultants, providers/delegates and vendors suspects that PHI may have been used or disclosed in violation of HIPAA Regulations or any of SCFHP's Privacy or Security Policies or Procedures, the employee must notify a supervisor and/or the Privacy Office. Any supervisor receiving such a report will submit an incident report immediately to the Privacy Office by accessing and completing the form located at: http://icat/Pages/Default.aspx.

PROCEDURE

2. If the disclosure involves a breach of security as outlined in SCFHP's Security Policies and Procedures, the reporting supervisor will forward the report to SCFHP's Security Office.

C. Responsibilities of the SCFHP Privacy Officer or Designee

The SCFHP Privacy Officer, with the advice of legal counsel and in accordance with applicable privacy policies and procedures, will:

1. Initiate a triage process to determine if it is, indeed, an incident and whether further investigation should be initiated;
2. Notify the SCFHP Security Officer if electronic PHI (ePHI) has been compromised;
3. Follow-up and/or investigate each suspected or confirmed incident reported on an incident report form in a manner that complies with SCFHP's internal standard operating procedures on investigation and reporting;
4. Oversee any required investigation including the collection of all relevant data for analysis;
5. Determine whether the use or disclosure is, or is suspected to be, a violation of federal or state laws, the HIPAA Privacy Rule or SCFHP's Policies and Procedures;
6. Immediately begin an identification process of the affected individuals and the information that was used or disclosed;
7. Implement mitigation steps to minimize further disclosure or use of the PHI;
8. Identify remediation or corrective action plans to reduce the possibility of a reoccurrence of the incident, including but not limited to:
    a. Monitor and/or audit to ensure the mitigation and remediation plans are in place and working,
    b. Notify management when appropriate,
    c. Determine the need to notify other internal or external stakeholders,
    d. Identify any needed changes to SCFHP's Privacy Policies and Procedures and develop a plan to update them,
    e. Communicate to the privacy training coordinator any changes to be included in upcoming training classes,
    f. Determine whether notification is required under the HIPAA Breach Notification Rule or your Breach Notification Policies and Procedures,
    g. If notification is required, follow the procedures outlined in SCFHP's Breach Notification Policy (HI.51 Breach Notification Requirements), and
    h. Maintain documentation of all pertinent and required information.

D. Other Obligations

SCFHP's Privacy Office and/or SCFHP's Security Office will immediately notify SCFHP's legal counsel of confirmed cases of impermissible uses or disclosure or other violations state or federal privacy laws or the HIPAA Regulations and provide updates as necessary or appropriate.

E. Burden of Proof

In the event of a Breach of PHI, SCFHP will have the burden of demonstrating that all required notifications were made or that the use or disclosure did not constitute a Breach. See HI.49

Administrative Requirements, HI.50 Breach Risk Assessment and HI.51 Breach Notification Requirements.

F. Documentation

SCFHP's Privacy Office will maintain a record of all impermissible uses or disclosures and other violations for inclusion in an Accounting of Disclosures. See HI.08 Accounting of Disclosures.

G. Document Retention

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.08 Accounting of Disclosures
HI.15 Reporting Impermissible Uses and Disclosures
HI.49 Administrative Requirements
HI.50 Breach Risk Assessment
HI.51 Breach Notification Requirements

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Reporting and Responding to Privacy Complaints**	**Policy No.:**	HI.16 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To define the circumstances under which Santa Clara Family Health Plan (SCFHP) accepts and responds to concerns or complaints by individuals regarding SCFP's Privacy Policies or Procedures or privacy practices in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to allow individuals to express concerns and complaints regarding SCFHP's Privacy Policies or Procedures or privacy practices and to respond to such concerns and complaints in a timely and appropriate manner.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.530(a) and (d)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager	Jordan Yamashita Compliance Director & Privacy	Robin Larmer Chief Compliance & Regulatory Affairs

Santa Clara Family Health Plan™

POLICY

	Officer	Officer
Date	Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Reporting and Responding to Privacy Complaints**	**Procedure No.:**	HI.16.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the circumstances under which Santa Clara Family Health Plan (SCFHP) accepts and responds to concerns or complaints by individuals regarding SCFHP's Privacy Policies or Procedures or privacy practices in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. Accepting Complaints

Individuals who express concerns or complaints about SCFHP's Privacy Policies or Procedures or privacy practices will be assured that SCFHP takes their concerns very seriously and intends to deal with the issue promptly and appropriately.

1. If the individual wishes to file a complaint regarding SCFHP's Privacy Policies or Procedures or privacy practices, the SCFHP staff, temporary help, or consultant who receives the complaint will:

    a. Access and complete the privacy complaint form located at: http://icat/com/default.aspx (see Quick Links on the right-hand side of the page and select "Privacy Complaint Form") and submit the form to the Privacy Office, or
    b. If preferred by the individual, direct them to directions on how to file a complaint located on SCFHP's public website (https://www.scfhp.com/for-members/helpful-information/notice-of-privacy-practices).

2. Individuals with concerns or complaints regarding SCFHP's Privacy Policies or Procedures or privacy practices will have the right to speak directly with the Privacy Office.

3. The individual is entitled to complain directly to the Secretary of DHHS and will be provided, upon request, the address and telephone number of the official or agency designated by DHHS to receive such complaints.

B. Investigation

PROCEDURE

The Privacy Officer, or designee, will promptly investigate any privacy related complaint in a manner consistent with procedures outlined in HI.15 Reporting Impermissible Uses and Disclosures.

C. Resolving the Privacy Related Complaint

If the complaint is justified, SCFHP will take prompt action to ensure that similar problems do not arise in the future.

1. Appropriate responses may range from changing certain practices, policies and procedures, providing additional privacy training, or taking necessary disciplinary action.

2. If the investigation of the complaint results in a determination that PHI has been improperly disclosed, the Privacy Office will coordinate the response in a manner consistent with HI.15 Reporting Impermissible Uses and Disclosures.

D. Notice to Person Who Complained

Once the matter is resolved, SCFHP's Privacy Office, in consultation with legal counsel, may respond to the individual who submitted the complaint.

E. Document Retention

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.15 Reporting Impermissible Uses and Disclosures
HI.16 Reporting and Responding to Privacy Complaints

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**No Retaliation or Waiver**	**Policy No.:**	HI.17 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To define Santa Clara Family Health Plan (SCFHP)'s policy not to intimidate or otherwise retaliate against individuals who exercise their privacy rights and not to require individuals to waive such rights as a condition of receiving treatment, payment, enrollment in a program or eligibility for benefits offered by a Covered Entity, in accordance with state and federal privacy laws, and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to encourage, rather than to retaliate against, individuals who exercise their privacy rights.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.530(g) and (h)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager	Jordan Yamashita Compliance Director & Privacy	Robin Larmer Chief Compliance & Regulatory Affairs

Santa Clara Family Health Plan™

POLICY

	Officer	Officer
Date	Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**No Retaliation or Waiver**	**Procedure No.:**	HI.17.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe Santa Clara Family Health Plan (SCFHP)'s policy not to intimidate or otherwise retaliate against individuals who exercise their privacy rights and not to require individuals to waive such rights as a condition of receiving treatment, payment, enrollment in a program or eligibility for benefits offered by a Covered Entity, in accordance with state and federal privacy laws, and HIPAA Regulations.

II. Procedure

A. No Threats, Intimidation, or Retaliation

Individuals and SCFHP's staff, temporary help, or consultants will not be intimidated or discouraged from exercising their privacy rights. Furthermore, SCFHP will not retaliate against any individual or SCFHP employee who:

1. Files a complaint with the Secretary of DHHS;

2. Testifies, assists, or participates in an investigation or compliance review of SCFHP's Privacy Policies and Procedures; or

3. Opposes any act or practice that the person believes in good faith violates the HIPAA Regulations provided that the opposition does not involve a disclosure of Protected Health Information (PHI) in violation of HIPAA Regulations.

B. No Waiver of Rights

Under no circumstances will SCFHP require an individual, including any SCFHP employee, to waive his or her privacy rights as a condition for receiving treatment, payment, enrollment in a Health Plan, or eligibility for benefits offered by a Covered Entity.

C. Reporting of Violations

Any SCFHP employee who witnesses or is the subject of intimidation, discouragement, threats or retaliation for exercising privacy rights, or who is asked to waive privacy rights as a condition for

receiving treatment, payment, enrollment in a Health Plan, or eligibility for benefits, will immediately notify SCFHP's Privacy Office which is responsible for investigating violations of this Policy.

D. Document Retention

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.17 No Retaliation or Waiver

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Safeguards**	**Policy No.:**	HI.18 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To establish workplace controls required of all Santa Clara Family Health Plan's (SCFHP) staff, temporary staff, consultants, providers/delegates and vendors so as to ensure adherence to privacy requirements in keeping with SCFHP's obligations to maintain the privacy or Protected Health Information (PHI) in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and to ensure that reasonable safeguards are implemented, that all staff, temporary help, consultants, providers/delegates and vendors are trained on and follow documented policies and procedures to prevent intentional or unintentional, impermissible use or disclosure of PHI in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary staff, consultants, providers/delegates and vendors must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.530(c)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval

Santa Clara Family Health Plan™

POLICY

Anna Vuong Compliance Manager **Date**	Jordan Yamashita Compliance Director & Privacy Officer Date	Robin Larmer Chief Compliance & Regulatory Affairs Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Safeguards**	**Procedure No.:**	HI.18.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To establish workplace controls required of all Santa Clara Family Health Plan SCFHP's (SCFHP) staff, temporary help, and consultants so as to ensure adherence to privacy requirements in keeping with SCFHP's obligations to maintain the privacy of Protected Health Information (PHI) in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. Privacy Requirements

SCFHP's Privacy Office is responsible for developing and maintaining complete, up-to-date Privacy Policies and Procedures, ensuring that all SCFHP employees are trained and sanctions are appropriately applied for non-compliance. See, HI.01 Privacy Office Assignment and Responsibilities and HI.02 Privacy Training Requirements.

B. Electronic PHI (ePHI) Safeguards

SCFHP's Security Office is responsible for ensuring that the safeguards described in the HIPAA Security Rule for ePHI are documented in SCFHP's Security Policies and Procedures, that all applicable employees are trained and have implemented these safeguards, and that sanctions are applied for non-compliance. In addition, the Security Office is responsible for ensuring that proper safeguards for devices not covered by the HIPAA Security Rule that create, maintain, store or transmit ePHI are documented and implemented (e.g. PDA, flash drives and email). See SCFHP's Security Policies and Procedures referenced in Section III of this policy.

C. Paper and Oral PHI Safeguards

SCFHP's Privacy Office is responsible for ensuring that the safeguards for written and oral PHI are documented in SCFHP's Privacy Policies and Procedures and that all applicable SCFHP employees are trained and have implemented these requirements, and that sanctions may be applied for non-compliance.

PROCEDURE

1. Written PHI safeguards include, but are not limited to, the proper handling, filing, storing, transporting and disposal of paper files, faxes, reports, authorizations, prescriptions, appointments, schedules, etc.

2. Oral PHI safeguards include, but are not limited to, verification of caller identification, content of voice messages, communications among SCFHP employees, communications with patients, announcements, etc.

3. Safeguards for telecommuter SCFHP employees include, but are not limited to, transporting PHI, computer use by family members, password management and time-outs, securing paper files and reports, phone discussion confidentiality, cell phone use, etc.

D. Facility Safeguards

SCFHP's facilities office is responsible for ensuring that safeguards for facility access and workplace safeguards are documented and that all applicable SCFHP employees are trained and have implemented these requirements. Some examples include, but are not limited to, the following:

1. Security Access Badges: All employees and visitors will wear security access badges prominently visible at all times.

    a. Security access badges will differentiate access to various parts of the building and limit access to the "minimum necessary" PHI depending on the responsibilities of the SCFHP staff, temporary help, and consultants or the purpose of the visit. See, HI.03 Minimum Necessary: Uses, Disclosures and Requests.
    b. There are certain restricted areas that require special access control. Permissions are programmed into issued badges for authorized SCFHP staff, temporary help, and consultants. Authorization for the restricted areas is granted by department managers, as approved by SCFHP's Privacy and Security Offices. **Access to restricted areas by unauthorized individuals is strictly prohibited without obtaining the appropriate advanced approvals**.

2. Visitors: Visitors will sign in at the receptionist desk, be issued a visitors' badge, be escorted by an authorized SCFHP employee at all times and sign out upon leaving the facility.

3. Site Tours: Site tours are strictly prohibited unless advance approval is obtained from the Privacy and Security Officers. The Privacy and Security Officers will take necessary precautions to protect against inadvertent disclosure of PHI found within SCFHP's working environment (e.g., limit site tour to viewing work spaces from a distance and staying within the non-working common areas such as hallways, kitchen and/or unoccupied conference rooms).

4. Access Control Cards: Access Control cards will be issued to authorized persons (i.e. vendors) by the facilities office as reviewed and approved by SCFHP's Privacy and Security Offices.

    a. Sign-in and out logs for building maintenance will be maintained by the facilities office and will include the purpose of the maintenance,

b. SCFHP employees will immediately report any attempt to enter a restricted area by unauthorized persons to the appropriate office.

5. Restricted Areas: Entries to restricted areas that are temporarily unlocked and/or propped open to allow moving of equipment, furniture, supplies, etc. will be continuously monitored by an authorized SCFHP employee.

6. Shredding Bins: Sufficient number of paper shredding bins will be located in appropriate areas, for example, near fax and copy machines and emptied weekly, or more frequently as needed, by a reputable company.

7. File Cabinets: An appropriate number and location of lockable file cabinets and storage areas will be provided to those SCFHP employees who need to protect paper PHI.

8. Camera Surveillance: Camera surveillance will be utilized at entry points and other sensitive areas.

9. Other Facility Controls: All other facility security controls and safeguards as required in the HIPAA Security Rule will be in place.

10. Reporting: SCFHP employees will report to the appropriate office any attempt by an unauthorized person to gain entrance to a restricted area.

E. Transporting PHI

SCFHP's staff, temporary help, and consultants are responsible for securing PHI in their possession during transit. This includes any and/or all of the following measures:

1. Store all forms of media containing PHI (paper format or encrypted electronic media) in a locked container.

2. Keep laptop, PDA or other Mobile Devices and all media containing PHI in personal possession during transport.

3. Avoid leaving laptops, PDA or other Mobile Devices unattended in public areas, especially airports.

4. Never leave laptops, PDA or other Mobile Devices or media containing PHI in luggage to be stored or transported via public transport.

5. Avoid leaving laptops, PDA or other Mobile Devices or media containing PHI in visible areas of an automobile; lock automobile doors when leaving the vehicle.

6. SCFHP employees working in home offices and other teleworker environments will assure that:

   a. Visitors and family members do not have access to SCFHP's business computers or media containing PHI,
   b. PHI in any format is not visible to unauthorized viewers,

c. SCFHP-owned laptops are locked with secure cable connection to off-site work stations at all times,
d. ePHI is never stored on non-SCFHP owned computers, laptops or computer readable storage media, and
e. PHI in paper format is stored in locked file devoted to SCFHP's operations.

7. When ending a remote session on a SCFHP computer, the SCFHP employee must wait for confirmation of the log-out command from the remotely connected SCFHP machine before leaving the work station.

F. Document Retention

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.01 Privacy Officer Assignment and Responsibilities
HI.02 Privacy Training Requirements
HI.03 Minimum Necessary Standards
HI.18 Safeguards

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Notice of Privacy Practices**	**Policy No.:**	HI.19 v2
Replaces Policy Title (if applicable):	Notice of Privacy Practices	**Replaces Policy No. (if applicable):**	CP010.02
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To ensure that Santa Clara Family Health Plan (SCFHP) adopts and implements Notices of Privacy Practices that meets the requirements of the HIPAA Privacy Rule.

II. Policy

It is the policy of SCFHP that appropriate individuals, at appropriate time, are provided with a Notice of Privacy Practices that describes how SCFHP may use and disclose their Protected Health Information (PHI), their rights with respect to PHI and the legal obligations of SCFHP and that meets the requirements of the HIPAA Privacy Rule.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.520
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager	Jordan Yamashita Compliance Director & Privacy	Robin Larmer Chief Compliance & Regulatory Affairs

Santa Clara Family Health Plan™

POLICY

	Officer	Officer
Date	Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v2	Revised	Compliance Committee		

POLICY

Policy Title:	**Personal Representatives**	**Policy No.:**	HI.20 v2
Replaces Policy Title (if applicable):	P&P for Health Information Privacy	**Replaces Policy No. (if applicable):**	CP.20
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To define the methods by which Santa Clara Family Health Plan (SCFHP) will receive and handle requests from an individuals to treat persons as Personal Representatives of individuals in keeping with SCFHP's obligations to maintain the privacy of Protected Health Information (PHI) in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and to comply with requests for designation of Personal Representative by an individual and to allow the Personal Representative to exercise privacy rights on behalf of the individual when the individual is not able to do so personally, in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

A. All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong	Jordan Yamashita	Robin Larmer

Santa Clara Family Health Plan™

POLICY

Compliance Manager	Compliance Director & Privacy Officer	Chief Compliance & Regulatory Affairs Officer
Date	Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V2	Revised	Compliance Committee		

PROCEDURE

Procedure Title:	**Personal Representatives**	**Procedure No.:**	HI.20.01 v2
Replaces Procedure Title (if applicable):	P&P for Health Information Privacy	**Replaces Procedure No. (if applicable):**	CP.20
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To define the methods by which Santa Clara Family Health Plan (SCFHP) will receive and handle requests from an individuals to treat persons as Personal Representatives of individuals in keeping with SCFHP's obligations to maintain the privacy of Protected Health Information (PHI) in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. Authority to Use or Disclose Protected Health Information (PHI)
A competent adult or emancipated minor who does not suffer from mental incapacity has authority to exercise his or her rights regarding the use or disclosure of PHI. A Personal Representative that has authority under state law to make health care decisions on behalf of an individual may also exercise the individual's privacy rights, on behalf of the individual. See, HI.23 Disclosures Related to Individuals with Mental Incapacities and Privacy Policy and HI.24 Communications with Minors.

B. Limitations on Rights of Personal Representative
Under the following certain limited circumstances, SCFHP may elect not to recognize the rights of a Personal Representative with respect to the privacy rights of the individual:

1. If SCFHP has a reasonable belief that:
   a. The individual has been or may be subjected to domestic violence, abuse, or neglect by the Personal Representative, or
   b. Treating such person as the Personal Representative could endanger the individual; and
   c. In the documented professional opinion of a licensed professional affiliated with SCFHP, it is not in the best interest of the individual to treat the person as the individual's Personal Representative. See HI.35 Disclosures for Suspected or Confirmed Abuse, Neglect or Domestic Violence.

2. If a request for access to PHI is made by an individual's Personal Representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such Personal Representative is reasonably likely to cause substantial harm to the individual or another person. See, HI.06 Request for Access.

C. Notification of Designation

1. SCFHP will accept written communication from an individual notifying SCFHP of the designation of a Personal Representative who has the authority under state law to make health care decisions for the individual.
2. SCFHP will accept written notification from a Personal Representative, if valid, legal documentation is provided indicating designation of a Personal Representative who has the authority under state law to make health care decisions for an individual. Any SCFHP employee who receives written communication from a Personal Representative will forward the written communication to the SCFHP Privacy Office.
3. SCFHP Privacy Office designee will make the determination of the validity of the Personal Representative's identification and authorization, and will document the following information in the individual's Health Profile:
   a. Personal Representative's name,
   b. Personal Representative's address (street, city, state),
   c. Date of notification of Personal Representative's designation,
   d. Signature of Personal Representative, and
   e. The method of valid notification.

D. Implementation

SCFHP's Privacy Office will oversee implementing the necessary procedures to comply with the request consistent with state and federal privacy laws and HIPAA Regulations.

E. Request to Remove a Personal Representative

Upon receiving valid notification that the individual no longer wishes to designate a previously designated Personal Representative, the Privacy Officer will notify, in a secure email, the Privacy Office designee who will update the individual's Health Profile marking the Personal Representative's information as "inactive".

F. Document Retention

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.06 Request for Access
HI.20 Personal Representatives
HI.23 Disclosures Related to Individuals with Mental Incapacities
HI.24 Communications with Minors
HI.35 Disclosures for Suspected or Confirmed Abuse, Neglect or Domestic Violence

PROCEDURE

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V2	Revised	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Disclosures to Family, Caregivers, and Friends**	**Policy No.:**	HI.21 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the circumstances under which Santa Clara Family Health Plan (SCFHP) staff, temporary help, and consultants will share relevant Protected Health Information (PHI) about an individual with the individual's family, friends, Personal Representative or other person identified by the individual in keeping with SCFHP's obligations to maintain the privacy PHI and in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and allow individuals the opportunity to agree or object to the disclosure of PHI to specified persons who are involved in the individual's care or who need to be notified of the individual's condition in accordance with state and federal laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.510(a) and (b)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval

POLICY

Anna Vuong Compliance Manager Date	Jordan Yamashita Compliance Director & Privacy Officer Date	Robin Larmer Chief Compliance & Regulatory Affairs Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

POLICY

Policy Title:	**Individual Caller Identification**	**Policy No.:**	HI.22 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe a process for verifying the authority and identity of a caller requesting Protected Health Information (PHI) of an individual prior to disclosing it, in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of Santa Clara Family Health Plan (SCFHP) to protect PHI and to verify the authority and identity of callers requesting PHI prior to disclosing it, in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.514(h)(1) and (2)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager	Jordan Yamashita Compliance Director & Privacy	Robin Larmer Chief Compliance & Regulatory Affairs

POLICY

	Officer	Officer
Date	Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

POLICY

Policy Title:	**Disclosures Related to Individuals with Mental Incapacities**	**Policy No.:**	HI.23 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the procedures for speaking with a Caregiver of an individual with mental incapacity, in keeping with Santa Clara Family Health Plan (SCFHP)'s obligations to maintain the privacy of Protected Health Information (PHI) in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI of individual's with mental incapacity and to disclose PHI of such individuals only as permitted by, and in accordance with, state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.510(a) and (b)
45 C.F.R. §164.514(h)(2)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong	Jordan Yamashita	Robin Larmer

Santa Clara Family Health Plan™

POLICY

Compliance Manager	Compliance Director & Privacy Officer	Chief Compliance & Regulatory Affairs Officer
Date	Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

POLICY

Policy Title:	**Communications with Minors**	**Policy No.:**	HI.24 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the process for Santa Clara Family Health Plan's (SCFHP) staff, temporary help, and consultants to provide services to individuals who are Minors and unable to make health care decisions (as determined by the laws of the state where the individual resides), in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and to provide services to individuals who are Minors and unable to make their own health care decisions in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

Cal. Bus. & Prof. Code § 2397
Cal. Family Code § 6922(a)
Cal. Family Code §§ 6925 – 6928
Cal. Family Code §6929(b)
Cal. Penal Code§ 11171.2
Cal. Family Code § 7050(e)
45 C.F.R. §164.502(g)
Omnibus Final Rule
DHCS Contract (Exhibit A, Attachment 9, Section D)

POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager Date	Jordan Yamashita Compliance Director & Privacy Officer Date	Robin Larmer Chief Compliance & Regulatory Affairs Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

POLICY

Policy Title:	**Permission to Leave Message with PHI**	**Policy No.:**	HI.25 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To protect an individual's confidentiality and privacy when Protected Health Information (PHI) is recorded on an approved telephone answering machine, voice mail, or is provided to a caregiver designated by the individual in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of Santa Clara Family Health Plan (SCFHP) to protect PHI and individual confidentiality and privacy by leaving PHI on messaging services or through caregivers only as designated, and consented to by the individual and in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.508(a)
45 C.F.R. §164.522(a) and (b)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval

POLICY

Anna Vuong Compliance Manager Date	Jordan Yamashita Compliance Director & Privacy Officer Date	Robin Larmer Chief Compliance & Regulatory Affairs Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

POLICY

Policy Title:	**Uses and Disclosures for Treatment Purposes**	**Policy No.:**	HI.26 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the circumstances under which Santa Clara Family Health Plan (SCFHP) will use or disclose Protected Health Information (PHI) for Treatment purposes in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and to use and disclose PHI for Treatment purposes in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.501
45 C.F.R. §164.502(a)
45 C.F.R. §164.506
45 C.F.R. §164.508
45 C.F.R. §164.522
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval

Santa Clara Family Health Plan™

POLICY

Anna Vuong Compliance Manager Date	Jordan Yamashita Compliance Director & Privacy Officer Date	Robin Larmer Chief Compliance & Regulatory Affairs Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Uses and Disclosures for Treatment Purposes**	**Procedure No.:**	HI.26.01
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the circumstances under which Santa Clara Family Health Plan (SCFHP) will use or disclose Protected Health Information (PHI) for Treatment purposes in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. Purposes Related to Treatment

Subject to any requirement of federal or state law or standards of professional ethics that requires patient consent, and the limitation on the use or disclosures of Psychotherapy Notes, PHI may be shared with Health Care Providers as necessary to arrange for appointments, referrals, diagnostic tests, consultations, management and coordination of care, determinations of suitability for services, and similar services directly related to Treatment in accordance with this Policy and consistent with state and federal privacy laws and HIPAA Regulations. If not otherwise required by federal or state law or standards of professional ethics, and subject to the limitation regarding Psychotherapy Notes, it is not mandatory for SCFHP to obtain written consent to use or disclose an individual's PHI for Treatment. See, Regulatory Authority Section below and HI.09 Authorization to Use or Disclose Protected Health Information.

B. Internal Access by SCFHP Employee

1. SCFHP employee may request and be given access to use the PHI of any individuals they are interacting with or have previously interacted with to the extent necessary to perform their assigned job functions on behalf of SCFHP. (See Section D below).
2. SCFHP's employees who believe they need access to the PHI of an individual with whom they do not have a job-related function, must contact the SCFHP Privacy Office, to determine whether such access is appropriate. See, HI.27 Uses and Disclosures for Health Care Operations.

C. Verification of Treatment Relationship

If a Health Care Provider requesting PHI is not known to SCFHP, the Provider's identity must be verified and documented. This may be accomplished by calling the Provider's office using an official phone number and asking a staff member to fax the request on official letterhead of the Provider. The SCFHP employee should contact the individual or the individual's Personal Representative directly to confirm

that the requesting Health Care Provider is involved in the individual's Treatment and to document the individual's consent, if consent was required. See, HI.39 Verification of Identity and Authority.

D. Minimum Necessary Access

Information that is used and shared for Treatment purposes is subject to the minimum necessary rules. Only SCFHP's employees who have been granted appropriate authority are allowed to use or review PHI for Treatment purposes, and may access only the information needed to carry out their duties. PHI may be shared only with those employees who have a need for it based on specific functions. See, HI.03 Minimum Necessary: Uses, Disclosure, and Requests.

E. Checking for Restrictions

Prior to using or disclosing any PHI, SCFHP's employee will check the individual's Health Profile to verify that the individual has not made a restriction request. If there is an applicable restriction request, the employee will not disclose the PHI. See, HI.13 Requests for Restrictions on Uses and Disclosures.

F. Prohibition on Conditioning of Authorizations

SCFHP may not condition the provision to an individual of Treatment on the provision of an Authorization, except:

a. A Health Care Provider may condition the provision of research-related Treatment on provision of an Authorization for the use or disclosure of PHI for such research, and
b. A Covered Entity may condition the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party on provision of an Authorization for the disclosure of the PHI to such third party.

G. No Waiver of Rights

SCFHP may not require individuals to waive their rights as a condition of the provision of Treatment, Payment, enrollment in a Health Plan, or eligibility for benefits. See, HI.17 No Retaliation or Waiver.

H. Accounting of Disclosures

Disclosures for Treatment do not need to be included in the Accounting of Disclosures. However, any disclosures made to persons outside SCFHP for purposes other than to provide Treatment will be documented and will indicate what information was disclosed, to whom, and date of disclosure. See, HI.08 Accounting of Disclosures.

I. Document Retention

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.03 Minimum Necessary Standards
HI.08 Accounting of Disclosures
HI.09 Authorization to Use or Disclose Protected Health Information
HI.13 Requests for Restrictions on Uses and Disclosures

PROCEDURE

HI.17 No Retaliation or Waiver
HI.26 Uses and Disclosures for Treatment Purposes
HI.27 Uses and Disclosures for Health Care Operations
HI.39 Verification of Identity and Authority

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Uses and Disclosures for Health Care Operations**	**Policy No.:**	HI.27 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the circumstances under which Santa Clara Family Health Plan's (SCFHP) Staff, temporary help, and consultant may use and disclose an individual's Protected Health Information (PHI) for Health Care Operations in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and to use and disclose PHI for Health Care Operations in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.501
45 C.F.R. §164.502(a)(1) and (3)
45 C.F.R. §164.506
45 C.F.R. §164.508
45 C.F.R. §164.522
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval

Santa Clara Family Health Plan™

POLICY

Anna Vuong Compliance Manager Date	Jordan Yamashita Compliance Director & Privacy Officer Date	Robin Larmer Chief Compliance & Regulatory Affairs Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Uses and Disclosures for Health Care Operations**	**Procedure No.:**	HI.27.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the circumstances under which Santa Clara Family Health Plan's (SCFHP) staff, temporary staff, and consultants may use and disclose an individual's Protected Health Information (PHI) for Health Care Operations in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. Use or Disclosure for Health Care Operations

Subject to any requirement of federal or state law or standards of professional ethics that requires individual consent, the PHI of individuals may be used or disclosed for the Health Care Operations of SCFHP in accordance with this Policy and consistent with state and federal privacy laws and HIPAA Regulations. If not otherwise required by federal or state law or standards of professional ethics, except in the circumstances described below, it is not mandatory for SCFHP to obtain written consent to use or disclose an individual's PHI for Health Care Operations. PHI may not be used or disclosed for Health Care Operations:

1. Except under very limited circumstances, if it is contained in Psychotherapy Notes (see, HI.09 Authorization to Use or Disclose Protected Health Information*),*
2. If it relates to Health Care services that the individual has fully paid for out-of-pocket (see, HI.09 Authorization to Use or Disclose Protected Health Information*), or*
3. If it is Genetic Information intended for use for underwriting purposes (see, HI.45 Uses and Disclosures for Underwriting Purposes*).*

B. Disclosures to Business Associates for Health Care Operations

1. SCFHP's Business Associates and other third parties (such as auditors, management companies, attorneys, accountants, and others) may assist in carrying out SCFHP's Health Care Operations. If these parties use or disclose PHI when assisting SCFHP with Health Care Operations, they will be considered Business Associates and will be required to sign a Business Associate Agreement. PHI is only shared with those Business Associates or other third parties, as needed for specific operations. See, HI.10 Uses By and Disclosures to Business Associates and Third Parties.
2. SCFHP's Privacy Office will confirm the categories of PHI reasonably needed for routine and non-routine requests in accordance with HI.03 Minimum Necessary: Uses, Disclosures and Requests.

PROCEDURE

C. Disclosures to Other Covered Entities

SCFHP may disclose PHI to a Covered Entity for its own Health Care Operations activities if both SCFHP and the Covered Entity that receives the information have or have had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is:

1. For a purpose listed in paragraph (1) or (2) of the definition of "health care operations" in 45 C.F.R. §164.501, or
2. For the purpose of health care fraud and abuse detection or compliance.

D. Minimum Necessary Access

PHI that is used and disclosed for Health Care Operations is subject to the minimum necessary rules. Only SCFHP's employees who have been granted appropriate authority are allowed to use or disclose PHI for Health Care Operations, and may access only the PHI needed to carry out their duties. See, HI.03 Minimum Necessary: Uses, Disclosure, and Requests.

E. Restriction Request

Prior to disclosing any PHI, SCFHP's employees will check the individual's Health Profile to verify that the individual has not made a restriction request. If there is an applicable restriction request, the employees will not disclose the PHI. See, HI.13 Requests for Restrictions on Uses and Disclosures.

F. Accounting of Disclosures

Disclosures for Health Care Operations do not need to be included in the Accounting of Disclosures. See, HI.08 Accounting of Disclosures.

G. Document Retention

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.03 Minimum Necessary Standards
HI.08 Accounting of Disclosures
HI.09 Authorization to Use or Disclose Protected Health Information
HI.10 Uses by and Disclosures to Business Associates and Third Parties
HI.13 Requests for Restrictions on Uses and Disclosures
HI.27 Uses and Disclosures for Health Care Operations
HI.45 Uses and Disclosures for Underwriting Purposes

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval

PROCEDURE

V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Uses and Disclosures for Payment**	**Policy No.:**	HI.28
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the circumstances under which Santa Clara Family Health Plan's (SCFHP) staff, employees, and consultants may use and disclose Protected Health Information (PHI) for Payment purposes in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and to use and disclose PHI for Payment in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.501
45 C.F.R. §164.502(a)
45 C.F.R. §164.506(a), (b) and (c)
45 C.F.R. §164.508(a) and (b)
45 C.F.R. §164.5109(b)
45 C.F.R. §164.522A(a) and (b)
45 C.F.R. §164.530(h)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval

Santa Clara Family Health Plan™

POLICY

Anna Vuong Compliance Manager	Jordan Yamashita Compliance Director & Privacy Officer	Robin Larmer Chief Compliance & Regulatory Affairs Officer
Date	Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Uses and Disclosures for Payment**	**Procedure No.:**	HI.28.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To define the circumstances under which Santa Clara Family Health Plan's (SCFHP) staff, temporary staff, and consultants may use and disclose Protected Health Information (PHI) for Payment purposes in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. Use or Disclosure for Payment

1. Subject to any requirement of federal or state law or standards of professional ethics that requires patient consent, SCFHP may use or disclose PHI for Payment purposes in accordance with this Policy and consistent with state and federal privacy laws and HIPAA Regulations. If not otherwise required by federal or state law or standards of professional ethics, except in the circumstances described below, it is not mandatory for SCFHP to obtain written consent to use or disclose an individual's PHI for Payment purposes. PHI may not be used or disclosed for Payment purposes:
2. Except under very limited circumstances, if it is contained in Psychotherapy Notes (see, HI.09 Authorization to Use or Disclose Protected Health Information), or
3. If it relates to Health Care services that the individual fully paid for out-of-pocket (see, HI.09 Authorization to Use or Disclose Protected Health Information).

B. SCFHP may disclose to a family member, other relative, or a close personal friend of the individual, or any other person identified by the individual, the PHI directly relevant to such person's involvement with the individual's care for Payment purposes related to the individual's health care. See, HI.21 Disclosures to Family, Caregivers and Friends.

C. Disclosure to Others

SCFHP may disclose PHI to a Covered Entity or Business Associate for the Payment activities of the entity that receives the information.

D. Minimum Necessary Access

Information that is used and shared for Payment purposes is subject to the minimum necessary rule. Only SCFHP's employee who has been granted appropriate authority are allowed to use or review PHI for Payment purposes, and may access only the information needed to carry out their duties. PHI may

be shared only with those employees who have a need for it based on specific operations. See, HI.03 Minimum Necessary: Uses, Disclosure, and Requests.

E. Prohibition on Conditioning of Authorizations
SCFHP may not condition Payment on behalf of an individual on the provision by the individual of an Authorization.

F. Restriction Request
SCFHP must permit an individual to request a restriction on the uses or disclosures of PHI for Payment purposes. See, HI.13 Requests for Restrictions on Uses and Disclosures.

G. Confidential Communications
SCFHP may require the individual to make a request for confidential communications in writing and may condition the provision of a reasonable accommodation on when appropriate, information as to how Payment, if any, will be handled and specification of an alternative address or other method of contact. See, HI.14 Requests for Confidential Communications.

H. Waiver of Rights
SCFHP may not require individuals to waive their rights as a condition of the provision of Treatment, Payment, enrollment in a Health Plan, or eligibility for benefits. See, HI.17 No Retaliation or Waiver.

I. Accounting of Disclosures
Disclosures for Payment activities do not need to be included in the Accounting of Disclosures. See, HI.08 Accounting of Disclosures.

J. Document Retention
This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.03 Minimum Necessary Standards
HI.08 Accounting of Disclosures
HI.09 Authorization to Use or Disclose Protected Health Information
HI.13 Requests for Restrictions on Uses and Disclosures
HI.14 Request for Confidential Communications
HI.17 No Retaliation or Waiver
HI.21 Disclosures to Family, Caregivers, and Friends
HI.28 Uses and Disclosures for Payment

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/	First Level Approval	Second Level Approval

PROCEDURE

Revised)			
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Uses and Disclosures for Marketing**	**Policy No.:**	HI.29 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the circumstances under which Santa Clara Family Health Plan's (SCFHP) staff, temporary help, and consultants may use and disclose Protected Health Information (PHI) for Marketing purposes in accordance with a valid Authorization and with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and to use and disclose PHI for Marketing purposes in accordance with a valid Authorization and state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.501
45 C.F.R. §164.508(a)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager	Jordan Yamashita Compliance Director & Privacy	Robin Larmer Chief Compliance & Regulatory Affairs

POLICY

	Officer	Officer
Date	Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Uses and Disclosure for Marketing**	**Procedure No.:**	HI.29.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒CMC	

I. Purpose

To describe the circumstances under which Santa Clara Family Health Plan's (SCFHP) staff, temporary staff, and consultants may use and disclose Protected Health Information (PHI) for Marketing purposes in accordance with a valid Authorization and with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. General Rule

With certain exceptions described below, SCFHP must obtain an Authorization for any use or disclosure of PHI for marketing purposes. See, HI.09 Authorization to Use or Disclose Protected Health Information.

B. Disclosure of Financial Remuneration

If the Marketing involves direct or indirect Financial Remuneration to the SCFHP from a third party, the Authorization must state that such Remuneration is involved.

C. Activities That Are Not Considered Marketing

Unless applicable state law provides otherwise, or as noted below, Marketing does not include communications made:

1. To describe a health-related product or service (or Payment for such product or service) that is provided by, or included in a plan of benefits of, SCFHP,
2. To provide information on general health topics such as dietary advice, weight management and importance of exercise to well-being,
3. For Treatment of the individual by a Health Care Provider including case management or care coordination for the individual,
4. To manage or coordinate the individual's care or to recommend alternative treatments, therapies, Health Care Providers or settings of care to the individual,
5. To describe enhancements to a Health Plan and health-related products or services available only to a Health Plan enrollee that add value to, but are not part of, a plan of benefits, and
6. For case management or care coordination, contacting of individuals with information about treatment alternatives, and related functions to the extent these activities do not fall within the definition of Treatment.

PROCEDURE

D. Communications Without Financial Remuneration

As long as SCFHP is not receiving payment to make the communications listed below, SCFHP may use or disclose PHI without being deemed to be engaged in Marketing:

1. Reminding individuals about appointments,
2. Sending reminders regarding annual exams and prescription refill,
3. Describing a product or service that is for:
   a. Health related plan benefits or services,
   b. Treatment, or
   c. Case management or care coordination,
4. Informing an individual that is a smoker about smoking cessation programs,
5. Referring individuals to other physicians or specialists,
6. Recommending alternative types of care or places to receive Treatment,
7. Providing PHI to Health Care Providers so they can provide Treatment to the individual, and
8. Notifying individuals about services or products provided by, or included in a plan of benefits of SCFHP, including communications about: the Covered Entities participating in a Health Care Provider network or Health Plan network, replacement of, or enhancements to, a Health Plan and health-related products or services available only to a Health Plan enrollee that add value to, but are not part of, a plan of benefits.

E. Face-to-Face Marketing Communications

SCFHP may, with the approval of SCFHP's Privacy Office and Compliance Officer, develop programs to provide Marketing information to individuals during face-to-face meetings. For SCFHP's Cal MediConnect line of business, a Scope of Appointment form, used only by SCFHP's authorized Medicare Outreach Agents, is required from the individual. Under no circumstances will an individual be pressured to accept the Marketing information.

F. Promotional Gifts of Nominal Value

SCFHP may provide small, promotional gifts of nominal value to individuals without obtaining the approval of the Privacy Office or an Authorization. Examples include coffee mugs, calendars, pens, samples, or similar items.

G. Responsibilities of the Privacy Office

SCFHP's Privacy Office, in consultation with the Compliance Officer, is responsible for:

1. Making determinations regarding the requirement to obtain an Authorization for the activity being considered (see, HI.09 Authorization to Use or Disclose Protected Health Information); and
2. Ensuring that the Authorization discloses the fact that SCFHP will receive direct or indirect payment or benefits from another party for marketing purposes, if applicable.

H. Uses or Disclosures involving Business Associates or Third Parties

1. If SCFHP discloses PHI to a third party for its Marketing purposes, SCFHP will ensure that each recipient agrees to use and re-disclose the PHI solely as expressly permitted in an individual's Authorization evidenced by signing a statement or agreement containing the following or similar wording:

"In consideration of receiving Protected Health Information for marketing purposes, _____ (the "Recipient") agrees not to use the information for any purpose or in any manner other than as authorized by the individual. Unless the authorization expressly permits re-disclosure, the Recipient also agrees not to re-disclose the Protected Health Information (more than once) to anyone other than its own agents and employees, who will also be bound by this restriction. After the information is no longer needed for the purposes authorized by the individual, the Recipient will destroy the information in a manner that protects the individual's privacy and will, upon request, provide SCFHP with certification of such destruction."

2. If a marketing company, consultant, or similar party assists SCFHP in Marketing, and these activities will involve the use or disclosure of PHI, SCFHP will treat the person or entity as a Business Associate and will ensure that, in addition to complying with Section H (1) above, the Business Associate will execute a Business Associate Agreement or a relevant addendum. See, HI.10 Uses By and Disclosures to Business Associates and Third Parties. The Business Associate will agree not to use PHI to market its own products or services unless the individual has provided a written Authorization as required by the Privacy Rule. See, HI.09 Authorization to Use or Disclose Protected Health Information.

I. Accounting of Disclosures

Disclosures for marketing purposes do not have to be included in the Accounting of Disclosures because they are either being made directly to the individual or being made pursuant to the individual's written Authorization.

J. Document Retention

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.09 Authorization to Use or Disclose Protected Health Information
HI.10 Uses by and Disclosures to Business Associates and Third Parties
HI.29 Uses and Disclosures for Marketing

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

PROCEDURE

POLICY

Policy Title:	**Uses and Disclosures for Court Orders and Subpoenas**	**Policy No.:**	HI.30 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the circumstances under which Santa Clara Family Health Plan (SCFHP) responds to court orders and subpoenas in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and to use and disclose PHI in response to court orders and subpoenas in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.512(a) and (e)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager	Jordan Yamashita Compliance Director & Privacy Officer	Robin Larmer Chief Compliance & Regulatory Affairs Officer

Santa Clara Family Health Plan™

POLICY

Date		Date		Date
Version Number	**Change (Original/ Reviewed/ Revised)**	**Reviewing Committee (if applicable)**	**Committee Action/Date (Recommend or Approve)**	**Board Action/Date (Approve or Ratify)**
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Uses and Disclosures for Court Orders and Subpoenas**	**Procedure No.:**	HI.30.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒CMC	

I. Purpose

To describe the circumstances under which Santa Clara Family Health Plan (SCFHP) responds to court orders and subpoenas in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. SCFHP uses the following procedure to respond to court orders and/or subpoenas:

1. Receipt of a Legal Process Document. Any SCFHP staff member who receives any Legal Process Documents will immediately notify and forward these documents to SCFHP's Compliance Officer.
2. Notification of the Privacy Office. SCFHP's Compliance Officer will forward any Legal Process Documents which involve or relate to PHI to the Privacy Office, which will assist in responding in accordance with this Policy.
3. Orders of Court or Administrative Tribunal. To the extent permitted by applicable state law, PHI may be released in response to a valid court order or an order from an administrative tribunal.
4. Subpoenas, Discovery Requests, and Other Legal Processes. PHI may not be released in response to a subpoena or discovery request unless:
    a. Applicable state law permits the disclosure; or
    b. One of the following circumstances applies:
        i. The individual provides a written and dated Authorization to release the information to the requesting party; the Authorization will meet the requirements set forth in HI.09 Authorization to Use or Disclose Protected Health Information,
        ii. The subpoena or request is accompanied by a valid order from a court or administrative tribunal, as described in Section 3 above,
        iii. The subpoena requires the PHI to be disclosed for law enforcement or investigation purposes, and meets the requirements of HI.32 Uses and Disclosures for Law Enforcement Purposes; this includes grand jury subpoenas and subpoenas issued by government attorneys on behalf of local, state, and federal enforcement agencies,
        iv. The Legal Process Documents are not accompanied by an order of a court or administrative tribunal, and

PROCEDURE

A. SCFHP receives satisfactory assurance from the party seeking the information that reasonable efforts have been made to ensure that the individual who is the subject of the PHI has been given notice of the request, or
B. SCFHP receives satisfactory assurance from the party seeking the information that reasonable efforts have been made to secure a qualified protective order as required by law.
C. For the purposes of this Subsection (iv), SCFHP will be deemed to have received satisfactory assurances from the entity seeking the PHI if it receives a written statement and accompanying documentation demonstrating that:
    1. The party requesting PHI has made a good faith attempt to provide written notice to the individual or, if the individual's location is unknown, to mail a notice to the individual's last known address,
    2. The notice included sufficient information about the litigation or proceeding in which the PHI is requested to permit the individual to raise an objection to the court or administrative tribunal; and
        a) The time for the individual to raise objections to the court or administrative tribunal has elapsed, and
        b) No objections were filed, or
        c) All objections filed by the individual have been resolved by the court or the administrative tribunal and the disclosures being sought are consistent with such resolution.
D. SCFHP may disclose PHI in response to lawful process without receiving satisfactory assurance if it makes reasonable efforts to provide notice to the individual or to seek a qualified protective order.

5. Scope of Disclosure. Only the information expressly authorized by the order or requested by the subpoena or court order will be released.

6. Accounting of Disclosure. All disclosures in response to a court order, administrative tribunal order, subpoena, discovery request, or other legal process will be included in the Accounting of Disclosure. See, HI.08 Accounting of Disclosures.

7. Document Retention
   This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.30 Uses and Disclosures for Court Orders and Subpoenas
HI.08 Accounting of Disclosures
HI.09 Authorization to Use or Disclose Protected Health Information
HI.32 Uses and Disclosures for Law Enforcement Purposes

PROCEDURE

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Uses and Disclosures Required by Law**	**Policy No.:**	HI.31 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the procedures under which Santa Clara Family Health Plan (SCFHP) will use or disclose Protected Health Information (PHI) as required by law and in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and to use and disclose PHI as required by law and in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.512(a)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager	Jordan Yamashita Compliance Director & Privacy Officer	Robin Larmer Chief Compliance & Regulatory Affairs Officer

Santa Clara Family Health Plan™

POLICY

Date	Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

POLICY

Procedure Title:	**Uses and Disclosures Required by Law**	**Procedure No.:**	HI.31.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒CMC	

I. Purpose

To describe the procedures under which SCFHP uses or discloses Protected Health Information (PHI) as required by law and in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. SCFHP uses the following process to ensure compliance as required by law:

1. General Rule. State and federal laws and regulations mandate certain uses or disclosures of individual PHI. For example, reports of child abuse are required under the laws of most states. If the law or regulation can be enforced by an official government agency, it is deemed to be required by law. (This does not include private contractual agreements between parties.)

2. Overlap with other Policies. Many uses and disclosures required by law are also covered by other policies in this manual. If a use or disclosure of PHI falls within the circumstances described in Subsections a – c below, the Privacy Policy related to those circumstances will govern those uses and disclosures. With respect to any other uses or disclosures of PHI required by law, this policy will govern.
   a. Uses and Disclosures for Reporting Abuse and Domestic Violence and Neglect. If state or federal law requires a use or disclosure for reporting abuse, neglect, or domestic violence, SCFHP staff members will follow the Policies and Procedures described in HI.35 Disclosure for Suspected or Confirmed Abuse, Neglect, or Domestic Violence.
   b. Uses and Disclosures for Judicial or Administrative Proceedings. If state or federal law requires a use or disclosure for judicial or administrative purposes (for example, in response to a subpoena, discovery request, order of a court), SCFHP staff members will follow the Policies and Procedures described in HI.30 Uses and Disclosures for Court Orders and Subpoenas.
   c. Uses and Disclosures for Law Enforcement. If state or federal law requires a use or disclosure for law enforcement purposes (for example, in response to search warrants or grand jury subpoenas), SCFHP staff members will follow the policies and procedures described in HI.32 Uses and Disclosures for Law Enforcement Purposes.

POLICY

3. Other disclosures Required by Law. If a SCFHP staff member becomes aware of any situation in which disclosure of an individual's PHI may be required by any state or federal law or regulation (other than the situations described in Section 2 a-c above), the staff member will complete an incident/disclosure report at the following link: Privacy and Security Incident Report Form and notify the Privacy Office. SCFHP's Privacy Office, in consultation with the Compliance Officer, is responsible for the determination of whether the PHI is required to be disclosed.

4. Limits on Disclosure. SCFHP staff members will limit the use or disclosure of PHI to the minimum necessary required by law and will follow the Policies and Procedures described in HI.03 Minimum Necessary: Uses, Disclosures and Requests.

5. Accounting of Disclosure. All disclosures required by law will be included in the Accounting of Disclosures. SCFHP's staff members will report the disclosure to SCFHP's Privacy Office in accordance with HI.08 Accounting of Disclosures.

6. Document Retention
   This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.03 Minimum Necessary Standards
HI.08 Accounting of Disclosures
HI.30 Uses and Disclosures for Court Orders and Subpoenas
HI.31 Uses and Disclosures Required by Law
HI.32 Uses and Disclosures for Law Enforcement Purposes
HI.35 Disclosures for Suspected or Confirmed Abuse, Neglect or Domestic Violence

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Uses and Disclosures for Law Enforcement Purposes**	**Policy No.:**	HI.32 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the procedures under which Santa Clara Family Health Plan (SCFHP) will use or disclose Protected Health Information (PHI) for law enforcement purposes in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and to use and disclose PHI for law enforcement purpose in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.512(f) and (j)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager	Jordan Yamashita Compliance Director & Privacy Officer	Robin Larmer Chief Compliance & Regulatory Affairs Officer

Santa Clara Family Health Plan™

POLICY

Date	Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Uses and Disclosures for Law Enforcement Purposes**	**Procedure No.:**	HI.32.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒CMC	

I. Purpose

To define the procedures under which Santa Clara Family Health Plan (SCFHP) will use or disclose Protected Health Information (PHI) for law enforcement purposes in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. Law Enforcement Agencies and Officials

Law enforcement agencies and officials may be provided with PHI only in accordance with this policy.

1. Any SCFHP employee who receives any Legal Process Documents will immediately notify and forward these documents to SCFHP's Compliance Officer.
2. The Compliance Officer will forward any Legal Process Documents which involve or relate to PHI to the Privacy Office, which will assist in responding in accordance with this Policy.
3. Any employee who believes that a disclosure may be appropriate or required under this policy will contact the Privacy Office and receive the approval of the Privacy Officer prior to making any disclosures of PHI.

B. Required By Law

PHI may be disclosed to law enforcement agencies to make reports that are required by law, such as in response to Legal Process Documents, as outlined below or to report abuse in accordance with HI.35: Disclosures for Suspected or Confirmed Abuse, Neglect, or Domestic Violence.

C. Response to Legal Process

As a part of SCFHP's legal responsibilities, SCFHP may disclose PHI to law enforcement officials in response to a legal process or summons, as follows:

1. To comply with a court order or court-ordered warrant ordering disclosure to the law enforcement agency,
2. To comply with a subpoena or summons issued by a grand jury, judicial officer or a private attorney,
3. Pursuant to an official administrative request from a law enforcement agency (for instance, the Bureau of Alcohol, Tobacco and Firearms) provided that:
   a. The PHI requested is relevant and material to a legitimate law enforcement inquiry,

b. The request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought, and
c. De-identified information could not be reasonably used.

In order to confirm that items a – c is met; SCFHP will provide the agency with a copy of Appendix A: Official Statement Regarding Administrative Request for Information (included at the end of this policy) and request that it be completed and returned before the information is released. See, HI.30 Disclosures for Court Orders and Subpoenas.

D. Identifying or Locating a Suspect, Fugitive, Material Witness or Missing Person

SCFHP may provide PHI to law enforcement agencies and officials who are attempting to identify or locate a suspect, fugitive, material witness, or missing person. The PHI may be provided in response to requests by a properly identified law enforcement officer or in response to a public bulletin issued by a law enforcement agency.

1. Only the following information about the individual may be provided:
   a. Name and address,
   b. Date and place of birth,
   c. Social security number,
   d. ABO blood type and rh factor,
   e. Type of injury,
   f. Date and time of treatment,
   g. Date and time of death (if applicable), and
   h. Description of any distinguishing physical characteristics including height, weight, gender, race, hair and eye color, facial hair, scars, and tattoos.
2. No information related to DNA or a DNA analysis, dental records, samples or analysis of body fluids or tissues, or any other information beyond the information listed above will be disclosed unless the law enforcement officer presents a warrant, subpoena, or court order meeting the requirements of Section C, above.

E. Victims of Crime

If the individual is suspected of being the victim of an alleged crime, PHI may be disclosed upon request of a law enforcement official. The Privacy Officer, or designee, is responsible for reviewing the circumstances and determining whether disclosure will be made as follows:

1. A conscious, competent individual will be asked for permission to disclose PHI to law enforcement officials. The Privacy Officer, or designee, will document in the individual's Health Profile, the time, date, and name of the persons who witnessed the individual's agreement or refusal which may be oral or in writing. The Privacy Officer, or designee, will, if possible, obtain a valid Authorization signed by the individual. See, HI.09 Authorization to Use or Disclose Protected Health Information.
2. If the individual is not competent, the individual's Personal Representative may agree orally or in writing to the disclosure of the individual's PHI. The Personal Representative's agreement will be documented in the individual's Health Profile. See, HI.20 Personal Representative. If no Personal Representative is available, the SCFHP Privacy Officer, or designee, will try to find a family member of the individual who may agree to contact law enforcement officials directly.
3. In an emergency, or when no Personal Representative or family member of an individual is available, the PHI may be disclosed by the Privacy Officer, or designee, only if the law enforcement officer signs the statement included at Appendix B: Official Statement Regarding Need for Information About Possible Victim of Crime (at the end of this policy) and either the Privacy

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Officer, or designee, or the individual's attending physician determine that disclosure is in the individual's best interests. The determination will be documented in the individual's Health Profile.

F. Deaths

SCFHP may disclose suspicious deaths, including related PHI, to law enforcement agencies and officials, if the death is suspected of being the result of criminal conduct. The Privacy Officer, or designee, is responsible for reviewing the circumstances and determining whether disclosure will be made.

G. Suspected Criminal Activity on Premises

SCFHP may disclose evidence of suspected criminal conduct occurring on SCFHP's premises, including related PHI, to law enforcement agencies and officers. The Privacy Officer, or designee, is responsible for reviewing the circumstances and determining whether disclosure will be made.

H. Suspected Criminal Activity Off-Site

A Health Care Provider may disclose to law enforcement officers information that he or she learned while responding to a medical emergency off-premises, if necessary to alert them to the commission of, or nature of a crime, the location of victims of a crime or the identity, description or location of the perpetrator of a crime.

I. Reports to Avert a Serious Threat

SCFHP may disclose information to law enforcement authorities to help identify or apprehend an individual if, in good faith, the SCFHP Privacy Officer, or designee, believes the use or disclosure is necessary to prevent or lessen a serious, imminent threat under the following circumstances:

1. The individual made a statement admitting participation in a violent crime that is reasonably believed to have caused serious physical harm to the victim,
2. It appears from all the circumstances that the individual has escaped from a correctional institution or from lawful custody, and
3. The only information that may be disclosed is the individual's statement and the individual information described in Section D.1 above).

NOTE: No disclosure may be made if the information was learned while providing care support to the individual for the problems from which the crime arose or through a request by the individual to initiate or to be referred for treatment, counseling, or therapy for the problem.

J. Verification of Identity and Authority

Before disclosing PHI to a law enforcement officer or agency, the officer or agency's identity and authority will be verified and documented. If the person is a police officer, SCFHP's employees will ask to see his or her badge and record the badge number. For persons who do not have a badge, SCFHP's employees will obtain their business card or other proof of their credentials. All requests received in writing must be on official letterhead. See, HI.39 Verification of Identity and Authority.

K. Specialized Government Purposes

For disclosures for specialized government purposes (such as to the Armed Forces, national security, or correctional institutions), the SCFHP's Privacy Officer, or designee, will refer to the HIPAA Regulations and consult the Compliance Officer. See, HI.37 Uses and Disclosures for Specialized Government Functions.

PROCEDURE

L. Minimum Necessary Disclosures
All disclosures made under this policy will be limited to the minimum amount necessary to carry out the purpose of the disclosure consistent with HI.03 Minimum Necessary: Uses, Disclosures and Requests. SCFHP may rely on a statement by a public official that only the minimum necessary information has been requested. Such statement will be documented in the individual's Health Profile.

M. Accounting of Disclosure
All disclosures for law enforcement purposes will be included in the Accounting of Disclosures. SCFHP Employees will report the disclosure to SCFHP's Privacy Office in accordance with HI.08: Accounting of Disclosures.

N. Document Retention
This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.03 Minimum Necessary Standards
HI.08 Accounting of Disclosures
HI.09 Authorization to Use or Disclose Protected Health Information
HI.20 Personal Representatives
HI.30 Uses and Disclosures for Court Orders and Subpoenas
HI.32 Uses and Disclosures for Law Enforcement Purposes
HI.35 Disclosures for Suspected or Confirmed Abuse, Neglect or Domestic Violence
HI.37 Uses and Disclosures for Specialized Government Functions
HI.39 Verification of Identity and Authority

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

Appendix A

Official Statement Regarding Administrative Request for Information

(To be completed by authorized representative of government enforcement agency)

Name of Individual: _____

I hereby certify that the information requested regarding the above-named individual is needed to carry out the purposes of an administrative request, such as an administrative subpoena or summons, a civil or investigative demand, or similar process authorized under law, and that all of the following statements are true:

1. The information being sought is relevant and material to a legitimate law enforcement inquiry;
2. The request for such information is specific and limited to the purpose for which the information is sought; and
3. The agency could not conduct the investigation using de-identified information. ("De-identified" means the removal of all information that could be used to identify the individual, either directly or in combination with other known information, and includes the individual's name, street address, city, county, zip code, date of birth (except for year), date of treatment (except for year), telephone, fax, e-mail, Social Security Number, medical record number, insurance or account numbers, photographs, and similar unique characteristics, numbers, and codes.)

Signed: _____ Date:_____

Print name: _____ Telephone: _____

Title: _____ Supervisor: _____

Name/address of law enforcement agency: _____

_____

Appendix B

Official Statement Regarding Need for Information About Possible Victim of Crime

(To be completed by authorized representative of law enforcement agency)

Name of Individual: _____

I hereby certify that the information requested regarding the above-named individual is needed to determine whether a violation of law committed by someone else has occurred, and the information is not intended to be used against the victim.

I also certify that the investigation would be materially and adversely affected by waiting until the individual is able to agree to the disclosure.

Signed: _____ Date:_____

Print name: _____ Telephone: _____

Title: _____ Supervisor: _____

Badge Number: _____

Name/address of law enforcement agency: _____

_____

POLICY

Policy Title:	**Uses and Disclosures for Public Health Activities**	**Policy No.:**	HI.33 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the circumstances under which Santa Clara Family Health Plan (SCFHP) will use or disclose Protected Health Information (PHI) for Public Health Activities in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and to use and disclose PHI for Public Health Activities in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.501
45 C.F.R. §164.512(b)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager	Jordan Yamashita Compliance Director & Privacy	Robin Larmer Chief Compliance & Regulatory Affairs

POLICY

	Officer	Officer
Date	Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

POLICY

Policy Title:	**Uses and Disclosures about Decedents**	**Policy No.:**	HI.34 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the procedures under which Santa Clara Family Health Plan (SCFHP) will disclose Protected Health Information (PHI) of decedents to certain persons and entities in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and to disclose the PHI of decedents to certain persons and entities in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.510(b)
45 C.F.R. §164.512(f), (g) and (i)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager	Jordan Yamashita Compliance Director & Privacy	Robin Larmer Chief Compliance & Regulatory Affairs

POLICY

Date	Officer Date	Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Uses and Disclosures About Decedents**	**Procedure No.:**	HI.34.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒CMC	

I. Purpose

To describe the procedures under which Santa Clara Family Health Plan (SCFHP) will disclose Protected Health Information (PHI) of decedents to certain persons and entities in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. Coroners and medical examiners
SCFHP's Privacy Office, or designee, may disclose PHI of a decedent to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.

B. Funeral directors
SCFHP's Privacy Office, or designee, may disclose the PHI of a decedent to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent. If necessary for funeral directors to carry out their duties, SCFHP may disclose the PHI prior to, and in reasonable anticipation of, the individual's death.

C. Law Enforcement Official
SCFHP's Privacy Office, or designee, may disclose PHI about a decedent to a law enforcement official for the purpose of alerting law enforcement of the death of the individual if SCFHP has a suspicion that such death may have resulted from criminal conduct. See, HI.32 Uses and Disclosures for Law Enforcement Purposes.

D. Family, Friends and Others Involved in Care
SCFHP's Privacy Office, or designee, may disclose to a family member or others who were involved in the individual's care before their death, relevant PHI after their death, unless doing so is inconsistent with the individual's previously expressed preference.

E. Research Purposes
SCFHP's Privacy Office, or designee, may disclose PHI about a decedent for research purposes if certain representations are obtained. See, HI.36 Uses and Disclosures for Research Purposes.

F. Accounting of Disclosures
All disclosures of PHI of a decedent will be included in the Accounting of Disclosures. See, HI.08 Accounting of Disclosures.

G. Document Retention
This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.08 Accounting of Disclosures
HI.32 Uses and Disclosures for Law Enforcement Purposes
HI.34 Uses and Disclosures about Decedents
HI.36 Uses and Disclosures for Research Purposes

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Disclosures for Suspected or Confirmed Abuse, Neglect or Domestic Violence**	**Policy No.:**	HI.35 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the procedures by which Santa Clara Family Health Plan (SCFHP) may disclose Protected Health Information (PHI) in cases of suspected or confirmed abuse, neglect or domestic violence in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and disclose PHI related to victims of abuse, neglect or domestic violence in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.512(c)
45 C.F.R. §164.502(g)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager	Jordan Yamashita Compliance Director & Privacy	Robin Larmer Chief Compliance & Regulatory Affairs

POLICY

	Officer	Officer
Date	Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

POLICY

Policy Title:	**Uses and Disclosures for Research Purposes**	**Policy No.:**	HI.36 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the procedure by which Santa Clara Family Health Plan (SCFHP) may use or disclose Protected Health Information (PHI) for research purposes in accordance with state and federal laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and to disclose PHI for research purposes in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.502(a)(5)
45 C.F.R. §164.512(i)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager	Jordan Yamashita Compliance Director & Privacy	Robin Larmer Chief Compliance & Regulatory Affairs

Santa Clara Family Health Plan™

POLICY

	Officer	Officer
Date	Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Uses and Disclosures for Research Purposes**	**Procedure No.:**	HI.36.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒CMC	

I. Purpose

To define the procedures by which Santa Clara Family Health Plan (SCFHP) may use or disclose Protected Health Information (PHI) for research purposes in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. Permitted uses and disclosures

SCFHP's Privacy Office, in consultation with the Compliance Officer, will make the determination of the use or disclosure of PHI for research purposes. SCFHP may use or disclose PHI for research, regardless of the source of funding of the research, provided that one of the circumstances described in Section A1 – 3 below applies.

1. SCFHP obtains documentation that an alteration to or waiver of the individual Authorization has been approved by either:
   a. An Institutional Review Board (IRB), or
   b. A privacy board consisting of members with varying backgrounds, appropriate professional competency and no conflict of interest.

2. SCFHP obtains from the researcher representations that:
   a. Use or disclosure is sought solely to review PHI as necessary to prepare a research protocol or for similar preparatory purposes,
   b. No PHI is to be removed from SCFHP by the researcher in the course of the review, and
   c. The PHI for which use or access is sought is necessary for the research purposes.

3. SCFHP obtains from the researcher:
   a. Representation that the use or disclosure sought is solely for research on the PHI of decedents,
   b. Documentation, at the request of SCFHP, of the death of such individuals, and
   c. Representation that the PHI for which use or disclosure is sought is necessary for the research purposes.

B. Documentation of waiver approval

PROCEDURE

For a use or disclosure to be permitted based on documentation of approval of an alteration or a waiver of Authorization, the documentation must include all of the following:

1. A statement identifying the IRB or privacy board and the date on which the alteration or waiver of Authorization was approved,

2. A statement that the IRB or privacy board has determined that the alteration or waiver of Authorization satisfies the following criteria:
   a. The use or disclosure of PHI involves no more than a minimal risk to the privacy of individuals, based on, at least, the presence of the following elements:
      i. An adequate plan to protect the identifiers from improper use and disclosure,
      ii. An adequate plan to destroy the identifiers at the earliest opportunity consistent with conduct of the research, unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law, and
      iii. Adequate written assurances that the PHI will not be reused or disclosed to any other person or entity, except as required by law, for authorized oversight of the research study, or for other research for which the use or disclosure of PHI would be permitted by this subpart,
   b. The research could not practicably be conducted without the waiver or alteration, and
   c. The research could not practicably be conducted without access to and use of the PHI.

3. A brief description of the PHI for which use or access has been determined to be necessary by the IRB or privacy board.

4. A statement that the alteration or waiver of Authorization has been reviewed and approved under either normal or expedited review procedures.

5. The documentation of the alteration or waiver of Authorization must be signed by the chair or other member, as designated by the chair, of the IRB or the privacy board, as applicable. See, HI.09 Authorization to Use or Disclose Protected Health Information.

C. Accounting of Disclosures

All disclosures for research purposes will be included in the Accounting of Disclosures. See, HI.08 Accounting of Disclosures.

D. Document Retention

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.08 Accounting of Disclosures
HI.09 Authorization to Use or Disclose Protected Health Information
HI.36 Uses and Disclosures for Research Purposes

PROCEDURE

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Uses and Disclosures for Specialized Government Functions**	**Policy No.:**	HI.37 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the procedures by which Santa Clara Family Health Plan (SCFHP) may use or disclose Protected Health Information (PHI) for specialized government functions in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and to disclose PHI for specialized government functions only in accordance with state and federal privacy laws, and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.512(k)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager	Jordan Yamashita Compliance Director & Privacy Officer	Robin Larmer Chief Compliance & Regulatory Affairs Officer

Santa Clara Family Health Plan™

POLICY

Date	Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Uses and Disclosures for Specialized Government Functions**	**Procedure No.:**	HI.37.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒CMC	

I. Purpose

To define the procedures by which Santa Clara Family Health Plan (SCFHP) may use or disclose Protected Health Information (PHI) for specialized government functions in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. Military and Veterans Activities

1. U.S. Armed Forces Personnel: SCFHP may use and disclose the PHI of individuals who are U.S. Armed Forces personnel for activities deemed necessary by appropriate military command authorities.

2. Separation or Discharge from Military Service: If SCFHP is, or has an affiliate that is, a component of the U.S. Departments of Defense or Homeland Security, it may disclose to the U.S .Department of Veterans Affairs (DVA) the PHI of an individual who is a member of the Armed Forces upon his or her separation or discharge from military service for the purpose of a determination by DVA of the individual's eligibility for, or entitlement to, benefits under laws administered by the Secretary of DVA.

3. Veterans: If SCFHP is, or has an affiliate that is, a component of the DVA, it may use and disclose PHI to components of the DVA that determine eligibility for, or entitlement to, or that provide, benefits under the laws administered by the Secretary of DVA.

4. Foreign military personnel: SCFHP may use and disclose the PHI of individuals who are foreign military personnel to their appropriate foreign military authority for the same purposes for which uses and disclosures are permitted for U.S. Armed Forces personnel in this section.

B. National Security and Intelligence Activities

SCFHP may disclose PHI to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities authorized by the National Security Act (50 U.S.C. 401, et seq.) and implementing authority (e.g., Executive Order 12333).

PROCEDURE

C. Protective Services for the President and Others

SCFHP may disclose PHI to authorized federal officials for the provision of protective services to the President or other authorized persons, or to foreign heads of state, or for the conduct of authorized investigations.

D. Medical Suitability Determinations

If SCFHP is, or has an affiliate that is, a component of the U.S. Department of State, it may use PHI to make medical suitability determinations and may disclose whether or not the individual was determined to be medically suitable to the officials in the Department of State who need access to such information for required security clearance, determining worldwide availability or availability for mandatory service abroad, or for a family to accompany a foreign service member abroad.

E. Correctional Institutions and Other Law Enforcement Custodial Situations

1. Permitted disclosures: SCFHP may disclose to a correctional institution or a law enforcement official having lawful custody of an inmate or other individual, PHI about such inmate or individual, if the correctional institution or such law enforcement official represents that such PHI is necessary for:
   a. The provision of Health Care to such inmate or individual,
   b. The health and safety of such inmate or individual,
   c. The health and safety of the officers or employees of, or others at, the correctional institution,
   d. The health and safety of such officers, employees or other persons responsible for the transporting of inmates or their transfer from one institution, facility, or setting to another,
   e. Law enforcement on the premises of the correctional institution, or
   f. The administration and maintenance of the safety, security, and good order of the correctional institution.

2. Permitted uses: If SCFHP is, or has an affiliate that is, a correctional institution, it may use PHI of individuals who are inmates for any purpose for which such PHI may be disclosed.

3. No Application After Release: For the purposes of this provision, an individual is no longer an inmate when released on parole, probation, supervised release, or otherwise is no longer in lawful custody.

F. Covered Entities that are Government Programs Providing Public Benefits

1. If SCFHP is a Health Plan that is a government program providing public benefits, it may disclose PHI relating to eligibility for or enrollment in the Health Plan to another agency administering a government program providing public benefits if the sharing of eligibility or enrollment information among such government agencies or the maintenance of such information in a single or combined data system accessible to all such government agencies is required or expressly authorized by statute or regulation.

2. If SCFHP is a government agency administering a government program providing public benefits it may disclose PHI relating to the program to another Covered Entity that is a government agency

administering a government program providing public benefits if the programs serve the same or similar populations and the disclosure of PHI is necessary to coordinate the covered functions of such programs or to improve administration and management relating to the covered functions of such programs.

G. Accounting of Disclosure
All disclosures for specialized government functions will be included in the Accounting of Disclosures. See, HI.08 Accounting of Disclosures.

H. Document Retention
This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.08 Accounting of Disclosures
HI.37 Uses and Disclosures for Specialized Government Functions

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Disclosures for Workers Compensation**	**Policy No.:**	HI.38 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the procedure by which Santa Clara Family Health Plan (SCFHP) may use or disclose Protected Health Information (PHI) for purposes related to workers' compensation or other similar programs that provide benefits for work-related injuries or illness in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and to disclose PHI as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation or other similar programs established by law that provide benefits for work-related injuries or illness without regard to fault in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.512(l)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval

POLICY

Anna Vuong Compliance Manager Date	Jordan Yamashita Compliance Director & Privacy Officer Date	Robin Larmer Chief Compliance & Regulatory Affairs Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Disclosure for Workers Compensation**	**Procedure No.:**	HI.38.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒CMC	

I. Purpose

To define the procedures by which Santa Clara Family Health Plan (SCFHP) may use or disclose Protected Health Information (PHI) for purposes related to workers' compensation or other similar programs that provide benefits for work-related injuries or illness in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. Permitted Disclosures
SCFHP may disclose PHI as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation or other similar programs established by law that provide benefits for work-related injuries or illness without regard to fault.

B. Role of Privacy Office
SCFHP's Privacy Office, in consultation with legal counsel, will determine the disclosures of PHI for these purposes.

C. Accounting of Disclosure
All disclosures for workers' compensation and related matters will be included in the Accounting of Disclosures. See, HI.08 Accounting of Disclosures.

D. Document Retention
This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.08 Accounting of Disclosures
HI.38 Disclosures for Workers Compensation

PROCEDURE

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Verification of Identity and Authority**	**Policy No.:**	HI.39 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe a process for verifying he identity and authority of an individual or entity prior to disclosing Protected health Information (PHI) to the individual or entity in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of Santa Clara Family Health Plan (SCFHP) to protect PHI and that SCFHP will verify the identity and the authority of the individual or entity prior to disclosing PHI to the individual or entity in accordance with state and federal laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.514(h)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager	Jordan Yamashita Compliance Director & Privacy	Robin Larmer Chief Compliance & Regulatory Affairs

Santa Clara Family Health Plan™

POLICY

	Officer	Officer
Date	Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Verification of Identity and Authority**	**Procedure No.:**	HI.39.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒ CMC	

I. Purpose

To describe a process for verifying the identity and authority of an individual or entity prior to disclosing Protected Health Information (PHI) to the individual or entity in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. General Rule

Prior to making a disclosure of PHI to a third party that is permitted by these Privacy Policies and Procedures, Santa Clara Family Health Plan's (SCFHP) employee will verify the recipient's identity and authority to receive the PHI. If these Policies and Procedures require any documentation, statements or representations from the intended recipient (such as a subpoena) as the basis for, or condition of, allowing a disclosure, SCFHP will obtain such documentation, statements or representations prior to making the disclosure.

B. Reliance on Documentation

If reasonable under the circumstances, SCFHP's employee may rely on documentation, statements or representations that, on their face, meet the requirements for disclosure. Examples of such documentation include signed authorization forms.

C. Verification for Inbound and Outbound calls

For telephone calls involving individuals, Personal Representatives, caregivers and Health care Providers, SCFHP's employee will verify identity and authority as set forth in HI.22 Individual Caller Identification: Inbound and Outbound.

D. Verification of Identity of Public Officials

When a government agency or public official requests PHI, SCFHP's employee may rely upon the following to verify their identity, if reliance is reasonable under the circumstances:

1. For in-person requests: The official's presentation of an agency identification badge, other official credentials or other proof of government status,

2. For written requests: The request, if it is on appropriate government letterhead,

3. For requests made by someone acting on behalf of a government official: Evidence or documentation that establishes that the person is acting on behalf of the public official, such as a written statement on appropriate government letterhead that the person is acting under the government's authority, a contract for services, a memorandum of understanding, or a purchase order.

E. Verification of Authority of Public Officials

When a government agency or public official requests PHI, employee may rely upon the following to verify their authority, if reliance is reasonable under the circumstances:

1. A written statement of the legal authority under which the information is requested,

2. If a written statement is not practical, an oral statement of the legal authority under which the information is requested, or

3. A copy of a warrant, subpoena, order or other Legal Process Document which is issued by a grand jury or a judicial or administrative tribunal is presumed to constitute legal authority.

F. Verification of Other Covered Entities Requesting PHI

When another Cover Entity requests an individual's PHI, SCFHP's employees verify the identity of a Covered Entity requesting PHI as follows:

1. Written Communications*:* employees verify that the communication is on the Covered Entity's letterhead or if an e-mail, contains the Covered Entity's domain name.

2. Telephone Calls: SCFHP's employees verify the caller's identity by either personal knowledge of the Covered Entity's employee or obtaining from the caller the following:
   a. Covered Entity's name,
   b. Individual's name ,
   c. Individual's date of birth, and
   d. Caller's name and telephone number.

G. Verification of Others Requesting PHI

If SCFHP's employees receive request(s) from others not covered in this policy, the request will be forwarded to SCFHP's Privacy Office to assist in verifying identity and authority.

H. Inability to Verify

If SCFHP's employees are unable to verify a requestor's identity and authority, PHI will not be disclosed. The request will be forwarded to the Privacy Office to assist in verifying authority and identity.

I. Scope of Disclosure

If the identity and authority of the party requesting PHI has been verified, SCFHP's employees may disclose PHI to the requestor, but only the amount of PHI permitted by the applicable Privacy Policies

and Procedures that permit the disclosure. See, HI.03 Minimum Necessary; Uses, Disclosures and Requests.

J. Document Retention

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.03 Minimum Necessary Standards
HI.22 Individual Caller Identification: Inbound and Outbound
HI.39 Verification of Identity and Authority

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Uses and Disclosures for Cadaveric Organ, Eye or Tissue Donation Purposes**	**Policy No.:**	HI.40 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the procedures by which Santa Clara Family Health Plan (SCFHP) may disclose Protected Health Information (PHI) for purposes related to organ procurement in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP protect PHI and to use or disclose PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation, in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.512(h)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong	Jordan Yamashita	Robin Larmer

Santa Clara Family Health Plan™

POLICY

Compliance Manager	Compliance Director & Privacy Officer	Chief Compliance & Regulatory Affairs Officer
Date	Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Uses and Disclosures for Cadaveric Organ, Eye or Tissue Donations**	**Procedure No.:**	HI.40.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒CMC	

I. Purpose

To define the procedures by which Santa Clara Family Health Plan (SCFHP) may disclose Protected Health Information (PHI) for purposes related to organ procurement in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. General Rule
SCFHP may use or disclose PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

B. No Authorization Required
SCFHP may use or disclose PHI without the written Authorization of the individual or the individual's Personal Representative, or the opportunity for the individual or the individual's Personal Representative, to agree or object in the situations covered by this Policy, subject to the applicable requirements of this Policy.

C. Privacy Office
SCFHP's Privacy Office, in consultation with the Compliance Officer and/or legal counsel, will determine the disclosures of PHI for these purposes.

D. Accounting of Disclosure
All disclosures related to procurement, banking, or transplantation of cadaveric organs, eyes, or tissue the will be included in the Accounting of Disclosures. See, HI.08 Accounting of Disclosures.

E. Document Retention
This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

PROCEDURE

III. Policy Reference

HI.08 Accounting of Disclosures
HI.40 Uses and Disclosures for Cadaveric Organ, Eye or Tissue Donation Purposes

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Uses and Disclosures for Health Oversight Activities**	**Policy No.:**	HI.41 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the procedures by which Santa Clara Family Health Plan (SCFHP) may disclose Protected Health Information (PHI) to a Health Oversight Agency for oversight activities in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and use or disclose PHI to a Health Oversight Agency for oversight activities only as necessary for appropriate oversight, in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.501
45 C.F.R. §164.512(d)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong	Jordan Yamashita	Robin Larmer

Santa Clara Family Health Plan™

POLICY

Compliance Manager	Compliance Director & Privacy Officer	Chief Compliance & Regulatory Affairs Officer
Date	Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Uses and Disclosures for Health Oversight Activities**	**Procedure No.:**	HI.41.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒CMC	

I. Purpose

To describe the procedures by which Santa Clara Family Health Plan (SCFHP) may disclose Protected Health Information (PHI) to a Health Oversight Agency for oversight activities in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. General Rule

SCFHP may disclose PHI to a Health Oversight Agency for health oversight activities authorized by law, including audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of:

1. The Health Care system,
2. Government benefit programs for which health information is relevant to beneficiary eligibility,
3. Entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards, or
4. Entities subject to civil rights laws for which health information is necessary for determining compliance.

B. Exception to Health Oversight Activities

A health oversight activity does not include an investigation or other activity in which the individual is the subject of the investigation or activity and such investigation or other activity does not arise out of and is not directly related to:

1. The receipt of Health Care,
2. A claim for public benefits related to health, or

3. Qualification for, or receipt of, public benefits or services when an individual's health is integral to the claim for public benefits or services.

C. Joint Activities or Investigations
If a health oversight activity or investigation is conducted in conjunction with a claim for public benefits not related to health, the joint activity or investigation is considered a health oversight activity.

D. Permitted Uses
If SCFHP is, or has an affiliate that is, a Health Oversight Agency, SCFHP may use PHI for health oversight activities.

E. Privacy Office
SCFHP's Privacy Office, in consultation with the Compliance Officer, will make the determination of disclosure, and will verify the identity and authority of the requestor. See, HI.39 Verification of Identity and Authority.

F. Accounting of Disclosure
All disclosures related to health oversight activities will be included in the Accounting of Disclosures. See, HI.08 Accounting of Disclosures.

G. Document Retention
This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.08 Accounting of Disclosures
HI.39 Verification of Identity and Authority
HI.40 Uses and Disclosures for Health Oversight Activities

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Uses and Disclosures for Disaster Relief Purposes**	**Policy No.:**	HI.42 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the procedures by which Santa Clara Family Health Plan (SCFHP) may disclose Protected Health Information (PHI) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and use or disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.510(b)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager	Jordan Yamashita Compliance Director & Privacy	Robin Larmer Chief Compliance & Regulatory Affairs

POLICY

	Officer	Officer
Date	Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Uses and Disclosures for Disaster Relief Purposes**	**Procedure No.:**	HI.42.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒CMC	

I. Purpose

To define the procedures by which Santa Clara Family Health Plan (SCFHP) may disclose Protected Health Information (PHI) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. Individual Present

SCFHP may disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for notifying, or assisting in the notification of (including identifying or locating) a family member, a Personal Representative of the individual, or another person responsible for the care of the individual, of the individual's location, general condition, or death, if

1. The individual is present and agrees to the disclosure,

2. The individual does not express an objection when given the opportunity to object to the disclosure, or

3. The SCFHP Privacy Officer, or designee, reasonably infers from the circumstances, based on the exercise of professional judgment that the individual does not object to the disclosure.

B. Individual Not Present

If the individual is not present or is incapacitated, or in the case of an emergency, the SCFHP Privacy Officer, or designee, in the exercise of professional judgment, may determine whether the disclosure is in the best interests of the individual and, if so, disclose only the PHI that is directly relevant to the situation. SCFHP's Privacy Office, in consultation with the Compliance Officer and/or legal counsel, will determine the disclosures of PHI for these purposes.

C. Accounting of Disclosure

All disclosures related to health oversight activities will be included in the Accounting of Disclosures. See, HI.08 Accounting of Disclosures.

PROCEDURE

D. Document Retention

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.08 Accounting of Disclosures
HI.42 Uses and Disclosures for Disaster Relief Purposes

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Uses and Disclosures to Avert a Serious Threat to Health or Safety**	**Policy No.:**	HI.43 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the procedures by which Santa Clara Family Health Plan (SCFHP) may disclose Protected Health Information (PHI) to prevent or lessen a serious and imminent threat to the health or safety of a person or the public in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and use or disclose PHI to prevent or lessen a serious and imminent threat to the health or safety of a person or the public in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.512(j)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager	Jordan Yamashita Compliance Director & Privacy	Robin Larmer Chief Compliance & Regulatory Affairs

POLICY

	Officer	Officer
Date	Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Uses and Disclosures to Avert a Serious Threat to Health or Safety**	**Procedure No.:**	HI.43.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒CMC	

I. Purpose

To define the procedures by which Santa Clara Family Health Plan (SCFHP) may disclose Protected Health Information (PHI) to prevent or lessen a serious and imminent threat to the health or safety of a person or the public in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. Permitted Uses and Disclosures

SCFHP may use or disclose PHI if SCFHP believes, in good faith, that the use or disclosure:

1. Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and is made to a person(s) reasonably able to prevent or lessen the threat, or

2. Is necessary for law enforcement authorities to identify or apprehend an individual because of a statement made by the individual admitting participation in a violent crime or where it appears that the individual has escaped from lawful custody, unless the disclosure is made as a result of treatment, counseling or therapy, or a request to initiate same by the Individual.

B. Notification

A SCFHP employee who believes that disclosure of PHI would avert a serious threat to health or injury should notify the SCFHP Privacy Office immediately.

C. Privacy Office

The SCFHP Privacy Office will, in consultation with the Compliance Officer and/or legal counsel, will make the determination of the use or disclosure of the PHI.

D. Accounting of Disclosure

All disclosures related to a serious or imminent threat to health or safety will be included in the Accounting of Disclosures. See, HI.08 Accounting of Disclosures.

PROCEDURE

E. Document Retention

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.08 Accounting of Disclosures
HI.43 Uses and Disclosures to Avert a Serious Threat to Health or Safety

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Uses and Disclosures for Fundraising**	**Policy No.:**	HI.44 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the circumstances under which Santa Clara Family Health Plan (SCFHP) is allowed to use or disclose Protected Health Information (PHI) for fundraising purposes in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and use or disclose PHI for fundraising purposes only in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.514(f)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager	Jordan Yamashita Compliance Director & Privacy Officer	Robin Larmer Chief Compliance & Regulatory Affairs Officer

Santa Clara Family Health Plan™

POLICY

Date	Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Uses and Disclosures for Fundraising**	**Procedure No.:**	HI.44.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒CMC	

I. Purpose

To describe the circumstances under which Santa Clara Family Health Plan (SCFHP) is allowed to use or disclose Protected Health Information (PHI) for fundraising purposes in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. Use and Disclosures for Fundraising

Subject to the approval of the SCFHP Privacy Officer, in consultation with legal counsel, SCFHP may use or disclose to a Business Associate or to an institutionally related foundation, the following PHI without an Authorization meeting the requirements set forth in HI.09 Authorization to Use or Disclose Protected Health Information for the purpose of raising funds for SCFHP's benefit:

1. Demographic information relating to an individual; including name, address, other contact information, age, gender and date of birth,
2. Dates of health care provided to an individual,
3. Department of service information,
4. Treating physician,
5. Outcome information, and
6. Health insurance status.

B. Required Disclosures in Notice of Privacy Practices

SCFHP's Notice of Privacy Practices must include the following information related to fundraising communications:

1. That SCFHP may not condition Treatment or Payment to the receipt of fundraising communications,

2. Appropriate information on how an individual may elect, without undue burden, not to receive fundraising communications,

3. That SCFHP may not send fundraising communications to an individual who has elected not to receive such communications,

4. That SCFHP may provide a method for an individual to opt back into receiving fundraising communications.

C. Role of Privacy Officer/Privacy Office

1. The SCFHP Privacy Officer, in consultation with the Compliance Officer, will approve, in advance, any uses or disclosures of PHI for fundraising purposes and will ensure that only the information listed in Section 1 above is used or disclosed.

2. SCFHP's Privacy Office will ensure that SCFHP's Notice of Privacy Practices includes the information required in Section 2 above.

3. SCFHP's Privacy Officer will ensure that appropriate processes, procedures, safeguards and applicable training are in place to ensure compliance with these policies governing fundraising communications.

D. Accounting of Disclosure

Disclosures for fundraising purposes do not have to be included in the Accounting of Disclosures because they are either being made directly to the individual or being made pursuant to the individual's written Authorization. See, HI.08 Accounting of Disclosures.

E. Document Retention

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.08 Accounting of Disclosures
HI.09 Authorization to Use or Disclose Protected Health Information
HI.44 Uses and Disclosures for Fundraising

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval

PROCEDURE

V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Uses and Disclosures for Underwriting Purposes**	**Policy No.:**	HI.45 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the circumstances under which Santa Clara Family Health Plan (SCFHP) is allowed to use or disclose Protected Health Information (PHI) for underwriting purposes in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and use or disclose PHI for underwriting purposes only in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.501(3)
45 C.F.R. §164.502(a)(5)
45 C.F.R. § 64.514(g)
45 C.F.R. §164.508(b)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval

Santa Clara Family Health Plan™

POLICY

Anna Vuong Compliance Manager Date	Jordan Yamashita Compliance Director & Privacy Officer Date	Robin Larmer Chief Compliance & Regulatory Affairs Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Uses and Disclosures for Underwriting Purposes**	**Procedure No.:**	HI.45.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒CMC	

I. Purpose

To describe the circumstances under which Santa Clara Family Health Plan (SCFHP) is allowed to use or disclose Protected Health Information (PHI) for underwriting purposes in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. General Rule
SCFHP may not use or disclose PHI for underwriting purposes except as described in Section B below.

B. Permitted Uses and Disclosures for Underwriting Purposes
SCFHP may use or disclose PHI for underwriting purposes that are a part of its Health Care Operations. Permitted underwriting purposes means, with respect to SCFHP:

1. Rules for, or determination of, eligibility (including enrollment and continued eligibility) for, or determination of, benefits under a Health Plan, coverage, or policy (including changes in deductibles or other cost-sharing mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program),

2. The computation of premium or contribution amounts under a Health Plan, coverage, or policy (including discounts, rebates, payments in kind, or other premium differential mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program),

3. The application of any pre-existing condition exclusion under a Health Plan, coverage, or policy, and

4. Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

Permitted underwriting purposes do not include determinations of medical appropriateness where an individual seeks a benefit under a Health Plan, coverage, or policy. See, HI.27 Uses and Disclosures for Health Care Operations for additional information on uses and disclosures for other Health Care

Operations.

C. Disclosure of Genetic Information Prohibited
SCFHP may not use or disclose genetic information for underwriting purposes.

D. Document Retention
This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.27 Uses and Disclosures for Health Care Operations
HI.45 Uses and Disclosures for Underwriting Purposes

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Photographing, Video Recording, Audio Recording and Other Imaging of Individuals, Visitors and Workforce Members**	**Policy No.:**	HI.46 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To establish guidelines for situations where individuals, including Santa Clara Family Health Plan (SCFHP) staff, temporary help, and consultants, may or may not be photographed, video or audio recorded or otherwise imaged in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to take reasonable steps to protect individuals, including SCFHP Staff, temporary help, and consultants from unauthorized photography, video or audio recordings, or other images in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §160.103
45 C.F.R. §164.502(a)
45 C.F.R. § 164.514(a)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval

Santa Clara Family Health Plan™

POLICY

Anna Vuong Compliance Manager Date	Jordan Yamashita Compliance Director & Privacy Officer Date	Robin Larmer Chief Compliance & Regulatory Affairs Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Photographing, Video Recording, Audio Recording and Other Imaging of Individuals, Visitors and Employees**	**Procedure No.:**	HI.46.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒CMC	

I. Purpose

To establish guidelines for situations where individuals, including Santa Clara Family Health Plan (SCFHP) staff, temporary staff, and/or consultants, may or may not be photographed, video or audio recorded or otherwise imaged in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. SCFHP -Owned Devices

1. Only designated SCFHP-owned devices to Photograph or Audio Record an individual may be used by SCFHP's employee. Personal cellular telephones, cameras, etc. may not be used.
2. SCFHP's procedures will address how SCFHP-owned devices are securely stored, how Photographs or Audio Recordings will be saved, stored, and disposed of, and designate appropriate personnel with access to the devices, Photographs and Audio Recordings.

B. Photographing/Audio Recording Individuals and Employees by Individuals, Family Members, and/or by the Individual's Visitors

1. SCFHP is not required to obtain Consent from the individual when the individual is the subject of the Photography/Audio Recording and such recording is performed by the individual or the individual's family members or the individual's visitors.
2. Individuals, family members, and/or visitors are not permitted to Photograph or Audio Record other individuals SCFHP's employee without Consent.
3. To the extent the SCFHP employee is aware of any inappropriate attempt to Photograph/Audio Record an individual and/or employee; the employee must take reasonable steps to ensure that individuals and/or employees are not Photographed/ Audio Recorded by an individual or the individual's family members or visitors.

C. Photographing/Audio Recording Individuals by Staff for Treatment Purposes
Written Consent is required before a SCFHP employee may Photograph or Audio Record an individual

for Treatment purposes.

D. Photographing Individuals by Employees for Security or Health Care Operations Purposes

1. SCFHP will inform individuals that Photographs or Audio Recordings may be taken for security or Health Care Operations purposes (e.g., quality assurance).
2. This policy does not apply to general security surveillance of public areas.

E. Photographing Individuals by Employees to Document Abuse or Neglect

Consent is not required to Photograph an individual to document suspected or confirmed abuse, neglect or domestic violence; however, the Photographs may not be used for any other purpose beyond submission to the investigating agency unless otherwise permitted by federal or state law or HIPAA Regulations (e.g. for Treatment purposes).

F. Photographing/Audio Recording Individuals by Employees for Research

1. Any use and/or disclosure of Photographs or Audio Recording for research purposes will be in compliance with state and federal privacy laws and HIPAA Regulations.
2. If a Photograph or Audio Recording is determined to be identifiable, the Institutional Review Board overseeing the specific research project will determine if additional Authorizations are required based on the criteria set forth in federal or state privacy laws or HIPAA Regulations.

G. Photographing/Audio Recording Individuals by Employee for Publicity Purposes

SCFHP must obtain written Authorization/Consent (Attachment A) from the individual prior to Photographing/Audio Recording the individual for publicity purposes. The Authorization is only good for the type of Photographs/Audio Recordings indicated and the timeframe listed in the Authorization. Otherwise, a new Authorization form must be obtained.

H. Photographing/Audio Recording Individuals by the Media or Law Enforcement

1. SCFHP may permit news media or law enforcement agencies to Photograph or Audio Record an individual if the individual's responsible (e.g., attending) physician agrees the individual is medically stable and the individual provides a Consent.
2. SCFHP may also disclose Photographs and/or Audio Recordings to law enforcement when required by state law, such as in cases of suspected or confirmed child abuse and neglect, domestic violence, elder abuse, rape, and similar disclosures required by law. See, HI.35 Disclosures for Suspected or Confirmed Abuse, Neglect or Domestic Violence.

I. Photographing for Gifts or Commemorative Purposes

1. SCFHP must obtain written Consent prior to Photographing an individual when the Photograph will be given as a gift or sold to the individual or the individual's family.
2. When a vendor is used to provide these services, SCFHP must obtain a written Authorization from the individual or have the individual initiate contact with the vendor.

PROCEDURE

J. Photographing/Audio Recording Individuals for Telemedicine or the Internet (i.e., official uses only)

1. Written Consent is required prior to transmitting or using individual Photographs/Audio Recordings for telemedicine or on the internet.
2. Information Security policies and procedures for encryption and other company requirements must be followed.

K. Photography/Audio Recording of Individuals or the Individual's Visitors within SCFHP's Facilities by employees for Personal Use

SCFHP's employees are prohibited from Photographing or Audio Recording individuals or the individual's visitors within SCFHP's facilities for personal use, including, but is not limited to:

1. Taking Photographs to share with friends and/or co-workers, or
2. Posting Photographs or Audio Recordings on the internet using social media.

L. Storage:

1. Refer to SCFHP's policy governing Designated Record Sets to determine which, if any, Photographs and/or Audio Recordings must be stored in an individual's medical record.
2. Photographs should not be stored on the device (e.g., camera) or on unencrypted memory cards and must be timely deleted (e.g., within 2 business days) from the device.
3. SCFHP will designate a secure area(s) to store Photographs and Audio Recordings that contain PHI which are not maintained in the individual's medical record.
4. Photographs and Audio Recordings will be clearly identified and securely stored and readily accessible for retrieval.

M. Disclosure

1. SCFHP's employee will not release Photographs or Audio Recordings without Authorization from the individual, unless the disclosure is for Treatment or Payment purposes or Health Care Operations or is otherwise permitted or required by law.
2. Unless prohibited by law, Photographs and Audio Recordings may be released to the individual in accordance with HI.06 Request for Access. SCFHP will retain the originals.

N. Reminders, Training and Sanctions

1. The SCFHP Privacy Officer ensures that policies, signs and posters addresses the contents of this Policy regarding Photography and Audio Recordings are posted in various locations in SCFHP's facilities.
2. The SCFHP Privacy Officer or designee ensures that HIPAA training includes the requirements outlined in this Policy.
3. The SCFHP Privacy Officer or designee ensures prompt investigation, and follow-ups on all reported incidents related to violations of this Policy.

4. The SCFHP Privacy Officer oversees the application of appropriate sanctions for non-compliance by any SCFHP employee.

O. Document Retention

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.06 Request for Access
HI.35 Disclosures for Suspected or Confirmed Abuse, Neglect or Domestic Violence
HI. 46 Photographing, Video Recording, Audio Recording and Other Imaging of Individuals, Visitors and Workforce Members

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

PROCEDURE

Attachment A
Authorization/Consent Form for Photographing, Video Recording,
Audio Recording and Other Imaging of Individuals

POLICY

Policy Title:	**Privacy Policies and Procedure**	**Policy No.:**	HI.47 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

The policy is designed to assure the timely development, implementation, modification and retention of documented Privacy Policies and Procedures related to Protected Health Information (PHI) in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of Santa Clara Family Health Plan (SCFHP) to develop, implement, modify (when needed or appropriate) and retain Privacy Policies and Procedures and to assure that all of SCFHP's staff, temporary help, or consultants comply with those Privacy Policies and Procedures.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.530(i)
45 C.F.R. §164.530(j)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong	Jordan Yamashita	Robin Larmer

Santa Clara Family Health Plan™

POLICY

Compliance Manager	Compliance Director & Privacy Officer	Chief Compliance & Regulatory Affairs Officer
Date	Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Privacy Policies and Procedures**	**Procedure No.:**	HI.47.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

This policy is designed to assure the timely development, implementation, modification and retention of documented Privacy Policies and Procedures related to Protected Health Information (PHI) in accordance with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. Developing SCFHP's Privacy and Breach Notification Policies and Procedures in coordination with SCFHP's management and legal counsel. See, HI.01 Privacy Office Assignment and Responsibilities.

B. Monitoring and assuring that any necessary revisions are made to SCFHP's Privacy and Breach Notification Policies and Procedures in a timely manner following changes in state or federal laws or HIPAA Regulations. See, HI.01 Privacy Office Assignment and Responsibilities.

C. Monitoring and assuring that any necessary revisions are made to SCFHP's Privacy and Breach Notification Policies and Procedures in a timely manner following changes in SCFHP's organization, operations or technology capabilities and, as needed, following a Security Incident and/or an impermissible use or disclosure of PHI. See, HI.01 Privacy Office Assignment and Responsibilities and HI.04 Reporting Violations, Mitigation and Sanctions.

D. Ensuring that any modifications in SCFHP's Privacy and Breach Notification Policies and Procedures are consistent with the applicable terms of SCFHP's Business Associate Agreements, and/or SCFHP's Notice of Privacy Practices.

E. Ensuring that SCFHP's Privacy and Breach Notification Policies and Procedures are in written or electronic form and available to appropriate SCFHP's employees.

F. Ensuring versioning control and retention of SCFHP's Privacy and Breach Notification Policies and Procedures for at least ten (10) years from the date of creation or date of last use, whichever is later.

G. Conducting periodic assessments of compliance with SCFHP's Privacy and Breach Notification Policies and Procedures, and making SCFHP's management aware of any known or potential problems that will be addressed. See, HI.01 Privacy Office Assignment and Responsibilities.

PROCEDURE

H. Ensuring the development and provision of SCFHP's initial and ongoing privacy training for employees, including orientation for new employees and updates for current employees periodically and when necessary. See, HI.02 Privacy Training Requirements.

I. Document Retention
This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.01 Privacy Officer Assignment and Responsibilities
HI.02 Privacy Training Requirements
HI.04 Reporting Violations Mitigation and Sanctions

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Sale of Protected Health Information**	**Policy No.:**	HI.48 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the circumstances under which Santa Clara Family Health Plan (SCFHP) may sell Protected Health Information (PHI) in accordance with a valid Authorization and with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and to sell PHI only in accordance with a valid Authorization and state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.502(a)(5)
45 C.F.R. §164.508(a)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager	Jordan Yamashita Compliance Director & Privacy	Robin Larmer Chief Compliance & Regulatory Affairs

POLICY

Date	Officer Date	Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Sale of Protected Health Information**	**Procedure No.:**	HI.48.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To define the circumstances under which Santa Clara Family Health Plan (SCFHP) may sell Protected Health Information (PHI) in accordance with a valid Authorization and with state and federal privacy laws and HIPAA Regulations.

II. Procedure

A. General Rule

SCFHP must obtain an Authorization for any disclosure of PHI which is a Sale of PHI and the Authorization must state that the disclosure will result in remuneration to SCFHP. See, HI.09 Authorization to Use or Disclose Protected Health Information.

B. Activities That Are Not Considered a Sale of PHI

Unless applicable state law provides otherwise, or as noted below, Sale of PHI does not include a disclosure of PHI:

1. For public health purposes or as a Limited Data Set (See, HI.33 Uses and Disclosures for Public Health Activities and HI.12 Uses and Disclosures of Limited Data Sets),
2. For research purposes where the only remuneration received by SCFHP is a reasonable cost-based fee to cover the cost to prepare and transmit the PHI for such purposes (See, HI.36 Uses and Disclosures for Research Purposes),
3. For Treatment and Payment purposes (See, HI.26 Uses and Disclosures for Treatment Purposes and HI.28 Uses and Disclosures for Payment Purposes),
4. For the sale, transfer, merger, or consolidation of all or part of SCFHP and for related due diligence as described in paragraph (6)(iv) of the definition of Health Care Operations (See, HI.27 Uses and Disclosures for Health Care Operations),
5. To or by SCFHP's Business Associate for activities that the Business Associate undertakes on behalf of SCFHP, and the only remuneration provided is for the performance of such activities by the Business Associate (See, HI.10 Uses and Disclosures to Business Associates and Third Parties),
6. To an individual, when the individual requests access to their PHI or an Accounting of Disclosures (See, HI.06 Request for Access and HI.08 Accounting of Disclosures),
7. Required by law (See, HI.31 Uses and Disclosures Required by Law), and

8. For any other purpose permitted by and in accordance with the HIPAA Privacy Rule, where the only remuneration received by SCFHP is a reasonable, cost-based fee to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by other law.

C. Responsibilities of the Privacy Office

SCFHP's Privacy Office, in consultation with legal counsel, is responsible for:

1. Making determinations regarding the requirement to obtain an Authorization for the proposed Sale activity being considered (see, HI.09 Authorization to Use or Disclose Protected Health Information), and
2. Ensuring that the Authorization discloses the fact that disclosure of the PHI will result in remuneration to SCFHP.

D. Uses or Disclosures involving Business Associates or Third Parties

If SCFHP discloses PHI to a Business Associate or third party in accordance with a valid Authorization for the Sale of PHI, SCFHP will ensure that each recipient agrees to use and re-disclose the PHI solely as expressly permitted in the individual's Authorization evidenced by signing a Business Associate Agreement or other statement or agreement containing the following or similar wording:

> *"In consideration of receiving Protected Health Information, _____ (the "Recipient") agrees not to use the information for any purpose or in any manner other than as authorized by the individual. Unless the authorization expressly permits re-disclosure, the Recipient also agrees not to re-disclose the Protected Health Information (more than once) to anyone other than its own agents and employees, who will also be bound by this restriction. After the information is no longer needed for the purposes authorized by the individual, the Recipient will destroy the information in a manner that protects the individual's privacy and will, upon request, provide SCFHP with certification of such destruction."*

See, HI.10 Uses By and Disclosures to Business Associates and Third Parties. The Business Associate will agree not to engage in any Sale of PHI unless it obtains a valid, written Authorization as required by the HIPAA Privacy Rule. See, HI.09 Authorization to Use or Disclose Protected Health Information.

E. Accounting of Disclosures

Disclosures for purposes of a Sale of PHI do not have to be included in an Accounting of Disclosures since they are made pursuant to the individual's written Authorization.

F. Document Retention

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

HI.06 Request for Access
HI.08 Accounting of Disclosures
HI.09 Authorization to Use or Disclose Protected Health Information
HI.10 Uses by and Disclosures to Business Associates and Third Parties

PROCEDURE

HI.12 Uses and Disclosures of Limited Data Sets
HI.26 Uses and Disclosures for Treatment Purposes
HI.27 Uses and Disclosures for Health Care Operations
HI.28 Uses and Disclosures for Payment
HI.31 Uses and Disclosures Required by Law
HI.33 Uses and Disclosures for Public Health Activities
HI.36 Uses and Disclosures for Research Purposes
HI.48 Sale of Protected Health Information

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Administrative Requirements**	**Policy No.:**	HI.49 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the process associated with ensuring that Santa Clara Family Health Plan (SCFHP) complies with the administrative requirements for training, complaints, sanctions, non-retaliation, policies and procedures, documentation and waiver of rights under the Breach Notification Rule.

II. Policy

It is SCFHP's policy that SCFHP's employees, temporary help, consultants, and providers/delegates are aware of and comply with the administrative requirements associated with breach identification and notification in compliance with state and federal law.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.414
45 C.F.R. §§164.530(b), (d), (e), (g) – (j)

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager	Jordan Yamashita Compliance Director & Privacy	Robin Larmer Chief Compliance & Regulatory Affairs

Santa Clara Family Health Plan™

POLICY

Date	Officer Date	Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Breach Administrative Requirements**	**Procedure No.:**	HI.49.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To define the processes associated with ensuring that Santa Clara Family Health Plan (SCFHP) complies with the administrative requirements (associated with the Privacy Rule, 45 C.F.R. §164.530 – (b) training, (d) Complaints, (e) Sanctions, (g) Refraining from intimidating or retaliatory acts, (h) Waiver of Rights, (i) Policies and Procedures, and (j) Documentation) as they relate to, and are required by, the Breach Notification Rule.

II. Procedure

A. Responsibility

SCFHP's Privacy Office is responsible for ensuring compliance with the administrative requirements of the Breach Notification Rule and for providing all guidance and determinations related to reported incidences in close consultation with SCFHP's Compliance Officer and/or legal counsel.

B. Training

The Privacy Officer or designee is responsible for ensuring the development and provision of a training program for all aspects of the Breach Notification Rule for all applicable employees, temporary staff, and consultants, upon hire and periodically, but no less frequently than annually, as well as providing updates following significant changes in regulatory requirements, organization, operations, or other material changes to SCFHP's policies and procedures that impact their job functions and/or responsibilities. A log will be maintained by the Privacy Officer or designee of all employees who have participated in applicable training. Failure of an employee to participate in training may result in corrective action, up to and including potential termination.

C. Complaints

1. SCFHP's Privacy Officer or designee is responsible for ensuring that complaints or concerns expressed by employees or others about SCFHP's privacy or breach practices are taken seriously and that SCFHP's employee have access to a Complaint Form, located at Privacy Complaint Form which is submitted to SCFHP's Privacy Office, or if preferred, are directed to instructions on how to file a complaint in SCFHP's Notice of Privacy Practices. Other means and methods to register a complaint will be made available and communicated to such individuals including the ability to speak directly to SCFHP's Privacy Officer or corresponding directly with the Department of Health and Human Services (DHHS).

PROCEDURE

2. SCFHP's Privacy Officer or designee will promptly investigate any privacy-related or breach-related complaint with appropriate SCFHP's management and document findings and disposition, if any.
3. If the complaint is justified, the Privacy Officer or designee will oversee the implementation of prompt action to ensure that similar problems do not arise in the future.
4. If updates to policies and procedures are required, or changes to SCFHP's Notice of Privacy Practices, the Privacy Officer or designee ensures timely and appropriate updates and training occur.
5. If the investigation results in a determination that Protected Health Information (PHI) has been improperly disclosed (See, HI.50 Breach Risk Assessment), the Privacy Officer or designee takes steps to mitigate any harm associated with future or ongoing disclosure, including the destruction or return of the PHI.
6. Once the matter is resolved, the Privacy Officer, in consultation with Compliance Officer, follows notification requirements (See, HI.51 Breach Notification) and may respond to the Individual or other persons who complained.

D. Disciplinary Actions

The Human Resources Department in consultation with SCFHP's Privacy Office will establish a range of disciplinary actions that may be imposed if SCFHP's breach notification policies and procedures are violated. Disciplinary action will be commensurate with the severity of the violation, the intent, the existence of previous violations and the degree of potential harm. Disciplinary actions may range from warnings and further training in the event the employee was not aware of policy requirements, to immediate termination in the event of a knowing and intentional violation. The Human Resources Department is responsible for ensuring that all employees are made aware of the disciplinary actions that may be imposed for non-compliance with SCFHP's Privacy and Security policies and procedures. Additionally, federal and state privacy and/or breach notification laws may impose civil and criminal penalties including fines and imprisonment for violations of the law.

E. Refraining from Intimidating or Retaliatory Acts

It is not a violation of SCFHP's policies for a SCFHP employee to file a complaint with the secretary of DHHS; testify, assist, or participate in an investigation or compliance review of SCFHP's breach notification policies; or oppose any act made unlawful by the federal privacy regulations, provided the employee has a good faith belief that SCFHP's action being opposed is unlawful, and the manner of the opposition is reasonable and does not involve a disclosure of PHI in violation of the federal breach notification regulations. Sanctions will not be imposed based on such actions. No person filing or assisting in the investigation of a compliant shall be retaliated against or subject to intimidation of any kind.

F. Waiver of Rights

SCFHP will not require anyone to waive their rights under the Breach Notification Rule as a condition of the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits.

G. Policies and Procedures

SCFHP's Privacy Officer or designee is responsible for ensuring the development, implementation and maintenance of appropriate and reasonably designed policies and procedures related to Breach Notification Rule requirements. The Privacy Officer or designee ensures that appropriate and timely changes to these policies and procedures due to changes in law, technology, organizational structure or

services are documented and approved by management, and made accessible and trained to SCFHP's employees.

H. Documentation

SCFHP's Privacy Officer or designee is responsible for ensuring all required documentation associated with training, disciplinary actions, complaints, investigations, mitigation activities, breach risk assessment, and policies and procedures are gathered and stored pursuant to SCFHP's record retention policy and Section I below.

I. Document Retention

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

CP.05 Record Retention
HI.49 Administrative Requirements
HI.50 Breach Risk Assessment
HI.51 Breach Notification Requirements

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Breach Risk Assessment**	**Policy No.:**	HI.50 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the follow-up process from reports of incidents and complaints in order to identify, investigate, and determine the possibility of a breach and to document the details that support resulting decisions related to mitigation, remediation and notification consistent with state and federal privacy laws.

II. Policy

It is Santa Clara Family Health Plan's (SCFHP) policy to exercise reasonable diligence in connection with the discovery and investigation of any breach of unsecured Protected Health Information (PHI).

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.414(b)

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager Date	Jordan Yamashita Compliance Director & Privacy Officer Date	Robin Larmer Chief Compliance & Regulatory Affairs Officer Date

Santa Clara Family Health Plan™

POLICY

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

PROCEDURE

Procedure Title:	**Breach Risk Assessment**	**Procedure No.:**	HI.50.01 v1
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To define the follow-up process from reports of incidents and complains in order to identify, investigate, and determine the possibility of a breach and to document the details that support resulting decisions related to mitigation, remediation and notification consistent with state and federal privacy laws governing burden of proof.

II. Procedure

A. Upon a suspicion or knowledge of a Privacy violation or Security Incident, a Santa Clara Family Health Plan (SCFHP) employee will immediately notify the Privacy Office of the incident as follows:

1. Notifies and fills out an Incident Report Privacy-Security Incident Report Form and forward to the Privacy Office including a brief description of what occurred, the date of the incident, the date on which the incident was discovered, potentially number of records, and a description of the PHI or Personally Identifiable Information (PII) suspected to have been breached.
2. Leaves the environment and evidence unaltered, and
3. Notifies his/her Supervisor of the issue to facilitate support of the Privacy Office's investigation of these types of situations (see, HI.04 Reporting Violations, Mitigation and Sanctions).

B. The Privacy Office updates the Incident Log and executes the following steps in order to determine whether SCFHP has breach reporting obligations:

1. Determine if the use or disclosure included unsecured PHI as defined by the Privacy Rule.
   If the Privacy Office determines that either:
   a. the use or disclosure did not include PHI, or
   b. if the use or disclosure did include PHI, it was encrypted or otherwise "secured" (see Definitions for Breach Notification Requirements), or
   c. if the use or disclosure or use met one of the exclusions to the definition of a data breach, then he/she updates the Incident Log accordingly, enters the date that the incident was closed and determines if an update to procedures, and/or training and/or disciplinary actions need to be considered.

PROCEDURE

2. If the Privacy Officer or designee determines that the disclosure did include unsecured PHI and did not meet one of the exclusions, then he/she will proceed to step (3).

3. Determine if the use or disclosure required an authorization or an opportunity to agree or object. If the Privacy Officer or designee, in consultation with the Supervisor and SCFHP's Compliance Officer, as appropriate, determines that the use or disclosure did not require an authorization or an opportunity to agree or object, then he/she updates the Incident Log accordingly and enters the date that the incident was closed. If the Privacy Officer or designee determines that the disclosure did require authorization, then he/she will proceed to step (4).

4. Conduct a breach risk assessment. The Privacy Officer or designee, in conjunction with the Compliance Officer as appropriate, conducts a "breach risk assessment" to determine whether or not there is a low probability that the PHI has been compromised based on at least the following factors:
   a. The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;
   b. The unauthorized person who used the PHI or to whom the disclosure was made;
   c. Whether the PHI was actually acquired or viewed; and
   d. The extent to which the risk to the PHI has been mitigated.

C. Following the Determination
   1. If the Privacy Officer or designee determines that the Incident does meet the threshold of low probability of compromise of PHI, then he/she updates the Incident Log documenting the risk assessment and decision, and enters the date that the incident was closed.
   2. If the Privacy Officer or designee determines that the Incident does not meet the threshold of low probability of compromise of the PHI, he/she determines that breach notification is required, documents the risk assessment and decision in the Incident Log and prepares for required notifications in accordance with the Breach Notification Rule and State regulations.

D. Mitigation
   The Privacy Officer or designee immediately implements activities to mitigate any harm associated with future impermissible use of disclosure of the PHI, such as verification of destruction or return of the PHI.

E. Remediate
   The Privacy Officer oversees the development and implementation of a remediation plan that may include changes to facility access, data access, data security, policies and procedures, training material, and/or disciplinary actions of an employee.

F. Updates to Policies & Procedures and SCFHP's Notice of Privacy Practices
   If the cause of the incident or breach requires updating SCFHP's policies and procedures or Notice of Privacy Practices, the Privacy Officer will oversee the appropriate and timely activities to complete.

G. Documentation

PROCEDURE

SCFHP's Privacy Officer is responsible for ensuring all required documentation associated with training, disciplinary actions, complaints, investigations, mitigation activities, breach risk assessment, and policies and procedures are maintained according to SCFHP's record retention policy (CP.05).

H. Document Retention

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by SCFHP for a period of at least 10 years plus the current year from the date of creation or the date when last in effect, whichever is later.

III. Policy Reference

CP.05 Record Retention
HI.04 Reporting Violations Mitigation and Sanctions

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
V1	Original	Anna Vuong, Compliance Manager Date	Jordan Yamashita, Privacy Officer & Compliance Director Date

POLICY

Policy Title:	**Breach Notification Requirements**	**Policy No.:**	HI.51 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe the process for the timely and complete notification requirements following the discovery of a Breach in accordance with state and federal laws governing notifications to individuals, the media, to the Department of Health & Human Services Secretary, to law enforcement and notices made by Business Associates.

II. Policy

Santa Clara Family Health Plan is committed to complying with the notification requirements following the discovery of an impermissible an unauthorized breach of unsecured Protected Health Information (PHI). Santa Clara Family Health Plan will ensure that notifications are made to individuals whose PHI or Personally Identifiable Information (PHII) has been breached as required by the Breach Notification Rule.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.404
45 C.F.R. §164.406
45 C.F.R. §164.408
45 C.F.R. §164.410
45 C.F.R. §164.412

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval

POLICY

Anna Vuong Compliance Manager Date	Jordan Yamashita Compliance Director & Privacy Officer Date	Robin Larmer Chief Compliance & Regulatory Affairs Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee		

Santa Clara Family Health Plan™

Compliance Activity Report
February 27, 2020

2018 CMS Program Audit Update

The Plan requested, and CMS granted, an extension of time to complete the Revalidation Audit for the Care Coordination and Quality Improvement Program Effectiveness (CCQIPE) Conditions. The primary purpose for the extension is to allow the Plan to recruit and train additional staff to achieve and sustain full compliance with respect to the relevant tasks.

Audit field work for the CCQIPE Conditions will now begin in August 2020. The auditors will evaluate data reflecting the Plan's performance between May 1, 2020 and July 31, 2020.

The Revalidation Audit for the Coverage Determinations, Appeals and Grievances (CDAG) and Compliance Program Effectiveness (CPE) Conditions is not affected by this extension. Field work for those Conditions will begin in March 2020 and May 2020, respectively.

The Final Revalidation Audit Report for the CDAG and CPE Conditions must be submitted to CMS on or before 6/19/2020, and the Final Report for the CCQIPE Conditions must be submitted on or before 9/25/2020.

Cal MediConnect

- The Plan is preparing for the 2020 Medicare Data Validation Audit (MDV), which will begin in the spring.
- The CMC Contract Management Team (CMT) previously directed several California Plans, including SCFHP, to submit a Performance Improvement Plan (PIP) demonstrating how the Plan will improve performance related to HRAs. SCFHP submitted a PIP addressing how we will bolster timely completion rates for ICPs. The PIP was accepted by the CMT, and SCFHP is submitting monthly status reports demonstrating progress on the measure.

Medi-Cal Healthier California for All

DHCS has continued to refine and revise the set of proposals it released in October 2019 to transform Medi-Cal through federal waiver updates and other mechanisms. The proposals were initially called CalAIM, but have since become known as Medi-Cal Healthier California for All. Medi-Cal managed care plans will be required to structure their services around a population health management plan, offer a new "enhanced care management" benefit and "in lieu of services" for the highest risk members, and become accredited by the National Committee on Quality Assurance. The five work groups DHCS assembled to provide input and feedback on its initial proposals—SCFHP staff were selected for two of the groups—will wrap up their work in February and the proposals will be finalized shortly thereafter. The primary initial focus will continue to be on meeting DHCS's July 1 deadline for submitting plans for transitioning Whole Person Care and Health Homes Program services into the new "enhanced care management" benefit and "in lieu of services."

2019 DMHC and DHCS Audit(s)

The 2019 DHCS Audit remains open. The CAP responses were initially submitted in August 2019 and the DHCS has been reviewing the Plan's responses and requesting additional information as needed.
The 2019 DMHC Preliminary Report was received in October 2019 with a total of 4 findings for the Medi-Cal and Healthy Kids Medical Survey. The Plan submitted corrective action responses for the four findings identified. The final DMHC Audit Report was received on February 6, 2020. The DMHC accepted two of the responses and requested a supplemental report for one of the remaining two findings.

2020 DHCS Audit

The Plan received the audit notice and pre-audit information request in December 2019. The Plan submitted the audit universes on January 13, 2020 and the pre-audit documents on January 17, 2020. However, the Plan has been receiving numerous additional request for documents on a daily basis. The on-site portion of the audit is scheduled for March 9 – 20th, 2020.

DMHC Complaints

The Plan received a total of 18 member complaints between December and February 2020. One case was forwarded to IMR.

Operational Compliance Report (Dashboard) – Corrective Actions

- Health Services (UM and CM): The business unit and IT are currently working on data verification. Hence, Compliance is postponing issuing CAPs until the team is able to produce accurate data.
- Quality Improvement: received 1 (one) CAP for not completing Facility Site Reviews (FSR) timely.
- Grievance and Appeals: In Q4 2019 4 (four) CAPs were issued to G&A. Two were closed in January 2020.
    - Medi-Cal's Standard Appeals Acknowledgement Letters sent within 5 calendar days, Expedited Appeals grouped on Resolution Letter Date and resolved within 72 hours, and Oct-Nov: Standard Grievances that received an Acknowledgement Letter within 5 Calendar days
    - CMC's Standard Pre-Service Reconsiderations that received Acknowledgement Letters within 5 days.
- Claims: For Medi-Cal, a Non-Compliance notification will be issued to Claims for missing Medi-Cal's Misdirected Claims Forwarded within 10 Business Days element for the month of December. IT fixed the problem immediately.
- Compliance: in Q4 2019, 1 CAP was issued to Compliance because 4 out of the 12 Board members did not complete their annual Compliance training within the required timeframe.

Joint Operations Committee (JOC) Meetings

As of January 1, 2020, the Provider Network Management department has accepted the responsibility of managing JOCs for Provider Groups and Adult Day Care Centers. The following JOCs have been held since the last Compliance Committee Meeting:

- November 2019: Golden Castle, VHP, PMGSJ
- December 2019: Focus Care, Kaiser
- January 2020: Carenet
- February 2020: Docustream, MedImpact, VHP

HIPAA Disclosures

There were 4 incidents between December 2019 and February 2020. Three incidents involved and were reported to DHCS by Kaiser. In the first three cases, members received another member's information. The other incident involved a SCFHP staff member. The staff member faxed an authorization to the incorrect provider.

FWA Activities

T&M (the Plan's FWA/SIU vendor) currently has 31 open cases for which it has identified anomalies through its datamining activities. T&M is currently reviewing the medical records for most of those cases, and has requested medical records for the others.

Santa Clara Family Health Plan™

Santa Clara Family Health Plan – Operational Compliance Report – Calendar Year 2019

Cal MediConnect CY 2019	Goal	Q2 2019	Q3 2019	Q4 2019
ENROLLMENT				
Enrollment Materials				
% of New member packets mailed within 10 days of effective date	100%	Met	Met	Met
% of New Member ID cards mailed within 10 days of effective date	100%	Met	Met	Met
Out of Area Members				
% Compliance with OOA Member Process	100%	Met	Met	Met
CUSTOMER SERVICE				
Call Stats				
Member Queue				
Member Average Speed of Answer in Seconds	≤ 30 seconds	Not Met		
Member Average Hold Time in Seconds	≤120 Seconds	Met	Met	Met
Member Abandonment Rate	≤5%	Met	Met	Met
Member Service Level	80% in ≤30 Seconds	Met	Met	Met
HEALTH SERVICES (UTILIZATION MANAGEMENT)				
Pre-Service Organization Determinations				
Standard Part C				
% of Timely Decisions made within 14 days	100%	Met	Met	Met
Expedited Part C				
% of Timely Decisions made within 72 Hours	100%	Met	Not Met	Met
Urgent Concurrent Organization Determinations				
% of Timely Decisions made within 24 hours	100%		Not Met	Not Met
Post Service Organization Determinations				
% of Timely Decisions made within 30 days	100%	Met	Met	Met
HEALTH SERVICES (CASE MANAGEMENT)				
HRAs and ICPs				
% of HRAs completed in 45 days for High Risk Members	100%	Met		
% of HRAs completed in 90 days for Low Risk Members	100%	Met		
% of ICPs completed within 30 days for High Risk Members	100%	Met		
% of ICPs completed within 30 working days for Low Risk Members	100%	Met		
General HRA % Completion	100%		Met	Pending
General ICP % Completion	100%		Not Met	Pending

Medi-Cal CY 2019	Goal	Q2 2019	Q3 2019	Q4 2019
ENROLLMENT				
Enrollment Materials				
% of New member packets mailed within 7 days of effective Ddte	100%	Met	Met	Met
% of New Member ID cards mailed within 7 days of effective date	100%	Met	Met	Met
CUSTOMER SERVICE				
Call Stats				
Member Queue				
Member Average Speed of Answer in Seconds	≤ 30 seconds	Not Met		
Member Average Hold Time in Seconds	≤120 Seconds	Met		
Member Abandonment Rate	≤5%	Met		
Member Service Level	80% in ≤30 Seconds	Not Met		
Member Average Speed of Answer in Seconds	≤600 Seconds		Met	Met
% of Reports Submitted Timely	100%		Met	Met
HEALTH SERVICES (UTILIZATION MANAGEMENT)				
Medical Authorizations				
Routine Authorizations				
% of Timely Decisions made within 5 Business Days of request	95%	Met	Met	Met
Expedited Authorizations				
% of Timely Decisions made within 72 Hours of request	95%	Met	Not Met	Met
Urgent Concurrent Review				
% of Timely Decisions made within 72 Hours of request	95%		Not Met	Not Met
Retrospective Review				
% of Retrospective Reviews completed within 30 Calendar Days of request	95%	Met	Met	Met
HEALTH SERVICES (CASE MANAGEMENT)				
Initial Health Assessment				
% of High Risk SPD Members who completed HRA in 45 days	100%	Not Met	Not Met	Report Pending
% of HRAs completed in 90 days for Low Risk SPD Members	100%	Not Met	Not Met	Report Pending
% of HRAs completed in 45 days for High Risk MLTSS Members	100%	Not Met		
% of HRAs completed in 90 days for Low Risk MLTSS Members	100%	Not Met		
% Overall compliance for High Risk SPD ICP requirements	100%		Not Met	Report Pending

Met = Measure substantially but not fully met; CAP/adverse action unlikely (or not anticipated)

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Cal MediConnect CY 2019	Goal	Q2 2019	Q3 2019	Q4 2019
CLAIMS				
Non-Contracted Providers				
% of Clean Claims to Non-Contracted Providers processed within 30 days	90%	Met	Met	Met
Contracted Providers				
% of Claims to Contracted Providers processed within 45 days	90%	Met	Met	Met
% of Claims to Contracted Providers processed within 90 days	99%	Met	Met	Met
% of Claims to Contracted Providers processed beyond 90 days	≤1%	Met		
PHARMACY - PART D				
Standard Part D Authorization Requests				
% of Standard Prior Authorizations completed within 72 Hours	100%	Met	Met	Met
Expedited Part D Authorization Requests				
% of Expedited Prior Authorizations completed within 24 Hours	100%	Met	Met	Met
Other Pharmacy Requirements (SCFHP)				
Formulary posted on website by 1st of the month	100%	Met		
Step Therapy posted on website by 1st of the month	100%	Met		
PA criteria posted on website by 1st of the month	100%	Met		
% MTM/CMR Completion Rate	22%	Met		
Other Pharmacy Requirements (MedImpact)				
Provider/Pharmacy Average Hold Time in Seconds	100%		Met	Met
Provider/Pharmacy Service Level	100%		Met	Met
Disconnect Rate	100%		Met	Met
Disconnect Rate from CMS Quarterly Report (part D)	22%		Met	Met

Medi-Cal CY 2019	Goal	Q2 2019	Q3 2019	Q4 2019
CLAIMS				
All Claims				
% Claims Processed within 45 business days / 62 calendar days	95%		Met	Not Met
% Claims Processed within 90 calendar days	99%		Met	Met
% Misdirected Claims forwarded within 10 business days	95%		Met	Met
Clean Claims				
% Practitioner/CBAS/SNF Claims Processed within 30 calendar days	90%		Met	Met
% of Claims Processed to Non Practitioners, SNF CBAS Providers within 45 wrk days	99%		Met	Met
Non-Contracted Providers				
% of Clean Claims to Non-Contracted Providers processed within 30 days	90%	Met		
Contracted Providers				
% of Claims to Contracted Providers processed within 45 working days	95%	Met		
Provider Claim Dispute Requests				
% of Provider Disputes Acknowledged within 15 business days	95%		Met	Met
% of Contracted Provider Disputes Processed within 45 days	95%	Met	Met	Met
Overturned Cases				
% Overturned Cases with Check Provided Within 5 Business Days	95%		Met	Met
PHARMACY				
Standard Authorization Request				
% of Standard Prior Authorizations completed within 24-hours July 1 2017	95%	Met	Met	Met
Expedited Authorization Request				
% of Standard Prior Authorizations completed within 24-hours July 1 2017	95%	Met	Met	Met
HEALTH SERVICES (QUALITY)				
Facility Site Reviews				
% of FSRs completed timely	100%		Met	Not Met

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Cal MediConnect CY 2019	Goal	Q2 2019	Q3 2019	Q4 2019
GRIEVANCE & APPEALS				
Grievances, Part C				
Standard Grievances Part C				
% of Standard Grievances that received Acknowledgement Letters within 5 days and were not resolved in < 5 calendar days	100%	Not Met	Not Met	Met
% of Standard Grievances resolved within 30/44 days	100%	Met	Met	Met
Expedited Grievances Part C				
% of Expedited Grievances resolved within 24 hours	100%	Met	Met	Met
Grievances, Part D				
Standard Grievance Part D				
% of Standard Grievances that received Acknowledgement Letters within 5 days and were not resolved in < 5 calendar days	100%	Met	Met	Met
% of Standard Grievances resolved within 30/44 days	100%	Met	Met	Met
Expedited Grievance Part D				
% of Expedited Grievances resolved within 24 hours	100%	Met	Met	Met
Reconsiderations, Part C				
Standard Pre-Service Part C				
% of Standard Pre-Service Reconsiderations that received Acknowledgement Letters within 5 days	100%	Met	Met	Not Met
% of Standard Pre-Service Reconsiderations resolved within 30/44 days	100%	Met	Met	Met
Standard Post-Service Part C				
% of Standard Post-Service Reconsiderations resolved within 60 days	100%	Met	Met	Met
Expedited Pre-Service Part C				
% of Expedited Pre-Service Reconsiderations resolved with oral notification to member within 72 Hours	100%	Met		
% of Expedited Pre-Service Reconsiderations resolved with written notification to member within 72 Hours	100%	Met		
% of Expedited Redeterminations grouped on Resolution Letter Date and resolved within 72 hours	100%		Met	Met
% Expedited Pre-Service Reconsiderations (upheld & untimely) submitted to IRE within 24-hours of decision	100%	Met	Met	Met
Redeterminations, Part D				
Standard Part D				
% of Standard Redeterminations resolved within 7 calendar days	100%	Met	Met	Met
Expedited Part D				
% of Expedited Redeterminations resolved with oral notification to member within 72 Hours	100%	Met		
% of Expedited Redeterminations resolved with written notification to member within 72 hours	100%	Met		
% of Expedited Redeterminations grouped on Resolution Letter Date and resolved within 72 hours with Resolution Letter and Oral Notification	100%		Met	Met
% of Untimely Expedited Redeterminations Submitted to IRE within 24 Hours of decision	100%	Met	Met	Met
Complaint Tracking Module (CTM) Complaints				
% Resolved Timely	100%	Met	Met	Met

Medi-Cal CY 2019	Goal	Q2 2019	Q3 2019	Q4 2019
GRIEVANCE & APPEALS				
Grievances				
Standard Grievances				
% of Standard Grievances that received Acknowledgement Letters within 5 days and were not resolved in < 5 calendar days	100%	Not Met	Met	Not Met
% of Grievances resolved within 30 days	100%	Not Met	Met	Met
Expedited Grievances				
% of Expedited Grievances grouped on Resolution Letter Date and resolved within 72 hours	100%	Met	Met	Not Met
% of Expedited Grievances that received Oral Notification within 72 hours	100%	Met		
% of Expedited Grievances that received Resolution Letter within 72 hours	100%	Met		
Appeals				
Standard Appeals				
% of Acknowledgement Letters sent within 5 calendar days	100%	Not Met	Not Met	Not Met
% of Standard Appeals resolved within 30/44 calendar days	100%	Met	Met	Met
Expedited Appeals				
% of Expedited Appeals grouped on Resolution Letter Date and resolved within 72 hours	100%	Met	Met	Not Met

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Company Wide Compliance CY 2019				
	Goal	Q1 2019	Q2 2019	Q3 2019
COMPLIANCE TRAINING				
% New Employee Training Completed Timely	100% completed within 3 business days	Not Met	Met	Met
% Annual Employee Training Completed	100% completed by year end	Met	Met	Met
BOARD OF DIRECTORS TRAINING				
% Annual Board Training Completed Timely	100% completed by year end	Met	Met	Not Met
HUMAN RESOURCE				
Excluded Individual Screening Completed Monthly	100%	Met	Met	Met
INTERNAL AUDITS				
% of Internal Audits Completed	100% completed by year end	Met	Met	Met
DELEGATION OVERSIGHT				
% of Scheduled Audits Completed	100%	Met	Met	Met
REPORTING				
% of CMC Routine Reports Submitted Timely	100%	Met	Met	Met
% of Medi-Cal Routine Reports Submitted Timely	100%	Not Met	Met	Met
FILINGS				
% of Key Personnel Filings Timely	100%	Met	Met	Met