Regular Meeting of the

Santa Clara County Health Authority
Compliance Committee

Thursday, February 24, 2022, 2:00 PM – 3:00 PM
Santa Clara Family Health Plan
6201 San Ignacio Ave, San Jose, CA 95119

Via Teleconference Only
(408) 638-0968
Meeting ID: 811 5131 9799
Passcode: CC2022!!
https://us06web.zoom.us/j/81151319799

AGENDA

1.	**Roll Call**	Ms. Murphy	2:00	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. Murphy	2:05	5 min
3.	**Meeting Minutes** Review meeting minutes of the November 18, 2021 Compliance Committee **Possible Action:** Approve November 18, 2021 Compliance Committee minutes.	Ms. Murphy	2:10	5 min
4.	**Compliance Activity Report** Discuss status of regulatory audits, related corrective action plans, and other compliance issues.	Mr. Haskell	2:15	10 min
5.	**Oversight Activity Report** Review the following oversight activities: **a.** Compliance dashboard and corrective action plans **b.** Oversight audits and corrective action plans **c.** CY 2022 risk assessment and audit work plan	Mr. Quan	2:25	15 min
6.	**Compliance Program** Review proposed amendments to the Compliance Program. **Possible Action:** Approve proposed amendments to the Compliance Program.	Mr. Quan	2:40	5 min
7.	**Fraud, Waste, and Abuse Report** Discuss FWA activities and investigations.	Ms. Nguyen	2:45	15 min

8. Adjournment Ms. Murphy 3:00

Notice to the Public—Meeting Procedures

- Persons wishing to address the Executive/Finance 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.
- The Committee may take other actions relating to the issues as may be determined following consideration of the matter and discussion of the possible action.
- In compliance with the Americans with Disabilities Act, those requiring accommodations in this meeting should notify Ashley Kerner 48 hours prior to the meeting at (408) 455-1335.
- To obtain a copy of any supporting document that is available, contact Ashley Kerner at (408) 455-1335. 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.

Regular Meeting of the

Santa Clara County Health Authority
Compliance Committee

Thursday, November 18, 2021, 2:00 PM – 3:00 PM
Santa Clara Family Health Plan
6201 San Ignacio Ave, San Jose, CA 95119

MINUTES

Members Present
Tyler Haskell, Interim Compliance Officer
Sue Murphy, Board Member
Neal Jarecki, Chief Financial Officer
Laurie Nakahira, D.O., Chief Medical Officer
Jonathan Tamayo, chief Information Officer
Christine Tomcala, Chief Executive Officer
Chris Turner, Chief Operations Officer
Ngoc Bui-Tong, VP, Strategies and Analytics
Laura Watkins, VP, Marketing and Enrollment

Members Absent
Teresa Chapman, VP, Human Resources

Staff Present
Chelsea Byom, Director, Marketing and Communications
Barbara Granieri, Controller
Alexandra Gutierrez, Compliance Coordinator
Mai-Phuong Nguyen, Oversight Manager
Daniel Quan, Manager, Medicare Compliance
Alejandro Rodriquez, Compliance Analyst
Megha Shah, Compliance Analyst
Anna Vuong, Manager, Medi-Cal Compliance
Sue Won, Compliance Audit Program Manager
Alicia Zhao, Audit Program Manager
Rita Zambrano, Executive Assistant

1. Roll Call

Sue Murphy, Chair, Called the meeting to order at 2:00 pm. Roll call was taken and a quorum was established.

2. Public Comment

There were no public comments.

3. Meeting Minutes

The meeting minutes of the August 26, 2021 Compliance Committee were reviewed.

It was moved, seconded, and the August 26, 2021 Compliance Committee minutes were **unanimously approved.**

Moved:	Mr. Haskell
Second:	Mr. Jarecki
Ayes:	Ms. Bui-Tong, Mr. Haskell, Mr. Jarecki, Ms. Murphy, Dr. Nakahira, Mr. Tamayo, Ms. Tomcala, Ms. Turner, Ms. Watkins
Absent:	Ms. Chapman

4. Oversight Activity Report

a. Tyler Haskell, Interim Compliance Officer, informed the Committee about a recent administrative penalty assessed against SCFHP by the Department of Managed Health Care (DMHC) relating to two deficiencies in the 2017 Timely Access and Network Adequacy Compliance Report. He discussed the recently-begun Compliance Program Effectiveness audit required annually by CMS, and the outcome of no finding relating

to a recent self-disclosure the Plan made to CMS about a technology issue that was preventing care coordination faxes from being sent to providers. Neal Jarecki, CFO, discussed an upcoming DMHC audit that will cover finance, claims, and pharmacy benefit management.

b. Daniel Quan, Compliance Director, provided an update of our internal compliance monitoring dashboard, for which we are currently meeting our targets 93.3% of the time on a fiscal year-to-date basis. Mr. Quan reported that three oversight audits are in the planning stage (Carenet, Arvato, and Human Resources), while three were recently completed (CHDP Gateway, Enrollment & Eligibility, and Production Services).

5. Fraud, Waste, and Abuse Report

Mai-Phuong Nguyen, Oversight Manager, provided an update on fraud, waste, and abuse (FWA) program activities and presented a year-to-date summary of cases. Compliance received 38 FWA leads, mostly from the Grievances and Appeals and Health Services teams, resulting from their reviews of unusual prior authorization activity. Other common sources are members alleging services not rendered. Through FWA activity, Compliance has recouped approximately $20,000 in 2021.

6. Compliance Policy

Mr. Haskell presented the annual review of the Compliance Program, Standards of Conduct, and Compliance policies and procedures. He stated that the only substantive edits were made to the Standards of Conduct in the section pertaining to gifts, which was changed to align with State Form 700 requirements. This section may be further updated at a future Compliance Committee meeting.

It was moved, seconded, and the Compliance Program, Standards of Conduct, and CP.07, CP.10, CP.12, CP.15, CP.17, DE.04, DE.05, and DE.12 Policies were **unanimously approved.**

Motion:	Mr. Haskell
Second:	Mr. Jarecki
Ayes:	Ms. Bui-Tong, Mr. Haskell, Mr. Jarecki, Ms. Murphy, Dr. Nakahira, Mr. Tamayo, Ms. Tomcala, Ms. Turner, Ms. Watkins
Absent:	Ms. Chapman

7. Adjournment

The meeting was adjourned at 3:00pm.

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Sue Murphy, Chair

Compliance Activity Report

February 24, 2022

- **Compliance Program Effectiveness (CPE) Audit**
  CMS requires Medicare plans to have an independent review of the effectiveness of its compliance program each year. In collaboration with Health Plan Alliance, SCFHP partnered with Piedmont Community Health Plan (Piedmont) to conduct peer-review audits of our respective compliance programs to meet CMS's CPE requirement for CY 2021. The audit process is based on recently approved Medicare Part C and D Program Audit Protocols which CMS will begin using for 2022 program audits. SCFHP received results from Piedmont in January and is working to address a few findings related to Production Services and Provider Network Operations.

- **Performance Measure Validation**
  The Plan was selected by CMS's external quality review organization to participate in the 2021 performance measure validation audit. The audit focused on 2020 reporting of data sets used to demonstrate compliance with two Cal MediConnect requirements: members with an initial health risk assessment and members with an initial care plan completed within 90 days of enrollment. A review session took place on August 19 and the Plan recently received a final report in December indicating that both data sets were deemed "reportable," meaning the data were valid compliant with CMS specifications.

- **CMS Notices of Noncompliance**
  The Plan recently received two notices of non-compliance from CMS related to late submissions of attestations and policies and procedures related to the use of a formulary for the Medicare Part D program, which are required to be submitted annually. The Pharmaceutical and Therapeutics Committee attestation, Prior Authorization/Step Therapy attestation, and Transition Policy were due on June 7, 2021. We submitted them on June 8. There are no penalties or corrective actions required by CMS, but we have taken steps to ensure future timely submissions.

- **Department of Health Care Services (DHCS) Annual Audit**
  The Plan recently received notice for the annual 2022 DHCS audit, which will take place between March 7 and March 18, covering a review period of March 2021 through February 2022. Compliance has submitted all information requested by DHCS from internal operations and delegates. Unlike previous DHCS audits, which covered only the Medi-Cal line of business, this audit will cover both Medi-Cal and Cal MediConnect.

- **Department of Managed Health Care (DMHC) Financial Audit**
  In January, we received notice of a routine financial audit that will be conducted by DMHC in June. This audit occurs every three years and examines the financial health and sustainability of the health plan, including cash, investments, liabilities, billing processes, claims data, and provider disputes. We expect DMHC to begin requesting documents starting in March.

Santa Clara Family Health Plan

Compliance Summary 2021-2022

FY 2021-2022 PLAN FOCUS - At least 95% of Metrics on Compliance Dashboard in Compliance

Fiscal Year to Month: **Jan-22**

561 out of 626 measures were compliant = **89.6%**

LOB	Category	2021						2022						FY to Date
		Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	
CMC (49 measures)	Met	40	43	44	41	33	36	39						276
	Monthly Count*	43	44	46	45	43	43	43						307
	% Met	93.0%	97.7%	95.7%	91.1%	76.7%	83.7%	90.7%						89.9%
Medi-Cal (38 measures)	Met	29	31	32	31	25	29	30						207
	Monthly Count*	35	35	34	35	34	34	34						241
	% Met	82.9%	88.6%	94.1%	88.6%	73.5%	85.3%	88.2%						85.9%
General Compliance (14 measures)	Met	11	11	11	11	11	12	11						78
	Monthly Count*	11	11	11	11	11	12	11						78
	% Met	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%						100.0%
Combined (101 measures)	Met	80	85	87	83	69	77	80						561
	Monthly Count*	89	90	91	91	88	89	88						626
	% Met	89.9%	94.4%	95.6%	91.2%	78.4%	86.5%	90.9%						89.6%

Yellow = at least 98% for measures with a goal of 100%

Santa Clara Family Health Plan.

Compliance Summary 2021-2022

Cal MediConnect

Measure	Goal	Q3-21	Q4-21	Q1-22	Q2-22
CLAIMS					
Non-Contracted Providers					
Clean Claims from Non-Contracted Providers paid or denied within thirty (30) calendar days	95%	99.4%	98.5%		
All Other Claims from Non-Contracted Providers or enrollees must be paid or denied within sixty (60) calendar days	100%	100.0%	100%		
Contracted Providers					
Clean Claims from Contracted Practitioners paid or denied within thirty (30) calendar days	90%	100%	99.5%		
Clean Claims from Contracted Providers paid or denied within ninety (90) calendar days	99%	99.9%	99.5%		
CUSTOMER SERVICE					
Call Stats					
Member Queue					
Member Average Hold Time in Seconds	≤120 Seconds	40	40		
Incoming calls that are answered within 30 seconds	80% in ≤30 sec	73.2%	79.2%		
Disconnect Rate from CMS Quarterly Report (part C)	≤5%	0.0%	n/a		
ENROLLMENT					
Enrollment Materials					
New member materials mailed within 10 calendar days of receipt of enrollment confirmation on TRR or by last calendar day of the month prior to the effective date, whichever occurs later	100%	99.8%	99.8%		
Out of Area Members					
% of compliance with member outreach process within 10 calendar days of notification of possible OOA for members	100%	100%	100%		
FINANCE					
Monthly submission of encounter data	100%	100%	100%		

Medi-Cal

Measure	Goal	Q3-21	Q4-21	Q1-22	Q2-22
CLAIMS					
All Claims					
Misdirected Claims forwarded within ten (10) working days	95%	91.4%	98.5%		
Processed Claims that receive acknowledgement timely	95%	100.0%	99.9%		
All Claims paid or denied to ALL providers within forty-five (45) working days	95%	99.8%	99.5%		
Clean Claims					
Clean Claims paid or denied to Practitioner within thirty (30) calendar days	90%	99.8%	98.2%		
Clean Claims paid or denied to All Providers within ninety (90) calendar days	95%	100.0%	100.0%		
Provider Claim Dispute Requests					
Provider Disputes acknowledged within fifteen (15) working days	95%	99.0%	98.9%		
Provider Disputes resolved within forty-five (45) working days/sixty-two (62) calendar days	95%	99.8%	100.0%		
Overturned Cases					
Overturned Cases with check provided within five (5) working days	95%	99.7%	100.0%		
CUSTOMER SERVICE					
Call Stats					
Member Queue					
Member calls that are answered in ≤ 10 minutes	100%	99.2%	99.1%		
ENROLLMENT					
Enrollment Materials					
New member Information mailed within 7 calendar days of the effective date of member's enrollment, or within 7 calendar days of receipt of enrollment, if enrollment is retroactive	100%	100%	100%		
New member ID mailed within 7 calendar days of the effective date of member's enrollment, or within 7 calendar days of receipt of enrollment, if enrollment is retroactive	100%	100%	100%		

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Santa Clara Family Health Plan.

Compliance Summary 2021-2022

Cal MediConnect

Measure	Goal	Q3-21	Q4-21	Q1-22	Q2-22
HEALTH SERVICES - CASE MANAGEMENT					
HRAs and ICPs					
Total ICP Completion	100%	98.0%	96.3%		
Total HRA Completion	100%	100.0%	96.9%		
Members with timely annual HRA completion	100%	89.6%	98.3%		
HEALTH SERVICES - MEDIMPACT/PHARMACY					
Standard Part D Authorization Requests					
Standard Prior Authorization requests (part D) completed within seventy-two (72) hours of request	100%	100.0%	100.0%		
Expedited Part D Authorization Requests					
Expedited Prior Authorization requests (part D) completed within twenty-four (24) hours of request	100%	100.0%	100.0%		
Non Part D Drugs Authorization Requests					
Non Part D Drugs Prior Authorization completed within twenty-four (24) hours of request	100%	96.6%	100.0%		
Call Monitoring					
Provider/Pharmacy Average Hold Time in Seconds	≤120 Seconds	14	7		
Provider/Pharmacy Service Level	80% in ≤30 sec	85.0%	92.0%		
Disconnect Rate	≤5%	0.0%	n/a		
HEALTH SERVICES - UTILIZATION MANAGEMENT					
Concurrent Organization Determinations					
Concurrent Review of Authorization Requests (part C) completed within five (5) working days of request	100%	99.8%	100.0%		
Pre-Service Organization Determinations					
Standard Part C					
Standard Pre-Service Prior Authorization Requests (part C) completed within five (14) calendar days	100%	99.6%	99.4%		

Medi-Cal

Measure	Goal	Q3-21	Q4-21	Q1-22	Q2-22
HEALTH SERVICES - CASE MANAGEMENT					
HRAs and ICPs for SPDs					
Newly enrolled SPD members who were due for risk stratification and were statified timely during the reporting month	100%	100%	100%		
Total High Risk SPD HRA Completion	100%	75.0%	100%		
Total Low Risk SPD HRA Completion	100%	96.0%	75.0%		
Total High Risk SPDs with ICP completion	100%	50.0%	100%		
HEALTH SERVICES - PHARMACY					
Standard Authorization Request					
Standard Prior Authorization requests (RX) completed within twenty-four (24) hours	100%	99.5%	99.5%		
Expedited Authorization Request					
Expedited Prior Authorization requests (RX) completed within twenty-four (24) hours of request.	100%	99.3%	99.0%		
HEALTH SERVICES - QUALITY					
Facility Site Reviews					
Annual Managed Care Division Facility Site Reviews/Physical-Accessibility Report submitted by Aug 1 each year	100%	100%	n/a		
IHAs completed within 120 calendar days of enrollment	100%	43.2%	47.5%		
HEALTH SERVICES - UTILIZATION MANAGEMENT					
Medical Authorizations					
Conncurrent Review					
Concurrent Review of Authorization Requests completed within 5 working days of request	100%	99.0%	99.8%		

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Santa Clara Family Health Plan.

Compliance Summary 2021-2022

Cal MediConnect

Measure	Goal	Q3-21	Q4-21	Q1-22	Q2-22
HEALTH SERVICES - UTILIZATION MANAGEMENT (cont.)					
Pre-Service Organization Determinations (cont.)					
Expedited Part C					
% of Expedited Pre-Service Prior Authorization Requests (part C) completed within sevety-two (72) hours	100%	99.3%	98.9%		
Post Service Organization Determinations					
Retrospective Requests (part C) completed within thirty (30) calendar days	100%	99.6%	99.4%		
Part B Drugs Organization Determinations					
Standard Prior Authorization Requests (part B drugs) completed within seventy-two (72) hours of request	100%	100.0%	98.4%		
Expedited Prior Authorization requests (part B drugs) completed within twenty-four (24) hours of request	100%	100.0%	92.0%		

Medi-Cal

Measure	Goal	Q3-21	Q4-21	Q1-22	Q2-22
HEALTH SERVICES - UTILIZATION MANAGEMENT (cont.)					
Medical Authorizations (cont.)					
Routine Authorizations					
Routine Prior Authorization Requests completed within five (5) working days of request	100%	99.6%	99.4%		
Expedited Authorizations					
Expedited Prior Authorization Requests completed within seventy-two (72) hours of request	100%	99.8%	99.8%		
Retrospective Review					
Retrospective Requests completed within thirty (30) calendar days of request	100%	100.0%	99.8%		
Member Notification of UM Decision					
Member Notification of UM decision in writing within two (2) working days of the decision.	100%	99.5%	99.3%		
Provider Notification of UM Decision					
Provider Notification of UM decision by phone, fax or electronic mail and then in writing within 24 hours of making the decision	100%	97.9%	98.2%		

Cal MediConnect

GRIEVANCE & APPEALS					
Grievances, Part C	**Goal**				
Standard Grievances Part C					
Standard Grievances (Part C) that provided Acknowledgment Letters within five (5) calendar days	100%	98%	95.5%		
Standard Grievances (Part C) that provided Resolution Letters within thirty day calendar (30) days	100%	99.6%	99.4%		
Expedited Grievances Part C					
Expedited Grievances (Part C) that provided Verbal or Written Resolution within twenty-four (24) hours	100%	100%	100%		
Grievances, Part D					
Standard Grievance Part D					
Standard Grievances (Part D) that provided Acknowledgment Letters within five (5) calendar days	100%	100%	100%		
Standard Grievances (Part D) that provided Resolution Letters within thirty (30) calendar days	100%	100%	100%		
Expedited Grievance Part D					
Expedited Grievances (Part D) provided Verbal OR Written Resolution within twenty-four (24) hours	100%	100%	100%		
Reconsiderations, Part C					
Standard Pre-Service Part C					
Standard Pre-Service Reconsiderations (Part C) that provided Acknowledgment Letters within five (5) calendar days	100%	100%	91.4%		
Standard Pre-Service Reconsiderations (part C) that provided Resolution Letters within thirty (30) calendar days	100%	100%	100%		
Standard Post-Service Part C					
Standard Post-Service Reconsiderations resolved within 60 days	100%	100%	92.9%		

Medi-Cal

GRIEVANCE & APPEALS					
Grievances					
Standard Grievances					
Standard Grievances that provided Acknowledgement Letters within five (5) calendar days	100%	97.9%	95.1%		
Standard Grievances that provided Resolution Letters within thirty (30) calendar days	100%	99.4%	98.9%		
Expedited Grievances					
Expedited Grievances that provided Verbal AND Written Notifications within seventy-two (72) hours	100%	100.0%	100.0%		
Appeals					
Standard Appeals					
Standard Appeals that provided Acknowledgement Letters within five (5) calendar days	100%	97.3%	93.0%		
Standard Appeals that provided Resolution Letters within thirty (30) calendar days	100%	99.5%	94.7%		
Expedited Appeals					
Expedited Appeals that provided Verbal AND Written Notifications within seventy-two (72) hours	100%	100.0%	85.7%		

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Santa Clara Family Health Plan.

Compliance Summary 2021-2022

Cal MediConnect

Measure	Goal	Q3-21	Q4-21	Q1-22	Q2-22
GRIEVANCE & APPEALS (cont.)					
Reconsiderations, Part C (cont.)					
Expedited Pre-Service Part C/Part B Drug					
Expedited Reconsiderations (part C) that provided Verbal AND Written Resolution within seventy-two (72) hours	100%	100%	100%		
Expedited Pre-Service Part C/Part B Drug (cont.)					
Expedited Pre-Service Reconsiderations (upheld & untimely) submitted to IRE within 24-hours of decision	100%	100%	100%		
Appeals, Part B					
Part B Drug Appeals that provided Verbal OR Written Resolution within seven (7) calendar days	100%	100%	100%		
Redeterminations, Part D					
Standard Part D					
% of Standard Redeterminations (part D) that provided Resolution Letters within seven (7) calendar days	100%	100%	95.7%		
Expedited Part D					
Expedited Redeterminations (part D) that provided Verbal AND Written Resolution within seventy-two (72) hours	100%	100%	100%		
Untimely Expedited Redeterminations (part D) submitted to IRE within twenty-four (24) hours of decision	100%	100%	100%		
Direct Member Reimbursement Redeterminations (Part D) resolved within fourteen (14) calendar days	100%	100%	100%		
Complaint Tracking Module (CTM) Complaints					
CTM Conplaints Resolved Timely	100%	100%	100%		
MARKETING					
Required Materials posted to the Plan's website by the first of each month	100%	100%	100%		
Required Member Materials posted to the Plan's website by October 15 each year	100%	n/a	100%		
Annual member materials distributed or notified by October 15 each year	100%	n/a	100%		
MEDICARE OUTREACH					
Annual Medicare Communications & Marketing Guidelines training completed by September 30 each year	100%	100%	n/a		
PROVIDER NETWORK MANAGEMENT					
PROVIDER DATABASE & REPORTING					
Provider Directories updated monthly by the first day of the month	100%	100%	100%		
Annual Health Service Delivery Tables submitted by September 30 of each year	100%	100%	n/a		

Medi-Cal

Measure	Goal	Q3-21	Q4-21	Q1-22	Q2-22
GRIEVANCE & APPEALS					
MARKETING					
Training and certification for Marketing Representatives completed timely	100%	100%	100%		
Medi-Cal Provider Directory posted on the Plan's website by the first of the month	100%	100%	100%		
INFORMATION TECHNOLOGY					
Encounter Files Successfully Submitted to DHCS by end of month	100%	100%	100%		
Monthly Eligibility Files successfully submitted to Delegates Timely	100%	100%	100%		
PROVIDER NETWORK MANAGEMENT					
PROVIDER NETWORK RELATIONS					
% of New Providers who received orientation within ten (10) working days after being placed on active status	100%	100%	100%		
PROVIDER NETWORK ACCESS & DATABASE					
Annual Network Certification submitted by March 31 of each year	100%	n/a	n/a		
Timely Access Compliance Report submitted by March 31 of each year	100%	n/a	n/a		

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Santa Clara Family Health Plan.

Compliance Summary 2021-2022

Cal MediConnect

Measure	Goal	Q3-21	Q4-21	Q1-22	Q2-22
GENERAL COMPLIANCE					
Exclusion Screenings					
Individual Exclusion Screening					
New Eligible Individuals screened prior to start date	100%	100%	100%		
Eligible Individuals who are screened monthly	100%	100%	100%		
FDR Exclusion Screening					
Initial Exclusion Screening Completed for FDRs prior to contracting	100%	100%	100%		
Monthly Exclusion Screening Completed for existing FDRs	100%	100%	100%		
Provider Monthly Screenings					
Monthly Exclusion Screening completed for the Plan's Contracted Providers	100%	100%	100%		
Monthly Exclusion Screening completed for Non-Contracted Providers	100%	100%	100%		
Compliance Training					
New Eligible Employees completed trainings within ninety (90) days of initial hiring (SCFHP's operational standard = 5 working days)	100%	100%	100%		
Annual Employee Training completed within sixty (60) calendar days of issuance	100%	100%	100%		
Annual Board Training completed within sixty (60) calendar days of issuance	100%	n/a	100%		
Standards Of Conduct And Compliance Policies					
New Eligible Employees receive Standards of Conduct and P&Ps within five (5) working days of initial hiring	100%	100%	100%		
Current Employees receive Standards of Conduct and Compliance P&Ps annually	100%	n/a	100%		

Medi-Cal

Measure	Goal	Q3-21	Q4-21	Q1-22	Q2-22
GENERAL COMPLIANCE					
Personnel Filings					
Key Personnel filings completed within five (5) calendar days of effective date	100%	100%	100%		
Department Of Fair Employment & Housing Training					
Employees who complete the CA harassment training course once every two years	100%	n/a	n/a		
Temporary Employees completed the CA harassment training within 30 calendar days from start date or 100 hours of work	100%	100%	100%		

Yellow = at least 98% for measures with a goal of 100%

Santa Clara Family Health Plan™

2021 Audit Work Plan - Updates

February 24, 2022

3-Year Audit Schedule

Santa Clara Family Health Plan

CMC + INTERNAL 3-YEAR SCHEDULE

Year	Internal/External	Q1		Q2		Q3		Q4	
		Medi-Cal	CMC	Medi-Cal	CMC	Medi-Cal	CMC	Medi-Cal	CMC
2019	Internal					Compliance*		Customer Service	
	External			MedImpact		Kaiser		T&M Focus Care	
2020	Internal	SCFHP Website IT (Security Risk Assessment)*		Claims		Compliance*		Quality Improvement	
			UM				Pharmacy		UM SCFHP Website
	External	Hanna		MedImpact VSP		New Directions			VHP PMGSJ
		Language Line		Cal IPA		Kaiser PCNC			
2021	Internal	CM Grievance and Appeals Provider Network		Enrollment Production Services		Compliance* Human Resources		SCFHP Website Medicare Outreach	
	External	Change Healthcare		MedImpact VSP Office Ally		Carenet Docustream		VerifPoint Arvato	
				CHDP Gateway		Kaiser PCNC		PMGSJ VHP	
2022	Internal					Compliance*		SCFHP Website	
	External	MedAid		MedImpact VSP		Kaiser PCNC		PMGSJ VHP	

MEDI-CAL 3-YEAR SCHEDULE

Note: Audit schedule was last reviewed and approved in Feb 2021 Compliance Committee

Compliance Program Effectiveness (CPE) Audit

Audited by: Piedmont Community Health Plan

Final Results

Scope

- Medicare Compliance Program, Standards of Conduct, Risk Assessment, Audit Work Plan, Compliance Officer and FDR Oversight Questionnaire, Organizational Structure and Governance Presentation, 2 Tracer Presentations (audit samples)

Findings:

Program Area	Total Opportunities	Total Met or NA	Partially Met	Not Met	Total Correct	Overall Score
Production Services Tracer	34	30	3	1	32	93%
PNO Tracer	34	32	2	0	33	97%
Tracer Totals	68	62	5	1	65	95%
Code of Conduct	15	15	0	0	15	100%
Structure/Governance	25	25	0	0	25	100%
RA and Work Plan	15	15	0	0	15	100%

Production Services Internal Audit Tracer:

- Some policies reviewed were over 5 years old with inconsistent P&P templates
- There was no evidence of training provided to staff when P&P was updated or created to address a CAP.
- SCFHP did not perform an impact analysis to identify members impacted on a finding where member's language preference was not updated upon request .

PNO Internal Audit Tracer:

- Some policies reviewed were over 5 years old with inconsistent P&P templates
- CAP was not completed timely. CAP required an update to P&Ps by 1/1/2022, but not documentation was provided to show completion as of 1/12/2022.

SCFHP Website CMC

Internal Monitoring

- **Scope:**
  - Ensure the Santa Clara Family Health Plan (SCFHP) website, www.scfhp.com, maintains and updates marketing and communication content for the Cal MediConnect (CMC) plan
    - Reviewed required components based on the Medicare Communications and Marketing Guidelines (MCMG) and the SCFHP Website – CMC Content & Submission policy (MK.02.02 v4)
    - Webpages, hyperlinks to posted documents were tested, specific to the CMC line of business
- **Findings:**
  - 2022 Formulary and Quality Improvement Program Description wasn't the most current, it has since been corrected.
  - DME List for English and Chinese was mismatched, it has since been corrected.
- **Observations:**
  - None noted at this time

Premier Care of Northern California (PCNC)

Delegate for Medi-Cal members

- Scope:
  - Compliance, C&L, Information Management, Utilization Management, Case Management, Initial Health Assessment, Provider Training, Timely Access and Availability, Claims/PDR
- Preliminary Findings (4 Observations and 20 Findings):
  - Untimely completion or distribution of Employee Compliance Requirements (Trainings, SOC, P&Ps)
  - C&L, CM, IHA policies need updating
  - Utilized an outdated Your Rights Template
  - Missing documentation of an Individual Care Plan (ICP) for 19 out of 19 samples
  - No outreach attempts were made to complete the HRA
  - Missing IHA medical records
  - Medical records were missing certain components of the IHA (comprehensive history, preventive services, physical and mental health exam, plan of care, IHEBA)
  - Claims were denied incorrectly
  - Overturned PDRs were not paid accurately.

Kaiser Delegation Audit

Final Results

Scope: UM, MH/BHT, Compliance, NEMT/NMT, PQI, Credentialing, QI, A&G, Claims and PDR, Health Education and Cultural Linguistics, Member Experience, Pharmacy, Population Health Mgmt, Provider Training

Final Audit Findings:

- **Compliance, NEMT/NMT, PQI, QI, Credentialing, Provider Training, Pharmacy, Member Experience, Cultural Linguistics :** No findings
- **A&G:** Medi-Cal Your Rights Attachment was not sent with the Acknowledgement Letter. KP updated their system to include the Attachment on 3/26/21. CAP Closed.
- **Claims**: 5/30 claims were denied inappropriately (CAP open).
- **PDR:** 1 out of 20 PDRs was upheld incorrectly (CAP open)
- **CCM:** Documentation was not provided to show when member was identified for CCM so we cannot determine if initial assessment was completed timely (CAP open).
- **UM:** For non-urgent pre-service (Routine) decisions, Kaiser did not notify members within 2 working days from decision for 25/30 samples reviewed. (CAP open)
- **MH/BHT:** Did not include a thorough description of patient information, reason for referral, brief background information in 22/29 treatment plans (CAP closed)

Pending Results:

- Health Education

Kaiser Delegation Audit

Final Results

Audited Area	Results	CAP Status
QI	P&P Review: 100%	NA
UM	P&P Review: 97% File Review: 94%	P&P Review: CAP Open File Review: CAP Open
Credentialing	P&P Review: 100%	NA
New Provider Training	P&P Review: 100%	NA
Claims & PDR	P&P Review : 100% File Review: 95%	P&P Review: CAP Closed File Review: CAP Open
Population Health Management	P&P Review: 100% File Review: 100%	P&P Review: NA File Review: CAP Open
Compliance	P&P review: 100%	CAP Closed
Appeals and Grievances	P&P Review: 100% File Review: 98%	P&P Review: NA File Review: CAP Closed
Pharmacy	P&P Review: 100%	NA
Behavioral Health / Mental Health	BH P&P Review: 100% BH File Review: 94% MH P&P Review: 100% MH File Review: 100%	BH P&P Review: NA BH File Review: CAP Closed MH P&P Review: NA MH File Review: NA
Member Experience	P&P Review: 100%	CAP Closed
PQI	File Review: 100%	NA
NEMT/NMT	P&P Review: 100% File Review: 100%	NA
Health Education and Cultural Linguistics	Health Education P&P Review: 63% (Pending Kaiser's rebuttal to preliminary finding) C&L P&P Review: 100%	Pending Kaiser's rebuttal to preliminary finding

Santa Clara Family Health Plan™

2021 Audit Work Plan - Updates

February 24, 2022

Santa Clara Family Health Plan™

Risk Assessment and Audit Work Plan

February 2022

Risk Assessment Process

Compliance Department conducts an annual Risk Assessment of First Tier Entities (FDRs), Delegates, and Internal Operational Departments to assist in developing our Auditing and Monitoring work plan.

In 2020, a 3-year audit plan was developed based on the Risk Assessment conducted at that time. As risk may change throughout time, this assessment is completed to ensure our 3-year audit plan is still valid.

Please note that the Risk Assessment and Auditing Work Plan may change throughout the year(s) based on various operational changes that may impact the Risk Level/Scores.

FDR/Delegates Risk Assessment – Scoring Criteria

Santa Clara Family Health Plan

Impact Category	Compliance Considerations	Scoring Guide Parameters
Beneficiary	Direct beneficiary contact	No direct or indirect impact = 0
	Indirect beneficiary contact that could result in potential harm	Indirect impact; no issues previously identified = 1
		Indirect impact with high volume of members; issues previously identified = 2
		Direct impact; no communication errors previously found = 3
		Direct impact with high volume of members; communication errors previously found = 4
		Direct impact with high volume of members; ongoing issues or accuracy not yet verified = 5
Audit Score	Pre-delegation audit deficiencies	No findings or observations = 0
	Annual delegation audit deficiencies	Pre-delegation or annual audit observations noted for future improvement = 1
	Recurring gaps or deficiencies identified	Pre-delegation or annual audit findings found, resolved = 2
	Failure to meet contractual reporting standards	Pre-delegation or annual audit findings found, unresolved, no member impact = 3
		Pre-delegation/annual audit findings, unresolved, member impacts (or no previous audits conducted) = 4
		Systemic issues, unresponsiveness, CAP validation failures = 5
IT Systems	Adequacy of systems supporting Medicare functions	No reliance on each other's systems (SCFHP or FDR/Delegate) = 0
	Testing of system accuracy	Integrated platforms, regular maintenance, successful testing of both SCFHP and FDR/Delegate systems = 1
	Monitoring and maintenance	Isolated systems and manual processes, successful data transfer processes = 2
		Isolated systems and manual processes, barriers identified in pulling data from systems; inconsistent testing results= 3
		Barriers identified in pulling data from systems - unresolved; System migrations = 4
		Systemic data integrity issues identified; No previous testing of data extraction completed = 5
FDR/Delegate Stability	Key changes in senior management	Have stable contacts; stable business relationship; longevity of FDR/Delegate = 0
	Key changes in personnel supporting delegated functions	Have contacts for most needs; stable or new business relationship; longevity of
	Key changes in operational processes or reporting structures	Have insufficient contacts; fairly new business relationship; fairly new FDR/Delegate = 2
	Stability/Longevity of the FDR/Delegate itself	Have insufficient contacts/staffing resources; fairly new business relationship; fairly new FDR/Delegate = 3
	Stability/Longevity of Business Relationship	Continued lack of experience, knowledge or communications on delegated functions = 4
		Recurring changes in key positions related to delegated functions; unsure of appropriate contacts = 5
Monitoring by Business Units	Ongoing monitoring of delegated functions	No gaps or deficiencies = 0
	Trending issues identified during monitoring efforts	Inconsistencies in delivering required reporting, no process gaps in data, resolved = 1
	Investigation and escalation of monitoring gaps identified	Inconsistencies in delivering required reporting, process gaps in data identified, resolved =
	Timely resolution of monitoring gaps	Inconsistencies in delivering required reporting, process gaps in data identified,
	Downstream Entities and Offshore	Inadequate responses to issues; delays in notifying health plan; impact analysis not done =
		Systemic reporting issues; failure to correct gaps; failure to self-disclose; no FDR/Delegate monitoring/auditing = 5

FDR Risk Assessment – Current FDR Risk Levels

FDR/Delegate Entity Name	Line of Business	Risk Score	Audit Schedule	Status
Premier Care	Medi-Cal	14	Conducted Annually	
Valley Health Plan	Medi-Cal	14	Conducted Annually	
Vision Service Plan	All	13	Conducted Annually	
Kaiser	Medi-Cal	13	Conducted Annually	
MedImpact	All	12	Conducted Annually	
Physicians Medical Group	Medi-Cal	11	Conducted Annually	
Arvato	All	11	2021 Q4	Not Completed
Silver & Fit	CMC	11		
Hanna	All	10	2020 Q1	Completed
Transportation Vendors (5)	All	10	2022	In Progress
Office Ally	All	9	2021 Q2	Not Completed
Docustream	All	9	2021 Q3	Not Completed
Carenet	All	9	2021 Q3	Not Completed
Language Line	All	8	2020 Q1	Completed
CHDP Gateway	Medi-Cal	7	2021 Q2	Not Completed
Focus Care	All	7	2019 Q4	Completed
New Directions	All	7	2020 Q3	Completed
Golden Castle	Medi-Cal	5	2020 Q4	Completed
Change Healthcare	All	4	2021 Q1	Not Completed
NEMS	Medi-Cal	4	Conducted Annually	
Palo Alto Medical Foundation	All	3	Conducted Annually	
Stanford Medical Group	All	2	Conducted Annually	
VerifPoint	All	2	2021 Q4	Completed

Internal Risk Assessment – Scoring Criteria 1 of 2

Assessment Activities	Scoring Value
P&Ps: date last reviewed and approved	
Current for assessment year	0
Past due by >30 days	1
Past due by >60 days	2
Past due by >90 days	3
Past due by greater than 1 year	4
Missing key policies and procedures OR P&Ps were never drafted	5
Staffing (stability)	
No needs beyond current staff; all available positions filled with permanent employees	0
1 or 2 temporary employees within department to provide coverage for unique project OR unexpected staff opening	1
3 or 4 temporary employees within department to provide coverage for unique project OR unexpected staff opening	2
5 or more temporary employees within department due to persistent turnover	3
Outsourcing of workload due to inability to locate and hire qualified staff	4
Ongoing staffing issues that may or may not have been escalated for resolution	5
Management (stability)	
No changes in management in last 2 years	0
No changes in management in previous year	1
New manager hired within the last year	2
New manager hired within the last 6 months	3
New manager hired within the last 3 months	4
Management position is open and remains unfilled at time of assessment	5

Specialized training: new hire	
Specialized training for job requirements completed for new hires as a part of orientation process; training materials and logs available; tracking maintained	0
Specialized training for job requirements completed for new hires >30 days post start date	1
Specialized training for job requirements completed for new hires >60 days post start date	2
Specialized training for job requirements completed for new hires >90 days post start date	3
Specialized training for job requirements developed but not implemented	4
No specialized training for job requirements developed or implemented	5
Specialized training: regular updates/annual training	
for regulatory changes, update training and handle staff training; tracking mechanism in place for annual training	0
Specialized training for job requirements completed for staff within 12 months from previous training; no documentation maintained	1
Specialized training for job requirements completed for staff exceeding the 12 month timefame from previous training; documentation maintained	2
Specialized training for job requirements not issued to staff on a consistent basis re: annual refresher training; no documentation maintained	3
Specialized training for job requirements developed but not implemented	4
No specialized training for job requirements developed or implemented	5

Self-reported and/or otherwise identified potential non-compliance, FWA, privacy and security issues	
Reports potential issues timely	0
Delay of 1 week before reporting potential issue to compliance dept	1
Delay of >2 weeks before reporting potential issue to compliance dept	2
Delay of >1 month before reporting potential issue to compliance dept	3
Issues reported to direct manager but direct manager fails to report potential issues to compliance	4
No identification or reporting of potential issues; but, issues identified through other means	5
Regulatory Reporting - Timeliness & Accuracy (inclusive of dashboard metrics and CMS/DHCS reporting requirements)	
Timely and accurate extraction, QA and delivery of metrics and/or regulatory reporting by compliance deadline	0
Accurate (QA conducted) but untimely submission by compliance deadline	1
Timely, but inaccurate/lackof QA on data upon submission by compliance deadline	2
Inaccurate and untimely data submitted by compliance deadline	3
Repeat tardiness and inaccuracies; failure to QA; missed compliance deadline for submission	4
Failure to submit data by the regulatory deadline; compliance not afforded an opportunity to QA and verify data prior to submision to CMS/DHCS	5

Internal Risk Assessment – Scoring Criteria 2 of 2

Last internal audit	
Audited within last year with no CAPs issued	0
Audited within last year with observations issued, but no CAPs	1
Audited within last year with CAPs issued	2
Targeted or ad hoc audits required within the last	3
Ineffective CAPs or repeat CAPs	4
Never audited	5
CAPs Issued (# within prior year)	
0	0
1	1
2	2
3	3
4	4
5	5
CMS NONCs (# received within the prior year)	
0	0
1	1
2	2
3	3
4	4
5	5

Direct member interaction by staff	
No	0
0	1
0	2
0	3
0	4
Yes	5
Oversight of FDR/Delegate	
No	0
0	1
0	2
0	3
0	4
Yes	5

Internal Risk Assessment – Current Internal Risk Scores

Department	Risk Score	Schedule(d)	Status
UM	33	2020 Q1/2020 Q4	Completed
CM	30	2021 Q1	Not Completed
Customer Service	27	2019 Q4	Completed
Quality	26	2020 Q4	Completed
Marketing	23	2021 Q4	Completed
Pharmacy	21	2020 Q3	Completed
G&A	20	2021 Q1	Completed
Production Services	19	2021 Q2	Completed
PNO / Credentialing	15	2021 Q1	Completed
Medicare Outreach	14	2021 Q4	Not Completed
Compliance	14	2021 Q1	Completed
Claims	13	2020 Q2	Completed
Human Resource	10	2021 Q3	In Progress
IT	10	2020 Q1	Completed
Finance	7		
Enrollment	3	2021 Q2	Completed

Scoring Parameters

Risk Category	Internal Business Unit	Total Risk Score Range FDR/Delegate Activity Score	Audit Recommendation
Low Risk	0 - 15	0 - 5	Routine audit at least once in 3-year audit cycle
Medium Risk	16 - 30	6 - 10	Schedule audit in Year 1 or Year 2 of 3- year audit cycle
Medium-High Risk	31 - 45	11 - 15	Include on annual audit work plan
High Risk	> 46	> 16	Quarterly ad hoc audits to track for and validate improvements; persistent fails for FDRs/Delegates may require revocation of delegated functions or contract termination; persistent fails for business units may require HR and/or Senior Management interventions on escalation of disciplinary standards

Audit Work Plan

Santa Clara Family Health Plan

COMBINED 3-YEAR AUDIT SCHEDULE

Year	Internal/ External	Q1		Q2		Q3		Q4	
		Medi-Cal	CMC	Medi-Cal	CMC	Medi-Cal	CMC	Medi-Cal	CMC
2020	Internal	SCFHP Website IT (Security Risk Assessment)*		Claims		Compliance*		Quality Improvement	
			UM				Pharmacy		UM SCFHP Website
	External	Hanna		MedImpact		New Directions			VHP PMGSJ
		Language Line		Cal IPA		Kaiser			
2021	Internal	CM Grievance and Appeals		Enrollment Production Services		Compliance* Human Resources		SCFHP Website Medicare Outreach	
	External	Change Healthcare		MedImpact VSP		Carenet Docustream		VerifPoint Arvato	
		NEMS		CHDP Gateway		Kaiser PCNC		PMGSJ VHP	
2022	Internal			UM		Compliance Grievance and Appeals		SCFHP Website	
	External	NovaTrans		Arvato Carenet VSP		Kaiser PCNC NEMS	MedImpact	PMGSJ VHP	
					Silver & Fit				

Santa Clara Family Health Plan™

Risk Assessment and Audit Work Plan

February 2022

SANTA CLARA COUNTY HEALTH AUTHORITY
d/b/a
SANTA CLARA FAMILY HEALTH PLAN

Compliance Program
2022

Governing Board approval date: December 16, 2021

Compliance Program Overview

Santa Clara County Health Authority d/b/a Santa Clara Family Health Plan ("SCFHP" or "Plan") has developed this Compliance Program to provide guidance and ensure its activities as a Medi-Cal Managed Care Plan, ~~and~~ a Cal MediConnect Managed Care Plan, and a soon to be Medicare Advantage Prescription Drug Plan (MAPD) with Medicare Parts C and D, are conducted in an ethical and legal manner, in accordance with the 3-way Contract between the United States Department of Health and Human Services Centers for Medicare and Medicaid Services ("CMS"), the California Department of Health Care Services ("DHCS"), and the Plan; the Plan's Medi-Cal contract with DHCS; the Plan's Standards of Conduct and policies and procedures; and with applicable State and Federal law and regulations. The Compliance Program includes seven core elements and focus on the following areas: oversight of first tier, downstream and related entities (FDRs), and fraud, waste and abuse (FWA) prevention, detection and correction principles. These elements serve as the directional basis and source of guidance for development of operational and oversight policies and procedures for all Plan lines of business. This Compliance Program also articulates the framework and guiding principles for how the Plan will effectively ensure its compliance with applicable program requirements. The Compliance Program reflects the Plan's commitment to compliance with all applicable program requirements, including all applicable Federal and State standards. It is updated annually, and as appropriate from time-to time, and such updates are reviewed, approved and adopted by the Plan's Compliance Committee and Governing Board ("Board").

The Compliance Program described herein governs the activities of the Plan's employees (including temporary staff), contractors and volunteers, as well as Board and Committee members, collectively referred to as "Personnel."

The Compliance Program also applies to any subcontractors, vendors, agents or entities otherwise defined as FDRs under the Centers for Medicare & Medicaid Services (CMS) regulations and guidance, to whom Plan has delegated administrative or health care service functions relating to the Plan's 3-Way contract, Medicare Parts C and D, and their employees (including temporary staff) and contractors who provide health and/or administrative services in connection with Plan's Cal Medi-Connect plan or that relate to Plan's Medicare functions.

The information contained in this Compliance Program is effective as of the date of approval by the Board.

Element I: Written Policies and Procedures and Standards of Conduct

SCFHP's Standards of Conduct is a policy and reference guide that describes the Plan's Standards of Conduct and Code of Ethics, including by way of practical application of the organization's core values and cultural attributes. This document sets forth the expectation of employees to report instances of potential non-compliance and Fraud Waste and Abuse ("FWA"). The Standards of Conduct, together with Plan's policies and procedures, are accessible to all employees within a shared location and demonstrate the Plan's commitment to comply with all applicable Federal and State laws and regulations. It is the Plan Leadership's expectation that all Personnel and FDRs shall adhere to the Plan's Standards of Conduct and policies and procedures, as well as applicable law, in the course of performing their duties on behalf of the Plan and its enrolled beneficiaries. This expectation is promoted through communications and training, and enforced through disciplinary, contractual and other standards.

The Standards of Conduct emphasize the need to maintain a high ethical standard for individual and organizational behavior and legal business practices. In addition, the Standards of Conduct and our policies and procedures provide practical guidance for Personnel and FDRs for effectuating compliance with law and promoting ethical and business practices in their daily roles. In doing so, the Standards of Conduct and our policies and procedures support the Plan's FWA prevention, detection and correction efforts, including but not limited to :

- Federal and state False Claims Acts;
- Federal and state Anti-Kickback Statutes;
- Health Insurance Portability and Accountability Act of 1996, as amended;
- Prohibition on inducements to beneficiaries; and
- Plan Conflict of Interest rules.

The Standards of Conduct, as well as SCFHP's policies and procedures, also describes the process that any and all Personnel and FDRs (and their employees) are expected to use to report possible compliance and FWA issues to management, or anonymously using the Plan's free hotline, and includes a statement of non-intimidation and non-retaliation for good faith participation in the Compliance Program. Disciplinary actions, such as suspension or termination of employment, termination of contractual relationship or removal from office or Board membership may be taken for failure to comply with the Standards of Conduct. Reported issues are investigated and resolved in accordance with Plan's established policies and procedures.

FDRs to whom Plan has delegated administrative or health care service functions relating to the Plan's Three-way contract may either adopt the Plan's policies and procedures (as relevant to delegated functions) and Standards of Conduct (as provided upon contracting and annually thereafter) or implement their own policies, procedures, and/or standards of conduct consistent with Plan's and in full compliance with DHCS, DMHC and CMS requirements. FDRs shall distribute such Standards of Conduct and/or policies and procedures to their employees upon hire, appointment or contracting, at any time material revisions are made, and annually thereafter. The FDR's compliance program, policies, procedures and standards of conduct are subject to review upon audit by the Plan.

The Standards of Conduct is presented to Personnel at the time of hire, appointment or contracting and any time material revisions are made. All Personnel must attest that they have read and agree to comply with the Standards of Conduct and guidelines. Such attestations are kept with the employee or other individual's record. Attestations of FDRs and their employees concerning receipt of the relevant materials are maintained by the FDRs and can be audited by the Plan at any time.

In addition to the Standards of Conduct, Plan has issued and implemented policies and procedures that are detailed and specific, and describe the operation of the Compliance Program. Compliance policies and procedures are reviewed and updated as necessary, but no less than annually, to incorporate any relevant changes in applicable laws, regulations and other program requirements. Proposed revisions are developed under the direction of the Chief Compliance Officer, referred to the Compliance Committee for review and approval, and reported to the Board.

Element II: Compliance Officer, Compliance Committee and High Level Oversight

The success of the Compliance Program is the responsibility of many individuals within the Plan. The Chief Compliance Officer, Senior Management, the Compliance Committee and the Board all play an important role in the implementation and success of the Compliance Program. As used in this Compliance Program, the phrase "Senior Management" refers to the Chief Executive Officer, the Chief Operating Officer, the Chief Financial Officer, the Chief Medical Officer, the Chief Information Officer, the Vice President of Human Resources, the Vice President of Marketing and Enrollment, and such other executive level staff as may join the organization.

The sections below serve to describe the responsibilities of the Chief Compliance Officer, Compliance Committee, the Board and Senior Management.

A. The **Chief Compliance Officer** (CCO) serves as the Compliance Officer (as the term is used within Chapters 9 and 21 of the Prescription Drug Benefit Manual and Medicare Managed Care Manual, respectively) and is an employee of, and reports directly to, the Plan's CEO and Board. The CCO has detailed involvement in, and familiarity with, the Plan's operational and compliance activities (but shall be independent from, and not have direct responsibility over program operations). The CCO is responsible for implementing the Compliance Program to define the program structure, educational requirements, reporting and compliant mechanisms, response and correction procedures, and compliance expectations of all Personnel and FDRs, in accordance with regulatory requirements.. The CCO is also a member of Senior Management and has direct access to the Plan's Chief Executive Officer (CEO) and the Board, and is provided with sufficient resources and authority to effectively carry out his or her duties.

The CCO shall have the authority to:

- Provide periodic written and/or in-person reports (as appropriate) directly to the Governing Board;
- Interview or delegate the responsibility to interview Plan employees and other relevant individuals;
- Review and retain company contracts and other documents pertinent to the Medi-Cal and Cal MediConnect programs;
- Review or delegate the responsibility to review the submission of data to CMS and DHCS to ensure that it is accurate and in compliance with their respective reporting requirements;
- Independently seek advice from legal counsel;
- Report misconduct and potential FWA to CMS, its designee and/or law enforcement;
- Conduct and direct audits and investigations of any first tier entities, downstream entities, or related entities;
- Conduct and/or direct audits of any area or function involved with Medi-Cal or Cal MediConnect plans (excluding those conducted under the purview of SCFHP's Executive/Finance Committee, such as external financial audits);
- Recommend policy, procedure and process changes;
- Enforce compliance program requirements at all levels of the Plan organization.

The duties for which the CCO is responsible include, but are not limited to:

- Communicating regularly with and reporting to the Board, Senior Management and the Compliance Committee on the status of the Compliance Program, including issues identified, investigated and resolved;
- Developing, implementing, managing, and monitoring the effectiveness of the Compliance Program and ensuring that the Board and Senior Management are aware of performance metrics and potential issues and their potential solutions;
- Identification and resolution of potential or actual instances of noncompliance or FWA;
- Creating, coordinating, and/or participating in educational training programs to ensure Personnel and FDRs are knowledgeable of Plan's Compliance Program, Standards of Conduct, operational and compliance policies and procedures, and applicable statutory, regulatory, and other program requirements;
- Monitoring Federal and State legal and regulatory developments (including but not limited to, Fraud Alerts and Advisory Opinions issued by the U.S. Department of Health and Human Services' Office of Inspector General (OIG) and Health Plan Management Systems (HPMS) memos and updating the Compliance Program as appropriate);
- Developing, maintaining and promoting use of retribution-free methods and programs for reporting in good faith suspected Medicare program non-compliance, misconduct or potential FWA by Personnel, FDRs or others;
- Working with Human Resources to ensure that the Plan conducts appropriate background checks, including routine screening, against all required exclusion lists;
- Developing risk analyses that are used to focus Compliance Program efforts in a manner designed to promote overall effectiveness;
- Developing and monitoring the implementation of, and adherence to, compliance policies and procedures through the creation and implementation of a compliance work plan (Work Plan) that defines internal monitoring, audit requirements, schedule and methodology;
- Maintaining documentation and tracking of each report of potential non-compliance and FWA received through any of the reporting methodologies or as self-identified through monitoring, auditing or other means;
- Conducting self-evaluations of the Compliance Program to assess overall effectiveness and identify areas for improvement;
- Conducting (or evaluating information obtained from) exit interviews; and,
- Responding to reports of potential instances of FWA, including through coordination of internal investigations and the development of appropriate corrective or disciplinary actions, or referral to law enforcement, as necessary.

B. The **Compliance Committee** assists the Plan's Board in the oversight of the Compliance Program and is accountable to provide support and guidance necessary to the CCO in overseeing the outcomes and performance of activities initiated under the Compliance Program. The Compliance Committee,

through the CCO, shall periodically report directly to the Board on the activities and status of the Compliance Program, including issues identified, investigated, and resolved by the Compliance Program.

The Compliance Committee shall include individuals from a variety of backgrounds to support the CCO in implementing the Compliance Program. Such members shall have both decision-making authority and understanding of vulnerabilities within their areas of expertise. Members shall include representatives from areas including, but not necessarily limited to, finance, health plan operations (including enrollment, appeals and grievances, and customer service), medical management, pharmacy services, quality improvement, marketing and sales, information technology and legal counsel. The Compliance Committee is a Brown Act Committee. The CCO will act as the Compliance Committee chairperson.

The Committee may invite other individuals, such as members of management, auditors, or other technical experts to attend meetings and provide pertinent information, as necessary.

The Committee has been delegated by the Board to uphold certain responsibilities, including but not limited to:

- Meeting on a quarterly basis, or more frequently as necessary, to enable reasonable oversight of the Compliance Program;
- Development, implementation and annual review and approval of compliance policies;
- Reviewing and approving relevant compliance documents, including but not limited to:
    - CCO's performance goals;
    - Compliance and FWA training;
    - Compliance risk assessment;
    - Compliance and FWA monitoring and auditing Work Plan and audit results; and
    - Corrective action plans resulting from audits or other means of identification (and monitoring of their effectiveness);
- Developing strategies to promote compliance and the detection of any potential compliance violations, especially as they relate to core beneficiary protection issues such as, but not limited to, appeals and grievances, enrollment, transition, coverage determinations and exceptions;
- Reviewing effectiveness of the system of internal controls, such as dashboards, scorecards, self-assessment tools, etc. designed to reveal compliance issues or FWA issues, and metrics concerning operational compliance with key Medicare regulatory requirements, such as, but not limited to, those governing enrollment, appeals and grievances, and prescription drug benefit administration; and
- Ensuring that SCFHP has an easy to use system for employees and FDRs to ask compliance questions and report potential instances of noncompliance and potential FWA confidentially or anonymously (if desired) without fear of retaliation

The Compliance Committee will collect and review measurable evidence (using tools such as dashboards reports, scorecards and key performance indicators) concerning Compliance Program

performance as a concrete means of measuring/demonstrating the extent to which the Compliance Program is detecting and correcting noncompliance and FWA on a timely basis, and providing insights into any potential needed process improvements. The CCO will provide the Compliance Committee with data showing the status of organizational compliance through:

- Use of monitoring tools to track and review open/closed corrective action plans, FDR compliance, Notices of Non-Compliance, Warning Letters, CMS sanctions, marketing material approval rates, training completion/pass rates, results of CMS readiness checklist review, past performance review metrics, etc.;
- Implementation of new or updated Medicare program requirements (*e.g.*, tracking HPMS memo from receipt to implementation) including monitoring or auditing and quality control measures to confirm appropriate and timely implementation;
- Increase or decrease in number and/or severity of complaints from employees, FDRs, providers, or beneficiaries through customer service calls or the Complaint Tracking Module (CTM), including those relating to alleged marketing misrepresentations, etc.;
- Timely response to reported instances of potential noncompliance and FWA (including issues raised by CMS), and effective resolution (*i.e.*, non-recurring issues);
- Application of consistent, timely and appropriate disciplinary action; and
- Detection of noncompliance and FWA issues through monitoring and auditing:
    - Whether root cause was determined and corrective action appropriately and timely implemented and tested for effectiveness;
    - Detection of FWA trends and schemes via, for instance, daily claims reviews, outlier reports, pharmacy audits, etc.; and
    - Actions taken in response to non-compliance or FWA reports submitted by FDRs.

C. The governing body providing appropriate oversight of the Compliance Program is SCFHP's Board. The Board reviews and approves the Compliance Program and subsequent updates as revisions are made. As mentioned previously, the Board has delegated certain responsibilities to the Compliance Committee, but the Board as a whole remains accountable for Compliance Program oversight.

In addition to the above, the duties for which the Board is responsible include, but are not limited to, active oversight of the effectiveness of the Compliance Program and compliance results as follows:

- Understanding the Compliance Program structure, content and operation (including through appropriate training that educates Board Members regarding the Compliance Program operations, compliance risks and strategies and methods of gauging Compliance Program effectiveness);
- Evaluation of SCFHP's Senior Management team's commitment to ethics and the Compliance Program;
- Reviewing, understanding and questioning information provided within reports presented to them, including by the CCO, at least quarterly, on the activities of the Compliance Program. Such activities include, but are not limited to, actively considering:

  - Compliance Program outcomes (such as results of internal and external audits);
  - The effectiveness of corrective action plans implemented in response to identified issues;
  - Governmental compliance enforcement activity, such as Notices of Non-Compliance, Warning Letters, Corrective Action Plan requests, contract actions and/or other sanctions;
  - Reports of potential noncompliance and/or FWA issues identified, investigated, and resolved;
  - Identified risks and mitigation performed; and
  - The results of performance and effectiveness assessments (including self-assessments) of the Compliance Program;
- Conducting follow-up on issues and taking appropriate action when necessary; and
- Approval of Standards of Conduct and Compliance Program (and modifications thereto).

The Board shall document in meeting minutes and related records its active engagement in the oversight of the Compliance Program and include documentation of the Board's discussion, follow-up on issues and actions taken in response and to ensure an effective Compliance Program.

D. Senior Management

The CCO shall provide SCFHP's CEO with periodic reports of risk areas facing the organization, the strategies being implemented to address them, and the results of those strategies. The CCO shall notify the CEO and the Senior Management team, as appropriate, of all governmental compliance enforcement activity, including the issuance of Notices of Non-compliance, Warning Letters, Corrective Action Plan requests, and contract actions and/or other sanctions, and seek consultation and assistance regarding how best to respond to and address the same.

Element III: Effective Training and Education

A. General Compliance Training

SCFHP provides a comprehensive education and training program to ensure communication and understanding of the Compliance Program and SCFHP's Standards of Conduct and Compliance policies and procedures. The education, training and communication program is designed to ensure that all Personnel (including without limitation the CEO, Senior Management and Board members), and any other applicable individual acting on behalf of SCFHP in connection with its Medicare program(s), such as FDRs and their employees, are fully capable of carrying out their duties in compliance with the Compliance Program, Standards of Conduct and relevant policies and procedures. The education program includes general Compliance Program awareness training, and specific training and education tailored to individuals' roles and responsibilities, delivered by the Compliance Department or operational business units. For example, employees whose job primarily focuses on enrollment or claims would receive additional training in these areas.

Compliance Program education and training occurs within ninety (90) days of hire (or appointment to Board), and, at a minimum, annually thereafter. The education and training may be provided through a variety of teaching methods, including classroom study, computer-based training, and distance learning. Additional tools may be used to communicate the Compliance Program process, such as use of posters, written Compliance Program updates, internet and intranet resources, and topical newsletters and other publications. SCFHP shall document and/or maintain records of Personnel who complete the required Compliance Program education and training in a format that is easily accessible. SCFHP shall implement controls to ensure that all Personnel are trained, as required. SCFHP shall review and update the general Compliance Program training, as necessary, whenever there are material changes in statute, regulation or Medicare Part C or Part D program guidance, and at least annually.

B. FWA Training

SCFHP provides Personnel with standard FWA training within ninety (90) days of initial hiring (or appointment to the Board), and annually thereafter. SCFHP may require that particular individuals participate in specialized or refresher training on issues posing FWA or other risks relevant to the individual's particular job function. Training may be required, as appropriate, when the Plan's program requirements change, when an individual is found to be non-compliant or needs additional training, or when training is appropriate to address an identified organizational deficiency or with respect to an area where FWA was identified in the past or presents heightened risk.

C. First Tier, Downstream and Related Entity Training

SCFHP requires FDRs, to whom SCFHP has delegated administrative or health care service functions relating to SCFHP's regulatory contract(s), to conduct training that meets CMS training requirements and is consistent with SCFHP's training materials. SCFHP shall accept the

certificate of completion of the CMS Standardized General Compliance Program Training and Education Module as satisfaction of the training requirement.

Any FDR that has met the FWA certification requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) supplier is deemed to have met, and fully satisfied, SCFHP's training and educational requirements related to FWA. In such context, no additional documentation beyond the documentation necessary for proper credentialing is required to establish that an employee or FDR or employee of an FDR has met SCFHP's FWA training requirements. In the case of chains, such as chain pharmacies, each individual location must be enrolled into Medicare Part A or B to be deemed. Such deemed individuals must, however, participate in the CMS general Medicare compliance training. FDRs that do not qualify for deeming status must take both the General Compliance and the FWA training programs offered by CMS.

Element IV: Effective Lines of Communication

SCFHP has established numerous mechanisms to ensure effective lines of communication exist between the CCO, members of the Compliance Committee, Personnel (including the Board) and SCFHP's FDRs (and their employees).

For instances, in order to facilitate communication among all Personnel, FDRs and the CCO, SCFHP offers a phone hotline, available 24 hours a day, 7 days a week, which can be used anonymously if preferred, through which an individual may seek guidance or disclose information about potential compliance or FWA issues. Through Compliance Program activities, Personnel and FDRs are encouraged to ask compliance and FWA related questions through various means, such as direct contact with the CCO, in order to assist such individuals in evaluating and dealing with suspected, detected or reported compliance or FWA issues. The CCO shall treat all communications confidential. The CCO also communicates with Personnel, FDRs and enrollees concerning compliance and FWA issues through various educational mechanisms, as discussed more fully below.

A. Procedures for Reporting Noncompliant or Unethical Behavior

All Personnel and FDRs are required to report compliance concerns and suspected or actual violations related to SCFHP's programs to SCFHP. The reporting process set forth in this Compliance Program, as well as CCO name and contact information, is communicated to Personnel and FDRs and their employees through various means, including general Compliance Program training. An individual may confidentially report compliance and FWA concerns in multiple ways, at their option, including: 1) directly to his/her supervisor or manager (as applicable), 2) to SCFHP's CCO, or 3) anonymously using SCFHP's toll-free phone hotline reporting tool (available 24/7). SCFHP's non-intimidation and non-retaliation policy provides the individual who makes a report, complaint, or inquiry in good faith with protection from retaliatory action, including with respect to reporting of False Claims Act complaints and/or reporting to appropriate officials. SCFHP has a no tolerance policy for intimidation of, or retaliation taken against, individuals making such good faith reports, complaints or inquiries and shall take disciplinary action against individuals who are determined to have intimidated or retaliated against such individuals.

SCFHP recognizes that enrollees, contracted providers and FDRs are important sources for identifying potential non-compliance and/or FWA. SCFHP widely publicizes the methods by which individuals and entities outside the SCFHP organization can report possible instances of fraud, waste, abuse or non-compliance to the organization and can ask questions, including through the hotline (which is accessible to all).

Hotline information is provided to enrollees through the quarterly enrollee newsletter FDRs receive quarterly informational bulletins containing, as a standing item, hotline availability and reasons for use (including for compliance questions). The CCO's contact information is also always contained within these materials. SCFHP customer service representatives, who intake

calls from both enrollees and FDRs, including providers, have also been trained to recognize potential instances of non-compliance or FWA, and to properly memorialize and direct issues within the Plans Sponsor organization for appropriate follow-up by the CCO or others.

B. Education

The CCO engages in active communication with Personnel, FDRs and enrollees concerning a wide range of compliance issues, including the standards for compliance with laws, regulation and guidance; changes in legal authorities and/or compliance policies and procedures; and guidance on how to identify and report FWA issues. Such communication is accomplished through various educational means, including through newsletters and posters, SCFHP Websites, formal training, and individual and group meetings.

C. Follow-Up and Tracking

Once received, issues of potential non-compliance or FWA will be documented and forwarded to the CCO and/or his or her designee for investigation/resolution and reporting to the Compliance Committee and the applicable State and/or Federal agency, or law enforcement, as required.

D. Integrated Communications

To enhance SCFHP's day-to-day communication, understanding and focus on its actual compliance, and to ensure that potential compliance and FWA issues are examined early and corrective actions are implemented timely, each department maintains a set of compliance "dashboard" metrics that are routinely shared with the CCO. These dashboard results are i) reported to department staff to increase their attention to compliance, and ii) reported to the CCO for monitoring and auditing activities (such as trend analysis and identification of anomalies), and to provide status of any corrective actions undertaken and implemented (including barriers to implementation). Reports on these and other compliance activities will be routinely reviewed by Senior Management and reported to the Compliance Committee and the Board at each meeting, as appropriate.

Element V: Well-Publicized Disciplinary Standards

Compliance training, in its various forms (*e.g.* mandatory formal training, newsletters, websites and posters), demonstrates practical application of the Standards of Conduct. These training programs provide instruction regarding various regulations and laws pertinent to our business, as well as "Questions and Answers" that describe the expectation that SCFHP has of Personnel when confronted with certain situations, including appropriate reporting and the duty to assist in issues resolution. These programs set forth the expectation by SCFHP of Personnel and FDRs and their employees to report illegal or unethical behavior and potential compliance and/or FWA issues, as well as to assist in their resolution. They also encourage Personnel to contact the CCO or others if they have questions concerning potential compliance or FWA issues.

In various communications, SCFHP explains the ramifications faced by SCFHP for non-compliance with regulations and laws affecting its business, as well as disciplinary action to be taken against individual(s) or entities who have either committed a crime and/or participated in or knew about potential non-compliance, unethical behavior and/or FWA, but failed to report it to SCFHP. *Disciplinary action will be assessed based on the infraction and could range from retraining of the individual/entity, up to termination of employment/Board membership/contract.*

Enforcement of the standards will be timely, consistent and effective when non-compliance or unethical behavior (such as fraud) is determined. As set forth in Element IV, Part A, employees have an affirmative obligation to identify non-compliance and unethical behaviors, and failure to meet this obligation will result in appropriate action according to the disciplinary standards. Records of enforcement of standards will be maintained for ten years for all disciplinary actions based on compliance violations or FWA (or the failure to report the same), and such records will capture the date the violation was reported, a description of the violation, the date(s) of investigation, a summary of findings, the disciplinary action taken and the date it was taken. SCFHP may, from time-to time, review such records to ensure that discipline is appropriate to the seriousness of the offense, fairly and consistently applied, and imposed within a reasonable time frame after the infraction and/or discovery of such.

Finally, compliance is a measurement on SCFHP's annual employee performance evaluation to reinforce the importance that compliance plays in each individual's role within the organization. Issues of non-compliance will be considered by SCFHP in connection with whether to renew or continue any particular arrangement with an FDR.

Element VI: Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks and FWA

SCFHP will establish and implement an effective system for identification of non-compliance or unethical behavior (such as activities involving fraud and abuse) and evaluation of the Compliance Program through risk analysis, engagement in monitoring and auditing activities and review of reported issues (including any issues identified by CMS). The system will include, among other things, routine and targeted internal monitoring and auditing of operational areas and auditing and monitoring of FDRs. SCFHP may from time-to-time engage external auditors to assist with focused review of particular areas where it deems such appropriate (*e.g.*, because of expertise required or resource limitations).

Multiple methods will be employed to facilitate monitoring and auditing of operational areas in a focused and efficient manner, including without limitation conducting risk assessments, developing annual Work Plans, engaging in on-site audits or desk reviews, conducting monitoring, including through periodic reports, and analyzing and responding to such monitoring and auditing results.

A. Risk Assessment

SCFHP will regularly conduct a risk assessment of all business operational areas, and those of FDRs to whom SCFHP has delegated functions under its regulatory contract(s). Each operational area (including those delegated to FDRs) will be assessed for the types and levels of risks the area presents to the Medi-Cal and CMC programs, to SCFHP and to its Medicare-Medi-Cal beneficiaries, paying close attention to those areas CMS considers high risk, such as but not limited to:

- enrollment and disenrollment non-compliance;
- appeals and grievances;
- benefit and formulary administration;
- credentialing;
- quality assessment;
- organization determinations;
- coverage determinations;
- transition and protected class policy;
- utilization management;
- accuracy of claims processing;
- previously identified areas of vulnerability for potentially fraudulent claims;
- outbound enrollment verification calls;
- marketing and enrollment violations, agent/broker misrepresentation, and selective marketing; and
- FDR oversight and monitoring.

In addition, SCFHP's risk assessment(s) will take into account information received from the OIG’s annual work plan and Medicare Managed Care Manual and Medicare Prescription Drug

Benefit Manual chapter guidance updates, as well as other CMS program guidance, Fraud Alerts, CMS audits and other CMS indicators regarding plan performance (such as Warning Letter, Deficiency Notices, audit results, etc.). The risk assessment will expressly take into account CMS guidance provided concerning its prior year audits findings and any recent interim sanction or civil monetary penalties assessed by the agency, as well as DHCS Policy, All Plan and Dual Plan Letters, and DHCS and DMHC audit findings. The CCO will rank those risks identified during this process in order to identify those areas presenting the greatest potential risk to SCFHP. Risks identified through CMS audits and oversight, as well as SCFHP's own monitoring, auditing and investigations, will be considered priority items in the overall risk analysis. The CCO will develop the proposed annual Work Plan in consultation with the Compliance Committee and/or departmental staff as appropriate, taking into account the results of the risk assessment.

B. Annual Monitoring and Auditing Work Plan

An annual Work Plan, based on the results of the risk assessment, will be developed and brought to the Compliance Committee for review, input and approval. The Work Plan will include the audits to be performed (both of SCFHP and FDRs), the audit schedule, methodology to be used, if it is to be performed desktop and/or onsite, and the responsible party for performing the audit, as well as specify routine monitoring to be conducted. Such monitoring and auditing activities are designed to test controls and prevent, detect and correct compliance issues and FWA through verification of compliance standards and adherence to State and Federal laws, contractual requirements, Medicare regulatory requirements, Part C and Part D program instruction, SCFHP Compliance Program policy and procedures, and Standards of Conduct. During the course of the year, the CCO may propose modifications to the Work Plan to the Compliance Committee, as developments warrant (such as changes in law or identified compliance or FWA issues).

C. Audits

The Compliance Department, which is independent from the Plan’s daily operations, will perform, or will arrange for independent, external parties to perform, audits of SCFHP’s internal operations and FDRs. The CCO shall coordinate with auditors regarding audit design and related considerations, and receive regular reports from the auditors regarding audit status and results. Auditors will be directed to use a standard audit report format addressing audit objectives, scope and methodology, findings (including regarding condition, cause and effect), and recommendations. They will use care in selecting sample and sample size, based on whether a targeted or statistically valid sample is intended. Auditors shall be knowledgeable about CMS and DHCS operational requirements for the operational areas (whether internal or of FDRs) under review. Operations staff may assist auditors, as long as such assistance does not interfere with the auditors' independent review. Such assistance can take the form of gathering data for samples or providing other basic information to auditors. Auditors shall have access to relevant Personnel, records and areas of operation under review, including the operational departments at SCFHP, as well as FDR employees and operations. All Personnel and FDRs have a duty to cooperate with monitoring and auditing efforts directed by the CCO.

D. Monitoring

Routine operational metrics relative to regulatory standards and compliance measures will be maintained by the business units and the results reported to the CCO. Monitoring will also be conducted in each instance to determine whether corrective action plans are effective in addressing the compliance issue identified.

E. Analyzing and Responding to Monitoring and Auditing Results

Results of audits and monitoring, and any required root cause analyses and corrective action plans will be reported by the CCO (or his or her designee) to the Compliance Committee and, as appropriate, Senior Management (including the CEO) and/or the Board. Audit findings will also serve to identify Personnel, business units and/or FDRs requiring additional training (general or focused); the need for clarification or amendment of policies and/or procedures; the need for correction of system logic; and/or other necessary actions. The CCO shall be responsible for overseeing follow-up reviews of areas found to be non-compliant, as necessary, to determine if implemented corrective action has fully addressed the underlying problem identified. If applicable and appropriate, the CCO will consider whether to voluntarily self-report audit findings of non-compliance and/or potential fraud or misconduct related to the Plan's programs to CMS or its designee, such as the National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC), DHCS or DMHC.

F. Excluded Parties

SCFHP, in an effort to prevent FWA, shall screen Personnel against United States Department of Health & Human Services' (DHHS) OIG List of Excluded Individuals and Entities and the General Services Administration's (GSA) Excluded Parties Lists System, prior to hiring or contracting and monthly thereafter, to ensure that such individual or entity does not appear on such list(s) (*i.e.*, is not an excluded individual or entity). SCFHP also requires its FDRs to have a similar policy and audits accordingly to ensure compliance with such requirements.

G. Compliance Program Effectiveness

SCFHP is committed to a process of continual process improvement with respect to its Compliance Program. As such, SCFHP will conduct an annual audit of the effectiveness of the Compliance Program. After completion of a baseline compliance program effectiveness audit, such audit will be conducted by external auditors (or Personnel not part of the Compliance department). To assist in determining effectiveness, the Compliance Committee will annually evaluate whether activities under the Work Plan were completed in a timely and appropriate manner, actual performance of the CCO against performance goals (if relevant), CMS compliance assessments *(e.g.*, Warning Letters, Notices of Non-compliance, CAP requests, audits, sanctions), results of CMS readiness checklist assessment, and past performance review measurements as they relate to compliance. Results of this audit will be shared with the Compliance Committee, Senior Management and the Board. Either the CCO, Compliance Committee and/or the Board may recommend modifications, such as enhancing or increasing internal monitoring frequency in areas that have previous low threshold results or areas that have become the subject of increased

scrutiny (through regulation, audit or guidance), by state and/or federal regulatory agencies, including but not limited to CMS or the OIG.

Element VII: Procedures and System for Prompt Response to Compliance and FWA Issues

SCFHP has established and will maintain a process for assuring prompt response to reports or other identification of potential non-compliance and/or FWA, including timely investigation of potential problems, implementation of corrective actions to address past issues and mitigate future occurrences; appropriate self-reporting of fraud and misconduct, and processes to ensure appropriate action is taken with regard to identified overpayments.

A. Investigations of Compliance and FWA Issues

SCFHP will establish and implement procedures and a system for promptly responding to potential compliance and FWA issues as they are raised. Compliance or FWA problems identified in the course of self-evaluations, reports or complaints to the SCFHP, audits and/or other means and verified through investigation will be corrected promptly and thoroughly to address the issue, reduce the potential for recurrence, and promote ongoing compliance with CMS requirements. External legal counsel, auditing, and other expert resources may be engaged to provide additional services and guidance, as applicable. SCFHP will immediately cease, or instruct its FDR to immediately cease, questionable practices upon knowledge or clear indication of a violation. In addition:

- SCFHP will conduct a timely, reasonable inquiry into any evidence of misconduct related to a payment or delivery of items or services under the contract with CMS and/or DHCS (with such inquiry initiated within 2 weeks after the date the potential non-compliance or FWA incident is identified);
- SCFHP will conduct appropriate corrective actions (for example, repayment of overpayments and/or disciplinary actions against responsible individuals) in response to the potential violations referenced above; and,
- SCFHP will have procedures to consider whether to voluntarily self-report fraud or misconduct related to the Plan's programs to CMS or its designee (such as NBI MEDIC), DHCS and DMHC in appropriate situations, consistent with guidelines and time frames.

SCFHP and its Pharmacy Benefit Manager (PBM) shall monitor Fraud Alerts and will review its contractual agreements (or direct the PBM to review contractual agreements) with the identified parties, as appropriate, to determine whether any additional action should be taken. SCFHP and/or its PBM will review past paid claims from the identified entities to determine if there are any claims that it may have paid that were not payable (*e.g.*, related to an Excluded Individual) and should be removed for prior sets of prescription drug event drug submissions.

Responses to detected offenses will vary according to the offense and circumstance; however the response will always be in accordance with requirements of regulation and law. The CCO shall maintain a record of reported issues, including documentation of the status, investigation, finding and resolution of each issue. This information shall be reported to the Compliance Committee regularly.

Any determination that potential FWA related to the Plan's programs has occurred will be referred to the appropriate regulatory agency, as appropriate, for further investigation after the determination that a violation may have occurred. SCFHP will, as appropriate, provide information timely in response to follow-up requests for information.

B. Corrective Action Plans (CAPs)

Corrective action plans will be implemented whenever it is determined by the CCO and the Compliance Committee that any Personnel, FDRs or their employees have engaged in an activity that violated SCFHP policies and procedures, federal or state laws or regulations or CMS contractual or other requirements. These corrective action plans will be in writing and developed based on a root cause analysis conducted in response to any wrongful activity discovered by way of investigation resulting from any report, complaint, and/or internal or external audit or monitoring efforts, or as identified by CMS. Through the root cause analysis, SCFHP will undertake to determine what caused or allowed the non-compliance or FWA to occur so that an appropriate and effective remedy can be developed.

The goal of any CAP implemented is to remedy underlying issues and prevent future recurrence. Each CAP will be tailored to the particular misconduct identified and include specific time frames for completion. SCFHP will immediately cease any non-compliant practice upon knowledge or clear indication of a violation. When developing a corrective action plan to address non-compliance by an FDR, the elements of the corrective action plan, and the ramifications for non-compliance, will be included in a written CAP provided to the FDR. Corrective actions may include, for instance, disciplinary action against any Personnel; prompt identification and refund of any overpayment to the government or any enrollee; and/or suspension or termination of any FDR contract (or delegated functions thereunder).

CAPs will be monitored to ensure the required remediation has been carried out, and is sustained over time. All corrective action plans recommended, in progress, and implemented, along with results of ongoing monitoring will be documented and reported at least quarterly to the Compliance Committee and to the Board.

C. Government Investigations

SCFHP's policy is to be forthright and cooperative when dealing with government investigations, inquiries, or requests for information. Any Personnel or FDR made aware of a government investigation, inquiry or request for information is required to notify the CCO and/or Compliance Department immediately to ensure prompt response to the request(s).

Appendix A
Fraud, Waste and Abuse (FWA)
(Measures for Prevention, Detection and Correction)

SCFHP employs multiple measures to prevent, detect and correct potential instances of FWA. Many of these measures are outlined in the Compliance Program, including, for instance:

- Communicating standards of individual and organizational ethical and legal business practices in the,including compliance with Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse;
- Educating Personnel and FDRs about FWA issues through appropriate training and the sharing of educational materials;
- Communicating to all (including FDRs and enrollees) the availability of an anonymous compliance hotline for potential FWA issue reporting and asking fraud related questions;
- Engaging in monitoring and auditing of Part C and Part D operations, based on risk analyses conducted that expressly consider FWA concerns;
- Engaging in timely and vigorous investigation of suspected FWA, in whatever manner reported to SCFHP;
- Responding to identified FWA, including as appropriate, by reporting to the MEDIC and/or returning identified overpayments and making adjustments to prescription drug event or other claims payment data.

SCFHP actively engages FDRs to assist in its FWA prevention, detection and correction efforts. Thus, for instance, FDRs perform compliance and FWA related activities on SCFHP's behalf, such as monitoring, auditing and training. SCFHP performs oversight of the FWA and compliance related activities of each FDR and has processes in place to revoke delegated functions in accordance with 42 C.F.R. § 42.422.504(i)(5) and42 C.F.R. § 423.505(i)(4) and its contractual rights if such functions are not being performed satisfactorily.

If identified instances of FWA are discovered, SCFHP, directly or through its FWA/SIU vendor, engages in vigorous investigation and will, as it determines appropriate, report to CMS, the MEDIC or other appropriate regulatory or law enforcement entities.

The purpose of this Appendix is to provide additional information concerning specific measures SCFHP will use to prevent, detect and correct FWA.

Targeted Efforts

A. Credentialing

SCFHP's credentialing program for contracted providers and pharmacies is comprehensive and includes elements that have both a direct and indirect effect on the quality, delivery, and outcome of health care provided to SCFHP's members. SCFHP's credentialing program is based on National Committee for Quality Assurance (NCQA) standards and in accordance with CMS requirements.

SCFHP has contracted with a PBM to provide pharmacy benefits to its members enrolled in the Plan. By contract, the PBM employs a similar, vigorous credentialing program for each pharmacy in

SCFHP's network, with each pharmacy needing to partake in the credentialing and re-credentialing process, performed at a minimum every three years, for participation, or continued participation, within the SCFHP's network.

B. Claims Adjudication

The Plan's claims are processed on a system using adjudication rules which employ FWA edits. Thus, for instance, such adjudication rules are designed to eliminate duplicate payments for services and make payment (or denial) of claims based on SCFHP eligibility rules, contracted provider pricing, referrals and authorizations and Correct Coding Initiative (CCI) edits. In addition, Local Coverage Determinations (LCDs) and national coverage determinations (NCDs) are also reviewed to ensure payment consistent with Medicare guidelines. Claims processes also ensure claims submitted, intentionally or unintentionally, by providers who have opted out of Medicare are not paid. Finally, certain check run controls are also in place to prevent inappropriate payments under Medicare or Medi-Cal.

Similarly, Part D has point of sale system edits that ensure appropriate authorizations are in place before dispensing and that prevent SCFHP from paying for prescriptions written by excluded prescribers.

C. Auditing and Data Analytics

SCFHP engages in auditing -- directly or through contracted entities -- pursuant to the terms of the annual compliance Work Plan. As part of its standing audit practice, SCFHP, by engagement of an external consultant and use of internal coding staff, performs Part C retrospective coding reviews annually. The reviewers substantiate the documentation of the Hierarchical Condition Categories (HCCs) supporting the Risk Adjustment Factors (RAF) scores submitted to CMS for member premium payment. SCFHP submits "additions" *and* "deletions" as appropriate dependent upon its ability to substantiate the HCCs within the audited documentation. In addition to ensuring accurate payment is received by the SCFHP ("adds"), and paid by CMS ("deletes"), these reviews can reveal potential fraudulent provider documentation practices and allow SCFHP to take corrective actions, as appropriate. It also allows SCFHP to identify providers who may need additional training regarding the appropriate provision of encounter data.

Where claims administration is delegated to an FDR, SCFHP audits the FDR annually for proof of data integrity, timeliness of claims payment, proper payment consistent with contractual and other requirements, and proper payment amounts.

Similarly, SCFHP has engaged its PBM to engage in analysis of pharmacy, prescribing provider, and beneficiary data to detect potentially defective claims. Such data analysis is a tool for identifying coverage and payment errors, and other indicators of potential FWA and non-compliance. To gather and analyze data to protect against FWA, on behalf of the SCFHP, the PBM, among other audits, performs retrospective (post-pay) audits. Standardized algorithms are applied to root out overpayments or erroneous payments to pharmacies. Through use of sophisticated modeling

techniques, auditors can identify patterns in the data that may indicate potential FWA that may not be readily apparent. Such data mining activities will focus on areas of concern identified by CMS in guidance and entities identified by the MEDIC, as well as known areas of potentially aberrant behavior or high incidence of fraud based on industry experience. SCFHP's PBM employs staff pharmacists, physicians and others (as appropriate) to engage in follow-up research and investigation of suspect claims.

Pharmacies within the SCFHP's network are also subject to desk top and/or onsite audit. Pharmacies can be chosen for a variety of reasons, such as aberrant claims patterns revealed through the modeling techniques noted above. Claim sample selection will focus on identifying claims and/or claims patterns that potentially deviate from the norm. SCFHP can designate particular pharmacies for in-depth audits, upon request.

If FWA is found through any of the auditing methodologies applied by the PBM, the SCFHP will receive a FWA alert and take appropriate follow-up action in a prompt manner.

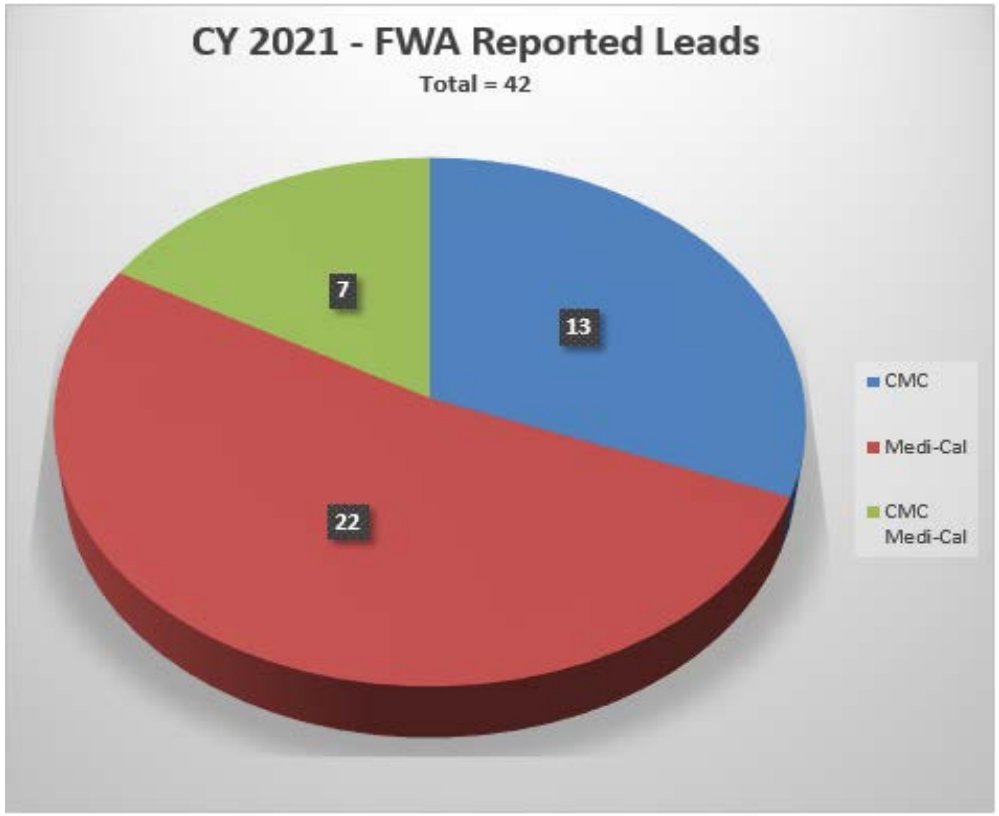
In addition to PBM audits, SCFHP receives various reports daily, weekly and monthly from the PBM. The reports are reviewed promptly and on a routine basis by the SCFHP's Pharmacy Department. Review of these reports can reveal potential fraudulent activity requiring investigation and action. Examples of reports received and reviewed regularly include (but are not limited to): summaries of controlled substances claims per member; top 3% prescribers; prescriber dispensing patterns; and FWA reports, which include results of all claims adjusted or reversed during the quarter due to audit results.

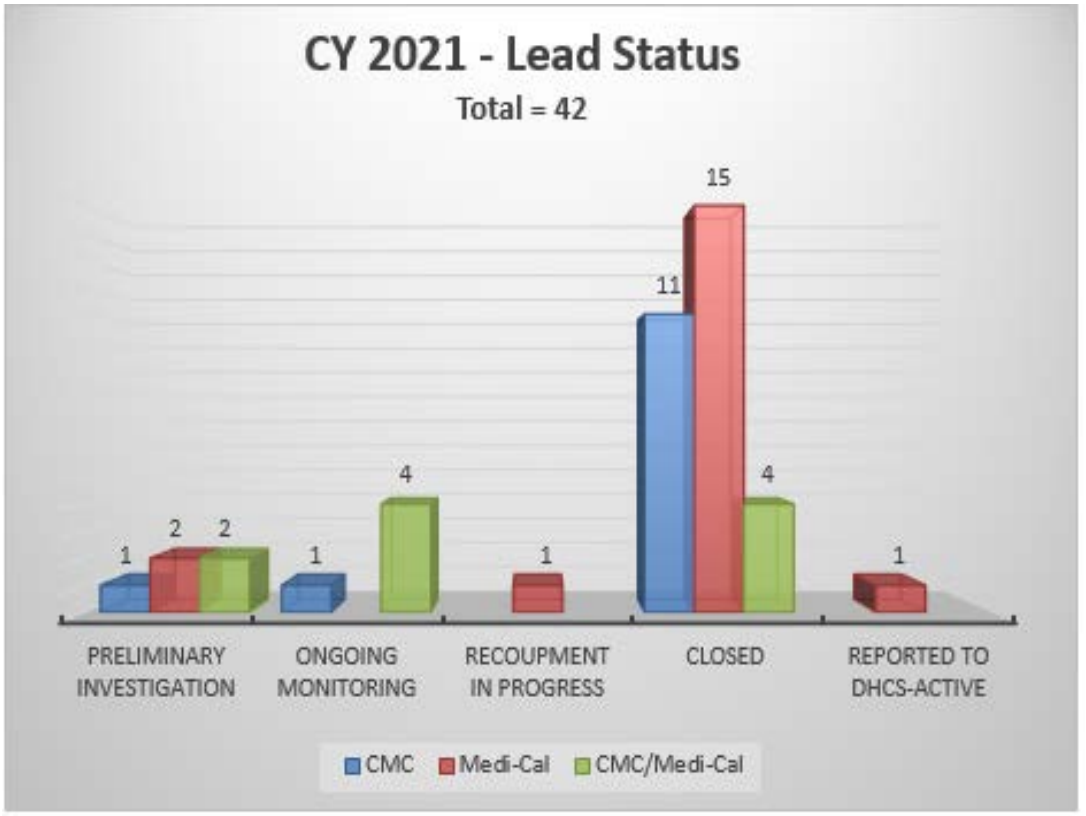
Santa Clara Family Health Plan™

Fraud, Waste, and Abuse Quarterly Report

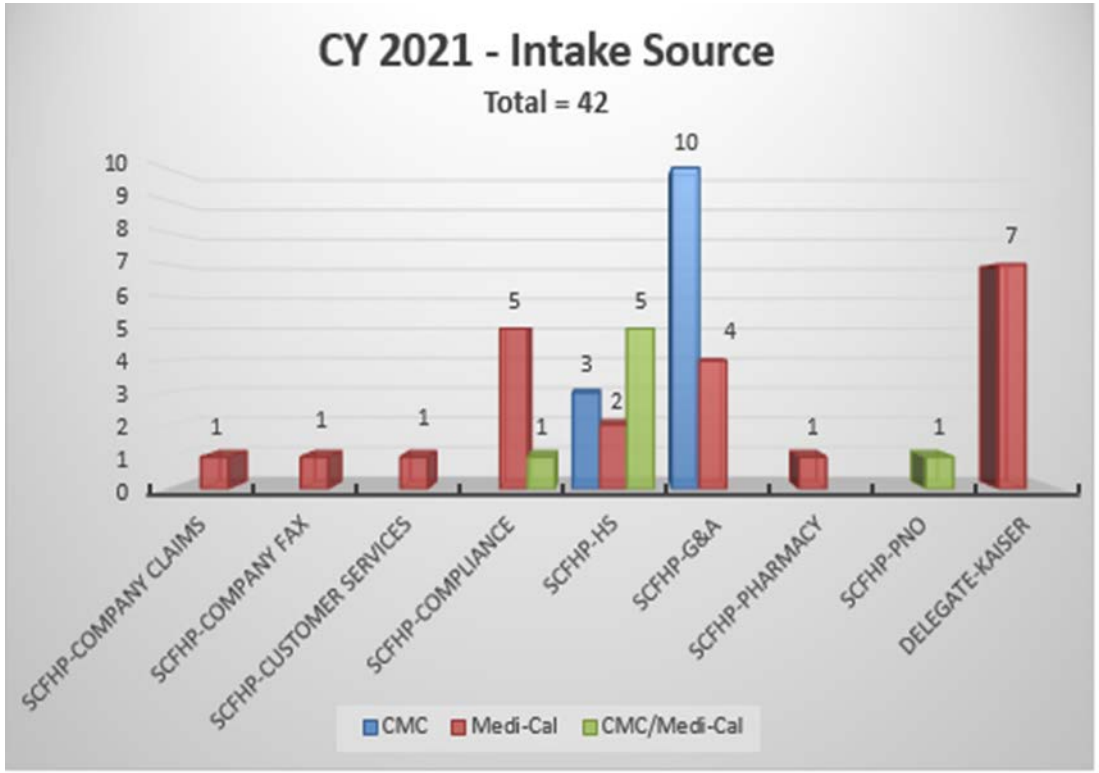
Compliance Committee Meeting – 02/24/2022

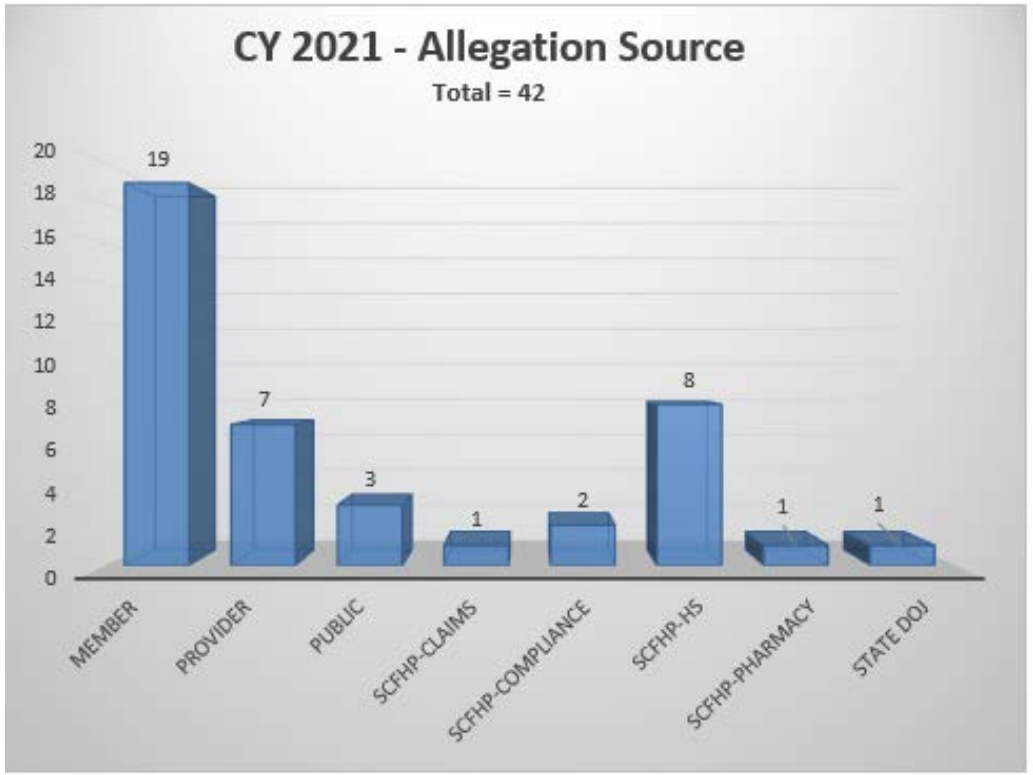
CY 2021 Report – FWA Leads





CY 2021 Report – FWA Leads (cont.)



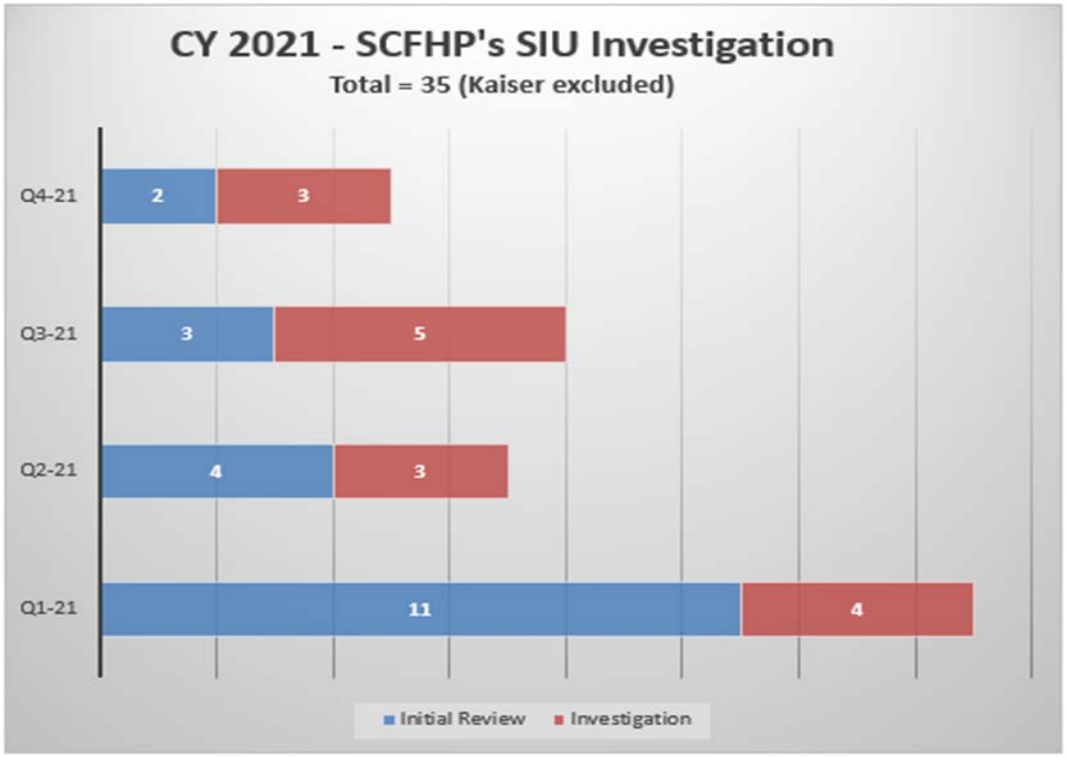


CY 2021 Report – FWA Leads (cont.)

Santa Clara Family Health Plan

CY 2021 - Allegation Type

Allegation Type	CMC	Medi-Cal	CMC/Medi-Cal	Total
Services not Rendered	4	5		9
Medically Unnecessary Services	2	1	3	6
Drug Diversion	1	3		4
Provider Fraud	1	3		4
Billing Issue	1		2	3
Identity Theft	1	2		3
Drug Seeking		3		3
Double Billing	2			2
Balance Bill	1			1
Altered Claims		1		1
Altered Documentation		1		1
Benefit Fraud		1		1
Card Sharing		1		1
Improper Opioid Prescriptions			1	1
Member Fraud		1		1
Overprescribing			1	1
YTD	13	22	7	42



CY 2021 Report – SIU Cases

SIU Case Updates
Update Date: 02/14/2022

ID	Allegation Source	Subject Investigated	Reason to Open	Status	Actions
SIU_2021_03_03_01	Member	Provider-DME	Inadequate evidence of deliveries	Closed	- Claim audit conducted - Recoupment request issued
SIU_2021_03_19_01	SCFHP-HS	Provider-Neurology	Altered claims, Upcoding	In Progress	- Medical record review conducted by external licensed specialists - Plan to request for more records
SIU_2021_03_22_01	State DOJ	Provider-Family Medicine	Charged for illegally distributing of hydrocodone and oxycodone pills in the provider's medical practice and committed health care fraud.	Closed	- Closed the provider's panel
SIU_2021_04_16_01	Non-SCFHP Member	Member-Medi-Cal	SCFHP's claims were submitted to Non-SCFHP Member's commercial insurance	Closed	- Worked with SCFHP's Third-Party vendor to identify the error.
SIU_2021_05_10_01	SCFHP-HS	Provider-Home Health Care	Suspected overprescribing (unusual number of PA requests)	Closed	- The Plan (Medical directors, PNO, G&A and Compliance) met with the Provider to discuss the problem. The Plan's request approval process was reviewed. Request for termination is postponed. Overprescribing case was closed. - A Potential Quality Issue investigation was opened and a CAP was
SIU_2021_05_05_01	Non-SCFHP Member	Member-Cal Mediconnect	Claims for services provided to an SCFHP member were submitted to a Non-SCFHP member's health insurance.	Closed	- Reported to DHCS - Reported to Social Security Administration Office - Member is no longer enrolled with SCFHP
SIU_2021_08_27_01	Member	Provider-DME	Provider, under contract with a delegate, continues to send DME supplies such as water chambers that the member no longer needs.	Closed	- Provided the responsible delegate with allegation info and requested for investigation.
SIU_2021_09_01_01	Member	Public (anonymous)	Reported a SCFHP member for welfare, food stamps, and medical fraud.	Closed	- Reported to DHCS - DHCS sent an educational letter to the member and closed the
SIU_2021_09_01_02	Member	Provider-Radiology	Member did not recognize the name of a radiologist on a letter of approved service.	Closed	- Medical charts and DME orders are being reviewed
SIU_2021_09_30_01	SCFHP-HS	Provider - DME	To endure that oxygen delivery to members has physician's order	Closed	- Documents for selected claims were reviewed and deemed compliant.
SIU_2021_09_15_01	SCFHP-Pharmacy	Member-MC	Evidence of forged medical charts/prescriptions to seek medical unnecessary procedures and non-narcotic drugs	In Progress	- Reported to DHCS - Reported to San Jose Police Department - Monitoring by SCFHP and Delegate - Provided documents to DHCS
SIU_2021_09_22_1	SCFHP-Compliance	Provider-Pediatrician	Evidence of providing medical unnecessary allergy tests	Monitoring	- Claim audit was conducted - Recoupment request was issued - Education materials were sent
SIU_2021_10_21_1	SCFHP-HS	Provider-Behavior Health	Unusual number of 60-minute sessions conducted per day	Closed	- Medical records are reviewed by Compliance and Health Services - Medical Records were reviewed and deemed compliant. Audit report sent.
SIU_2021_10_21_2	SCFHP-Compliance	Provider-Behavior Health	Unusual number of 60-minute sessions conducted per day	In Progress	- Medical records are reviewed by Compliance and Health Services - Medical Records were reviewed and deemed compliant. Audit report is being prepared.
SIU_2021_11_22_01	SCFHP-Claims	Provider - Transportation	Provider submitted claims for rides that were supposed to provide after date of death.	In Progress	- Requested for verification of at-risk claims - Sent two demand letters for a potential 7K repay - Requested provider to complete a Corrective Action Plan

Santa Clara Family Health Plan™

Fraud, Waste, and Abuse Quarterly Report

Compliance Committee Meeting – 02/24/2022