Item #15

Attachment 15.A

2018 Annual Compliance Evaluation

CALVIVA HEALTH
2018 ANNUAL REGULATORY AFFAIRS & COMPLIANCE EVALUATION

I. EXECUTIVE SUMMARY

The Compliance Program exists to ensure that all CalViva Health ("Plan") members have access to quality health care services that are in compliance with all applicable state and federal statutes and regulations, and the Plan's contractual requirements with the Department of Health Care Services. This in essence is the Plan's mission. The Compliance Program is implemented by all Plan Departments: Compliance, Medical Management, Finance and Operations. Compliance Program results are the collective achievements of individual, dedicated staff members. As will be presented below, the Plan continues to improve its policies, improve its oversight of delegates/subdelegates, increase its network adequacy, and improve quality HEDIS® outcomes. Corrective actions were required in some operational areas but overall the Plan achieved success in improving network adequacy, resolving grievances/appeals in timely manner, and providing access to services to more than 358,000 members in Fresno, Kings and Madera counties. Going forward, the Compliance Program will focus on resolving any elements identified through Corrective Action Plans (CAPs) as well as maintaining overall operational effectiveness and regulatory compliance.

II. REGULATORY AFFAIRS

A. Regulatory Reporting

As a licensed health plan, CalViva Health is required to submit a wide variety of information and data for review and approval to the Department of Managed Health Care (DMHC) in compliance with Knox-Keene regulations, and to the Department of Health Care Services (DHCS) in compliance with its contract and All Plan Letters (e.g., material modifications, amendments, undertakings, annual timely access, annual network certification, fraud waste and abuse, alleged discrimination cases, marketing and member-informing materials, new benefit-associated deliverables, changes in commission/committee members, key policies and procedures, etc.) In 2018, CalViva Health made over 150 regulatory filings to DMHC and DHCS. These filings do not include the various "routine" monthly/quarterly data reports or audit-related information that are sent to the two agencies.

B. Summary of STATE AUDITS AND CORRECTIVE ACTION PLANS (CAPS)

1. **Department of Health Care Services (DHCS):**

   a. 2017 DHCS CAP Approval – On May 8, 2018, DHCS accepted the Plan's Response to the CAP (Specialty Access, CCS-related ER Claims Processing, and State-Supported Services).

   b. April 2018 DHCS Annual Audit - The DHCS Final Report was issued on December 17, 2018 and

requested a CAP for a finding related to lack of documentation showing that new providers received the training package within 10-working days. *[The Plan filed the response to the CAP on January 18, 2019. Plan is awaiting DHCS review/approval.]*

c. February 2019 DHCS Annual Audit - DHCS initiated its 2019 Pre-Audit request for documents on November 30, 2018. *[All requested documents and case files were submitted by January 17, 2019.]* DHCS will be on–site the week of February 25, 2019 in a joint audit with the Department of Managed Care (DMHC).

d. December 2017 DHCS Encounter Data CAP – DHCS identified that the volume of encounter data submitted for Kings and Madera counties in 2015 and 2016 had trended down even though enrollment was increasing and requested the Plan to provide a CAP addressing this finding and submit any missing encounter data. The Plan largely met the DHCS December 31, 2018 due date for submitting 100% of the gap encounters. *[In January 2019, it was identified that newly discovered additional encounter data for this time period had to be submitted. Additionally, due to a DHCS delay in issuing December reports of files rejected, any rejected files could not be corrected and resubmitted by the end of 2018. Final submissions of the newly identified claims and corrections for any remaining rejections are due to DHCS by January 31, 2019.]*

e. HEDIS® 2018 Compliance Audit™ - The DHCS requires plans to undergo an annual NCQA HEDIS Compliance Audit conducted by an external quality review organization (EQRO). The EQRO, Health Services Advisory Group, Inc. (HSAG) assesses the plans' information systems (IS) capabilities and compliance with HEDIS specifications to ensure standardized reporting of performance measure results. HSAG reviews Plan data, policies and processes and conducted an onsite review of CalViva Health during March. CalViva Health received the final report in July 2018 and was deemed fully compliant with all requirements.

f. DHCS HEDIS Quality CAP received on September 25, 2018 - Focused on three measures that did not meet the minimum performance level for 3 years in Madera County: MPM-Diuretics, MPM ACE/ARB, and AAB. Plan submitted its response on October 10, 2018 and it was accepted by the DHCS.

g. DHCS 2018 Encounter Data Validation (EDV) – DHCS contracted with Health Services Advisory Group (HSAG) to conduct the EDV study for fiscal year 2017–2018. The EDV study evaluated encounter data completeness and accuracy by comparing submitted encounter data to information documented in the medical records (411 records) for sampled physician services rendered between July 1, 2016 and December 31, 2016. Preliminary study results assessing encounter data completeness and accuracy were issued on December 26, 2018. Overall, the Plan scored higher in the accuracy section and the results for all elements reviewed were comparable to statewide rates.

h. 2018 DHCS Annual Network Certification (ANC) – The Plan submitted the ANC in March of 2018 and the DHCS certified the Plan's network on July 5, 2018 stating no deficiencies.

2. Department of Managed Health Care (DMHC):

a. Measurement Year (MY) 2017 Timely Access Report (TAR) submitted in Reporting Year (YR) 2018 – The Plan submitted its annual TAR filing in March of 2018. DMHC issued preliminary findings in November 2018 and the Plan has until mid-February 2019 to respond to the findings and any deficiencies identified.

b. 2016 18-Month Follow-up Desk Audit – On April 17, 2018, the DMHC accepted the Plan's evidence that it had corrected previously identified deficiencies related to not allowing members to submit grievances on-line through the Plan's web site, not immediately informing members of their right to contact the DMHC regarding an expedited grievance, and not consistently displaying telephone numbers in 12-point boldface type in member letters.

c. February 2019 DMHC Audit – DMHC initiated its 2019 Pre-Audit Request for documents on September 28, 2018. *[All requested documents and case files were submitted by February 1, 2019.]* DMHC auditors will join DHCS auditors for the on-site audit during the week of February 25, 2019.

C. DMHC UNDERTAKINGS:

By August 31, 2018, the Plan completed the transition of remaining Kaiser-assigned members back to CalViva Health. The Plan completed its requirements to file all requested DMHC Undertakings related to the termination of the Kaiser contract by September 13, 2018. On December 7, 2018, the DMHC closed the Undertaking requirement pending the submission of a Material Modification for Alternative Access Standards, and a Significant Network Change Amendment. *[These filings were submitted by January 31, 2019]*.

D. DMHC Network Adequacy

By the end of Calendar year 2018, the Plan calculated its projected enrollment for 2020 to be 374,163 members. Based on that assumption, and current contracted full-time equivalent (FTE) PCP and Specialists with open practices, the table below shows the projected PCP to Enrollee and Total Physician (PCP and Specialist) to Enrollee ratios across the Plan's service area.

PCPs

County	Total FTE PCPs	Available FTE PCPs	Total Projected Enrollment	Projected PCP to Enrollee Ratio
Fresno	265.5	242.1	305,376	1:1,261
Kings	45.6	41.6	30,368	1:730
Madera	42.0	38.3	38,419	1:1,003
Total	**353.1**	**322.0**	**374,163**	**1:1,162**

Specialists

County	Total FTE Physicians	Available FTE Physicians	Total Projected Enrollment	Projected Physician to Enrollee Ratio
Fresno	1078.7	1038.3	305,376	1:294
Kings	184.6	177.7	30,368	1:171
Madera	334.4	321.9	38,419	1:119
Total	**1,597.7**	**1,537.9**	**374,163**	**1:243**

These ratios meet the Knox-Keene requirements for projected enrollment.

E. Fraud, Waste and Abuse Reporting:

In 2018, the Plan identified and investigated four cases which were determined to reflect a suspected fraud and/or abuse case. Accordingly, four MC609 reports were filed with the DHCS. All four were provider-related. The California Department of Justice (DOJ) has open cases on two of these four cases and has requested information from the Plan. The Plan is cooperating with the DOJ requests. These four cases were reported to DHCS within the 10 working days requirement following substantiation of potential fraud. DHCS has not informed the Plan of the outcome of the cases reported to them in 2018. There were no cases referred to other law enforcement agencies by the Plan.

F. New Benefits:

1. Behavioral Health Treatment (BHT) – Beginning July 1, 2018, DHCS began transitioning the provision of medically necessary BHT services for eligible members under 21 years of age without an ASD diagnosis, from the Regional Centers to Managed Care Plans (MCPS). Approximately 150 members were transitioned to CalViva Health providers.

2. Health Homes Program (HHP) – The HHP is an integrated service delivery system for populations with complex, chronic conditions intended to improve outcomes by reducing fragmented care and promoting patient-centered care. This program will be implemented only in Fresno County initially. In anticipation of the Plan's July 1, 2019 launch of the Health Homes Program, a Town Hall meeting was conducted in November 2018 to identify potential Community-Based Care Management Entities (CB-CMEs) within Fresno County. DMHC and DHCS filings (e.g. Plan readiness status, policies and procedures, provider network information, etc.) are due in March 2019 for this new program.

3. Palliative Care – In anticipation of the ending of DHCs' Pediatric Palliative Care Waiver Program (PPCW) as of December 31, 2018, MCPs were preparing to receive transitioning members. The Plan did not have transitioning members as of December 31, 2018.

III. Compliance Program Activities

A. Program Document Reviews/Updates:

CalViva Health continued to operate a comprehensive Compliance Program in 2018. The Plan's Compliance Program includes the following written descriptions which were reviewed and updated as necessary in 2018.

- Compliance Program Description
- Code of Conduct
- Compliance Committee Charter
- Anti-Fraud Plan
- Privacy and Security Plan
- Compliance Policies and Procedures

B. Oversight and Monitoring of Delegated Activities:

1. Delegation Oversight Audits and CAPS

The table below lists the Plan's oversight audits of functions delegated to Health Net and their subdelegates. Audits included desk reviews of policies and procedures, reports, and evidence submitted to meet the required audit elements. An onsite audit was conducted for the delegated activity of Claims.

Appeals & Grievances	Claims*	Provider Disputes*
Call Center/Mbr Services *	Cultural and Linguistics	Privacy and Security
Credentialing	Emergency Services	Utilization Management
Provider Relations/Network		

* CAPs were required for the above functions and CAPs all have been completed and approved.

2. Periodic Monitoring

During 2018, CalViva Health staff continued a wide variety of activities to provide oversight and monitoring of the functions performed by Health Net and Health Net's delegated provider groups and subcontracted health plans on CalViva Health's behalf. These activities included:

- Monthly management oversight meetings with Health Net key management staff to review reports, discuss issues and any improvement actions needed.
- Monthly/Quarterly monitoring and analysis of key performance measures and reports from delegated entities for timeliness, accuracy and issues.
- Ongoing workgroup collaborations with Health Net to ensure process integrity and contract

deliverables in the following areas:

- Grievance System
- Quality Improvement, Utilization Management and Credentialing
- Encounter Data Integrity
- Access and Availability

3. 2018 CalViva Internal Audit

During 2018, the Compliance Department conducted an internal audit of employee, Commission and Committee member files to ensure Commissioners, officers and employees completed a Statement of Economic Interests (Form 700) and/or conflict of interest disclosure statement as applicable, and that various "exclusion lists" did not identify any employees, contracted consultants, Commission or Committee members (e.g., Office of Inspector General ("OIG") exclusion list, the Medi-Cal suspended/ineligible provider lists, and licensing board sites). All files were found compliant and no CAP was issued.

4. CalViva Health Staff Trainings

A primary requirement of a successful Compliance Program is conducting ongoing education and training programs. Ongoing training helps CalViva Health staff to carry out daily Plan operations in an efficient and compliant manner. During 2018 the Plan conducted trainings for two new hires as well as the following mandatory annual staff trainings:

Compliance Program and Code of Conduct	Anti-Fraud and Abuse Program
Privacy and Security Program	Confidentiality and Conflict of Interest
Drug Free Awareness Program	Cultural Competency

All employees successfully completed all required trainings.

5. Member Communications

CalViva Health maintains a process for the review and approval of communications with members. In 2018, 69 communications were reviewed by the Plan. This included member-informing materials, health education, and information about incentive programs. It also included 12 Printed Provider Directories and 4 Member Newsletters. After a delay in receiving a Model Handbook from DMHC and DHCS, the Plan printed and distributed a final version to members by July 2018.

6. Provider Communications

CalViva Health maintains a process for the review and approval of communications to contracted providers within the CalViva Health service area.

In 2018, contracted providers were sent approximately 122 Provider Updates with information on contractual and regulatory matters as well as health plan news and announcements. CalViva Health staff also reviewed 32 informational letter templates and 26 forms intended for provider use.

7. Provider Relations

In 2018, CalViva Health continued productive relationships with participating providers by completing 3,316 provider visits throughout Fresno, Kings, and Madera Counties. Plan staff conducted routine face-to-face visits, trainings and assisted providers with Medi-Cal guidelines and CalViva Health requirements in their day to day operations.

8. Member Services Call Center

Member Services met and exceeded call performance standards in 2018.

Performance Indicators	CalViva Call Ctr.	MHN Call Ctr.
Calls Received (includes calls that were not handled by Member Services and routed out to another department and abandoned calls)	135,511	4,630
Calls Handled	133,919	4,532
Abandonment Rate % (Goal 5% or less)	1.2%	2.1%
Average Speed of Answer (Goal 30 secs) or less)	20 sec.	14 sec.
Service Level (Goal 80%)	90%	85%

9. Appeal and Grievance Resolution Summary

CalViva monitors all appeal and grievance activity on an ongoing basis. Cases are reviewed for compliance with regulatory resolution timeframes, accuracy of language used in resolution letters, correct use of approved letter templates and completeness of case records. Expedited grievances and appeals must be resolved within 72 hours and standard appeals and grievances must be resolved within 30 calendar days. Exempt grievances are grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental/investigational treatment that are resolved by the close of the next business day.

The following table summarizes the number and type of A&G cases received in 2018, and the percent resolved within the compliance turnaround times (TAT) standards. For instances of non-compliance, corrective action was implemented to ensure there would not be future similar occurrences.

	No. of Cases Received	No. of Cases Resolved †	% of Cases Resolved within TAT (No.)
Expedited Grievances	170	162	98.77 % (160)
Standard Grievances	859	807	100% (807)
Expedited Appeals	124	123	92.68% (114)
Standard Appeals	420	387	100% (387)
Total:	**1,573**	**1,479**	**99.25% (1,479)**
SPD Appeals & Grievances *	425	391	100%
Exempt Grievances #	5,286	5,286	100%

† Total will not match as some cases received in December 2018 may remain open at the start of 2019, and the resolved case number may include some cases received in December 2017 and resolved in 2018.

* The total number of A&G cases attributed to seniors and persons with disabilities (SPD).

Exempt Grievance are grievances that can be resolved within one business day.

10. Independent Medical Reviews (IMRs) and State Hearings

The following table summarizes the number of DMHC IMR and DHCS State Hearing **requests** processed by the Plan in 2018. All cases were submitted within the required turnaround times.

Cases Received	2018 Total	% Cases Submitted w/in the TAT
DMHC Cases	**68**	**100%**
DHCS State Hearings	**33**	**100%**
Total:	**101**	**100%**

IV. 2019 ACTIVITIES

In 2019, the Plan expects to undergo additional audits and reviews from regulatory agencies. The Plan anticipates developing new policies and implementing/revising processes as a result of new programs (e.g. Health Homes Program) and new regulatory guidance and laws effective in 2019. In 2019, the Plan will focus on implementation of federal regulatory changes passed as the part of the Medicaid Managed Care regulation (aka Mega-Reg) and the associated Medi-Cal contract changes mandating the Plan's implementation of the changes.

CalViva Health also expects the reporting requirements to intensify. Specifically, the DHCS will increase its oversight and monitoring of health plan activities, particularly in the following areas:

- Provider network adequacy and certification requirements
- Timely Access
- Member Grievances/Appeals and State Hearings

The Plan will need to prepare and respond to a new DHCS-required Quarterly Monitoring Report (QMRT), and new Encounter Data quality reports (Stoplight Reports).

The Compliance Department's efforts will focus on preparing for and monitoring the successful implementation of all new and current requirements.

APPROVAL:

		Date:	
Name:	Mary Beth Corrado		
Title:	Chief Compliance Officer		
		Date:	
Name:	Gregory Hund		
Title:	Chief Executive Officer		
		Date:	
Name:	David S. Hodge, M.D.		
Title:	RHA Commission Chairperson		

Item #16

Attachment 16.A

2019 Compliance Program Description

COMPLIANCE PROGRAM

For inquiries regarding this Compliance Program, please contact:

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CALVIVA HEALTH COMPLIANCE PROGRAM

I. CalViva Health Overview

The Fresno-Kings-Madera Regional Health Authority (referred to as the "RHA"), is a public entity created pursuant to a Joint Exercise of Powers Agreement between the Counties of Fresno, Kings and Madera. RHA is governed by a board ("The Commission") consisting of representatives from these three counties. On April 15, 2010, RHA Commission adopted the name "CalViva Health" under which it does business. RHA was licensed on December 30, 2010 as a full-service health care plan ("The Plan") pursuant to the provisions of the Knox-Keene Health Care Service Plan Act of 1975 as amended. RHA is licensed to offer health care services to enrollees in the Medi-Cal Managed Care Plan under the Two Plan Model in the counties of Fresno, Kings, and Madera. On December 30, 2010, RHA executed a contract with the California Department of Health Care Services ("DHCS") to provide services to Medi-Cal managed care enrollees in all zip codes in these three counties.

CalViva Health contracts with health plans, provider organizations and other contractors to provide administrative services on behalf of the Plan and/or provide health care services to CalViva Health members. These first-tier subcontractors, and their downstream contracted entities, are required to have programs, standards, policies and processes in place that comply with state and federal regulations and Medi-Cal requirements as applicable to the type of entity.

In serving its membership, CalViva Health ("CalViva" or the "Plan") is committed to establishing and maintaining its business operations in compliance with ethical standards, contractual obligations, and all applicable state and federal statutes and regulations, especially those pertaining to the Medi-Cal program. To that end, CalViva established a Compliance Program as described below.

II. Compliance Program Purpose and Objectives

The Compliance Program exists to ensure that all CalViva members have access to quality health care services that are in compliance with all applicable state and federal statutes and regulations, and CalViva's contractual requirements to DHCS.

Table 1 presents the primary objectives implicit in this purpose.

Table 1. Program Objectives

Ensure the integrity of CalViva's Health Plan by upholding the ethical standards stated in the Code of Conduct, and complying with the policies and procedures that reflect our commitment to compliance.
Develop and maintain effective communication and collaboration with CalViva employees, subcontractors and regulators in order to maintain operational and regulatory integrity.
Provide oversight of subcontractors, including auditing of delegated functions.
Detect noncompliance as soon as possible, and in cooperation with CalViva subcontractors and stakeholders, make all reasonable efforts to correct or remedy the operational factors/circumstances under which the noncompliance occurred.
Report promptly to the appropriate state and federal agencies all required or contracted operational data, and also any suspected criminal and civil violations of statutes governing the provision of health care and health care plans.
Comply with the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC) in their audits of CalViva and its providers.

Additionally, CalViva's Compliance Program is based on seven key elements stated in the Federal Sentencing Guidelines Manual as necessary for an effective compliance program:

1. Written standards of compliance
2. Designation of a Chief Compliance Officer
3. Effective education and training
4. Audits and evaluation techniques to monitor compliance
5. Reporting processes and procedures for complaints
6. Appropriate disciplinary mechanisms
7. Investigation and remediation of systemic problems

III. SCOPE

CalViva's Compliance Program oversight extends to the members of the Commission and the Commission's subcommittees, CalViva's employees and CalViva's delegated subcontractors, including contracted Knox-Keene licensed health plans, participating providers, and suppliers.

IV. AUTHORITY AND OVERSIGHT

A. GOVERNMENT AGENCIES

The following are some of the state and federal agencies that have legal authority to regulate various aspects of health care and health care plans.

- Centers for Medicare and Medicaid (CMS)
- Office of Civil Rights (OCR)
- Department of Managed Health Care (DMHC)
- Department of Health Care Services (DHCS)

By extension, CalViva assumes contractual responsibility from DHCS for assuring compliance with the regulations promulgated by these agencies and has developed various operational policies and procedures for that purpose. Section VIII of this Program Description lists the statutes and regulations that specifically relate to CalViva's Compliance Program. Moreover, these agencies have the right to access premises to determine/investigate compliance with the applicable regulations, executed contracts, and for any other reasonable purpose with or without notice to CalViva or its subcontractors and delegates.

Corporate oversight of CalViva's Compliance Program is shared by the RHA Commission, CalViva's Compliance Committee, and CalViva's Chief Compliance Officer ("CCO"). Their respective roles are briefly outlined below:

B. RHA COMMISSION

1. Bears ultimate responsibility for overseeing and supporting CalViva's operations, including the Compliance Program.
2. Reviews and approves the Compliance Program annually, including the Privacy and Security Plan, the Anti-Fraud Plan, and the Code of Conduct.
3. Reviews periodic reports of Compliance Program activities

C. THE COMPLIANCE COMMITTEE

1. Oversees CalViva's Compliance Program and advises the CCO on Program adequacy.
2. Reviews the Compliance Program annually, including the Privacy and Security Plan, the Anti-Fraud Plan, and the Code of Conduct and recommends revisions as needed.
3. Analyzes CalViva's contractual, legal, and regulatory requirements and risk areas and consults with advisors and legal counsel as necessary.
4. Monitors reports of fraud, waste and abuse, and unauthorized use and/or disclosures of personal information ("PI"), including protected health information ("PHI").
5. Reviews and approves recommendations to modify or establish internal systems and controls necessary to carry out the Compliance Program.
6. Supports investigational activities performed by the CCO, and or state and federal

officials, as they relate to violations of the federal False Claims Act, Anti-Kickback Statute, and the Health Insurance Portability and Accountability Act (HIPAA).

7. Reviews and approves disciplinary and corrective actions related to non-compliance with the Compliance Program.

D. CHIEF COMPLIANCE OFFICER (CCO)

1. Has operational accountability for the entire Compliance Program as detailed in this document.
2. Oversees the development, operation, evaluation and improvement of the Compliance Program, including corrective actions.
3. Develops the annual Compliance Program Work Plan.
4. Reports to CalViva's Chief Executive Officer and the Commission.
5. Chairs the CalViva Compliance Committee.
6. Serves as CalViva's "Anti-Fraud Officer".
7. Is the primary CalViva liaison with DHCS and DMHC.

V. COMPLIANCE RISK AREAS

The following presents just some of the potential risks associated with the delivery of health care and health plan administration. These, and many others, are the focus of the Compliance Program's due diligence in monitoring, reporting, taking corrective action and improving**.**

A. Access & Availability, and Quality of Care:

- Unavailable or inaccessible covered services to members;
- Inappropriate withholding or delay of covered services;
- Improper interference with health care professionals' advice to members regarding member's health status, medical care and treatment;
- Non-credentialed physicians or unlicensed/certified practitioners and providers;
- Discrimination on the basis of race, color, national origin, sex, age or disability.

B**.** Data Collection and Submission**:**

- Noncompliance with contractual and regulatory requirements related to the accurate, complete, timely and truthful submission of data (e.g., encounters data, claims data, financial reports and other required operational reports).

C. Member Grievance and Appeal Procedures:

- Failure to ensure that members are properly notified of their grievance and appeal

rights;
- Failure to respond and resolve member grievances and appeals within the required timeframes.

D. Emergency Services:

- Improper use of prior authorization for emergency services;
- Denial of payment for emergency services based on contractual standards, including the "prudent layperson" standard;
- Unavailable or inaccessible emergency services within the Plan's service area.

E. Kickbacks and Other Inducements:

- Willful offer, payment, solicitation or receipt of remuneration to induce the referral of business reimbursable under the Medi-Cal program;
- Inappropriate incentives or remuneration to enrollees to induce them to use a particular practitioner, provider, or supplier.

F. False Claims:

- False or fraudulent claims knowingly presented for payment or approval;
- False records or statements material to a false or fraudulent claim knowingly made, used, or caused to be made or used.

G. Confidentiality:

- Unauthorized use and or disclosure of a member's or an employee's personal information (PI) or protected health information (PHI);
- Improper disclosure of protected peer review information.

H. Excluded Providers:

- Contractual or employment relationships with persons or entities which are suspended, excluded or otherwise not eligible to participate in federal or state health care programs;
- Improper reimbursement for items or services furnished, ordered, prescribed, or supplied by an excluded person or entity;
- Failure to take appropriate corrective action upon subsequently learning of a person's or entity's excluded status.

I. Member Dis-Enrollment:

- Improper action to request or encourage an individual to dis-enroll from any health plan.

J. Marketing

- Improper or misleading marketing materials

VI. Compliance Program Elements

A. Policies and Procedures

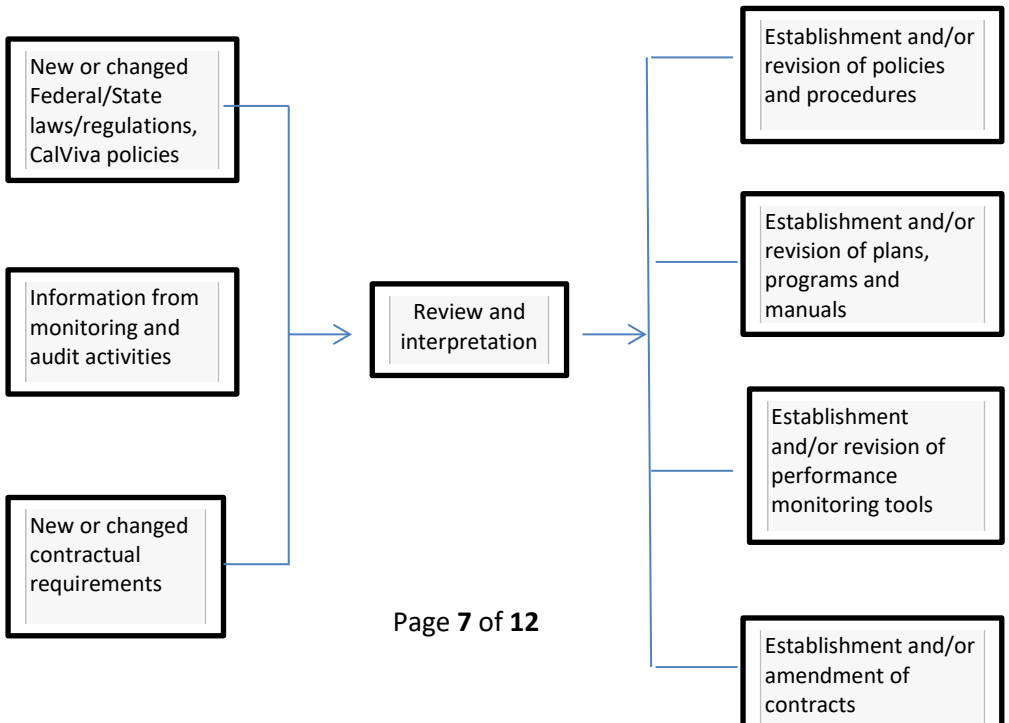
Prevention is the cornerstone to CalViva's Compliance Program. Efforts to prevent noncompliance are articulated through written policies, procedures, work plans, program descriptions and manuals. The Compliance Department staff implements the Program in collaboration with its internal stakeholders from the Medical Management and Finance Departments. CalViva's Compliance Committee or other Plan Committees, as applicable, meet regularly to review and approve proposed changes to CalViva's Policies and Procedures. CalViva maintains an on-line library of policies and procedures. Although it contains many policies, Table 2 lists those key policy topics that underpin the majority of CalViva's risk management approach and compliance methodologies. Two fundamental Compliance Program plans, the "Privacy and Security Plan" and the "Anti-Fraud Plan", are reviewed annually by the Commission and provide detailed plan requirements and activities.

Table 2. Key Compliance-Related Policy Topics

Code of Conduct	**Quality Improvement**
Conflict of Interest	**Utilization Management**
Privacy and Security	**Credentialing**
Anti-Fraud	**Peer Review**
Appeals and Grievances	**Delegation Oversight**
Claims	**Provider Disputes**

Figure 1 shows the factors that may precipitate changes in various policies, procedures, and ancillary documents.

Figure 1.



B. MONITORING

The Compliance Program incorporates periodic monitoring and auditing of its subcontractors. Mechanisms such as delegation oversight audits, case file audits, and periodic review of operational metrics are employed. Additionally, CalViva conducts joint operational and management meetings with subcontractors. Table 3 presents some of the key activities that are monitored and reported on a periodic basis (e.g., monthly, quarterly, annually).

Table 3. Activities Monitored by CalViva

Provider Network Contracting and Updating	Member Appeals and Grievances	Practitioner and Provider Credentialing
Provider Access	Facility Site Reviews & Medical Record Reviews	Encounter Data
Member Rights and Services	Cultural and Linguistic services	Claims Payment
Marketing	Provider Grievances and Disputes	Utilization Management & Case Management
Health Education	Mental Health & Behavioral Health Services	Quality Improvement
Pharmaceutical Services	Provider Training	Continuity of Care

When monitoring indicates problems, an appropriate Corrective Action Plan (CAP) is implemented to ensure issues are communicated and resolved.

C. EDUCATION AND TRAINING

The Compliance Department provides continuous training and education of its employees on their legal and ethical obligations under applicable laws, regulations and organizational policies. For example, upon completion of new hire training and annually thereafter, all employees must sign a certification statement acknowledging that they have read and understood the documents listed in Table 4.

Table 4. Program Documents

Compliance Program Description	Code of Conduct	Conflict of Interest	Anti-Fraud Plan
Privacy and Security Plan	Confidentiality Agreement	Drug and Alcohol Policy	

Contracted consultants also receive copies of the Compliance Program, Anti-Fraud Plan, Privacy and Security Plan, and Code of Conduct. They must sign a certification statement acknowledging that they have read and understand the documents.

Employees also receive training on the proper execution of key work processes. CalViva regularly reviews and updates its training programs as well as identifies additional areas of training as needed based on new developments. Information regarding these developments and their implications are also communicated to and from CalViva's contractors as applicable.

Additionally, CalViva's CCO, Management and staff receive additional education and training through professional associations, webinars and regulatory agency meetings related to federal and state requirements and compliance.

D. REPORTING NONCOMPLIANCE

Fundamental to the effectiveness of CalViva's Compliance Program is the concept of nonretaliation. All persons associated with CalViva, including its Commission members, Committees, employees, subcontractors, consultants, and vendors are free to come forward and report suspected noncompliance with the Code of Conduct, Program Documents, CalViva policy and procedures, and state and federal regulations without fear of retaliation or retribution. The following types of noncompliance are of particular concern for expeditious reporting and corrective action:

1. **Criminal and Civil Violations of Law**: CalViva conducts fact-finding activities, and reports to the proper authorities for further investigation and action, all credible, suspected occurrences of fraud, waste, abuse, kickbacks, and unauthorized uses and disclosures of protected information, including PHI.

2. **Contractual Violations**: As outlined in the "Scope of Work" section of CalViva's contract with DHCS (and occasionally as issued in DHCS "All Plan Letters"), CalViva must submit a broad range of Plan data and information to DHCS and DMHC (e.g., encounter data, grievances /appeals, provider network, timely access, etc.). Many of these reports are submitted in agency-specified formats by each Department's stated due date. Additionally, CalViva must also respond to DMHC and DHCS as it relates to members' requests for Independent Medical Reviews (IMRs) and State Hearings (SHs) by each Department's due date. Failure to comply in a timely manner to these agency's requests may result in CalViva receiving an Enforcement Action.

3. **Other Misconduct**: Those behaviors that do not comport with the general principles outlined in the Code of Conduct of treating other employees, subcontractors, providers, and Plan members with honesty, dignity, respect and courtesy.

E. RESPONSE AND CORRECTIVE ACTION

Noncompliance with, and violation of, state and federal regulations can threaten CalViva's status as a reliable and trustworthy provider capable of participating in federal health care programs. Accordingly, CalViva in cooperation with subcontractors and regulators, will make all reasonable efforts to prevent, correct and remedy the operational factors and circumstances under which such noncompliance or violations occurs. Depending on the nature, circumstances and severity of the noncompliance/violation, if any CalViva employee is determined to be involved or responsible, these efforts may include a range of disciplinary and corrective actions up to and including termination. If any consultant or subcontractor is determined to be involved or responsible, these efforts may include a range of disciplinary and corrective actions up to and including termination of CalViva's contract with the consultant or subcontractor.

VII. SUMMARY

CalViva's Compliance Program employs a comprehensive approach to ensuring its business operations are in compliance with ethical standards, contractual obligations, and all applicable state and federal statutes and regulations, including those specifically related to the Medi-Cal program. Moreover, CalViva maintains an on-going commitment to ensure that the Compliance Program remains relevant and vigilant to the requirements of a constantly evolving and regulated managed health care system.

VIII. AUTHORITY

1. Knox-Keene Health Care Service Plan Act of 1975 and its amendments (California Health and Safety Code)
2. Title 28 of the California Code of Regulations
3. Title 22 of the California Code of Regulations
4. California Welfare and Institutions Codes
5. 42 CFR 438 (Managed Care)
6. 45 CFR 160, 162, and 164 (HIPAA Privacy & Security Rules)
7. 45 CFR 92 (Anti-Discrimination)
8. California Information Practices Act of 1977 (IPA)
9. The California Confidentiality of Medical Information Act (CMIA)
10. CalViva-DHCS Medi-Cal Contract (Including all amendments)
11. Federal Sentencing Guidelines Manual: Chapter 8, §8B2.1. Effective Compliance and Ethics Program

IX. Program Documents

1. Code of Conduct
2. Anti-Fraud Plan

3. Privacy and Security Plan
4. CalViva Policies & Procedures

X. APPROVAL

	_____	_____
Name:	Mary Beth Corrado	Date
Title:	Chief Compliance Officer	
	_____	_____
Name:	Gregory Hund	Date
Title:	Chief Executive Officer	
	_____	_____
Name:	David S. Hodge, M.D.	Date
Title:	Chair, RHA Commission	

DOCUMENT HISTORY	
Date	**Comments**
03/01/2011	New Program Description
02/09/2012	Annual Update of Program Description
01/17/2013	Annual Update of Program Description
02/06/2014	Annual Review: Changes to clarify current contractual relationships and activities; comply with new regulations and Medi-Cal contract requirements
01/26/2015	Annual Review: Changes to clarify monitoring and auditing activities
02/08/2016	Annual Review, added reference document
02/02/2017	Annual Review: Program Description is replaced in its entirety. Overall content is the same; reduced duplication with other program plans, formatting, editorial and organizational enhancements to all sections.
2/1/2018	Annual Review: Deleted "Privacy & Security Officer" from the CCO's responsibilities. CalViva's COO will now serve as the "Privacy & Security Officer", and this is reflected in the Privacy and Security Plan.
01/07/19	Annual Review: No changes.

Item #17

Attachment 17.A

2019 Code of Conduct

Code of Conduct

For inquiries regarding this Code of Conduct, please contact:

Mary Beth Corrado
Chief Compliance Officer
CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711
mbcorrado@calvivahealth.org
Phone: 559-540-7847

Table of Contents

I. CalViva Health Overview:

The Fresno-Kings-Madera Regional Health Authority (referred to as the "RHA"), is a public entity created pursuant to a Joint Exercise of Powers Agreement between the Counties of Fresno, Kings and Madera. RHA is governed by a board ("The Commission") consisting of representatives from these three counties. On April 15, 2010, RHA Commission adopted the name "CalViva Health" under which it does business. RHA was licensed on December 30, 2010 as a full-service health care plan ("The Plan") pursuant to the provisions of the Knox-Keene Health Care Service Plan Act of 1975 as amended. RHA is licensed to offer health care services to enrollees in the Medi-Cal Managed Care Plan under the Two Plan Model in the counties of Fresno, Kings, and Madera. On December 30, 2010, RHA executed a contract with the California Department of Health Care Services ("DHCS") to provide services to Medi-Cal managed care enrollees in all zip codes in these three counties.

CalViva Health contracts with health plans, provider organizations and other contractors to provide administrative services on behalf of the Plan and/or provide health care services to CalViva Health members. These first-tier subcontractors and their contracted downstream, and related entities are required to have programs, standards, policies and processes in place that comply with state and federal regulations and Medi-Cal requirements as applicable to the type of entity.

II. Purpose:

All employees and all persons associated with CalViva Health, including its Commission members, delegated organizations, consultants, contracted providers and vendors, are responsible for acting in a manner consistent with the code of conduct summarized in the following general principles:

1. We will treat all members with dignity, respect and courtesy.
2. We will consistently & accurately represent ourselves & our capabilities to members the public and the Medi-Cal program.
3. We expect all employees to perform their jobs with honesty and integrity.
4. We will strive to ensure that our providers render services that meet the identified needs of our members and avoid the provision of services which are not medically necessary, effective or efficient.
5. We will strive to respond in a meaningful way to the concerns of our stakeholders, Members, Providers, Counties of Fresno, Kings, and Madera.
6. We will strive to achieve an excellent standard of performance throughout the organization.

III. Elements:

The following provisions of the CalViva Health Code of Conduct are intended to guide employees and all persons associated with CalViva Health in their day-to-day activities. The above general principles are applied in the following:

1. Member Services and Rights:

A. CalViva Health requires its providers to adopt a standard of care that reflects federal and state laws and regulations, clinical practice guidelines, and the standards of each professional discipline.

B. CalViva Health employees and providers will treat members in a manner that reflects the following rights:

1. To be treated with respect, dignity and courtesy from health plan providers and staff. Members have the right to be free from retaliation or force of any kind when making decisions about their care.

2. To be provided with free aids and services to communicate effectively with CalViva Health employees and providers and not be discriminated against on the basis of race, color, national origin, age, disability or sex.

3. To have a private relationship with their provider and to have their medical record kept confidential. To be noticed if there is a breach of their protected health information. Members also have the right to receive a copy of, amend and request corrections to their medical record. Minors have the right to certain services that do not need a parent's okay.

4. To receive information about CalViva Health, its services, its doctors and other providers. Members have the right to choose their Primary Care Physician from the doctors and clinics listed in CalViva Health's provider directory. They also have the right to get appointments within a reasonable amount of time.

5. To talk with their doctor about any care the doctor provides or recommends, discuss all treatment options, and participate in making decisions about their care. Members have the right to talk candidly to their doctor about appropriate or medically necessary treatment options for their condition, regardless of the cost or what their benefits are.

6. To receive information about treatment regardless of the cost or what their benefits are. Members have the right to say "no" to treatment. Members have a right to decide in advance how they want to be cared for in cases of a life-threatening disease, illness, or injury.

7. To complain about CalViva Health, the health plans and providers we work

with, or the care provided without fear of losing their benefits. CalViva Health will help the member with the process. If a member doesn't agree with a decision, they have the right to appeal. Members have the right to disenroll from CalViva Health whenever they want.

8. To request a State Hearing.

9. To receive emergency or urgent services as well as family planning and sexually transmitted disease services outside of CalViva Health's network. No services are covered outside the United States, except for emergency services requiring hospitalization in Canada or Mexico.

10. To request an interpreter at no charge and not use a family member or a friend to interpret. Members have the right to get the Member Handbook and other information in another language or format.

11. To receive information about member rights and responsibilities. Members have the right to make recommendations about these rights and responsibilities.

2. Provider/Vendor Relations and Contracts:

A. CalViva Health does not enter into contracts or other arrangements with providers which, directly or indirectly, pay or offer to pay anything of value, be it money, gifts, space, equipment or services, in return for the referral of members to or by CalViva Health for services paid by the Medicaid program or by any other federal health care program.

B. CalViva Health does not enter into financial arrangements with providers that base compensation on the volume of Medicaid services provided.

C. CalViva Health does not approve nor cause claims to be submitted to the Medicaid program or any other federal health care program:

1. For services provided as a result of payments made in violation of (1) above.

2. For services not rendered by the provider identified on the claim form.

3. For services rendered by a person who is not properly licensed or is known to have falsely claimed to be a specialist.

4. For services that are not reasonable and necessary.

5. For services, which cannot be supported by the documentation in the medical record.

D. CalViva Health does not falsify or misrepresent facts concerning the delivery of services or payment of claims in connection with the Medicaid program or any other federal health care benefit program.

E. CalViva Health does not provide improper or inappropriate incentives to providers to reduce or limit services to Medicaid beneficiaries or recipients of other federal health care programs.

F. CalViva Health conducts all business with provider and vendors at arm's length and pursuant to written contract.

G. All contracts with providers are for no less than a one year term, clearly state the responsibilities of the provider and clearly delineate compensation or fee schedules that meet regulatory guidelines and are not based on the volume of Medicaid services to be provided.

H. All provider contracts meet Medicaid program subcontracting requirements, including, but not limited to, a "hold harmless" provision.

I. Contracts with providers and vendors contain a provision that requires the vendor or provider to abide by all applicable provisions of the Plan.

3. Business Operations and Accounting:

A. CalViva Health does not retain Medicaid funds that are not properly owed to CalViva Health or one of its contracted providers.

B. CalViva Health does not engage in transactions that provide excessive economic benefit to persons with a vested interest in CalViva Health (e.g. members, directors, officers).

C. All financial reports, accounting records, research reports; expense accounts, time sheets and other financial documents shall accurately represent performance of operations.

D. CalViva Health strives to preserve and protect its assets and to direct such assets to its appropriate purposes.

E. CalViva Health has established procedures to ensure a system of internal controls that provide reasonable assurance that financial records are executed consistent

with local, state and federal regulatory requirements and accounting industry guidelines.

F. CalViva Health trains and/or educates accounting staff regarding asset accountability and the need to account for all financial transactions.

G. CalViva Health has an audit performed annually by an independent certified public accountant or independent accountant.

H. The accounting staff maintains documents and other records of original entry to support asset acquisitions and dispositions. Books and records shall fairly and accurately reflect, in reasonable detail, CalViva Health's business transactions, assets acquisitions, sales and deposits, as well as other activity.

I. CalViva Health regularly maintains assets and other such records in accordance with CalViva Health's policy, but no less frequent than monthly, to include, but not be limited to, Cash, Accounts Receivable, Fixed Assets, etc.

J. CalViva Health management regularly provides financial statements to the RHA Commission.

K. CalViva Health protects and secures its financial data. Record destruction is conducted in accordance with approved document destruction policies and procedures.

L. CalViva Health recognizes the potential for conflicts of interest in business activities. To achieve our goals and to maintain integrity, any employee or other persons associated with CalViva Health who could potentially benefit from a contract shall not participate in CalViva Health's decision-making process relative to that business entity.

M. To guard against any conflicts of interest, CalViva Health requests all RHA Commissioners, officers and employees to complete a Statement of Economic Interests (Form 700) and/or conflict of interest disclosure statement as applicable on an annual basis.

N. In compliance with Article 2.4 of Chapter 2 of Part 1 of Division 2 of Title 5 of the Government Code, on a biannual basis RHA Commissioners and CalViva Health officers will take the two-hour public service ethics law and principles AB 1234 course approved by the Attorney General and Fair Political Practices Commission.

O. CalViva Health prohibits the solicitation or acceptance of gifts, gratuities, favors or other benefits from persons or entities that do business with CalViva Health.

Notwithstanding the foregoing, acceptance of common business hospitality, such as occasional meals, entertainment or nominal gifts with a value of $50.00 or less, are not considered a violation of this paragraph.

P. CalViva Health is a not-for-profit public entity, and CalViva Health requires all employees to comply with campaign finance and ethics laws. No employee may use CalViva Health's funds to make any contribution to any political candidate, or political organization except as allowed under federal law. Individual employees may personally participate in and contribute to political organizations or campaigns with their own funds, but must do so as individuals and not as representatives of CalViva Health. CalViva Health may publicly offer recommendations concerning legislation or regulations being proposed which pertain to managed health care. However, neither CalViva Health nor a CalViva Health employee may attempt to influence the decision-making process of any governmental body or official by an improper offer.

Q. CalViva Health avoids any activities that unfairly or illegally reduce or eliminate competition, control prices, allocate markets or exclude competitors. To this end, CalViva Health:

1. Does not enter into agreements to unduly influence prices, charges, profits and service or supplier selection;

2. Negotiates contracts with contractors or suppliers on a competitive basis based upon such factors as price, quality and service; and,

3. Employees who attend association or professional association meetings, or who otherwise come in contact with competitors, avoid discussions at those meetings regarding pricing or any other topic which could be interpreted as collusion between competitors.

R. CalViva Health prepares Medicaid Capitation Program reports as necessary. The reports are prepared based upon the Accounting and Auditing Guidelines issued by the California Department of Managed Health Care and California Department of Health Care Services, which administer the various State Regulations as they relate to CalViva Health and its contractors.

S. No employee or person associated with CalViva Health prevents or delays the communication of information or records related to violation of the Plan's Compliance Program to the Chief Compliance Officer (CCO).

T. CalViva Health shall respond appropriately to government subpoenas. If CalViva Health has reason to believe that there is an impending government investigation,

it retains all documents that may pertain to that investigation.

U. CalViva Health, in cooperation with subcontractors and regulators, will make all reasonable efforts to prevent, correct and remedy the operational factors and circumstances under which such noncompliance or violation occurs. Depending on the nature, circumstances and severity of the noncompliance/violation, if any CalViva employee is determined to be involved or responsible, these efforts may include a range of disciplinary and corrective actions up to and including termination. If a subcontractor fails to remedy the circumstance, corrective action may include a range of disciplinary and corrective actions up to and including termination of the contract.

4. Medical Records:

A. Contractually, CalViva Health providers are required to maintain member medical records in accordance with Federal and State laws and regulations. Such records may be forwarded for review by CalViva Health (or CalViva Health is given access to such records) in a confidential manner, with access to medical records limited to those CalViva Health employees involved in claims adjudication, grievance/appeal review, quality improvement or medical/utilization review management.

B. CalViva Health handles and transmits electronic or paper medical record information in accordance with the HIPAA privacy and security regulations. CalViva Health will timely implement HIPAA-compliant systems. As part of its Compliance Program, CalViva Health will:

1. Enter into written contracts with all business associates (as that term is defined in the HIPAA privacy regulations) to ensure that all entities performing services on behalf of CalViva Health comply with the HIPAA privacy and security regulations.

2. Maintain a member specific log of all requests for access to the medical information of a member by third parties and all releases of medical record information to third parties.

3. Report in a timely manner any suspected privacy and security incidents and/or breaches to the required regulatory agencies.

4. Conduct ongoing training of employees to ensure awareness and adherence with the HIPAA privacy and security regulations.

C. CalViva Health retains records in accordance with a written policy which incorporates Medicaid and all federal, state and local regulatory guidelines.

5. Medical Management and Claims:

A. CalViva Health monitors the claims submitted by providers to ensure honest, fair and accurate claim practices. All entities providing claims functions on behalf of CalViva Health are required to demonstrate experience and knowledge in performing such functions in accordance with federal, state and local law.

B. CalViva Health monitors and periodically audits (part of delegation audits) the claims process of its contracted administrative organization and when applicable, other contracted delegated organizations, to ensure honest, fair and accurate claims processes.

C. CalViva Health reviews the written claims policies and procedures of its contracted administrative organization and when applicable, other contracted delegated organizations, to ensure that the policies properly reflect CalViva Health's policies and the requirements of the Medicaid program.

D. CalViva Health ensures that its' contracted administrative organization and when applicable, other contracted delegated organizations, properly coordinate benefits with any applicable third-party payor.

E. CalViva Health ensures that its' contracted administrative organization and when applicable, other contracted delegated organizations, have prior authorization policies, as applicable, for all inpatient admissions, partial hospitalizations and therapies requiring prior authorization and that prior authorization numbers accompany all claims from providers. CalViva Health and its contracted administrative organization maintain records to support decisions regarding prior authorization.

F. CalViva Health, its' contracted administrative organization and when applicable, other contracted delegated organizations, send denial letters and provide reconsideration and appeal of denials in accordance with applicable federal or state law.

G. CalViva Health does not compensate its contracted administrative organization and when applicable, other contracted delegated organizations, or contracted providers/vendors in such a manner as to induce improper or up-coded claims.

6. Employee Relations:

A. CalViva Health encourages all employees and contractors to respect the rights and cultural differences of other individuals.

B. CalViva Health does not discriminate on the basis of age, religion, color, race, sex, sexual preference or national origin in personnel policies and procedures.

C. CalViva Health strives to provide equal employment opportunities and a working environment free from harassment.

7. Avoiding Potential Conflict of Interest or Retribution

It is the policy of CalViva Health to promote a working environment free from conflict of interest or retribution against individuals who report suspected fraud. In training sessions with employees regarding fraud prevention, employees are informed that there is no retribution against employees for reporting fraud. Employees and members are notified in writing of the procedures for reporting fraud and that there is no retribution against individuals reporting suspected fraud. If anyone has concerns about retribution, he or she may elect to remain anonymous in reporting suspected fraud.

If the Chief Compliance Officer or any member of the Executive Management Staff has a conflict of interest in an incident of suspected fraud, the person must report the conflict of interest to the Chief Executive Officer or Chairman of the RHA Commission and be disassociated from the investigation. If necessary and appropriate, the report will be referred to outside counsel for investigation.

APPROVAL:

_____ Date: _____
Name: Mary Beth Corrado
Title: Chief Compliance Officer

_____ Date: _____
Name: Greg Hund
Title: Chief Executive Officer

_____ Date: _____
Name: David S. Hodge
Title: RHA Commission Chairperson

Item #18

Attachment 18.A

2019 Anti-Fraud Plan

ANTI-FRAUD PLAN

For inquiries regarding this Anti-Fraud Plan, please contact:

Mary Beth Corrado
Chief Compliance Officer
CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711
mbcorrado@calvivahealth.org
Phone: 559-540-7847

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I. CalViva Health Overview

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CalViva Health contracts with health plans, provider organizations and other contractors to provide administrative services on behalf of the Plan and/or provide health care services to CalViva Health members. These first-tier subcontractors and their contracted downstream, and related entities are required to have programs, standards, policies and processes in place that comply with state and federal regulations and Medi-Cal requirements as applicable to the type of entity.

1. Statement of Purpose:

The purpose of the RHA/CalViva Health ("CalViva" or the "Plan") Anti-Fraud Plan is to organize and implement an anti-fraud strategy to identify and reduce costs to the Plan, providers, members, and others caused by fraudulent and abusive activities, and to protect members and the public in the delivery of health care services through the timely detection, investigation, and prosecution of suspected fraud. Through the Anti-Fraud Plan, CalViva also seeks to prevent violations of the Federal False Claims Act, as codified in Section 3729 of Title 31 of the United States Code. The Plan's Anti-Fraud Program will also comply with the federal Medicaid managed care requirements in 42 CFR 438.608, Health & Safety Code Section 1348 and the Department of Health Care Services Medi-Cal Contract requirements in Exhibit E, Attachment 2, Provision 26.

2. Definitions:

A. **Fraud** is defined as the intentional deception or misrepresentation made by a person with the knowledge that the deception could result in unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Health care fraud is a crime. Any person convicted of health care fraud faces imprisonment and substantial fines. Health care fraud could be committed by dishonest

health care providers such as doctors, laboratories, medical equipment suppliers, by health plan members, Plan staff, and Plan subcontractors.

Some examples of fraud include:

1. Billing for services or supplies not provided
2. Altering or falsifying claims
3. Falsifying a patient's diagnosis to justify tests, surgeries or other procedures that are not medically necessary
4. Using another person's Medi-Cal card to obtain medical care

See Appendix A for a more extensive set of examples.

B. **Abuse** means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (42 CFR 455.2 and as further defined in W. & I. Code Section 14043.1(a).)

Some examples of abuse include**:**

1. Excessive charges for services or supplies
2. Overutilization/underutilization of medical or health care services

C. **Waste** means the overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act, as stated in CMS' Fraud, Waste, and Abuse Toolkit (42 CFR 455.2).

II. Scope of Anti-Fraud Plan:

In an effort to assure public accountability, conduct proper business practices, and operate within the limited resources of the Medi-Cal program, CalViva/delegated organizations will investigate and pursue prosecution of fraudulent activity by providers, enrollees, employees, and other individuals or entities. CalViva/delegated organizations also cooperate with local, state and federal authorities whenever appropriate.

The Anti-Fraud Plan is part of CalViva's comprehensive Compliance program and includes the following:

A. the designation of, or a contract with, individuals with specific investigative expertise in the management of fraud investigations;
B. training of plan personnel and contractors concerning the detection of health care fraud;

C. the plan's procedure for managing incidents of suspected fraud; and
D. the internal procedure for referring suspected fraud to the appropriate government agency.

1. Responsibilities for Anti-Fraud Plan:

The RHA Commission has ultimate responsibility for this Anti-Fraud Plan. The Anti-Fraud Plan will be submitted to the Commission for annual approval. An annual report will be made to the Commission regarding the Plan's Anti-Fraud activities, subject to any confidentiality protections which may be required.

The implementation of the Anti-Fraud Plan will be the responsibility of the Chief Compliance Officer ("CCO"), under the supervision of the Chief Executive Officer ("CEO"). The CEO will make certain that sufficient resources are in place to properly implement the Anti-Fraud Plan. The CCO will be responsible for overseeing any investigation or necessary corrective action, except as otherwise provided in this Plan.

The CCO will serve as the Anti-Fraud Officer and have the following duties:

1. Receive information (formal and informal) on cases of suspected fraud
2. Provide oversight of activities and investigations carried out on CalViva's behalf by Health Net and other delegated entities.
3. Receive information from Health Net and other delegated entities on cases of suspected fraud and abuse related to CalViva and investigated by the delegated entities' SIU.
4. Provide oversight and receive information from delegated organizations on cases of suspected fraud and abuse related to CalViva
5. Report to the CEO on suspected cases of fraud, plan of investigation, timelines, and resources required
6. Maintain logs to assure timely investigations and reporting
7. Review and approve training and other anti-fraud materials sent to participating providers on CalViva's behalf.
8. When directed by the CEO or legal counsel, make referrals to appropriate law enforcement agencies

2. General Anti-Fraud Oversight Mechanisms:

The general oversight mechanisms of the Plan's Anti-Fraud program include the following:

1. CalViva Health will conduct background checks on all employees, which includes staff designated to handle funds and prepare financial statements.

2. Policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program.
3. Development and implementation of corrective actions addressing fraud and abuse issues as appropriate.
4. Ongoing monitoring and oversight by the CalViva Compliance Committee.
5. Provide contracted providers with anti-fraud information including how to report suspected fraud incidents.
6. Provide members with information on how to report suspected fraud incidents.
7. Investigate cases of suspected fraud with the most appropriate internal or external resources, appropriate to the problem.
8. Assure that conflicts of interest are not present in the investigation of suspected fraud cases.
9. Ensure that findings from independent audits and regulatory audits and surveys are followed up promptly by both the Plan as well as the subcontractors who may be cited; and identify any recurring trends.
10. Monitor member and provider issues, tracking and trending types of grievances and settings; and implementing corrective action when necessary.
11. Perform an annual file audit of a sample of contracted providers credentialed by Health Net and their delegated entities which have delegated credentialing responsibilities.
12. Monitor and review fraud cases/issues reported by delegated organizations.
13. Conduct formal and informal ongoing monitoring of the administrative services contracted to Health Net and delegated entities, through the review of performance reports and annual audits; and developing corrective action plans, when appropriate.
14. Review the Anti-Fraud Plan annually and, if revised, maintain documentation that approval has been received from the Department of Managed Health Care (DMHC).
15. Review Health Net's annual anti-fraud report to the DMHC.
16. Assure that Medicaid/Medi-Cal or Medicare terminated or suspended providers do not receive program funds.

3. Procedures for Investigating Suspected Fraud:

Processes used to investigate suspected cases of fraud are described in CalViva's policies and procedures.

1. The procedure for undertaking an investigation includes:
    A. A review of all identified related documents;
    B. Consultation, if necessary, with internal or external resources with knowledge of applicable law, regulations or policies, procedures or standards; and
    C. Interviews with persons with knowledge of the alleged activity.
2. A description of the investigation process is included in Plan policies and procedures. The policies and procedures are reviewed annually and revised as needed.
3. The Compliance Committee reviews reports of fraud, waste and abuse cases investigated and any corrective actions implemented.
4. All cases of suspected fraud, waste and/or abuse where there is reason to believe that an incident of fraud, waste and/or abuse has occurred by subcontractors, members, providers, or employees will be reported to the DHCS.
5. In addition, in situations where fraud is confirmed, disciplinary action may be taken and reports to appropriate third parties may be made, including the following:
    A. For employees, incidents may be grounds for immediate dismissal, and, if appropriate, referral to law enforcement agencies.
    B. For contracted providers, disciplinary action may include terminating any contracted relationship between the Plan and the provider or, in the case of a group or institutional provider, removal of the provider's subcontractor or employee from providing services with respect to CalViva members.
    C. For Medi-Cal members, disciplinary action will include referral to the Department of Health Care Services and, if appropriate, the initiation of procedures to disenroll the member from CalViva, according to provisions of the Medi-Cal managed care contract.
6. Appropriate local, State or Federal authorities will be notified as necessary.
7. A summary report of cases and outcomes is provided quarterly to the Compliance Committee and summary reports are included in the regular compliance reports to the RHA Commission.
8. To prevent repeat offenses, the CCO, and if applicable, in consultation with Health Net, may create new policies, procedures and employee training programs to address new issues regarding the Anti-Fraud Plan's implementation as they arise.

4. Use of External Resources for Special Investigations:

The following external resources are utilized by the Plan:

1. CalViva Employee, Consultant and Contractor Investigations - CalViva has retained Prentice, Long & Epperson, LLP to provide its General Counsel services. The law firm has municipal and litigation attorneys experienced in matters involving public agency ethics rules, restrictions on self-dealing, and prohibited financial transactions. Cases involving alleged fraud and improprieties by CalViva employees, officers, directors, consultants or contractors will be referred to Prentice, Long & Epperson, LLP for investigation as needed.
2. CalViva Member and Provider Investigations - As described in Section 3, in accordance with the ASA and CPSA between CalViva and Health Net, Health Net Special Investigations Unit (SIU) performs fraud and abuse investigations (i.e. prepay reviews; retrospective reviews, etc.) related to potential fraud cases involving CalViva members or providers. Health Net also conducts routine reviews of provider's billing/coding practices to ensure compliance with state and federal regulations. In addition, Health Net will review claim reports to ensure that codes and practices used in billing are correct and that the Plan has paid health care providers appropriately. The SIU team has a diverse range of qualifications that stem from the legal, healthcare, loss prevention, law enforcement, medical and other experience/educational backgrounds. Several members of the team are also credentialed as Accredited Health Care Fraud Investigators ("AHFI"), Certified Professional Coders ("CPC"), and Certified Fraud Examiners ("CFE").
3. Member and Provider Investigations – Delegated Organizations -Organizations with delegated responsibilities (e.g. sub-contracted health plans, participating provider groups, etc.) that the Plan may contract with to provide services to CalViva Health members are required to comply with Plan requirements and all applicable state and federal regulations. Delegated organizations must participate with CalViva's Anti-Fraud Program and/or have policies, processes, experienced investigative staff/contractor in place for the detection, identification, and investigation of suspected fraud incidents.

5. Additional Internal and External Resources:

Other internal and external investigative resources available to the Plan include the following:

1. The Plan's Chief Medical Officer, Chief Financial Officer, Chief Operating officer ("COO") other Compliance and Operations Department staff.
2. The Plan's independent financial audit firm
3. DHCS audits and surveys
4. DMHC audits and surveys

6. Freedom from Retaliation and Avoiding Conflicts of Interest:

CalViva will promote an environment free from retaliation or threats of retaliation against individuals who report suspected fraud. The Plan will comply with Section 3730(h) of Title 31 of the United States Code, which prohibits employer discrimination against employees in the terms or conditions of their employment because of the employees' lawful acts in furtherance of an action under the False Claims Act. In training sessions with employees regarding the Plan's anti-fraud efforts, employees will be informed that there is no retaliation against employees for reporting fraudulent activities. Employees are also notified in writing of the procedures for reporting fraudulent activities, including that there is no retaliation against individuals for reporting potential fraudulent activities. If the reporting party still has concerns about retribution, the reporting party may choose to remain anonymous.

If the CEO, CCO, or member of the RHA Commission has a conflict of interest regarding an incident of suspected fraud, the individual must report the conflict of interest to the Chairperson of the RHA Commission, and disassociate him/herself from the relevant investigation. If appropriate, the investigation will be referred to outside counsel for investigation.

7. Referrals to or from Appropriate Outside Agencies:

Depending on the nature of fraud cases, CalViva may receive notices directly from the DHCS or will refer cases to the appropriate regulatory authority.

1. Fraud, Waste and Abuse Reporting to DHCS - CalViva will comply with the DHCS contractual requirements to report to DHCS any potential fraud, waste, or abuse that the Plan identifies to DHCS' Medi-Cal Managed Care Program Integrity Unit or any potential fraud directly to DHCS' Medicaid Fraud Control Unit. The Plan will provide DHCS with the results of a preliminary investigation of the suspected fraud, waste and/or abuse within 10 working days of the date the Plan first becomes aware of, or is on notice of, such activity

   The report will be submitted on a Confidential Medi-Cal Complaint Report (MC 609) that can be sent to DHCS in one of three ways:

   a) Email at PIUCases@DHCS.ca.gov;
   b) E-fax at (916) 440-5287; or
   c) U.S. Mail at:
   Department of Health Care Services
   Audits & Investigations Division
   Attention: Chief, Intake Unit
   MS 2500
   Sacramento, CA 95814

2. Receipts of a Credible Allegation from DHCS - CalViva may be notified by DHCS when there has been a credible allegation of fraud against a provider that is part of the Plan's provider network. In these cases, CalViva must take one or more of the following four actions and submit all supporting documentation to the PIUCases@DHCS.ca.gov inbox:

    1. Terminate the provider from its network
    2. Temporarily suspend the provider from its network pending resolution of the fraud allegation
    3. Temporarily suspend payment to the provider pending resolution of the fraud allegation; and/or
    4. Conduct additional monitoring including audits of the provider's claims history and future claims submissions for appropriate billing.

3. Removed, Suspended, Excluded, or Terminated Provider Report - CalViva/delegated organizations are prohibited from employing, contracting or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs. CalViva/delegated organizations will check the list of suspended and ineligible providers maintained in the Medi-Cal Provider Manual, which is updated monthly and available on line and in print at the DHCS Medi-Cal Web site (http://www.medi-cal.ca.gov) and by the Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals and Entities (http://oig.hhs.gov). CalViva/delegated organizations are deemed to have knowledge of any providers on these lists. CalViva will notify the Medi-Cal Managed Care Program/Program Integrity Unit within 10 State working days of removing a suspended, excluded, or terminated provider from its provider network and confirm that the provider is no longer receiving payments in connection with the Medicaid program. A removed, suspended, excluded, or terminated provider report can be sent to DHCS in one of three ways:

    1. Email at PIUCases@DHCS.ca.gov;
    2. E-fax at (916) 440-5287; or
    3. U.S. Mail at:

    Department of Health Care Services
    Medi-Cal Managed Care Division
    Attention: Chief, Program Integrity Unit
    MS 4417
    P.O. Box 997413
    Sacramento, CA 95899-7413

4. Referrals to Other Regulatory Authorities - If the occurrence of fraudulent activity is confirmed, CalViva may refer cases to the appropriate local, state or federal authority for prosecution of health care fraud committed by enrollees, providers, agents, company employees and other individuals. Such referrals include but are not limited to:
    1. Local police departments,
    2. U.S. Postal Inspector,
    3. Federal Bureau of Investigation,
    4. Office of the Inspector General of the U.S. Department of Health and Human Services,
    5. Internal Revenue Service
    6. Local departments of Public Health in Fresno, Kings, or Madera counties,
    7. DMHC,
    8. Centers for Medicare and Medicaid Services,
    9. State medical licensing and disciplinary boards or
    10. Any other appropriate authorities or agencies.

5. Prosecution - In the event of fraud, the CEO or the RHA Commission will evaluate the appropriateness of pursuing civil prosecution. The Plan will consult with legal counsel, as described in section 8.A.

8. Staff Training and Education:

CalViva recognizes that the most effective way to combat fraud is to increase staff awareness through education. The Plan is therefore committed to assuring the education and training of its staff, the staff of its administrative contractor, and providers on fraud and fraud prevention.

The CEO and CCO, in consultation with the RHA Commission, and other executive staff as applicable, will develop a strategic approach to educating CalViva and its community about fraudulent activities that occur in health care environments. CalViva will work closely with Health Net to assure that appropriate fraud prevention strategies are in place and that staff are trained and educated to detect, deter, and refer instances of suspected fraud to the appropriate levels of the organization.

1. CalViva will provide information regarding the detection, prevention and investigation of fraudulent activity to all new staff during initial employment orientation. Employees will also be notified in writing of the procedures for reporting fraud and that there is no retribution taken against individuals reporting fraud.

2. An annual training session will be required for all CalViva staff. External experts for training will be consulted, as necessary, to augment and implement the training program.

9. Public Awareness:

CalViva members and their families are the ultimate victims of any fraud activity occurring within the Plan. It is therefore essential for them to be aware of activities that may constitute fraud and to have avenues to report suspected fraudulent activities in order to assist with the prevention and cessation of such activities. Information is included in the Member Handbook/Evidence of Coverage and articles regarding health care fraud and CalViva's efforts to prevent fraud will be sent out in periodic newsletters to members.

The Plan will publicize a fraud reporting telephone number. Potential fraud, waste and abuse incidents may be reported directly to CalViva via one of the following methods:

Toll-free Phone: 1-866-863-2465
Fax: 559-446-1998
Mail: Chief Compliance Officer
CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711
Email: fraudtips@calvivahealth.org

CalViva is sensitive to providing a quick response to any member service concerns that may arise for health plan members. Plan employees will convey any complaints, grievances and/or customer service concerns to the CCO, its administrative subcontractor, Health Net, or, if necessary, to the appropriate regulatory or law enforcement agency.

Concerns expressed are documented and investigation is initiated immediately. If appropriate, within 30 days, a letter is sent out to the originator to acknowledge receipt of the concern and to provide a brief status update.

Medi-Cal anti-fraud information resources are also available through the Department of Health Care Services through the following:

Websites:

- www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx
- www.stopmedi-calfraud.dhs.ca.gov

The Medi-Cal Program has a hotline maintained by the Department of Health Care Services: Medi-Cal Fraud Hotline: 1-800-822-6222

10. Participating Health Care Providers:

The Plan contracts with health care provider organizations, Health Net and other delegated organizations to provide services to CalViva members through their network of health care providers. These provider networks include but are not limited to: primary care providers, medical specialists, mental health specialists, acute care hospitals, skilled nursing facilities, clinical laboratories, pharmacies and other ancillary providers. Providers are given information about fraud prevention, how to report suspected fraud or abuse incidents, and how the Plan and/or contracted organizations respond to fraudulent activity.

11. Location:

The address for the CEO, the CCO, and the Chairperson of the RHA Commission is:

CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711

12. Annual Report to the Department of Managed Health Care:

In compliance with California Health & Safety Code Section 1348, CalViva will file with the Department of Managed Health Care a written annual report regarding the Plan's anti-fraud activities, including, but not limited to:

1. CalViva's efforts to deter, detect and investigate fraud, and report cases of fraud to law enforcement agencies.
2. Of the cases reported to law enforcement agencies, a listing of the number of cases prosecuted and the status of prosecution if known.
3. Recommendations to further improve and refine the Plan's Anti-Fraud Plan.

Authority

DHCS Contract, Exhibit E, Attachment 2, Provision 26
Health & Safety Code Section 1348
Code of Federal Regulations, 42 CFR 438.608, 42 CFR 438.610 and 42 CFR 455.2
United States Code, 31 U.S.C. Section 3729 and 42 USC Section 1396a(a)(68)
Welfare & Institutions Code Section 14043.1(a) and (i), and Section 14115.75

DHCS All Plan Letter 08-007, 15-026, 16-001

References
CalViva Health Compliance Plan
CalViva Health Policies and Procedures

APPENDIX A

Types of Fraudulent Acts and Examples/Indicators of Potential Fraud (Adapted from National Health Care Anti-Fraud Association publications)

I. Types of Fraudulent Acts

It is virtually impossible to itemize every conceivable health care fraud; any opportunity to bill for services is an opportunity to commit health care fraud and every fraud scheme has its own unique characteristics. Most health care frauds, however, fall into one or more broad categories of activity, including the outright fabrication of claims and the falsification of claims.

A. Fabrication of Claims

In the outright fabrication of claims or portions of claims, a fraud perpetrator uses legitimate patient names and insurance information either to concoct entirely fictitious claims, or adds to otherwise legitimate claims fictitious charges for treatments or services that were never provided. Some examples of such fabrication are:

1. An individual provider who, using existing information on his/her patients creates claims for office visits or treatments that never took place.
2. A provider who, in the case of billing for patient treatments, adds charges for x-rays or lab tests that were never performed.
3. A contracted service provider/institution bills for services that were ordered but did not occur due to unforeseen circumstances (patient refused or was unable to make the appointment).

B. Falsification of Claims

In the falsification of claims, the perpetrator makes a material and intentional misrepresentation of one or more element(s) of information in a claim for the purpose of obtaining, a payment (or a higher payment) to which he/she is not entitled. Examples of outright falsifications include:

1. Falsifying patients' symptoms or diagnosis and/or the procedures performed as a pretext for obtaining payment for otherwise non-covered services (i.e.: alternative therapies; elective cosmetic surgeries etc.) and/or performing medically unnecessary services solely in order to submit claims and be paid.
2. Falsifying the dates on which service was provided so as to fall within a given coverage period.

3. Falsifying the identity of the provider of the service in an attempt to obtain payment for services rendered by a non-covered and/or non-licensed provider (i.e.: billing for massages as licensed physical therapy or counseling by a Social Worker as psychiatric treatment).
4. "Upcoding" or falsifying the nature of services provided to obtain a higher rate on payment (i.e.: filling a prescription with the generic equivalent but billing for the higher-priced brand-name drug).
5. "Unbundling" or deliberately billing separately for the various elements of a given medical procedure to which one all-encompassing billing code applies, so as to obtain a higher aggregate payment.

II. Examples of Indicators of Potential Fraud

Indicators of potential claims fraud are as varied as they are numerous, ranging from the obvious to more subtle signs. Visibly discernible alterations or handwriting anomalies on a given claim are examples of an obvious indicator. A subtler indicator would be an inconsistency of diagnosis and treatment or an unusually high incidence of a given condition among a provider's patients.

Deciding what factors represent indicators of potential fraud is a subjective matter that varies widely. There is no formulaic or universal set of such indicators. The presence of one or more indicators in and of itself does not necessarily signify fraud, it merely serves to call attention to a claim or situation that is out of the ordinary and therefore requires further review.

The following examples illustrate some of the signs that might represent indicators of potential fraud on the part of a dishonest provider, a provider employee and/or a dishonest claimant:

1. Misspelled medical terminology on claim.
2. Similarity of patient/provider handwriting.
3. Apparent alteration of dates, amounts and/or other claim information.
4. Claims for non-emergency services dated Sundays or holidays.
5. Inconsistency between treatment billed and patient's diagnosis, age, gender etc.
6. Inconsistency between provider type and treatment billed.
7. Inconsistency between patient diagnosis and prescription billed.
8. Inconsistency between patient's medical history and treatment billed.
9. Consistent submission of photocopied claims.
10. Provider's lack of support documentation for claim selected for audit.
11. High-dollar claim for service dated either soon after effective date of coverage or just before the termination of coverage.
12. Unusual time lapse between date of service and date claim submitted.
13. Anonymous and/or persistent telephone inquiries re: status of claims.
14. Undue pressure to pay claims quickly.
15. Payments to P.O. Box not under provider or claimant name.

APPENDIX B

CalViva Health Referral Form for Incident of Suspected Fraud

Please Note: CalViva Health will not discriminate against employees in the terms or conditions of their employment because of the employees' lawful acts in furtherance of an action under the Federal or California False Claims Act, including an investigation for, initiation of, testimony for, or assistance in such an action.

Name: _____ Contact Phone: _____

Department: _____

Please indicate here if you wish to remain anonymous: _ Yes, I wish to remain anonymous

Case Type: __ Provider __ Member __ Employee ___ Subcontractor ____Other ____

INFORMATION ABOUT THE SUSPECTED INDIVIDUAL/ENTITY

Name of Individual or Provider or Other: _____

Address: _____

Phone: _____

Other Identifying Information (Member ID Number, Date of Service, etc.) _____

Please describe how you were informed of the incident: _____

_____

_____

Please provide a description of the suspect incident: _____

_____

_____

_____

_____

Signed: _____ Date: _____

The completed form should be put in an envelope marked "Confidential, for CalViva Health Chief Compliance Officer and submitted to CalViva Health, 7625 N. Palm Ave., Suite 109, Fresno, CA 93711

APPROVAL:

Date: _____

Name: Mary Beth Corrado
Title: Chief Compliance Officer

Date: _____

Name: Gregory Hund
Title: Chief Executive Officer

Date: _____

Name: David S. Hodge, M.D.
Title: RHA Commission Chairperson

Program Description History		
Date	**Section #**	**Comment(s)**
3/1/2011		New Program Description
4/30/2012	Replaces former version	Annual review; changes to clarify and reflect current activity
1/7/2013	various	Annual review, clarified descriptions of activities
6/7/13	Cover page, sections 8 & 9	Changes to address DMHC requirements
2/6/14	Various	Annual review, changes to clarify current contractual relationships and activities
1-26-15	Sections 5, 6, 7, 8, 11, 13 and 15	Annual review, changes to update General Counsel information, clarify several sections to better reflect current activities and correct typographical errors
2-18-16	Section 11 and office address throughout	Updated office address and phone numbers and added information from APL15-026

2-17-17	Various	Clarified the overview and operational structure of CalViva Health. Removed reference to Optum as Health Net no longer uses Optum in their SIU activity.
2-15-18	Various	Annual Review, minor grammatical changes and added a reference to the COO and Operations Department staff.
01/07/19	Section II 7.	Inserted PIU e-mail address.

Item #19

Attachment 19.A

2019 Privacy and Security Plan

PRIVACY AND SECURITY PLAN

For inquiries regarding this Privacy and Security Plan, please contact:

Jeffrey Nkansah
Chief Operating Officer
CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711
jnkansah@calvivahealth.org
Phone: 559-540-7850

Table of Contents

I. CalViva Health Overview

The Fresno-Kings-Madera Regional Health Authority (referred to as the "RHA"), is a public entity created pursuant to a Joint Exercise of Powers Agreement between the Counties of Fresno, Kings and Madera. RHA is governed by a board ("The Commission") consisting of representatives from these three counties. On April 15, 2010, RHA Commission adopted the name "CalViva Health" under which it does business. RHA was licensed on December 30, 2010 as a full-service health care plan ("The Plan") pursuant to the provisions of the Knox-Keene Health Care Service Plan Act of 1975 as amended. RHA is licensed to offer health care services to enrollees in the Medi-Cal Managed Care Plan under the Two Plan Model in the counties of Fresno, Kings, and Madera. On December 30, 2010, RHA executed a contract with the California Department of Health Care Services ("DHCS") to provide services to Medi-Cal managed care enrollees in all zip codes in these three counties.

CalViva Health contracts with health plans, provider organizations and other contractors to provide administrative services on behalf of the Plan and/or provide health care services to CalViva Health members. These first-tier subcontractors and their contracted downstream, and related entities are required to have programs, standards, policies and processes in place that comply with state and federal regulations and Medi-Cal requirements as applicable to the type of entity.

All of the processes and activities performed by contracted or delegated entities on CalViva Health's behalf are performed in compliance with CalViva Health's Privacy and Security Plan described in the following pages. These entities agree to the same restrictions and conditions that apply to CalViva Health with respect to protected health information (PHI) and applicable provisions governing the use of PHI are incorporated into CalViva Health's service and/or business associate agreements with contracted or delegated entities.

1. **Statement of Purpose**:

The purpose of CalViva Health's Privacy and Security Plan is to safeguard the confidentiality of personal information (PI) and protected health information (PHI) while not impeding the exchange of information needed to provide quality health care treatment, payment and operations. To that end, CalViva Health develops and implements policies and procedures designed to enable compliance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH), the American Recovery and Reinvestment Act (ARRA) California's Information Practices Act of 1977 (IPA) and Confidentiality of Medical Information Act (CMIA). CalViva Health is committed to creating a culture that effectively encourages its employees and associates to comply with applicable laws, regulations and policies related to privacy of health information and to perform work duties with a conscious regard for the privacy rights of its members.

CalViva Health ensures that member health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care.

Everyone has a responsibility for monitoring and reporting any activity that appears to violate this program or the supporting policies and procedures. Failure to follow the Privacy and Security Plan and related policies and procedures are grounds for appropriate discipline, which may include immediate termination.

2. **Confidentiality Guideline:**

CalViva Health and its business associates have adopted a strict guideline regarding the confidentiality of certain information provided to CalViva Health employees and business associates. This guideline applies to all CalViva Health employees/business associates:

All employees/associates are prohibited from any unauthorized access to, use or disclosure of patient ("Member") protected health information (PHI), health care provider confidential information, or CalViva Health proprietary information. This includes, but is not limited to: medical records, claims, benefits or other administrative data that is personally identifiable, CalViva Health compliance program cases, peer review cases, quality improvement and utilization management programs, reports and disease management information containing PHI (hereinafter, collectively referred to as "Confidential Information").

Employees/associates must hold in strict confidence, and not copy, disclose or permit the disclosure to any person of any PHI or Confidential Information disclosed or delivered to him/her by CalViva Health or any provider except that which is allowable based on employee job role, by regulation, or by contractual and business associate agreements.
Employees/associates must comply with all CalViva Health policies and procedures concerning the maintenance of all Confidential Information made known to him/her as a CalViva Health employee/associate.

Employees must comply with all applicable state and federal laws and regulations regarding the Confidential Information. CalViva Health limits access to CalViva Health employee data to a subset of employees who are permitted the use and disclosure of other employee confidential information as required in the scope of their duties.

Any violation of statutes, regulations, policies and/or procedures designed to safeguard the confidentiality of the Confidential Information may include a range of disciplinary and corrective actions up to and including immediate discharge from CalViva Health. Failure to comply with this guideline and all applicable policies, laws, and regulations may result in legal action brought against the violating employee/associate.

II. OVERSIGHT AND EVALUATION OF PLAN

1. Designation of Privacy and Security Officer:

CalViva Health has appointed a Chief Operating Officer ("COO") to serve as the focal point for privacy and security activities and report directly to the Chief Executive Officer and to the RHA Commission. The COO is charged with the responsibility for developing, operating and monitoring the Privacy and Security Plan. This includes establishing and overseeing an auditing and monitoring plan, continuously reviewing organizational risk areas to identify necessary auditing and monitoring activities; assisting management with formulation of corrective action plans and overseeing and/or verifying implementation of corrective action. The COO works with a Compliance Committee to assist in implementation of the Privacy and Security Plan.

The COO responsibilities include:

A. Serving as the Privacy and Security Officer

B. Ensuring a Privacy and Security Plan is developed along with any applicable policies and procedures;

C. Ensuring Risk Analyses and Risk Mitigation plans are implemented;

D. Ongoing oversight and monitoring of Privacy and Security activities;

E. Preparing and overseeing distribution of the Notice of Privacy Practices;

F. Reporting on a regular basis to the RHA Commission on implementation and compliance;

G. Developing, coordinating and participating in an educational and training program on the elements of the Plan and ensuring that employees and managers are informed;

H. Developing an atmosphere to encourage employees to report possible noncompliance to CalViva Health, DHCS, or the Secretary of HHS without fear of retaliation;

I. Acting on matters related to privacy compliance, with the authority to design and coordinate internal reviews and any resulting need for corrective action;

J. Coordinating with the CEO regarding disciplinary sanctions for violations of the Privacy and Security Plan, policies and procedures;

K. Coordinating mitigation efforts in the event of a disclosure that violates the privacy laws; and

L. Periodically evaluating and revising the Privacy and Security Plan and policies and procedures in light of changes at CalViva Health or in response to changes in federal or state requirements.

2. CalViva Health's Compliance Committee:

CalViva Health has a Compliance Committee to advise the Privacy and Security Officer and to assist in the implementation of the Privacy and Security Plan. The Committee is composed of the Plan's Chief Officers and meets at least quarterly and more frequently, as necessary. The Chief Compliance Officer ("CCO") serves as chairperson of the meeting. The Committee shall maintain minutes of all its meetings to document its activities and recommendations.

The Committee's responsibilities include:

A. Recommending and monitoring, in conjunction with the relevant business units or departments, the development of internal systems to carry out the privacy and security policies and procedures as part of daily operations;

B. Determining the appropriate strategy/approach to promote compliance with the Privacy and Security Plan and detection of any potential violations, such as through hotlines and other reporting mechanisms;

C. Developing a system to solicit, evaluate and respond to complaints and problems;

D. Monitoring ongoing operations for the purpose of identifying potentially deficient areas and implementing corrective and preventive action;

E. Reviewing and tracking of possible confidentiality breaches that may be identified through incident reports, reports from CalViva Health's COO, reports from contractors, appeals and grievances, etc.;

F. Overseeing the analysis and data collection of business processes, systems and relationships to understand the cause of a breach;

G. Creating or revising policies to better prevent or address privacy and security breaches; and

H. Overseeing development of resolutions to breach issues.

When a potential problem is identified, the COO may also select various individuals to serve on

an ad hoc task force to provide assistance in investigating an incident, such as an unauthorized disclosure, implementing mitigation measures and/or designing protocols to prevent a recurrence in the future.

3. CalViva Health Management:

Chief Officers and Directors must be available to discuss with each employee under their direct supervision and every contractor/business associate with which they are the primary liaison:

A. The content and procedures in the Privacy and Security Plan and any applicable Policies and Procedures

B. The legal requirements applicable to Employees' and Contractors' job functions or contractual obligations, as applicable

C. That adherence to the Plan and Policies and Procedures is a condition of employment

D. That CalViva Health shall take appropriate disciplinary action, including termination of employment or a Contractor's agreement with CalViva Health, for violation of the principles and requirements set forth in the Privacy and Security Plan and applicable law and regulations

The Chief Operating Officer will include any significant privacy and security issues as part of the operations reports to the RHA Commission (CalViva Health's governing board).

4. Auditing and Monitoring of Delegated Activities and Internal Operations:

CalViva Health is committed to aggressive monitoring of its Privacy and Security Plan and applicable policies and procedures. Routine and random audits will be conducted to identify problems, reduce identified problems and maintain a high level of privacy.

The COO along with Department staff are responsible for ensuring the implementation of the Privacy and Security Plan and all associated policies and procedures, performance standards and activities. This includes oversight and monitoring activities of CalViva Health internal business units and subcontractors (i.e. administrative services contractors, delegated providers).

Oversight monitoring of delegated entities is done to ensure that delegated responsibilities and services comply with requirements and the appropriate state and federal regulatory requirements. Any deficiencies identified during the monitoring process will result in corrective action plans. The corrective action plan developed will identify the deficiency, outline how the deficiency will be corrected and set a time frame for implementing the corrective actions.

III. DEFINITIONS, MISSION, AND GOALS AND OBJECTIVES

1. Definitions:

A. **Abuse** - incidents or practices of a provider, which although are not usually considered fraudulent, are inconsistent with accepted sound medical, business, or fiscal practices. These practices may directly or indirectly result in unnecessary cost to the program, improper payment, or payment for services that fail to meet professionally recognized standards of care, or that are medically unnecessary.

B. **Access and Uses** - allows employee access to PHI subject to qualifying job requirements. Each employee is provided appropriate levels of security to perform their job duties.

C. **Authorization** - written authorization for any use or disclosure of PHI that is not for treatment, payment, health care operations or otherwise permitted or required by regulations and/or statutes.

D. **Breach** - the acquisition, access, use, or disclosure of protected health information, where the security or privacy of an individual's information is compromised; the compromise shall be presumed to be a breach unless CalViva Health or one of its Business Associates as applicable demonstrates that there is a low probability that the protected health information has been compromised based on a risk assessment. See 45 C.F.R. § 164.402.

a. "Breach" excludes three scenarios:

- Any unintentional acquisition, access, or use of protected health information by a CalViva Health employee or person acting under the authority of CalViva Health or one of its business associates, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure.

- Any inadvertent disclosure between employees of CalViva Health or of a CalViva Health business associate, where both employees are authorized to access such protected health information, and where the information received as a result of such disclosure is not further used or disclosed.

- A disclosure of protected health information where CalViva Health or one of its business associates has a good faith belief that an unauthorized person to whom the disclosure was made

would not reasonably have been able to retain such information.

E. **Confidentiality** - the obligation of the holder of personal information to protect an individual's privacy. This obligation is determined by common practice, federal and state laws and regulations.

F. **Data Aggregation –**the combining of PHI created or received by the Plan on behalf of DHCS with PHI received by CalViva Health in its capacity as the contractor of another covered entity, to permit data analyses that relate to the health care operations of DHCS.

G. **Disclosure** means the release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the information.

H. **Protected Health Information (PHI)** - Individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. "Individually identifiable health information" is information, including demographic data, that relates to: 1) the individual's past, present or future physical or mental health or condition, 2) the provision of health care to the individual, or 3) the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number)

I. **Risk Assessment/Analysis** – the process of identifying, prioritizing, and estimating risks of organizational operations (including mission, functions, image, and reputation), organizational assets, individuals, other organizations, and the Nation, resulting from the operation of an information system.

J. **Risk Management** – The program and supporting processes to manage information security risk to organizational operations (including mission, functions, image, reputation), organizational assets, individuals, other organizations, and the Nation, and includes: (i) establishing the context for risk-related activities; (ii) assessing risk; (iii) responding to risk once determined; and (iv) monitoring the risk over time.

K. **Risk Mitigation** – Prioritizing, evaluating, and implementing the appropriate risk-reducing controls/countermeasures recommended from the risk management process.

L. **Security** - security or security measures encompassing all of the administrative, physical and technical safeguards in an information system. It relates to the extent to which information can be stored and provided with access limited to those who are authorized and have a legitimate "need to know".

M. **Threat** – Any circumstance or event with the potential to adversely impact organizational operations (including mission, functions, image or reputation), organizational assets, individuals, other organizations, or the Nation through an information system via unauthorized access, destruction, disclosure, or modification of information, and/or denial of service.

N. **Vulnerability** – Weakness in an information system, system security procedures, internal controls, or implementation that could be exploited by a threat source.

2. **Mission:**

CalViva Health has incorporated the HIPAA General Administrative Privacy Rule Requirements, the administrative, physical and technical safeguards of the HIPAA Security Rule, as required by the HITECH Act and the National Institute of Standards and Technology (NIST) Risk Management Guide for Information Technology systems into its Privacy and Security Plan. CalViva Health has administrative and management arrangements or procedures, including a Privacy and Security Plan, which is designed to guard against the unauthorized access and/or use of PHI. This document provides a description of these requirements, which are as follows:

A. Written standards of conduct, policies, and procedures, which promote CalViva Health's commitment to comply with all applicable Federal and State standards.
B. The designation of a Privacy and Security Officer and compliance committee responsible for implementing and monitoring privacy and security activities.
C. Effective lines of communication with the organization's employees
D. Conducting ongoing education and training programs
E. Conducting ongoing Risk Analyses to identify threats and vulnerabilities within the organization.
F. Conducting ongoing Risk Mitigation efforts to protect PHI from threats and vulnerabilities.
G. Monitoring and auditing processes to assess the effectiveness of the Privacy and Security Plan.
H. An internal reporting system for receiving complaints and for prompt response to detected offenses.
I. Mechanisms for enforcing compliance standards through well-publicized disciplinary guidelines.
J. The implementation of appropriate measures to prevent future offenses.

The elements of the mission allow CalViva Health to:

A. Ensure that Member's health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care.
B. Comply with the requirements of ARRA including, but not limited to, Member

requests for restrictions and accounting of disclosures.

C. Protect the public's health and well-being.
D. Adhere to the HIPAA General Administrative Privacy Rule Requirements as published in the final rule on December 28, 2000 and amended on March 27, 2002 and August 14, 2002. These requirements are found in 45 C.F.R. Part 160 and Part 164, sections 101 through 106 (otherwise known as Subparts A, B and C).
E. Adhere to the HIPAA General Administrative Security Rule as published in the final rule on February 20, 2003. These requirements are found in 45 C.F.R. Part 160, 162 and 164.
F. Adhere to the HIPAA Omnibus Rule as published on January 17, 2013.
G. Comply with the administrative, physical and technical safeguards of the HIPAA Security Rule, as required by the Health Information Technology for Economic and Clinical Health Act (HITECH Act).
H. Comply with the California Civil Code sections 1798.29(a) and 1798.82(a), California Confidentiality of Medical Information Act, Civil Code 56 et seq. and California Health and Safety Code sections 1364.5 and 1386 (b) (15) requirements and the California information Practices Act of 1977.
I. Comply with the California Department of Health Care Services (DHCS) contract requirements Exhibit G; Department of Managed Health Care (DMHC), California Civil Code section 1798.82, Center for Medicare and Medicaid Services (CMS); and, the HITECH Act breach reporting requirements.
J. Ensure privacy and security training is provided to CalViva Health employees, management and business associates.
K. Ensure Risk Analyses and Risk Mitigation Implementation Plans are conducted and implemented.

3. **Goals and Objectives:**

The goal is to assure that a CalViva Health member's personal health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care.

CalViva Health's Privacy and Security Plan incorporates the following objectives:

A. Provides oversight and monitoring of responsibilities delegated to contracted and sub- contracted entities.
B. Implement corrective action plans to address deficiencies in the safeguard or use of protected health information.
C. Conducting ongoing Risk Analyses to identify threats and vulnerabilities within the organization.
D. Conducting ongoing Risk Mitigation efforts to protect PHI from threats and vulnerabilities.
E. Conduct internal monitoring and auditing of CalViva Health operations and functions to assess compliance with state and federal requirements.

F. Identify and investigate potential privacy and security breaches. Take appropriate action(s) to resolve and report breaches.

G. Provide education and other available resources to assist contracted providers and sub- contractors in becoming compliant with privacy and information security requirements.

H. Educate staff and enforce adherence to CalViva Health's Code of Conduct standards, privacy and security policies and procedures and mission.

I. Provide new legislation updates to providers and contractors that specify required actions to ensure contractual compliance and makes available additional information about privacy and security activities and requirements on an ongoing basis as needed.

Anyone with questions or concerns about the Privacy and Security Plan or a particular policy or procedure should seek the guidance of the Privacy and Security Officer. The Privacy and Security Officer provides support in CalViva Health's ongoing commitment to provide quality services in compliance with the health information privacy and security laws.

IV. SCOPE OF PLAN

1. Policy and Procedures:

CalViva Health has adopted a set of policies and procedures. The policies and procedures are available to employees and business associates. Employees and business associates are able to access the policies in either a paper or electronic format. The policies and procedures along with this plan are the core of CalViva Health's Privacy and Security Plan and outline areas such as:

A. How PHI is used and disclosed
B. The individual's rights to PHI
C. CalViva Health's relationship with contractors and sub-contractors
D. CalViva Health's response plan for complaints and privacy breaches
E. CalViva Health's training programs
F. CalViva Health's risk analyses and risk mitigation measures
G. CalViva Health's contingency plans

2. Permitted Uses and Disclosures:

CalViva Health's Privacy and Security Plan covers the permitted uses and disclosures pertaining to protected health information. This includes sending a Notice of Privacy Practice to members upon enrollment and annually thereafter explaining how CalViva Health uses and discloses protected health information. CalViva Health is permitted to use and disclose protected health information for activities that are directly connected with the administration of the Plan's healthcare program, which includes but is not limited to establishing eligibility and methods of reimbursement, and providing services for members. CalViva Health extends this commitment to its own internal business operations, as well as its oversight and monitoring responsibilities relating to its business partners. CalViva Health provides DHCS with a list of external entities, including persons, organizations, and agencies to which it discloses PHI annually. The guiding principles of CalViva Health's Permitted Uses and Disclosures of PHI include:

A. Use/disclosure of PHI for CalViva Health management and administration
B. Use/disclosure of PHI by CalViva Health for data aggregation services to DHCS
C. Use/disclosure of PHI by CalViva Health for conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the Plan's healthcare program
D. Use/disclosure of PHI by CalViva Health for legislative investigations/audits related to the administration of the Plan's healthcare program

3. CalViva Health Responsibilities:

CalViva Health has made several commitments in its Privacy and Security Plan, policies and

procedures and business operations. CalViva Health takes steps to ensure a member's Medi-Cal status is not divulged without prior approval except for treatment, payment and operations, or as required by law. CalViva Health's commitment to privacy and security of PHI also includes:

A. **Implementing Safeguards –** CalViva Health has in place appropriate administrative, technical and physical safeguards to protect the privacy of health information in both electronic and hard-copy form. CalViva Health employees are trained in methods to assure that they use all reasonable measures to safeguard protected health information from any use or disclosure that would violate the HIPAA or state regulations or CalViva Health's privacy and security policies. CalViva Health's employees have limited access to protected health information through role-based access and password protections. CalViva Health also has firewalls to protect information from those who do not need to access the protected health information to perform their job functions.

B. **Implementing Security Measures –** CalViva Health employees working with PHI sign a confidentiality agreement; undergo a background check and use workstations and laptops with encryption mechanisms. CalViva Health enforces the "minimum necessary" principle in regards to PHI and ensures employees send secure emails or utilize another appropriate secure method (i.e. secure file transfer protocol ("FTP") when PHI is involved. CalViva Health uses the latest antivirus software and security patches on their workstation and/or laptops. Any uses of removable media devices or remote access used by CalViva Health associates for PHI are encrypted. CalViva Health incorporates a data destruction method consistent with the Department of Defense standard methods and assigns unique usernames and passwords to users accessing PHI. CalViva Health enforces security measures in several ways:

    1. **Use of System Security Controls –** CalViva Health will ensure computer systems automatically timeout after no more than 20 minutes of inactivity. CalViva Health will make sure all systems containing PHI display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only. CalViva Health's systems will include system-logging functions, access controls, transmission encryption and host based intrusion detection. Logs and user activities are maintained by CalViva Health in accordance with the Plan's document and data retention policy and procedures.

    2. **Use of Audit Controls –** CalViva Health will conduct system security reviews of all systems processing and/or storing PHI. The audit controls in place include reviewing systems logs for unauthorized access and ensuring there is a documented change control procedure in place.

    3. **Use of Paper Document Controls –** CalViva Health's paper document controls includes protection of data by making sure PHI in paper form is locked in a file

cabinet rather than left unattended. CalViva Health also escorts visitors to areas in which PHI is housed. CalViva Health confidentially shreds and destroys PHI in paper form and never removes PHI from the premises except for routine business purposes or with the express written permission of a state and/or federal agency. Faxes containing PHI are never left unattended and outgoing faxes include a confidentiality statement notifying the recipient receiving to destroy faxes received in error. PHI is mailed using secure means and for large volume mailings of PHI, CalViva Health uses a bonded courier with signature required on receipt.

4. **Use of a Contingency Plan –** CalViva Health's contingency plan includes an ability to enable continuation of critical business processes and protection of the security of electronic PHI in the event of an emergency. CalViva Health makes sure all sensitive data including PHI is backed up regularly. Data backups are stored offsite, which allows for restoration of data in the event of an outage.

C. Notification and Investigation of Incidents and/or Breaches - CalViva Health is committed to compliance with HIPAA and state health information compliance laws and to correcting violations. Upon discovery of a suspected security incident and/or breach, CalViva Health notifies the applicable state and federal agencies without unreasonable delay. CalViva Health takes prompt corrective action to mitigate any risks or damages involved with the breach. Refer to the Plan's Privacy and Security policies and procedures for detailed descriptions of the breach investigation and notification processes.

1. **Investigation and Corrective Action -** If there is a report of noncompliance, or the Privacy and Security Officer, a member of the Compliance Committee or a Plan employee/associate discovers credible evidence of a violation, an investigation will immediately ensue. When CalViva Health substantiates a reported violation, it is the policy to institute corrective action.

2. **Initiating Systemic Changes to Correct Problems** - After a problem has been identified and corrected, the Privacy and Security Officer and Compliance Committee will review the circumstances to determine 1) whether similar problems have been uncovered elsewhere and 2) whether modifications of the policies and procedures are necessary to prevent and detect other inappropriate conduct or violations. The Privacy and Security Officer will work with the Compliance Committee to initiate systemic changes throughout the company to avoid future problems of a similar nature.

4. Education and Training Programs:

CalViva Health will ensure that training is provided to all employees and business associates. All employees with access to protected health information are required to attend and participate

in privacy and security training sessions. Adherence to the provisions of this Plan, such as attending training sessions, will be a factor in the annual evaluation of each employee. All new employees will be provided training within a reasonable period after orientation.

5. Risk Analysis and Risk Management:

CalViva Health understands a risk analysis is the first step in identifying and implementing safeguards that comply with and carry out the standards and implementation specifications in the Security rule. CalViva Health works to ensure an accurate and through assessment of the potential risks and vulnerabilities to the confidentiality, integrity and availability of PHI held by the Plan.

CalViva Health implements these steps when conducting a risk analysis:

a. Step 1: System Characterization
b. Step 2: Threat Identification
c. Step 3: Vulnerability Identification
d. Step 4: Control Analysis
e. Step 5: Likelihood Determination
f. Step 6: Impact Analysis
g. Step 7: Risk Determination
h. Step 8: Control Recommendations
i. Step 9: Results Documentation

The steps referenced above are consistent with the methodologies described in the National Institute of Standards and Technology (NIST) Special Publication (SP) 800-30 Risk Management Guide for Information Technology Systems and NIST SP 800-66 An Introductory Resource Guide for Implementing the Health Insurance Portability and Accountability Act (HIPAA) Security rule.

Along with risk analyses, CalViva Health maintains a risk management protocol which provides a structure for the evaluation, prioritization, and implementation of risk-reducing security measures. CalViva Health has a team of individuals in place who are knowledgeable about the organization's Privacy and Security policies, procedures, training program, computer system set up, and technical security controls.

APPROVAL:

_____ **Date:** _____

Name: Jeffrey Nkansah
Title: Chief Operating Officer

_____ **Date:** _____

Name: Gregory Hund
Title: Chief Executive Officer

_____ **Date:** _____

Name: David S. Hodge, M.D.
Title: RHA Commission Chairperson

Program Description History		
Date	**Section #**	**Comment(s)**
1/1/2012		New Program Description
3/1/2013		Updated entire document to properly reflect Privacy and Security Measures
2/6/2014		Changes to the Breach and Protected Health Information definition to align with the HIPAA FINAL Rule published on January 17, 2013; added language pertaining to the Risk Management Team; clarification to identify the Chief Compliance Officer is also the Privacy and Security Officer and other minor changes to clarify current contractual relationships and activities; comply with new regulations and Medi-Cal contract requirements
1/5/2015		Annual Review; No Changes Needed
2/18/2016		Annual Review; Updated the contact information for the Compliance Officer. Minor edits to clarify current practices.

2/16/2017		Annual Review; Updated overview clarify current contractual relationships and activities. Updated the name of document from Privacy and Security Program to Privacy and Security Plan.
2/15/2018		Annual Review; Updated the officer responsible for the Privacy and Security Plan, added a reference to comply with California's Data Breach Security Reporting Requirements, Updated the Department Responsible for the Plan and the reference to the name of the report which would be provided to the RHA Commission. Re-arranged sections for readability.
2/21/2019		Annual Review; No Changes Needed