

Item #11

Attachment 11.A

2019 Annual Compliance Evaluation

CALVIVA HEALTH
2019 ANNUAL REGULATORY AFFAIRS & COMPLIANCE EVALUATION

I. EXECUTIVE SUMMARY

The Fresno-Kings-Madera Regional Health Authority (“RHA”) dba CalViva Health (“CalViva” or the “Plan”) operates as a public agency, Local Initiative Medi-Cal managed care plan covering the counties of Fresno, Kings and Madera. The Plan does not offer commercial or other product lines. CalViva Health is committed to maintaining its business operations in compliance with ethical standards, Department of Health Care Services (“DHCS”) Medi-Cal contractual obligations, Department of Managed Health Care (“DMHC”) requirements, and all-applicable state and federal statutes, regulations and rules. CalViva Health’s compliance commitment extends to its own internal business operations, as well as its oversight and monitoring responsibilities relating to its business partners.

CalViva Health has an Administrative Services Agreement (“ASA”) with Health Net Community Solutions (“Health Net”) to provide certain administrative and operational services on the Plan’s behalf. CalViva Health also has a Capitated Provider Services Agreement (“CPSA”) with Health Net for the provision of health care services to CalViva Health members through Health Net’s network of contracted providers and subcontracted health plans. CalViva Health also has direct contracts with three (3) Federally Qualified Health Centers. A primary responsibility of the Plan is to ensure Health Net and their subcontractors perform delegated services and activities in compliance with CalViva Health standards, contractual requirements and state and federal regulatory requirements.

The Compliance Program is guided by the Plan’s mission “To provide access to quality cost-effective healthcare and promote the health and well-being of the communities we serve in partnership with health care providers and our community partners.” The Compliance Program is implemented by all Plan Departments: Compliance, Medical Management, Finance and Operations. Compliance Program results are the collective achievements of dedicated Plan staff members, the Plan’s administrator, providers and community-based organizations working together to meet the needs of CalViva members and the community we serve. As will be presented below, the Plan continues to improve its policies, improve its oversight of delegates/subdelegates and increase its network adequacy, while meeting increased regulatory requirements and oversight. Overall in 2019, the Plan achieved success in increasing oversight of delegates/subdelegates, improving network adequacy, resolving grievances/appeals in timely manner, and providing access to services to more than 350,000 members in Fresno, Kings and Madera counties. Going forward, the Compliance Program will focus on meeting new regulatory challenges in 2020 and beyond, improving performance by addressing issues identified through Corrective Action Plans (CAPs) as well as maintaining overall operational effectiveness and regulatory compliance.

II. REGULATORY AFFAIRS

A. Administrative and Operational 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 DMHC in compliance with Knox-Keene regulations, and to the DHCS in compliance with its contract, Medi-Cal regulations and All Plan Letters. Regulatory filing activities include but are not limited to: material modification and amendment filings, annual timely access submissions, annual network certification, fraud waste and abuse case review and submissions, member-informing materials, new benefit-associated deliverables, changes in commission/committee members, key policies and procedures, etc. In 2019, CalViva Health made over 200 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. In addition to regulatory filings and report submissions, the Plan undergoes annual audits by DHCS, triennial medical and financial audits by DMHC, annual HEDIS® audits and implements and addresses regulatory agency CAPs as needed.

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

1. Department of Health Care Services (DHCS):

- a. December 2017 DHCS Encounter Data CAP – The Plan successfully completed the CAP and DHCS closed this CAP on February 27, 2019.
- b. 2018 DHCS Medical Survey CAP Approval – On March 27, 2019, DHCS accepted the Plan’s Response to the 2018 Final Report/CAP regarding Provider Qualifications/Training and closed the CAP.
- c. February 2019 DHCS Annual Audit - The DHCS Final Reports were issued on October 29, 2019. The Medical Survey Report indicated that the Plan successfully passed most audit areas and requested a CAP related to the Plan’s deficiencies in three areas. The Plan filed the response to the CAP on December 3, 2019 and is in the process of implementing corrective actions. The State Supported Services Final Report found no deficiencies.
- d. DHCS 2018 HEDIS® Quality of Care CAP – The Plan successfully implemented its quality improvement interventions, met the CAP goals and DHCS closed this CAP effective September 1, 2019.
- e. HEDIS® 2019 Compliance Audit™ - The Plan was notified in July 2019 that it successfully passed all elements of the annual compliance audit.
- f. DHCS 2017-2018 Performance Evaluation – The report identified only four (4) external quality review (EQR) recommendations from the previous year. The Plan

successfully implemented interventions addressing all four (4) areas.

- g. 2019 DHCS Managed Care Quality Awards – the Plan was the Health Equity Award Winner for the CalViva Postpartum Visit Disparities Project with United Health Centers Mendota Clinic.
- h. DHCS 2018 Encounter Data Validation (EDV) –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, 2017 and December 31, 2017. Preliminary study results assessing encounter data completeness and accuracy were issued on November 21, 2019. Overall, the Plan did not meet the standard for completeness (i.e., < 10%) for the elements reviewed. The Plan met the accuracy standard (>90%) for all elements reviewed.
- i. 2019 DHCS Annual Network Certification (ANC) – The Plan submitted the ANC in March of 2019. The DHCS issued a CAP on July 9, 2019 related to non-compliant time and distance standards. Accordingly, the Plan submitted Alternative Access Standard (AAS) requests and the DHCS closed the CAP on November 15, 2019 and certified the Plan’s network.
- j. February 2020 DHCS Annual Audit - DHCS initiated its 2020 Pre-Audit request for documents on November 7, 2019. All requested documents and case files were submitted by December 9, 2019. DHCS will be on-site the week of February 3, 2020.

2. Department of Managed Health Care (DMHC):

- a. Measurement Year (MY) 2018 Timely Access Report (TAR): The Plan submitted its annual TAR filing in March of 2019. As of the end of 2019, DMHC has not issued its preliminary findings.
- b. February 2019 (Triennial) DMHC Audit – DMHC issued its Preliminary Report on September 19, 2019 citing deficiencies in four areas. The Plan submitted its response to the preliminary findings and a CAP on November 4, 2019. The Plan is awaiting the DMHC’s Final Report.
- c. 2019 Triennial Routine Financial Exam – In June of 2019, the DMHC conducted a routine examination of the Plan’s fiscal and administrative affairs, including an examination of the financial report for the period ended March 31, 2019. The only finding was related to the Plan’s fidelity bond which did not include language covering non-compensated individuals as required. The Plan promptly rectified the issue and the DMHC issued their Final Report on November 8, 2019 with no further action required.

- d. DMHC Enforcement Matter 17-1703 - DMHC issued an enforcement action against a dozen health plans including CalViva Health and our administrator Health Net for lack of oversight of a contracted medical group (Employee Health Systems Medical Group (EHS)), which DMHC said led to improper denials and delays of enrollees' care. After lengthy discussions with DMHC regarding the enforcement action, CalViva Health and Health Net agreed to sign Letters of Agreement (LOAs) with DMHC in December 2019 and pay fines to DMHC to resolve this matter. CalViva Health's fine was \$360,000.
- e. DMHC Enforcement Matter 18-370 - DMHC issued an enforcement action against CalViva Health for two administrative violations in not meeting MY 2016 Timely Access Reporting requirements. After several discussions with DMHC regarding the enforcement action, CalViva Health agreed to sign a Letter of Agreement (LOA) with DMHC in June 2019 and pay a \$2500.00 fine to DMHC to resolve this matter.

C. DHCS Fraud, Waste and Abuse Required Reporting:

In 2019, the Plan identified and investigated sixteen (16) cases which were determined to reflect suspected fraud and/or abuse cases. Accordingly, sixteen (16) MC609 reports were promptly filed with the DHCS. All sixteen (16) were provider-related (1 DME supplier, 2 pharmacies, and 13 physicians and/or clinics). These sixteen (16) cases were reported to DHCS within the 10 working days requirement following the suspicion of potential fraud. The DHCS closed two of these cases. The California Department of Justice (DOJ) has open cases on four (4) of the these sixteen (16) cases and requested information from the Plan. The Plan cooperated with the DOJ requests. There were no cases referred to other law enforcement agencies by the Plan.

D. Privacy and Security Oversight

1. Regulatory and Contractual Obligations

CalViva Health continued to review and refine their practices and processes to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA), Department of Health Care Services (DHCS) contractual obligations and any other privacy and security related laws and regulations. The following key activities were completed for 2019:

- Breach Notifications and Assessments – Risk assessments were conducted on cases to determine the probability of compromise of protected health information in the event of a breach of unsecured protected health information.
- Risk Analysis – CalViva Health updated the Plan's prior risk analysis with a new risk analysis in 2019.

- New Vendor HIPAA One – Contract signed to utilize HIPAA One as the Plan’s new risk analysis in 2020 and moving forward.
- Cybersecurity Assessment – CalViva Health contracted with a vendor to have a Cybersecurity Assessment conducted for the first time within the Plan.
- Periodic and Ongoing Training – The Plan conducted ad-hoc and annual privacy and security training to all employees. Educational newsletters were distributed quarterly.

CalViva Health also continued their efforts in the oversight and monitoring of Business Associates (BA) who create, maintain and/or transmit protected health information (PHI). In addition, CalViva Health maintained a contract with a company to conduct security and vulnerability scans, and another company for use of their software to assess CalViva Health’s compliance with the HIPAA privacy and security regulations.

In 2020, CalViva Health will continue assessing their practices and processes to ensure compliance with HIPAA and any applicable state regulations. These assessments could include, but is not limited to, reviewing operational business practices, completing a new risk analysis with HIPAA One, engaging in ongoing risk management activities, and reviewing program documents related to HIPAA.

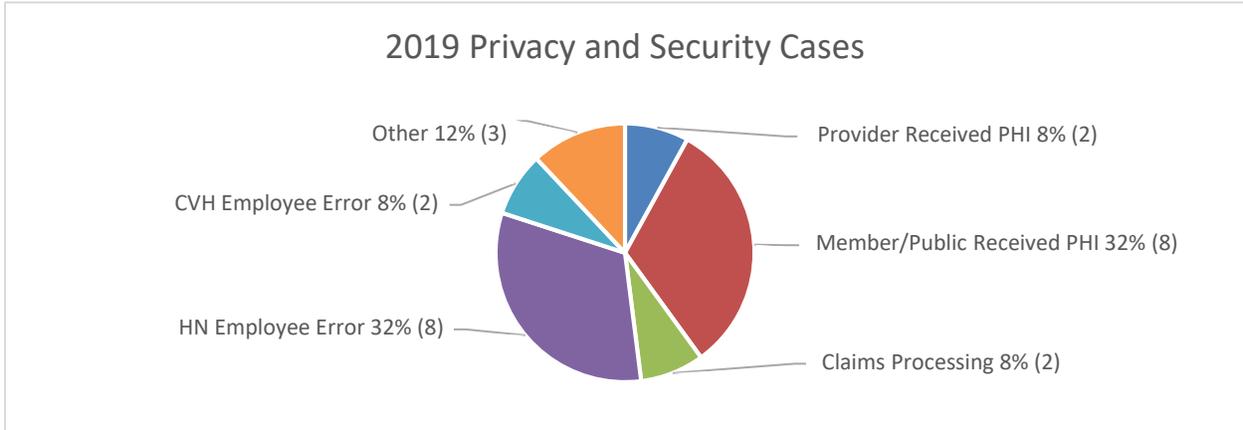
2. Reports of Possible Privacy and Security Incidents/Breaches

As described in the Plan’s privacy and security policies and procedures, upon discovery of an incident/breach, CalViva Health must notify state and federal agencies of the incident/breach in accordance with regulatory requirements. In addition, the Plan must take prompt corrective action to mitigate any risks or damages involved.

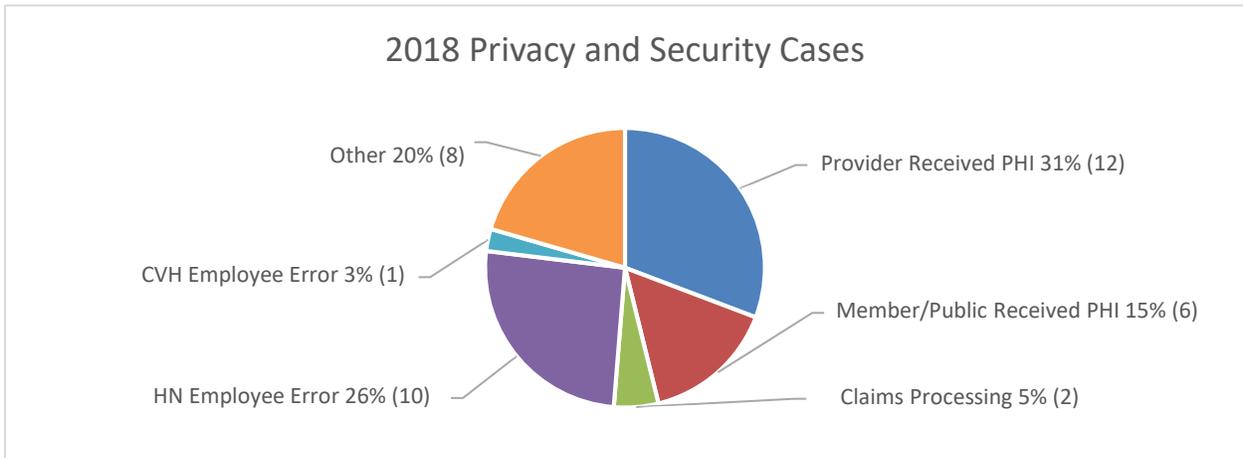
In 2019, twenty-five (25) privacy and security incidents were reported to the DHCS. Two (2) incidents occurred within CalViva Health. The remaining twenty-three (23) incidents involved the Plan’s Administrator Health Net. Eighteen (18) cases were deemed low risk or no risk after the completion of a risk assessment. Four (4) cases did not require completion of a risk assessment as there were zero (0) individuals affected by the privacy incidents. One (1) case was deemed moderate-risk, which required notifications to affected individuals. There are two (2) cases which are still under investigation and waiting to be determined as a high-risk, moderate-risk, or low-risk case.

The first pie chart provides a high-level overview of the types of incidents which occurred in 2019. The second pie chart provides high-level overview of the types of incidents which occurred in 2018 for comparison purposes:

2019 Privacy and Security Cases



2018 Privacy and Security Cases



The pie charts reveal that the total number of privacy and security incidents decreased by 36% in 2019 (25 incidents) from 2018 (39 incidents). The total number of claim processing related privacy and security incidents had no change between 2019 and 2018. On the other hand, the number of incidents involving providers receiving PHI decreased by 83%.

3. CalViva Health Internal Audits

CalViva Health conducts monthly workstation audits to enforce standards for protecting the privacy of Personal Health Information (PHI). Compliance staff conduct an after-business hours audit of internal workstations/offices and communal workspaces (e.g. document storage, fax machines, printers, and copy machines) to see if PHI is exposed and to determine if computers have been logged off. Spot check audits are also conducted during work hours to see if PHI is being exposed inappropriately or left unattended.

In 2019, there were two (2) incidents where an employee was subject to disciplinary action due to a privacy and security non-compliance issue.

E. DHCS Notice of New Benefits or Programs:

1. Full-Scope Medi-Cal Expansion to Undocumented Young Adults - Pursuant to Senate Bill 104, young adults between the ages of 19 and 25 who do not have satisfactory immigration status will be eligible for full scope Medi-Cal beginning in 2020. An estimated 1,617 beneficiaries in Fresno county, 228 in Kings county and 438 in Madera county will be transitioned.
2. Restoration of Medi-Cal Optional Benefits - The 2019-2020 state budget restored the following optional benefits as of January 1, 2020: audiology and speech therapy services, incontinence creams and washes, optician and optical lab services, and podiatric services.
3. Maternal Mental Health Continuity of Care - AB 577 adds a “maternal mental health condition” to the list of conditions that qualify for completion of covered services. Section 1 amends section 1373.96 of the Health & Safety Code to add a definition for “Maternal mental health condition” and expands on Pregnancy as a condition for completion of covered services. A subpart B was added to say “For purposes of an individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual’s treating health care provider, completion of covered services for the maternal mental health condition shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.”
4. DHCS is implementing a Preventive Care Outreach project. The California State Auditor conducted an audit of DHCS’ oversight of the delivery of preventive services to children in the Medi-Cal Program in 2018. The audit concludes that millions of children do not receive preventive services to which they are entitled. As a result, DHCS is implementing this Outreach Project in two phases.
 - Phase 1 - DHCS will use targeted outreach (via mail and a call campaign) to inform beneficiaries under 21 with full-scope Medi-Cal eligibility about the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services available and how to access these services. The number of beneficiaries under 21 total approximately 5.6 million. DHCS will mail the outreach notices and the plans will conduct the call campaign. Implementation no sooner than March 1, 2020.
 - Phase 2 of the Preventive Care Outreach project will involve DHCS contracting with an independent entity to conduct surveys of beneficiaries, design outreach materials and engage with stakeholders in order to determine the best outreach processes moving forward. It is expected that Phase 2 will be completed by December 31, 2020.

III. Compliance Program Activities

A. Program Document Reviews/Updates:

CalViva Health continued to operate a comprehensive Compliance Program in 2019. The Plan's Compliance Program includes the following written descriptions which were reviewed and updated as necessary in 2019.

- 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 2019 oversight audits of functions delegated to Health Net. Audits included desk reviews of any applicable functions subdelegated by Health Net, policies and procedures, reports, and evidence submitted to meet the required audit elements. An onsite audit was conducted for the delegated activity of Claims.

Access & Availability	Claims*	Provider Disputes*
Continuity of Care	Cultural and Linguistics	Emergency Services
Health Education	Marketing	Privacy and Security
Quality Improvement	Pharmacy*	

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

2. Periodic Monitoring of Health Net

During 2019, 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
 - Implementation of increased oversight of subdelegated functions through the introduction of new report dashboards of comprehensive performance metrics accompanied by narrative reports explaining outlier data or issues.
 - Implementation of new contract amendments to the ASA and CPSA between the Plan and Health Net effective July 1, 2019. The amendments extended the terms of the ASA and CPSA to June 30, 2024 with three one-year renewals. The ASA amendment includes the following additional provisions:
 - Added and or updated performance measures, standards for compliance with the measure, and detail supporting each.
 - Penalty to Health Net for failure to meet standards is increased for all measures with a Maximum Penalty within any measurement period (i.e. calendar year). Penalties continue to be assessed by the Plan as a deduction in Administrative Fees owed to Health Net by the Plan for services under the ASA.
 - Enhanced process for CalViva Health and Health Net to periodically review Health Net performance and modify standards pursuant to changes in law or regulation; and for Health Net to dispute Plan findings of non-performance.

3. 2019 CalViva Internal Audit

During 2019, 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 2019 the Plan conducted training for one new hire 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 2019, 70 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 2 Member Newsletters. The 2019 Annual Mailing was distributed to members for calendar year 2019 with information about benefit changes in 2019 and a flyer telling members how to obtain the Member Handbook (2018 version) and a Provider Directory. A 2019 Member Handbook/Evidence of Coverage (EOC) was not issued by the Plan as the DHCS did not issue a 2019 model Member Handbook. A 2020 Member Handbook/EOC is in production now and will be mailed to members in late Q1, 2020.

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 2019, contracted providers were sent approximately 217 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 18 forms intended for provider use.

7. Provider Relations

CalViva Health continued productive relationships with participating providers by completing 1932 provider visits and 1353 training 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 2019.

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)	116,930	4,673
Calls Handled	116,107	4,615
Abandonment Rate % (Goal 5% or less)	0.7%	1.2%
Average Speed of Answer (Goal 30 secs) or less)	10 sec.	22 sec.
Service Level (Goal 80%)	91%	87%

11,281 welcome calls were made to new members during 2019.

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 2019, 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	189	189	100 % (189)
Standard Grievances	1118	1101	99.91% (1100)
Expedited Appeals	158	158	100.% (158)
Standard Appeals	744	729	99.59% (726)
Total:	2209	2177	99.81% (2173)
SPD Appeals & Grievances [*]	692	684	99.85% (683)
Exempt Grievances [#]	3589	3589	100%

[†] Total will not match as some cases received in December 2019 may remain open at the start of 2020, and the resolved case number may include some cases received in December 2018 and resolved in 2019.

^{*} 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 2019. All cases were submitted within the required turnaround times.

Cases Received	2019 Total	% Cases Submitted w/in the TAT
DMHC Cases	91	100%
DHCS State Hearings	30	100%
Total:	121	100%

IV. 2020 ACTIVITIES

In 2020, the Plan expects to undergo additional audits and reviews from regulatory agencies. The Plan anticipates developing new policies and implementing/revising existing processes as a result of new regulatory guidance and laws effective in 2019 and 2020.

The Plan 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 for direct and delegated networks
- Timely Access
- Encounter data quality and timeliness
- Clinical Quality Improvement (35 MCAS measures)
- Member Grievances/Appeals
- Independent Medical Reviews and State Hearings

In September 2019, the DHCS launched the Managed Care Program Data Quality Improvement Project (MCPDIP) in an effort to improve Medi-Cal data quality. For several data sets that the Plan currently provides DHCS in an Excel format on a **quarterly** basis, (i.e., Grievances, Appeals, Continuity of Care and Out of Network Referrals), a new, single, **monthly** file format (JSON) which includes all four categories will have to be submitted starting July 1, 2020. Additionally, a new monthly data set, Primary Care Provider Assignment (PCPA), which identifies the PCPs assigned to each Plan member will be implemented. Penalties and sanctions will apply for noncompliance.

In October 2019, the DHCS released a proposed framework for the upcoming waiver renewals that encompassed a broader delivery system, program and payment reform across the Medi-Cal program called Medi-Cal Healthier California for All (MCHCA). MCHCA contains 20+ initiatives that will be phased in over several years. The following initiatives are currently the primary focus and many will significantly impact the Plan:

CORE INITIATIVE	TIMELINE
NCQA Accreditation for Plans, Delegates	By 2025
Population Health Management	Incorporated into plan contracts by 2021.
Enhanced Care Management + In Lieu of Services (Incentive payments to shared savings)	ECM benefit by 1/2021 for mandated populations and 1/2023 for individuals transitioning from incarceration
LTC Integration + Duals + D-SNPs Organ Transplants	LTC & organ transplants for all plans by 1/2021; duals mandatory 1/2023; mandate D-SNPs 1/2023
Regional Rates	Phase I for targeted counties and MCPs by 1/1/2021. Statewide regional rates no sooner than 1/1/2023
Behavioral Health (Payment Reform, Revising Medical Necessity Criteria, Administrative Integration of SMI and SUD, County Regional Contracting)	January 1, 2021 or later depending on county readiness
Mandatory Managed Care Populations	Non-dual and pregnancy related aid code group, and population-based transitions by 1/1/2021; dual aid code group by 1/1/2023.

Among all the new requirements in 2020, the Plan will continue to focus on implementing the federal regulatory changes passed as the part of the Medicaid Managed Care regulation (aka Mega-Reg). These changes were officially incorporated into the Plan's DHCS Medi-Cal contract Amendment No. 12 in December 2019 but were retro-effective as of July 1, 2017.

The Plan will also be involved in transition activities related to the carve-out of outpatient pharmacy benefits back to the Medi-Cal FFS program. This transition is effective January 1, 2021 and there are many transition activities the Plan and its administrator, Health Net, will have to carry out during 2020.

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

APPROVAL:

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

Name: _____ **Date:** _____
Title: Gregory Hund
Chief Executive Officer

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

Item #12

Attachment 12.A

2020 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, religion, ancestry, ethnic group identification, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identify -or sexual orientation. - 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

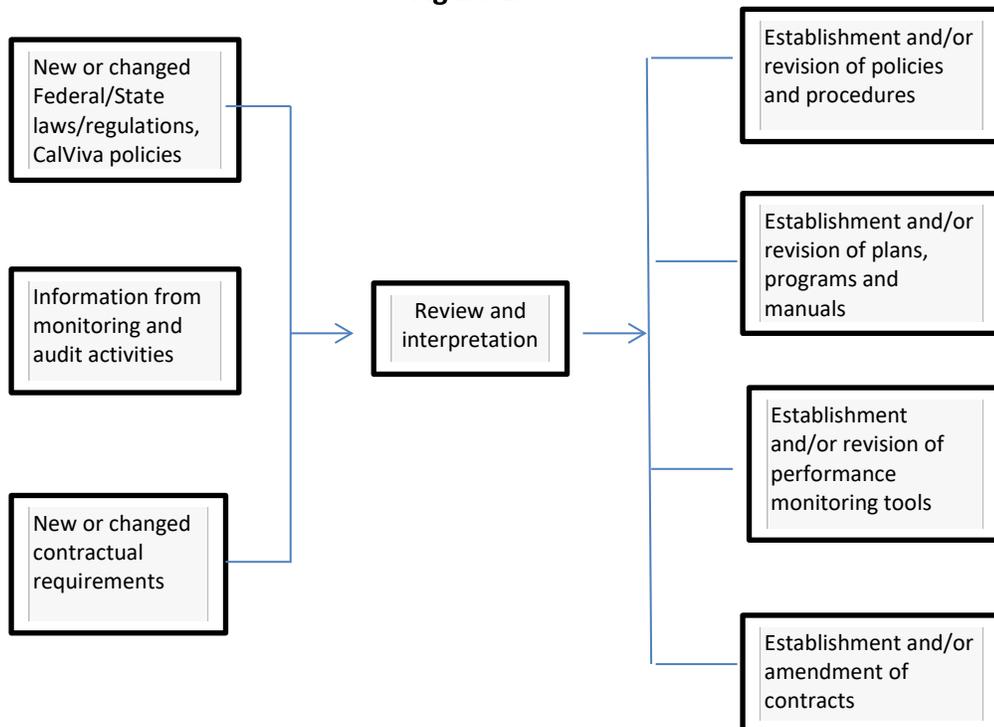
Prevention is the cornerstone to CalViva’s Compliance Program. Efforts to prevent noncompliance are articulated through written policies, procedures, work plans, program descriptions and manuals. The Compliance Department staff implements the Program in collaboration with its internal stakeholders from 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: _____ Date _____
 Title: Mary Beth Corrado
 Chief Compliance Officer

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

Name: _____ Date _____
 Title: David S. Hodge, M.D.
 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.
<u>02/20/2012/19/19</u>	<u>Added additional Discrimination language to V. Compliance Risk areas, Section A.</u>

Item #13

Attachment 13.A

2020 Code of Conduct



Code of Conduct

For inquiries regarding this Code of Conduct, please contact:

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Fresno, CA 93711
mbcorrado@calvivahealth.org
Phone: 559-540-7847

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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,~~ religion, ancestry, ethnic group identification, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation.
 - 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 [and/or an Independent Medical Review \(IMR\)](#).
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 Medi-Cal 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, ancestry, ethnic group identification, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation 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:

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

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

 Date: _____

Name: David S. Hodge
Title: RHA Commission Chairperson

Item #14

Attachment 14.A

2020 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

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.

[RHA has an Administrative Services Agreement \(“ASA”\) with Health Net Community Solutions \(“Health Net”\) to provide certain administrative services on the Plan’s behalf. RHA also has a Capitated Provider Services Agreement \(“CPSA”\) with Health Net for the provision of health care services to CalViva Health members through Health Net’s network of contracted providers. Health Net is contracted to provide a broad range of administrative and operational services on CalViva Health’s behalf, including but not limited to: enrollment processing, provider contracting and credentialing, utilization management, claims processing, member and provider services and maintaining the systems for most CalViva Health operations.](#)

[Under the term of the ASA and CPSA, Health Net is responsible for fraud and abuse investigations related to potential fraud cases involving CalViva Health members, providers, Health Net employees and subcontractors performing functions on behalf of CalViva Health. CalViva Health maintains overall responsibility for anti-fraud and abuse activities, and performs oversight and monitoring of Health Net and their Special Investigations Unit \(“SIU”\). The Plan also retains responsibility for investigating and addressing any potential incidents of fraud and abuse involving CalViva Health employees and consultants.](#)

[In addition to Health Net, CalViva Health ~~may contracts~~ contract- with other 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 \[Plan requirements\]\(#\), 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. ([42 CFR 455.2; W&I Code Section 14043.1\(i\).](#))

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 Law Group, PC](#) 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 Law Group, PC, LLP](#) for investigation as needed.
2. CalViva Member and Provider Investigations - As described in Section [3](#), [CalViva Health Overview](#), in accordance with the ASA and CPSA between CalViva and Health Net, [Health Net](#) the Special Investigations Unit (SIU) [for Health Net](#) 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 DepartmentPlan](#) 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 [for prompt referral of any potential Fraud, Waste, or Abuse that the Plan identifies to the DHCS Audits and Investigations](#)

Intake Unit. The Plan shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the Plan first becomes aware of, or is on notice of, such activity.

On CalViva's behalf, the Health Net SIU will conduct an investigation and provide the Plan with a report of the results. CalViva retains the discretion to determine if potential fraud and abuse claims are reportable to DHCS. The Plan's CCO will review the report with other Plan executives as appropriate to determine if the results involve a matter of suspected Fraud, Waste or Abuse. The CCO or designated Compliance staff will submit reports of suspected Fraud, Waste or Abuse to DHCS within 10 working days of the date the Plan first becomes aware of, or is on notice of, such activity. ~~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
~~Medi-Cal Managed Care Division~~Audits & Investigations Division
~~Attention: Chief, Program Integrity Unit~~Attention: Chief, Intake Unit
1500 Capitol Avenue
~~MS 4417~~MS 2500
~~P.O. Box 997413~~
Sacramento, CA ~~95899-7413~~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:

- a. Terminate the provider from its network
- b. Temporarily suspend the provider from its network pending resolution of the fraud allegation

- c. Temporarily suspend payment to the provider pending resolution of the fraud allegation; and/or
- d. 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:

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
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 highly suspected or 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:

- a. Local police departments,
- b. U.S. Postal Inspector,
- c. Federal Bureau of Investigation,
- d. Office of the Inspector General of the U.S. Department of Health and Human Services,

- e. Internal Revenue Service
- f. Local departments of Public Health in Fresno, Kings, or Madera counties,
- g. DMHC,
- h. Centers for Medicare and Medicaid Services,
- i. State medical licensing and disciplinary boards or
- j. 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-All.4.1](#).

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 [may contract with](#) 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 Letters [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:

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

Name: _____ **Date:** _____
Title: Gregory Hund
Chief Executive Officer

Name: _____ **Date:** _____
Title: David S. Hodge, M.D.
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.
2-20-20	Overview; Sections II.4.1; II.-7, 1 & 4	Clarified contractual relationships related to anti-fraud activity; updated external resources information; added revisions to reflect new requirements specified in DHCS– CalViva Contract (10-87050 A12) and made other minor editorial changes (grammar, regulatory citations, clarification to reflect current activities, etc.).

Item #15

Attachment 15.A

2020 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

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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** - 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 and lead to a compromise in the integrity of that system.

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 ~~25~~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
- G-H. CalViva Health's utilization of technology to communicate with members, providers, consumers, and employees.

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, 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 thorough 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:

Name: _____ **Date:** _____
Title: Jeffrey Nkansah
Chief Operating Officer

Name: _____ **Date:** _____
Title: Gregory Hund
Chief Executive Officer

Name: _____ **Date:** _____
Title: David S. Hodge, M.D.
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
<u>2/20/2020</u>		<u>Annual Review; Added language referencing new policy HI-031 Member Communications under Telephone Consumer Protections Act (TCPA). Clarified a definition and a publishing date for a previously released regulatory law.</u>