Kern Family Health Care™

# Kern Health Systems

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# 2024 CORPORATE COMPLIANCE PROGRAM

# Table of Contents

## Executive Summary

Why Have a Compliance Program

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

- Stops fraud.
- Protects patient privacy.
- Nurtures an ethical culture.
- Prevents conflicts of interest.
- Ensures proper credentialing.
- Identifies and prevents waste.
- Furthers accurate billing and coding.
- Assists in obeying state and federal laws.
- Maintains and promotes high quality care; and
- Strives to promote the use of best practices in management and board governance.

Kern Health System Health's Compliance Program applies to:

- Vendors
- Contractors
- Consultants
- All staff no matter the title or position
- Board of Directors

What you must do:

- Act fairly.
- Act ethically.
- Act honestly.
- Act as a team.
- Report a conflict of interest that you may have.
- Treat patients and one another with respect at all times.
- Identify ways to do things better in your department and act; and
- Report problems immediately to your supervisor, directly to the Compliance Director and/or the Chief Compliance and Fraud Prevention Officer or take advantage of our anonymous compliance hotline options.

## I. INTRODUCTION

Kern Health System (KHS) d.b.a. Kern Family Health Care (KFHC) is the Local Initiative for the arrangement of medical, social, and behavioral health care for Medi-Cal enrollees in Kern County. KHS is a public agency formed under Section 14087.38 of the California Welfare and Institutions Code. KHS began full operations on September 1, 1996, under the Kern County Board of Supervisors. KHS serves more than 365,000 Medi-Cal participants in Kern County. Medi-Cal is a jointly funded, Federal-State health insurance program for certain low-income beneficiaries. KHS is committed to the mission of improving the health of members with an emphasis on prevention and access to quality healthcare services. KHS strives to be a leader in developing innovative partnerships with the safety net and community providers to elevate the health status of all community members. with a commitment to health equity, diversity, and inclusion. We are strongly committed to and have a longstanding reputation for lawful and ethical conduct. We take pride in earning the trust of those we serve, government regulators and one another.

The Department of Health Care Services (DHCS), Department of Managed Health Care, and Knox Keene License, requires organizations that participate as California Med-Cal plan, to have a formal compliance program. The Unites States Department of Health and Human Services, Office of the Inspector General (OIG) requires Medi-Cal providers to have a compliance program as well. Additionally, in response to the many laws, rules and regulations governing healthcare, e.g., federal and state false claims and whistleblower laws, KHS has established a comprehensive compliance program to help the organization achieve our commitment to adhere to the highest ethical standards of conduct in all business practices.

One goal of KHS's compliance program is to prevent fraud, waste, and abuse while at the same time advancing the mission of providing affordable and extraordinary primary and specialty care. Our compliance efforts are aimed at prevention, detection, and resolution of variances.

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

1. Written policies and procedures
2. Designation of a Compliance Officer/Committee
3. Training and education programs
4. Open lines of communication to the responsible compliance position
5. Disciplinary policies to encourage good faith participation
6. A system for routine identification of compliance risk areas

7. A system for responding to compliance issues

8. A policy of non-intimidation and non-retaliation for good faith participation in the compliance program

Our Compliance Program further supports KHS' overall commitment to ensure we have the organizational capacity, leadership, financial well-being, commitment to invest in our communities, and demonstrated ability to ensure program integrity and compliance with all applicable federal and state requirements and the standards under the DHCS Contract.

## II. COMPLIANCE STRUCTURE

KHS's compliance program starts with its Board of Directors, who must assure the organization operates in compliance with applicable Federal, state, and local laws and regulations. The Board of Directors provide direction to our CEO, who sets the tone for the organization's compliance activities.

The Chief Compliance and Fraud Prevention Officer works to ensure the organization has the appropriate policies, procedures, and processes in place to minimize its risk and further the organization's mission to provide a holistic approach to services offerings while promoting equitable and timely access. In addition to the Chief Compliance and Fraud Prevention Officer, the Compliance Team consists of the Director of Compliance, a Compliance Manager, a Compliance Manager of Audits and Investigations, Compliance Analyst(s), Compliance Auditor, and Compliance Specialist. On a quarterly basis, the Chief Compliance and Fraud Prevention Officer and the Director of Compliance meet with the Compliance Committee and provide updates on the department's current and future activities.

KHS recognizes the importance of fostering a culture of compliance. As a result, KHS maintains and supports a Compliance Organizational Structure that allows the Compliance Program to act independently of operational and program areas without fear of repercussions for uncovering deficiencies or areas of noncompliance.

# How KHS's Compliance Program Aligns to OIG Standards

| Eight Steps of Compliance | | | | | | | |
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| **Written Policies and Procedures** | **Designation of a Compliance Officer/ Committee** | **Training and Education Programs** | **Open Lines of Communication** | **Disciplinary policies to encourage good faith participation** | **A system for routine identification of compliance risk areas** | **A system for responding to compliance issues** | **A policy of non-intimidation and non-retaliation** |
| • Fraud, Waste & Abuse, Anti-Kickback Statute, False Claims Act and Stark Law policies<br>• Whistle Blower/ Non-retaliation policy<br>• Clinical policies<br>• HIPAA<br>• Conflict of Interest<br>• Exclusion screening | • Compliance Officer job description<br>• Compliance Committee Chair<br>• Oversight responsibility of the Program<br>• Prepare an Annual Compliance Report | • Annual compliance training<br>• Compliance on-boarding training<br>• Monthly Spotlight<br>• Department training events<br>• Training at periodic all Staff meetings<br>• Ad Hoc training informs and train on recent events | • Open door policy<br>• Compliance Hotline: allows individuals to report perceived compliance issues anonymously either online, through email, fax or mail | • All members of organization are required to comply with applicable standards, laws, and procedures.<br>• Supervisors and/or Managers are account-able for the foreseeable compliance failures of their subordinates | • Annual identification of top risks<br>• Ongoing audit and monitoring activities<br>• Ad hoc audits<br>• Monthly exclusion screening<br>• Maintain anonymous outside Hotline.<br>• Annual risk assessment<br>• Credentialing and peer review | • Internal investigations and reporting<br>• Review of an Annual Conflict of Interest Disclosure Forms<br>• Process for reporting and resolving incidents | • Whistleblower/ non-retaliation policy |

## III. WRITTEN POLICIES AND PROCEDURES

The written compliance policies and procedures provide a clear explanation of the organization's compliance and quality goals and provide clear and understandable mechanisms and procedures designed to achieve those goals in compliance with Federal, state, and other program requirements and standards. The organization has specific, individual policies for an array of matters ranging from proper documentation of services to whistle blower protections. In addition, the Compliance Policies describe how we implement and operationalize the Compliance Program. KHS' policies and procedures are available online at the KHS's company site.

### A. Code of Conduct

The KHS Code of Conduct is a foundational statement of our governing principles and clearly articulates KHS' commitment to comply with all applicable regulatory requirements, including the DHCS contract, and all applicable state and federal laws. The Code of Conduct describes KHS expectation that all employees act ethically and have a responsibility for ensuring compliance. The full Board of Directors will approve the Code of Conduct. The Code of Conduct is part of the training provided upon hire and annually thereafter. It is also reviewed during the New Hire Orientation and available on the KHS Intranet.

### B. Conflict of Interest Policy and Disclosure Statement

KHS is required to ensure that it adheres to the highest standards of ethical conduct by identifying instances which an independent observer might reasonably conclude that the potential for individual or institutional conflict could influence decision making or carrying out responsibilities. KHS has a conflict of interest policy that is based upon full disclosure and appropriate management of any possible conflict of interest. The policy requires staff to conduct their business according to the highest ethical standards of conduct and to comply with all applicable laws.

KHS requires individuals to complete the annual conflict of interest disclosure form to assist in identifying and evaluating potential conflicts of interests. Individuals also are required to disclose any actual, potential, or perceived conflicts as they arise during their affiliation or employment with KHS. The forms are reviewed on an annual basis or when the need to complete the statement arises (new hires or changed circumstances). It is the responsibility of everyone to have a working knowledge of these policies and procedures and refer to them.

KHS does not utilize any state officer, employee in state civil service, other appointed state official, or intermittent state employee, or contracting consultant for DHCS, unless the employment, activity, or enterprise is required as a condition of the officer's or employee's regular state employment.

C. Other Written Policies and Procedures

Annual Work Plan

Every year, the Chief Compliance and Fraud Prevention Officer will prepare a Work Plan after reviewing the latest Department of Health Care Services (DHCS) and Department of Managed Care (DMHC) priorities, recent enforcement activities, recent internal and external audit findings and other relevant topics that necessitate additional scrutiny. Additionally, the Chief Compliance and Fraud Prevention Officer will obtain input from the Chief Executive Officer, the Director of Compliance, the Compliance Committee, and various departments.

Additionally, the Work Plan includes a list of areas that the Compliance Department will audit and monitor. The Compliance Department may add additional monitoring audits to its duties in response to new and emerging risks. The Compliance Department and audited departments will review the audit findings and develop audit responses to address findings. The parties will develop remediation plans and associated timelines. The Compliance Department will conduct follow-up on remediation activities and report progress to the Chief Executive Officer and the Chief Compliance and Fraud Prevention Officer. Additionally, the Compliance Department will coordinate external audits from state and other regulatory oversight organizations.

D. Ad Hoc Policy and Procedure Development

From time to time, the Compliance Department will work with other departments to develop and revise policies and procedures to reflect new legal requirements and new concerns that may arise.

## IV. DESIGNATION OF A COMPLIANCE OFFICER AND/OR A COMPLIANCE COMMITTEE

DHCS requires KHS to designate a compliance officer to carry out and enforce compliance activities. The compliance officer functions as an independent and objective person that reviews and evaluates organizational compliance and privacy/confidentiality issues and concerns. The compliance officer's main duties include coordination and communication of the compliance plan; this involves planning, implementing, and monitoring the program. The Chief Compliance and Fraud Prevention Officer is a full-time employee, reporting directly to the Chief Executive Officer (CEO) and the Board of Directors. The CCO reports to the Compliance Committee on the activities and status of the Compliance Program and has the authority to report matters directly to the Board of Directors at any time. The Chief Compliance Officer is an independent employee of KHS and does not serve in any operational capacity.

A. Chief Compliance Officer

The responsibilities of the Chief Compliance Officer include:

- developing, implementing, and ensuring compliance with the requirements and standards under the DHCS contract.
- Chair the Compliance Committee and serve as a spokesperson for the Committee.
- Oversee and monitor the implementation of the compliance program.
- Report periodically to the Compliance Committee, the Chief Executive Officer, and the Board of Directors on the progress of implementation of compliance initiatives, corrective actions, and recommendations to reduce the vulnerability to allegations of fraud, waste, and abuse.
- Develop and distribute all written compliance policies and procedures to all affected employees.
- Periodically revise the program in light of changes in the needs of the organization and in the law, and changes in policies and procedures of government payer health plans and emerging threats.
- Develop, coordinate, and participate in a multifaceted educational and training program that focuses on the elements of the compliance program and seeks to ensure that all employees are knowledgeable of, and comply with, pertinent federal and state payer standards.
- Ensure that employees, vendors, and Board of Directors do not appear on any of the Federal or State “excluded, debarred or suspended” listings published by Medicare and Medicaid.
- Ensure that all Providers/Staff are informed of compliance program standards with respect to coding, billing, documentation, and marketing, etc.
- Assist in coordinating internal compliance review and monitoring activities, including annual or whenever necessary reviews of policies.
- Review the results of compliance audits, including internal reviews of compliance, independent reviews, and external compliance audits.
- Independently investigate and act on matters related to compliance, including the flexibility to design and coordinate internal investigations.
- Develop policies and programs that encourage managers and employees to report suspected fraud and other improprieties without fear of retaliation. (See Whistleblower Policy)
- Interact with external legal counsel to discuss the Organization’s initiatives on regulatory compliance.
- Handle inquiries by employees, affiliates, members, and family members regarding compliance issues.

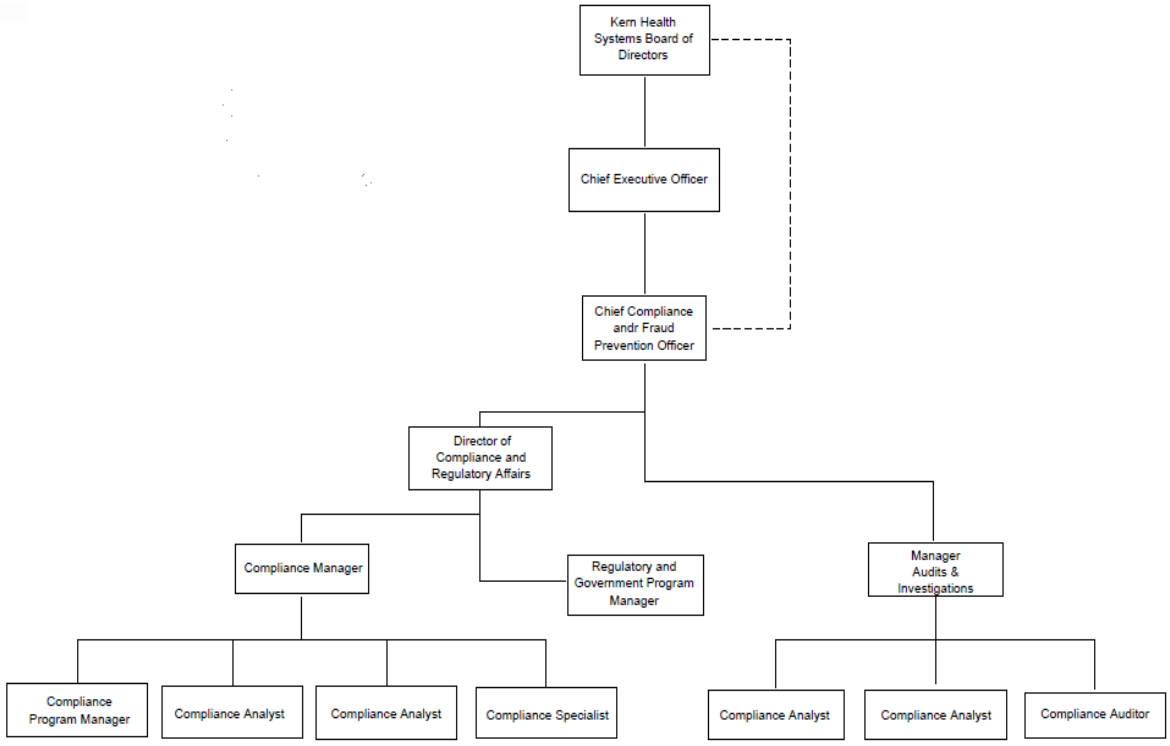
The Chief Compliance and Fraud Prevention Officer has the authority to review all documents and other information relative to compliance activities, including, but not limited to Human Resources/Personnel records, requisition forms, billing

information, claims information, and records concerning marketing efforts and arrangements with vendors.

B. Compliance Department Organizational Structure

The Chief Compliance and Fraud Prevention Officer supervises the Director of Compliance. The Director of Compliance and Regulatory Affairs supervises the Compliance Manager. The Compliance Manager oversees the Compliance Program Manager, Compliance Analyst(s), Compliance Auditor, and compliance Specialist, and other positions which may be added based on the department's identified operational needs.

Because the Chief Compliance and Fraud Prevention Officer is responsible for compliance oversight for all other departments of the organization, this position reports directly to the Chief Executive Officer and Board of Directors to mitigate risk.




C. Compliance Committee

KHS has established a regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the Compliance Program and compliance with the state and federal requirements, and

the DHCS contract. The Compliance Committee will advise the Chief Compliance and Fraud Prevention Officer and assist in the implementation of the compliance program as needed. The Compliance Committee will consist of at least the Executive Officers and Departmental leadership. The Chief Compliance and Fraud Prevention Officer will also select designees representing other departments as needed.

The functions of the Compliance Committee are to:

- Analyze the organization's regulatory environment, the legal requirements with which it must comply, and specific risk areas.
- Assess existing policies and procedures that address risk areas for possible incorporation into the Compliance Program.
- Work within the organization's standards of conduct, policies, and procedures to promote compliance.
- Recommend and monitor the development of internal systems and controls to implement standards, policies, and procedures as part of the daily operations.
- Determine the appropriate strategy/approach to promote compliance with the program and detection of any potential problems or violations.
- Develop a system to solicit, evaluate, and respond to complaints and problems.
- Monitor Corrective Action Plans
- Review and approve the Compliance Program at least biennually.

## V. CONDUCTING EFFECTIVE TRAINING AND EDUCATION

An effective Compliance Program is rooted in an active and adaptive education and training program. Active education and training are designed to teach each individual how to carry out their responsibilities effectively, efficiently and in compliance with statutory and regulatory compliance requirements. Adaptive education and training are designed to be responsive to the educational needs of the organization's workforce identified through internal and/or external reviews, audits, or compliance assessments or by government notices, alerts, and/or other advisory statements. KHS has established a system for training and educating the compliance officer, senior management, and employees on federal and State standards and requirements of the DHCS contract.

KHS utilizes a variety of training methods including but not limited to web-based training courses and in-person training. Compliance trainings must be verified such as through a certification or attestation upon training completion and review of the standard of conduct, compliance program, and compliance policies and procedures.

Inadequate training significantly increases the risks of compliance issues and possible violations of the applicable statutes and regulations. KHS requires all

employees, contractors, and volunteers to attend specific training upon hire and on an annual and as needed basis thereafter. This will include training in federal and state statutes, regulations, program requirements, policies, code of conduct and corporate ethics. The training emphasizes KHS's commitment to compliance with these legal requirements and policies.

The training programs will include sessions highlighting KHS's Compliance Program, summaries of fraud and abuse laws, HIPAA regulations, policy and procedures that reflect current legal and program standards.

The Chief Compliance and Fraud Prevention Officer or other designated staff member will document the attendees, the subjects covered, and any materials distributed at the training sessions.

Basic training will include:

- Overview of the organization's regulatory environment
- Examples of fraud, waste, and abuse.
- Recent enforcement activities
- KHS's compliance structure
- Eight elements of compliance
- Location of compliance plan and policies and procedures on the KHS's SharePoint site and company website
- Key laws and regulations
- KHS's commitment to non-retaliation
- Compliance hotline information for making anonymous complaints
- Duty to report misconduct.

The Compliance Program will be posted to the KHS Intranet and website.

## VI. DEVELOPING EFFECTIVE AND OPEN LINES OF COMMUNICATION

### A. Open Lines of Communication

Open lines of communication encourage everyone to express their compliance, quality, and other concerns and/or suggestions for improvement without fear of retaliation. Open communication is essential to maintaining an effective Compliance Program and enables the organization to learn about issues that may arise, generating faster responses and quicker fixes. Additionally, open communications allow KHS to address small problems before they become big ones.

Any potential problem or questionable practice which is, or is reasonably likely to be, in violation of, or inconsistent with, federal or state laws, rules, regulations, or directives or the organization rules or policies relative to the delivery of healthcare services, or the billing and collection of revenue derived from such services, and any associated requirements regarding documentation, coding, supervision, and

other professional or business practices must be reported to the Chief Compliance and Fraud Prevention Officer.

Any person who has reason to believe that a potential problem or questionable practice is or may be in existence should report the circumstance to the Chief Compliance and Fraud Prevention Officer. Such reports may be made verbally or in writing and may be made on an anonymous basis. KHS utilizes an external vendor, Ethics Point, so that employees may anonymously report violations though the following mediums:

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| Online: | www.kernfamilyhealthcare.com<br>FraudTeam@khs-net.com<br>HIPAATeam@khs-net.com<br>Compliance@khs-net.com |
| Phone: | Ethics Hotline 1 (833) 607-6589 |
| Mail: | Kern Health System Health c/o Chief Compliance and Fraud Prevention Officer, 2900 Buck Owens Blvd, Bakersfield CA 93308. |

The Chief Compliance and Fraud Prevention Officer or designee will promptly document and investigate reported matters that suggest substantial violations of policies, regulations, statutes, or program requirements to determine their veracity.

The Chief Compliance and Fraud Prevention Officer will work closely with legal counsel who can provide guidance regarding complex legal and management issues.

B. Exit Interviews

## VII. DISCIPLINARY GUIDELINES

All employees of KHS will be held accountable for failing to comply with applicable standards, laws, and procedures. Directors, Manages, and/or Supervisors will be held accountable for the foreseeable compliance failures of their subordinates.

The Director, Manager, or Supervisor will be responsible for taking appropriate disciplinary actions in the event an employee fails to comply with applicable regulations or policies. The disciplinary process for violations of compliance programs will be administered according to KHS protocols (generally oral warning, written warning, suspension without pay, and may lead to termination) depending upon the seriousness of the violation. The Chief Compliance and Fraud

Prevention Officer is to be consulted and may consult legal counsel in determining the seriousness of the violation. However, the Chief Compliance and Fraud Prevention Officer should never be involved in imposing discipline.

If the deviation occurred due to legitimate, explainable reasons, the Chief Compliance and Fraud Prevention Officer and director/manager/supervisor may want to limit disciplinary action or take no action. If the deviation occurred because of improper procedures, misunderstanding of rules, including systemic problems, KHS should take immediate action to correct the problem.

When disciplinary action is warranted, it should be prompt and imposed according to written standards of disciplinary action established and defined within the Human Resources Personnel Manual.

Within thirty (30) working days after receipt of an investigative report, the Director/Manager/Supervisor and/or Chief Human Resources Officer or their designee shall determine the action to be taken upon the matter and refer to the CEO for final recommendations. The action may include, without limitation, one or more of the following:

1) Dismissal of the matter.
2) Verbal counseling.
3) Issuing a warning, a letter of admonition, or a letter of reprimand.
4) Entering and monitoring of a formal corrective action plan. The corrective action plan may include requirements for individual or group remedial education and training, consultation, proctoring, and/or concurrent review.
5) Reduction, suspension, or revocation of clinical/assigned privileges.
6) Suspension or termination of employment.
7) Modification of assigned duties.
8) Reduction in the amount of salary compensation in parallel with demotion.

The CEO shall have the authority to, at any time, suspend summarily the involved employee or contractor's privileges or to summarily impose consultation, concurrent review, proctoring, or other conditions or restrictions on the assigned duties of the involved party in order to reduce the substantial likelihood of violation of standards of conduct.

## VIII. AUDITING AND MONITORING

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

The Chief Compliance and Fraud Prevention Officer will develop an annual audit plan that is designed to address KHS's key compliance risks, including but not

limited to the Department of Health Care Services contract and the Department of Managed Care Knox-Keen license requirements. The audit work program steps will inquire into compliance with specific rules and policies that have been the focus of Medi-Cal regulatory agencies.

The Chief Compliance and Fraud Prevention Officer should be aware of patterns and trends in deviations identified by the audit that may indicate a systemic problem.

## IX. RESPONDING TO DETECTED OFFENSES AND DEVELOPING CORRECTIVE ACTION INITIATIVES

Violations of the organization's compliance program, failure to comply with applicable state or federal law, and other requirements of government health plans, and other types of misconduct may threaten KHS's status as a reliable, honest, and trustworthy provider, capable of participating in federal and state healthcare programs. Detected, but uncorrected, misconduct may seriously endanger the mission, reputation, and legal status of the organization. Consequently, upon reports or reasonable indications of suspected noncompliance, the Chief Compliance and Fraud Prevention Officer must initiate an investigation to determine whether a material violation of applicable laws or requirements has occurred.

The steps in the internal investigation may include interviews and a review of relevant documentation. Records of the investigation should contain documentation of the alleged violation, a description of the investigative process, copies of interview notes and key documents, a log of witnesses interviewed, and the documents reviewed, results of the investigation, and the corrective actions implemented.
Additionally, the Chief Compliance and Fraud Prevention Officer must take appropriate steps to secure or prevent the destruction of documents or other evidence relevant to the investigation.

If the results of the internal investigation identify a problem, the response may be immediate referral to criminal and/or civil law enforcement authorities, development of a corrective action plan, a report to the government, and submission of any overpayments, if applicable. If potential fraud or violations of the False Claims Act are involved, the Chief Compliance and Fraud Prevention Officer should report the potential violation to the Office of the Inspector General or the Department of Justice.

The CEO shall have the authority and responsibility to direct repayment to payers and the reporting of misconduct to enforcement authorities as is determined, in consultation with legal counsel, to be appropriate or required by applicable laws and rules.

If the CEO discovers credible evidence of misconduct and has reason to believe that the misconduct may violate criminal, civil, or administrative law, then the Chief Compliance and Fraud Prevention Officer will promptly report the matter to the appropriate government authority within the required timeframe after determining that there is credible evidence of a violation.

When reporting misconduct to the government, the Chief Compliance and Fraud Prevention Officer should provide all evidence relevant to the potential violation of applicable federal or state laws and the potential cost impact.

## X. NON-INTIMIDATION AND NON-RETALIATION POLICIES

The organization will protect whistle-blowers from retaliation. KHS will not retaliate against employees who, in good faith, have raised a complaint against some practice of the organization, or of another individual or entity with whom KHS has a business relationship, on the basis of a reasonable belief that the practice is in violation of law, or a clear mandate of public policy.

Staff, vendors, interns, contractors, and Board Members are obligated to report to the Chief Compliance and Fraud Prevention Officer any activity he or she believes to be inconsistent with KHS's policies or state and federal law. KHS has a Whistleblower policy which is intended to encourage and enable employees and others to raise serious concerns within the organization, prior to seeking resolution outside of the organization. The policy protects employees who in good faith reports an ethics violation from harassment, retaliation, or adverse employment consequence. Any employee who retaliates against someone who has reported a violation in good faith is subject to discipline up to and including termination of employment.

Reports of violations or suspected violations will be kept confidential to the extent possible, consistent with the need to conduct an adequate investigation. The Chief Compliance and Fraud Prevention Officer will notify the sender and acknowledge receipt of the reported violation or suspected violation within the required timeframes. All reports will be promptly investigated, and appropriate corrective action will be taken if warranted by the investigation.

## XI. KERN HEALTH SYSTEM'S COMMITMENT TO COMPLIANCE

### A. Standards of Conduct

KHS's employees are bound to comply, in all official acts and duties, with all applicable laws, rules, regulations, standards of conduct, including, but not limited to laws, rules, regulations, and directives of the federal government and the state

of California, including KHS's rules, policies, and procedures. These current and future standards of conduct are incorporated by reference in this Compliance Plan.

All candidates for employment shall undergo a reasonable and prudent background investigation, including a reference and criminal background check. Due diligence will be used in the recruitment and hiring process to prevent the appointment to positions with substantial discretionary authority, persons whose record (professional licensure, credentials, prior employment, criminal record or specific "exclusion" from Medi-Cal funded programs) gives reasonable cause to believe the individual has a propensity to fail to adhere to applicable standards of conduct.

All new employees will receive orientation and training in compliance policies and procedures. Participation in required training is a condition of employment. Failure to participate in required training may result in disciplinary actions, up to and including, termination of employment.

Every employee is asked to attest that they have received, read, and understood the contents of the compliance plan.

Every employee will receive an initial compliance orientation and periodic training updates in compliance protocols as they relate to the employee's individual duties.

Non-compliance with the plan or violations will result in sanctioning of the involved employee(s) up to, and including, termination of employment.

## B. Member Rights

We treat our members with respect and dignity and provide care that is both necessary and appropriate. No distinction is made in the admission, transfer, discharge, or care of individuals on the basis of race, creed, religion, national origin, gender, gender expression, sexual orientation, or disability. Clinical care is provided based on identified healthcare needs and Care Management is provided based on needs identified through a uniform assessment tool, and no treatment or action is undertaken without the informed consent of the patient or an authorized representative. Members are provided with a written statement of rights which conforms to all applicable laws, and ensure their autonomy and privacy are respected.

Employees involved in member's care are expected to know and comply with all applicable laws and regulations and our policies and procedures governing their particular program.

## C. Personal Health Information/HIPAA

# COMPLIANCE PROGRAM

KHS collects and aggregates personal health information about our members to provide the best possible care. We realize the sensitive nature of this information and are committed to safeguarding our member's privacy.

The Chief Compliance and Fraud Prevention Officer is responsible for development and implementation of policies, procedures and educational programs that will ensure that KHS will continue to be compliant with the Privacy regulations and will also ensure that protected health information is secure.

To ensure that confidentiality is maintained, employees and their representatives must adhere to the following rules:

- Do not discuss protected health information (PHI)/ client information in public areas such as elevators, hallways, common gathering areas.
- Limit release of PHI/client information to the minimum reasonably necessary for the purpose of the disclosure.
- Do not disclose PHI without an appropriate consent signed by the member unless it is related to the person's care, payment of care, or health care operations of the organization. In an emergency, a member's consent may not be required when a healthcare provider treating the patient requests information, but the name and affiliation of the person requesting the information must be confirmed and documented in the medical record.
- Honor any restrictions on uses or disclosure of information placed by the member.
- Make sure PHI/member information stored in the computer system is properly secured.
- Be familiar with and comply with special confidentiality rules governing the disclosure of sensitive health care conditions, alcohol and substance abuse and behavioral/mental health treatment.

KHS maintains a Chief Information Officer who is responsible for the development and implementation of the policies and procedures required by the Security Rule.

The Chief Information Officer is responsible for ensuring Kern Health System engages in the following activities:

- Maintain appropriate security measures to ensure the confidentiality, integrity, and availability of patients' electronic protected health information (EPHI).
- Adhere to applicable federal and state security laws and standards.
- Provide security training and orientation to all employees, volunteers, medical and professional staff.
- Comply with Security Policies including periodic risk assessments.

- Monitor access controls to EPHI to ensure appropriate access to authorized personnel.
- Maintain hardware and software with the appropriate patches and updates.
- Maintain a validation of compliance with the Data Security Standards, a set of security controls that businesses are required to implement to protect data.

### D. Medical Necessity

KHS will take reasonable measures to ensure that only claims for services that are reasonable and necessary, given the member's condition/ client's needs are billed.

Documentation will support the determinations of medical necessity/member need when providing services.

KHS is aware that DHCS will only pay for services that meet the coverage criteria and are reasonable and necessary to treat or diagnose a suspected condition. Therefore, KHS's Providers will use prudent ordering practices.

In requesting diagnostic procedures or tests, KHS's Providers will make an independent medical necessity decision with regard a treatment plan. Documentation of findings and diagnoses will support the medical necessity of the service.

KHS's Providers understand that there may be limitations on services; therefore, the prior authorization process will be followed.

### E. Billing

All claims for services submitted will correctly identify the services ordered.
Only those services that are performed and that meet payer criteria will be billed.

Intentionally or knowingly up coding (the selection of a code to maximize reimbursement when such code is not the most appropriate descriptor of the service offered) may result in disciplinary. KHS's providers must provide documentation to support services provided and billed based on clinical and behavioral findings and diagnoses.

Immediate disciplinary action, up to and including termination will be implemented for instances of intentional misrepresentation of any service if results in over billing.

All individuals who provide billing information and billing department employees who prepare or submit billing statements must comply with all applicable laws, rules and regulations and the organization's policies.

KHS will promptly return to payers any payments which we determine do not conform to our policies and applicable laws.

As healthcare providers, KHS's business involves reimbursement under government programs which require submission of certain reports of our costs of operations. KHS complies with all federal and state laws and regulations relating to cost reports, which define what costs are allowable and describe the appropriate methodologies to claim reimbursement for the cost of services provided to program beneficiaries. Given the complexity of this area, all issues related to the completion and settlement of cost reports must be communicated through or coordinated with the Chief Financial Officer.

### F. Compliance with Applicable Fraud Alerts

The Chief Compliance and Fraud Prevention Officer will review the Medi-Cal/Medicare Fraud Alerts.

The Chief Compliance and Fraud Prevention Officer will ensure that any conduct disparaged by the Fraud Alert is immediately ceased, implement corrective actions, and take reasonable actions to ensure that future violations do not occur.

### G. Marketing

KHS will promote only honest, straightforward, fully informative, and non-deceptive marketing. We use marketing to educate the public, increase awareness of our services and recruit employees. All marketing materials must accurately describe our services and programs. To ensure that no incorrect information is disseminated, employees must coordinate all marketing materials with and direct all media requests to the CEO or designee. KHS will only use and/or disclose any member protected health information for marketing activities if a written prior authorization is obtained.

### H. Anti-Kickback/Inducements

KHS will not participate in nor condone the provision of inducements or receipt of kickbacks to gain business or influence referrals. KHS's Providers will consider the member's interests in offering referral for treatment, diagnostic, or service options.

Federal and state laws prohibit any form of kickback, bribe, or rebate, either directly or in directly, in cash or in kind, to induce the purchase or referral of goods, services or items paid for by Medicare or Medi-Cal.

Self-referral laws prohibit a Provider from referring a patient for certain types of health services to an entity with which the Provider or members of his or her immediate family has a financial relationship unless there is an applicable exception under the self-referral law.

Since violations of these laws may subject both KHS and the individual involved to civil and criminal penalties and exclusion from government-funded healthcare programs, all proposed transactions with healthcare providers must be reviewed with legal counsel.

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

## I. Relationships with Subcontractors, Vendors and Suppliers

KHS is committed to employing the highest ethical standards in its relationships with subcontractors, vendors, and suppliers with respect to source selection, negotiation, determination of contract awards, and administration of purchasing activities. All subcontractors, vendors, and suppliers are to be selected solely based on objective criteria; personal relationships and friendships will play no part in the selection process. KHS does not knowingly contract or do business with a subcontractor, or vendor that has been excluded from a government-funded healthcare program. Any subcontractor, vendor, or suppler who has access to the organization's PHI and is not a covered entity, will be required to enter into a Business Associate Agreement to comply with applicable federal and state confidentiality and data protections rules, including HIPAA and 42 C.F.R. KHS will maintain a subcontractor review program for selecting and assessing the appropriate safeguards and security controls for key vendors.

## J. Delegation Reporting and Compliance Plan

KHS will provide the Department of Health Care Services (DHCS) with a delegation reporting and compliance plan describing, all contractual relationships with Subcontractors and Downstream Subcontractors; KHS's oversight responsibilities for all delegated obligations; and how KHS will oversee all delegated activities, including, but not limited to, details regarding key personnel who will be overseeing such delegated functions. This reporting is provided to DHCS in the format and frequency requested and outlined in KHS policies and procedures.

## K. Retention of Records/Documentation/Destruction

KHS will ensure that all records required by federal and/or state law are created and maintained. All records will be maintained as required under specific laws.

Documentation of compliance efforts will include staff meeting and committee minutes, audit reports, memoranda concerning compliance protocols, problems identified, and corrective actions taken, the results of any investigations, and documentation supportive of assessment findings, diagnoses, treatments, and plan of care.

Hard copy data that is not necessary or which the organization is no longer required to retain will be shredded and disposed of according to KHS policies.

L. Medical Record Documentation

Timely, accurate and complete documentation is important to clinical care. This documentation not only facilitates high quality care, but also serves to verify that billing is accurate as submitted.

KHS requires that Providers follow these documentation guidelines:

- The medical record is complete and organized.
- Documentation is timely
- The documentation of each encounter includes the reason for the encounter, any relevant history, physical examination findings, prior diagnostic test results, assessment, clinical impression or diagnosis, plan of care, and date and legible identity of the observer.
- CPT and ICD-10 codes used for claims submission are supported by documentation in the medical record.
- Appropriate health risk factors are identified. The patient's progress, his or her response to treatment.
- Care management encounters will be documented

KHS will maintain a process for identifying and reviewing its billing and coding to ensure compliance with applicable state and federal requirements.

This plan has attempted to provide the foundation for development of an effective and cost-efficient compliance program.