Kern Family Health Care™

Kern Health Systems

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Bakersfield CA 93308
661/664-5000

2025 CORPORATE COMPLIANCE PROGRAM

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Executive Summary

Why Have a Compliance Program?

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

- Prevents, detects, and corrects non-compliance and fraud, waste, and abuse (FWA).
- 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 400,000 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.

The health care industry is heavily regulated by federal and state agencies responsible for ensuring health care organizations operate in compliance with contractual and regulatory obligations. KHS will be regulated by the Centers for Medicare & Medicaid Services (CMS) with the implementation of a Dual Special Needs Medicare Advantage Plan in 2026, the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC).

The Centers for Medicare & Medicaid Services (CMS)

CMS is an agency within the U.S. Department of Health & Human Services responsible for administration of several key federal health care programs. CMS oversees Medicare (the federal health insurance program for seniors and persons with disabilities) and Medicaid (the federal needs-based program).

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The Department of Health Care Services (DHCS)

DHCS is one of thirteen departments within the California Health and Human Services Agency (CHHS) that provides a range of health care services, social services, mental health services, alcohol and drug treatment services, income assistance and public health services to Californians. DHCS administers publicly financed health insurance and safety net programs and works to effectively use federal and state funds to operate the Medi-Cal program. DHCS ensures that high-quality, efficient health care services are delivered to more than 13 million Californians (or one in three Californians).KHS maintains contracts with DHCS to operate Medi-Cal managed care services.

The Department of Managed Health Care (DMHC)

DMHC regulates health care service plans that deliver health, dental, vision and behavioral health care benefits. DMHC protects the rights of approximately 20 million enrollees, educates consumers about their rights and responsibilities, ensures financial stability of the managed health care system and assists Californians in navigating the changing health care landscape. DMHC reviews all aspects of the plan's operations to ensure compliance with California law. KHS maintains one Knox-Keene Licenses with DMHC to operate in California.

KHS is committed to the highest standards of ethics, integrity and professionalism throughout every aspect of our business. We are firmly committed to ensuring full compliance with all federal and state health care program requirements. Our compliance efforts are aimed at prevention, detection, and resolution of variances.

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

1. Written policies and procedures
2. Compliance Leadership and Oversight
3. Training and education
4. Effective lines of communication
5. Enforcement Standards: Consequences and Incentives
6. Risk Assessment, Auditing and Monitoring
7. Responding to Detected Offenses and Developing Corrective Action Initiatives

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The information contained within the program applies to all– the KHS Governing Board Members, our Chief Officers, the KHS Leadership team, staff, and KHS's business associates – and it should be reviewed and referenced often. Our shared commitment to honesty, integrity, transparency and accountability helps develop the trust of our members and our providers. It also helps us establish good working relationships with our federal and state regulators. The Compliance Program supports this commitment by helping to understand how KHS must comply with laws and regulations that govern health care to ensure KHS maintains a reputation of excellence.

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.

KHS's Compliance Program Alignment with OIG Standards

Written Policies and Procedures	**Chief Compliance and Fraud Prevention Officer Compliance Leadership and Oversight**	**Training and Education**	**Effective Lines of Communication with Chief Compliance and Fraud Prevention Officer and Disclosure Programs**	**Enforcement Standards: Consequence and Incentive**	**Risk Assessment, Auditing and Monitoring**	**Responding to Detected Offenses and Developing Corrective Action Initiatives**
• Fraud, Waste & Abuse, Anti-Kickback Statute, False Claims Act and Stark Law policies • Whistle Blower/ Non-retaliation policy • Clinical policies • HIPAA • Conflict of Interest	• Chief Compliance and Fraud Prevention Officer job description • Compliance Committee • Oversight of the Program • Annual Compliance Report	• Annual compliance training/on-boarding training • Monthly Spotlight • Periodic training at staff meetings • Ad Hoc training informs and train	• Open door policy • Ethics Hotline • Exclusion screening	• Comply with applicable standards, laws, and procedures • Supervisor and/or Managers oversight of process failures	• Annual risk review • Ongoing audit and oversight activities • Ad hoc audits • Monthly exclusion screening • Maintain anonymous. • Annual risk assess-ment • Credential and peer review	• Internal investi-gations and reporting • Review Annual Conflict of Interest Disclosure Forms • Process for reporting and resolving incidents

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.

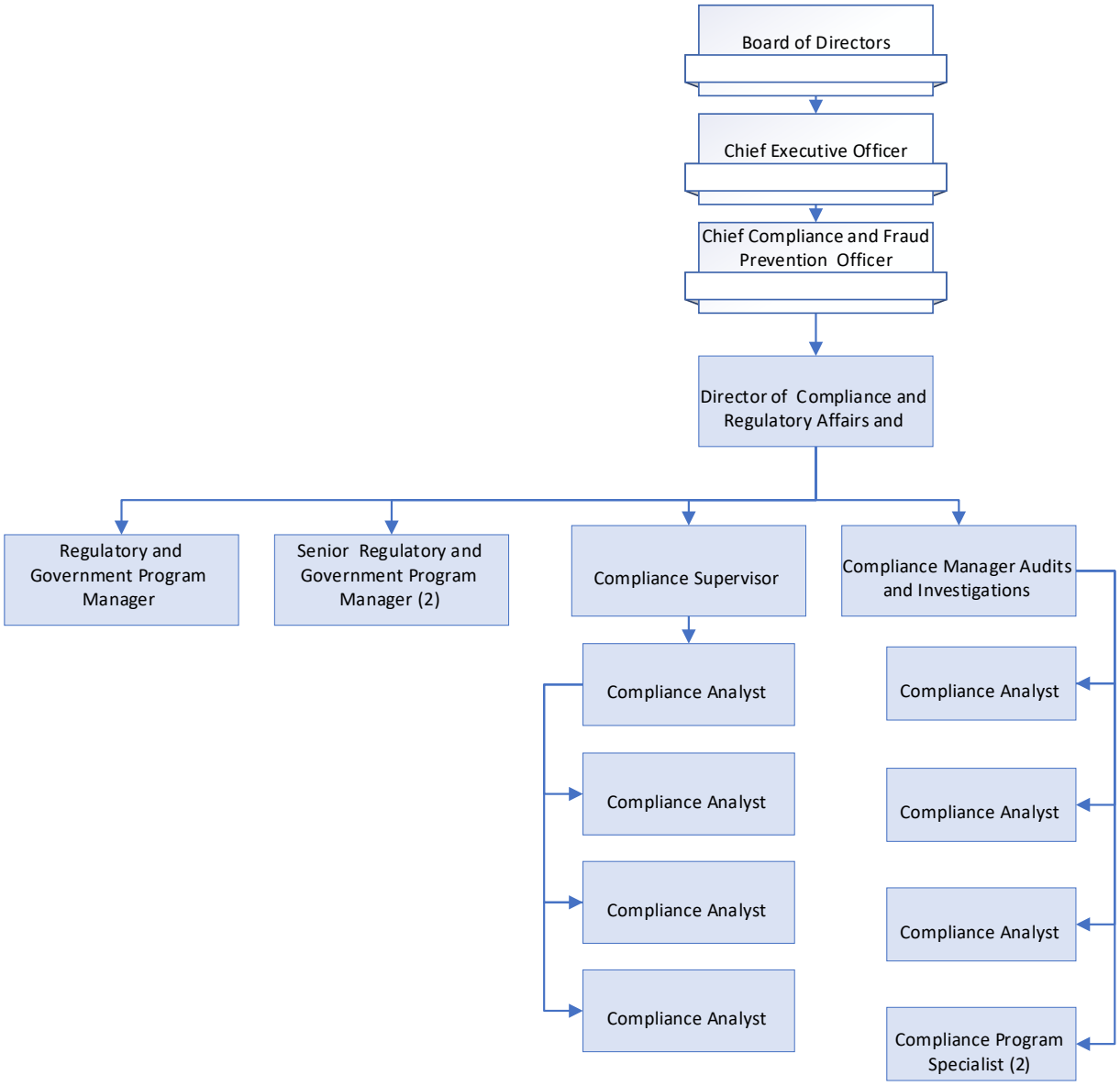
The Chief Compliance and Fraud Prevention Officer (CCFPO) provides oversight and supervision to the Compliance department. Positions may be added or revised based on the department's identified operational needs.

Because the Chief Compliance and Fraud Prevention Officer is responsible for compliance oversight for all other department activities of the organization, this position reports directly to the Chief Executive Officer to mitigate risk. The Chief Compliance and Fraud Prevention Officer is responsible for implementing a Compliance Program that includes and addresses quality and patient safety compliance risks just as they do for any other compliance risk area integral to KHS's Board of Directors, staff, members, providers, and community.

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

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.

COMPLIANCE PROGRAM



III. ELEMENT 1 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. Access to policies and procedure include relevant individuals such as employees, contractors, members, customers, subcontractors, agents, or people in other roles, or a subset of the above. KHS' policies and procedures are available online at the KHS's company site www.kernfamilyhealthcare.com.

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.

These six fundamental values: **EQUITY, EXCELLENCE, COMPASSION, COLLABORATION, INNOVATION, and INTEGRITY**, remind us that preserving an ethical workplace is critical to our long-term success as an organization. The Code articulates the standards of behavior that each one of us is expected to observe while performing our jobs, as well as our commitment to complying with all regulatory requirements, state, and federal laws.

As employees, we are all required to ensure compliance and report any potential issues, ethical concerns, or violations of this Code of Conduct in accordance with policies and procedures. For additional information please refer to the Compliance Program Description, Compliance Guide, Employee Handbook, and Policies and Procedures located on the KHS Intranet website.

KERN HEALTH SYSTEMS CORE VALUES

KERN HEALTH SYSTEMS CORE VALUES

B. Conflict of Interest (COI) Policy and Disclosure Statement

Workplace business decisions must be made with objectivity and fairness. A Conflict of Interest (COI), or even the appearance of one, should be avoided. A COI presents itself in the form of a personal or financial gain for an individual or entity that could possibly corrupt the motivation of that individual or entity.

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.

Examples of COI include, but are not limited to:

- Accepting concurrent employment with, acting for, or rendering services to any business or endeavor, with or without compensation, which competes with or conducts business with KHS
- Selling products directly or indirectly in competition with KHS financial interest or business involvement with an outside concern which conducts business with or is a competitor of KHS
- Representing KHS in any transaction in which a personal interest exists
- Accepting gifts in excess of $150 or any substantial materials or supplies, from an outside company that does business with or is seeking to do business with KHS. The annual gift limit is adjusted biennially and subject to change based on the Consumer Price Index. Designated employees may not accept a gift that is worth more than the financial thresholds set forth in FPPC regulation 2 CCR§ 18730, sections 7-9.5. $590.001 (2023-2024 limit amounts) in a twelve (12) month period.

KHS Board members, Chief Executives, and all management staff should avoid any business, activity or situation, which may possibly constitute a COI between their personal interests and the interests of KHS. Immediate disclosures are required if any potential situation may involve a COI.

KHS requires certain identified 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). If KHS has a potential, suspected, and/or actual conflict of interest, KHS will provide a description of the

relationship and a Conflict Avoidance Plan to ensure that such a relationship will not adversely affect DHCS, DMHC, other Managed Care Plans, or Medi-Cal Members. 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. 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.

IV. ELEMENT 2 DESIGNATION OF A CHIEF COMPLIANCE AND FRAUD PREVENTION OFFICER AND/OR A COMPLIANCE COMMITTEE

An effective Compliance Program reduces and mitigates risk, provides patients safe and high-quality care, and saves costs. DHCS requires KHS to designate a Chief Compliance and Fraud Prevention Officer to carry out and enforce compliance activities. The Chief Compliance and Fraud Prevention Officer functions as an independent and objective person that reviews and evaluates organizational compliance and privacy/confidentiality issues and concerns. The Chief Compliance and Fraud Prevention 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 and Fraud Prevention Officer is an independent employee of KHS and does not serve in any operational capacity.

A. Chief Compliance and Fraud Prevention Officer

The responsibilities of the Chief Compliance and Fraud Prevention Officer as defined in the Department of Health Care Services contract 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. Coordinate with Human Resources to ensure that all directors, officers, employees, and contractors, if applicable, are screened before appointment or engagement and monthly thereafter against any applicable State Medicaid program exclusion lists
- 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.
- 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.

Coordination and communication are the Chief Compliance and Fraud Prevention Officer's key tools for planning, implementing, and monitoring an effective Compliance Program. The Chief Compliance and Fraud Prevention Officer should strive to develop, and promote, productive working relationships with organizational leaders. Coordinating work and sharing information with leaders of other support functions, including (as applicable), Legal, Internal Audit, Information Technology, Human Resources, Quality, Risk Management, and Security will enhance the strength and success of the Compliance Program.

B. Compliance Committee

Actively leading the Compliance Committee and its meetings is an important and integral function of the Chief Compliance and Fraud Prevention Officer. As the Compliance Committee chair, the Chief Compliance and Fraud Prevention Officer should establish and facilitate committee discussion and encourage active participation by all committee members.

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.
- Assessing education and training needs and effectiveness, and regularly reviewing required training
- Monitor Corrective Action Plans
- Develop. review and approve the Compliance Program and Workplan at least annually.
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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.

C. Governance and Compliance Committee

Newly created in 2024, the Governance and Compliance Committee has the regulatory and fiduciary responsibility to oversee the KHS Compliance Program to ensure an effective and ethical program through its design, implementation, and monitoring in the prevention and detection of risks or compliance violations. Specifically, for evaluating KHS's compliance with all regulatory (federal, state, and local) as applicable and contractual obligations for all internal and delegated activities.

This Committee assists the Board to improve its functioning, structure, and infrastructure. The Committee reviews and makes recommendations regarding KHS's Bylaws and Governance Structure, including committee composition, auditing and investigative practices. The Chief Compliance and Fraud Prevention Officer periodically provides a report to the board assessing the Compliance Committee's performance. This report compares KHS's expectations of the committee's performance with its actual performance. As part of the assessment, the Chief Compliance and Fraud Prevention Officer seeks input from the members of the Compliance Committee, the CEO, and the board.

D. Board Compliance Oversight

The United States Sentencing Commission's Guidelines require that a governing authority shall be knowledgeable about the content and operation of the

compliance program and shall exercise reasonable oversight with respect to the implementation and effectiveness of the compliance and ethics program. The board should have access to sufficient knowledge and resources to allow it to fulfill its compliance-related obligations competently. Oversight of the Chief Compliance and Fraud Prevention Officer is a critical component of the board's compliance role. The board should ensure that the Chief Compliance and Fraud Prevention Officer has sufficient power, independence, and resources to implement, maintain, and monitor the Compliance Program and advise the board about compliance operations and risk.

V. ELEMENT 3 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 KHS Board of Directors, Chief Compliance and Fraud Prevention Officer, Senior management, and employees on federal and State standards and requirements.

KHS requires First Tier Entities to provide Compliance Training to their employees and Downstream Entities within 90 days of hire, assignment or appointment and annually thereafter. First Tier Entity is any party that enters into a written arrangement with KHS to provide administrative services or health care services to a KHS member. Downstream Entity is any party that enters into a written arrangement with persons or entities below the level of the arrangement between KHS and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

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
- Seven 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. ELEMENT 4 EFFECTIVE LINES OF COMMUNICATION WITH THE CHIEF COMPLIANCE AND FRAUD PREVENTION OFFICER AND DISCLOSURE PROGRAMS

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 to allow employees to anonymously report violations, including other reporting mediums:

Online:	www.kernfamilyhealthcare.com FraudTeam@khs-net.com HIPAATeam@khs-net.com 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. Disclosure Programs

All disclosures of compliance concerns, including potential violations of policies or Federal or State requirements, should be recorded in a log maintained by the Chief Compliance and Fraud Prevention Officer or their designee. All disclosures should be logged regardless of how they are made. whether made directly to the Chief Compliance and Fraud Prevention Officer or other compliance personnel, to another organizational leader, or through the anonymous reporting mechanism,

The Chief Compliance and Fraud Prevention Officer may take responsibility for reviewing some reported concerns, some reported concerns may be referred to other leaders or departments, for example, Human Resources, and some reports, such as those involving substantial legal violations, may be referred to counsel or law enforcement. The Chief Compliance and Fraud Prevention Officer should remain involved in all health care compliance investigations in which counsel takes the lead.

VII. ELEMENT 5 ENFORCING STANDARDS: CONSEQUENCES AND INCENTIVES

a. Consequences

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 and/or any law or regulation 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 and has responsibility for monitoring the consistency of the discipline. 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.

b. Incentives

KHS has developed appropriate incentives to encourage participation in the Compliance Program. The Chief Compliance and Fraud Prevention Officer, Compliance Committee, and other leaders consider the compliance performance or activities to incentivize, both across the organization and within specific departments or positions. Excellent compliance performance or significant contributions to the Compliance Program could be the basis for, significant recognition, or other, smaller forms of encouragement.
Behaviors that KHS could incentivize include:

- Achievement of compliance goals that are specific to a department or a specific position description.
- Achievements that reduce compliance risk (e.g., a team that develops a process that reduces compliance risk or enhances compliant outcomes, or an individual who suggests a method of attaining a strategic goal with less risk); or
- Performance of compliance activities outside of the individual's job description (e.g., mentoring of colleagues in compliant performance or performing as a compliance representative within their department or team).

Achievements in compliance should be treated commensurately with achievements in other areas valued by the organization. Through the thoughtful and deliberate use of incentives, KHS acts to reduce its compliance risk, enhance adherence to the Compliance Program, and develop a positive association with KHS's compliance culture.

VIII. ELEMENT 6 RISK ASSESSMENT, AUDITING AND MONITORING

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

A. Risk Assessment

Risk assessment, auditing, and monitoring each play a role in identifying and quantifying compliance risk. Although identifying and addressing risk have always been at the core of Compliance Programs, in recent years, compliance leaders have come to recognize and place increasing emphasis upon the importance of a formal compliance risk assessment process as part of the Compliance Program.

Risk assessment is a process for identifying, analyzing, and responding to risk. A compliance risk assessment is a risk assessment process that looks at risk to the organization stemming from violations of law, regulations, or other legal requirements. In organizations affected by government health care programs, a compliance risk assessment focuses on risks stemming from violations of government health care program requirements and other actions (or failures to act) that may adversely affect KHS's ability to comply with those requirements. Risk assessments are an integral part of the fiscal internal control process and to enterprise risk management and are essential for state and federal monetary funding.

B. Auditing and Monitoring

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 compliance work plan also should contain insight to organizational capacity to monitor the effectiveness of controls and risk remediation.

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. ELEMENT 7 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. Therefore, monitoring of hotlines, program integrity, and other operational activities is essential in detecting, noncompliance. 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.

A. Investigations of Violations

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.

B. Reporting to the Government

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 or legal counsel should report the potential violation not more than 60 days after the determination that credible evidence of a violation exists to the Office of the Inspector General, Department of Justice, Centers of Medicare and Medicaid Services (CMS), or other appropriate Government authority.

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.

C. Implementing Corrective Actions Initiatives

Once KHS has gathered sufficient credible information to determine the nature of the misconduct, steps for prompt corrective action are taken, including:

- Refunding of overpayments.
- Enforcing disciplinary policies and procedures; and
- Making any policy or procedure changes necessary to prevent a recurrence of the misconduct.

Throughout any investigation of any noncompliant conduct the Chief Compliance and Fraud Prevention Officer should gather information to aid them in determining

the root causes of the conduct. Additionally, the Chief Compliance and Fraud Prevention Officer should also determine whether the conduct exposed any compliance weaknesses that could place the entity at risk for other, unrelated misconduct.

X. NON-INTIMIDATION AND NON-RETALIATION POLICIES

The organization will protect whistle-blowers from retaliation. KHS maintains a zero tolerance for retaliation 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 Program.

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

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. A member’s protected health information (PHI) is protected by the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act and state confidentiality laws.

The Security Standards for the Protection of Electronic Protected Health Information, known as the Security Rule, was also promulgated pursuant to HIPAA. It specifies a series of administrative, physical, and technical safeguards for covered entities and their business associates to ensure, among other provisions, the confidentiality, integrity, and security of electronic PHI. Covered entities and their business associates can consider their organization and capabilities, as well as costs, in designing their security plans and procedures to comply with Security Rule requirements.

If a staff member discovers a potential privacy incident or breach, they are required to report the issue immediately to the Compliance Department . When a breach of PHI is discovered, KHS must report it to the DHCS Privacy Office, DHCS Contract Manager and DHCS Information Security Officer within twenty-four hours of discovery and to the Office for Civil Rights (OCR) under the Department of Health and Human Services (HHS) within the required time frames. A failure to report according to our regulated time frames may result in monetary penalties and/or sanctions against KHS.

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). Examples of member information that is protected by these regulations includes but is not limited to:

- 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.

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.

D. Compliance with Applicable Fraud Alerts

The Chief Compliance and Fraud Prevention Officer will review the Medi-Cal/Medicare Fraud Alerts. KHS has an established Fraud, Waste and Abuse (FWA) Committee that assists as a consolidation point for monitoring of FWA activities within the health plan. The committee also serves as a forum for the exchange of ideas and make recommendations for remediation.

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.

KHS has a Fraud Plan that is submitted to the regulators on an annual basis that outlines the internal process for mitigating the implication of fraudulent activities. Fraud Risk Management demonstrates the commitment to high integrity, control, and ethical values of the organization.

The Federal False Claims Act and similar state laws make it a crime to submit false claim to the government for payment. False claims include but are not limited to billing for treatment not rendered; upcoding to bill for higher reimbursement; and falsifying records to support billed amounts. Under the Federal False Claims Act, whistleblowers may bring a civil lawsuit against the company on behalf of the U.S. Government and, if the suit is successful, they may be awarded a percentage of the funds recovered. There is a provision in the Federal False Claims Act that protects a whistleblower from retaliation by an employer. Actions such as suspension, threats, harassment, or discrimination could be considered retaliatory. By statute, different categories of conduct result in different penalty amounts. For example, false claims may result in penalties of up to $20,000 per item or service falsely claimed, and improper kickback conduct results in penalties of up to $100,000 per violation.

KHS will not tolerate retaliation against any person who has suspected fraudulent activity and reported those suspicions in compliance with KHS policy.

E. 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. If KHS staff are approached or contacted by the media to discuss KHS, staff are required to refer them to the Senior Director of Marketing and Member Engagement.

All co-branded (KHS and other companies or vendors) and other marketing materials created by other companies or vendors must be approved by the Marketing Department prior to distribution. Marketing materials, including health education information, is subject to DHCS review and approval before using with community events or member education.

F. 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.

Violation of the Federal anti-kickback statute constitutes a felony punishable by a maximum fine of $100,000, imprisonment up to 10 years, or both. Conviction also will lead to mandatory exclusion from Federal health care programs, including Medicare and Medicaid. Liability under the Federal anti-kickback statute is determined separately for each party involved.

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

G. 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.

In addition, KHS has entered new arenas in support of its membership. For example, new technology such as Artificial Intelligence and organizations providing non-traditional services in health care settings (such as social services, food delivery, housing support, and care coordination services). While these organizations may be familiar with compliance risks applicable to their current business, KHS will need to evaluate and familiarize the potential for new risk areas associated with new and different lines of health care businesses and technology.

H. 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.

KHS remains fully responsible for the performance of all duties and obligations it delegates to Subcontractors and Downstream Subcontractors. Regardless of the relationship KHS has with a Subcontractor, whether direct or indirect through additional layers of contracting or delegation, KHS has the ultimate responsibility for adhering to, and fully complying with, all terms and conditions of the DHCS Contract, and all state and federal regulations.

KHS maintains a Delegation Oversight Committee to ensure adequate oversight and enforcement of all regulatory, contractual, and policy requirements under which KHS is accountable to contractually to our regulatory agencies. This oversight entails the entire spectrum from pre-delegation auditing to annual compliance audits, both internally and externally, conducted by Department heads and staff with coordination through the Compliance department.

Responsibilities include:

- Ensure KHS Departments which delegate functions establish performance and reporting deliverables for departmental business needs designed to assess the effectiveness of health care delivery to members in compliance with regulatory requirements.
- Assist Departments with establishing effective departmental auditing tools designed to measure and report delegated entity performance in order to ensure compliance with regulatory requirements.
- Oversee all audits of delegated entities and assure that departments perform all necessary audits of delegated entities which are responsible for those functions delegated as set forth in the written delegation agreement on behalf of KHS. Audits and review of monthly and quarterly reports to be completed on a timely basis.
- Review and evaluate delegated entity's performance including identifying opportunities for performance improvement, recommending and/or issue corrective action plans when a deficiency has been identified.
- Distribute information to the Delegation Oversight Committee regarding findings, recommended changes to contracts and policies, and requested initiatives or project updates by the delegate entity.
- Make recommendations to the Quality Improvement Committee, the Chief Medical Officer, and the Chief Compliance and Fraud Prevention Officer/Director of Compliance regarding the compliance status of the delegated entity as it relates to DHCS contract, DHCS and DMHC All Plan Letters, and CMS and other documented requirements.
- Outstanding issues from the Committee could be advanced to the Kern Health Systems Board of Directors as identified.

KHS will not delegate the following contractual elements, as specified in the DHCS contract:

- Chief Health Equity Officer
- Medical Loss Ratio (MLR)
- Compliance Program
- NCQA Accreditation
- Duty to Ensure Subcontractor, Downstream Contractor, and Network Provider Compliance
- Delegation of Authority
- Conflict of Interest Avoidance

An effective Compliance Program is critical to meeting internal operational goals; decreasing errors; improving the quality of patient care and patient safety; and preventing, detecting, and addressing fraud, waste, and abuse. KHS strives to provide the foundation for the development and sustainment of an effective and

cost-efficient Compliance Program. By fostering a true cultural shift for the organization from “following” risk management to “living” risk management, KHS is poised to strengthen its enterprise-wide governance, risk, and compliance, now and in the future.