Orange County Health Authority

dba CalOptima

2017~~6~~ Compliance Plan

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A. OVERVIEW OF THE COMPLIANCE PROGRAM

The Orange County Health Authority, dba CalOptima, is committed to conducting its operations in compliance with ethical standards, contractual obligations, and all applicable statutes, regulations and rules, including those pertaining to Medi-Cal, Medicare, PACE (Program of All-Inclusive Care for the Elderly), MSSP (Multipurpose Senior Services Program), and other CalOptima programs.

CalOptima's compliance commitment encompasses its own internal operations, as well as its oversight and monitoring responsibilities related to CalOptima's First Tier, Downstream and Related Entities (FDRs), such as health networks, physician groups, participating providers, suppliers, pharmacy benefit manager (PBM), and consultants. The term FDR is used in this document to refer to CalOptima's delegated subcontractors that perform administrative functions and/or provide health care services that CalOptima is required to perform and/or provide under its State and Federal contracts ~~(i.e. contracts~~ with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS)~~)~~. Such persons/entities, referred to as FDR herein, include those that directly contract with CalOptima and those that are Downstream or Related Entities (i.e. subcontracts) with CalOptima's First Tier Entities.

CalOptima has developed a comprehensive Compliance Program applicable to all of CalOptima's Programs, including, but not limited to, its Medi-Cal Program, its Medicare Advantage Prescription Drug Program (MA-PDP referred to as "OneCare"), its Medicare-Medicaid Plan (MMP referred to as "OneCare Connect"), PACE, and MSSP. The Compliance Program incorporates all of the elements of an effective compliance program as recommended by the Office of the Inspector General (OIG) and required by CMS regulations. The Compliance Program is continually evolving and may be modified and enhanced based on compliance monitoring and identification of new areas of operational, regulatory, or legal risk. CalOptima requires that CalOptima Board Members, Employees, and FDRs conduct themselves in accordance with the requirements of CalOptima's Compliance Program.

B. THE COMPLIANCE PLAN

This Compliance Plan sets forth CalOptima's commitment to legal and ethical conduct by establishing compliance activities, along with CalOptima principles and standards, to efficiently monitor adherence to all applicable laws, regulations, and guidelines. The Compliance Plan addresses the fundamental elements of an effective Compliance Program and identifies how CalOptima is implementing each of the fundamental elements of an effective Compliance Program in its operations to meet its contractual, legal, and regulatory obligations. Moreover, the Compliance Plan is designed to provide guidance and to ensure that CalOptima's operations and the practices of its Board Members, Employees, and FDRs comply with contractual requirements, ethical standards, and applicable law.

This Compliance Plan is adopted by the Governing Body. It was developed and is managed by the Executive Director of Compliance (referred to hereinafter as the "Compliance Officer") with the Compliance Committee. Because the complex laws governing CalOptima and its programs are constantly evolving, the Compliance Plan may be revised and updated from time to time to respond to changes in the law and/or to reflect improvements in CalOptima's operations and processes.

Board Members, Employees, and FDRs are expected to review and adhere to the requirements and standards set forth in the Compliance Plan, the Code of Conduct, and all related Policies and Procedures, as may be amended. Furthermore, Board Members, Employees, and FDRs are expected to be familiar with the contractual, legal, and regulatory requirements pertinent to their respective roles and responsibilities. If a Board Member, Employee, and/or FDR has/have any questions about the application or implementation of this Compliance Plan, or questions related to the Code of Conduct or CalOptima Policies and Procedures, he or she should seek guidance from the Compliance Officer and/or the CalOptima Office of Compliance ~~Department~~.

I. WRITTEN STANDARDS

To demonstrate CalOptima's commitment to complying with all applicable Federal and State standards and to ensure a shared understanding of what ethical and legal standards and requirements are expected of Board Members, Employees, and FDRs, CalOptima developed, maintains, and distributes its written standards in the form of this Compliance Plan, a separate Code of Conduct, and written Policies and Procedures.

a. Compliance Plan

As noted above, this Compliance Plan outlines how contractual and legal standards are reviewed and implemented throughout the organization and communicated to CalOptima Board Members, Employees, and FDRs. This Compliance Plan also includes a comprehensive section articulating CalOptima's commitment to preventing Fraud, Waste & Abuse (FWA), and setting forth guidelines and procedures designed to detect, prevent and remediate FWA in the administration of CalOptima Programs. The Compliance Plan is available on CalOptima's external Website for Board Members and FDRs as well as on ~~the~~ CalOptima's ~~Compliance Department's~~ internal intranet site, referred to as ~~CalOptima's~~ InfoNet, accessible to all Employees.

b. Policies and Procedures

CalOptima also developed written Policies and Procedures to address specific areas of CalOptima's operations, compliance activities, and FWA prevention, detection, and remediation to ensure CalOptima can efficiently monitor adherence to all applicable laws, regulations, and guidelines. These policies are designed to provide guidance to Board Members, Employees, and FDRs concerning compliance expectations and outline processes on how to identify, report, investigate, and/or resolve suspected, detected or reported compliance issues. Board Members, Employees, and FDRs are expected to be familiar with the Policies and Procedures pertinent to their respective roles and responsibilities, and are expected to perform their responsibilities in compliance with ethical standards, contractual obligations, and applicable law. The Compliance Officer, or designee, will ensure that Board Members, Employees, and FDRs are informed of applicable policy requirements, and that such dissemination of information is documented and retained in accordance with applicable record retention standards.

The Policies and Procedures are reviewed annually and updated, as needed, depending on State and Federal regulatory changes and/or operational improvements to address identified risk factors. Changes to CalOptima's Policies and Procedures are reviewed and approved by CalOptima's Policy Review Committee. The Policy Review Committee, comprised of executive officers and key staff, meets regularly to review and approve proposed changes and additions to CalOptima's Policies and Procedures. Policies and Procedures are available on CalOptima's internal website and Compliance 360, a separate web portal accessible to Board Members, Employees, and FDRs. Board Members, Employees, and FDRs receive notice when Policies and Procedures are updated via a monthly memorandum.

c. Code of Conduct

Finally, the Code of Conduct is CalOptima's foundational document detailing fundamental principles, values, and the framework for business practices within and applicable to CalOptima. The objective of the Code of Conduct is to articulate compliance expectations and broad principles that guide CalOptima Board Members, Employees, and FDRs in

conducting their business activities in a professional, ethical, and lawful manner. The Code of Conduct is a separate document from the Compliance Plan and can be found in Appendix A of the Compliance Plan. The Code of Conduct is approved by CalOptima's Board of Directors and distributed to Board Members, Employees, and FDRs upon appointment, hire, or the commencement of the contract, and annually thereafter. New Board Members, Employees, and FDRs are required to sign an attestation acknowledging receipt and review of the Code of Conduct within ninety (90) days of the appointment, hire, or commencement of the contract, and annually thereafter.

II. OVERSIGHT

The successful implementation of the Compliance Program requires dedicated commitment and diligent oversight throughout CalOptima's operations, including, but not limited to, key roles and responsibilities by CalOptima's Board, the Compliance Officer, the Compliance Committee, the ~~Delegation~~ Audit & Oversight Committee, and Senior Management.

a. Governing Body

The CalOptima Board of Directors, as the Governing Body, is responsible for approving, implementing, and monitoring a Compliance Program governing CalOptima's operations. The CalOptima Board delegates the Compliance Program oversight and day-to-day compliance activities to the Chief Executive Officer (CEO), who then delegates such oversight and activities to the Compliance Officer. The Compliance Officer is an employee of CalOptima, who handles compliance oversight and activities full-time. The Compliance Officer, in conjunction with the Compliance Committee, are both accountable for the oversight and reporting roles and responsibilities as set forth in this Compliance Plan. However, the CalOptima Board remains accountable for ensuring the effectiveness of the Compliance Program within CalOptima and monitoring the status of the Compliance Program to ensure its efficient and successful implementation.

To ensure the CalOptima Board exercises reasonable oversight with respect to the implementation and effectiveness of CalOptima's Compliance Program, the CalOptima Board:

- Understands the content and operation of CalOptima's Compliance Program;
- Approves the Compliance Program, including this Compliance Plan and the Code of Conduct;
- Requires an effective information system that allows it to properly exercise its oversight role and be informed about the Compliance Program outcomes, including, but not limited to, results of internal and external audits;
- Receives training and education upon appointment, and annually thereafter, concerning the structure and operation of the Compliance Program;
- Remains informed about governmental compliance enforcement activity, such as Notices of Non-Compliance, Corrective Action Plans, Warning Letters, and/or more formal sanctions;
- Receives regularly scheduled, periodic updates from CalOptima's Compliance Officer and Compliance Committee, including, but not limited to, monthly reports summarizing overall compliance activities and any changes that are recommended; and
- Reviews the results of performance and effectiveness assessments of the Compliance Program.

The CalOptima Board reviews the measurable indicators of an effective Compliance Program and remains appropriately engaged in overseeing its efficient and successful implementation; however, the CalOptima Board delegates several compliance functions and activities as described in the following subsections.

b. Executive Director of Compliance (Compliance Officer)

The Executive Director of Compliance serves as the Compliance Officer and coordinates and communicates all assigned compliance activities and programs, as well as plans, implements, and monitors the day-to-day activities of the Compliance Program. The Compliance Officer reports directly to the CEO and the Compliance Committee on the activities and status of the Compliance Program. The Compliance Officer has authority to report matters directly to the CalOptima Board at any time. Furthermore, the Compliance Officer ensures that CalOptima meets all state and federal regulatory and contractual requirements.

The Compliance Officer interacts with the CalOptima Board, CEO, CalOptima's executive and departmental management, FDRs, legal counsel, State and Federal representatives and others as required. In addition, the Compliance Officer supervises the Office of Compliance ~~Department~~, which includes compliance professionals with expertise and responsibilities for the following areas: Medi-Cal and Medicare Regulatory Affairs & Compliance, Special Investigations, Privacy, FDR and internal oversight, Policies and Procedures, and training on compliance activities.

The CalOptima Board delegates the following responsibilities to the Compliance Officer, and/or his or her designee(s):

- Chair the Compliance Committee, which shall meet no less than quarterly and which committee assists the Compliance Officer in fulfilling his or her responsibilities;

- Ensure that the Compliance Program, including this Compliance Plan and Policies and Procedures, are developed, maintained, revised, revised and updated, annually or as needed based on changes in CalOptima's needs, regulatory requirements, and applicable law and distributed to all affected Board Members, Employees, and FDRs, as appropriate;

- Oversee and monitor the implementation of the Compliance Program, and provide regular reports no less than quarterly to the CalOptima Board and CEO summarizing all efforts, including, but not limited to, the Compliance Committee's efforts to ensure adherence to the Compliance Program, identification and resolution of suspected, detected or reported instances of noncompliance, and CalOptima's compliance oversight and audit activities;

- Maintain the compliance reporting mechanisms and manage inquiries and reports from CalOptima's Compliance and Ethics Hotline in accordance with specified protocols, including, but not limited to, maintenance of documentation for each report of potential noncompliance or potential FWA received from any source through any reporting method;

- Design, coordinate, and/or conduct regular internal audits to ensure the Compliance Program is being implemented and followed and to ensure appropriate financial and administrative controls are in place;

- Develop and implement an annual schedule of Compliance Program activities for each of CalOptima's Programs, and regularly report CalOptima's progress in implementing those plans to the appropriate Board Committee and/or to the Board of Directors;

- Serve as a liaison between CalOptima and all applicable State and Federal agencies for noncompliance and/or FWA issues, including facilitating any documentation or procedural requests by such agency/ies;

- Oversee and monitor all compliance investigations, including investigations performed by CalOptima's regulators (e.g. DHCS and CMS) and consult with legal counsel, as necessary;

- Create and coordinate educational training programs and initiatives to ensure that the CalOptima Board, Employees, and FDRs are knowledgeable about CalOptima's Compliance Program, including the Code of Conduct, Policies and Procedures, and all current and emerging applicable statutory and regulatory requirements;

- Timely initiate, investigate, and complete risk assessments and related activities, and direct and implement appropriate corrective action plans, sanctions, and/or other remediation, including, but not limited to, collaboration with the Human Resources Department to ensure consistent, timely, and effective disciplinary standards are followed; and

- Coordinate with CalOptima departments and FDRs to ensure exclusion screening (including through the OIG LEIE, GSA SAM, and Medi-Cal Provider Manual) has been conducted and acted upon, as appropriate, in accordance with regulatory and contractual requirements.

c. Compliance Committee

The Compliance Committee, chaired by the Compliance Officer, is composed of CalOptima's senior management and operational staff, as designated by the CEO. The members of the Compliance Committee serve at the discretion of the CEO and may be removed or added at any time. The role of the Compliance Committee is to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The Compliance Committee meets at least on a quarterly basis, or more frequently as necessary, to enable reasonable oversight of the Compliance Program.

The CalOptima Board delegates the following responsibilities to the Compliance Committee:

- Maintain and update the Code of Conduct consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the CalOptima Board;

- Maintain written notes, records, correspondence, or minutes (as appropriate) of Compliance Committee meetings reflecting reports made to the Compliance Committee and the Compliance Committee's decisions on the issues raised (subject to all applicable privileges);

- Review and monitor the effectiveness of the Compliance Program, including monitoring key performance reports and metrics, evaluating business and administrative operations, and overseeing corrective actions to ensure they are promptly and effectively implemented;

- Develop standards of business conduct and Policies and Procedures to promote compliance;

- Review, approve, and/or update Policies and Procedures to ensure the successful implementation and effectiveness of the Compliance Program consistent with regulatory, legal and contractual requirements;

- Recommend and monitor the development of internal systems and controls to implement CalOptima's standards and Policies and Procedures as part of its daily operations;

- ► Determine the appropriate strategy and/or approach to promote compliance and detect potential violations and advise the Compliance Officer accordingly;

- ► Develop and maintain a reporting system to solicit, evaluate, and respond to complaints and problems;

- ► Review and address reports designating areas in which CalOptima is at risk for program noncompliance and potential FWA, and ensure that corrective action plans are implemented and monitored for effectiveness;

- ► Suggest and implement whatever actions are appropriate and necessary to ensure that CalOptima and its FDRs conduct activities and operations in compliance with the applicable law and regulations and sound business ethics; and

- ► Provides regular and ad hoc reports on the status of compliance with recommendations to the CalOptima Board.

d. ~~Delegation~~ Audit & Oversight Committee (A~~D~~OC)

The ~~Delegation~~ Audit & Oversight Committee (A~~D~~OC) is a subcommittee of the Compliance Committee and is chaired by the Director of Audit & Oversight. The A~~D~~OC is responsible for overseeing the delegated and internal activities of CalOptima. The Compliance Committee~~DOC~~ has final approval authority for any delegated and internal~~ion~~ activities~~y as permitted by the CalOptima Board~~~~Compliance Committee~~. Committee members include representatives from CalOptima's departments as provided for in the A~~D~~OC charter. In addition to the monthly scheduled meetings, the A~~D~~OC may conduct ad hoc ~~online~~ meetings either in-person or via teleconference, as needed. All materials requiring action by the AOC presented are approved by a quorum. A quorum is defined as one over fifty percent. A~~D~~OC may approve and/or implement Corrective Act Plans (CAPs); however, recommendations for FDR sanctioning and/or de-delegation are submitted to the Compliance Committee for final approval. The ~~DOC~~ AOC also contributes to external reviews and accreditation audits, such as the National Committee for Quality Assurance (NCQA).

Responsibilities of the ~~Delegation~~ Audit & Oversight Committee with regard to FDRs include:

- ► Annual review, revision, and approval of the ~~Delegation~~ Audit & Oversight Department Program Description, Policies and Procedures, and audit tools;

- ► Review findings of the pre-delegation audit and readiness assessment to evaluate a potential FDR's ability to perform the delegated function(s);

- ► Review and approve potential FDR entities for delegation of functions;

- ► Ensure written agreements with each delegated FDR clearly define and describe the delegated activities, responsibilities, and reporting requirements of all Parties consistent with applicable laws, regulations, and contractual obligations;

- ► Conduct formal, ongoing evaluation and monitoring of FDR performance and compliance through review of periodic reports submitted, complaints/grievances filed, and findings of the annual onsite~~on-sight~~ audit;

- ► Ensure all Downstream and Related Entities are monitored in accordance with CalOptima oversight procedures;

- Conduct formal risk assessment on an annual basis, and update as needed, on an ongoing basis;
- Initiate and manage Corrective Action Plans (CAPs) for compliance issues;
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- Propose sanctions, subject to the Compliance Committee's approval, if an FDR's performance is substandard and/or violates the terms of the applicable agreement; and
- Review and initiate recommendations, such as termination of delegation, to the Compliance Committee for unresolved issues of compliance.

Responsibilities of the Audit & Oversight Committee with regard to internal business functions include:

- Annual review, revision, and approval of the Audit & Oversight Department Program Description and audit tools;
- Conduct formal, ongoing evaluation and monitoring of internal business areas' performance and compliance through review of periodic reports submitted, ongoing monitoring, and findings of the annual audit;
- Conduct formal risk assessment on an annual basis, and update as needed, on an ongoing basis; and
- Initiate and manage Corrective Action Plans (CAPs) for compliance issues.

e. Senior Management

The CEO and other executive management of CalOptima shall:

- Ensure that the Compliance Officer is integrated into the organization and is given the credibility, authority and resources necessary to operate a robust and effective compliance program;
- Receive periodic reports from the Compliance Officer of risk areas facing the organization, the strategies being implemented to address them and the results of those strategies; and
- Be advised of all governmental compliance and enforcement findings and activity, including audit findings, notices of non-compliance, and formal enforcement actions, and participate in corrective actions and responses, as appropriate.

III. TRAINING

Education and training are critical elements of the Compliance Program. CalOptima requires that all Board Members, Employees, Temporary Employees and FDRs complete training upon appointment, hire, or commencement of contract, as applicable, and on an annual basis thereafter. Required courses cover CalOptima's Code of Conduct, compliance obligations, and relevant laws, and FWA, as applicable. Specialized education courses are assigned to individuals based on their respective roles or positions within or with CalOptima's departments and its programs, which may include, but is not limited to, the fundamentals of managing seniors and people with disabilities (SPD) and cultural competency.

CalOptima utilizes state of the art web-based training courses that emphasize CalOptima's commitment to the Compliance Program, and which courses are updated regularly to ensure that employees are kept fully informed about any changes in procedures, regulations and requirements. Training may be conducted using new technology resources if materials meet the needs of the organization. The Compliance Officer is responsible for coordinating compliance education and training programs, and ensuring that records evidencing an individual's/FDR's completion of the training requirements are documented and maintained, such as sign-in sheets, attestations, or electronic certifications, as required by law. The Compliance Officer and the CalOptima management staff are responsible for ensuring that Board Members, Employees, Temporary Employees, and FDRs complete training on an annual basis.

a. Code of Conduct

CalOptima's training program includes the distribution of CalOptima's Code of Conduct to Board Members, Employees, and FDRs. Board Members, Employees, Temporary Employees, and FDRs are required to sign an attestation acknowledging receipt, review, and understanding of the Code of Conduct within ninety (90) days of their appointment, date of hire, or commencement of the contract, and annually thereafter. Completion and attestation of such review of the Code of Conduct is a condition of continued appointment, employment, or contract services. Signed attestations are maintained in each person's files, as legally required.

b. Mandatory Training Courses (Compliance Oversight, ~~and~~ FWA **and HIPAA**)

CalOptima requires Board Members, Employees, Temporary Employees, and FDRs, regardless of role or position with CalOptima, to complete mandatory compliance training courses. Mandatory courses may include, but are not limited to: the fundamentals of the Compliance Program; FWA training; HIPAA privacy and security requirements; ethics; and a high level overview of the Medicare and Medi-Cal Programs. CalOptima's training courses cover CalOptima's commitment to compliance with Federal and State laws and regulations, contractual obligations, internal policies and ethics. Elements of the Compliance Program are highlighted, including, but not limited to, an emphasis on CalOptima's requirement to and different means to report suspected or actual noncompliance, violations, and/or FWA issues, along with CalOptima's policy on confidentiality, anonymity, and non-retaliation for such reporting. CalOptima's HIPAA privacy and security training course covers the administrative, technical and physical safeguards ~~necesary~~necessary to secure ~~m~~Members' protected health information.

Employees must complete the required compliance training courses within ~~sixty~~ ninety (~~9~~60) days of hire, and annually thereafter. Adherence to the Compliance Program requirements, including training requirements, shall be a condition of continued employment and a factor in the annual performance evaluation of each Employee. Board Members and FDRs are required to complete

the required compliance training courses within ninety (90) days of appointment or commencement of the contract, as applicable, and annually thereafter. Some FDRs may be exempt or deemed to have met the FWA training and education requirement if the FDR has met the CMS requirements, the applicable certification requirements and attests to complying with the standards, or through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Completion of the training courses are documented electronically and records of completion are maintained for each individual as required by law.

c. Additional Training

The Compliance Department may provide additional training opportunities throughout the year focused on essential elements of the Compliance Program. These training opportunities are available to managers and Employees depending on their respective roles or positions within or with CalOptima's departments and its programs and their involvement in CalOptima's oversight responsibilities. For these training courses, information is presented in a "train the trainer" format, providing managers the tools and resources to train and share the information with Employees in their respective departments. If additional training related to FWA is required, the Compliance Officer will develop relevant materials.

Employees have access through CalOptima's internal intranet website (referred to as the "InfoNet") to CalOptima's Policies and Procedures governing the Compliance Program and pertinent to their respective roles and responsibilities. Employees may receive such additional compliance training as is reasonable and necessary based on changes in job descriptions/duties, promotions, and/or the scope of their job functions.

Board members receive a copy of the Compliance Plan, Code of Conduct, and Policies and Procedures pertinent to their appointment as part of orientation within ninety (90) days of their appointment to the CalOptima Board. Board members may receive additional compliance training related to the CalOptima Board's role in overseeing and ensuring organizational compliance with CalOptima's Compliance Program.

The Code of Conduct and Policies and Procedures pertinent to their engagement with CalOptima, if directly engaged by CalOptima, are made available to FDRs upon commencement of the FDR contract. FDRs are required to disseminate copies of the Code of Conduct and Policies and Procedures to their employees, agents, and/or Downstream Entities. CalOptima may also develop compliance training and education presentations and/or roundtables for specified FDRs.

IV. LINES OF COMMUNICATION AND REPORTING

a. General Compliance Communication

CalOptima regularly communicates the requirements of the Compliance Program and the importance of performing individual roles and responsibilities in compliance with applicable laws, contractual obligations, and ethical standards. CalOptima utilizes various methods and forms to communicate general information, statutory or regulatory updates, process changes, updates to Policies and Procedures, contact information for the Compliance Officer, relevant federal and state fraud alerts and policy letters, pending/new legislation reports, and advisory bulletins from the Compliance Officer to CalOptima Board Members, Employees, Temporary ~~Employees ,~~Employees, FDRs, and members, including, but not limited to:

- Presentations and Updates at Meetings – CalOptima periodically holds and utilizes in-person and conference call meetings with the CalOptima Board, FDRs, Employees, individual CalOptima departments, and members.

- Compliance 360 – CalOptima maintains an internal and external website and portal referred to as Compliance 360, accessible to Board Members, Employees, and FDRs, which contains CalOptima's updated Policies and Procedures.

- Newsletters or Mailed Notices – CalOptima develops, and where appropriate, translates, publications and/or notices, to Board Members, Employees, FDRs, and members.

- Electronic Mail – The CEO or Compliance Officer, or their respective designee, periodically sends out e-mail communication and/or alerts to Board Members, Employees, FDRs and/or members, as applicable.

- CalOptima's Internal Intranet Website – CalOptima maintains an internal intranet website, referred to as InfoNet, where CalOptima posts applicable updates and notices to Employees.

- CalOptima's Compliance Internal Website – The Regulatory Affairs & Compliance Department maintains an internal department website accessible to CalOptima Employees to communicate different Compliance initiatives ~~(including monthly themes)~~, notices, key documents and forms, and updates to the Compliance Program, Code of Conduct, and/or Policies and Procedures.

- Postings – The Regulatory Affairs & Compliance Department posts flyers concerning key initiatives, themes, and updates throughout CalOptima's facilities, including, but not limited to, break rooms, which are accessible to CalOptima employees.

- Written Reports – The Compliance Officer, in coordination with the CEO and Compliance Committee prepares written ~~quarterly and annual~~monthly reports concerning the status of the Compliance Program to be presented to the CalOptima Board.

- Direct Contact with the Compliance Officer - Board Members, Employees, Temporary Employees and FDRs can obtain additional compliance information directly from the Compliance Officer. Any questions, which cannot be answered by the Compliance Officer,

shall be referred to the Compliance Committee.

b. Reporting Mechanisms

CalOptima Board Members, Employees, Temporary Employees, and FDRs have an affirmative duty and are directed in CalOptima's Code of Conduct and Policies and Procedures to report compliance concerns, questionable conduct or practices, and suspected or actual violations immediately upon discovery. Failure by Board Members, Employees, Temporary Employees and/or FDRs to report known violations, failure to detect violations due to negligence or reckless conduct, and making false reports may constitute grounds for disciplinary action, up to and including, recommendation for removal from appointment, termination of employment, or termination of an FDR contract, where appropriate.

CalOptima has established multiple reporting mechanisms to receive, record and respond to compliance questions, potential non-compliance issues and/or FWA incidents or activities. These reporting systems, which are outlined in greater detail below, provide for anonymity and confidentiality (to the extent permitted by applicable law and circumstances). Reminders and instructions on how to report compliance and FWA issues are also provided to Board Members, Employees, FDRs and members in newsletters, on CalOptima's website, in trainings, on posters and at meetings. CalOptima maintains and supports a no retaliation policy governing good-faith reports of suspected or actual non-compliance and/or FWA.

Upon receipt of a report through one of the following mechanisms, the Compliance Officer shall follow appropriate Policies and Procedures to promptly review, investigate and resolve such matters. The Compliance Officer shall monitor the process for follow-up communications to persons submitting reports or disclosures through these reporting mechanisms and shall ensure documentation concerning such reports is maintained according to all applicable legal and contractual requirements.

1. Report Directly to a Supervisor or Manager

CalOptima employees are encouraged to contact their immediate supervisor or manager when non-compliant activity is suspected or observed. A report should be made immediately upon suspecting or identifying the potential or suspected non-compliance or violation. The supervisor or manager will promptly escalate the report to the Compliance Officer for further investigation and reporting to the CalOptima Compliance Committee. If an Employee is concerned that his or her supervisor or manager did not adequately address his or her report or complaint, the Eemployee may go directly to the Compliance Officer or the CEO.

2. Call the Compliance and Ethics Hotline

CalOptima maintains an easily accessible Compliance and Ethics Hotline, available 24 hours a day, 7 days a week, with Spanish and English capability, in which CalOptima may receive anonymous issues on a confidential basis. Members are encouraged to call the Compliance and Ethics Hotline if they have identified potential non-compliant activity or FWA issues. The Compliance and Ethics Hotline information is as follows:

TOLL FREE COMPLIANCE and ETHICS HOTLINE
(877) 837-4417

Calls or issues reported through the Cceompliance and Ethics Hhotline are received, logged into a database and investigated by the Regulatory Affairs & Compliance Department. No disciplinary action will be taken against individuals making good-faith reports. Every effort will be made to

keep reports confidential to the extent permitted by law. The process for reporting suspected violations to the Compliance and Ethics Hotline is part of the education and/or orientation for all Board Members, Employees, FDRs and members. Members also have access to the Compliance Officer through the hotline and/or the right to contact the OIG Compliance Hotline directly.

3. Report Directly to the Compliance Officer

The Compliance Officer is available to receive reports of suspected or actual compliance violations or FWA issues on a confidential basis (to the extent permitted by applicable law or circumstances) from Board Members, Employees, FDRs and Members. The Compliance Officer may be contacted by telephone, written correspondence, email, or by a face-to-face appointment. FDRs are generally contractually obligated to report suspected fraud and abuse to CalOptima pursuant to regulatory and contractual requirements.

4. Report Directly to ~~the~~ Office of Compliance ~~Department~~

Reports may be made directly to CalOptima's Office of Compliance ~~Department~~ via mail , ~~facsimile~~ or email for confidential reporting. Emails can be sent to Compliance@caloptima.org. ~~Faxes can be sent to (714) 481-6457~~.

5. Confidentiality and Non-Retaliation

Every effort will be made to keep reports confidential to the extent permitted by applicable law and circumstances, but there may be some instances where the identity of the individual making the report will have to be disclosed. As a result, CalOptima has implemented and enforces a non-retaliation policy to protect individuals who report suspected or actual non-compliance or FWA issues in good faith. This non-retaliation policy extends to reports received from FDRs and members. CalOptima's non-retaliation policy is communicated along with reporting instructions.

CalOptima also takes violations of CalOptima's non-retaliation policy seriously, and the Compliance Officer will review and enforce disciplinary and/or other corrective action plans for violations, as appropriate, with the approval of the Compliance Committee.

V. ENFORCEMENT AND DISCIPLINARY STANDARDS

Board Members, Employees, and FDRs are provided copies of CalOptima's Code of Conduct and the Compliance Plan and have access on CalOptima's internal and external website to applicable Policies and Procedures, including, but not limited to, CalOptima's Progressive Discipline Policy and Office of Compliance Policies addressing corrective action plans and sanctions. Consistent, timely, and effective enforcement of CalOptima's standards are implemented when noncompliance or unethical behavior is determined, and appropriate disciplinary and/or corrective action is implemented to address improper conduct, activity and/or behavior.

a. Conduct Subject to Enforcement and Discipline

Board Members, Employees, and FDRs are subject to appropriate disciplinary and/or corrective actions if they have violated CalOptima's standards, requirements, or applicable laws as specified and detailed in the Compliance Program documents and related Policies and Procedures, including CalOptima's Progressive Discipline Policy, as applicable. Board members, Employees, and FDRs may be disciplined or sanctioned, as applicable, for failing to adhere to CalOptima's Compliance Program and/or violating standards, regulatory requirements and/or applicable laws, including, but not limited to:

- Conduct that leads to the filing of a false or improper claim in violation of Federal or State laws and/or contractual requirements;
- Conduct that results in a violation, or violations, of any other Federal or State laws or contractual requirements relating to participation in Federal and/or State health care programs;
- Failure to perform any required obligation relating to compliance with the Compliance Program, applicable laws, Policies and Procedures and/or contracts; or
- Failure to report violations or suspected violations of the Compliance Program or applicable laws or to report suspected or actual FWA issues to an appropriate person through one of the reporting mechanisms.
- Conduct that violates HIPAA and other privacy laws and/or CalOptima's HIPAA privacy and security policies, including actions that harm the privacy of Members or the CalOptima information systems that store Member data.

b. Enforcement and Discipline

CalOptima maintains a "zero tolerance" policy towards any illegal or unethical conduct that impacts the operation, mission, or image of CalOptima. The standards established in the Compliance Program shall be enforced consistently through appropriate disciplinary actions. Individuals or entities may be disciplined by way of reprimand, suspension, financial penalties, sanctions, and/or termination, depending on the nature and severity of the conduct or behavior. Board Members may be subject to removal, Employees are subject to discipline, up to and including termination, and FDR's may be sanctioned or contracts may be terminated, where permitted. Violations of applicable laws and regulations, even unintentional, could potentially subject individuals, entities or CalOptima to civil, criminal or administrative sanctions and/or penalties. Further, violations could lead to suspension or exclusion from participation in Federal and/or State health care programs.

CalOptima employees shall be evaluated annually based on their compliance with CalOptima's Compliance Program. Where appropriate, CalOptima shall promptly initiate education and training to correct identified problems or behaviors.

VI. MONITORING, AUDITING, AND IDENTIFICATION OF RISKS

Activities associated with monitoring and auditing are identified through a combination of activities: risk assessments, ~~Delegation~~Audit & Oversight and Compliance Committee discussions and decisions, and internal and external reporting. Through monitoring, auditing, and identification of risks, CalOptima can prevent, detect, and correct noncompliance with applicable Federal and/or State requirements.

a. Risk Assessment

The Compliance Officer will collaborate with the Compliance Committee to identify areas of focus for monitoring and auditing potential non-compliant activity and FWA issues. A Compliance Risk Assessment will be performed no less than annually, and as needed, to evaluate the current status of CalOptima's operational areas as well as the operations of FDRs. Operations and processes will be evaluated based on: (1) deficiencies found by regulatory agencies; (2) deficiencies found by internal and external audit and monitoring reports; (3) the institution of new or updated procedures; (4) cross departmental interdependencies; and (5) the effect on the beneficiary experience. The Readiness Checklist established by CMS and the OIG Work Plan shall be used as resources to evaluate operational risks.

The Compliance Officer will work with the Chief Operating Officer, or his or her designee in each operational area, to answer the questions associated with each process and to continually examine and identify potential risk areas requiring monitoring and auditing. Those operational areas determined to be high risk may be subject~~ed~~ to ~~a~~ more frequent monitoring and auditing ~~schedule~~, as well as additional reporting requirements. The risk assessment process~~,~~ will be managed by the Compliance Officer, or his/her designee, and presented to the Audit & Oversight Committee (AOC), and subsequently to ~~the Compliance~~the Compliance Committee, for review and ~~discussion~~approval. ~~The Compliance Officer will then determine if certain processes should be deemed as high, medium or low risk. High risk processes will be included as part of CalOptima's regular monitoring activities. Processes identified as medium risk are coded yellow and are subject to increased oversight for a quarter. Upon successful completion of the oversight, the risk level will be moved to low risk.~~ Monitoring plans will be developed in collaboration with the operational areas, and focused audits ~~will~~ may be scheduled based on ~~according~~ the results of the ongoing monitoring and ~~to the~~ respective risk score. ~~The Office of Compliance Department will be involved in the testing and preliminary outcomes in order to ensure that processes are working appropriately and meet all applicable regulatory standards.~~

The~~A~~ risk assessment shall also be updated~~completed~~ as processes change or are identified as being deficient. ~~New processes that are identified as high risk shall be monitored for at least six months, and the Compliance Officer shall ensure that any required training, policy modifications and/or ad hoc audits are performed.~~

b. Monitoring and Auditing

CalOptima conducts both internal and external routine monitoring and auditing activities to test and confirm compliance with all applicable regulations, guidance, contractual agreements, and Federal and State laws, as well as CalOptima Policies and Procedures to protect against noncompliance and potential FWA in CalOptima Programs. Monitoring activities are regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective. An audit is a formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards ~~of compliance with a particular set of~~

~~standards~~ (e.g., policies and procedures, laws and regulations) used as base measures. As part of the monitoring process, CalOptima has created a dashboard, which is a monitoring tool to track key metrics, including, but not limited to, ~~eligibility and enrollment,~~ ~~inquiries,~~ coverage determinations, complaints, appeals, grievances, regulatory communications, credentialing, customer service, ~~third party reporting (e.g., Maximus),~~ transition of coverage (TOC), and claims. The dashboard will be used to communicate results associated with monitoring operations and outcomes and to identify areas in need of targeted auditing on at least a monthly basis. ~~During the first 30 days of the beginning or continuation of a new program year, the dashboard will be reviewed daily. Thereafter, the information will be reviewed weekly or monthly (depending on the metric) with the operational area and during CEO updates.~~ Information taken from the dashboard along with grievance and complaint call information will be used to develop monitoring and auditing work plans. Monitoring and auditing work plans are used to detect potential areas of risk and/or non-compliant activity. The monitoring and auditing work plans are subject to daily updates and additions, and are therefore, working documents. The Compliance Officer, in collaboration with the AOC and Compliance Committee, develops the monitoring and auditing work plans to address the risks associated with each of CalOptima's Programs.

The Compliance Officer will coordinate with CalOptima's Audit &~~and~~ Oversight Department in connection with appropriate auditing and monitoring activities. Audits for each operational area will be conducted throughout the year consistent with the monitoring and auditing work plans. The Compliance Officer will coordinate the audits with internal audit staff, and, in some cases, with the assistance from an outside vendor. Audit methodologies shall be consistent with regulatory requirements and standards. All audits will include review of applicable documents and evaluation of actual processes to ensure compliance with all applicable regulations and contractual obligations. Once the audit review is completed, the audit team will meet with the Compliance Officer to discuss results and propose follow up corrective action(s). The Compliance Officer will provide reports to the CEO and the Compliance Committee concerning the results of the audits. The A~~D~~OC reports to the Compliance Officer and the Compliance Committee on audits that involve FDRs as discussed below. If Fraud, Waste, or Abuse (FWA) issues are identified during an audit, the matter will be further investigated and resolved in a timely manner. In addition, an audit of the Compliance Program and its effectiveness should occur at least annually, and the results shall be reported to the CalOptima Board.

c. Oversight of Delegated Activities

To ensure the terms and conditions of statutory and contractual obligations to CMS, DHCS, and other governmental and regulatory entities are adhered to, CalOptima implements a comprehensive oversight monitoring and auditing process of FDRs who perform delegated activities. The processes that CalOptima implements to oversee, monitor and audit FDRs are incorporated into CalOptima's written Policies and Procedures, including processes involving pre-contractual evaluations and audits of First Tier Entities. CalOptima may implement corrective action plans, sanctions and/or revoke its delegation of duties (in a manner permitted under the contract) if CalOptima determines that an FDR is unable or unwilling to carry out its responsibilities consistent with statutory and contractual obligations.

The Compliance Officer, or his/her designee, determines the process for monitoring delegated FDRs and develops the annual monitoring and audit calendar in order to validate compliance with contractual standards and regulatory requirements. The A~~D~~OC is responsible for overseeing all of the delegated activities and will review the pre-delegation audit, ensure the annual review of FDRs for delegated functions are completed, conduct formal on-going evaluation of FDR

performance and compliance, ensure Downstream and Related Entitles are monitored, and impose corrective action plans and/or sanctions if the FDR's performance fails to meet statutory and contractual standards and requirements. The AD~~D~~OC may recommend termination of delegation to the Compliance Committee for unresolved matters.

d. Monitoring and Audit Review Process for FDRs

1. Initial Evaluation

Prior to executing a contract or delegation agreement with a potential FDR, a risk assessment is performed to determine the type of initial evaluation that will be performed. If it is deemed necessary, an initial evaluation, referred to as a Readiness Assessment as detailed in CalOptima's Policies and Procedures, is completed to determine the ability of the potential FDR to assume responsibility for delegated activities and to maintain CalOptima standards, applicable State, CMS, and regulatory requirements, and accreditation requirements. The initial evaluation includes, but is not limited to, review of the entity's operational capacity and resources to perform the delegated functions, evaluation of the entity's ability to meet contractual and regulatory requirements, verification that the entity is not excluded in the OIG ~~Office of Inspector General (OIG)~~ List of Excluded Individuals/Entities (LEIE), the General Services Administration (GSA) System of Award Management (SAM), or the DHCS Medi-Cal Provider Manual from participating in health programs, and/or an initial onsite evaluation. Results of the initial evaluation are presented to the ~~Delegation~~ Audit & Oversight Committee and subsequently the Compliance Committee for review and/or approval.

2. Contracting with FDRs

Once an entity has been approved, the delegation agreement specifies the activities CalOptima delegates to the FDRs, each party's respective roles and responsibilities, reporting requirements and frequency, submission of data requirements, the process for performance evaluations and audits, and remedies, including disciplinary actions, available to CalOptima. Prior to any sub-delegation to any Downstream or Related Entity, a First Tier Entity must obtain approval from CalOptima. CalOptima determines who will directly monitor the Downstream or Related Entity's compliance with requirements.

FDRs shall be required to institute a training program consistent with CalOptima's requirements intended to communicate CalOptima's compliance requirements as well as compliance characteristics related to the FDR and their contractually delegated area(s). Furthermore, FDRs will be required to complete, sign, and return attestation forms confirming the FDR's compliance with new hire and annual training and education requirements, which includes courses on general compliance and FWA as well as exclusion screening and FWA reporting obligations.

3. Annual Risk Assessment

The Compliance Officer, or his or her designee, will conduct an annual comprehensive risk assessment to determine the FDR's vulnerabilities and high risk areas. High risk FDRs are those that are continually non-compliant or at risk of non-compliance based on identified gaps in processes with regulatory and CalOptima requirements. Any previously identified issues, which includes any corrective actions, service level performance, reported detected offenses, and/or complaints and appeals from the previous year will be factors that are included in the risk assessment. Any FDR deemed high risk or vulnerable is presented to the ~~Delegation~~ AOC~~Oversight Committee~~ for suggested follow-up audit. FDRs determined to be high risk may be subjected to a more frequent monitoring and auditing schedule, as well as additional reporting

requirements. The risk assessment process, along with reports from FDRs, will be managed by the Compliance Officer, or his/her designee, and presented to the AOC and subsequently to the Compliance Committee for review and ~~discussion~~approval.

4. FDR Performance Reviews and Audits

CalOptima conducts a periodic comprehensive performance review of the FDR's ability to provide delegated services in accordance with contractual standards and applicable state, CMS, and accreditation requirements, as further detailed in CalOptima's Policies and Procedures. CalOptima may conduct audits of FDRs at any time. Such audits may include an evaluation of the FDR's training and education program and materials covering general compliance and FWA, as well as compliance with applicable laws, regulations, and contractual obligations governing delegated activities. High risk FDRs, as determined by the annual risk assessment and/or continued non-compliance, will obtain priority status on the annual audit calendar; however, CalOptima does not limit its auditing schedule to only high risk FDRs.

If CalOptima has reason to believe the FDR's ability to perform a delegated function is compromised, an additional focused audit may be performed. The Compliance Officer may also recommend focused audits upon evaluation of non-compliant trends or reported incidents. The results of these audits will be reported to the ~~Delegation~~ AOC~~Oversight Committee~~ and then to the Compliance Committee.

A focused audit may be initiated for any of the following activities, or any other reason at the discretion of CalOptima:

- Failure to comply with regulatory requirements and/or the CalOptima's service level performance indicators;
- Failure to comply with a corrective action plan;
- Reported or alleged fraud, waste and/or abuse;
- Significant policy variations that deviate from the CalOptima or state, CMS, or accreditation requirements;
- Bankruptcy or impending bankruptcy which may impact services to members (either suspected or reported);
- Sale, merger or acquisition involving the FDR;
- Significant changes in the management of the FDR; and/or
- Changes in resources which impact CalOptima's and/or the FDR's operations.

5. Corrective Actions and Additional Monitoring and Auditing

The Compliance Officer shall submit regular reports of all monitoring, audit, and corrective action activities to the Compliance Committee. In instances where non-compliance is identified, a corrective action plan shall be developed by the FDR and reviewed and approved by the Compliance Officer, or his or her designee. Every corrective action plan is presented to the ~~Delegation Audit & Oversight Committee~~AOC for review~~approval~~. Supplemental and focused audits of FDRs, as well as additional reporting, may be required until compliance is achieved.

At any time, CalOptima may implement sanctions or require remediation by an FDR for failure to fulfill contractual obligations including development and implementation of a corrective action plan. Failure to cooperate with CalOptima in any manner may result in termination of the delegation agreement, in a manner authorized under the terms of the agreement.

e. Evaluation of Audit Activities

An external review of CalOptima's auditing process is conducted through identified process measures. These measures support organizational, accreditation, and regulatory requirements and are reported on a yearly basis. CalOptima uses an independent, external consultant firm to periodically review the auditing processes, including policy and procedures, audit tools, and audit findings, to ensure all regulatory requirements are being audited in accordance with industry standards/practices and are in compliance with federal and state regulations

The current measures reviewed include:

- The central database of all pending, active and terminated FDRs to monitor and track functions, performance, and audit schedules;
- Implementation of an escalation process for compliance/performance issues;
- Implementation of a process for validation of audit tools;
- Implementation of a process for noticing FDRs and functional areas of corrective action plans;
- Tracking and trending internal compliance with oversight standards, performance, and outcomes;
- Implementation of an annual training program for internal staff regarding delegation standards, auditing, and monitoring FDR performance; and/or
- Implementation a process for dissemination of regulatory changes to include Medi-Cal and Medicare lines of business.

The following key performance metrics will be evaluated and reported periodically:

- Evaluations of FDR performance and reporting of delegated functions in accordance with the terms of the agreement;
- Number of annual oversight audits completed within 12 months; and
- Corrective Action Plans (CAPs) completed within the established timeframe ~~within 90 days~~.

f. Regular Exclusion Screening

As detailed in CalOptima's Policies and Procedures, CalOptima performs Participation Status Reviews by reviewing the OIG –LEIE, the GSA–SAM, and DHCS Medi-Cal Provider Manual lists upon appointment, hire, or commencement of a contract, as applicable, and monthly thereafter, to ensure Board Members, Employees, and/or FDRs are not excluded or do not become excluded from participating in federal and state health programs. Board Members, Employees, and FDRs are required to disclose their Participation Status as part of their initial appointment, employment, commencement of the contract and registration/application processes and when Board Members, Employees, and FDRs receive notice of a suspension, exclusion, or debarment during the period of appointment, employment, or contract term. CalOptima also requires that its First Tier Entities comply with Participation Status Review requirements with respect to their relationships with Downstream Entities, including without limitation, the delegated credentialing and re-credentialing processes.

The Compliance Officer will review reports from Employees responsible for conducting the Participation Status Reviews to ensure Employees record and maintain the results of the reviews and notices/disclosures. Employees shall immediately notify the Compliance Officer of affirmative findings of a person or entity's failure to meet the Participation Status Review requirements. If CalOptima learns that any prospective or current Board Member, Employee or

FDR has been proposed for exclusion or excluded, CalOptima will promptly remove him/her/the FDR from CalOptima's Programs consistent with applicable policies and/or contract terms.

Payment may not be made for items or services furnished or prescribed by an excluded person or entity. Payments made by CalOptima to excluded persons or entities after the effective date of their suspension, exclusion, debarment, or Felony Conviction, and/or for items or services furnished at the medical direction or on the prescription of a physician who is suspended, excluded or otherwise ineligible to participate are subject to repayment/recoupment. The Compliance Officer will review potential organizational obligations related to the reporting of identified excluded or suspended individuals or entities and/or refund obligations and consult with legal counsel, as necessary and appropriate, to resolve such matters.

VII. RESPONSE AND REMEDIATION

a. Response to Notice of Violation or Suspected Violation

Upon receipt of a report or notice of violation or suspected violation of CalOptima's Compliance Program and/or FWA issues, the Compliance Officer shall, upon promptly verifying the facts related to the violation or likely violation, notify the Compliance Committee, as appropriate. The Compliance Committee (in consultation with legal counsel, as appropriate) shall determine a response as soon as practicable, which shall include, but not be limited to:

- ~~Investigating, or causing to be investigated~~Recommending investigation~~,~~ of all aspects of the suspected violation or questionable conduct;

- ~~Preparing recommendations for and a~~Approving disciplinary actions, sanctions, termination of any agreement and/or any other corrective action (including repayment of overpayments) consistent with applicable Policies and Procedures, subject to consultation with legal counsel and/or notifying the Governing Body, as appropriate;

- ~~Reporting the reported violation or suspected violation to appropriate governmental agencies, where required by law or contract (or where otherwise appropriate under the circumstances);~~

- Implementing education and training programs for Board Members, Employees, and/or FDRs, where applicable, to correct the violation and prevent recurrence;

- Amending, if necessary, CalOptima's Compliance Plan, Code of Conduct, and/or relevant Policies and Procedures in an effort to avoid any future recurrence of a violation; and/or

- ~~Adequately documenting reports of violations or suspected violations, along with CalOptima's response and resolution of such report; and/or~~

- Ensuring that compliance reports are kept confidential, where permitted by law, and if appropriate, protected under applicable privileges, including, but not limited to, the attorney/client privilege and ensuring that all files regarding Compliance matters are appropriately secured.

It is the responsibility of the Compliance Officer and the Compliance Committee to review and implement any appropriate corrective and/or disciplinary action in consultation with the Human Resources Department, as applicable, consistent with applicable Policies and Procedures after considering such recommendations. The Compliance Officer, or his or her designee, shall monitor and review corrective actions after their implementation to ensure that they are effective.

b. Referral to Enforcement Agencies

In appropriate circumstances, CalOptima shall report violations of Medi-Cal Program requirements to DHCS Audits and Investigations, violations of Medicare Program requirements to the MEDIC, and violations of other state and federal laws to the appropriate law enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies.

c. Response to Fraud Alerts

CMS issues alerts to Part D sponsors concerning fraud schemes indentified by law enforcement officials. Typically, these alerts describe alleged activities involving pharmacies practicing drug diversion or prescribers participating in illegal remuneration schemes. CalOptima may take action (including denying or reversing claims) in instances where CalOptima's own analysis of its claims activity indicates that fraud may be occurring. CalOptima's decision to deny or reverse claims shall be made on a claim-specific basis.

When a Fraud Alert is received, CalOptima shall review its delegation agreements with the identified parties, and shall consider terminating the contract(s) with the identified parties if indictments have been issued against the particular parties and the terms of the delegation agreement(s) authorizes contract termination.

CalOptima is also obligated to review its past paid claims from entities identified in a fraud alert. With the issuance of a fraud alert, CMS places CalOptima on notice (see 42 CFR 423.505(k)(3)) that claims involving the identified party needs to be reviewed. To meet the "best knowledge, information, and belief" standard of certification, CalOptima shall make its best efforts to identify claims that may be or may have been part of an alleged fraud scheme and remove them from the sets of prescription drug event data submissions.

d. Identifying and Monitoring Providers with a History of Complaints

CalOptima shall maintain files for a period of 10 years on both in-network and out-of-network providers who have been the subject of complaints, investigations, violations, and prosecutions. This includes member complaints, DHCS Audits and Investigations referrals, MEDIC investigations, OIG and/or DOJ investigations, US Attorney prosecution, and any other civil, criminal, or administrative action for violations of state or federal health care program requirements. CalOptima shall also maintain files that contain documented warnings (i.e., fraud alerts) and educational contacts, the results of previous investigations, and copies of complaints resulting in investigations. CalOptima shall comply with requests by law enforcement, DHCS, CMS and CMS' designee regarding monitoring of FDRs within CalOptima's network that DHCS or CMS has identified as potentially abusive or fraudulent.

C. FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention and remediation of ~~fraud, waste and abuse (~~FWA~~)~~ is a component of CalOptima's Compliance Program. FWA activities are implemented and overseen by CalOptima's Compliance Officer in conjunction with other compliance activities, and investigations are performed or overseen by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima's ~~Compliance Department~~Office of Compliance, ~~-~~responsible for FWA investigations. The Compliance Officer reports FWA activities to the CalOptima Compliance Committee, CEO, the CalOptima Board, and regulatory agencies.

CalOptima utilizes various resources to detect, prevent and remediate FWA. In addition, CalOptima promptly investigates suspected FWA issues and implements disciplinary or corrective action to avoid recurrence of FWA issues. The objective of the FWA program is to ensure that the scope of benefits covered by the CalOptima Programs are appropriately delivered to members and resources are effectively utilized in accordance with Federal and State guidelines. CalOptima incorporates a system of internal assessments which are organized to identify FWA and promptly respond appropriately to such incidents of FWA.

I. TRAINING

As detailed above, FWA training is provided to all Board Members and Employees as part of the overall compliance training courses in order to help detect, prevent, and remediate FWA. FDRs are also required to complete FWA training as described above. CalOptima's FWA training provides guidance to Board Members, Employees and FDRs on how to identify activities and behaviors that would constitute FWA and how to report suspected or actual FWA activities. Training materials are retained for a period of at least ten (10) years, and such training includes, but is not limited to:

- The process for detection, prevention and reporting of suspected or actual FWA;
- Examples of the most common types of member FWA (see Appendix B, attached hereto and incorporated herein) and FDR FWA (see Appendix C, attached hereto and incorporated herein) as well as common local and national schemes relevant to managed care organization operations;
- Information on how to identify FWA in CalOptima's PACE Program (e.g. suspicious activities suggesting PACE participants or their family members may be engaged in improper drug utilization or drug-seeking behavior, conduct suggesting improper utilization, persons offering kickbacks for referring or enrolling individuals in the PACE program, etc.);
- Information on how to identify potential ~~Prescription~~ prescription ~~Drug~~ drug FWA (e.g. identification of significant outliers whose drug utilization patterns far exceed those of the average member in terms of cost or quantity, disproportionate utilization of controlled substances; use of prescription medications for excessive periods of time, high-volume prescriptions of a particular manufacturer's drugs, submission of false claims or false data for prescription drug claims, misrepresenting the type of drug that was actually dispensed, excessive prescriptions by a particular physician, etc.);

- How to report potential FWA using CalOptima's reporting options, including CalOptima's Compliance and Ethics Hotline, and for FDRs, reporting obligations;

- CalOptima's policy of non-retaliation and non-retribution toward individuals who make such reports in good faith; and

- Information on the False Claims Act and CalOptima's requirement to train ~~e~~Employees and FDR~~'~~s on the False Claims Act and other applicable FWA laws.

CalOptima shall provide Board Members, Employees, FDRs, and members with reminders and additional training and educational materials through print and electronic communications, including, but not limited to, newsletters, alerts, and/or applicable meetings.

II. DETECTION OF FWA

a. Data Sources

In partnership with the Regulatory Affairs & Compliance Department, CalOptima's SIU utilizes different sources and analyzes various data information in an effort to detect patterns of FWA. Potential fraudulent cases will not only come from claims data but can also originate from many sources internally and externally. Members, FDRs, Employees, law enforcement and regulatory agencies, and others are able to contact CalOptima by phone, mail, and e-mail if they suspect any individual or entity is engaged in inappropriate practices. Furthermore, the sources identified below can be used to identify problem areas within CalOptima, such as enrollment, finance or data submission.

Sources used to detect FWA include, but are not limited to:

- CalOptima's Compliance and Ethics Hotline or other reporting mechanisms;
- Claims data history;
- Encounter data;
- Medical record audits;
- Member and provider complaints, appeals, and grievance reviews;
- Utilization Management reports;
- Provider utilization profiles;
- Pharmacy data;
- Monitoring and auditing activities;
- Monitoring external health care FWA cases and determining if CalOptima's FWA Program can be strengthened with information gleaned from the case activity; and/or
- Internal and external surveys, reviews and audits.

b. Data Analytics

CalOptima ~~has engaged the services of a vendor who~~ uses technology and data analysis~~clinical validation~~ to reduce FWA externally. ~~CalOptima contracts with this vendor to provide pre-payment and overpayment detection and prevention services~~. Using a combination of industry standard edits and CalOptima-specific edits, CalOptima ~~this software~~ identifies claims for which procedures have been unbundled or upcoded. CalOptima~~This software~~ also identifies suspect FDRs based on billing patterns. ~~Potential FWA claims are reviewed by the vendor's clinical staff, recommendations to CalOptima are made, and the reports are returned to CalOptima to determine next steps.~~

CalOptima also uses the services of an external Medicare Secondary Payer (MSP) vendor to reduce costs associated with its Medicare Advantage Part D program, OneCare, by ensuring that Medicare funds are not used where certain health insurance, or coverage, is primarily responsible.

c. Analysis and Identification of Risk Areas Using Claims Data

Claims data is analyzed in numerous ways to uncover fraudulent billing schemes. Routine review of claims data will be conducted in order to identify unusual patterns, outliers in billing and utilization, and identify the population of providers and pharmacies that will be further investigated and/or audited. Any medical claim can be pended and reviewed in accordance with applicable State or Federal law if they meet certain criterion that warrants additional review. Payments for pharmacy claims may also be pended and reviewed in accordance with applicable State or Federal law based on criteria focused on the types of drugs (for example narcotics), provider patterns, and challenges previously reported pertaining to certain pharmacies. CalOptima along with the ~~Pharmacy Benefit Manager (~~PBM~~)~~ ~~PBM~~ will conduct data mining activities in order to identify potential issues of FWA.

The following trends will be reviewed and flagged for potential FWA, including:

- Over utilized services;
- Aberrant provider billing practices;
- Abnormal billing in relation to peers;
- Manipulation of modifiers;
- Unusual Coding practices such as excessive procedures per day, or excessive surgeries per patient;
- Unbundling of services;
- Unusual Durable Medical Equipment (DME) billing; and/or
- Unusual utilization patterns by members and providers.

The following claims data may be utilized to evaluate and uncover fraudulent billing schemes:

- Average dollars paid per medical procedure;
- Average medical procedures per office visit;
- Average visits per member;
- Average distance a member travels to see a provider/pharmacy;
- Excessive patient levels of high-risk diagnoses; and/or
- Peer to p~~P~~eer comparisons within specialties.

Once vulnerabilities are identified, immediate actions are taken in order to mitigate the possible losses, including, but not limited to, claims denial or reversal and/ or the reporting of suspected FWA. The data review includes, but is not limited to:

- Analysis of provider medical billing activity within their own peer group;
- Analysis of pharmacy billing and provider prescribing practices;
- Controlled drug prescribing exceeds two standard deviations of the provider's peer group; and/or
- Number of times a provider bills a CPT code in relation to all providers or within their own peer group.

The claims data from the ~~Pharmacy Benefit Manager (~~PBM~~)~~ will go through the same risk assessment process. The analysis will be focused on the following characteristics:

- Prescription drug shorting, which occurs when pharmacy staff provides less than the prescribed quantity and intentionally does not inform the beneficiary, or makes arrangements to provide the balance but bills for the prescribed amount.
- Bait and switch pricing, which occurs when a member is led to believe that a drug will cost one price, but at the point of sale, they are charged a higher amount. One example of this type of scheme is when the pharmacy switches the prescribed medication to a form that increases the pharmacy's reimbursement.
- Prescription forging or altering, which occurs when existing prescriptions are altered to increase the quantity or the number of refills, without the prescriber's authorization. Usually, the medications are diverted after being billed to the Medicare Part D program.
- Dispensing expired or adulterated prescription drugs, which occurs when pharmacies dispense drugs after the expiration date on the package. This also includes drugs that are intended as samples not for sale, or have not been stored or handled in accordance with manufacturer and FDA requirements.
- Prescription refill errors, which occur when pharmacy staff deliberately provides a number of refills different from the number prescribed by the provider.
- Failure to offer negotiated prices, which occurs when a pharmacy charges a member the wrong amount.

d. Sample Indicators

No one indicator is evidence of FWA. The presence of several indicators may suggest FWA, but further investigation is needed to determine if a suspicion of FWA actually exists. The following list below highlights common industry indicators and red flags that are used to determine whether or not to investigate an FDR or their claim disposition:

- Claims that show any altered information (dates; codes; names).
- Photocopies of claim forms and bills or handwritten claims and bills.
- Provider's last name is the same as the member/patient's last name.
- Insured's address is the same as the servicing provider.
- Same provider submits multiple claims for the same treatment for multiple family members or group members of provider's practice.
- Provider resubmitting claim with changed diagnosis code for a date of service already denied.

Cases identified through these data sources and risk assessments are entered into the FWA database and a report is generated and submitted to the Compliance Officer, Compliance Committee, and CEO.

III. INVESTIGATIVE PROCESS

Once the SIU receives an allegation of suspected FWA or detects FWA through an evaluation of the data sources identified above, the SIU utilizes the following steps as a guide to investigate and document the case:

- The allegation is logged into the Fraud Tracking Database (Access database maintained by SIU on an internal drive);
- The allegation is assigned an investigation number (sequentially by year of receipt) and an electronic file is assigned on the internal drive, by investigation number and name;
- SIU develops an investigative plan;

- SIU obtains a legal opinion from CalOptima's Legal Counsel on specific cases or issues;
- Quality of care issues are referred to CalOptima's Quality Improvement Department;
- Where appropriate, SIU will submit a Request for Information (RFI) directly to an FDR to obtain relevant information;
- SIU, or a designee, interviews the individual who reported the FWA, affected members and/or FDRS, or any other potential witnesses, as appropriate;
- SIU conducts a data analytics review of the allegation for overall patterns, trends, and errors using applicable data sources and reports;
- Review of FDR enrollment applications, history, and ownership, as necessary;
- Review of member enrollment applications and other documents, as necessary;
- All supporting documentation is scanned and saved in the assigned electronic file. Any pertinent information, gathered during the SIU review/investigation, is placed into the electronic file;
- After an allegation is logged into the Fraud Tracking System, the investigation is tracked to its ultimate conclusion, and the Fraud Tracking System shall reflect all information gathered and documentation received to ensure timely receipt, review, and resolution, and report may be made to applicable State or Federal agencies within mandated/required time periods, if appropriate;
- If a referral to another investigative agency is warranted, the information is collected and a referral is made to the appropriate agency; and/or
- If the investigation results in recommendations for disciplinary or corrective actions, the results of the investigation shall be forwarded to the Compliance Officer and Compliance Committee for discussion and approval.

IV. FINDINGS, RESPONSE AND REMEDIATION

Outcomes and findings of the investigation may include, but are not limited to, confirmation of violations, insufficient evidence of FWA, need for contract amendment, education and training requirement, recommendation of focused audits, additional investigation, continued monitoring, new policy implementation, and/or criminal or civil action. When the root cause of the potential FWA issue has been identified, the SIU will track and trend the FWA allegation and investigation, including, but not limited to, the data analysis performed, which shall be reported to the Compliance Committee on a quarterly basis. Investigation findings can be used to determine whether or not disciplinary or corrective action is appropriate, whether there is a need for a change in CalOptima's Policies and Procedures, and/or whether the matter should be reported to applicable State and Federal Agencies.

In accordance with applicable CalOptima Policies and Procedures, CalOptima shall take appropriate disciplinary or corrective action against Board Members, Employees, and/or FDRs related to validated instances of FWA. Corrective actions will be monitored by the Compliance Committee, and progressive discipline will be monitored by the Department of Human Resources, as appropriate. Corrective actions may include, but are not limited to, financial sanctions, regulatory reporting, corrective action plans, or termination of the delegation agreement, when permitted by the contract terms. Should such disciplinary or corrective action need to be issued, CalOptima Office of Compliance will initiate review and discussion at the first Compliance Committee following the date of identification of the suspected FWA, the date of report to DHCS, or the date of FWA substantiation by DHCS subsequent to the report. If vulnerability is identified through a single FWA incident, the correction action may be applied universally.

V. REFERRAL TO ENFORCEMENT AGENCIES

CalOptima's SIU shall coordinate timely referrals of potential FWA to appropriate regulatory agencies or their designated program integrity contractors, including the CMS MEDIC, DHCS Audits and Investigations, and/or other enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies. FDRs shall report FWA to CalOptima within the time frames required by the applicable contract and in sufficient time for CalOptima to timely report to applicable enforcement agencies. Significant program non-compliance or suspected FWA should be reported to CMS and/or DHCS as soon as possible after discovery, but no later than ten (10) working days to DHCS after CalOptima first becomes aware of and is on notice of such activity, and within thirty (30) calendar days to MEDIC after a OneCare, OneCare Connect or PACE case is reported to CalOptima's SIU.

Potential cases that should be referred include, but are not limited to:

- Suspected, detected or reported criminal, civil or administrative law violations;
- Allegations that extend beyond the CalOptima and involve multiple health plans, multiple states, or widespread schemes;
- Allegations involving known patterns of FWA;
- Patterns of FWA threatening the life or well-being of CalOptima members; and/or
- Schemes with large financial risk to CalOptima or its members.

VI. ANNUAL EVALUATION

CalOptima's Compliance Committee shall periodically review and evaluate the FWA activities and its effectiveness as part of the overall Compliance Program monitoring and audit activities. Revisions should be made based on industry changes, trends in FWA activities (locally and nationally), the OIG Work Plan, the CalOptima Compliance Plan, and other input from applicable sources.

VII. RETENTION OF RECORDS

CalOptima shall maintain reports and summaries of FWA activities and all proceedings of the various committees in original, electronic, or other media format in accordance with applicable statutory, regulatory, contractual, CalOptima policy, and other requirements. CalOptima shall file copies of member records containing PHI in a secure and confidential manner, regardless of the outcome of a review. CalOptima shall file copies of FWA investigations in a secure and confidential manner, regardless of the outcome of an investigation.

VIII. CONFIDENTIALITY

CalOptima and its FDRs shall maintain all information associated with suspected or actual FWA in confidential files, which may only be released in accordance with applicable laws and CalOptima ~~Polices~~Policies and Procedures. All participants and attendees of CalOptima's Quality Improvement Committee, Compliance Committee, and respective subcommittees, shall sign a "Confidentiality Agreement" agreeing to hold all committee discussions confidential.

D. COMPLIANCE PROGRAM EVALUATION

In order to ensure the effectiveness of the Compliance Program, CalOptima will conduct a self-assessment no less than annually. The assessment will evaluate the Compliance Program against the elements of an effective compliance program as recommended by OIG and required by CMS regulations. The following areas will be reviewed:

- Policies and procedures;
- Compliance Officer and Compliance Committee;
- Training and education of Board Members, Employees, and FDRs;
- Effective lines of communication;
- Well publicized disciplinary guidelines;
- Internal monitoring and auditing; and
- Prompt responses to detected offenses.

The Compliance Program will be evaluated no less than annually by an outside entity. The results of the evaluation will be shared with senior management, the Compliance Committee, and the CalOptima Board. Updates to the Compliance Program will be based on the results of the evaluation and will be referred to the CalOptima Board for review and approval.

E. FILING SYSTEMS

The Compliance Officer shall establish and maintain a filing system (or systems) for all compliance-related documents. The following files shall be established at CalOptima (as applicable):

Compliance Plan, Code of Conduct, and Policies and Procedures File

This file shall contain copies of the following (unless originals specified):

- Compliance Plan and any amendments;
- Any Compliance Program Policies and Procedures issued after the initiation of the Compliance Program;
- Reports to, and Resolutions/Minutes of CalOptima's Board approving the Compliance Program, Compliance Plan, Code of Conduct and/or appointment of the Compliance Officer;
- All non-privileged communications to the Compliance Officer (original);
- All Compliance Committee and CalOptima Board minutes in which compliance issues are discussed; and/or
- Any other written records of the AD~~D~~OC or other oversight activities (originals if generated by the Compliance Officer).

Information and Education File

This file shall contain copies of the following (unless originals specified):

- ~~Board member, Employee and~~ FDR training and attestation records (including attendance records, Affirmation Statements, and the outline of topics covered);
- Board member and Employee training records, attestations, and attendance records are maintained by HR.
- Educational materials provided to Board Members, Employees and FDRs;
- Notices, fraud alerts, and/or federal and state laws and regulations which have been posted on bulletin boards, placed in payroll stuffers, or sent via print or electronic communication (and the dates and locations of such notices); and/or
- All other written records of training activities.

Monitoring, Enforcement and Response File

This file shall contain copies of the following (unless originals specified):

- Records relating to Compliance reports including reports to the Compliance and Ethics Hotline and/or to the Compliance Officer (originals);
- Records relating to periodic monitoring and auditing of the Compliance Program (originals);
- Records relating to Board Member, Employee and FDR Participation Status Review or background checks (originals except where FDRs perform Participation Status Reviews);
- Records relating to established periodic monitoring mechanisms;
- All documents pertaining to the enforcement of the Compliance Program, including, investigations and disciplinary and/or corrective actions; and/or
- All documents reflecting actions taken after an offense has been detected, and all efforts to deter and prevent future violations.

Privileged File

This file shall be protected by, and marked, privileged and confidential and its contents shall be

kept in a secure location. Only the Compliance Officer, legal counsel, and the Compliance Committee, where appropriate, shall have access to its contents. All material in this file shall be treated as attorney-client privileged and shall not be disclosed to persons outside the privileged relationship. This file contains the following original documents (except where only a copy is available):

- Records of requests for legal assistance or legal opinions in connection with Compliance and Ethics Hotline telephone calls, correspondence related thereto, and/or problems reported to the Compliance Officer;
- The response from legal counsel regarding any such issues; and/or
- Legal opinions concerning FDR delegation agreement interpretations and remedies available to CalOptima.

Document Retention

All of the documents to be maintained in the filing system described above shall be retained for five (5) years from end of the fiscal year in which the CalOptima Medi-Cal contract expires or is terminated (other than privileged documents which shall be retained until the issue raised in the documentation has been resolved, or longer if necessary). Records pertaining to CalOptima's OneCare, OneCare Connect, or PACE programs shall be retained for ten (10) years from end date of the applicable contract.

CalOptima shall maintain the documentation required by HIPAA for at least six (6) years from the date of its creation or the date when it last was in effect, whichever, is later. Such documentation includes: (i) policies and procedures (and changes thereto) designed to comply with the standards, implementation specifications or other designated requirements; (ii) writings or electronic copies of communications required by HIPAA; (iii) writings or electronic copies of actions, activities or designations required to be documented under HIPAA; and (iv) documentation to meet its burden of proof related to identification of breaches under 45 CFR Section 164.414(b).

Appendix A

Code of Conduct

Code of Conduct

Principle	Standard
Mission, Vision, and Values CalOptima is committed to its Mission, Vision and Values	**Mission** To provide members with access to quality health care services delivered in a cost-effective and compassionate manner. **Vision** To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all CalOptima members. **Values = CalOptima CARES** **C**ollaboration; **A**ccountability; **R**espect; **E**xcellence; **S**tewardship
Compliance with the Law CalOptima is committed to conducting all activities and operations in compliance with applicable laws.	**Transparent, Legal and Ethical Business Conduct** CalOptima is committed to conducting its business with integrity, honesty and fairness and in compliance with all laws and regulations that apply to its operations. CalOptima depends on its Board Members, Employees and those who do business with it to help fulfill this commitment. **Obeying the Law** Board members, Employees and Contractors (including First Tier and Downstream Entities included in the term "FDRs") shall not lie, steal, cheat or violate any law in connection with their employment and/or engagement with CalOptima. **Fraud, Waste & Abuse (FWA)** CalOptima shall refrain from conduct, which would violate the fraud, waste and abuse laws. CalOptima is committed to the detection, prevention, and reporting of fraud, waste and abuse. CalOptima is also responsible for ensuring that Board members, Employees and FDRs receive appropriate FWA training as described in regulatory guidance. CalOptima's Compliance Plan, Fraud, Waste and Abuse Plan and policies describe examples of potential fraud, waste and abuse and discuss Employee and Contractor FWA obligations and potential sanctions arising from relevant federal and state FWA laws. CalOptima expects and requires that its Board members, Employees, and Contractors do not participate in any conduct that may violate the FWA laws including, federal and state anti-kickback laws, false claims acts, and civil monetary penalty laws. **Political Activities** CalOptima's political participation is limited by law. CalOptima funds, property, and resources are not to be used to contribute to political campaigns, political parties, and/or organizations. Board members, Employees and Contractors may participate in the political process on their own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima in these activities. **Anti-Trust** All Board members, Employees, and Contractors must comply with applicable antitrust, unfair competition and similar laws, which regulate competition. Such persons shall seek advice from legal counsel if they encounter any business decisions involving a risk of violation of antitrust laws. The types of activities that potentially implicate antitrust laws include, without limitation, agreements to fix prices, bid rigging and related activities; boycotts, certain exclusive dealings and price discrimination agreements; unfair trade practices; sales or purchases conditioned on reciprocal purchases or sales; and discussion of factors determinative of prices at trade association meetings.

Code of Conduct

Principle	Standard
Member Rights CalOptima is committed to meeting the health care needs of its members by providing access to quality health care services.	**Member Choice, Access to Health Care Services, Continuity of Care** Employees and Contractors shall comply with CalOptima policies and procedures and applicable law governing member choice, access to health care services and continuity of Member care. Employees and Contractors shall comply with all requirements for coordination of medical and support services for persons with special needs. **Cultural and Linguistic Services** CalOptima and Contractors shall provide culturally, linguistically and sensory appropriate services to CalOptima members to ensure effective communication regarding diagnosis, medical history and treatment, and health education. **Disabled Member Access** CalOptima's Facilities shall adhere to the requirements of Title III of the Americans with Disabilities Act of 1990 by providing access for disabled Members. **Emergency Treatment** Employees and Contractors shall comply with all applicable guidelines, policies and procedures and law governing CalOptima member access and payment of emergency services including, without limitation, the Emergency Medical Treatment and Active Labor Act ("EMTALA") and state patient "anti-dumping" laws, prior authorization limitations, and payment standards. **Grievance and Appeals Processes** CalOptima, its Physician Groups, its Health Networks and Third Party Administrators (TPA) shall ensure that CalOptima members are informed of their grievance and appeal rights including, the State Hearing process, through member handbooks and other communications in accordance with CalOptima policies and procedures and applicable laws. Employees and Contractors shall address, investigate, and resolve CalOptima member complaints and grievances in a prompt and nondiscriminatory manner in accordance with CalOptima Policies and applicable law.
Business Ethics In furtherance of CalOptima's commitment to the highest standards of business ethics, Employees and Contractors shall accurately and honestly represent CalOptima and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.	**Candor & Honesty** CalOptima requires candor and honesty from individuals in the performance of their responsibilities and in communications including, communications with CalOptima's Board of Directors, supervisory employees attorneys, and auditors. No Board member, Employee, or Contractor shall make false or misleading statements to any members and/or persons or entities doing business with CalOptima or about products or services of CalOptima. **Financial and Data Reporting** All financial reports, accounting records, research reports, expense accounts, data submissions, attestations, timesheets and other documents must accurately and clearly represent the relevant facts and the true nature of a transaction. CalOptima maintains a system of internal controls to ensure that all transactions are executed in accordance with management's authorization and recorded in a proper manner to maintain accountability of the agency's assets. Improper or fraudulent accounting documentation or financial reporting or false or misleading encounter, claims, cost or other required regulatory data submissions is contrary to the policy of CalOptima and may be in violation of applicable law and regulatory obligations. **Regulatory Agencies and Accrediting Bodies** CalOptima will deal with all regulatory agencies and accrediting bodies in a direct, open and honest manner. Employees and Contractors shall not take action with regulatory agencies and accrediting bodies that is false or misleading.

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Code of Conduct

Principle	Standard
Public Integrity CalOptima and its Board members and Employees shall comply with laws and regulations governing public agencies.	**Public Records** CalOptima shall provide access to CalOptima Public Records to any person, corporation, partnership, firm or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq. and CalOptima Policies. **Public Funds** CalOptima, its Board members, and Employees shall not make gifts of public funds or assets or lend credit to private persons without adequate consideration unless such actions clearly serve a public purpose within the authority of the agency and are otherwise approved by legal counsel. CalOptima, its Board members, and Employees shall comply with applicable law and CalOptima Policies governing the investment of public funds and expenditure limitations. **Public Meetings** CalOptima, and its Board members, and Employees shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act, California Government Code Sections 54950 et seq.
Confidentiality Board members, Employees, and Contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima policies, procedures, and applicable law.	**No Personal Benefit** Board members, Employees and Contractors shall not use confidential or proprietary CalOptima information for their own personal benefit or for the benefit of any other person or entity, while employed at or engaged by CalOptima, or at any time thereafter. **Duty to Safeguard Member Confidential Information** CalOptima recognizes the importance of its members' right to confidentiality and implements policies and procedures to ensure its members' confidentiality rights and the protection of medical and other confidential information. Board members, Employees and Contractors shall safeguard CalOptima member identity, eligibility, social security, medical information and other confidential information in accordance with applicable laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and implementing regulations, the California Security Breach Notification Law, the California Confidentiality of Medical Information Act, other applicable federal and state privacy laws and CalOptima policies and procedures. **Personnel Files** Personal information contained in Employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable law. **Proprietary Information** Subject to its obligations under the Public Records Act, CalOptima shall safeguard confidential proprietary information including, without limitation, Contractor information and proprietary computer software, in accordance with and, to the extent required by, contract or law. CalOptima shall also safeguard provider identification numbers including, without limitation, Medi-Cal license, Medicare numbers, social security numbers, and other identifying numbers.

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Code of Conduct

Principle	Standard
Business Relationships Business transactions with vendors, Contractors, and other third parties shall be conducted at arm's length in fact and in appearance, transacted free from improper inducements and in accordance with applicable law and ethical standards.	**Business Inducements** Board members, Employees, and Contractors shall not seek to gain advantage through improper use of payments, business courtesies, or other inducements. The offering, giving, soliciting, or receiving any form of bribe or other improper payment is prohibited. Board members, Employees, Contractors and providers shall not use their positions to personally profit or assist others in profiting in any way at the expense of Federal and/or State health care programs, CalOptima or CalOptima members. **Gifts to CalOptima** Board members and Employees are specifically prohibited from soliciting and accepting personal gratuities, gifts, favors, services, entertainment or any other things of value from any person or entity that furnishes items or services used, or that may be used, in CalOptima and its programs unless specifically permitted under CalOptima Policies. Employees may not accept cash or cash equivalents. Perishable or consumable gifts given to a department or group are not subject to any specific limitation and business meetings at which a meal is served is not considered a prohibited business courtesy. **Provision of Gifts by CalOptima** Employees may provide gifts, entertainment or meals of nominal value to CalOptima's current and prospective business partners and other persons when such activities have a legitimate business purpose, are reasonable, and are otherwise consistent with applicable law and CalOptima Policies on this subject. In addition to complying with statutory and regulatory requirements, it is critical to even avoid the appearance of impropriety when giving gifts to persons and entities that do business or are seeking to do business with CalOptima. **Third-Party Sponsored Events** CalOptima's joint participation in Contractor, vendor or other third-party sponsored events, educational programs and workshops is subject to compliance with applicable law including gift of public fund requirements and fraud and abuse prohibitions, and must be approved in accordance with CalOptima Policies on this subject. In no event, shall CalOptima participate in any joint Contractor, vendor, or third party sponsored event where the intent of the other participant is to improperly influence, or gain unfair advantage from, CalOptima or its operations. Employees' attendance at Contractor, vendor or other third-party sponsored events, educational programs and workshops is generally permitted where there is a legitimate business purpose but is subject to prior approval in accordance with CalOptima Policies. **Provision of Gifts to Government Agencies** Board members, Employees and Contractors shall not offer or provide any money, gifts or other things of value to any government entity or its representatives, except campaign contributions to elected officials in accordance with applicable campaign contribution laws. **Broad Application of Standards** CalOptima intends that these standards be construed broadly to avoid even the appearance of improper activity.

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Code of Conduct

Principle	Standard
Conflicts of Interests Board members and Employees owe a duty of undivided and unqualified loyalty to CalOptima.	**Conflict of Interest Code** Designated Employees, including Board members, shall comply with the requirements of the CalOptima Conflict of Interest Code and applicable laws. Board members and Employees are expected to conduct their activities to avoid impropriety and/or the appearance of impropriety, which might arise from the influence of those activities on business decisions of CalOptima, or from disclosure of CalOptima's business operations. **Outside Services and Interests** Without the prior written approval of the Chief Executive Officer (or in the case of the Chief Executive Officer, the Chair of the CalOptima Board of Directors), no employee shall (1) perform work or render services for any Contractor, association of Contractors or other organizations with which CalOptima does business or which seek to do business with CalOptima, (2) be a director, officer, or consultant of any Contractor or association of Contractors; or (3) permit his or her name to be used in any fashion that would tend to indicate a business connection with any Contractor or association of Contractors.
Discrimination CalOptima acknowledges that fair and equitable treatment of employees, members, providers, and other persons is fundamental to fulfilling its mission and goals.	**No Discrimination** CalOptima is committed to compliance with applicable anti-discrimination laws including Title VI of the Civil Rights Act of 1964. Board members, Employees and Contractors shall not unlawfully discriminate on the basis of race, color, religion, national origin, age, gender, sexual orientation, physical or mental disability or any other classification protected by law. CalOptima is committed to providing a work environment free from discrimination and harassment based on any classification noted above. **Reassignment** CalOptima, Physician Groups, and Health Networks shall not reassign members in a discriminatory manner, including based on the enrollee's health status.
Participation Status CalOptima requires that Employees, Contractors, Providers and Suppliers meet Government requirements for participation in CalOptima's programs.	**Federal and State Health Care Program Participation Status** Board members, Employees, and Contractors shall not be currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal or State health care program, including the Medi-Cal program and Medicare programs. **CalOptima Screening** CalOptima will monitor the participation status of Employees, individuals and entities doing business with CalOptima by conducting regular exclusion screening reviews in accordance with CalOptima Policies. **Disclosure of Participation Status** Board members, Employees and Contractors shall disclose to CalOptima whether they are currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal and/or State Health Care program. Employees and individuals and entities that do business with CalOptima shall disclose to CalOptima any pending investigation, disciplinary action or other matter that could potentially result in their exclusion from participation in any Federal or State health care program.
	Delegated Third Party Administrator Review CalOptima requires that its Health Networks, Physician Groups, and third party administrators review participating providers and suppliers for licensure and participation status as part of the delegated credentialing and recredentialing processes when such obligations have been delegated to them. **Licensure** CalOptima requires that all Employees, Contractors, Health Networks, participating providers and suppliers who are required to be licensed, credentialed, certified and/or registered in order to furnish items or services to CalOptima and its members have valid and current licensure, credentials, certification and/or registration as applicable.

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Code of Conduct

Principle	Standard
Government Inquiries/Legal Disputes Employees shall notify CalOptima upon receipt of Government inquiries and shall not destroy or alter documents in response to a government request for documents or information.	**Notification of Government Inquiry** Employees shall notify the Executive Director, Department of Compliance and/or their Supervisor immediately upon the receipt (at work or at home) of an inquiry, subpoena or other agency or government requests for information regarding CalOptima. **No Destruction of Documents** Employees shall not destroy or alter CalOptima information or documents in anticipation of, or in response to, a request for documents by any governmental agency or from a court of competent jurisdiction. **Preservation of Documents Including Electronically Stored Information** Board members and employees shall comply with all obligations to preserve documents, data, and records including, electronically stored information, in accordance with CalOptima Policies and shall comply with instructions on preservation of information and prohibitions on destruction of information issued by Legal Counsel.
Compliance Program Reporting Board members, Employees, and Contractors have a duty to comply with CalOptima's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.	**Reporting Requirements** All Board members, Employees and Contractors are expected and required to promptly report suspected violations of any statute, regulation or guideline applicable to Federal and/or State health care programs or of CalOptima's own Policies in accordance with CalOptima's reporting Policies and its Compliance Plan. Such reports may be made to a Supervisor, the Executive Director, Office of Compliance. Reports can also be made to CalOptima's hotline number below. Persons making reports to the hotline can do so on an anonymous basis **Compliance and Ethics Hotline: 877-837-4417** **Disciplinary Action** Failure to comply with the Compliance Program, including the Code of Conduct, Policies and/or applicable statutes, regulations and guidelines may lead to disciplinary action. Discipline for failure to abide by the Code of Conduct may, in CalOptima's discretion, range from oral correction to termination in accordance with CalOptima's Policies. In addition, failure to comply may result in the imposition of civil, criminal or administrative fines on the individual or entity and CalOptima or exclusion from participation in Federal and/or State health care programs. **Training and Education** CalOptima provides training and education to Board members, Employees, and FDRs. Timely completion of compliance and HIPAA training is mandatory for all CalOptima Employees. **No-Retaliation Policy** CalOptima prohibits retaliation against any individual who reports discrimination or harassment or compliance concerns or participates in an investigation of such reports. Employees involved in any retaliatory acts may be subject to discipline, up to and including termination of employment. **Referrals of FWA to Government Agencies** CalOptima is obligated to coordinate compliance activities with federal and state regulators. Employees shall comply with CalOptima policies related to FWA referral requirements to federal and state regulators, delegated program integrity contractors and law enforcement agencies. **Certification** All Board members, Employees and Contractors are required to certify, in writing, that they have received, read, understand and will abide by the Code of Conduct and applicable Policies.

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Appendix B

Types of Member FWA

MEMBER FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
M01	Using another individual's identity or documentation of Medi-Cal eligibility to obtain Covered Services.	Members with multiple areas of service; members who attempt more than one PCP; reports of members who are hiding assets or income
M02	Selling, loaning, or giving a member's identity or documentation of Medi-Cal eligibility to obtain services.	Members with multiple areas of service; members who attempt more than one PCP; reports of members who are hiding assets or income
M03	Making an unsubstantiated declaration of eligibility.	Members with multiple areas of service; members who attempt more than one PCP; reports of members who are hiding assets or income
M04	Using a Covered Service for purposes other than the purpose for which it was described including use of such Covered Service.	Selling a covered wheelchair; selling medications; abusing prescription medications
M05	Failing to report other health coverage.	Payments by OHI
M06	Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive Covered Services.	Hotline reports; internal reports; reports by Health Networks
M07	Other (please specify).	Any source
M08	Member Pharmacy Utilization.	PBM reports; data analytics; claims data; encounter data; FWA software
M09	Doctor Shopping.	PBM reports; data analytics; claims data; encounter data; FWA software
M10	Altered Prescription.	Provider report; DEA report; pharmacy report; PBM reports; data analytics; claims data; encounter data; FWA software

Appendix C

Types of FDR FWA

FDR FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P01	Unsubstantiated declaration of eligibility to participate in the CalOptima program.	Provider information not able to be verified during credentialing or contracting process; providers on the excluded provider list
P02	Submission of claims for Covered Services that are substantially and demonstrably in excess of any individual's usual charges for such Covered Services.	PBM reports; data analytics; claims data; encounter data; FWA software
P03	Submission of claims for Covered Services that are not actually provided to the member for which the claim is submitted.	PBM reports; data analytics; claims data; encounter data; FWA software; verification survey; hotline
P04	Submission of claims for Covered Services that are in excess of the quantity that is Medically Necessary.	PBM reports; data analytics; claims data; encounter data; FWA software
P05	Submission of claims for Covered Services that are that are billed using a code that would result in great payment than the code that reflects the covered services.	PBM reports; data analytics; claims data; encounter data; FWA software
P06	Submission of claims for Covered Services that is already included in the capitation rate.	PBM reports; data analytics; claims data; encounter data; FWA software
P07	Submission of claims for Covered Services that are submitted for payment to both CalOptima and another third party payer without full disclosure.	PBM reports; data analytics; claims data; encounter data; FWA software; payment by OHI
P08	Charging a member in excess of allowable co-payments and deductibles for Covered Services.	Member report; hotline report; oversight audits
P09	Billing a member for Covered Services without obtaining written consent to bill for such services.	Member report; hotline report; oversight audits
P10	Failure to disclose conflict of interest.	Hotline; credentialing or contracting process
P11	Receiving, soliciting, or offering a kickback, bribe or rebate to refer or fail to refer a member.	Hotline report; oversight report
P12	Failure to register billing intermediary with the Department of Health Services.	Oversight audit; report by regulatory body; hotline
P13	False certification of Medical Necessity.	Medical record review; claims data; encounter data; FWA

		software
P14	Attributing a diagnosis code to a member that does not reflect the member's medical condition for the purpose of obtaining higher reimbursement.	Medical record review; claims data; encounter data; FWA software
P15	False or inaccurate Minimum Standards or credentialing information.	Hotline; credentialing or contracting process
P16	Submitting reports that contain unsubstantiated data, data that is inconsistent with records, or has been altered in a manner that is inconsistent with policies, contracts, statues or regulations.	Medical record review; claims data; encounter data; FWA software
P17	Other (please specify).	Any source
P18	Provider Pharmacy Utilization.	PBM reports; data analytics; claims data; encounter data; FWA software
P19	Billing Medi-Cal Member for Services.	Member report; hotline report; oversight audits
P20	Durable Medical Equipment-Covered Services that are not actually provided to beneficiary.	Member report; hotline report; oversight audits; verification survey

Appendix D

Types of Employee FWA

EMPLOYEE FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
E01	Use of a Member's identity or documentation of Medi-Cal eligibility to obtain services	Employees obtaining services on a Member's account. Hotline report. Data analytics. Referrals to SIU.
E02	Use of a Member's identity or documentation of Medi-Cal eligibility to obtain a gain.	Employees obtaining unjust enrichment, funds, or other gain by selling Member's account information. Hotline report.
E03	Employee assistance to providers with the submission of claims for Covered Services that are not actually provided to the Member for which the claim is submitted.	Employees obtaining unjust enrichment, funds, or other gain from provider by using Member's account information to assist in the submission of false claims. Hotline report. Referrals to SIU.
E04	Employee deceptively accessing company confidential information for purpose of a gain.	Employees obtaining unjust enrichment, funds, or other gain from another by deceptive and unauthorized accessing of information. Hotline Service. Data Analytics. Referrals to SIU.

AFFIRMATION STATEMENTS

CalOptima
AFFIRMATION STATEMENT-SUPERVISORS

I have received and read a copy of the Compliance Plan, Code of Conduct, and relevant Policies and Procedures as part of my compliance training, and I understand, acknowledge, and agree to abide by its contents and requirements.

I understand that it is my responsibility to respond to questions from employees under my direct supervision regarding the Compliance Plan, Code of Conduct, or applicable Policies and Procedures. If I am unable to respond to questions from employees under my direct supervision, I will refer them to the Compliance Officer. In addition, I understand that if an employee under my direct supervision reports a violation or suspected violation of CalOptima's Compliance Program to me, I will escalate and report the issue to the Compliance Officer.

By signature below, I also certify that I have completed the Compliance Training as indicated:

I attended the initial Compliance Training Session on _____.

_____	_____
Print Name	Signature
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Print Name	Signature
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Print Name	Signature

CalOptima
AFFIRMATION STATEMENT-EMPLOYEES

I have received and read a copy of the Compliance Plan, Code of Conduct, and relevant Policies and Procedures specific to my job duties and responsibilities as part of my compliance training, and I understand, acknowledge, and agree to abide by its contents and requirements.

By signature below, I also certify that I have completed the Compliance Training Session on _____:

_____	_____
Print Name	Signature
_____	_____
Print Name	Signature
_____	_____
Print Name	Signature
_____	_____
Print Name	Signature
_____	_____
Print Name	Signature
_____	_____
Print Name	Signature
_____	_____
Print Name	Signature
_____	_____
Print Name	Signature
_____	_____
Print Name	Signature

CalOptima
AFFIRMATION STATEMENT-FDRs

I have received and read a copy of the Compliance Plan, Code of Conduct, and applicable Policies and Procedures relevant to the delegated activities, and I understand, acknowledge, and agree to abide by its contents and requirements.

I will disseminate the Compliance Plan, Code of Conduct, and applicable Policies and Procedures to those employees and agents who will furnish items or services to CalOptima under the Contractor Agreement.

_____
Print Name

_____
Signature

_____
Title

_____
Company

_____
Date

SIGN, DATE AND RETURN TO CalOptima SUPERVISOR

CalOptima

AFFIRMATION STATEMENT-BOARD MEMBERS

I have received and read a copy of the Compliance Plan, the Code of Conduct, and applicable Policies and Procedures, and I understand, acknowledge, and agree to abide by its contents and requirements.

By signature below, I also certify that I have completed the initial or regular training as indicated:

I attended the initial Compliance Training Session on _____.

I attended the annual Compliance Training Session on _____.

_____

Print Name

_____

Signature

_____

Date

RETURN TO THE COMPLIANCE OFFICER

GLOSSARY

Abuse ("Abuse") means actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Audit ("Audit") means a formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and, completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications. ~~formal review of compliance with a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures.~~

Board Members ("Board Members") means the members of the CalOptima Board of Directors.

CalOptima ("CalOptima") means the Orange County Health Authority, d.b.a. CalOptima, a County Organized Health System ("COHS") created under California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended.

CalOptima Board of Directors ("CalOptima Board") means the Board of Directors of CalOptima, which serves as the Governing Body of CalOptima, appointed by the Orange County Board of Supervisors in accordance with the Codified Ordinances of the County of Orange.

CalOptima Members ("CalOptima members" or "members") means a beneficiary who is enrolled in a CalOptima Program.

CalOptima Programs ("CalOptima Programs") means the Medi-Cal program administered by CalOptima under contract with DHCS, the Medicare Advantage Program ("OneCare") administered by CalOptima under contract with CMS, the Program of All Inclusive Services for the Elderly ("PACE") program administered by CalOptima under contract with DHCS and CMS, and the Multipurpose Senior Services Program ("MSSP") administered by CalOptima under contract with the California Department of Aging, as well as any other program now or in the future administered by CalOptima.

Centers for Medicare & Medicaid Services ("CMS") means the federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.

Code of Conduct ("Code of Conduct") means the statement setting forth the principles and standards governing CalOptima's activities to which Board Members, Employees, FDRs, and

agents of CalOptima are expected to adhere.

Compliance Committee ("Compliance Committee") means that committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consists of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; ~~Executive Director of~~ Compliance Officer; and Executive Director of Human Resources.

Compliance Plan ("Compliance Plan") means this plan and all attachments, exhibits, modifications, supplements, or amendments thereto.

Compliance Program ("Compliance Program" or "Program") means the program (including, without limitation, this Compliance Plan, Code of Conduct and Policies and Procedures ~~and Procedures~~) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Members, Employees and FDRs comply with applicable law and ethical standards.

Conflict of Interest Code ("Conflict of Interest Code") means CalOptima's Conflict of Interest Code approved and adopted on December 6, 1994, as amended and updated from time to time.

Corrective Action Plan ("CAP") means a plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs~~S~~ to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.

Delegation ("Delegated") means a legal assignment to another party of the authority for particular functions, tasks and decisions on behalf of the original party. The original party remains liable for compliance for compliance and fulfillment of any and all rules, requirements and obligations pertaining to the delegated functions.

~~Delegation~~Audit & Oversight Committee ("A~~D~~OC") means a subcommittee of the Compliance Committee chaired by the Director of Audit and Oversight to oversee CalOptima's delegated functions. The composition of the A~~D~~OC includes representatives from CalOptima's departments as provided for in the A~~D~~OC charter.

Department of Health and Human Services-Office of Inspector General ("OIG") means the Office of Inspector General of the United States Department of Health and Human Services.

Department of Health Care Services ("DHCS") means the California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.

Department of Managed Health Care ("DMHC") means the California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health

maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code, Sections 1340 *et seq*.

Designated Employee ("Designated Employee") means the persons holding positions listed in the Appendix to the CalOptima Conflict of Interest Code.

Downstream Entity ("Downstream Entity") means any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Employee or Employees ("Employee" or "Employees") means any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.

Executive Director of Compliance ("Executive Director of Compliance" or "Compliance Officer") means that person designated as the Compliance Officer for CalOptima charged with the responsibility of implementing and overseeing the Compliance Program and the Compliance Plan and Fraud, Waste, and Abuse Plan.

False Claims Act ("FCA") means the False Claims Act pursuant to 31 United States Code [U.S.C.] Sections 3729-3733, which protects the Government from being overcharged or sold substandard goods or services. The FCA imposes civil liability on any person who knowingly submits, or causes to be submitted, a false or fraudulent claim to the Federal Government. The "knowing" standard includes acting in deliberate ignorance or reckless disregard of the truth related to the claim. Civil penalties for violating the FCA may include fines and up to 3 times the amount of damages sustained by the Government as a result of the false claims. There also are criminal penalties for submitting false claims, which may include fines, imprisonment, or both. (18 U.S.C. Section 287.)

FDR ("FDR") means First Tier, Downstream or Related Entity, as separately defined herein.

Federal and/or State Health Care Programs ("Federal and/or State health care programs") means "any plan or program providing health care benefits, directly through insurance or otherwise, that is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program), including Medicare, or any State health care program" as defined in 42 U.S.C. § 1320a-7b (f) including the California Medicaid program, Medi-Cal.

First Tier Entity ("First Tier Entity") means any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.

Fraud ("fraud") means knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347.)

Governing Body ("Governing Body") means the Board of Directors of CalOptima.

Health Network or Health Networks ("Health Network" or "Health Networks") means the contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").

Health Insurance Portability and Accountability Act (HIPAA) means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.

Monitoring Activities ("Monitoring") means regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

National Committee for Quality Assurance Standards for Accreditation of MCOs ("NCQA Standards") means the written standards for accreditation of managed care organizations published by the National Committee for Quality Assurance.

Participating providers and suppliers ("participating providers and suppliers") include all health care providers and suppliers (e.g. physicians, mid-level practitioners, hospitals, long term care facilities, pharmacies etc.) that receive reimbursement from CalOptima or its Health Networks for items or services furnished to Members. Participating providers and suppliers for purposes of this Compliance Plan may or may not be contracted with CalOptima and/or the health networks.

Participation Status ("Participation Status") means whether a person or entity is currently suspended, excluded, or otherwise ineligible to participate in Federal and/or State health care programs as provided in CalOptima Policies and Procedures.

Participation Status Review ("Participation Status Review") means the process by which CalOptima reviews its Board members, Employees, FDRs, and CalOptima Direct providers to determine whether they are currently suspended, excluded, or otherwise ineligible to participate in Federal and/or State health care programs.

Policies and Procedures ("Policies and Procedures") means CalOptima's written Policies and Procedures regarding the operation of CalOptima's Compliance Program, including applicable Human Resources policies, outlining CalOptima's requirements and standards in compliance with applicable law.

Related Entity ("Related Entity") means any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

Sanction ("Sanction") means an action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.

Sub-delegation ("Sub-delegation") means the process by which a First Tier Entity expressly grants, by formal agreement, to a Downstream Entity the authority to carry out one or more functions that would otherwise be required to be performed by the First Tier Entity in order to meet its obligations under the delegation agreement.

Supervisor ("Supervisor") means an Employee in a position representing CalOptima who has one or more Employees reporting directly to him or her. With respect to FDRs, the term "Supervisor" shall mean the CalOptima Employee that is the designated liaison for that contractor.

Third Party Administrator ("TPA") means a Contractor that furnishes designated claims processing and other administrative services to CalOptima.

Waste ("Waste") means the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Orange County Health Authority

dba CalOptima

2017 Compliance Plan

(Revised December 2016)

Document maintained by:
Silver Ho
CalOptima Compliance Officer

Table of Contents

A. OVERVIEW OF THE COMPLIANCE PROGRAM

The Orange County Health Authority, dba CalOptima, is committed to conducting its operations in compliance with ethical standards, contractual obligations, and all applicable statutes, regulations and rules, including those pertaining to Medi-Cal, Medicare, PACE (Program of All-Inclusive Care for the Elderly), MSSP (Multipurpose Senior Services Program), and other CalOptima programs.

CalOptima's compliance commitment encompasses its own internal operations, as well as its oversight and monitoring responsibilities related to CalOptima's First Tier, Downstream and Related Entities (FDRs), such as health networks, physician groups, participating providers, suppliers, pharmacy benefit manager (PBM), and consultants. The term FDR is used in this document to refer to CalOptima's delegated subcontractors that perform administrative functions and/or provide health care services that CalOptima is required to perform and/or provide under its State and Federal contracts with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS). Such persons/entities, referred to as FDR herein, include those that directly contract with CalOptima and those that are Downstream or Related Entities (i.e. subcontracts) with CalOptima's First Tier Entities.

CalOptima has developed a comprehensive Compliance Program applicable to all of CalOptima's Programs, including, but not limited to, its Medi-Cal Program, its Medicare Advantage Prescription Drug Program (MA-PDP referred to as "OneCare"), its Medicare-Medicaid Plan (MMP referred to as "OneCare Connect"), PACE, and MSSP. The Compliance Program incorporates all of the elements of an effective compliance program as recommended by the Office of the Inspector General (OIG) and required by CMS regulations. The Compliance Program is continually evolving and may be modified and enhanced based on compliance monitoring and identification of new areas of operational, regulatory, or legal risk. CalOptima requires that CalOptima Board Members, Employees, and FDRs conduct themselves in accordance with the requirements of CalOptima's Compliance Program.

B. THE COMPLIANCE PLAN

This Compliance Plan sets forth CalOptima's commitment to legal and ethical conduct by establishing compliance activities, along with CalOptima principles and standards, to efficiently monitor adherence to all applicable laws, regulations, and guidelines. The Compliance Plan addresses the fundamental elements of an effective Compliance Program and identifies how CalOptima is implementing each of the fundamental elements of an effective Compliance Program in its operations to meet its contractual, legal, and regulatory obligations. Moreover, the Compliance Plan is designed to provide guidance and to ensure that CalOptima's operations and the practices of its Board Members, Employees, and FDRs comply with contractual requirements, ethical standards, and applicable law.

This Compliance Plan is adopted by the Governing Body. It was developed and is managed by the Executive Director of Compliance (referred to hereinafter as the "Compliance Officer") with the Compliance Committee. Because the complex laws governing CalOptima and its programs are constantly evolving, the Compliance Plan may be revised and updated from time to time to respond to changes in the law and/or to reflect improvements in CalOptima's operations and processes.

Board Members, Employees, and FDRs are expected to review and adhere to the requirements and standards set forth in the Compliance Plan, the Code of Conduct, and all related Policies and Procedures, as may be amended. Furthermore, Board Members, Employees, and FDRs are expected to be familiar with the contractual, legal, and regulatory requirements pertinent to their respective roles and responsibilities. If a Board Member, Employee, and/or FDR has/have any questions about the application or implementation of this Compliance Plan, or questions related to the Code of Conduct or CalOptima Policies and Procedures, he or she should seek guidance from the Compliance Officer and/or the CalOptima Office of Compliance.

I. WRITTEN STANDARDS

To demonstrate CalOptima's commitment to complying with all applicable Federal and State standards and to ensure a shared understanding of what ethical and legal standards and requirements are expected of Board Members, Employees, and FDRs, CalOptima developed, maintains, and distributes its written standards in the form of this Compliance Plan, a separate Code of Conduct, and written Policies and Procedures.

a. Compliance Plan

As noted above, this Compliance Plan outlines how contractual and legal standards are reviewed and implemented throughout the organization and communicated to CalOptima Board Members, Employees, and FDRs. This Compliance Plan also includes a comprehensive section articulating CalOptima's commitment to preventing Fraud, Waste & Abuse (FWA), and setting forth guidelines and procedures designed to detect, prevent and remediate FWA in the administration of CalOptima Programs. The Compliance Plan is available on CalOptima's external Website for Board Members and FDRs as well as on CalOptima's internal intranet site, referred to as InfoNet, accessible to all Employees.

b. Policies and Procedures

CalOptima also developed written Policies and Procedures to address specific areas of CalOptima's operations, compliance activities, and FWA prevention, detection, and remediation to ensure CalOptima can efficiently monitor adherence to all applicable laws, regulations, and guidelines. These policies are designed to provide guidance to Board Members, Employees, and FDRs concerning compliance expectations and outline processes on how to identify, report, investigate, and/or resolve suspected, detected or reported compliance issues. Board Members, Employees, and FDRs are expected to be familiar with the Policies and Procedures pertinent to their respective roles and responsibilities, and are expected to perform their responsibilities in compliance with ethical standards, contractual obligations, and applicable law. The Compliance Officer, or designee, will ensure that Board Members, Employees, and FDRs are informed of applicable policy requirements, and that such dissemination of information is documented and retained in accordance with applicable record retention standards.

The Policies and Procedures are reviewed annually and updated, as needed, depending on State and Federal regulatory changes and/or operational improvements to address identified risk factors. Changes to CalOptima's Policies and Procedures are reviewed and approved by CalOptima's Policy Review Committee. The Policy Review Committee, comprised of executive officers and key staff, meets regularly to review and approve proposed changes and additions to CalOptima's Policies and Procedures. Policies and Procedures are available on CalOptima's internal website and Compliance 360, a separate web portal accessible to Board Members, Employees, and FDRs. Board Members, Employees, and FDRs receive notice when Policies and Procedures are updated via a monthly memorandum.

c. Code of Conduct

Finally, the Code of Conduct is CalOptima's foundational document detailing fundamental principles, values, and the framework for business practices within and applicable to CalOptima. The objective of the Code of Conduct is to articulate compliance expectations and broad principles that guide CalOptima Board Members,

Employees, and FDRs in conducting their business activities in a professional, ethical, and lawful manner. The Code of Conduct is a separate document from the Compliance Plan and can be found in Appendix A of the Compliance Plan. The Code of Conduct is approved by CalOptima's Board of Directors and distributed to Board Members, Employees, and FDRs upon appointment, hire, or the commencement of the contract, and annually thereafter. New Board Members, Employees, and FDRs are required to sign an attestation acknowledging receipt and review of the Code of Conduct within ninety (90) days of the appointment, hire, or commencement of the contract, and annually thereafter.

II. OVERSIGHT

The successful implementation of the Compliance Program requires dedicated commitment and diligent oversight throughout CalOptima's operations, including, but not limited to, key roles and responsibilities by CalOptima's Board, the Compliance Officer, the Compliance Committee, the Audit & Oversight Committee, and Senior Management.

a. Governing Body

The CalOptima Board of Directors, as the Governing Body, is responsible for approving, implementing, and monitoring a Compliance Program governing CalOptima's operations. The CalOptima Board delegates the Compliance Program oversight and day-to-day compliance activities to the Chief Executive Officer (CEO), who then delegates such oversight and activities to the Compliance Officer. The Compliance Officer is an employee of CalOptima, who handles compliance oversight and activities full-time. The Compliance Officer, in conjunction with the Compliance Committee, are both accountable for the oversight and reporting roles and responsibilities as set forth in this Compliance Plan. However, the CalOptima Board remains accountable for ensuring the effectiveness of the Compliance Program within CalOptima and monitoring the status of the Compliance Program to ensure its efficient and successful implementation.

To ensure the CalOptima Board exercises reasonable oversight with respect to the implementation and effectiveness of CalOptima's Compliance Program, the CalOptima Board:

- Understands the content and operation of CalOptima's Compliance Program;
- Approves the Compliance Program, including this Compliance Plan and the Code of Conduct;
- Requires an effective information system that allows it to properly exercise its oversight role and be informed about the Compliance Program outcomes, including, but not limited to, results of internal and external audits;
- Receives training and education upon appointment, and annually thereafter, concerning the structure and operation of the Compliance Program;
- Remains informed about governmental compliance enforcement activity, such as Notices of Non-Compliance, Corrective Action Plans, Warning Letters, and/or more formal sanctions;
- Receives regularly scheduled, periodic updates from CalOptima's Compliance Officer and Compliance Committee, including, but not limited to, monthly reports summarizing overall compliance activities and any changes that are recommended; and

- ► Reviews the results of performance and effectiveness assessments of the Compliance Program.

The CalOptima Board reviews the measurable indicators of an effective Compliance Program and remains appropriately engaged in overseeing its efficient and successful implementation; however, the CalOptima Board delegates several compliance functions and activities as described in the following subsections.

b. Executive Director of Compliance (Compliance Officer)

The Executive Director of Compliance serves as the Compliance Officer and coordinates and communicates all assigned compliance activities and programs, as well as plans, implements, and monitors the day-to-day activities of the Compliance Program. The Compliance Officer reports directly to the CEO and the Compliance Committee on the activities and status of the Compliance Program. The Compliance Officer has authority to report matters directly to the CalOptima Board at any time. Furthermore, the Compliance Officer ensures that CalOptima meets all state and federal regulatory and contractual requirements.

The Compliance Officer interacts with the CalOptima Board, CEO, CalOptima's executive and departmental management, FDRs, legal counsel, State and Federal representatives and others as required. In addition, the Compliance Officer supervises the Office of Compliance, which includes compliance professionals with expertise and responsibilities for the following areas: Medi-Cal and Medicare Regulatory Affairs & Compliance, Special Investigations, Privacy, FDR and internal oversight, Policies and Procedures, and training on compliance activities.

The CalOptima Board delegates the following responsibilities to the Compliance Officer, and/or his or her designee(s):

- ► Chair the Compliance Committee, which shall meet no less than quarterly and which committee assists the Compliance Officer in fulfilling his or her responsibilities;

- ► Ensure that the Compliance Program, including this Compliance Plan and Policies and Procedures, are developed, maintained, revised, revised and updated, annually or as needed based on changes in CalOptima's needs, regulatory requirements, and applicable law and distributed to all affected Board Members, Employees, and FDRs, as appropriate;

- ► Oversee and monitor the implementation of the Compliance Program, and provide regular reports no less than quarterly to the CalOptima Board and CEO summarizing all efforts, including, but not limited to, the Compliance Committee's efforts to ensure adherence to the Compliance Program, identification and resolution of suspected, detected or reported instances of noncompliance, and CalOptima's compliance oversight and audit activities;

- ► Maintain the compliance reporting mechanisms and manage inquiries and reports from CalOptima's Compliance and Ethics Hotline in accordance with specified protocols, including, but not limited to, maintenance of documentation for each report of potential noncompliance or potential FWA received from any source through any reporting method;

- ► Design, coordinate, and/or conduct regular internal audits to ensure the Compliance Program is being implemented and followed and to ensure appropriate financial and administrative controls are in place;

- Develop and implement an annual schedule of Compliance Program activities for each of CalOptima's Programs, and regularly report CalOptima's progress in implementing those plans to the appropriate Board Committee and/or to the Board of Directors;

- Serve as a liaison between CalOptima and all applicable State and Federal agencies for noncompliance and/or FWA issues, including facilitating any documentation or procedural requests by such agency/ies;

- Oversee and monitor all compliance investigations, including investigations performed by CalOptima's regulators (e.g. DHCS and CMS) and consult with legal counsel, as necessary;

- Create and coordinate educational training programs and initiatives to ensure that the CalOptima Board, Employees, and FDRs are knowledgeable about CalOptima's Compliance Program, including the Code of Conduct, Policies and Procedures, and all current and emerging applicable statutory and regulatory requirements;

- Timely initiate, investigate, and complete risk assessments and related activities, and direct and implement appropriate corrective action plans, sanctions, and/or other remediation, including, but not limited to, collaboration with the Human Resources Department to ensure consistent, timely, and effective disciplinary standards are followed; and

- Coordinate with CalOptima departments and FDRs to ensure exclusion screening (including through the OIG LEIE, GSA SAM, and Medi-Cal Provider Manual) has been conducted and acted upon, as appropriate, in accordance with regulatory and contractual requirements.

c. Compliance Committee

The Compliance Committee, chaired by the Compliance Officer, is composed of CalOptima's senior management and operational staff, as designated by the CEO. The members of the Compliance Committee serve at the discretion of the CEO and may be removed or added at any time. The role of the Compliance Committee is to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The Compliance Committee meets at least on a quarterly basis, or more frequently as necessary, to enable reasonable oversight of the Compliance Program.

The CalOptima Board delegates the following responsibilities to the Compliance Committee:

- Maintain and update the Code of Conduct consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the CalOptima Board;

- Maintain written notes, records, correspondence, or minutes (as appropriate) of Compliance Committee meetings reflecting reports made to the Compliance Committee and the Compliance Committee's decisions on the issues raised (subject to all applicable privileges);

- Review and monitor the effectiveness of the Compliance Program, including monitoring key performance reports and metrics, evaluating business and administrative operations, and overseeing corrective actions to ensure they are promptly and effectively implemented;

- Develop standards of business conduct and Policies and Procedures to promote compliance;

- ► Review, approve, and/or update Policies and Procedures to ensure the successful implementation and effectiveness of the Compliance Program consistent with regulatory, legal and contractual requirements;

- ► Recommend and monitor the development of internal systems and controls to implement CalOptima's standards and Policies and Procedures as part of its daily operations;

- ► Determine the appropriate strategy and/or approach to promote compliance and detect potential violations and advise the Compliance Officer accordingly;

- ► Develop and maintain a reporting system to solicit, evaluate, and respond to complaints and problems;

- ► Review and address reports designating areas in which CalOptima is at risk for program noncompliance and potential FWA, and ensure that corrective action plans are implemented and monitored for effectiveness;

- ► Suggest and implement whatever actions are appropriate and necessary to ensure that CalOptima and its FDRs conduct activities and operations in compliance with the applicable law and regulations and sound business ethics; and

- ► Provides regular and ad hoc reports on the status of compliance with recommendations to the CalOptima Board.

d. Audit & Oversight Committee (AOC)

The Audit & Oversight Committee (AOC) is a subcommittee of the Compliance Committee and is chaired by the Director of Audit & Oversight. The AOC is responsible for overseeing the delegated and internal activities of CalOptima. The Compliance Committee has final approval authority for any delegated and internal activities. Committee members include representatives from CalOptima's departments as provided for in the AOC charter. In addition to the monthly scheduled meetings, the AOC may conduct ad hoc meetings either in-person or via teleconference, as needed. All materials requiring action by the AOC presented are approved by a quorum. A quorum is defined as one over fifty percent. AOC may approve and/or implement Corrective Act Plans (CAPs); however, recommendations for FDR sanctioning and/or de-delegation are submitted to the Compliance Committee for final approval. The AOC also contributes to external reviews and accreditation audits, such as the National Committee for Quality Assurance (NCQA).

Responsibilities of the Audit & Oversight Committee with regard to FDRs include:

- ► Annual review, revision, and approval of the Audit & Oversight Department Program Description, Policies and Procedures, and audit tools;

- ► Review findings of the pre-delegation audit and readiness assessment to evaluate a potential FDR's ability to perform the delegated function(s);

- ► Review and approve potential FDR entities for delegation of functions;

- ► Ensure written agreements with each delegated FDR clearly define and describe the delegated activities, responsibilities, and reporting requirements of all Parties consistent with applicable laws, regulations, and contractual obligations;

- Conduct formal, ongoing evaluation and monitoring of FDR performance and compliance through review of periodic reports submitted, complaints/grievances filed, and findings of the annual onsite audit;
- Ensure all Downstream and Related Entities are monitored in accordance with CalOptima oversight procedures;
- Conduct formal risk assessment on an annual basis, and update as needed, on an ongoing basis;
- Initiate and manage Corrective Action Plans (CAPs) for compliance issues;
- Propose sanctions, subject to the Compliance Committee's approval, if an FDR's performance is substandard and/or violates the terms of the applicable agreement; and
- Review and initiate recommendations, such as termination of delegation, to the Compliance Committee for unresolved issues of compliance.

Responsibilities of the Audit & Oversight Committee with regard to internal business functions include:

- Annual review, revision, and approval of the Audit & Oversight Department Program Description and audit tools;
- Conduct formal, ongoing evaluation and monitoring of internal business areas' performance and compliance through review of periodic reports submitted, ongoing monitoring, and findings of the annual audit;
- Conduct formal risk assessment on an annual basis, and update as needed, on an ongoing basis; and
- Initiate and manage Corrective Action Plans (CAPs) for compliance issues.

e. Senior Management

The CEO and other executive management of CalOptima shall:

- Ensure that the Compliance Officer is integrated into the organization and is given the credibility, authority and resources necessary to operate a robust and effective compliance program;
- Receive periodic reports from the Compliance Officer of risk areas facing the organization, the strategies being implemented to address them and the results of those strategies; and
- Be advised of all governmental compliance and enforcement findings and activity, including audit findings, notices of non-compliance, and formal enforcement actions, and participate in corrective actions and responses, as appropriate.

III. TRAINING

Education and training are critical elements of the Compliance Program. CalOptima requires that all Board Members, Employees, Temporary Employees and FDRs complete training upon appointment, hire, or commencement of contract, as applicable, and on an annual basis thereafter. Required courses cover CalOptima's Code of Conduct, compliance obligations, and relevant laws, and FWA, as applicable. Specialized education courses are assigned to individuals based on their respective roles or positions within or with CalOptima's departments and its programs, which may include, but is not limited to, the fundamentals of managing seniors and people with disabilities (SPD) and cultural competency.

CalOptima utilizes state of the art web-based training courses that emphasize CalOptima's commitment to the Compliance Program, and which courses are updated regularly to ensure that employees are kept fully informed about any changes in procedures, regulations and requirements. Training may be conducted using new technology resources if materials meet the needs of the organization. The Compliance Officer is responsible for coordinating compliance education and training programs, and ensuring that records evidencing an individual's/FDR's completion of the training requirements are documented and maintained, such as sign-in sheets, attestations, or electronic certifications, as required by law. The Compliance Officer and the CalOptima management staff are responsible for ensuring that Board Members, Employees, Temporary Employees, and FDRs complete training on an annual basis.

a. Code of Conduct

CalOptima's training program includes the distribution of CalOptima's Code of Conduct to Board Members, Employees, and FDRs. Board Members, Employees, Temporary Employees, and FDRs are required to sign an attestation acknowledging receipt, review, and understanding of the Code of Conduct within ninety (90) days of their appointment, date of hire, or commencement of the contract, and annually thereafter. Completion and attestation of such review of the Code of Conduct is a condition of continued appointment, employment, or contract services. Signed attestations are maintained in each person's files, as legally required.

b. Mandatory Training Courses (Compliance Oversight, FWA and HIPAA)

CalOptima requires Board Members, Employees, Temporary Employees, and FDRs, regardless of role or position with CalOptima, to complete mandatory compliance training courses. Mandatory courses may include, but are not limited to: the fundamentals of the Compliance Program; FWA training; HIPAA privacy and security requirements; ethics; and a high level overview of the Medicare and Medi-Cal Programs. CalOptima's training courses cover CalOptima's commitment to compliance with Federal and State laws and regulations, contractual obligations, internal policies and ethics. Elements of the Compliance Program are highlighted, including, but not limited to, an emphasis on CalOptima's requirement to and different means to report suspected or actual noncompliance, violations, and/or FWA issues, along with CalOptima's policy on confidentiality, anonymity, and non-retaliation for such reporting. CalOptima's HIPAA privacy and security training course covers the administrative, technical and physical safeguards necessary to secure Members' protected health information.

Employees must complete the required compliance training courses within ninety (90) days of hire, and annually thereafter. Adherence to the Compliance Program requirements, including training requirements, shall be a condition of continued employment and a factor in the annual performance evaluation of each Employee. Board Members and FDRs are required to complete

the required compliance training courses within ninety (90) days of appointment or commencement of the contract, as applicable, and annually thereafter. Some FDRs may be exempt or deemed to have met the FWA training and education requirement if the FDR has met the CMS requirements, the applicable certification requirements and attests to complying with the standards, or through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Completion of the training courses are documented electronically and records of completion are maintained for each individual as required by law.

c. Additional Training

The Compliance Department may provide additional training opportunities throughout the year focused on essential elements of the Compliance Program. These training opportunities are available to managers and Employees depending on their respective roles or positions within or with CalOptima's departments and its programs and their involvement in CalOptima's oversight responsibilities. For these training courses, information is presented in a "train the trainer" format, providing managers the tools and resources to train and share the information with Employees in their respective departments. If additional training related to FWA is required, the Compliance Officer will develop relevant materials.

Employees have access through CalOptima's internal intranet website (referred to as the "InfoNet") to CalOptima's Policies and Procedures governing the Compliance Program and pertinent to their respective roles and responsibilities. Employees may receive such additional compliance training as is reasonable and necessary based on changes in job descriptions/duties, promotions, and/or the scope of their job functions.

Board members receive a copy of the Compliance Plan, Code of Conduct, and Policies and Procedures pertinent to their appointment as part of orientation within ninety (90) days of their appointment to the CalOptima Board. Board members may receive additional compliance training related to the CalOptima Board's role in overseeing and ensuring organizational compliance with CalOptima's Compliance Program.

The Code of Conduct and Policies and Procedures pertinent to their engagement with CalOptima, if directly engaged by CalOptima, are made available to FDRs upon commencement of the FDR contract. FDRs are required to disseminate copies of the Code of Conduct and Policies and Procedures to their employees, agents, and/or Downstream Entities. CalOptima may also develop compliance training and education presentations and/or roundtables for specified FDRs.

IV. LINES OF COMMUNICATION AND REPORTING

a. General Compliance Communication

CalOptima regularly communicates the requirements of the Compliance Program and the importance of performing individual roles and responsibilities in compliance with applicable laws, contractual obligations, and ethical standards. CalOptima utilizes various methods and forms to communicate general information, statutory or regulatory updates, process changes, updates to Policies and Procedures, contact information for the Compliance Officer, relevant federal and state fraud alerts and policy letters, pending/new legislation reports, and advisory bulletins from the Compliance Officer to CalOptima Board Members, Employees, Temporary Employees, FDRs, and members, including, but not limited to:

- Presentations and Updates at Meetings – CalOptima periodically holds and utilizes in-person and conference call meetings with the CalOptima Board, FDRs, Employees, individual CalOptima departments, and members.

- Compliance 360 – CalOptima maintains an internal and external website and portal referred to as Compliance 360, accessible to Board Members, Employees, and FDRs, which contains CalOptima's updated Policies and Procedures.

- Newsletters or Mailed Notices – CalOptima develops, and where appropriate, translates, publications and/or notices, to Board Members, Employees, FDRs, and members.

- Electronic Mail – The CEO or Compliance Officer, or their respective designee, periodically sends out e-mail communication and/or alerts to Board Members, Employees, FDRs and/or members, as applicable.

- CalOptima's Internal Intranet Website – CalOptima maintains an internal intranet website, referred to as InfoNet, where CalOptima posts applicable updates and notices to Employees.

- CalOptima's Compliance Internal Website – The Regulatory Affairs & Compliance Department maintains an internal department website accessible to CalOptima Employees to communicate different Compliance initiatives, notices, key documents and forms, and updates to the Compliance Program, Code of Conduct, and/or Policies and Procedures.

- Postings – The Regulatory Affairs & Compliance Department posts flyers concerning key initiatives, themes, and updates throughout CalOptima's facilities, including, but not limited to, break rooms, which are accessible to CalOptima employees.

- Written Reports – The Compliance Officer, in coordination with the CEO and Compliance Committee prepares written monthly reports concerning the status of the Compliance Program to be presented to the CalOptima Board.

- Direct Contact with the Compliance Officer - Board Members, Employees, Temporary Employees and FDRs can obtain additional compliance information directly from the Compliance Officer. Any questions, which cannot be answered by the Compliance Officer, shall be referred to the Compliance Committee.

b. Reporting Mechanisms

CalOptima Board Members, Employees, Temporary Employees, and FDRs have an affirmative duty and are directed in CalOptima's Code of Conduct and Policies and Procedures to report compliance concerns, questionable conduct or practices, and suspected or actual violations immediately upon discovery. Failure by Board Members, Employees, Temporary Employees and/or FDRs to report known violations, failure to detect violations due to negligence or reckless conduct, and making false reports may constitute grounds for disciplinary action, up to and including, recommendation for removal from appointment, termination of employment, or termination of an FDR contract, where appropriate.

CalOptima has established multiple reporting mechanisms to receive, record and respond to compliance questions, potential non-compliance issues and/or FWA incidents or activities. These reporting systems, which are outlined in greater detail below, provide for anonymity and confidentiality (to the extent permitted by applicable law and circumstances). Reminders and instructions on how to report compliance and FWA issues are also provided to Board Members, Employees, FDRs and members in newsletters, on CalOptima's website, in trainings, on posters and at meetings. CalOptima maintains and supports a no retaliation policy governing good-faith reports of suspected or actual non-compliance and/or FWA.

Upon receipt of a report through one of the following mechanisms, the Compliance Officer shall follow appropriate Policies and Procedures to promptly review, investigate and resolve such matters. The Compliance Officer shall monitor the process for follow-up communications to persons submitting reports or disclosures through these reporting mechanisms and shall ensure documentation concerning such reports is maintained according to all applicable legal and contractual requirements.

1. Report Directly to a Supervisor or Manager

CalOptima employees are encouraged to contact their immediate supervisor or manager when non-compliant activity is suspected or observed. A report should be made immediately upon suspecting or identifying the potential or suspected non-compliance or violation. The supervisor or manager will promptly escalate the report to the Compliance Officer for further investigation and reporting to the CalOptima Compliance Committee. If an Employee is concerned that his or her supervisor or manager did not adequately address his or her report or complaint, the Employee may go directly to the Compliance Officer or the CEO.

2. Call the Compliance and Ethics Hotline

CalOptima maintains an easily accessible Compliance and Ethics Hotline, available 24 hours a day, 7 days a week, with Spanish and English capability, in which CalOptima may receive anonymous issues on a confidential basis. Members are encouraged to call the Compliance and Ethics Hotline if they have identified potential non-compliant activity or FWA issues. The Compliance and Ethics Hotline information is as follows:

TOLL FREE COMPLIANCE and ETHICS HOTLINE
(877) 837-4417

Calls or issues reported through the Compliance and Ethics Hotline are received, logged into a database and investigated by the Regulatory Affairs & Compliance Department. No disciplinary action will be taken against individuals making good-faith reports. Every effort will be made to keep reports confidential to the extent permitted by law. The process for reporting suspected violations to the Compliance and Ethics Hotline is part of the education and/or orientation for all

Board Members, Employees, FDRs and members. Members also have access to the Compliance Officer through the hotline and/or the right to contact the OIG Compliance Hotline directly.

3. Report Directly to the Compliance Officer

The Compliance Officer is available to receive reports of suspected or actual compliance violations or FWA issues on a confidential basis (to the extent permitted by applicable law or circumstances) from Board Members, Employees, FDRs and Members. The Compliance Officer may be contacted by telephone, written correspondence, email, or by a face-to-face appointment. FDRs are generally contractually obligated to report suspected fraud and abuse to CalOptima pursuant to regulatory and contractual requirements.

4. Report Directly to Office of Compliance

Reports may be made directly to CalOptima's Office of Compliance via mail or email for confidential reporting. Emails can be sent to Compliance@caloptima.org. .

5. Confidentiality and Non-Retaliation

Every effort will be made to keep reports confidential to the extent permitted by applicable law and circumstances, but there may be some instances where the identity of the individual making the report will have to be disclosed. As a result, CalOptima has implemented and enforces a non-retaliation policy to protect individuals who report suspected or actual non-compliance or FWA issues in good faith. This non-retaliation policy extends to reports received from FDRs and members. CalOptima's non-retaliation policy is communicated along with reporting instructions.

CalOptima also takes violations of CalOptima's non-retaliation policy seriously, and the Compliance Officer will review and enforce disciplinary and/or other corrective action plans for violations, as appropriate, with the approval of the Compliance Committee.

V. ENFORCEMENT AND DISCIPLINARY STANDARDS

Board Members, Employees, and FDRs are provided copies of CalOptima's Code of Conduct and the Compliance Plan and have access on CalOptima's internal and external website to applicable Policies and Procedures, including, but not limited to, CalOptima's Progressive Discipline Policy and Office of Compliance Policies addressing corrective action plans and sanctions. Consistent, timely, and effective enforcement of CalOptima's standards are implemented when noncompliance or unethical behavior is determined, and appropriate disciplinary and/or corrective action is implemented to address improper conduct, activity and/or behavior.

a. Conduct Subject to Enforcement and Discipline

Board Members, Employees, and FDRs are subject to appropriate disciplinary and/or corrective actions if they have violated CalOptima's standards, requirements, or applicable laws as specified and detailed in the Compliance Program documents and related Policies and Procedures, including CalOptima's Progressive Discipline Policy, as applicable. Board members, Employees, and FDRs may be disciplined or sanctioned, as applicable, for failing to adhere to CalOptima's Compliance Program and/or violating standards, regulatory requirements and/or applicable laws, including, but not limited to:

- Conduct that leads to the filing of a false or improper claim in violation of Federal or State laws and/or contractual requirements;

- Conduct that results in a violation, or violations, of any other Federal or State laws or contractual requirements relating to participation in Federal and/or State health care programs;

- Failure to perform any required obligation relating to compliance with the Compliance Program, applicable laws, Policies and Procedures and/or contracts; or

- Failure to report violations or suspected violations of the Compliance Program or applicable laws or to report suspected or actual FWA issues to an appropriate person through one of the reporting mechanisms.

- Conduct that violates HIPAA and other privacy laws and/or CalOptima's HIPAA privacy and security policies, including actions that harm the privacy of Members or the CalOptima information systems that store Member data.

b. Enforcement and Discipline

CalOptima maintains a "zero tolerance" policy towards any illegal or unethical conduct that impacts the operation, mission, or image of CalOptima. The standards established in the Compliance Program shall be enforced consistently through appropriate disciplinary actions. Individuals or entities may be disciplined by way of reprimand, suspension, financial penalties, sanctions, and/or termination, depending on the nature and severity of the conduct or behavior. Board Members may be subject to removal, Employees are subject to discipline, up to and including termination, and FDRs may be sanctioned or contracts may be terminated, where permitted. Violations of applicable laws and regulations, even unintentional, could potentially subject individuals, entities or CalOptima to civil, criminal or administrative sanctions and/or penalties. Further, violations could lead to suspension or exclusion from participation in Federal and/or State health care programs.

CalOptima employees shall be evaluated annually based on their compliance with CalOptima's Compliance Program. Where appropriate, CalOptima shall promptly initiate education and training to correct identified problems or behaviors.

VI. MONITORING, AUDITING, AND IDENTIFICATION OF RISKS

Activities associated with monitoring and auditing are identified through a combination of activities: risk assessments, Audit & Oversight and Compliance Committee discussions and decisions, and internal and external reporting. Through monitoring, auditing, and identification of risks, CalOptima can prevent, detect, and correct noncompliance with applicable Federal and/or State requirements.

a. Risk Assessment

The Compliance Officer will collaborate with the Compliance Committee to identify areas of focus for monitoring and auditing potential non-compliant activity and FWA issues. A Compliance Risk Assessment will be performed no less than annually, and as needed, to evaluate the current status of CalOptima's operational areas as well as the operations of FDRs. Operations and processes will be evaluated based on: (1) deficiencies found by regulatory agencies; (2) deficiencies found by internal and external audit and monitoring reports; (3) the institution of new or updated procedures; (4) cross departmental interdependencies; and (5) the effect on the beneficiary experience. The Readiness Checklist established by CMS and the OIG Work Plan shall be used as resources to evaluate operational risks.

The Compliance Officer will work with the Chief Operating Officer, or his or her designee in each operational area, to answer the questions associated with each process and to continually examine and identify potential risk areas requiring monitoring and auditing. Those operational areas determined to be high risk may be subject to more frequent monitoring and auditing, as well as additional reporting requirements. The risk assessment process will be managed by the Compliance Officer, or his/her designee, and presented to the Audit & Oversight Committee (AOC), and subsequently to the Compliance Committee, for review and approval. Monitoring plans will be developed in collaboration with the operational areas, and focused audits may be scheduled based on the results of the ongoing monitoring and respective risk score.

The risk assessment shall also be updated as processes change or are identified as being deficient.

b. Monitoring and Auditing

CalOptima conducts both internal and external routine monitoring and auditing activities to test and confirm compliance with all applicable regulations, guidance, contractual agreements, and Federal and State laws, as well as CalOptima Policies and Procedures to protect against noncompliance and potential FWA in CalOptima Programs. Monitoring activities are regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective. An audit is a formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. As part of the monitoring process, CalOptima has created a dashboard, which is a monitoring tool to track key metrics, including, but not limited to, coverage determinations, complaints, appeals, grievances, regulatory communications, credentialing, customer service, transition of coverage (TOC), and claims. The dashboard will be used to communicate results associated with monitoring operations and outcomes and to identify areas in need of targeted auditing on at least a monthly basis. Information taken from the dashboard along with grievance and complaint call information will be used to develop monitoring and auditing work plans. Monitoring and auditing work plans are used to detect potential areas of risk and/or non-compliant activity. The monitoring and auditing work plans are subject to daily updates and additions, and are therefore, working documents. The

Compliance Officer, in collaboration with the AOC and Compliance Committee, develops the monitoring and auditing work plans to address the risks associated with each of CalOptima's Programs.

The Compliance Officer will coordinate with CalOptima's Audit & Oversight Department in connection with appropriate auditing and monitoring activities. Audits for each operational area will be conducted throughout the year consistent with the monitoring and auditing work plans. The Compliance Officer will coordinate the audits with internal audit staff, and, in some cases, with the assistance from an outside vendor. Audit methodologies shall be consistent with regulatory requirements and standards. All audits will include review of applicable documents and evaluation of actual processes to ensure compliance with all applicable regulations and contractual obligations. Once the audit review is completed, the audit team will meet with the Compliance Officer to discuss results and propose follow up corrective action(s). The Compliance Officer will provide reports to the CEO and the Compliance Committee concerning the results of the audits. The AOC reports to the Compliance Officer and the Compliance Committee on audits that involve FDRs as discussed below. If Fraud, Waste, or Abuse (FWA) issues are identified during an audit, the matter will be further investigated and resolved in a timely manner. In addition, an audit of the Compliance Program and its effectiveness should occur at least annually, and the results shall be reported to the CalOptima Board.

c. Oversight of Delegated Activities

To ensure the terms and conditions of statutory and contractual obligations to CMS, DHCS, and other governmental and regulatory entities are adhered to, CalOptima implements a comprehensive oversight monitoring and auditing process of FDRs who perform delegated activities. The processes that CalOptima implements to oversee, monitor and audit FDRs are incorporated into CalOptima's written Policies and Procedures, including processes involving pre-contractual evaluations and audits of First Tier Entities. CalOptima may implement corrective action plans, sanctions and/or revoke its delegation of duties (in a manner permitted under the contract) if CalOptima determines that an FDR is unable or unwilling to carry out its responsibilities consistent with statutory and contractual obligations.

The Compliance Officer, or his/her designee, determines the process for monitoring delegated FDRs and develops the annual monitoring and audit calendar in order to validate compliance with contractual standards and regulatory requirements. The AOC is responsible for overseeing all of the delegated activities and will review the pre-delegation audit, ensure the annual review of FDRs for delegated functions are completed, conduct formal on-going evaluation of FDR performance and compliance, ensure Downstream and Related Entitles are monitored, and impose corrective action plans and/or sanctions if the FDR's performance fails to meet statutory and contractual standards and requirements. The AOC may recommend termination of delegation to the Compliance Committee for unresolved matters.

d. Monitoring and Audit Review Process for FDRs

1. Initial Evaluation

Prior to executing a contract or delegation agreement with a potential FDR, a risk assessment is performed to determine the type of initial evaluation that will be performed. If it is deemed necessary, an initial evaluation, referred to as a Readiness Assessment as detailed in CalOptima's Policies and Procedures, is completed to determine the ability of the potential FDR to assume responsibility for delegated activities and to maintain CalOptima standards, applicable State,

CMS, and regulatory requirements, and accreditation requirements. The initial evaluation includes, but is not limited to, review of the entity's operational capacity and resources to perform the delegated functions, evaluation of the entity's ability to meet contractual and regulatory requirements, verification that the entity is not excluded in the OIG List of Excluded Individuals/Entities (LEIE), the General Services Administration (GSA) System of Award Management (SAM), or the DHCS Medi-Cal Provider Manual from participating in health programs, and/or an initial onsite evaluation. Results of the initial evaluation are presented to the Audit & Oversight Committee and subsequently the Compliance Committee for review and/or approval.

2. Contracting with FDRs

Once an entity has been approved, the delegation agreement specifies the activities CalOptima delegates to the FDRs, each party's respective roles and responsibilities, reporting requirements and frequency, submission of data requirements, the process for performance evaluations and audits, and remedies, including disciplinary actions, available to CalOptima. Prior to any sub-delegation to any Downstream or Related Entity, a First Tier Entity must obtain approval from CalOptima. CalOptima determines who will directly monitor the Downstream or Related Entity's compliance with requirements.

FDRs shall be required to institute a training program consistent with CalOptima's requirements intended to communicate CalOptima's compliance requirements as well as compliance characteristics related to the FDR and their contractually delegated area(s). Furthermore, FDRs will be required to complete, sign, and return attestation forms confirming the FDR's compliance with new hire and annual training and education requirements, which includes courses on general compliance and FWA as well as exclusion screening and FWA reporting obligations.

3. Annual Risk Assessment

The Compliance Officer, or his or her designee, will conduct an annual comprehensive risk assessment to determine the FDR's vulnerabilities and high risk areas. High risk FDRs are those that are continually non-compliant or at risk of non-compliance based on identified gaps in processes with regulatory and CalOptima requirements. Any previously identified issues, which includes any corrective actions, service level performance, reported detected offenses, and/or complaints and appeals from the previous year will be factors that are included in the risk assessment. Any FDR deemed high risk or vulnerable is presented to the AOC for suggested follow-up audit. FDRs determined to be high risk may be subjected to a more frequent monitoring and auditing schedule, as well as additional reporting requirements. The risk assessment process, along with reports from FDRs, will be managed by the Compliance Officer, or his/her designee, and presented to the AOC and subsequently to the Compliance Committee for review and approval.

4. FDR Performance Reviews and Audits

CalOptima conducts a periodic comprehensive performance review of the FDR's ability to provide delegated services in accordance with contractual standards and applicable state, CMS, and accreditation requirements, as further detailed in CalOptima's Policies and Procedures. CalOptima may conduct audits of FDRs at any time. Such audits may include an evaluation of the FDR's training and education program and materials covering general compliance and FWA, as well as compliance with applicable laws, regulations, and contractual obligations governing delegated activities. High risk FDRs, as determined by the annual risk assessment and/or continued non-compliance, will obtain priority status on the annual audit calendar; however, CalOptima does not limit its auditing schedule to only high risk FDRs.

If CalOptima has reason to believe the FDR's ability to perform a delegated function is compromised, an additional focused audit may be performed. The Compliance Officer may also recommend focused audits upon evaluation of non-compliant trends or reported incidents. The results of these audits will be reported to the AOC and then to the Compliance Committee.

A focused audit may be initiated for any of the following activities, or any other reason at the discretion of CalOptima:

- Failure to comply with regulatory requirements and/or the CalOptima's service level performance indicators;
- Failure to comply with a corrective action plan;
- Reported or alleged fraud, waste and/or abuse;
- Significant policy variations that deviate from the CalOptima or state, CMS, or accreditation requirements;
- Bankruptcy or impending bankruptcy which may impact services to members (either suspected or reported);
- Sale, merger or acquisition involving the FDR;
- Significant changes in the management of the FDR; and/or
- Changes in resources which impact CalOptima's and/or the FDR's operations.

5. Corrective Actions and Additional Monitoring and Auditing

The Compliance Officer shall submit regular reports of all monitoring, audit, and corrective action activities to the Compliance Committee. In instances where non-compliance is identified, a corrective action plan shall be developed by the FDR and reviewed and approved by the Compliance Officer, or his or her designee. Every corrective action plan is presented to the AOC for review. Supplemental and focused audits of FDRs, as well as additional reporting, may be required until compliance is achieved.

At any time, CalOptima may implement sanctions or require remediation by an FDR for failure to fulfill contractual obligations including development and implementation of a corrective action plan. Failure to cooperate with CalOptima in any manner may result in termination of the delegation agreement, in a manner authorized under the terms of the agreement.

e. Evaluation of Audit Activities

An external review of CalOptima's auditing process is conducted through identified process measures. These measures support organizational, accreditation, and regulatory requirements and are reported on a yearly basis. CalOptima uses an independent, external consultant firm to periodically review the auditing processes, including policy and procedures, audit tools, and audit findings, to ensure all regulatory requirements are being audited in accordance with industry standards/practices and are in compliance with federal and state regulations

The current measures reviewed include:

- The central database of all pending, active and terminated FDRs to monitor and track functions, performance, and audit schedules;
- Implementation of an escalation process for compliance/performance issues;
- Implementation of a process for validation of audit tools;
- Implementation of a process for noticing FDRs and functional areas of corrective action plans;

- Tracking and trending internal compliance with oversight standards, performance, and outcomes;
- Implementation of an annual training program for internal staff regarding delegation standards, auditing, and monitoring FDR performance; and/or
- Implementation a process for dissemination of regulatory changes to include Medi-Cal and Medicare lines of business.

The following key performance metrics will be evaluated and reported periodically:

- Evaluations of FDR performance and reporting of delegated functions in accordance with the terms of the agreement;
- Number of annual oversight audits completed within 12 months; and
- Corrective Action Plans (CAPs) completed within the established timeframe.

f. Regular Exclusion Screening

As detailed in CalOptima's Policies and Procedures, CalOptima performs Participation Status Reviews by reviewing the OIG –LEIE, the GSA–SAM, and DHCS Medi-Cal Provider Manual lists upon appointment, hire, or commencement of a contract, as applicable, and monthly thereafter, to ensure Board Members, Employees, and/or FDRs are not excluded or do not become excluded from participating in federal and state health programs. Board Members, Employees, and FDRs are required to disclose their Participation Status as part of their initial appointment, employment, commencement of the contract and registration/application processes and when Board Members, Employees, and FDRs receive notice of a suspension, exclusion, or debarment during the period of appointment, employment, or contract term. CalOptima also requires that its First Tier Entities comply with Participation Status Review requirements with respect to their relationships with Downstream Entities, including without limitation, the delegated credentialing and re-credentialing processes.

The Compliance Officer will review reports from Employees responsible for conducting the Participation Status Reviews to ensure Employees record and maintain the results of the reviews and notices/disclosures. Employees shall immediately notify the Compliance Officer of affirmative findings of a person or entity's failure to meet the Participation Status Review requirements. If CalOptima learns that any prospective or current Board Member, Employee or FDR has been proposed for exclusion or excluded, CalOptima will promptly remove him/her/the FDR from CalOptima's Programs consistent with applicable policies and/or contract terms.

Payment may not be made for items or services furnished or prescribed by an excluded person or entity. Payments made by CalOptima to excluded persons or entities after the effective date of their suspension, exclusion, debarment, or Felony Conviction, and/or for items or services furnished at the medical direction or on the prescription of a physician who is suspended, excluded or otherwise ineligible to participate are subject to repayment/recoupment. The Compliance Officer will review potential organizational obligations related to the reporting of identified excluded or suspended individuals or entities and/or refund obligations and consult with legal counsel, as necessary and appropriate, to resolve such matters.

VII. RESPONSE AND REMEDIATION

a. Response to Notice of Violation or Suspected Violation

Upon receipt of a report or notice of violation or suspected violation of CalOptima's Compliance Program and/or FWA issues, the Compliance Officer shall, upon promptly verifying the facts related to the violation or likely violation, notify the Compliance Committee, as appropriate. The Compliance Committee (in consultation with legal counsel, as appropriate) shall determine a response as soon as practicable, which shall include, but not be limited to:

- Recommending investigation of all aspects of the suspected violation or questionable conduct;

- Approving disciplinary actions, sanctions, termination of any agreement and/or any other corrective action (including repayment of overpayments) consistent with applicable Policies and Procedures, subject to consultation with legal counsel and/or notifying the Governing Body, as appropriate;

- Implementing education and training programs for Board Members, Employees, and/or FDRs, where applicable, to correct the violation and prevent recurrence;

- Amending, if necessary, CalOptima's Compliance Plan, Code of Conduct, and/or relevant Policies and Procedures in an effort to avoid any future recurrence of a violation; and/or

- Ensuring that compliance reports are kept confidential, where permitted by law, and if appropriate, protected under applicable privileges, including, but not limited to, the attorney/client privilege and ensuring that all files regarding Compliance matters are appropriately secured.

It is the responsibility of the Compliance Officer and the Compliance Committee to review and implement any appropriate corrective and/or disciplinary action in consultation with the Human Resources Department, as applicable, consistent with applicable Policies and Procedures after considering such recommendations. The Compliance Officer, or his or her designee, shall monitor and review corrective actions after their implementation to ensure that they are effective.

b. Referral to Enforcement Agencies

In appropriate circumstances, CalOptima shall report violations of Medi-Cal Program requirements to DHCS Audits and Investigations, violations of Medicare Program requirements to the MEDIC, and violations of other state and federal laws to the appropriate law enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies.

c. Response to Fraud Alerts

CMS issues alerts to Part D sponsors concerning fraud schemes identified by law enforcement officials. Typically, these alerts describe alleged activities involving pharmacies practicing drug diversion or prescribers participating in illegal remuneration schemes. CalOptima may take action (including denying or reversing claims) in instances where CalOptima's own analysis of

its claims activity indicates that fraud may be occurring. CalOptima's decision to deny or reverse claims shall be made on a claim-specific basis.

When a Fraud Alert is received, CalOptima shall review its delegation agreements with the identified parties, and shall consider terminating the contract(s) with the identified parties if indictments have been issued against the particular parties and the terms of the delegation agreement(s) authorizes contract termination.

CalOptima is also obligated to review its past paid claims from entities identified in a fraud alert. With the issuance of a fraud alert, CMS places CalOptima on notice (see 42 CFR 423.505(k)(3)) that claims involving the identified party needs to be reviewed. To meet the "best knowledge, information, and belief" standard of certification, CalOptima shall make its best efforts to identify claims that may be or may have been part of an alleged fraud scheme and remove them from the sets of prescription drug event data submissions.

d. Identifying and Monitoring Providers with a History of Complaints

CalOptima shall maintain files for a period of 10 years on both in-network and out-of-network providers who have been the subject of complaints, investigations, violations, and prosecutions. This includes member complaints, DHCS Audits and Investigations referrals, MEDIC investigations, OIG and/or DOJ investigations, US Attorney prosecution, and any other civil, criminal, or administrative action for violations of state or federal health care program requirements. CalOptima shall also maintain files that contain documented warnings (i.e., fraud alerts) and educational contacts, the results of previous investigations, and copies of complaints resulting in investigations. CalOptima shall comply with requests by law enforcement, DHCS, CMS and CMS' designee regarding monitoring of FDRs within CalOptima's network that DHCS or CMS has identified as potentially abusive or fraudulent.

C. FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention and remediation of FWA is a component of CalOptima's Compliance Program. FWA activities are implemented and overseen by CalOptima's Compliance Officer in conjunction with other compliance activities, and investigations are performed or overseen by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima's Office of Compliance, responsible for FWA investigations. The Compliance Officer reports FWA activities to the CalOptima Compliance Committee, CEO, the CalOptima Board, and regulatory agencies.

CalOptima utilizes various resources to detect, prevent and remediate FWA. In addition, CalOptima promptly investigates suspected FWA issues and implements disciplinary or corrective action to avoid recurrence of FWA issues. The objective of the FWA program is to ensure that the scope of benefits covered by the CalOptima Programs are appropriately delivered to members and resources are effectively utilized in accordance with Federal and State guidelines. CalOptima incorporates a system of internal assessments which are organized to identify FWA and promptly respond appropriately to such incidents of FWA.

I. TRAINING

As detailed above, FWA training is provided to all Board Members and Employees as part of the overall compliance training courses in order to help detect, prevent, and remediate FWA. FDRs are also required to complete FWA training as described above. CalOptima's FWA training provides guidance to Board Members, Employees and FDRs on how to identify activities and behaviors that would constitute FWA and how to report suspected or actual FWA activities. Training materials are retained for a period of at least ten (10) years, and such training includes, but is not limited to:

- The process for detection, prevention and reporting of suspected or actual FWA;

- Examples of the most common types of member FWA (see Appendix B, attached hereto and incorporated herein) and FDR FWA (see Appendix C, attached hereto and incorporated herein) as well as common local and national schemes relevant to managed care organization operations;

- Information on how to identify FWA in CalOptima's PACE Program (e.g. suspicious activities suggesting PACE participants or their family members may be engaged in improper drug utilization or drug-seeking behavior, conduct suggesting improper utilization, persons offering kickbacks for referring or enrolling individuals in the PACE program, etc.);

- Information on how to identify potential prescription drug FWA (e.g. identification of significant outliers whose drug utilization patterns far exceed those of the average member in terms of cost or quantity, disproportionate utilization of controlled substances; use of prescription medications for excessive periods of time, high-volume prescriptions of a particular manufacturer's drugs, submission of false claims or false data for prescription drug claims, misrepresenting the type of drug that was actually dispensed, excessive prescriptions by a particular physician, etc.);

- How to report potential FWA using CalOptima's reporting options, including CalOptima's Compliance and Ethics Hotline, and for FDRs, reporting obligations;

- CalOptima's policy of non-retaliation and non-retribution toward individuals who make such reports in good faith; and

- Information on the False Claims Act and CalOptima's requirement to train Employees and FDRs on the False Claims Act and other applicable FWA laws.

CalOptima shall provide Board Members, Employees, FDRs, and members with reminders and additional training and educational materials through print and electronic communications, including, but not limited to, newsletters, alerts, and/or applicable meetings.

II. DETECTION OF FWA

a. Data Sources

In partnership with the Regulatory Affairs & Compliance Department, CalOptima's SIU utilizes different sources and analyzes various data information in an effort to detect patterns of FWA. Potential fraudulent cases will not only come from claims data but can also originate from many sources internally and externally. Members, FDRs, Employees, law enforcement and regulatory agencies, and others are able to contact CalOptima by phone, mail, and e-mail if they suspect any individual or entity is engaged in inappropriate practices. Furthermore, the sources identified below can be used to identify problem areas within CalOptima, such as enrollment, finance or data submission.

Sources used to detect FWA include, but are not limited to:

- CalOptima's Compliance and Ethics Hotline or other reporting mechanisms;
- Claims data history;
- Encounter data;
- Medical record audits;
- Member and provider complaints, appeals, and grievance reviews;
- Utilization Management reports;
- Provider utilization profiles;
- Pharmacy data;
- Monitoring and auditing activities;
- Monitoring external health care FWA cases and determining if CalOptima's FWA Program can be strengthened with information gleaned from the case activity; and/or
- Internal and external surveys, reviews and audits.

b. Data Analytics

CalOptima uses technology and data analysis to reduce FWA externally. . Using a combination of industry standard edits and CalOptima-specific edits, CalOptima identifies claims for which procedures have been unbundled or upcoded. CalOptima also identifies suspect FDRs based on billing patterns.

CalOptima also uses the services of an external Medicare Secondary Payer (MSP) vendor to reduce costs associated with its Medicare Advantage Part D program, OneCare, by ensuring that Medicare funds are not used where certain health insurance, or coverage, is primarily responsible.

c. Analysis and Identification of Risk Areas Using Claims Data

Claims data is analyzed in numerous ways to uncover fraudulent billing schemes. Routine review of claims data will be conducted in order to identify unusual patterns, outliers in billing and utilization, and identify the population of providers and pharmacies that will be further investigated and/or audited. Any medical claim can be pended and reviewed in accordance with applicable State or Federal law if they meet certain criterion that warrants additional review. Payments for pharmacy claims may also be pended and reviewed in accordance with applicable State or Federal law based on criteria focused on the types of drugs (for example narcotics), provider patterns, and challenges previously reported pertaining to certain pharmacies. CalOptima along with the PBM will conduct data mining activities in order to identify potential issues of FWA.

The following trends will be reviewed and flagged for potential FWA, including:

- Over utilized services;
- Aberrant provider billing practices;
- Abnormal billing in relation to peers;
- Manipulation of modifiers;
- Unusual Coding practices such as excessive procedures per day, or excessive surgeries per patient;
- Unbundling of services;
- Unusual Durable Medical Equipment (DME) billing; and/or
- Unusual utilization patterns by members and providers.

The following claims data may be utilized to evaluate and uncover fraudulent billing schemes:

- Average dollars paid per medical procedure;
- Average medical procedures per office visit;
- Average visits per member;
- Average distance a member travels to see a provider/pharmacy;
- Excessive patient levels of high-risk diagnoses; and/or
- Peer to peer comparisons within specialties.

Once vulnerabilities are identified, immediate actions are taken in order to mitigate the possible losses, including, but not limited to, claims denial or reversal and/ or the reporting of suspected FWA. The data review includes, but is not limited to:

- Analysis of provider medical billing activity within their own peer group;
- Analysis of pharmacy billing and provider prescribing practices;
- Controlled drug prescribing exceeds two standard deviations of the provider's peer group; and/or
- Number of times a provider bills a CPT code in relation to all providers or within their own peer group.

The claims data from the PBM will go through the same risk assessment process. The analysis will be focused on the following characteristics:

- Prescription drug shorting, which occurs when pharmacy staff provides less than the prescribed quantity and intentionally does not inform the beneficiary, or makes arrangements to provide the balance but bills for the prescribed amount.

- Bait and switch pricing, which occurs when a member is led to believe that a drug will cost one price, but at the point of sale, they are charged a higher amount. One example of this type of scheme is when the pharmacy switches the prescribed medication to a form that increases the pharmacy's reimbursement.
- Prescription forging or altering, which occurs when existing prescriptions are altered to increase the quantity or the number of refills, without the prescriber's authorization. Usually, the medications are diverted after being billed to the Medicare Part D program.
- Dispensing expired or adulterated prescription drugs, which occurs when pharmacies dispense drugs after the expiration date on the package. This also includes drugs that are intended as samples not for sale, or have not been stored or handled in accordance with manufacturer and FDA requirements.
- Prescription refill errors, which occur when pharmacy staff deliberately provides a number of refills different from the number prescribed by the provider.
- Failure to offer negotiated prices, which occurs when a pharmacy charges a member the wrong amount.

d. Sample Indicators

No one indicator is evidence of FWA. The presence of several indicators may suggest FWA, but further investigation is needed to determine if a suspicion of FWA actually exists. The following list below highlights common industry indicators and red flags that are used to determine whether or not to investigate an FDR or their claim disposition:

- Claims that show any altered information (dates; codes; names).
- Photocopies of claim forms and bills or handwritten claims and bills.
- Provider's last name is the same as the member/patient's last name.
- Insured's address is the same as the servicing provider.
- Same provider submits multiple claims for the same treatment for multiple family members or group members of provider's practice.
- Provider resubmitting claim with changed diagnosis code for a date of service already denied.

Cases identified through these data sources and risk assessments are entered into the FWA database and a report is generated and submitted to the Compliance Officer, Compliance Committee, and CEO.

III. INVESTIGATIVE PROCESS

Once the SIU receives an allegation of suspected FWA or detects FWA through an evaluation of the data sources identified above, the SIU utilizes the following steps as a guide to investigate and document the case:

- The allegation is logged into the Fraud Tracking Database (Access database maintained by SIU on an internal drive);
- The allegation is assigned an investigation number (sequentially by year of receipt) and an electronic file is assigned on the internal drive, by investigation number and name;
- SIU develops an investigative plan;

- SIU obtains a legal opinion from CalOptima's Legal Counsel on specific cases or issues;
- Quality of care issues are referred to CalOptima's Quality Improvement Department;

- Where appropriate, SIU will submit a Request for Information (RFI) directly to an FDR to obtain relevant information;
- SIU, or a designee, interviews the individual who reported the FWA, affected members and/or FDRS, or any other potential witnesses, as appropriate;
- SIU conducts a data analytics review of the allegation for overall patterns, trends, and errors using applicable data sources and reports;
- Review of FDR enrollment applications, history, and ownership, as necessary;
- Review of member enrollment applications and other documents, as necessary;
- All supporting documentation is scanned and saved in the assigned electronic file. Any pertinent information, gathered during the SIU review/investigation, is placed into the electronic file;
- After an allegation is logged into the Fraud Tracking System, the investigation is tracked to its ultimate conclusion, and the Fraud Tracking System shall reflect all information gathered and documentation received to ensure timely receipt, review, and resolution, and report may be made to applicable State or Federal agencies within mandated/required time periods, if appropriate;
- If a referral to another investigative agency is warranted, the information is collected and a referral is made to the appropriate agency; and/or
- If the investigation results in recommendations for disciplinary or corrective actions, the results of the investigation shall be forwarded to the Compliance Officer and Compliance Committee for discussion and approval.

IV. FINDINGS, RESPONSE AND REMEDIATION

Outcomes and findings of the investigation may include, but are not limited to, confirmation of violations, insufficient evidence of FWA, need for contract amendment, education and training requirement, recommendation of focused audits, additional investigation, continued monitoring, new policy implementation, and/or criminal or civil action. When the root cause of the potential FWA issue has been identified, the SIU will track and trend the FWA allegation and investigation, including, but not limited to, the data analysis performed, which shall be reported to the Compliance Committee on a quarterly basis. Investigation findings can be used to determine whether or not disciplinary or corrective action is appropriate, whether there is a need for a change in CalOptima's Policies and Procedures, and/or whether the matter should be reported to applicable State and Federal Agencies.

In accordance with applicable CalOptima Policies and Procedures, CalOptima shall take appropriate disciplinary or corrective action against Board Members, Employees, and/or FDRs related to validated instances of FWA. Corrective actions will be monitored by the Compliance Committee, and progressive discipline will be monitored by the Department of Human Resources, as appropriate. Corrective actions may include, but are not limited to, financial sanctions, regulatory reporting, corrective action plans, or termination of the delegation agreement, when permitted by the contract terms. Should such disciplinary or corrective action need to be issued, CalOptima Office of Compliance will initiate review and discussion at the first Compliance Committee following the date of identification of the suspected FWA, the date of report to DHCS, or the date of FWA substantiation by DHCS subsequent to the report. If vulnerability is identified through a single FWA incident, the correction action may be applied universally.

V. REFERRAL TO ENFORCEMENT AGENCIES

CalOptima's SIU shall coordinate timely referrals of potential FWA to appropriate regulatory agencies or their designated program integrity contractors, including the CMS MEDIC, DHCS Audits and Investigations, and/or other enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies. FDRs shall report FWA to CalOptima within the time frames required by the applicable contract and in sufficient time for CalOptima to timely report to applicable enforcement agencies. Significant program non-compliance or suspected FWA should be reported to CMS and/or DHCS as soon as possible after discovery, but no later than ten (10) working days to DHCS after CalOptima first becomes aware of and is on notice of such activity, and within thirty (30) calendar days to MEDIC after a OneCare, OneCare Connect or PACE case is reported to CalOptima's SIU.

Potential cases that should be referred include, but are not limited to:

- Suspected, detected or reported criminal, civil or administrative law violations;
- Allegations that extend beyond the CalOptima and involve multiple health plans, multiple states, or widespread schemes;
- Allegations involving known patterns of FWA;
- Patterns of FWA threatening the life or well-being of CalOptima members; and/or
- Schemes with large financial risk to CalOptima or its members.

VI. ANNUAL EVALUATION

CalOptima's Compliance Committee shall periodically review and evaluate the FWA activities and its effectiveness as part of the overall Compliance Program monitoring and audit activities. Revisions should be made based on industry changes, trends in FWA activities (locally and nationally), the OIG Work Plan, the CalOptima Compliance Plan, and other input from applicable sources.

VII. RETENTION OF RECORDS

CalOptima shall maintain reports and summaries of FWA activities and all proceedings of the various committees in original, electronic, or other media format in accordance with applicable statutory, regulatory, contractual, CalOptima policy, and other requirements. CalOptima shall file copies of member records containing PHI in a secure and confidential manner, regardless of the outcome of a review. CalOptima shall file copies of FWA investigations in a secure and confidential manner, regardless of the outcome of an investigation.

VIII. CONFIDENTIALITY

CalOptima and its FDRs shall maintain all information associated with suspected or actual FWA in confidential files, which may only be released in accordance with applicable laws and CalOptima Policies and Procedures. All participants and attendees of CalOptima's Quality Improvement Committee, Compliance Committee, and respective subcommittees, shall sign a "Confidentiality Agreement" agreeing to hold all committee discussions confidential.

D. COMPLIANCE PROGRAM EVALUATION

In order to ensure the effectiveness of the Compliance Program, CalOptima will conduct a self-assessment no less than annually. The assessment will evaluate the Compliance Program against the elements of an effective compliance program as recommended by OIG and required by CMS regulations. The following areas will be reviewed:

- Policies and procedures;
- Compliance Officer and Compliance Committee;
- Training and education of Board Members, Employees, and FDRs;
- Effective lines of communication;
- Well publicized disciplinary guidelines;
- Internal monitoring and auditing; and
- Prompt responses to detected offenses.

The Compliance Program will be evaluated no less than annually by an outside entity. The results of the evaluation will be shared with senior management, the Compliance Committee, and the CalOptima Board. Updates to the Compliance Program will be based on the results of the evaluation and will be referred to the CalOptima Board for review and approval.

E. FILING SYSTEMS

The Compliance Officer shall establish and maintain a filing system (or systems) for all compliance-related documents. The following files shall be established at CalOptima (as applicable):

Compliance Plan, Code of Conduct, and Policies and Procedures File

This file shall contain copies of the following (unless originals specified):

- ► Compliance Plan and any amendments;
- ► Any Compliance Program Policies and Procedures issued after the initiation of the Compliance Program;
- ► Reports to, and Resolutions/Minutes of CalOptima's Board approving the Compliance Program, Compliance Plan, Code of Conduct and/or appointment of the Compliance Officer;
- ► All non-privileged communications to the Compliance Officer (original);
- ► All Compliance Committee and CalOptima Board minutes in which compliance issues are discussed; and/or
- ► Any other written records of the AOC or other oversight activities (originals if generated by the Compliance Officer).

Information and Education File

This file shall contain copies of the following (unless originals specified):

- ► FDR training and attestation records (including attendance records, Affirmation Statements, and the outline of topics covered);
- ► Board member and Employee training records, attestations, and attendance records are maintained by HR.
- ► Educational materials provided to Board Members, Employees and FDRs;
- ► Notices, fraud alerts, and/or federal and state laws and regulations which have been posted on bulletin boards, placed in payroll stuffers, or sent via print or electronic communication (and the dates and locations of such notices); and/or
- ► All other written records of training activities.

Monitoring, Enforcement and Response File

This file shall contain copies of the following (unless originals specified):

- ► Records relating to Compliance reports including reports to the Compliance and Ethics Hotline and/or to the Compliance Officer (originals);
- ► Records relating to periodic monitoring and auditing of the Compliance Program (originals);
- ► Records relating to Board Member, Employee and FDR Participation Status Review or background checks (originals except where FDRs perform Participation Status Reviews);
- ► Records relating to established periodic monitoring mechanisms;
- ► All documents pertaining to the enforcement of the Compliance Program, including, investigations and disciplinary and/or corrective actions; and/or
- ► All documents reflecting actions taken after an offense has been detected, and all efforts to deter and prevent future violations.

Privileged File

This file shall be protected by, and marked, privileged and confidential and its contents shall be

kept in a secure location. Only the Compliance Officer, legal counsel, and the Compliance Committee, where appropriate, shall have access to its contents. All material in this file shall be treated as attorney-client privileged and shall not be disclosed to persons outside the privileged relationship. This file contains the following original documents (except where only a copy is available):

- Records of requests for legal assistance or legal opinions in connection with Compliance and Ethics Hotline telephone calls, correspondence related thereto, and/or problems reported to the Compliance Officer;
- The response from legal counsel regarding any such issues; and/or
- Legal opinions concerning FDR delegation agreement interpretations and remedies available to CalOptima.

Document Retention

All of the documents to be maintained in the filing system described above shall be retained for five (5) years from end of the fiscal year in which the CalOptima Medi-Cal contract expires or is terminated (other than privileged documents which shall be retained until the issue raised in the documentation has been resolved, or longer if necessary). Records pertaining to CalOptima's OneCare, OneCare Connect, or PACE programs shall be retained for ten (10) years from end date of the applicable contract.

CalOptima shall maintain the documentation required by HIPAA for at least six (6) years from the date of its creation or the date when it last was in effect, whichever, is later. Such documentation includes: (i) policies and procedures (and changes thereto) designed to comply with the standards, implementation specifications or other designated requirements; (ii) writings or electronic copies of communications required by HIPAA; (iii) writings or electronic copies of actions, activities or designations required to be documented under HIPAA; and (iv) documentation to meet its burden of proof related to identification of breaches under 45 CFR Section 164.414(b).

Appendix A

Code of Conduct

Code of Conduct

Principle	Standard
Mission, Vision, and Values CalOptima is committed to its Mission, Vision and Values	**Mission** To provide members with access to quality health care services delivered in a cost-effective and compassionate manner. **Vision** To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all CalOptima members. **Values = CalOptima CARES** **C**ollaboration; **A**ccountability; **R**espect; **E**xcellence; **S**tewardship
Compliance with the Law CalOptima is committed to conducting all activities and operations in compliance with applicable laws.	**Transparent, Legal and Ethical Business Conduct** CalOptima is committed to conducting its business with integrity, honesty and fairness and in compliance with all laws and regulations that apply to its operations. CalOptima depends on its Board Members, Employees and those who do business with it to help fulfill this commitment. **Obeying the Law** Board members, Employees and Contractors (including First Tier and Downstream Entities included in the term "FDRs") shall not lie, steal, cheat or violate any law in connection with their employment and/or engagement with CalOptima. **Fraud, Waste & Abuse (FWA)** CalOptima shall refrain from conduct, which would violate the fraud, waste and abuse laws. CalOptima is committed to the detection, prevention, and reporting of fraud, waste and abuse. CalOptima is also responsible for ensuring that Board members, Employees and FDRs receive appropriate FWA training as described in regulatory guidance. CalOptima's Compliance Plan, Fraud, Waste and Abuse Plan and policies describe examples of potential fraud, waste and abuse and discuss Employee and Contractor FWA obligations and potential sanctions arising from relevant federal and state FWA laws. CalOptima expects and requires that its Board members, Employees, and Contractors do not participate in any conduct that may violate the FWA laws including, federal and state anti-kickback laws, false claims acts, and civil monetary penalty laws. **Political Activities** CalOptima's political participation is limited by law. CalOptima funds, property, and resources are not to be used to contribute to political campaigns, political parties, and/or organizations. Board members, Employees and Contractors may participate in the political process on their own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima in these activities. **Anti-Trust** All Board members, Employees, and Contractors must comply with applicable antitrust, unfair competition and similar laws, which regulate competition. Such persons shall seek advice from legal counsel if they encounter any business decisions involving a risk of violation of antitrust laws. The types of activities that potentially implicate antitrust laws include, without limitation, agreements to fix prices, bid rigging and related activities; boycotts, certain exclusive dealings and price discrimination agreements; unfair trade practices; sales or purchases conditioned on reciprocal purchases or sales; and discussion of factors determinative of prices at trade association meetings.

Code of Conduct

Principle	Standard
Member Rights CalOptima is committed to meeting the health care needs of its members by providing access to quality health care services.	**Member Choice, Access to Health Care Services, Continuity of Care** Employees and Contractors shall comply with CalOptima policies and procedures and applicable law governing member choice, access to health care services and continuity of Member care. Employees and Contractors shall comply with all requirements for coordination of medical and support services for persons with special needs. **Cultural and Linguistic Services** CalOptima and Contractors shall provide culturally, linguistically and sensory appropriate services to CalOptima members to ensure effective communication regarding diagnosis, medical history and treatment, and health education. **Disabled Member Access** CalOptima's Facilities shall adhere to the requirements of Title III of the Americans with Disabilities Act of 1990 by providing access for disabled Members. **Emergency Treatment** Employees and Contractors shall comply with all applicable guidelines, policies and procedures and law governing CalOptima member access and payment of emergency services including, without limitation, the Emergency Medical Treatment and Active Labor Act ("EMTALA") and state patient "anti-dumping" laws, prior authorization limitations, and payment standards. **Grievance and Appeals Processes** CalOptima, its Physician Groups, its Health Networks and Third Party Administrators (TPA) shall ensure that CalOptima members are informed of their grievance and appeal rights including, the State Hearing process, through member handbooks and other communications in accordance with CalOptima policies and procedures and applicable laws. Employees and Contractors shall address, investigate, and resolve CalOptima member complaints and grievances in a prompt and nondiscriminatory manner in accordance with CalOptima Policies and applicable law.
Business Ethics In furtherance of CalOptima's commitment to the highest standards of business ethics, Employees and Contractors shall accurately and honestly represent CalOptima and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.	**Candor & Honesty** CalOptima requires candor and honesty from individuals in the performance of their responsibilities and in communications including, communications with CalOptima's Board of Directors, supervisory employees attorneys, and auditors. No Board member, Employee, or Contractor shall make false or misleading statements to any members and/or persons or entities doing business with CalOptima or about products or services of CalOptima. **Financial and Data Reporting** All financial reports, accounting records, research reports, expense accounts, data submissions, attestations, timesheets and other documents must accurately and clearly represent the relevant facts and the true nature of a transaction. CalOptima maintains a system of internal controls to ensure that all transactions are executed in accordance with management's authorization and recorded in a proper manner to maintain accountability of the agency's assets. Improper or fraudulent accounting documentation or financial reporting or false or misleading encounter, claims, cost or other required regulatory data submissions is contrary to the policy of CalOptima and may be in violation of applicable law and regulatory obligations. **Regulatory Agencies and Accrediting Bodies** CalOptima will deal with all regulatory agencies and accrediting bodies in a direct, open and honest manner. Employees and Contractors shall not take action with regulatory agencies and accrediting bodies that is false or misleading.

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Code of Conduct

Principle	Standard
Public Integrity CalOptima and its Board members and Employees shall comply with laws and regulations governing public agencies.	**Public Records** CalOptima shall provide access to CalOptima Public Records to any person, corporation, partnership, firm or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq. and CalOptima Policies. **Public Funds** CalOptima, its Board members, and Employees shall not make gifts of public funds or assets or lend credit to private persons without adequate consideration unless such actions clearly serve a public purpose within the authority of the agency and are otherwise approved by legal counsel. CalOptima, its Board members, and Employees shall comply with applicable law and CalOptima Policies governing the investment of public funds and expenditure limitations. **Public Meetings** CalOptima, and its Board members, and Employees shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act, California Government Code Sections 54950 et seq.
Confidentiality Board members, Employees, and Contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima policies, procedures, and applicable law.	**No Personal Benefit** Board members, Employees and Contractors shall not use confidential or proprietary CalOptima information for their own personal benefit or for the benefit of any other person or entity, while employed at or engaged by CalOptima, or at any time thereafter. **Duty to Safeguard Member Confidential Information** CalOptima recognizes the importance of its members' right to confidentiality and implements policies and procedures to ensure its members' confidentiality rights and the protection of medical and other confidential information. Board members, Employees and Contractors shall safeguard CalOptima member identity, eligibility, social security, medical information and other confidential information in accordance with applicable laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and implementing regulations, the California Security Breach Notification Law, the California Confidentiality of Medical Information Act, other applicable federal and state privacy laws and CalOptima policies and procedures. **Personnel Files** Personal information contained in Employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable law. **Proprietary Information** Subject to its obligations under the Public Records Act, CalOptima shall safeguard confidential proprietary information including, without limitation, Contractor information and proprietary computer software, in accordance with and, to the extent required by, contract or law. CalOptima shall also safeguard provider identification numbers including, without limitation, Medi-Cal license, Medicare numbers, social security numbers, and other identifying numbers.

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Code of Conduct

Principle	Standard
Business Relationships Business transactions with vendors, Contractors, and other third parties shall be conducted at arm's length in fact and in appearance, transacted free from improper inducements and in accordance with applicable law and ethical standards.	**Business Inducements** Board members, Employees, and Contractors shall not seek to gain advantage through improper use of payments, business courtesies, or other inducements. The offering, giving, soliciting, or receiving any form of bribe or other improper payment is prohibited. Board members, Employees, Contractors and providers shall not use their positions to personally profit or assist others in profiting in any way at the expense of Federal and/or State health care programs, CalOptima or CalOptima members. **Gifts to CalOptima** Board members and Employees are specifically prohibited from soliciting and accepting personal gratuities, gifts, favors, services, entertainment or any other things of value from any person or entity that furnishes items or services used, or that may be used, in CalOptima and its programs unless specifically permitted under CalOptima Policies. Employees may not accept cash or cash equivalents. Perishable or consumable gifts given to a department or group are not subject to any specific limitation and business meetings at which a meal is served is not considered a prohibited business courtesy. **Provision of Gifts by CalOptima** Employees may provide gifts, entertainment or meals of nominal value to CalOptima's current and prospective business partners and other persons when such activities have a legitimate business purpose, are reasonable, and are otherwise consistent with applicable law and CalOptima Policies on this subject. In addition to complying with statutory and regulatory requirements, it is critical to even avoid the appearance of impropriety when giving gifts to persons and entities that do business or are seeking to do business with CalOptima. **Third-Party Sponsored Events** CalOptima's joint participation in Contractor, vendor or other third-party sponsored events, educational programs and workshops is subject to compliance with applicable law including gift of public fund requirements and fraud and abuse prohibitions, and must be approved in accordance with CalOptima Policies on this subject. In no event, shall CalOptima participate in any joint Contractor, vendor, or third party sponsored event where the intent of the other participant is to improperly influence, or gain unfair advantage from, CalOptima or its operations. Employees' attendance at Contractor, vendor or other third-party sponsored events, educational programs and workshops is generally permitted where there is a legitimate business purpose but is subject to prior approval in accordance with CalOptima Policies. **Provision of Gifts to Government Agencies** Board members, Employees and Contractors shall not offer or provide any money, gifts or other things of value to any government entity or its representatives, except campaign contributions to elected officials in accordance with applicable campaign contribution laws. **Broad Application of Standards** CalOptima intends that these standards be construed broadly to avoid even the appearance of improper activity.

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Code of Conduct

Principle	Standard
Conflicts of Interests Board members and Employees owe a duty of undivided and unqualified loyalty to CalOptima.	**Conflict of Interest Code** Designated Employees, including Board members, shall comply with the requirements of the CalOptima Conflict of Interest Code and applicable laws. Board members and Employees are expected to conduct their activities to avoid impropriety and/or the appearance of impropriety, which might arise from the influence of those activities on business decisions of CalOptima, or from disclosure of CalOptima's business operations. **Outside Services and Interests** Without the prior written approval of the Chief Executive Officer (or in the case of the Chief Executive Officer, the Chair of the CalOptima Board of Directors), no employee shall (1) perform work or render services for any Contractor, association of Contractors or other organizations with which CalOptima does business or which seek to do business with CalOptima, (2) be a director, officer, or consultant of any Contractor or association of Contractors; or (3) permit his or her name to be used in any fashion that would tend to indicate a business connection with any Contractor or association of Contractors.
Discrimination CalOptima acknowledges that fair and equitable treatment of employees, members, providers, and other persons is fundamental to fulfilling its mission and goals.	**No Discrimination** CalOptima is committed to compliance with applicable anti-discrimination laws including Title VI of the Civil Rights Act of 1964. Board members, Employees and Contractors shall not unlawfully discriminate on the basis of race, color, religion, national origin, age, gender, sexual orientation, physical or mental disability or any other classification protected by law. CalOptima is committed to providing a work environment free from discrimination and harassment based on any classification noted above. **Reassignment** CalOptima, Physician Groups, and Health Networks shall not reassign members in a discriminatory manner, including based on the enrollee's health status.
Participation Status CalOptima requires that Employees, Contractors, Providers and Suppliers meet Government requirements for participation in CalOptima's programs.	**Federal and State Health Care Program Participation Status** Board members, Employees, and Contractors shall not be currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal or State health care program, including the Medi-Cal program and Medicare programs. **CalOptima Screening** CalOptima will monitor the participation status of Employees, individuals and entities doing business with CalOptima by conducting regular exclusion screening reviews in accordance with CalOptima Policies. **Disclosure of Participation Status** Board members, Employees and Contractors shall disclose to CalOptima whether they are currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal and/or State Health Care program. Employees and individuals and entities that do business with CalOptima shall disclose to CalOptima any pending investigation, disciplinary action or other matter that could potentially result in their exclusion from participation in any Federal or State health care program.
	Delegated Third Party Administrator Review CalOptima requires that its Health Networks, Physician Groups, and third party administrators review participating providers and suppliers for licensure and participation status as part of the delegated credentialing and recredentialing processes when such obligations have been delegated to them. **Licensure** CalOptima requires that all Employees, Contractors, Health Networks, participating providers and suppliers who are required to be licensed, credentialed, certified and/or registered in order to furnish items or services to CalOptima and its members have valid and current licensure, credentials, certification and/or registration as applicable.

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Code of Conduct

Principle	Standard
Government Inquiries/Legal Disputes Employees shall notify CalOptima upon receipt of Government inquiries and shall not destroy or alter documents in response to a government request for documents or information.	**Notification of Government Inquiry** Employees shall notify the Executive Director, Department of Compliance and/or their Supervisor immediately upon the receipt (at work or at home) of an inquiry, subpoena or other agency or government requests for information regarding CalOptima. **No Destruction of Documents** Employees shall not destroy or alter CalOptima information or documents in anticipation of, or in response to, a request for documents by any governmental agency or from a court of competent jurisdiction. **Preservation of Documents Including Electronically Stored Information** Board members and employees shall comply with all obligations to preserve documents, data, and records including, electronically stored information, in accordance with CalOptima Policies and shall comply with instructions on preservation of information and prohibitions on destruction of information issued by Legal Counsel.
Compliance Program Reporting Board members, Employees, and Contractors have a duty to comply with CalOptima's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.	**Reporting Requirements** All Board members, Employees and Contractors are expected and required to promptly report suspected violations of any statute, regulation or guideline applicable to Federal and/or State health care programs or of CalOptima's own Policies in accordance with CalOptima's reporting Policies and its Compliance Plan. Such reports may be made to a Supervisor, the Executive Director, Office of Compliance. Reports can also be made to CalOptima's hotline number below. Persons making reports to the hotline can do so on an anonymous basis **Compliance and Ethics Hotline: 877-837-4417** **Disciplinary Action** Failure to comply with the Compliance Program, including the Code of Conduct, Policies and/or applicable statutes, regulations and guidelines may lead to disciplinary action. Discipline for failure to abide by the Code of Conduct may, in CalOptima's discretion, range from oral correction to termination in accordance with CalOptima's Policies. In addition, failure to comply may result in the imposition of civil, criminal or administrative fines on the individual or entity and CalOptima or exclusion from participation in Federal and/or State health care programs. **Training and Education** CalOptima provides training and education to Board members, Employees, and FDRs. Timely completion of compliance and HIPAA training is mandatory for all CalOptima Employees. **No-Retaliation Policy** CalOptima prohibits retaliation against any individual who reports discrimination or harassment or compliance concerns or participates in an investigation of such reports. Employees involved in any retaliatory acts may be subject to discipline, up to and including termination of employment. **Referrals of FWA to Government Agencies** CalOptima is obligated to coordinate compliance activities with federal and state regulators. Employees shall comply with CalOptima policies related to FWA referral requirements to federal and state regulators, delegated program integrity contractors and law enforcement agencies. **Certification** All Board members, Employees and Contractors are required to certify, in writing, that they have received, read, understand and will abide by the Code of Conduct and applicable Policies.

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Appendix B

Types of Member FWA

MEMBER FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
M01	Using another individual's identity or documentation of Medi-Cal eligibility to obtain Covered Services.	Members with multiple areas of service; members who attempt more than one PCP; reports of members who are hiding assets or income
M02	Selling, loaning, or giving a member's identity or documentation of Medi-Cal eligibility to obtain services.	Members with multiple areas of service; members who attempt more than one PCP; reports of members who are hiding assets or income
M03	Making an unsubstantiated declaration of eligibility.	Members with multiple areas of service; members who attempt more than one PCP; reports of members who are hiding assets or income
M04	Using a Covered Service for purposes other than the purpose for which it was described including use of such Covered Service.	Selling a covered wheelchair; selling medications; abusing prescription medications
M05	Failing to report other health coverage.	Payments by OHI
M06	Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive Covered Services.	Hotline reports; internal reports; reports by Health Networks
M07	Other (please specify).	Any source
M08	Member Pharmacy Utilization.	PBM reports; data analytics; claims data; encounter data; FWA software
M09	Doctor Shopping.	PBM reports; data analytics; claims data; encounter data; FWA software
M10	Altered Prescription.	Provider report; DEA report; pharmacy report; PBM reports; data analytics; claims data; encounter data; FWA software

Appendix C

Types of FDR FWA

FDR FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P01	Unsubstantiated declaration of eligibility to participate in the CalOptima program.	Provider information not able to be verified during credentialing or contracting process; providers on the excluded provider list
P02	Submission of claims for Covered Services that are substantially and demonstrably in excess of any individual's usual charges for such Covered Services.	PBM reports; data analytics; claims data; encounter data; FWA software
P03	Submission of claims for Covered Services that are not actually provided to the member for which the claim is submitted.	PBM reports; data analytics; claims data; encounter data; FWA software; verification survey; hotline
P04	Submission of claims for Covered Services that are in excess of the quantity that is Medically Necessary.	PBM reports; data analytics; claims data; encounter data; FWA software
P05	Submission of claims for Covered Services that are that are billed using a code that would result in great payment than the code that reflects the covered services.	PBM reports; data analytics; claims data; encounter data; FWA software
P06	Submission of claims for Covered Services that is already included in the capitation rate.	PBM reports; data analytics; claims data; encounter data; FWA software
P07	Submission of claims for Covered Services that are submitted for payment to both CalOptima and another third party payer without full disclosure.	PBM reports; data analytics; claims data; encounter data; FWA software; payment by OHI
P08	Charging a member in excess of allowable co-payments and deductibles for Covered Services.	Member report; hotline report; oversight audits
P09	Billing a member for Covered Services without obtaining written consent to bill for such services.	Member report; hotline report; oversight audits
P10	Failure to disclose conflict of interest.	Hotline; credentialing or contracting process
P11	Receiving, soliciting, or offering a kickback, bribe or rebate to refer or fail to refer a member.	Hotline report; oversight report
P12	Failure to register billing intermediary with the Department of Health Services.	Oversight audit; report by regulatory body; hotline
P13	False certification of Medical Necessity.	Medical record review; claims data; encounter data; FWA

		software
P14	Attributing a diagnosis code to a member that does not reflect the member's medical condition for the purpose of obtaining higher reimbursement.	Medical record review; claims data; encounter data; FWA software
P15	False or inaccurate Minimum Standards or credentialing information.	Hotline; credentialing or contracting process
P16	Submitting reports that contain unsubstantiated data, data that is inconsistent with records, or has been altered in a manner that is inconsistent with policies, contracts, statues or regulations.	Medical record review; claims data; encounter data; FWA software
P17	Other (please specify).	Any source
P18	Provider Pharmacy Utilization.	PBM reports; data analytics; claims data; encounter data; FWA software
P19	Billing Medi-Cal Member for Services.	Member report; hotline report; oversight audits
P20	Durable Medical Equipment-Covered Services that are not actually provided to beneficiary.	Member report; hotline report; oversight audits; verification survey

Appendix D

Types of Employee FWA

EMPLOYEE FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
E01	Use of a Member's identity or documentation of Medi-Cal eligibility to obtain services	Employees obtaining services on a Member's account. Hotline report. Data analytics. Referrals to SIU.
E02	Use of a Member's identity or documentation of Medi-Cal eligibility to obtain a gain.	Employees obtaining unjust enrichment, funds, or other gain by selling Member's account information. Hotline report.
E03	Employee assistance to providers with the submission of claims for Covered Services that are not actually provided to the Member for which the claim is submitted.	Employees obtaining unjust enrichment, funds, or other gain from provider by using Member's account information to assist in the submission of false claims. Hotline report. Referrals to SIU.
E04	Employee deceptively accessing company confidential information for purpose of a gain.	Employees obtaining unjust enrichment, funds, or other gain from another by deceptive and unauthorized accessing of information. Hotline Service. Data Analytics. Referrals to SIU.

AFFIRMATION STATEMENTS

CalOptima
AFFIRMATION STATEMENT-SUPERVISORS

I have received and read a copy of the Compliance Plan, Code of Conduct, and relevant Policies and Procedures as part of my compliance training, and I understand, acknowledge, and agree to abide by its contents and requirements.

I understand that it is my responsibility to respond to questions from employees under my direct supervision regarding the Compliance Plan, Code of Conduct, or applicable Policies and Procedures. If I am unable to respond to questions from employees under my direct supervision, I will refer them to the Compliance Officer. In addition, I understand that if an employee under my direct supervision reports a violation or suspected violation of CalOptima's Compliance Program to me, I will escalate and report the issue to the Compliance Officer.

By signature below, I also certify that I have completed the Compliance Training as indicated:

I attended the initial Compliance Training Session on _____.

_____	_____
Print Name	Signature
_____	_____
Print Name	Signature
_____	_____
Print Name	Signature
_____	_____
Print Name	Signature
_____	_____
Print Name	Signature
_____	_____
Print Name	Signature
_____	_____
Print Name	Signature
_____	_____
Print Name	Signature

Print Name	Signature

CalOptima
AFFIRMATION STATEMENT-EMPLOYEES

I have received and read a copy of the Compliance Plan, Code of Conduct, and relevant Policies and Procedures specific to my job duties and responsibilities as part of my compliance training, and I understand, acknowledge, and agree to abide by its contents and requirements.

By signature below, I also certify that I have completed the Compliance Training Session on _____:

_____	_____
Print Name	Signature
_____	_____
Print Name	Signature
_____	_____
Print Name	Signature
_____	_____
Print Name	Signature
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Print Name	Signature
_____	_____
Print Name	Signature
_____	_____
Print Name	Signature
_____	_____
Print Name	Signature
_____	_____
Print Name	Signature

CalOptima
AFFIRMATION STATEMENT-FDRs

I have received and read a copy of the Compliance Plan, Code of Conduct, and applicable Policies and Procedures relevant to the delegated activities, and I understand, acknowledge, and agree to abide by its contents and requirements.

I will disseminate the Compliance Plan, Code of Conduct, and applicable Policies and Procedures to those employees and agents who will furnish items or services to CalOptima under the Contractor Agreement.

_____
Print Name

_____
Signature

_____
Title

_____
Company

_____
Date

SIGN, DATE AND RETURN TO CalOptima SUPERVISOR

CalOptima

AFFIRMATION STATEMENT-BOARD MEMBERS

I have received and read a copy of the Compliance Plan, the Code of Conduct, and applicable Policies and Procedures, and I understand, acknowledge, and agree to abide by its contents and requirements.

By signature below, I also certify that I have completed the initial or regular training as indicated:

I attended the initial Compliance Training Session on _____.

I attended the annual Compliance Training Session on _____.

_____

Print Name

_____

Signature

_____

Date

RETURN TO THE COMPLIANCE OFFICER

GLOSSARY

Abuse ("Abuse") means actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Audit ("Audit") means a formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.

Board Members ("Board Members") means the members of the CalOptima Board of Directors.

CalOptima ("CalOptima") means the Orange County Health Authority, d.b.a. CalOptima, a County Organized Health System ("COHS") created under California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended.

CalOptima Board of Directors ("CalOptima Board") means the Board of Directors of CalOptima, which serves as the Governing Body of CalOptima, appointed by the Orange County Board of Supervisors in accordance with the Codified Ordinances of the County of Orange.

CalOptima Members ("CalOptima members" or "members") means a beneficiary who is enrolled in a CalOptima Program.

CalOptima Programs ("CalOptima Programs") means the Medi-Cal program administered by CalOptima under contract with DHCS, the Medicare Advantage Program ("OneCare") administered by CalOptima under contract with CMS, the Program of All Inclusive Services for the Elderly ("PACE") program administered by CalOptima under contract with DHCS and CMS, and the Multipurpose Senior Services Program ("MSSP") administered by CalOptima under contract with the California Department of Aging, as well as any other program now or in the future administered by CalOptima.

Centers for Medicare & Medicaid Services ("CMS") means the federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.

Code of Conduct ("Code of Conduct") means the statement setting forth the principles and standards governing CalOptima's activities to which Board Members, Employees, FDRs, and agents of CalOptima are expected to adhere.

Compliance Committee ("Compliance Committee") means that committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consists of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.

Compliance Plan ("Compliance Plan") means this plan and all attachments, exhibits, modifications, supplements, or amendments thereto.

Compliance Program ("Compliance Program" or "Program") means the program (including, without limitation, this Compliance Plan, Code of Conduct and Policies and Procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Members, Employees and FDRs comply with applicable law and ethical standards.

Conflict of Interest Code ("Conflict of Interest Code") means CalOptima's Conflict of Interest Code approved and adopted on December 6, 1994, as amended and updated from time to time.

Corrective Action Plan ("CAP") means a plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.

Delegation ("Delegated") means a legal assignment to another party of the authority for particular functions, tasks and decisions on behalf of the original party. The original party remains liable for compliance for compliance and fulfillment of any and all rules, requirements and obligations pertaining to the delegated functions.

Audit & Oversight Committee ("AOC") means a subcommittee of the Compliance Committee chaired by the Director of Audit and Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's departments as provided for in the AOC charter.

Department of Health and Human Services-Office of Inspector General ("OIG") means the Office of Inspector General of the United States Department of Health and Human Services.

Department of Health Care Services ("DHCS") means the California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.

Department of Managed Health Care ("DMHC") means the California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code, Sections 1340 *et seq*.

Designated Employee ("Designated Employee") means the persons holding positions listed in the Appendix to the CalOptima Conflict of Interest Code.

Downstream Entity ("Downstream Entity") means any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Employee or Employees ("Employee" or "Employees") means any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.

Executive Director of Compliance ("Executive Director of Compliance" or "Compliance Officer") means that person designated as the Compliance Officer for CalOptima charged with the responsibility of implementing and overseeing the Compliance Program and the Compliance Plan and Fraud, Waste, and Abuse Plan.

False Claims Act ("FCA") means the False Claims Act pursuant to 31 United States Code [U.S.C.] Sections 3729-3733, which protects the Government from being overcharged or sold substandard goods or services. The FCA imposes civil liability on any person who knowingly submits, or causes to be submitted, a false or fraudulent claim to the Federal Government. The "knowing" standard includes acting in deliberate ignorance or reckless disregard of the truth related to the claim. Civil penalties for violating the FCA may include fines and up to 3 times the amount of damages sustained by the Government as a result of the false claims. There also are criminal penalties for submitting false claims, which may include fines, imprisonment, or both. (18 U.S.C. Section 287.)

FDR ("FDR") means First Tier, Downstream or Related Entity, as separately defined herein.

Federal and/or State Health Care Programs ("Federal and/or State health care programs") means "any plan or program providing health care benefits, directly through insurance or otherwise, that is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program), including Medicare, or any State health care program" as defined in 42 U.S.C. § 1320a-7b (f) including the California Medicaid program, Medi-Cal.

First Tier Entity ("First Tier Entity") means any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.

Fraud ("fraud") means knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347.)

Governing Body ("Governing Body") means the Board of Directors of CalOptima.

Health Network or Health Networks ("Health Network" or "Health Networks") means the contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"),

Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").

Health Insurance Portability and Accountability Act (HIPAA) means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.

Monitoring Activities ("Monitoring") means regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

National Committee for Quality Assurance Standards for Accreditation of MCOs ("NCQA Standards") means the written standards for accreditation of managed care organizations published by the National Committee for Quality Assurance.

Participating providers and suppliers ("participating providers and suppliers") include all health care providers and suppliers (e.g. physicians, mid-level practitioners, hospitals, long term care facilities, pharmacies etc.) that receive reimbursement from CalOptima or its Health Networks for items or services furnished to Members. Participating providers and suppliers for purposes of this Compliance Plan may or may not be contracted with CalOptima and/or the health networks.

Participation Status ("Participation Status") means whether a person or entity is currently suspended, excluded, or otherwise ineligible to participate in Federal and/or State health care programs as provided in CalOptima Policies and Procedures.

Participation Status Review ("Participation Status Review") means the process by which CalOptima reviews its Board members, Employees, FDRs, and CalOptima Direct providers to determine whether they are currently suspended, excluded, or otherwise ineligible to participate in Federal and/or State health care programs.

Policies and Procedures ("Policies and Procedures") means CalOptima's written Policies and Procedures regarding the operation of CalOptima's Compliance Program, including applicable Human Resources policies, outlining CalOptima's requirements and standards in compliance with applicable law.

Related Entity ("Related Entity") means any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

Sanction ("Sanction") means an action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.

Sub-delegation ("Sub-delegation") means the process by which a First Tier Entity expressly grants, by formal agreement, to a Downstream Entity the authority to carry out one or more

functions that would otherwise be required to be performed by the First Tier Entity in order to meet its obligations under the delegation agreement.

Supervisor ("Supervisor") means an Employee in a position representing CalOptima who has one or more Employees reporting directly to him or her. With respect to FDRs, the term "Supervisor" shall mean the CalOptima Employee that is the designated liaison for that contractor.

Third Party Administrator ("TPA") means a Contractor that furnishes designated claims processing and other administrative services to CalOptima.

Waste ("Waste") means the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Attachment 3: Summary of Proposed Actions for Office of Compliance Policies and Procedures

Table 1: Revisions to the Office of Compliance Policies and Procedures

The following table lists the proposed revisions to the CalOptima Office of Compliance policies and procedures by department.

Department	Policy	Summary of Change(s)	Reason for Change(s)
Audit & Oversight	HH.2025: Health Network Sub-delegation and Sub-contracting	▪ Added provisions regarding regulatory entities permitted to inspect and audit records ▪ Incorporated MA.5004: Health Network Sub-delegation and Sub-contracting ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Audit & Oversight	HH.2026: Claims Delegation and Oversight	▪ Incorporated MA.9112: Claims Delegation and Oversight ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Audit & Oversight	HH.2027: Annual Risk Assessment (Delegate)	▪ Updated the roles and responsibilities with the Audit & Oversight Department ▪ Incorporated MA.9117: Annual Risk Assessment ▪ Updated defined terms, references, employee titles, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Audit & Oversight	HH.4001Δ: Audit &Oversight Committee	▪ Updated the roles and responsibilities with the Audit & Oversight Department ▪ Incorporated MA.9127: Audit & Oversight Committee ▪ Updated defined terms, references, employee titles, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Fraud, Waste, and Abuse (FWA)	HH.1105Δ: Fraud, Waste, and Abuse Detection	▪ Incorporated MA.9107: Fraud, Waste, and Abuse Detection ▪ Updated defined terms, references, and CalOptima Departments and Committees ▪ Attachment "Suspected Fraud or Abuse Referral Form" updated to include the new fax number (translated versions all contain the new fax number)	Annual review to include revisions to align with the 2017 Compliance Plan and current operations

Department	Policy	Summary of Change(s)	Reason for Change(s)
FWA	HH1107Δ: Fraud, Waste, and Abuse Investigation and Reporting	▪ Clarified provisions of the roles and responsibilities of the departments responsible for tracking FWA case information ▪ Updated provision regarding the data used to investigate FWA ▪ Added provision regarding reporting and referring potential FWA to the Department of Health Care Services (DHCS) ▪ Incorporated MA.9108: Fraud, Waste, and Abuse Investigation and Reporting ▪ Updated defined terms, references, and CalOptima Departments and Committees ▪ Attachment "Suspected Fraud or Abuse Referral Form" updated to include the new fax number (translated versions all contain the new fax number)	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Privacy	HH.3000Δ: Notice of Privacy Practices	▪ Added provisions in accordance with the 2013 Omnibus Rule ▪ Added provisions regarding National Committee on Quality Assurance (NCQA) requirements ▪ Incorporated MA.9202: Notice of Privacy Practices ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Privacy	HH.3001Δ: Member Access to Designated Record Set	▪ Added provision regarding the timeframe for notification to a member of a designated record set (DRS) request ▪ Updated record retention requirements ▪ Added provision to exclude case or medical management notes created by providers or health networks ▪ Incorporated MA.9203: Member Access to Designated Record Set ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations

Department	Policy	Summary of Change(s)	Reason for Change(s)
Privacy	HH.3002Δ: Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	▪ Added provisions regarding NCQA requirements ▪ Deleted obsolete references to CalOptima Programs ▪ Incorporated MA.9204: Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Privacy	HH.3003Δ: Verification of Identity for Disclosures of Protected Health Information	▪ Incorporated MA.9205: Verification of Identity for Disclosures of Protected Health Information ▪ Updated defined terms, references, and CalOptima ▪ Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Privacy	HH.3004Δ: Member Request to Amend Records	▪ Clarified the role and responsibility of the Privacy Officer in receiving, processing, and responding to requests for Protected Health Information (PHI)-related inquiries ▪ Updated provisions regarding timeframes for notifications to members ▪ Updated record retention requirements ▪ Added provisions regarding NCQA requirements ▪ Incorporated MA.9207: Member Request to Amend Record ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Privacy	HH.3005Δ: Member Request for Accounting of Disclosures	▪ Updated record retention requirements ▪ Added provisions regarding NCQA requirements ▪ Incorporated MA.9209: Member Request for Accounting of Disclosures ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Privacy	HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information	▪ Updated provision regarding the routine disclosures that are tracked by CalOptima ▪ Incorporated MA.9210: Tracking and Reporting Disclosures of Protected Health Information ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations

Department	Policy	Summary of Change(s)	Reason for Change(s)
Privacy	HH.3007Δ: Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	▪ Incorporated MA.9206: Member Right to Request Restrictions on Use and Disclosure of Protected Health Information ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Privacy	HH.3008Δ: Member Right to Request Confidential Communications	▪ Updated provision regarding how a member may deliver a request to CalOptima ▪ Incorporated MA.9211: Member Right to Request Confidential Communications ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Privacy	HH.3009Δ: Access by Member's Authorized Representative	▪ Added provision regarding adhering to state/federal regulations for use/disclosure of PHI ▪ Incorporated MA.9212: Access by Member's Authorized Representative ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Privacy	HH.3010Δ: Protected Health Information Disclosures Required by Law	▪ Clarified provisions regarding applicability to specific health care programs ▪ Incorporated MA.9213: Protected Health Information Disclosures Required by Law ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Privacy	HH.3011Δ: Use and Disclosure for Treatment, Payment Health Care Operations, and Research	▪ Incorporated: – HH.3017: Use and Disclosure of PHI for Research – MA.9214: Use and Disclosure for Treatment, Payment, and Health Care Operations – MA.9215: Use or Disclosure of Protected Health Information (PHI) for Research ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations

Department	Policy	Summary of Change(s)	Reason for Change(s)
Privacy	HH.3014Δ: Use of Electronic Mail with Protected Health Information	▪ Incorporated HH.9218: Use of Electronic Mail with Protected Health Information ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Privacy	HH.3015Δ: Authorization for Release of Protected Health Information	▪ Added provision regarding mailing and receipt of Authorization for Release of Information form ▪ Updated record retention requirements ▪ Added provision regarding NCQA requirements ▪ Added provision regarding non-CalOptima HIPAA release of information forms ▪ Incorporated: – HH.3021: Disclosure of Information to Family Members or Friends Involved in Member Care – MA.9219: Authorization for Release of Protected Health Information – MA.9224: Disclosure of Information to Family Members or Friends Involved in Member Care ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Privacy	HH.3016Δ: Guidelines for Handling Protected Health Information Offsite	▪ Clarified applicability to Business Associates ▪ Incorporated MA.9220: Guidelines for Handling Protected Health Information Offsite ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Privacy	HH.3019Δ: De-identification of Protected Health Information	▪ Incorporated MA.9221: De-identification of Protected Health Information ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations

Department	Policy	Summary of Change(s)	Reason for Change(s)
Privacy	HH.3020Δ: Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	▪ Added provision regarding CalOptima's breach mitigation policy ▪ Added provision regarding notification to regulatory agencies and individuals of breaches based on the size of the breach ▪ Incorporated provision to include social media as a manner in which PHI could be posted and result in a breach ▪ Updated timeframes ▪ Updated regulatory agencies to which CalOptima reports breaches ▪ Added provision regarding the obligation of Business Associates to immediately report breaches when there is a direct contract with DHCS ▪ Incorporated: – HH.3013: Mitigation – MA.9217: Mitigation – MA.9222: Reporting an Unauthorized Use or Disclosure of Protected Health Information (PHI), or Breach of Data, Security, or Intrusion ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Regulatory Affairs & Compliance	HH.2002Δ: Sanctions	▪ Clarified provisions regarding corrective action plans as well as penalties for First Tier Entities ▪ Incorporated MA.9105: Sanctions ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations

Department	Policy	Summary of Change(s)	Reason for Change(s)
Regulatory Affairs & Compliance	HH.2005Δ: Corrective Action Plan	▪ Clarified provisions regarding responsibilities for corrective actions plans. ▪ Added provisions regarding responses to Immediate Corrective Action Plan due to regulatory findings ▪ Revised provisions regarding CalOptima's compliance communication methods ▪ Incorporated MA.9104: Corrective Action Plan ▪ Updated defined terms, references, employee titles, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Regulatory Affairs & Compliance	HH.2007Δ: Compliance Committee	▪ Added provisions regarding components of the Compliance Plan that are monitored for effectiveness ▪ Added provisions regarding the analysis of federal and state programs to ensure adequacy of the Compliance program ▪ Incorporated MA.9123: Compliance Committee ▪ Updated defined terms, references, employee titles, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Regulatory Affairs & Compliance	HH.2014Δ: Compliance Program	▪ Added provisions regarding the responsibility of the CalOptima Board of Directors for overseeing the implementation and effectiveness of the Compliance Program and approving the Compliance Plan and Code of Conduct ▪ Clarified the role and responsibilities of the CalOptima Compliance Officer ▪ Incorporated MA.9101: Compliance Program ▪ Updated defined terms, references, employee titles, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations

Department	Policy	Summary of Change(s)	Reason for Change(s)
Regulatory Affairs & Compliance	HH.2018Δ: Compliance and Ethics Hotline	▪ Clarified provisions regarding responsibilities of the Office of Compliance to maintain confidentiality to the extent possible ▪ Added provisions regarding the third party vendor's responsibilities for receipt and documentation of a call ▪ Incorporated MA.9113: Compliance and Ethics Hotline ▪ Updated defined terms, references, employee titles, and CalOptima Departments	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Regulatory Affairs & Compliance	HH.2019Δ: Reporting Suspended Misconduct or Violation	▪ Clarified provisions regarding CalOptima's compliance communication methods ▪ Incorporated MA.9114: Reporting Suspected Misconduct or Violation ▪ Updated defined terms, references, employee titles, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Regulatory Affairs & Compliance	HH.2020Δ: Conducting Compliance Investigations	▪ Clarified the role and responsibilities of the CalOptima Security Officer ▪ Added provisions regarding self-disclosure of incidents to CMS ▪ Incorporated MA.9125: Conducting Compliance Investigations	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Regulatory Affairs & Compliance	HH.2021Δ: Exclusion Monitoring	▪ Clarified the role and responsibilities of the departments responsible for exclusion monitoring activities ▪ Incorporated MA.9121: Exclusion Monitoring ▪ Updated defined terms, references, employee titles, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Regulatory Affairs & Compliance	HH.2022Δ: Record Retention and Access	▪ Updated provisions regarding record retention requirements ▪ Incorporated MA.9106: Record Retention and Access ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations

Department	Policy	Summary of Change(s)	Reason for Change(s)
Regulatory Affairs & Compliance	HH.2023Δ: Compliance Training	▪ Updated provisions to clarify that FDRs who have met the FWA training and education certification requirements through enrollment into Parts A or B of the Medicare program, or through accreditation as a supplier of Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS), are NOT exempt from the general compliance training requirement ▪ Updated timeframe for completion of compliance training ▪ Incorporated MA.9119: Compliance Training ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Regulatory Affairs & Compliance	HH.2028Δ: Code of Conduct	▪ Added provisions regarding the distribution of the Code of Conduct to the CalOptima Board of Directors and associated monitoring activities ▪ Incorporated MA.9120: Code of Conduct ▪ Updated defined terms, references, employee titles, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Regulatory Affairs & Compliance	HH.2029Δ: Annual Compliance Program Effectiveness Audit	▪ Added provision regarding the timing of the CalOptima self-assessment ▪ Incorporated MA.9116: Annual Compliance Program Effectiveness Audit ▪ Updated defined terms, references, employee titles, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Regulatory Affairs & Compliance	HH.3012Δ: Non-Retaliation for Reporting Violations	▪ Added communication method for reporting suspected violations ▪ Incorporated MA.9223: Non-Retaliation for Reporting Violations ▪ Updated defined terms, references, employee titles, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations

Department	Policy	Summary of Change(s)	Reason for Change(s)
Regulatory Affairs & Compliance	MA.9124: CMS Self-Disclosure	▪ Added provision regarding reporting to DHCS ▪ Incorporated provision regarding department designees ▪ Updated defined terms, references, employee titles, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations

Table 2: New Office of Compliance Policies and Procedures

The following table contains the proposed list of new policies for the CalOptima Office of Compliance, by department.

Department	Policy	Summary of Change(s)	Reason for Change(s)
Audit & Oversight	HH.4002: CalOptima Internal Oversight	▪ New policy to describe the oversight activities of internal CalOptima Departments ▪ Incorporated MA.9118: Internal Auditing and Monitoring	N/A
Audit & Oversight	HH.4003: Annual Risk Assessment (Internal)	▪ New policy to describe the describe the annual internal risk assessment process ▪ Incorporated MA.9117: Annual Risk Assessment	N/A
FWA	HH.5000Δ: Provider Overpayment Investigation and Determination	▪ This policy describes the process for reviewing suspect claims to detect and prevent FWA within a CalOptima program.	N/A

Table 3: Retiring Office of Compliance Policies and Procedures

The following table contains the proposed list of policies and procedures to be retired within the CalOptima Office of Compliance, by department.

Department	Policy	Summary of Change(s)	Reason for Change(s)
Audit & Oversight	MA.5004: Health Network Sub-delegation and Sub-contracting	▪ Requesting retirement of this policy.	Policy was incorporated within incorporated within HH.2025: Health Network Sub-delegation and Sub-contracting

Department	Policy	Summary of Change(s)	Reason for Change(s)
Audit & Oversight	MA.9112: Claims Delegation and Oversight	▪ Requesting retirement of this policy.	Policy was incorporated within HH.2026: Claims Delegation and Oversight
Audit & Oversight	MA.9117: Annual Risk Assessment	▪ Requesting retirement of this policy.	Policy was incorporated within HH.2027: Annual Risk Assessment (Delegate)
Audit & Oversight	MA.9118: Internal Auditing and Monitoring	▪ Requesting retirement of this policy.	Policy was incorporated within HH.4002: CalOptima Internal Oversight
Audit & Oversight	MA.9127: Audit and Oversight Committee	▪ Requesting retirement of this policy.	Policy was incorporated within HH.4001Δ: Audit and Oversight Committee
FWA	MA.9107: Fraud, Waste, and Abuse Detection	▪ Requesting retirement of this policy.	Policy was incorporated within HH.1105Δ: Fraud, Waste, and Abuse Detection
FWA	MA.9108: Fraud, Waste, and Abuse Investigation and Reporting	▪ Requesting retirement of this policy.	Policy was incorporated within HH.1107Δ: Fraud, Waste, and Abuse Investigation and Reporting
Privacy	HH.3013: Mitigation	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI
Privacy	HH.3017: Use and Disclosure of PHI for Research	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3011Δ: Use and Disclosure for Treatment, Payment Health Care Operations, and Research

Department	Policy	Summary of Change(s)	Reason for Change(s)
Privacy	HH.3021: Disclosure of Information to Family Members or Friends Involved in Member Care	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3015Δ: Authorization for Release of Protected Health Information
Privacy	MA.9202: Notice of Privacy Practices	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3000Δ: Notice of Privacy Practices
Privacy	MA.9203: Member Access to Designated Record Set	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3001Δ: Member Access to Designated Record Set
Privacy	MA.9204: Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3002Δ: Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls
Privacy	MA.9205: Verification of Identity for Disclosures of Protected Health Information	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3003Δ: Verification of Identity for Disclosures of Protected Health Information
Privacy	MA.9206: Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3007Δ: Member Right to Request Restrictions on Use and Disclosure of Protected Health Information
Privacy	MA.9207: Member Request to Amend Record	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3004Δ: Member Request to Amend Records

Department	Policy	Summary of Change(s)	Reason for Change(s)
Privacy	MA.9209: Member Request for Accounting of Disclosures	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3005Δ: Member Request for Accounting of Disclosures
Privacy	MA.9210: Tracking and Reporting Disclosures of Protected Health Information	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information
Privacy	MA.9211: Member Right to Request Confidential Communications	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3008Δ: Member Right to Request Confidential Communications
Privacy	MA.9212: Access by Member's Authorized Representative	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3009Δ: Access by Member's Authorized Representative
Privacy	MA.9213: Protected Health Information Disclosures Required by Law	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3010Δ: Protected Health Information Disclosures Required by Law
Privacy	MA.9214: Use and Disclosure for Treatment, Payment, and Health Care Operations	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3011Δ: Use and Disclosure for Treatment, Payment Health Care Operations, and Research
Privacy	MA.9215: Use or Disclosure of Protected Health Information (PHI) for Research	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3011Δ: Use and Disclosure for Treatment, Payment Health Care Operations, and Research

Department	Policy	Summary of Change(s)	Reason for Change(s)
Privacy	MA.9217: Mitigation	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI
Privacy	MA.9218: Use of Electronic Mail with Protected Health Information	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3014Δ: Use of Electronic Mail with Protected Health Information
Privacy	MA.9219: Authorization for Release of Protected Health Information	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3015Δ: Authorization for Release of Protected Health Information
Privacy	MA.9220: Guidelines for Handling Protected Health Information Offsite	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3016Δ: Guidelines for Handling Protected Health Information Offsite
Privacy	MA.9221: De-identification of Protected Health Information	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3019 Δ: De-identification of Protected Health Information
Privacy	MA.9222: Reporting an Unauthorized Use or Disclosure of Protected Health Information (PHI), or Breach of Data, Security, or Intrusion	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3020Δ: Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information

Department	Policy	Summary of Change(s)	Reason for Change(s)
Privacy	MA.9224: Disclosure of Information to Family Members or Friends Involved in Member Care	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3015Δ: Disclosure of Information to Family Members or Friends Involved in Member Care
Regulatory Affairs & Compliance	MA.9101: Compliance Program	▪ Requesting retirement of this policy.	Policy was incorporated within HH.2014Δ: Compliance Program
Regulatory Affairs & Compliance	MA.9104: Corrective Action Plan	▪ Requesting retirement of this policy.	Policy was incorporated within HH.2005Δ: Corrective Action Plan
Regulatory Affairs & Compliance	MA.9105: Sanctions	▪ Requesting retirement of this policy.	Policy was incorporated within HH.2002Δ: Sanctions
Regulatory Affairs & Compliance	MA.9106: Record Retention and Access	▪ Requesting retirement of this policy.	Policy was incorporated within HH.2022Δ: Record Retention and Access
Regulatory Affairs & Compliance	MA.9113: Compliance and Ethics Hotline	▪ Requesting retirement of this policy.	Policy was incorporated within HH.2018Δ: Compliance and Ethics Hotline
Regulatory Affairs & Compliance	MA.9114: Reporting Suspected Misconduct or Violation	▪ Requesting retirement of this policy.	Policy was incorporated within HH.2019Δ: Reporting Suspected Misconduct or Violation
Regulatory Affairs & Compliance	MA.9116: Annual Compliance Program Effectiveness Audit	▪ Requesting retirement of this policy.	Policy was incorporated within HH.2029Δ: Annual Compliance Program Effectiveness Audit
Regulatory Affairs & Compliance	MA.9119: Compliance Training	▪ Requesting retirement of this policy.	Policy was incorporated within HH.2023Δ: Compliance Training

Department	Policy	Summary of Change(s)	Reason for Change(s)
Regulatory Affairs & Compliance	MA.9120: Code of Conduct	▪ Requesting retirement of this policy.	Policy was incorporated within HH.2028Δ: Code of Conduct
Regulatory Affairs & Compliance	MA.9121: Exclusion Monitoring	▪ Requesting retirement of this policy.	Policy was incorporated within HH.2021Δ: Exclusion Monitoring
Regulatory Affairs & Compliance	MA.9123: Compliance Committee	▪ Requesting retirement of this policy.	Policy was incorporated within HH.2007Δ: Compliance Committee
Regulatory Affairs & Compliance	MA.9125: Conducting Compliance Investigations	▪ Requesting retirement of this policy.	Policy was incorporated within HH.2020Δ: Conducting Compliance Investigations
Regulatory Affairs & Compliance	MA.9223: Non-Retaliation for Reporting Violations	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3012Δ: Non-Retaliation for Reporting Violations

Policy #:	HH.2025
Title:	**Health Network Sub-delegation and Sub-contracting**
Department:	Office of Compliance
Section:	Audit & Oversight
CEO Approval:	Michael Schrader
Effective Date:	09/01/15
Last Review Date:	~~N/A~~~~DATE~~12/01/16
Last Revision Date:	~~N/A~~~~DATE~~12/01/16

Applicable to:

- Medi-Cal
- OneCare
- OneCare Connect
-

I. PURPOSE

This policy~~e~~ details the requirements and processes required for Health Network Sub-delegation and S~~s~~ub-contracting.

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~
~~Health Network~~	~~A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.~~
~~Centers for Medicare & Medicaid Services (CMS)~~	~~The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.~~
~~Corrective Action Plan (CAP)~~	~~First Tier, Downstream or Related Entity (A plan delineating specific and identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the State, or designated representatives. Health Networks and Providers may be required to complete CAPs to ensure that they are in compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements identified by CalOptima and its regulators.~~
~~Department of Health Care Services (DHCS)~~	~~The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California). DHCS is generally referred to as the state in this document.~~
~~Department of Managed Health Care (DMHC)~~	~~The state department charged with overseeing health care service plans licensed under the Knox-Keene Health Care Act of 1975.~~

~~Term~~	~~Definition~~
~~The contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").National Committee of Quality Assurance (NCQA)~~	~~An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.~~
~~Sub-delegation~~	~~The process by which a Health Network expressly grants, by a formal agreement, to a sub-delegated entity the authority to carry out a function that would otherwise be required to be performed by the Health Network in order to meet its obligations under the Health Network Service Agreement.~~
~~Sub-contracting~~	~~A written agreement entered into by the Contractor with any of the following:~~ ~~a. A provider of health care services who agrees to furnish Covered Services to Members.~~ ~~b. Any other organization or person(s) who agree(s) to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor's obligations to DHCS.~~
~~Management Services Organization (MSO)~~	~~A healthcare entity providing management and administrative support service on behalf of the delegated medical group.~~

~~III.~~II. POLICY

A. Sub-delegation

1. Except as otherwise limited by the CalOptima Health Network Service Agreement or CalOptima policies, a Health Network may delegate required administrative functions to a Management Services Organization (MSO), medical group, or Independent Practice Association (IPA).

2. Sub-delegation shall not absolve a Health Network of oversight responsibilities or ultimate obligation and responsibilities set forth in the CalOptima Health Network Service Agreement.

   a. A Health Network may give a sub-delegated entity the authority to act on behalf of the Health Network, but the Health Network shall retain oversight and accountability for the delegated function.

   b. A Health Network shall not abdicate responsibility for the function performed by a sub-delegated entity according to the requirements of the CalOptima Health Network Service Agreement and those established by CalOptima policies.

3. A Health Network shall obtain CalOptima's written approval for Sub-delegation in accordance with the terms and conditions of this policy.

4. A Health Network shall provide CalOptima with written evidence of Sub-delegation including:

   a. A copy of the written agreement that meets all requirements of the CalOptima Health Network Service Agreement and CalOptima policies and includes the following:

      i. The sub-delegated entity shall comply with all applicable regulatory ~~-~~standards, Centers for Medicare & Medicaid Services (CMS) instructions, Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and the National Committee of Quality Assurance (NCQA) instructions;

      ii. The sub-delegated entity shall comply with all state and federal confidentiality requirements;

      iii. The sub-delegated entity shall grant the Department of Health and Human Services (DHHS), CMS, DHCS, the Comptroller General, Office of Inspector General, or their designees the right to inspect all pertinent information related to the contract during the contract term and for ten (10) years from the final date of the contract period, and in certain instances described in the regulation, periods in excess of ten (10) years;

      iv. The Health Network shall have the right to revoke the delegation if the sub-delegated entity fails to perform in a satisfactory manner; and

      v. The sub-delegated entity shall meet all applicable credentialing requirements.

   b. A description of the relationship between the Health Network and the sub-delegated entity including the following information:

      i. The delegated functions;

      ii. The responsibilities of the Health Network and the sub-delegated entity;

      iii. The frequency of reporting and reviewing ~~-~~the sub-delegated entity's performance of the delegated functions;

      iv. The process by which the Health Network evaluates the sub-delegated entity's performance; and

      v. The Health Network's remedies if the sub-delegated entity fails to fulfill its obligations including revocation of the delegation.

   c. A description of the Health Network's process by which it evaluated and selected the sub-delegated entity to perform the delegated functions, including the sub-delegated entity's score on a selection tool, if any; and

   d. A record of the Health Network's ongoing oversight process, as requested by CalOptima including:

i. The Health Network's annual evaluation of whether the sub-delegated entity is performing the delegated functions in accordance with the CalOptima Health Network Service Agreement ~~and~~, ~~Centers for Medicare & Medicaid Services~~CMS ~~(CMS)~~ instructions, ~~Department of Health Care Services (~~DHCS~~)~~, ~~Department of Managed Health Care (~~DMHC~~)~~, and the ~~National Committee of Quality Assurance (~~NCQA~~)~~ standards;

ii. The Health Network's review of the sub-delegated entity's regular reports; and

iii. Reports and data required to be submitted to CalOptima.

5. A Health Network shall terminate, as soon as practical ~~practicable practical~~ to meet the health care needs of Members upon receiving written notification from CalOptima, any delegation that fails to meet standards established by CalOptima or any requirement in the CalOptima Health Network Delegation ~~Service~~ Agreement or CalOptima ~~policy~~ Policy GG.1619Δ: Delegation Oversight.

6. A Health Network shall report to CalOptima in accordance with all requirements established in the CalOptima Health Network ~~Service Delegation Service~~Delegation Agreement and in CalOptima policies, data and information that includes and encompasses all of the Health Network's membership, including those receiving services from a sub-delegated entity.

7. A Health Network shall audit a sub-delegated entity not less than once in any twelve (12) - month period.

8. A Health Network shall establish standards and performance requirements for the delegated function and requirements for a sub-delegated entity to meet or exceed all requirements of the Health Network in the CalOptima Health Network Service Agreement and in CalOptima policy GG.1619Δ: Delegation Oversight.

9. If a sub-delegated entity fails to meet performance requirements, the Health Network shall place the sub-delegated entity on a Corrective Action Plan (CAP). The CAP shall meet the requirement of CalOptima ~~policy~~ Policy ~~MA.9104 and~~ HH.2005Δ: Corrective Action Plan and detail:

a. The sub-delegated entity's deficiencies;

b. Specific steps, tasks, and activities to bring the sub-delegated entity into compliance; and

c. A timeline for completion of corrective action and to achieve compliance with performance requirements.

10. A Health Network shall notify CalOptima of any sub-delegated entity providing services to Members that is on a CAP. The Health Network shall provide CalOptima with a copy of the CAP upon request.

B. Sub-contracting

1. A Health Network may subcontract for certain functions covered by the CalOptima Health Network Service Agreement, in accordance with CalOptima policies.

2. A Health Network shall ensure that a subcontract is in writing and includes all provisions required by the CalOptima Health Network ~~Service Delegation~~ Service Agreement.

3. A Health Network shall inform CalOptima of a subcontractor's name and business address within thirty (30) ~~(thirty)~~ calendar days of execution of subcontract.~~.~~

4. A Health Network shall include the following in a subcontract that relates to the provision of Covered Services:

   a. The subcontractor shall make all books and records relative to the provision of and reimbursement for items and services furnished by the subcontractor to the Health Network available at all reasonable times for inspection, examination, or copying by CalOptima or duly authorized representatives of the state or federal government;

   b. The subcontractor shall maintain such books and records:

      i. In accordance with the general standards applicable to such books and records and any record requirements in the CalOptima Health Network Service Agreement and CalOptima ~~policy~~ Policy ~~MA. 9106 and~~ HH.2022Δ: Record Retention and Access; and

      ii. At the subcontractor's place of business or at such other mutually agreeable location in California.

   c. The subcontractor shall establish and maintain access to Medical and Administrative Records as set forth in the CalOptima Health Network Service Agreement and in CalOptima ~~policy~~ Policy ~~MA. 9106 and~~ HH.2022Δ: Record Retention and Access;

   d. The subcontractor shall ensure access to premises as set forth in the CalOptima Health Network Service Agreement and in CalOptima ~~policy~~ Policy ~~MA. 9106 and~~ HH.2022Δ: Record Retention and Access;

   e. The subcontractor shall provide Covered Services to Members in the same manner that it provides such services to other patients;

   f. The subcontractor shall notify the Health Network of any investigation of a sub-contractor's professional conduct or any suspension of, or comment on, a subcontractor's professional licensure, whether temporary or permanent;

   g. The subcontractor shall comply with the Compliance Program as described in CalOptima ~~policy~~ Policy ~~MA. 9101 and~~ HH.2014Δ: Compliance Program;

   h. The subcontractor shall comply with the CalOptima Approved Drug List, as set fort in the CalOptima Health Network Service Agreement and in CalOptima policies;

   i. The subcontractor shall comply with all applicable Medicare laws, regulations, and CMS, DHCS, NCQA, and DMHC instructions;

j. The subcontractor shall comply with all state and federal confidentiality requirements;

k. The subcontractor shall meet all applicable credentialing requirements;

l. The subcontractor shall grant Department of Health and Human Services (DHHS), CMS, DHCS, the Comptroller General, Office of Inspector General,~~DHHS, the Comptroller General~~, or their designees the right to inspect all pertinent information related to the contract during the contract term and for ten (10) years from the final date of the contract period, and in certain instances described in the regulation, periods in excess of ten (10) years; and

m. The Health Network shall have the right to revoke the subcontract if the subcontractor fails to perform in a satisfactory manner.

~~IV.~~III. PROCEDURE

A. A Health Network shall notify Audit ~~and~~ & Oversight Department of any Sub-delegation or S~~s~~ub-contracted relationships in writing.

B. The Audit ~~and~~ & Oversight and~~,~~ ~~and~~ Regulatory Affairs & Compliance ~~, and~~ Department~~s~~'s~~s~~ staff shall review requests for approval of delegation submitted by a Health Network.

C. CalOptima's review may include:

1. Site visits with the prospective sub-delegated entity;

2. Audits;

3. Interviews of the prospective sub-delegated entity staff;

4. Assessment of the prospective sub-delegated entity obtained from other clients or patients of the prospective sub-delegated entity;

5. Demonstration of capabilities by the prospective sub-delegated entity;

6. Review of the prospective sub-delegated entity's financial reports, statements, and audits; and

7. Background investigations of the prospective sub-delegated entity and key staff of the prospective sub-delegated entity.

D. Upon completion of the initial review, CalOptima may approve Sub-delegation, deny Sub-delegation, or approve Sub-delegation with corrective action requirements.

1. CalOptima shall notify the Delegate of its determination in writing within thirty (30) days of the initial review).

2. If CalOptima approves Sub-delegation with corrective action requirements, CalOptima shall detail corrective action requirements in a corrective action plan provided to the Health Network and the sub-delegated entity.

   a. The Health Network and the sub-delegated entity shall comply with the corrective action requirements within the time frames specified in the CAP.

   b. The Health Network and the sub-delegated entity shall document meeting all requirements of any CAP to CalOptima.

   c. CalOptima may further review the sub-delegated entity to confirm that the sub-delegated entity met requirements of the CAP.

   d. CalOptima may require further corrective action or may approve or deny Sub-delegation upon review of actions taken by the sub-delegated entity to meet requirements of any CAP.

~~V.~~IV. ATTACHMENTS

Not Applicable

~~VI.~~V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Policy GG.1619Δ: Delegation Oversight
E. CalOptima Policy HH.2005Δ: Corrective Action Plan
F. CalOptima Policy HH.2014Δ: Compliance Program
G. CalOptima Policy HH.2022Δ: Record Retention and Access
~~A.~~H. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~CalOptima Contract with the Centers for Medicare & Medicaid Services for the One Care Program~~
~~B. Three-way Agreement with the Department of Health Care Services and Centers for Medicare & Medicaid Services for the OneCare Connect Program~~
~~C. CalOptima Policy GG.1619: Delegation Oversight~~
~~D. CalOptima Policy MA.9104 and HH.2005Δ: Corrective Action Plan~~
~~E. CalOptima Policy MA.9101 and HH.2014Δ: Compliance Program~~
~~F. CalOptima Policy MA.9106 and HH.2022Δ: Record Retention and Access~~

~~VII.~~VI. REGULATORY AGENCY APPROVALS

None to Date

~~VIII.~~VII. BOARD ACTIONS

None to Date

~~IX.~~VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	08/01/2005	MA.5004	Health Network Sub-delegation and Sub-contracting	OneCare
Revised	09/01/2015	MA.5004	Health Network Sub-delegation and Sub-contracting	OneCare OneCare Connect
Effective	09/01/2015	HH.2025	Health Network Sub-delegation and Sub-contracting	Medi-Cal
Revised	12/01/2016	HH.2025	Health Network Sub-delegation and Sub-contracting	Medi-Cal OneCare OneCare Connect
Retired	12/01/2016	MA.5004	Health Network Sub-delegation and Sub-contracting	OneCare OneCare Connect

IX. DEFINITIONS

Term	Definition
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers that Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), or designated representatives. First Tier, Downstream or Related Entity (FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Department of Managed Health Care (DMHC)	The California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code, Sections 1340 *et seq*.
Health Network	The contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").
Management Services Organization (MSO)	A healthcare entity providing management and administrative support service on behalf of the delegated medical group.
National Committee of Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
Sub-delegation	The process by which First Tier Entity expressly grants, by formal agreement, to a Downstream Entity the authority to carry out one or more functions that would otherwise be required to be performed by the First Tier Entity in order to meet its obligations under the delegation agreement.
Sub-contracting	A written agreement entered into by the Contractor with any of the following: a. A provider of health care services who agrees to furnish Covered Services to Members. b. Any other organization or person(s) who agree(s) to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor's obligations to DHCS.

Policy #:	HH.2025
Title:	**Health Network Sub-delegation and Sub-contracting**
Department:	Office of Compliance
Section:	Audit & Oversight
CEO Approval:	Michael Schrader
Effective Date:	09/01/15
Last Review Date:	12/01/16
Last Revision Date:	12/01/16

Applicable to:

- Medi-Cal
- OneCare
- OneCare Connect

I. PURPOSE

This policy details the requirements and processes required for Health Network Sub-delegation and Sub-contracting.

II. POLICY

A. Sub-delegation

1. Except as otherwise limited by the CalOptima Health Network Service Agreement or CalOptima policies, a Health Network may delegate required administrative functions to a Management Services Organization (MSO), medical group, or Independent Practice Association (IPA).

2. Sub-delegation shall not absolve a Health Network of oversight responsibilities or ultimate obligation and responsibilities set forth in the CalOptima Health Network Service Agreement.

   a. A Health Network may give a sub-delegated entity the authority to act on behalf of the Health Network, but the Health Network shall retain oversight and accountability for the delegated function.

   b. A Health Network shall not abdicate responsibility for the function performed by a sub-delegated entity according to the requirements of the CalOptima Health Network Service Agreement and those established by CalOptima policies.

3. A Health Network shall obtain CalOptima's written approval for Sub-delegation in accordance with the terms and conditions of this policy.

4. A Health Network shall provide CalOptima with written evidence of Sub-delegation including:

   a. A copy of the written agreement that meets all requirements of the CalOptima Health Network Service Agreement and CalOptima policies and includes the following:

      i. The sub-delegated entity shall comply with all applicable regulatory standards, Centers for Medicare & Medicaid Services (CMS) instructions, Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and the National Committee of Quality Assurance (NCQA) instructions;

ii. The sub-delegated entity shall comply with all state and federal confidentiality requirements;

iii. The sub-delegated entity shall grant the Department of Health and Human Services (DHHS), CMS, DHCS, the Comptroller General, Office of Inspector General, or their designees the right to inspect all pertinent information related to the contract during the contract term and for ten (10) years from the final date of the contract period, and in certain instances described in the regulation, periods in excess of ten (10) years;

iv. The Health Network shall have the right to revoke the delegation if the sub-delegated entity fails to perform in a satisfactory manner; and

v. The sub-delegated entity shall meet all applicable credentialing requirements.

b. A description of the relationship between the Health Network and the sub-delegated entity including the following information:

i. The delegated functions;

ii. The responsibilities of the Health Network and the sub-delegated entity;

iii. The frequency of reporting and reviewing the sub-delegated entity's performance of the delegated functions;

iv. The process by which the Health Network evaluates the sub-delegated entity's performance; and

v. The Health Network's remedies if the sub-delegated entity fails to fulfill its obligations including revocation of the delegation.

c. A description of the Health Network's process by which it evaluated and selected the sub-delegated entity to perform the delegated functions, including the sub-delegated entity's score on a selection tool, if any; and

d. A record of the Health Network's ongoing oversight process, as requested by CalOptima including:

i. The Health Network's annual evaluation of whether the sub-delegated entity is performing the delegated functions in accordance with the CalOptima Health Network Service Agreement, CMS instructions, DHCS, DMHC, and the NCQA standards;

ii. The Health Network's review of the sub-delegated entity's regular reports; and

iii. Reports and data required to be submitted to CalOptima.

5. A Health Network shall terminate, as soon as practical to meet the health care needs of Members upon receiving written notification from CalOptima, any delegation that fails to meet standards established by CalOptima or any requirement in the CalOptima Health Network Delegation Agreement or CalOptima Policy GG.1619Δ: Delegation Oversight.

6. A Health Network shall report to CalOptima in accordance with all requirements established in the CalOptima Health Network Delegation Agreement and in CalOptima policies, data and information that includes and encompasses all of the Health Network's membership, including those receiving services from a sub-delegated entity.

7. A Health Network shall audit a sub-delegated entity not less than once in any twelve (12) - month period.

8. A Health Network shall establish standards and performance requirements for the delegated function and requirements for a sub-delegated entity to meet or exceed all requirements of the Health Network in the CalOptima Health Network Service Agreement and in CalOptima policy GG.1619Δ: Delegation Oversight.

9. If a sub-delegated entity fails to meet performance requirements, the Health Network shall place the sub-delegated entity on a Corrective Action Plan (CAP). The CAP shall meet the requirement of CalOptima Policy HH.2005Δ: Corrective Action Plan and detail:

    a. The sub-delegated entity's deficiencies;

    b. Specific steps, tasks, and activities to bring the sub-delegated entity into compliance; and

    c. A timeline for completion of corrective action and to achieve compliance with performance requirements.

10. A Health Network shall notify CalOptima of any sub-delegated entity providing services to Members that is on a CAP. The Health Network shall provide CalOptima with a copy of the CAP upon request.

B. Sub-contracting

1. A Health Network may subcontract for certain functions covered by the CalOptima Health Network Service Agreement, in accordance with CalOptima policies.

2. A Health Network shall ensure that a subcontract is in writing and includes all provisions required by the CalOptima Health Network Service Agreement.

3. A Health Network shall inform CalOptima of a subcontractor's name and business address within thirty (30) calendar days of execution of subcontract.

4. A Health Network shall include the following in a subcontract that relates to the provision of Covered Services:

    a. The subcontractor shall make all books and records relative to the provision of and reimbursement for items and services furnished by the subcontractor to the Health Network available at all reasonable times for inspection, examination, or copying by CalOptima or duly authorized representatives of the state or federal government;

    b. The subcontractor shall maintain such books and records:

i. In accordance with the general standards applicable to such books and records and any record requirements in the CalOptima Health Network Service Agreement and CalOptima Policy HH.2022Δ: Record Retention and Access; and

ii. At the subcontractor's place of business or at such other mutually agreeable location in California.

c. The subcontractor shall establish and maintain access to Medical and Administrative Records as set forth in the CalOptima Health Network Service Agreement and in CalOptima Policy HH.2022Δ: Record Retention and Access;

d. The subcontractor shall ensure access to premises as set forth in the CalOptima Health Network Service Agreement and in CalOptima Policy HH.2022Δ: Record Retention and Access;

e. The subcontractor shall provide Covered Services to Members in the same manner that it provides such services to other patients;

f. The subcontractor shall notify the Health Network of any investigation of a sub-contractor's professional conduct or any suspension of, or comment on, a subcontractor's professional licensure, whether temporary or permanent;

g. The subcontractor shall comply with the Compliance Program as described in CalOptima Policy HH.2014Δ: Compliance Program;

h. The subcontractor shall comply with the CalOptima Approved Drug List, as set fort in the CalOptima Health Network Service Agreement and in CalOptima policies;

i. The subcontractor shall comply with all applicable Medicare laws, regulations, and CMS, DHCS, NCQA, and DMHC instructions;

j. The subcontractor shall comply with all state and federal confidentiality requirements;

k. The subcontractor shall meet all applicable credentialing requirements;

l. The subcontractor shall grant Department of Health and Human Services (DHHS), CMS, DHCS, the Comptroller General, Office of Inspector General,, or their designees the right to inspect all pertinent information related to the contract during the contract term and for ten (10) years from the final date of the contract period, and in certain instances described in the regulation, periods in excess of ten (10) years; and

m. The Health Network shall have the right to revoke the subcontract if the subcontractor fails to perform in a satisfactory manner.

III. PROCEDURE

A. A Health Network shall notify Audit & Oversight Department of any Sub-delegation or Sub-contracted relationships in writing.

B. The Audit & Oversight and Regulatory Affairs & Compliance Departments' staff shall review requests for approval of delegation submitted by a Health Network.

C. CalOptima's review may include:

1. Site visits with the prospective sub-delegated entity;

2. Audits;

3. Interviews of the prospective sub-delegated entity staff;

4. Assessment of the prospective sub-delegated entity obtained from other clients or patients of the prospective sub-delegated entity;

5. Demonstration of capabilities by the prospective sub-delegated entity;

6. Review of the prospective sub-delegated entity's financial reports, statements, and audits; and

7. Background investigations of the prospective sub-delegated entity and key staff of the prospective sub-delegated entity.

D. Upon completion of the initial review, CalOptima may approve Sub-delegation, deny Sub-delegation, or approve Sub-delegation with corrective action requirements.

1. CalOptima shall notify the Delegate of its determination in writing within thirty (30) days of the initial review).

2. If CalOptima approves Sub-delegation with corrective action requirements, CalOptima shall detail corrective action requirements in a corrective action plan provided to the Health Network and the sub-delegated entity.

a. The Health Network and the sub-delegated entity shall comply with the corrective action requirements within the time frames specified in the CAP.

b. The Health Network and the sub-delegated entity shall document meeting all requirements of any CAP to CalOptima.

c. CalOptima may further review the sub-delegated entity to confirm that the sub-delegated entity met requirements of the CAP.

d. CalOptima may require further corrective action or may approve or deny Sub-delegation upon review of actions taken by the sub-delegated entity to meet requirements of any CAP.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Compliance Plan

B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Policy GG.1619Δ: Delegation Oversight
E. CalOptima Policy HH.2005Δ: Corrective Action Plan
F. CalOptima Policy HH.2014Δ: Compliance Program
G. CalOptima Policy HH.2022Δ: Record Retention and Access
H. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	08/01/2005	MA.5004	Health Network Sub-delegation and Sub-contracting	OneCare
Revised	09/01/2015	MA.5004	Health Network Sub-delegation and Sub-contracting	OneCare OneCare Connect
Effective	09/01/2015	HH.2025	Health Network Sub-delegation and Sub-contracting	Medi-Cal
Revised	12/01/2016	HH.2025	Health Network Sub-delegation and Sub-contracting	Medi-Cal OneCare OneCare Connect
Retired	12/01/2016	MA.5004	Health Network Sub-delegation and Sub-contracting	OneCare OneCare Connect

IX. DEFINITIONS

Term	Definition
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers that Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), or designated representatives. First Tier, Downstream or Related Entity (FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Department of Managed Health Care (DMHC)	The California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code, Sections 1340 *et seq*.
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National Committee of Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
Sub-delegation	The process by which First Tier Entity expressly grants, by formal agreement, to a Downstream Entity the authority to carry out one or more functions that would otherwise be required to be performed by the First Tier Entity in order to meet its obligations under the delegation agreement.
Sub-contracting	A written agreement entered into by the Contractor with any of the following: a. A provider of health care services who agrees to furnish Covered Services to Members. b. Any other organization or person(s) who agree(s) to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor's obligations to DHCS.

Policy #:	HH.2026
Title:	**Claims Delegation and Oversight**
Department:	Office of Compliance
Section:	Audit & Oversight (External)
CEO Approval:	Michael Schrader _____
Effective Date:	09/01/15
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy~~o~~ ensures a delegated Health Network is in compliance with statutory, regulatory, contractual, CalOptima policy, and other claims processing requirements.

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~
~~Corrective Action Plan (CAP)~~	~~A plan delineating specific and identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the State, or designated representatives. Health Networks and Providers may be required to complete CAPs to ensure that they are in compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements identified by CalOptima and its regulators.~~
~~Division of Financial Responsibility (DOFR)~~	~~A matrix that identifies how CalOptima identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.~~
~~Health Network~~	~~The contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.~~
~~Member~~	~~A beneficiary who is enrolled in a CalOptima Program.A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.~~
~~Provider~~	~~A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.~~
~~Readiness Assessment~~	~~An assessment conducted by a Review Team prior to the effective date of a Health Network's or other contracted entity's Contract with CalOptima of a the Health Network's or contracted entity's compliance with all or a specified~~

~~Term~~	~~Definition~~
	~~number of operational functional areas as determined by CalOptima.~~
~~Sanction~~	~~An action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.Action taken by CalOptima including, without limitations, restrictions, monetary fines, termination or a combination thereof, based on a Health Network's or its delegate's, subcontractor's, or any Health Network partner's failure to comply with statutory, regulatory, contractual, CalOptima policy, or other requirements related to the CalOptima Medi-Cal program.~~

~~III.~~II. POLICY

A. CalOptima may delegate the processing and adjudication of claims to a Health Network for services rendered to Members, in accordance with the CalOptima Division of Financial Responsibility (DOFR), as set forth in the CalOptima Health Network Service Agreement.

B. CalOptima shall maintain ultimate responsibility for all delegated claims activities.

C. CalOptima shall conduct ongoing monitoring of a delegated Health Network, including an annual performance review, to ensure that the delegated Health Network adheres to claims processing standards, as set forth in CalOptima Policy HH.2015: Health Network Claims Processing.

D. Prior to delegating activities, ~~T~~the Audit and Oversight Department shall conduct a pre-delegation assessment of a Health Network to determine the Health Network's ability to implement delegated claims activities, ~~prior to delegating such activities~~including ~~S~~subcontracting or ~~S~~sub-delegation of activities as outlined in CalOptima Policy GG.1619Δ: Delegation Oversight.

E. CalOptima may impose Sanctions against a delegated Health Network based on such Health Network's or its agent's failure to comply with any statutory, regulatory, contractual, CalOptima policy and other requirements related to CalOptima, in accordance with ~~-~~CalOptima Policy HH.2002Δ: Sanctions.

~~IV.~~III. PROCEDURE

A. Pre-delegation Readiness Assessment

1. The pre-delegation readiness assessment shall consist of a comprehensive on-site assessment utilizing the Readiness Assessment Tool, and shall evaluate the Health Network's capacity to successfully administer all delegated functions, including, but not limited to, the Health Network's ability to:

   a. Process claims and all claims related functions in a timely manner; and

   b. Make claims determinations in accordance with applicable statutory, regulatory and contractual requirements.

2. The Auditor shall report the pre-delegation assessment results to the ~~Delegation~~ Audit & Oversight Committee (AOC).

3. The ~~Delegation~~ Audit ~~and~~& Oversight Committee shall determine if the Health Network meets CalOptima's criteria for delegation of claims activities, based on the Health Network's pre-delegation assessment.

B. Monitoring

1. The Audit ~~and~~ & Oversight Department shall monitor a delegated Health Network's claims activities through routine audits, reports and continuous improvement~~s~~ activities.

2. A Health Network shall submit reports to CalOptima on a periodic basis, as specified by CalOptima, including, but not limited to, those reports specified in the CalOptima Health Network Service Agreement and CalOptima policies.

3. A Health Network shall forward copies of ~~all~~selected Claims ~~Member~~ notice~~s of denial of payment letters~~ to CalOptima for review. CalOptima's Office of Compliance shall review the notice of denial of payment letters for appropriate denial language.

C. Performance Reviews

1. CalOptima shall conduct annual performance reviews of a delegated Health Network, in accordance with CalOptima Policy GG.1619Δ~~A~~: Delegation Oversight~~HH.2004: Health Network Performance Review~~.

2. The delegated Health Network shall:

a. Cooperate in furnishing information in response to performance reviews, the Corrective Action Plan (CAP) process, and validation reviews; and

b. Make staff available during the performance review to answer questions and provide information necessary to complete the review.

3. The Audit ~~and~~ & Oversight Department~~Office of Compliance~~ shall provide a Health Network with the performance review report after completing a performance review.

4. CalOptima may take the following actions, based on a performance review:

a. Require a Health Network to submit a CAP addressing all areas of deficiency, as determined by CalOptima, in accordance with Section III~~V~~.D. of this policy;

b. Audit a Health Network's implementation and completion of an approved CAP, and any performance area that CalOptima required the Health Network to address in the CAP;

c. Impose Sanctions against a Health Network, in accordance with CalOptima Policy HH.2002Δ: Sanctions; and

d. Initiate the de-delegation process, in accordance with Section III~~V~~.E. of this policy.

5. The Audit ~~and~~& Oversight Department ~~Office of Compliance~~ shall report its findings from performance reviews and CAPs to the C Audit ~~and~~& Oversight ~~ompliance~~ Committee, with recommendations for follow-up activities.

D. Corrective Action Plan

1. CalOptima may require a delegated Health Network to develop and submit a CAP for any area of deficiency or non-compliance related to delegated claims activities, in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

E. De-delegation

1. The Audit ~~and~~& Oversight Department ~~Office of Compliance~~ shall report all CAP activities to the Audit ~~and~~& Oversight Committee and Compliance Committee.

2. The Audit and Oversight ~~Compliance~~ Committee shall review a delegated Health Network's delegation status based on the CAP timeline and level of achievement and recommendations from the Quality Improvement Department.

3. If a delegated Health Network fails to achieve compliance within the timeframes set forth in the CAP, the Audit ~~and~~& Oversight Committee~~Office of Compliance~~ may recommend de-delegation of claims activities to the Compliance Committee.

4. The Compliance Committee may approve complete, or partial, de-delegation of claims activities from a delegated Health Network.

5. If the Compliance Committee approves de-delegation of claims activities from a Health Network, CalOptima shall:

   a. Provide the Health Network with thirty (30) calendar day written notice of CalOptima's intent to de-delegate.

   b. Inform Members and Providers of the de-delegation and instructions for continued services;

   c. Adjust the Health Network's payments as appropriate to the de-delegated claims activities; and

   d. Prepare appropriate CalOptima departments to provide the de-delegated claims activities.

6. The Health Network shall cooperate with CalOptima to ensure smooth transition and continuous care for Members during the transition period.

7. CalOptima shall re-evaluate a Health Network's ability to perform delegated claims activities not less than twelve (12) months after de-delegation.

   a. CalOptima shall utilize the pre-delegation assessment process, as described in Section III~~V~~.A. of this policy.

   b. CalOptima shall delegate claims activities to the Health Network based on the pre-delegation assessment results.

   c. If the Compliance Committee approves delegation of claims activities to the Health Network, CalOptima shall re-delegate such activities, and adjust the Health Network's payment accordingly.

d. If the Compliance Committee denies re-delegation of claims activities to the Health Network, it may recommend additional Sanctions on the Health Network, up to and including termination of the CalOptima Health Network Service Agreement.

F. A delegated Health Network shall establish and maintain a Provider Appeal and dispute process.

G. A Health Network may file a Grievance with CalOptima, in accordance with CalOptima ~~Policy~~ Policies HH.1101: CalOptima Provider Complaint ~~Process~~ and MA.9006: Provider Complaint Process.

~~V.~~IV. ATTACHMENTS

Not Applicable

~~VI.~~V. REFERENCES

A. CalOptima ~~-~~Health Network Service Agreement
B. OneCare Physician Medical Group Service Agreement
~~A.~~C. OneCare Connect Health Network Service Agreement
D. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
E. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
F. CalOptima PACE Program Agreement
G. CalOptima ~~-~~Policy AA.1000: Glossary of Terms
~~B.~~H. CalOptima Policy GG.1619~~A~~: Delegation Oversight
~~C.~~I. CalOptima ~~-~~Policy HH.1101: CalOptima Provider Complaint ~~Process~~
~~D.~~J. CalOptima ~~-~~Policy HH.2002 Δ: Sanctions
~~E. CalOptima Policy HH.2004: Physician Medical Group Performance Review~~
~~F.~~K. CalOptima ~~-~~Policy HH.2005 Δ: Corrective Action Plan
L. CalOptima Policy~~:~~ HH.2015: Health Network Claims Processing
M. CalOptima Policy MA.1001: Glossary of Terms
N. CalOptima Policy MA.3101: Claims Processing
O. CalOptima Policy MA.9103: Physician Medical Group Performance Review
P. CalOptima Policy MA.9006: Provider Complaint Process
~~G.~~Q. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect

~~VII.~~VI. REGULATORY AGENCY APPROVALS

None to Date

~~VIII.~~VII. BOARD ACTION~~S~~s

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	08/01/2005	MA.3102	Claims Delegation and Oversight	OneCare
Revised	07/01/2007	MA.3102	Claims Delegation and Oversight	OneCare
Revised	10/01/2012	MA.9112	Claims Delegation and Oversight	OneCare
Revised	09/01/2015	MA.9112	Claims Delegation and Oversight	OneCare OneCare Connect PACE
Effective	09/01/2015	HH.2026	Claims Delegation and Oversight	Medi-Cal
Revised	12/01/2016	HH.2026	Claims Delegation and Oversight	Medi-Cal OneCare OneCare Connect
Retired	12/01/2016	MA.9112	Claims Delegation and Oversight	OneCare OneCare Connect PACE

~~**IX.**~~

~~Version~~	~~Version Date~~	~~Policy Number~~	~~Policy Title~~
~~Original Date~~Effective	~~09/01/2015~~	~~HH.2026~~	~~Claims Delegation and Oversight~~
~~Revised~~	~~DATE12/01/2016~~	~~HH.2026~~	~~Claims Delegation and Oversight~~

IX. GLOSSARY

Term	Definition
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.~~A plan delineating specific and identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the State, or designated representatives. Health Networks and Providers may be required to complete CAPs to ensure that they are in compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements identified by CalOptima and its regulators.~~
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.
Health Network	For the purposes of this policy, t~~T~~he contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").
Member	A beneficiary who is enrolled in a CalOptima Program.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Readiness Assessment	An assessment conducted by a Review Team prior to the effective date of a Health Network's or other contracted entity's Contract with CalOptima of a the Health Network's or contracted entity's compliance with all or a specified number of operational functional areas as determined by CalOptima.
Sanction	An action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.

Policy #:	HH.2026
Title:	**Claims Delegation and Oversight**
Department:	Office of Compliance
Section:	Audit & Oversight (External)
CEO Approval:	Michael Schrader _____
Effective Date:	09/01/15
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy ensures a delegated Health Network is in compliance with statutory, regulatory, contractual, CalOptima policy, and other claims processing requirements.

II. POLICY

A. CalOptima may delegate the processing and adjudication of claims to a Health Network for services rendered to Members, in accordance with the CalOptima Division of Financial Responsibility (DOFR), as set forth in the CalOptima Health Network Service Agreement.

B. CalOptima shall maintain ultimate responsibility for all delegated claims activities.

C. CalOptima shall conduct ongoing monitoring of a delegated Health Network, including an annual performance review, to ensure that the delegated Health Network adheres to claims processing standards, as set forth in CalOptima Policy HH.2015: Health Network Claims Processing.

D. Prior to delegating activities, the Audit and Oversight Department shall conduct a pre-delegation assessment of a Health Network to determine the Health Network's ability to implement delegated claims activities, including subcontracting or sub-delegation of activities as outlined in CalOptima Policy GG.1619Δ: Delegation Oversight.

E. CalOptima may impose Sanctions against a delegated Health Network based on such Health Network's or its agent's failure to comply with any statutory, regulatory, contractual, CalOptima policy and other requirements related to CalOptima, in accordance with CalOptima Policy HH.2002Δ: Sanctions.

III. PROCEDURE

A. Pre-delegation Readiness Assessment

1. The pre-delegation readiness assessment shall consist of a comprehensive on-site assessment utilizing the Readiness Assessment Tool, and shall evaluate the Health Network's capacity to successfully administer all delegated functions, including, but not limited to, the Health Network's ability to:

    a. Process claims and all claims related functions in a timely manner; and

b. Make claims determinations in accordance with applicable statutory, regulatory and contractual requirements.

2. The Auditor shall report the pre-delegation assessment results to the Audit & Oversight Committee (AOC).

3. The Audit & Oversight Committee shall determine if the Health Network meets CalOptima's criteria for delegation of claims activities, based on the Health Network's pre-delegation assessment.

B. Monitoring

1. The Audit & Oversight Department shall monitor a delegated Health Network's claims activities through routine audits, reports and continuous improvement activities.

2. A Health Network shall submit reports to CalOptima on a periodic basis, as specified by CalOptima, including, but not limited to, those reports specified in the CalOptima Health Network Service Agreement and CalOptima policies.

3. A Health Network shall forward copies of selected Claims notices to CalOptima for review. CalOptima's Office of Compliance shall review the notice of denial of payment letters for appropriate denial language.

C. Performance Reviews

1. CalOptima shall conduct annual performance reviews of a delegated Health Network, in accordance with CalOptima Policy GG.1619Δ: Delegation Oversight.

2. The delegated Health Network shall:

a. Cooperate in furnishing information in response to performance reviews, the Corrective Action Plan (CAP) process, and validation reviews; and

b. Make staff available during the performance review to answer questions and provide information necessary to complete the review.

3. The Audit & Oversight Department shall provide a Health Network with the performance review report after completing a performance review.

4. CalOptima may take the following actions, based on a performance review:

a. Require a Health Network to submit a CAP addressing all areas of deficiency, as determined by CalOptima, in accordance with Section III.D. of this policy;

b. Audit a Health Network's implementation and completion of an approved CAP, and any performance area that CalOptima required the Health Network to address in the CAP;

c. Impose Sanctions against a Health Network, in accordance with CalOptima Policy HH.2002Δ: Sanctions; and

d. Initiate the de-delegation process, in accordance with Section III.E. of this policy.

5. The Audit & Oversight Department shall report its findings from performance reviews and CAPs to the C Audit & Oversight Committee, with recommendations for follow-up activities.

D. Corrective Action Plan

1. CalOptima may require a delegated Health Network to develop and submit a CAP for any area of deficiency or non-compliance related to delegated claims activities, in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

E. De-delegation

1. The Audit & Oversight Department shall report all CAP activities to the Audit & Oversight Committee and Compliance Committee.

2. The Audit and Oversight Committee shall review a delegated Health Network's delegation status based on the CAP timeline and level of achievement and recommendations from the Quality Improvement Department.

3. If a delegated Health Network fails to achieve compliance within the timeframes set forth in the CAP, the Audit & Oversight Committee may recommend de-delegation of claims activities to the Compliance Committee.

4. The Compliance Committee may approve complete, or partial, de-delegation of claims activities from a delegated Health Network.

5. If the Compliance Committee approves de-delegation of claims activities from a Health Network, CalOptima shall:

a. Provide the Health Network with thirty (30) calendar day written notice of CalOptima's intent to de-delegate.

b. Inform Members and Providers of the de-delegation and instructions for continued services;

c. Adjust the Health Network's payments as appropriate to the de-delegated claims activities; and

d. Prepare appropriate CalOptima departments to provide the de-delegated claims activities.

6. The Health Network shall cooperate with CalOptima to ensure smooth transition and continuous care for Members during the transition period.

7. CalOptima shall re-evaluate a Health Network's ability to perform delegated claims activities not less than twelve (12) months after de-delegation.

a. CalOptima shall utilize the pre-delegation assessment process, as described in Section III.A. of this policy.

b. CalOptima shall delegate claims activities to the Health Network based on the pre-delegation assessment results.

c. If the Compliance Committee approves delegation of claims activities to the Health Network, CalOptima shall re-delegate such activities, and adjust the Health Network's payment accordingly.

d. If the Compliance Committee denies re-delegation of claims activities to the Health Network, it may recommend additional Sanctions on the Health Network, up to and including termination of the CalOptima Health Network Service Agreement.

F. A delegated Health Network shall establish and maintain a Provider Appeal and dispute process.

G. A Health Network may file a Grievance with CalOptima, in accordance with CalOptima Policies HH.1101: CalOptima Provider Complaint and MA.9006: Provider Complaint Process.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Health Network Service Agreement
B. OneCare Physician Medical Group Service Agreement
C. OneCare Connect Health Network Service Agreement
D. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
E. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
F. CalOptima PACE Program Agreement
G. CalOptima Policy AA.1000: Glossary of Terms
H. CalOptima Policy GG.1619: Delegation Oversight
I. CalOptima Policy HH.1101: CalOptima Provider Complaint
J. CalOptima Policy HH.2002 Δ: Sanctions
K. CalOptima Policy HH.2005 Δ: Corrective Action Plan
L. CalOptima Policy HH.2015: Health Network Claims Processing
M. CalOptima Policy MA.1001: Glossary of Terms
N. CalOptima Policy MA.3101: Claims Processing
O. CalOptima Policy MA.9103: Physician Medical Group Performance Review
P. CalOptima Policy MA.9006: Provider Complaint Process
Q. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	08/01/2005	MA.3102	Claims Delegation and Oversight	OneCare
Revised	07/01/2007	MA.3102	Claims Delegation and Oversight	OneCare
Revised	10/01/2012	MA.9112	Claims Delegation and Oversight	OneCare
Revised	09/01/2015	MA.9112	Claims Delegation and Oversight	OneCare OneCare Connect PACE
Effective	09/01/2015	HH.2026	Claims Delegation and Oversight	Medi-Cal
Revised	12/01/2016	HH.2026	Claims Delegation and Oversight	Medi-Cal OneCare OneCare Connect
Retired	12/01/2016	MA.9112	Claims Delegation and Oversight	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.
Health Network	For the purposes of this policy, the contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").
Member	A beneficiary who is enrolled in a CalOptima Program.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Readiness Assessment	An assessment conducted by a Review Team prior to the effective date of a Health Network's or other contracted entity's Contract with CalOptima of a the Health Network's or contracted entity's compliance with all or a specified number of operational functional areas as determined by CalOptima.
Sanction	An action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.

Policy #:	HH.2027
Title:	**Annual Risk Assessment (Delegate)**
Department:	Office of Compliance
Section:	Audit and Oversight (External)
CEO Approval:	Michael Schrader _____
Effective Date:	09/01/15
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy describes the Annual Risk Assessment Plan process conducted by the CalOptima Audit & Oversight Department to identify specific areas vulnerable to Fraud, Waste, or Abuse and potential Compliance risk. Such areas are documented in CalOptima's Risk Plan risk assessment, which will influence the development of CalOptima's Internal Delegated First Tier Entities Audit and Monitoring Work Plan.

II. DEFINITIONS

Term	Definition
Abuse	A Provider practiceActions that is inconsistent with sound fiscal, business,may, directly or medical practice, and results in anindirectly, result in: unnecessary costcosts to a CalOptima programs, or in reimbursementprogram, improper payment, payment for services that are not Medically Necessary or that fail to meet professionally recognized standards for healthof care. It also includes Member practices that result in, or services that are medically unnecessary cost. Abuse involves payment for items or services when there is no legal entitlement to CalOptima programsthat payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Annual Risk Assessment Tool	A tool utilized to stratify (high, medium, low) audit results and corrective actions issued to identify specific CalOptima functional areas vulnerable to potential Compliance risk.
Centers for Medicare and % Medicaid Services (CMS)	The federal agency underwithin the United States Department of Health and Human Services responsible for administering(DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	The CalOptima committee that consists of executive officers, leadership of key operating divisions, and legal counsel that implements and oversees CalOptima's Compliance Program.That Ccommittee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of the Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief

	Medical Officer; Chief Operating Officer; Chief Financial Officer; Executive Director of Compliance Officer; and Executive Director of Human Resources.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal Program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Department of Managed Health Care (DMHC)	The State Agency California Department of Managed Health Care that responsible for licensing and regulatingoversees California's managed care system. DMHC regulates health care services plans/health maintenance organizations in accordance withlicensed under the Knox Keene Health Care Service Plan Act of 1975 and as subsequently amended, Health & Safety Code, Sections 1340 *et seq*.
Downstream Entity	Any party that enters into an acceptable a written arrangement acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and/or administrative services.
First Tier, Downstream, and Related Entities (FDR)	FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Medicare or Medicaid eligible individualMember under thea CalOptima program.
First Tier, Downstream, and Related Entities (FDR)Fraud	FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations. Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. Section 1347.)
FraudInternal Audit and Monitoring Work Plan	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i)An outline of goals and objectives to define the audit scope for internal functional areas to ensure health plan compliance, as well as conduct on-going performance measurements to determine opportunities for improvement and/or the effectiveness of interventions.
Member	A beneficiary who is enrolled in a CalOptima Program.An enrollee beneficiary of a CalOptima program.A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security

	~~Administration, who is enrolled in the CalOptima program.~~
~~Regulatory Agencies~~	~~For the purposes of this policy regulatory agencies include Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Health and Human Services Office of Inspector General (OIG) and Office of Civil Rights (OCR).~~
~~Related Entity~~	~~Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.Any entity that is related to CalOptima by common ownership or control and:~~ ~~1. Performs that: performs some of the management functions under contract or delegation;~~ ~~2. Furnishes furnishes services to Medicare or Medicaid enrollees under an oral or written agreement; or~~ ~~3. Leases leases real property or sells materials to CalOptima at a cost of more than two thousand five hundred dollars ($$2,500) during a contract period.~~
~~Waste~~	~~The Ooverutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima ProgramsProgram. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.~~

II. POLICY

~~The Office of Compliance~~

A. The Audit ~~and~~& Oversight Department is responsible for completing a Program Risk Assessment, at least annually, to develop its Delegated First Tier Entities~~Internal~~ Audit and Monitoring Work Plan that provides a comprehensive assessment of CalOptima's ~~Regulatory Agency~~regulatory obligations, including~~, but not limited to, financial and encounter reporting, and~~ oversight of First Tier, Downstream, Related Entities (FDRs~~) oversight, as well as delegated FDR obligations.~~). ~~-~~In assessing risk, ~~CalOptima should~~the Audit ~~and~~& Oversight Department shall consider the following:

~~1. Size of the department;~~

~~2. Complexity of work;~~

~~3. Amount of training that has taken place;~~

1. Statutory, regulatory, and contractual standards;

2. CalOptima's policies and procedures;

3. Business impact on Member care; and

4. Past ~~Compliance~~ compliance issues~~; and~~.

~~5. Budget.~~

B. ~~In assessing additional risk, CalOptima~~The Audit ~~and~~& Oversight Department shall stay ~~up to date~~current with all regulatory ~~-~~communication and guidance from the ~~regulatory agencies~~Rregulatory Aagencies.

C. ~~CalOptima's Risk Assessment~~The Audit ~~and~~& Oversight Department shall present annual risk assessment results and the proposed ~~Internal~~ Delegated First Tier Entities Audit and Monitoring Work Plan ~~shall be presented~~ to the Compliance Committee ~~by the Office of Compliance~~ for review and approval by the end of the ~~Fiscal Year~~fiscal year~~calendar year~~ to be effective for the following year.

III. PROCEDURE

A. ~~The Office of Compliance~~The Audit ~~and~~& Oversight Department shall schedule meetings with all operational department leads that provide oversight of delegated F~~f~~irst T~~t~~ier E~~e~~ntities in order to complete the assessment.

1. Discovery and Analysis. The ~~two key steps in the risk assessment process are~~Audit ~~and~~& Oversight Department shall undertake a discovery ~~and analysis. Discovery is the~~ process ~~of determining~~to determine which regulatory, statutory, regulatory, contractual, and CalOptima policy requirements that are completely implemented, ~~their~~ its operational effectiveness, and how the practices and the documentation support compliance.~~-~~ The discovery process ~~consists~~shall consist of document review, an interview process, and review of other relevant information. ~~-~~The analysis component of risk assessment is based on the evaluation of the data from the ~~actual practices.~~business area~~.~~.

~~B.~~a. ~~Discovery Process.~~ In order to determine whether there are accurate and compliant processes and systems in place, ~~CalOptima conducts~~the Audit ~~and~~& Oversight Department shall conduct the following activities:

~~1.~~i. ~~Review~~A review ~~of Policies~~CalOptima policies ~~and Procedures~~procedures ~~and~~ Delegated F~~f~~irst T~~t~~ier E~~e~~ntity reporting and any other supporting documents such as regulatory communications~~.~~ ~~For each internal area reviewed in the risk assessment process, the Compliance audit team requests~~Audit and Oversight Department shall ~~request~~ ~~from the applicable department the policies and procedures and supporting documentation that describe processes used to meet the regulatory agencies requirements. The documents~~ are evaluated for compliance and receive a risk score that is entered into the Annual Risk Assessment Tool.

~~2.~~ii. ~~Staff interviews. The Compliance team may schedule~~Schedule interviews with internal functional area department ~~supervisors~~management and relevant support staff to discuss the compliance level of each delegated first tier entity.~~the following:~~

~~a.Processes that are supported by policies and procedures and other relevant documentation;~~

~~b.Changes in laws or regulations in the previous year that impact their area;~~

~~c.Changes in management and staffing;~~

~~d.The degree to which the activities conducted by their area affect financial, encounter, and other Regulatory Agency~~regulatory agency ~~reporting requirements; and~~

~~e.The degree to which the activities conducted by their area impact CalOptima Members.~~

~~iii. FDR interviews.~~ The ~~business areas responsible for oversight of FDRs may schedule interviews with their contact at the FDR to discuss the same four items listed in section IV. B.2. of this policy.~~

~~C. The Office of Compliance also interviews the Special Investigation Unit to determine the activities that have confirmed or potential fraud identification.~~

~~D.~~C. ~~Review of other risk factors. The Office of Compliance oversees~~Audit ~~and~~ & ~~reviews~~Oversight Department shall oversee and review the following information ~~for internal areas, and~~with the appropriate business unit ~~reviews~~shall review ~~the following information~~ as it applies to activities delegated to ~~FDRs~~first tier entities~~,~~ as part of the risk assessment process:

1. A ~~Regulatory~~ regulatory ~~agencies identify~~Aagency identifies a particular area as problematic through enforcement actions that may impact CalOptima, including but not limited to, ~~'s~~ Star Ratings, National Committee on Quality Assurance (NCQA) status, and Healthcare Effectiveness Data and Information Set (HEDIS) scores;~~, etc.:~~

2. ~~,~~CalOptima audit findings;

3. ~~, n~~Notices of non-compliance~~, etc.~~;

~~1.~~4. Accuracy of delegate encounter data, submissions, coding, medical loss ratio (MLR) reported data, and other areas that may impact CalOptima payments (e.g. MLR, Hierarchical Condition Category (HCC) risk scores); and~~And~~

~~2.~~5. Whether there is a Corrective Action Plan (CAP~~): whether there is a CAP~~) in effect, and if so, its relative risk for the non-compliance area;

~~3. CalOptima's Star Ratings scores for specific requirements, to be populated as applicable.~~

~~E.~~D. Analysis. To validate compliance of the staff interviews, and review other relevant information, the ~~Office of Compliance relies~~Audit ~~and~~& Oversight Department shall rely on data gathered ~~through~~using the ~~internal monitoring process~~Annual Risk Assessment Tool, and ~~conducts~~conduct baseline risk assessment audits ~~as part of the risk assessment process. Because regulatory agencies expect significant use of~~evaluating file reviews, ~~data in determining risks to Members,~~ data collected from annual audit results ~~from internal monitoring and from the risk assessment audits of requirements are weighted heavily in the risk scoring on the Annual Risk Assessment Tool.~~, and number of CAPs issued during the review period.

~~F.~~1. ~~The Office of Compliance~~As data-driven analysis is significant to determine functional area risk

to Members, the Audit ~~and~~& Oversight Department shall compile the data, using the scoring methodology for the risk assessment tool and then rank the risks based on the greatest impact.

~~G.~~E. The ~~Office of Compliance prioritizes~~Audit ~~and~~& Oversight Department shall prioritize those with greatest risk when developing the annual audit and monitoring plan.

~~H.~~F. The ~~Office of Compliance~~Audit ~~and~~& Oversight Department shall present the ~~internal risk and FDR~~delegated first tier entity risk assessment results and proposed audit and monitoring plan ~~for~~to the Audit ~~and~~& Oversight Committee (AOC) for a recommendation to be presented ~~following~~ for approval ~~by~~by the Compliance Committee.

~~I.~~G. The ~~Office of Compliance~~Audit ~~and~~& Oversight Department shall re-~~evaluates~~evaluate the risk plan based on ~~internal changes~~changes (e.g., staffing and organizational structure changes, ~~internal~~ audit results, monitoring results, etc.) and external changes (e.g., regulatory changes, marketplace changes, regulatory agency audit results).

~~J. Results of the internal FDR risk assessment are~~shall be presented to the Delegation~~Audit and Oversight Committee (DOC) to be used in the evaluation process as established by the DOC.~~AOC).

IV. ATTACHMENTS

Not Applicable
~~FDR Risk Assessment Tool~~
~~A. Internal Auditing and Monitoring Work Plan~~
~~B. FDR Risk Assessment Tool~~

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Contract for Health Care Services
E. CalOptima PACE Program Agreement
F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Health Network Service Agreement
H. Prescription Drug Benefit Manual Chapter 9 - Compliance Program Guidelines
I. Medicare Managed Care Manual Chapter 21 – Compliance Program Guidelines
J. Title 42, Code of Federal Regulations (C.F.R.), §455.2
~~A.~~K. Welfare and Institutions Code. §14043.1(a)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

~~-~~None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2014	MA.9117	Annual Risk Assessment	OneCare
Revised	11/01/2014	MA.9117	Annual Risk Assessment	OneCare
Revised	09/01/2015	MA.9117	Annual Risk Assessment	OneCare OneCare Connect PACE
Effective	09/01/2015	HH.2027	Annual Risk Assessment	Medi-Cal
Revised	12/01/2016	HH.2027	Annual Risk Assessment	Medi-Cal OneCare OneCare Connect
Retired	12/01/2016	MA.9117	Annual Risk Assessment	OneCare OneCare Connect PACE

~~VIII.~~

~~Version~~	~~Version Date~~	~~Policy Number~~	~~Policy Title~~
~~Original Date~~Effective	~~09/01/2015~~	~~HH.2027~~	~~Annual Risk Assessment~~
~~Revision Date 1~~Revised	~~DATE12/01/2016~~	~~HH.2027A~~	~~Annual Risk Assessment~~

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Annual Risk Assessment Tool	A tool utilized to stratify (high, medium, low) audit results and corrective actions issued to identify specific CalOptima functional areas vulnerable to potential Compliance risk.
Centers for Medicare &~~%~~ Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	That committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of the Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Department of Managed Health Care (DMHC)	The California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox Keene Health Care Service Plan Act of 1975, Health & Safety Code, Sections 1340 *et seq.*
Downstream Entity	Any party that enters into a written arrangement acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
First Tier, Downstream, and Related Entities (FDR)	FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima program.

Term	Definition
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. Section 1347.)
Member	A beneficiary who is enrolled in a CalOptima Program.
Regulatory Agencies	For the purposes of this policy regulatory agencies include Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Health and Human Services Office of Inspector General (OIG) and Office of Civil Rights (OCR).
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period..
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1

Policy #:	HH.2027
Title:	**Annual Risk Assessment (Delegate)**
Department:	Office of Compliance
Section:	Audit and Oversight (External)
CEO Approval:	Michael Schrader _____
Effective Date:	09/01/15
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy describes the Annual Risk Assessment process conducted by the CalOptima Audit & Oversight Department to identify specific areas vulnerable to potential Compliance risk. Such areas are documented in CalOptima's risk assessment, which will influence the development of CalOptima's Delegated First Tier Entities Audit and Monitoring Work Plan.

II. POLICY

A. The Audit & Oversight Department is responsible for completing a Program Risk Assessment, at least annually, to develop its Delegated First Tier Entities Audit and Monitoring Work Plan that provides a comprehensive assessment of CalOptima's regulatory obligations, including oversight of First Tier, Downstream, Related Entities (FDRs). In assessing risk, the Audit & Oversight Department shall consider the following:

1. Statutory, regulatory, and contractual standards;

2. CalOptima's policies and procedures;

3. Business impact on Member care; and

4. Past compliance issues.

B. The Audit & Oversight Department shall stay current with all regulatory communication and guidance from the regulatory agencies.

C. The Audit & Oversight Department shall present annual risk assessment results and the proposed Delegated First Tier Entities Audit and Monitoring Work Plan to the Compliance Committee for review and approval by the end of the calendar year to be effective for the following year.

III. PROCEDURE

A. The Audit & Oversight Department shall schedule meetings with all operational department leads that provide oversight of delegated First Tier Entities in order to complete the assessment.

1. Discovery and Analysis. The Audit & Oversight Department shall undertake a discovery process to determine which regulatory, statutory, regulatory, contractual, and CalOptima policy requirements that are completely implemented, its operational effectiveness, and how the

practices and the documentation support compliance. The discovery process shall consist of document review, an interview process, and review of other relevant information. The analysis component of risk assessment is based on the evaluation of the data from the business area.

a. In order to determine whether there are accurate and compliant processes and systems in place, the Audit & Oversight Department shall conduct the following activities:

i. Delegated First Tier Entity reporting and any other supporting documents such as regulatory communications are evaluated for compliance and receive a risk score that is entered into the Annual Risk Assessment Tool.

ii. Schedule interviews with internal functional area department management and relevant support staff to discuss the compliance level of each delegated first tier entity.

C. The Audit & Oversight Department shall oversee and review the following information with the appropriate business unit s as it applies to activities delegated to first tier entities as part of the risk assessment process:

1. A regulatory agency identifies a particular area as problematic through enforcement actions that may impact CalOptima, including but not limited to, Star Ratings, National Committee on Quality Assurance (NCQA) status, and Healthcare Effectiveness Data and Information Set (HEDIS) scores;

2. CalOptima audit findings;

3. Notices of non-compliance;

4. Accuracy of delegate encounter data, submissions, coding, medical loss ratio (MLR) reported data, and other areas that may impact CalOptima payments (e.g. MLR, Hierarchical Condition Category (HCC) risk scores); and

5. Whether there is a Corrective Action Plan (CAP) in effect, and if so, its relative risk for the non-compliance area;

D. Analysis. To validate compliance of the staff interviews, and review other relevant information, the Audit & Oversight Department shall rely on data gathered using the Annual Risk Assessment Tool, and conduct baseline risk assessment audits evaluating file reviews, data collected from annual audit results, and number of CAPs issued during the review period.

1. As data-driven analysis is significant to determine functional area risk to Members, the Audit & Oversight Department shall compile the data, using the scoring methodology for the risk assessment tool and then rank the risks based on the greatest impact.

E. The Audit & Oversight Department shall prioritize those with greatest risk when developing the annual audit and monitoring plan.

F. The Audit & Oversight Department shall present the delegated first tier entity risk assessment results and proposed audit and monitoring plan to the Audit & Oversight Committee (AOC) for a recommendation to be presented for approval by the Compliance Committee.

G. The Audit & Oversight Department shall re-evaluate the risk plan based on changes (e.g., staffing and organizational structure changes, audit results, monitoring results, etc.) and external changes (e.g., regulatory changes, marketplace changes, regulatory agency audit results).

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Contract for Health Care Services
E. CalOptima PACE Program Agreement
F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Health Network Service Agreement
H. Prescription Drug Benefit Manual Chapter 9 - Compliance Program Guidelines
I. Medicare Managed Care Manual Chapter 21 – Compliance Program Guidelines
J. Title 42, Code of Federal Regulations (C.F.R.), §455.2
K. Welfare and Institutions Code. §14043.1(a)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2014	MA.9117	Annual Risk Assessment	OneCare
Revised	11/01/2014	MA.9117	Annual Risk Assessment	OneCare
Revised	09/01/2015	MA.9117	Annual Risk Assessment	OneCare OneCare Connect PACE
Effective	09/01/2015	HH.2027	Annual Risk Assessment	Medi-Cal
Revised	12/01/2016	HH.2027	Annual Risk Assessment	Medi-Cal OneCare OneCare Connect
Retired	12/01/2016	MA.9117	Annual Risk Assessment	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Annual Risk Assessment Tool	A tool utilized to stratify (high, medium, low) audit results and corrective actions issued to identify specific CalOptima functional areas vulnerable to potential Compliance risk.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	That committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of the Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Department of Managed Health Care (DMHC)	The California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox Keene Health Care Service Plan Act of 1975, Health & Safety Code, Sections 1340 *et seq*.
Downstream Entity	Any party that enters into a written arrangement acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
First Tier, Downstream, and Related Entities (FDR)	FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima program.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. Section 1347.)

Term	Definition
Member	A beneficiary who is enrolled in a CalOptima Program.
Regulatory Agencies	For the purposes of this policy regulatory agencies include Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Health and Human Services Office of Inspector General (OIG) and Office of Civil Rights (OCR).
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period..
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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Policy #:	HH.4001Δ
Title:	**Audit ~~and~~& Oversight Committee**
Department:	Office of Compliance
Section:	Audit & Oversight (External)
CEO Approval:	Michael Schrader _____
Effective Date:	09/01/15
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

~~To~~This policy identifies~~y~~ the functions and responsibilities of the sub-committee of the Compliance Committee responsible for oversight of activities of CalOptima's internal departments and its First Tier, Downstream, and Related Entities (FDRs). ~~This policyo establishes a committee comprised of CalOptima executives that shall provide assistance to the CalOptima Board of Directors (BOD) in fulfilling its oversight and monitoring responsibilities with respect to federal, state, and accreditation compliance of its delegated entities.~~

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~
~~Abuse~~	~~Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima and its programs, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima and its programs. Or the intentional or careless act that causes harm or serious risk of harm to an older person or vulnerable adult, including: physical abuse, emotional abuse, sexual abuse, and exploitation, neglect, abandonment or self-neglect.~~

~~Term~~	~~Definition~~
~~Compliance Committee~~	~~Committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of the Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Executive Director of Compliance; and Executive Director of Human Resources.The CalOptima committee that consists of executive officers, managers of key operating divisions, and legal counsel that oversees implementation of CalOptima's Compliance Program.~~
~~Compliance Program~~	~~The program (including, without limitation, the Compliance Plan, Code of Conduct and Policies and Procedures and Procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Members, Employees, and FDRs comply with applicable law and ethical standards.A comprehensive program that incorporates the fundamental elements identified by the state and federal governments and CalOptima as necessary to prevent and detect violations of ethical standards, contractual obligations, and applicable laws and the involvement of CalOptima's governing body and executive staff. Elements of the Compliance Program include standards, oversight, training, reporting, monitoring, enforcement, and remediation. The Compliance Program applies to CalOptima's Board of Directors, employees, and contractors including delegated entities, providers, and suppliers.~~
~~Corrective Action Plan~~	~~A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.~~
~~Designee~~	~~A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.~~
~~Downstream Entity~~	~~Any party that enters into a written arrangement acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.Any party that enters into an acceptable written arrangement below the level of the arrangement between a CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.~~

~~Term~~	~~Definition~~
~~First Tier Entity~~	~~Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima program.Any party that enters into a written arrangement with CalOptima or contract applicant to provide administrative services or health care services for a Medicare or Medicaid eligible individual under the CalOptima program.~~
~~First Tier, Downstream, and Related Entities (FDR)~~	~~FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.~~
~~Fraud~~	~~Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. Section 1347.)An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42, Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14013.1(i).~~
~~Physician Medical Group (PMG)~~	~~A California professional medical corporation that employs or has entered into contracts with physicians who are licensed to practice medicine in the State of California that has entered into a contract with CalOptima to arrange for the provision of Covered Service to Member assigned to that Provider Group.~~
~~Health Network~~	~~The contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.~~
~~Related Entity~~	~~Any entity that is related to CalOptima by common ownership or control and that: performs some of the management functions under contract or delegation; furnishes services to Medicare or Medicaid enrollees under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.Any entity that is related to CalOptima by common ownership or control and: Performs some of the management functions under contract or delegation; Furnishes services to Medicare or Medicaid enrollees under an oral or written agreement; or Leases real property or sells materials to CalOptima at a cost of more than two-thousand five hundred ($2,500) during a contract period.~~

~~Term~~	~~Definition~~
~~Waste~~	~~Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a the CalOptima programs. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.~~
~~Audit and Oversight Committee (AOC)~~	~~A subcommittee of the Compliance Committee co-chaired by the internal and external Directors of Audit and Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's operational departments. as provided for in the AOC charter.~~

~~HH.~~II. POLICY

A. ~~Delegation oversight~~Oversight of delegated and internal operations ~~Delegation and Internal Oversight~~Audit and Oversight is critical to CalOptima, as this process is mandated by federal, state, regulatory contracts, regulations, and accreditation standards and is necessary to ensure sound fiscal practices, prevent ~~fraud~~Fraud, ~~waste~~Waste, and ~~abuse~~Abuse, and the provision of ~~provide~~ quality care to CalOptima Members.

~~B. CalOptima's Delegation Oversight~~Audit and Oversight ~~Committee (DOC~~AOC~~) shall primarily conduct the following activities:~~

~~1. Oversee the monitoring, auditing, and reporting processes for CalOptima internal departments and identified First Tier, Downstream and Related Entities (FDRs) including, but not limited to delegated Health Networks;~~

~~2. Provide oversight of internal departments and FDRs who perform applicable core administrative functions and/or health care services for any of CalOptima's programs by evaluating performance measures and audit findings;~~

~~3. Impose and recommend sanctions upon an FDR, 's up to and including the revocation and/or~~or ~~termination of delegation if the delegated entity's performance is inadequate in accordance with CalOptima Policy MA.9105 and HH.2002A: Sanctions;~~

~~4. Assist CalOptima in ensuring delegate and internal department compliance with accreditation, contractual, and regulatory requirements for administering all CalOptima programs including Medi-Cal, OneCare, OneCare Connect, Program of All-Inclusive Care for the Elderly (PACE), and any future programs in which CalOptima participates.~~

~~5. Establish clearly defined processes and criteria for the evaluation and categorization of CalOptima's internal departments, vendors and delegated health care providers, as to the entity's qualification as an qualifying or not qualifying, as FDRs and conduct such determinations on an ongoing basis.~~

~~6. Develop and/or~~or ~~revise policies and procedures related to oversight of and reporting for by for internal departments and FDRs oversight and reporting including, but not limited to, identifying the scope, frequency and nature of oversight monitoring and auditing, and recommendations related to corrective Corrective action Action planPlans(s) (CAPs), in accordance with CalOptima Policy MA 9104 and HH.2005A: Corrective Action Plan, and~~

~~present such policies and procedures to the Compliance Committee for review and approval prior to presentation to the Policy Review Committee (PRC) and Board of Directors.~~

~~IV.~~III. PROCEDURE

A. Audit ~~and~~& Oversight Committee (~~DOC~~AOC) members shall include the following CalOptima staff ~~members~~, serving either on a permanent, or interim, basis:

1. Chief Operating Officer;

2. ~~Chief~~ Executive Director Network ~~Officer~~Management;

3. Chief Financial Officer;

4. Chief Medical Officer;

5. ~~-~~Medical Director, Behavioral Health

~~4. Medical Director, Quality~~

~~5. Medical Director~~

~~6. Executive Director, Clinical Operations;~~

~~7.~~6. Executive Director, Compliance; and

~~Director, Audit and Oversight, External; , as Chair of the who is the AOC Chair;;~~

~~8. Director of Audit and Oversight, Internal; and~~

~~9. Director, Regulatory Affairs;~~

~~10.~~ Director, Pharmacy Management~~.~~;

7.

~~11. Director, Network Management; and~~

~~12. Executive Director, Quality.~~

B. The ~~External and Internal~~ Directors~~s~~ of Audit and Oversight will serve as ~~co-~~chairs of the AOC.

~~B.~~C. Voting members may appoint a Designee, as appropriate. The Designee shall serve as a subject matter expert at the ~~Compliance Audit and Oversight Committee~~AOC.

B. CalOptima's Audit ~~and~~& Oversight Committee (AOC) shall conduct the following activities:

1. Oversee the monitoring, auditing, and reporting processes for CalOptima internal departments and identified First Tier, Downstream and Related Entities (FDRs) including, but not limited to delegated Health Networks;

2. Provide oversight of internal departments and FDRs who perform applicable core administrative functions and/or health care services for any of CalOptima's programs by evaluating performance measures and audit findings;

3. Impose and recommend sanctions upon an FDR, up to and including the revocation or termination of delegation if the delegated entity's performance is inadequate in accordance with CalOptima Policy HH.2002Δ: Sanctions;

4. Assist CalOptima in ensuring delegate and internal department compliance with accreditation, contractual, and regulatory requirements for administering all CalOptima programs including Medi-Cal, OneCare, OneCare Connect, Program of All-Inclusive Care for the Elderly (PACE), and any future programs in which CalOptima participates.

5. Establish clearly defined processes and criteria for the evaluation and categorization of CalOptima's internal departments, vendors and delegated health care providers, as to the entity's qualification as an -FDR and conduct such determinations on an ongoing basis.

6. Develop or revise policies and procedures related to oversight of and reporting for- internal department and FDRs including, but not limited to, identifying the scope, frequency and nature of oversight monitoring and auditing, and recommendations related to Corrective Action Plans (CAPs), in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan, and present such policies and procedures to the Compliance Committee for review and approval prior to presentation to the Policy Review Committee (PRC) and Board of Directors.

~~C.~~D. All activities of the ~~DOC~~AOC shall be privileged and not subject to disclosure.

~~D.~~E. ~~DOC~~AOC Responsibilities:

1. Oversight and Reporting

   a. Oversee the pre-delegation/~~contract~~ readiness assessment processes conducted by ~~Compliance~~ Audit ~~and~~& Oversight Department in conjunction with relevant operational departments;

      ~~a.~~i. Review and approve findings or pre-delegation/readiness assessment to evaluate FDRs ability to perform delegated functions.

   b. Report~~Provide~~ quarterly ~~report~~ findings and recommendations related to ~~delegation oversight~~Audit ~~and~~& Oversight to the Compliance Committee for corrective/remedial action;

   c. Conduct follow-up oversight reviews deemed necessary by the ~~DOC~~AOC to ensure that any deficiencies reported during the oversight of the delegates and/or internal departments ~~FDRs~~ have been fully addressed; and

   d. Report and make recommendations to the Compliance Committee on a regular, but no less than quarterly basis. All ~~DOC~~AOC recommendations that potentially impact Members' access to covered services or quality of care that require prompt action shall be referred

immediately to CalOptima's Compliance Committee ~~and/or Quality Improvement Committee~~, as appropriate under the circumstances for review and action.

2. ~~Delegation Oversight~~Audit ~~and~~& Oversight Work Plan

a. Based upon a risk assessment that identifies the highest risk FDR and internal departments, ~~Prepare~~ an annual ~~Delegation Oversight~~Audit and Oversight Work Plan is created. ~~based on a risk assessment to identify highest risk First Tier Entities and internal departments.~~

~~b. Include activities identified in other Department Work Plans (e.g., Quality Improvement Delegation Work Plan) in the Delegation Oversight Work Plan.~~

b. Include activities identified in other Department Work Plans in the Audit ~~and~~& Oversight Work Plan.

c. Submit the annual ~~Delegation Oversight~~Audit ~~and~~& Oversight Work Plan ~~for review~~ to the Compliance Committee for review.

3. Annual Report

a. Prepare an Annual Report of internal department and ~~agency-wide~~ FDR oversight activities resulting from the ~~Delegation Oversight~~Audit ~~and~~& Oversight Work Plan and other relevant ad hoc oversight activities including those related to risk assessments and/or arising from auditing activities (both internal and external).

b. Include in the Annual Report recommendations related to changes to and/or addition of oversight activities.

c. Deliver Annual Report to the Compliance Committee for further action.

4. ~~DOC~~AOC Meetings

a. The ~~DOC~~AOC shall meet at least monthly and may meet more frequently, as appropriate. The ~~Co-~~Chair~~s~~ or any ~~three five~~four (~~3~~5~~4~~) members of the ~~DOC~~AOC may call a meeting of the ~~DOC~~AOC. Annually, ~~DOC~~AOC members shall receive a calendar request of meetings for the following calendar year.

b. ~~A committee binder~~The following, but not limited to, shall be distributed to all meeting attendees prior to the ~~DOC~~AOC meeting. ~~Committee binder shall include, but is not limited to:~~

i. ~~Current meeting~~Meeting agenda;

ii. ~~Previous meeting f~~Final draft of previous AOC minutes for approval; ~~and~~

iii. Listing of open action items; ~~and.~~

~~iii.~~iv. Presentation items.

c. Minutes of the ~~DOC~~AOC meeting shall be confidential.

d. Ad-hoc ~~DOC~~AOC meetings may be held at the discretion of the chairpersons, as deemed appropriate.

5. Establishment of Quorum

~~a. Quorum for the Subcommittee is based on a simple majority. The support of a majority of the quorum present is required for the DOC to take action on any agenized item. There must be at least five members of the AOC present to begin the meeting.~~

a. Quorum for the Committee is based on a simple majority. The support of a majority of the quorum present is required for the AOC to take action on any agenized item.

~~b.~~ There must be at least ~~five~~four (~~5~~4) members of the AOC present, in addition to the ~~co-~~chairs~~, present~~ to establish a quorum.~~begin the meeting.~~

b.

In the absence of quorum, the meeting may proceed, however, any issues requiring a vote shall be deferred until the next regular meeting or subjected to an electronic vote.~~In the absence of quorum, the meeting may proceed, however, any issues requiring a vote shall be deferred until the next regular meeting.~~

c.

~~V.~~IV. ATTACHMENTS

Not Applicable

~~VI.~~V. REFERENCES

A. ~~Not Applicable~~A. ~~2017 Compliance Plan~~CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Contract for Health Care Services
E. CalOptima PACE Program Agreement
F. CalOptima Policy HH.2002Δ: Sanctions
G. CalOptima Policy HH.2005Δ: Corrective Action Plan
H. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
I. Health Network Service Agreement

~~B. CalOptima Policy MA.9105 and HH.2002Δ: Sanctions~~
~~CalOptima PolcyPolicy MA.9104 and HH.2005Δ: Corrective Action Plan~~

~~VII.~~VI. REGULATORY AGENCY APPROVALS

None to Date

~~VIII.~~VII. BOARD ACTIONS

None to Date

~~IX.~~VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	09/01/2015	HH.4001	Delegation Oversight Committee	Medi-Cal
Effective	09/01/2015	MA.9127	Delegation Oversight Committee	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.4001	Audit & Oversight Committee	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9127	Delegation Oversight Committee	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Audit and Oversight Committee (AOC)	A subcommittee of the Compliance Committee co-chaired by the internal and external Directors of Audit and Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's operational departments.
Compliance Committee	Committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of the Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Executive Director of Compliance; and Executive Director of Human Resources.
Corrective Action Plan	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services, or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
First Tier, Downstream, and Related Entities (FDR)	FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. Section 1347.)
Health Network	The contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").

Term	Definition
Waste	Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1

~~Version~~	~~Version Date~~	~~Policy Number~~	~~Policy Title~~
~~Original Date~~Effective	~~09/01/2015~~	~~HH.4001~~	~~Delegation Oversight~~ Delegation Audit and Oversight ~~Committee~~
~~Revised~~	~~DATE12/01/2016~~	~~HH.4001Δ~~	~~Audit and Oversight Committee~~

2

Policy #:	HH.4001Δ
Title:	**Audit & Oversight Committee**
Department:	Office of Compliance
Section:	Audit & Oversight (External)
CEO Approval:	Michael Schrader _____
Effective Date:	09/01/15
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy identifies the functions and responsibilities of the subcommittee of the Compliance Committee responsible for oversight of activities of CalOptima's internal departments and its First Tier, Downstream, and Related Entities (FDRs).

II. POLICY

A. Oversight of delegated and internal operations is critical to CalOptima, as this process is mandated by federal, state, regulatory contracts, regulations, and accreditation standards and is necessary to ensure sound fiscal practices, prevent Fraud, Waste, and Abuse, and the provision of quality care to CalOptima Members.

III. PROCEDURE

A. Audit & Oversight Committee (AOC) members shall include the following CalOptima staff, serving either on a permanent, or interim, basis:

1. Chief Operating Officer;
2. Executive Director Network Management;
3. Chief Financial Officer;
4. Chief Medical Officer;
5. Medical Director, Behavioral Health
6. Executive Director, Compliance; and
7. Director, Pharmacy Management.

B. The Directors of Audit and Oversight will serve as chairs of the AOC.

C. Voting members may appoint a Designee, as appropriate. The Designee shall serve as a subject matter expert at the AOC.

B. CalOptima's Audit & Oversight Committee (AOC) shall conduct the following activities:

1. Oversee the monitoring, auditing, and reporting processes for CalOptima internal departments and identified First Tier, Downstream and Related Entities (FDRs) including, but not limited to delegated Health Networks;

2. Provide oversight of internal departments and FDRs who perform applicable core administrative functions and/or health care services for any of CalOptima's programs by evaluating performance measures and audit findings;

3. Impose and recommend sanctions upon an FDR, up to and including the revocation or termination of delegation if the delegated entity's performance is inadequate in accordance with CalOptima Policy HH.2002Δ: Sanctions;

4. Assist CalOptima in ensuring delegate and internal department compliance with accreditation, contractual, and regulatory requirements for administering all CalOptima programs including Medi-Cal, OneCare, OneCare Connect, Program of All-Inclusive Care for the Elderly (PACE), and any future programs in which CalOptima participates.

5. Establish clearly defined processes and criteria for the evaluation and categorization of CalOptima's internal departments, vendors and delegated health care providers, as to the entity's qualification as an FDR and conduct such determinations on an ongoing basis.

6. Develop or revise policies and procedures related to oversight of and reporting for internal department and FDRs including, but not limited to, identifying the scope, frequency and nature of oversight monitoring and auditing, and recommendations related to Corrective Action Plans (CAPs), in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan, and present such policies and procedures to the Compliance Committee for review and approval prior to presentation to the Policy Review Committee (PRC) and Board of Directors.

D. All activities of the AOC shall be privileged and not subject to disclosure.

E. AOC Responsibilities:

1. Oversight and Reporting

a. Oversee the pre-delegation/readiness assessment processes conducted by Audit & Oversight Department in conjunction with relevant operational departments;

i. Review and approve findings or pre-delegation/readiness assessment to evaluate FDRs ability to perform delegated functions.

b. Report quarterly findings and recommendations related to Audit & Oversight to the Compliance Committee for corrective/remedial action;

c. Conduct follow-up oversight reviews deemed necessary by the AOC to ensure that any deficiencies reported during the oversight of the delegates and/or internal departments have been fully addressed; and

d. Report and make recommendations to the Compliance Committee on a regular, but no less than quarterly basis. All AOC recommendations that potentially impact Members' access to covered services or quality of care that require prompt action shall be referred immediately to CalOptima's Compliance Committee, as appropriate under the circumstances for review and action.

2. Audit & Oversight Work Plan

a. Based upon a risk assessment that identifies the highest risk FDR and internal departments, an annual Audit and Oversight Work Plan is created.

b. Include activities identified in other Department Work Plans in the Audit & Oversight Work Plan.

c. Submit the annual Audit & Oversight Work Plan to the Compliance Committee for review.

3. Annual Report

a. Prepare an Annual Report of internal department and FDR oversight activities resulting from the Audit & Oversight Work Plan and other relevant ad hoc oversight activities including those related to risk assessments and/or arising from auditing activities (both internal and external).

b. Include in the Annual Report recommendations related to changes to and/or addition of oversight activities.

c. Deliver Annual Report to the Compliance Committee for further action.

4. AOC Meetings

a. The AOC shall meet at least monthly and may meet more frequently, as appropriate. The Chair or any four (4) members of the AOC may call a meeting of the AOC. Annually, AOC members shall receive a calendar request of meetings for the following calendar year.

b. The following, but not limited to, shall be distributed to all meeting attendees prior to the AOC meeting.

i. Meeting agenda;

ii. Final draft of previous AOC minutes for approval;

iii. Listing of open action items; and

iv. Presentation items.

c. Minutes of the AOC meeting shall be confidential.

d. Ad-hoc AOC meetings may be held at the discretion of the chairpersons, as deemed appropriate.

5. Establishment of Quorum
   a. Quorum for the Committee is based on a simple majority. The support of a majority of the quorum present is required for the AOC to take action on any agenized item.

   b. There must be at least four (4) members of the AOC present, in addition to the chair, to establish a quorum.

   c. In the absence of quorum, the meeting may proceed, however, any issues requiring a vote shall be deferred until the next regular meeting or subjected to an electronic vote.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Contract for Health Care Services
E. CalOptima PACE Program Agreement
F. CalOptima Policy HH.2002Δ: Sanctions
G. CalOptima Policy HH.2005Δ: Corrective Action Plan
H. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
I. Health Network Service Agreement

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	09/01/2015	HH.4001	Delegation Oversight Committee	Medi-Cal
Effective	09/01/2015	MA.9127	Delegation Oversight Committee	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.4001	Audit & Oversight Committee	Medi-Cal OneCare OneCare Connect PACE

Version	Date	Policy Number	Policy Title	Line(s) of Business
Retired	12/01/2016	MA.9127	Delegation Oversight Committee	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Audit and Oversight Committee (AOC)	A subcommittee of the Compliance Committee co-chaired by the internal and external Directors of Audit and Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's operational departments.
Compliance Committee	Committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of the Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Executive Director of Compliance; and Executive Director of Human Resources.
Corrective Action Plan	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services, or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
First Tier, Downstream, and Related Entities (FDR)	FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. Section 1347.)
Health Network	The contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").

Term	Definition
Waste	Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1
2

Policy #:	HH.1105Δ
Title:	**Fraud, Waste, and Abuse Detection**
Department:	Office of Compliance
Section:	Fraud, Waste, and Abuse – Special Investigations Unit
CEO Approval:	Michael Schrader _____
Effective Date:	06/01/99
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

~~To~~ This policy establish~~ies~~es a process to detect, correct, and prevent suspected Fraud, Waste, or Abuse in a CalOptima program by a Member, Provider, Practitioner, a CalOptima ~~e~~Employee, ~~First~~First Tier, Downstream, and Related Entit~~ies ies~~ies (FDRs~~'s~~), Billing Intermediary, and CalOptima's Health Network~~s~~, in accordance with federal and state regulations.

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~
~~Abuse~~	~~Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.~~
~~Authorized Representative~~	~~Has the meaning given such term in section 164.502(g) of title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of un-emancipated minors.~~
~~Centers for Medicare & Medicaid Services (CMS)~~	~~The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.~~
~~Complaint~~	~~An oral or written expression indicating dissatisfaction with any aspect of the CalOptima program.~~

~~Term~~	~~Definition~~
~~Covered Service~~	~~Medi-Cal:~~ ~~Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), or other services as authorized by the Board of Directors, which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.~~ ~~OneCare:~~ ~~Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Center of Medicare & Medicaid Services (CMS) Contract.~~ ~~OneCare Connect:~~ ~~Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).~~ ~~PACE:~~ ~~Items and services provided by CalOptima under the provisions of Welfare & Institutions Code section 14132, except those services specifically excluded under the CalOptima PACE Program Agreement, Exhibit E, Attachment 1, Section 26.~~
~~Department of Health Care Services (DHCS)~~	~~The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.~~
~~Downstream Entity~~	~~Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.~~
~~Employee~~	~~Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.~~
~~Encounter~~	~~Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.~~

Term	Definition
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. §Section 1347).
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information as amended.
Health Network	The contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy. A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term "Medical Record" is used both for the physical folder for each individual patient and for the body Information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the Cal Optima program. A beneficiary who is enrolled in a CalOptima Program.An enrollee beneficiary of a CalOptima program.

~~Term~~	~~Definition~~
~~Pharmacy:~~	~~An area, place or premises licensed by the State Board of Pharmacy in which the profession of pharmacy is practiced and where Prescriptions are compounded and dispensed, and for the purpose of this policy, the licensed dispensing area of a community clinic.~~
~~Pharmacy Benefit Manager (PBM)~~	~~The entity that performs certain functions and tasks including, but not limited to, Pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement. An entity that provides pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.~~
~~Practitioner~~	~~A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.~~
~~Provider~~	~~A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.~~
~~Related Entity~~	~~Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.~~
~~Waste~~	~~The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Programthe Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.~~

~~III.~~II. POLICY

A. CalOptima maintains a zero tolerance policy toward Fraud, Waste, and Abuse.

B. CalOptima shall establish a process for detecting suspected Fraud, Waste, or Abuse, in accordance with this policy.

C. CalOptima and its First Tier, Downstream, and Related Entities (FDRs) shall comply with applicable statutory, regulatory, other requirements, sub-regulatory guidance, and contractual commitments related to the delivery of ~~covered~~ Covered ~~Medi-Cal services~~Services, which include, but are not limited to, federal and state False Claims Acts, Anti-Kickback statutes, prohibitions on

inducements to beneficiaries, Health Insurance Portability and Accountability Act (HIPAA), and other applicable statutes.

D. CalOptima's Office of Compliance shall investigate and report suspected Fraud, Waste, or Abuse, in accordance with CalOptima Policy HH.1107Δ: Fraud, Waste and Abuse Investigation and Reporting.

E. ~~CalOptima shall provide regular training and information sessions to FDRs regarding Fraud, Waste, and Abuse, and CalOptima shall inform Members regarding Fraud, Waste, and Abuse and the provisions of this policy.~~ CalOptima shall provide regular training and information sessions to its FDR~~'~~s regarding Fraud, Waste, and Abuse, and shall ~~CalOptima shall~~ inform Members regarding Fraud, Waste, and Abuse and the provisions of this policy.

~~E. (Please note this was deleted in error).~~

F. CalOptima ~~employees~~ Employees and FDRs are expected and required to promptly report suspected violations of any statute, regulations, or guidelines applicable to any CalOptima program. CalOptima maintains a strict policy of non-retaliation and non-retribution toward employees and its FDRs who make such reports in good faith. CalOptima ~~employees~~ Employees and its FDRs are protected from retaliation under Title 31, United States Code, Section 3730(h), for False Claims Act complaints, as well as any other anti-retaliation protections. CalOptima shall treat the detection of suspected FWA in a confidential manner.

G. CalOptima shall review this ~~This policy is reviewed~~ policy on an annual basis ~~annually~~ to ensure relevancy and accuracy, ensuring that CalOptima's FWA program ~~are~~ is in alignment with industry best practices.

~~F.~~

~~IV.~~III. PROCEDURE

A. CalOptima may detect Fraud, Waste, or Abuse by a Member in circumstances that include, but are not limited to, the following:

1. Using another individual's identity, Benefits Identification Card (BIC), CalOptima or Health Network identification (ID) card, Medi-Cal or Medicare number, or other documentation of Medi-Cal, Medicare, ~~-~~ or CalOptima program eligibility to obtain Covered Services, unless such person is an Authorized Representative who is presenting such document, or information, on behalf of a Member to obtain Covered Services for that Member;

2. Selling, loaning, or giving a Member's identity, Benefits Identification Card (BIC), Health Network identification (ID) card, Medi-Cal or Medicare number, or other documentation of Medi-Cal, Medicare or CalOptima program eligibility to obtain Covered Services, unless such person is an Authorized Representative who is obtaining services on behalf of a Member;

3. Making an unsubstantiated declaration of Medi-Cal or Medicare eligibility;

4. Using a Covered Service for purposes other than the purposes for which it was prescribed or provided, including use of such Covered Service by an individual other than the Member for whom the Covered Service was prescribed or provided;

5. Failing to report other health coverage; and

6. Soliciting or receiving a kickback, bribe, rebate, or other financial incentive as an inducement to receive or not receive Covered Services.

B. CalOptima may detect Fraud, Waste or Abuse by an FDR in circumstances that include, but are not limited to, the following:

1. Unsubstantiated declaration of eligibility to participate in the Medi-Cal, OneCare, OneCare Connect, or Program of All-Inclusive Care for the Elderly (PACE) ~~-~~program as a Provider, Practitioner, Billing Intermediary, or Health Network;

2. Submission of a claim or a request for payment for:

   a. Covered Services that are substantially and demonstrably in excess of an individual's usual charges for such Covered Services;

   b. Covered Services that were not provided to the Member for whom such Covered Services were claimed;

   c. Covered Services substantially in excess of the quantity that is Medically Necessary for the Member;

   d. Covered Services using a billing code that will result in greater payment than the billing code that reflects the Covered Services actually provided;

   e. Covered Services that were already included in the capitation rate; and

   f. Covered Services billed to both CalOptima and another third party payer without making full disclosure of material facts or notification of other insurance payments.

3. Charging a Member in excess of allowable co-payments or deductibles for Covered Services;

4. Billing a Member for Covered Services without obtaining written consent to bill for such Covered Services;

5. Soliciting, offering, receiving, or paying a kickback, bribe or rebate as an inducement to refer or fail to refer a Member;

6. Failing to disclose any s~~S~~ignificant b~~B~~eneficial i~~I~~nterest in any other Provider to which the Provider or Practitioner may refer a Member for the provision of Covered Services;

7. Billing i~~I~~ntermediary failure to register with the California Department of Health Care Services (DHCS), as appropriate;

8. False certification of Medical Necessity;

9. Attributing a diagnosis code to a Member that does not accurately reflect the Member's Medical Condition for the purposes of obtaining higher reimbursement;

10. Providing false or inaccurate Credentialing information;

11. Providing false or inaccurate information during the CalOptima provider registration process; and.

12. Submitting data files or r~~R~~eports that contain:

    a. Unsubstantiated data;

    b. Data that is inconsistent with underlying clinical, encounter, or payment records; or

    c. Data that has been altered in a manner, or for a purpose, that is inconsistent with CalOptima policies, c~~C~~ontract, or applicable regulations and statutes.

~~c.~~

C. Training~~Prevention:~~

1. CalOptima's Office of Compliance shall provide regular training to e~~E~~mployees and FDRs regarding the process for detecting suspected FWA, the specific provisions regarding FWA under the False Claims Act, and the protections afforded to those who report such concerns in good faith.

~~CalOptima has developed system controls, including claims edits, claims review processes, internal controls for protection of CalOptima assets, education programs for CalOptima eEmployees, contractors and members, and metrics for monitoring potential FWA.~~

2. CalOptima shall provide regular FWA training and information sessions to:

    a. New ~~E~~Employees;

    b. Annually to CalOptima ~~E~~Employees; and

    c. Health Networks.

3. CalOptima shall provide Members with information related to FWA through:

    a. The Member Handbook;

    b. Periodic communications; and

    c. The CalOptima website.

D. ~~D.~~Detection~~:~~

1. CalOptima may receive ~~C~~complaints of suspected FWA from sources, including but not limited

~~to: any of the following sources, but is not limited to only these sources:~~

a. CalOptima's Compliance and Ethics Hotline;

b. Claims data history:

c. Encounter data;

d. Medical records audits ~~data~~

e. Member and provider complaints, appeals, and grievance reviews;

f. Utilization Management reports;

g. Provider utilization profiles;

h. Pharmacy Data;

i. Monitoring and auditing activities;

j. Monitoring external health care FWA cases and determining if CalOptima's FWA Program can be strengthened with information gleaned from the case activity; and/or

k. Internal and external surveys, reviews, and audits. ~~and~~

~~.~~

2. The ~~CalOptima~~ Office of Compliance shall provide oversight to the Health Networks' Compliance Programs ~~by the Office of Compliance~~, to ensure that the programs are in place, and are comprehensive and in compliance with CalOptima contractual requirements.

3. CalOptima shall utilize "claims edits" in accordance with Federal and State regulations, the DHCS Contract, and industry best practices, including but not limited to the National Correct Coding Initiative (NCCI).

4. CalOptima shall conduct data validation reviews by claims auditors within the Office of Compliance. These reviews are intended to detect any anomalies between items billed, items rendered, and all affiliated documentation related to the claims and Encounters.

5. CalOptima shall utilize data analytics including software to identify potential FWA cases. This data compares CalOptima claims and Encounters against national data to identify any suspected instances of FWA. ~~-~~These cases are forwarded to the Special Investigations Unit (SIU) for investigation.

6. CalOptima shall perform reviews on data samples to test the following, but not limited to:

a. Ensure that documentation of ~~P~~prior ~~A~~authorizations ~~are on~~is on file for services~~/~~ or ~~drugs~~medications requiring ~~P~~prior ~~A~~authorization;

b. Review ~~L~~low-~~D~~dollar/~~H~~high-~~V~~volume utilization by doctor, specialty and geographic comparison;

c. CalOptima shall conduct monthly reviews of claims to review for adjustment codes and denials, reviewing for inappropriate denials and improper down coding~~, with a focus on Current Procedural Terminology (CPT)s codes 99284 and 99285~~. CalOptima's Claims Auditors shall review claims for ~~E~~emergency ~~R~~roomservices ~~claims~~ to ensure that down coding does not occur when claims are submitted without accompanying Medical Records. Emergency ~~R~~room claims are reviewed during regular claims audits, and documentation is requested from the Health Network, at the time of the audit. Results of the audit are reviewed by the Audit and Oversight Committee (AOC). The AOC ~~will be~~is responsible for issuing corrective actions for Health Networks who are found to be down coding inappropriately;

d. CalOptima reviews ~~p~~Provider claims that ~~have been~~are identified as potential FWA. Claims may be identified by the claims review software system, by the ~~C~~claims ~~A~~auditors, by internal and external claims and compliance audits, or any other source that identifies potential FWA. -As part of the review process, CalOptima ~~will~~ documents the investigation of the claims or P~~p~~rovider in the FWA Tracking Database.- Once the investigation is completed, CalOptima shall report FWA as applicable and in accordance with CalOptima Policy HH.1107Δ: Fraud, Waste, Abuse Investigation and Reporting. ~~(in accordance with the investigation process outlined elsewhere in this policy), the case information will be documented in the FWA database, and a referral may be made to the State, if appropriate. The referral shall be submitted on a Medi-Cal Complaint Report (MC 609) that can be sent to DHCS via secure e-mail (Iron Port), secure facsimile, Federal Express with Tracking number or certified mail, in accordance with the instructions provided in Exhibit E of CalOptima's contract with the Department of Health Care Services for Medi-Cal.~~

e. In accordance with the Pharmacist Referral to SIU Team Desktop, CalOptima's Pharmacy Department shall refers cases to the SIU Team for ~~m~~Members exhibiting drug seeking behavior or suspected of FWA issues related to Pharmacy services.

7. CalOptima shall implement a Service Verification Survey process to survey a sampling of Members monthly to ensure that:

a. Covered Services that were billed were received;

b. Face-~~-~~to-~~-~~face services were- provided for services/equipment/medications requiring recent or regular face to face appointments;

c. Durable Medical Equipment (DME) that were billed were received;

d. Medications that were billed were received; and~~.~~

e. The focus of these surveys will vary as decided by the SIU and/or the Office of Compliance designated staff. The focus may be on a specific code, Provider, Member category, geographic area, and DME description, reports by other agencies of potential FWA, and

industry findings and best practices.

~~CalOptima shall utilize the forum of the Compliance Committee to detect any suspected FWA throughout the organization and the FDRs and determine appropriate investigative and reporting steps.~~

~~CalOptima shall treat the detection of suspected FWA in a confidential manner, and shall not retaliate or make retribution against any CalOptima employee, FDR, or Member for such detection in accordance with CalOptima policy MA.9223: Non-Retaliation for Reporting Violations.~~

~~C.~~ E. Upon detection of suspected Fraud, Waste, and/or Abuse, the Office of Compliance shall review the suspected activity using data from reports, including, but not limited to, the following:

1. Claims data;
2. Encounter data;
3. Medical Records;
4. Member and Provider ~~Complaints~~complaints, ~~Appeals~~appeals, and ~~Grievance~~ grievance reviews;
5. Utilization ~~Management~~ Management reports;
6. Pharmacy data;
7. Audits;
8. Provider utilization profiles;
9. Member utilization profiles;
10. Geographic and demographic studies;
11. Evaluation of a Provider's Member capacity; and
12. Interviews.

~~D.~~F. A CalOptima E~~e~~mployee who detects suspected Fraud, Waste or Abuse shall complete a Suspected Fraud or Abuse Referral Form and transmit it to the Office of Compliance.

~~E.~~ G.~~,~~ ~~-~~An FDR with a contractual obligation to report suspected Fraud, Waste, or Abuse shall notify CalOptima of suspected Fraud, Waste, or Abuse, in accordance with the terms and conditions of its c~~C~~ontract and this policy.

~~F.~~ H. CalOptima shall provide a method for CalOptima E~~e~~mployees, FDRs, and Members to anonymously report suspected Fraud, Waste, or Abuse to the Office of Compliance. CalOptima employees, FDRs, and Members may call the Compliance and Ethics Hotline at (877) 837-4417 to anonymously report concerns regarding Fraud, Waste, and Abuse.

~~G. CalOptima's Office of Compliance shall provide regular training to employees and FDRs regarding the process for detecting suspected Fraud, Waste, or Abuse, the specific provisions regarding Fraud, Waste, and Abuse under the False Claims Act, and the protections afforded to those who report such concerns in good faith.~~

~~H.~~I. CalOptima departments and its FDRs shall track, trend and analyze data for suspected Fraud, Waste, or Abuse, and report such suspected Fraud, Waste or Abuse to CalOptima's Office of Compliance.

~~I.~~J. CalOptima shall treat the detection of suspected Fraud, Waste, or Abuse in a confidential manner, and shall not retaliate or make retribution against any CalOptima Eemployee, FDR, or Member for such detection in accordance with CalOptima policy HH.3012Δ: Non-Retaliation for Reporting Violations.

~~V.~~IV. ATTACHMENTS

A. Suspected Fraud or Abuse Referral Form (English)
B. Suspected Fraud or Abuse Referral Form (Spanish)
C. Suspected Fraud or Abuse Referral Form (Vietnamese)
D. Suspected Fraud or Abuse Referral Form (Korean)
E. Suspected Fraud or Abuse Referral Form (Chinese)
F. Suspected Fraud or Abuse Referral Form (Farsi)
G. Suspected Fraud or Abuse Referral Form (Arabic)

~~VI.~~V. REFERENCES

A. California Business and Professions Code, §4040
~~B. California Welfare and Institutions Code, §§14026 and 14107.2~~
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with Department of Health Care Services for Medi-Cal ~~(DHCS) #99-86099~~
~~Contract for Centers for Medicare & Medicaid Services for OneCare~~
~~Three-Way Agreement with the Department of Health Care Service and Centers for Medicare & Medicaid Services for OneCare Connect~~
~~C.~~
D. CalOptima Contract for Health Care Services
~~E. CalOptima Policy AA.1000: Glossary of Terms~~
~~F. CalOptima Policy HH.1107: Fraud, Waste and Abuse Investigation and Reporting~~
~~G. CalOptima Policy HH. 3012: Non-Retaliation for Reporting Violations.~~
~~H. Title 42, Code of Federal Regulations, §455.2~~
~~United States Code, Title 31, §3730 (h).~~
E. CalOptima PACE Program Agreement
~~CalOptima Policy AA.1000: Glossary of Terms~~
~~CalOptima Policy CMC.1001: Glossary of Terms~~
F. CalOptima Policy HH.1107Δ: Fraud, Waste and Abuse Investigation and Reporting
G. CalOptima Policy HH.3012Δ: Non-Retaliation for Reporting Violations
H. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Service (DHCS) for Cal MediConnect

I. Title 42, Code of Federal Regulations, §455.2
J. United States Code, Title 31, §3730 (h).
K. Welfare and Institutions Code, §§14026 and 14107.2
L. Welfare and Institutions Code, §14043.1(a)
~~CalOptima Policy HH.3012: Non-Retaliation for Reporting Violations~~
~~CalOptima Policy MA.9108: Fraud, Waste and Abuse Investigation and Reporting~~
~~CalOptima Policy MA.9223: Non-Retaliation for Reporting Violations~~
~~I.~~

~~VII.~~VI. REGULATORY AGENCY APPROVALS

None to Date

~~VIII.~~VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/1999	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	08/2000	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	09/01/2004	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	01/01/2007	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Effective	01/01/2007	MA.9107	Fraud, Waste, and Abuse Detection	OneCare
Revised	02/01/2013	HH.1105Δ	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare
Revised	04/01/2014	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	04/01/2014	MA.9107	Fraud, Waste, and Abuse Detection	OneCare
Revised	12/01/2014	MA.9107	Fraud, Waste, and Abuse Detection	OneCare OneCare Connect PACE
Revised	09/01/2015	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	09/01/2015	MA.9107	Fraud, Waste, and Abuse Detection	OneCare OneCare Connect PACE
Revised	06/01/2016	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	06/01/2016	MA.9107	Fraud, Waste, and Abuse Detection	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.1105Δ	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9107	Fraud, Waste, and Abuse Detection	OneCare OneCare Connect PACE

~~**IX.**~~

~~Version~~	~~Date~~	~~Policy Number~~	~~Policy Title~~
~~Effective~~	~~06/1999~~	~~HH.1105~~	~~Fraud, Waste and Abuse Detection~~
~~Revised~~	~~08/2000~~	~~HH.1105~~	~~Fraud, Waste and Abuse Detection~~
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~~Revised~~	~~09/01/2015~~	~~HH.1105~~	~~Fraud, Waste and Abuse Detection~~
~~Revised~~	~~06/01/2015~~	~~HH.1105~~	~~Fraud, Waste, and Abuse Detection~~
~~Revised~~	~~DATE12/01/2016~~	~~HH.1105Δ~~	~~Fraud, Waste, and Abuse Detection~~

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Authorized Representative	Has the meaning given such term in section 164.502(g) of title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of un-emancipated minors.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Complaint	An oral or written expression indicating dissatisfaction with any aspect of the CalOptima program.
Covered Service	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), or other services as authorized by the Board of Directors, which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Center of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way contract with the Department of Health Care Services (DHCS)

Term	Definition
	and Centers for Medicare & Medicaid Services (CMS). PACE: Items and services provided by CalOptima under the provisions of Welfare & Institutions Code section 14132, except those services specifically excluded under the CalOptima PACE Program Agreement, Exhibit E, Attachment 1, Section 26.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347).

Term	Definition
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information as amended.
Health Network	The contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury
Member	A beneficiary who is enrolled in a CalOptima Program.
Pharmacy	An area, place or premises licensed by the State Board of Pharmacy in which the profession of pharmacy is practiced and where Prescriptions are compounded and dispensed, and for the purpose of this policy, the licensed dispensing area of a community clinic.
Pharmacy Benefit Manager (PBM)	An entity that provides pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.

Term	Definition
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Policy #:	HH.1105Δ
Title:	**Fraud, Waste, and Abuse Detection**
Department:	Office of Compliance
Section:	Fraud, Waste, and Abuse – Special Investigations Unit
CEO Approval:	Michael Schrader _____
Effective Date:	06/01/99
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy establishes a process to detect, correct, and prevent suspected Fraud, Waste, or Abuse in a CalOptima program by a Member, Provider, Practitioner, a CalOptima Employee, First Tier, Downstream, and Related Entities (FDRs), Billing Intermediary, and CalOptima's Health Networks, in accordance with federal and state regulations.

II. POLICY

A. CalOptima maintains a zero tolerance policy toward Fraud, Waste, and Abuse.

B. CalOptima shall establish a process for detecting suspected Fraud, Waste, or Abuse, in accordance with this policy.

C. CalOptima and its First Tier, Downstream, and Related Entities (FDRs) shall comply with applicable statutory, regulatory, other requirements, sub-regulatory guidance, and contractual commitments related to the delivery of Covered Services, which include, but are not limited to, federal and state False Claims Acts, Anti-Kickback statutes, prohibitions on inducements to beneficiaries, Health Insurance Portability and Accountability Act (HIPAA), and other applicable statutes.

D. CalOptima's Office of Compliance shall investigate and report suspected Fraud, Waste, or Abuse, in accordance with CalOptima Policy HH.1107Δ: Fraud, Waste and Abuse Investigation and Reporting.

E. CalOptima shall provide regular training and information sessions to its FDRs regarding Fraud, Waste, and Abuse, and shall inform Members regarding Fraud, Waste, and Abuse and the provisions of this policy.

F. CalOptima Employees and FDRs are expected and required to promptly report suspected violations of any statute, regulations, or guidelines applicable to any CalOptima program. CalOptima maintains a strict policy of non-retaliation and non-retribution toward employees and its FDRs who make such reports in good faith. CalOptima Employees and its FDRs are protected from retaliation under Title 31, United States Code, Section 3730(h), for False Claims Act complaints, as well as any other anti-retaliation protections. CalOptima shall treat the detection of suspected FWA in a confidential manner.

G. CalOptima shall review this policy on an annual basis to ensure relevancy and accuracy, ensuring that CalOptima's FWA program is in alignment with industry best practices.

III. PROCEDURE

A. CalOptima may detect Fraud, Waste, or Abuse by a Member in circumstances that include, but are not limited to, the following:

1. Using another individual's identity, Benefits Identification Card (BIC), CalOptima or Health Network identification (ID) card, Medi-Cal or Medicare number, or other documentation of Medi-Cal, Medicare, or CalOptima program eligibility to obtain Covered Services, unless such person is an Authorized Representative who is presenting such document, or information, on behalf of a Member to obtain Covered Services for that Member;

2. Selling, loaning, or giving a Member's identity, Benefits Identification Card (BIC), Health Network identification (ID) card, Medi-Cal or Medicare number, or other documentation of Medi-Cal, Medicare or CalOptima program eligibility to obtain Covered Services, unless such person is an Authorized Representative who is obtaining services on behalf of a Member;

3. Making an unsubstantiated declaration of Medi-Cal or Medicare eligibility;

4. Using a Covered Service for purposes other than the purposes for which it was prescribed or provided, including use of such Covered Service by an individual other than the Member for whom the Covered Service was prescribed or provided;

5. Failing to report other health coverage; and

6. Soliciting or receiving a kickback, bribe, rebate, or other financial incentive as an inducement to receive or not receive Covered Services.

B. CalOptima may detect Fraud, Waste or Abuse by an FDR in circumstances that include, but are not limited to, the following:

1. Unsubstantiated declaration of eligibility to participate in the Medi-Cal, OneCare, OneCare Connect, or Program of All-Inclusive Care for the Elderly (PACE)program as a Provider, Practitioner, Billing Intermediary, or Health Network;

2. Submission of a claim or a request for payment for:

a. Covered Services that are substantially and demonstrably in excess of an individual's usual charges for such Covered Services;

b. Covered Services that were not provided to the Member for whom such Covered Services were claimed;

c. Covered Services substantially in excess of the quantity that is Medically Necessary for the Member;

d. Covered Services using a billing code that will result in greater payment than the billing code that reflects the Covered Services actually provided;

e. Covered Services that were already included in the capitation rate; and

f. Covered Services billed to both CalOptima and another third party payer without making full disclosure of material facts or notification of other insurance payments.

3. Charging a Member in excess of allowable co-payments or deductibles for Covered Services;

4. Billing a Member for Covered Services without obtaining written consent to bill for such Covered Services;

5. Soliciting, offering, receiving, or paying a kickback, bribe or rebate as an inducement to refer or fail to refer a Member;

6. Failing to disclose any significant beneficial interest in any other Provider to which the Provider or Practitioner may refer a Member for the provision of Covered Services;

7. Billing intermediary failure to register with the California Department of Health Care Services (DHCS), as appropriate;

8. False certification of Medical Necessity;

9. Attributing a diagnosis code to a Member that does not accurately reflect the Member's Medical Condition for the purposes of obtaining higher reimbursement;

10. Providing false or inaccurate Credentialing information;

11. Providing false or inaccurate information during the CalOptima provider registration process; and

12. Submitting data files or reports that contain:

a. Unsubstantiated data;

b. Data that is inconsistent with underlying clinical, encounter, or payment records; or

c. Data that has been altered in a manner, or for a purpose, that is inconsistent with CalOptima policies, contract, or applicable regulations and statutes.

C. Training

1. CalOptima's Office of Compliance shall provide regular training to Employees and FDRs regarding the process for detecting suspected FWA, the specific provisions regarding FWA under the False Claims Act, and the protections afforded to those who report such concerns in good faith.

2. CalOptima shall provide regular FWA training and information sessions to:

a. New Employees;

b. Annually to CalOptima Employees; and

c. Health Networks.

3. CalOptima shall provide Members with information related to FWA through:

a. The Member Handbook;

b. Periodic communications; and

c. The CalOptima website.

D. Detection

1. CalOptima may receive complaints of suspected FWA from sources, including but not limited to:

a. CalOptima's Compliance and Ethics Hotline;

b. Claims data history:

c. Encounter data;

d. Medical records audits

e. Member and provider complaints, appeals, and grievance reviews;

f. Utilization Management reports;

g. Provider utilization profiles;

h. Pharmacy Data;

i. Monitoring and auditing activities;

j. Monitoring external health care FWA cases and determining if CalOptima's FWA Program can be strengthened with information gleaned from the case activity; and/or

k. Internal and external surveys, reviews, and audits.

2. The Office of Compliance shall provide oversight to the Health Networks' Compliance Programs, to ensure that the programs are in place, and are comprehensive and in compliance with CalOptima contractual requirements.

3. CalOptima shall utilize "claims edits" in accordance with Federal and State regulations, the DHCS Contract, and industry best practices, including but not limited to the National Correct Coding Initiative (NCCI).

4. CalOptima shall conduct data validation reviews by claims auditors within the Office of Compliance. These reviews are intended to detect any anomalies between items billed, items rendered, and all affiliated documentation related to the claims and Encounters.

5. CalOptima shall utilize data analytics including software to identify potential FWA cases. This data compares CalOptima claims and Encounters against national data to identify any suspected instances of FWA. These cases are forwarded to the Special Investigations Unit (SIU) for investigation.

6. CalOptima shall perform reviews on data samples to test the following, but not limited to:

    a. Ensure that documentation of prior authorization is on file for services or medications requiring prior authorization;

    b. Review low-dollar/high-volume utilization by doctor, specialty and geographic comparison;

    c. CalOptima shall conduct monthly reviews of claims to review for adjustment codes and denials, reviewing for inappropriate denials and improper down coding. CalOptima's Claims Auditors shall review claims for emergency services to ensure that down coding does not occur when claims are submitted without accompanying Medical Records. Emergency room claims are reviewed during regular claims audits, and documentation is requested from the Health Network, at the time of the audit. Results of the audit are reviewed by the Audit and Oversight Committee (AOC). The AOC is responsible for issuing corrective actions for Health Networks who are found to be down coding inappropriately;

    d. CalOptima reviews Provider claims that are identified as potential FWA. Claims may be identified by the claims review software system, by the claims auditors, by internal and external claims and compliance audits, or any other source that identifies potential FWA. As part of the review process, CalOptima documents the investigation of the claims or Provider in the FWA Tracking Database. Once the investigation is completed, CalOptima shall report FWA as applicable and in accordance with CalOptima Policy HH.1107Δ: Fraud, Waste, Abuse Investigation and Reporting.

    e. In accordance with the Pharmacist Referral to SIU Team Desktop, CalOptima's Pharmacy Department shall refers cases to the SIU Team for Members exhibiting drug seeking behavior or suspected of FWA issues related to Pharmacy services.

7. CalOptima shall implement a Service Verification Survey process to survey a sampling of Members monthly to ensure that:

    a. Covered Services that were billed were received;

    b. Face-to-face services were provided for services/equipment/medications requiring recent or regular face to face appointments;

    c. Durable Medical Equipment (DME) that were billed were received;

    d. Medications that were billed were received; and

e. The focus of these surveys will vary as decided by the SIU and/or the Office of Compliance designated staff. The focus may be on a specific code, Provider, Member category, geographic area, and DME description, reports by other agencies of potential FWA, and industry findings and best practices.

E. Upon detection of suspected Fraud, Waste, and/or Abuse, the Office of Compliance shall review the suspected activity using data from reports, including, but not limited to, the following:

1. Claims data;
2. Encounter data;
3. Medical Records;
4. Member and Provider complaints, appeals, and grievance reviews;
5. Utilization Management reports;
6. Pharmacy data;
7. Audits;
8. Provider utilization profiles;
9. Member utilization profiles;
10. Geographic and demographic studies;
11. Evaluation of a Provider's Member capacity; and
12. Interviews.

F. A CalOptima Employee who detects suspected Fraud, Waste or Abuse shall complete a Suspected Fraud or Abuse Referral Form and transmit it to the Office of Compliance.

G. An FDR with a contractual obligation to report suspected Fraud, Waste, or Abuse shall notify CalOptima of suspected Fraud, Waste, or Abuse, in accordance with the terms and conditions of its contract and this policy.

H. CalOptima shall provide a method for CalOptima Employees, FDRs, and Members to anonymously report suspected Fraud, Waste, or Abuse to the Office of Compliance. CalOptima employees, FDRs, and Members may call the Compliance and Ethics Hotline at (877) 837-4417 to anonymously report concerns regarding Fraud, Waste, and Abuse.

I. CalOptima departments and its FDRs shall track, trend and analyze data for suspected Fraud, Waste, or Abuse, and report such suspected Fraud, Waste or Abuse to CalOptima's Office of Compliance.

J. CalOptima shall treat the detection of suspected Fraud, Waste, or Abuse in a confidential manner, and shall not retaliate or make retribution against any CalOptima Employee, FDR, or Member for

such detection in accordance with CalOptima policy HH.3012Δ: Non-Retaliation for Reporting Violations.

IV. ATTACHMENTS

A. Suspected Fraud or Abuse Referral Form (English)
B. Suspected Fraud or Abuse Referral Form (Spanish)
C. Suspected Fraud or Abuse Referral Form (Vietnamese)
D. Suspected Fraud or Abuse Referral Form (Korean)
E. Suspected Fraud or Abuse Referral Form (Chinese)
F. Suspected Fraud or Abuse Referral Form (Farsi)
G. Suspected Fraud or Abuse Referral Form (Arabic)

V. REFERENCES

A. California Business and Professions Code, §4040
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
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VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

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Term	Definition
	Items and services provided by CalOptima under the provisions of Welfare & Institutions Code section 14132, except those services specifically excluded under the CalOptima PACE Program Agreement, Exhibit E, Attachment 1, Section 26.
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Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347).
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information as amended.
Health Network	The contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury

Term	Definition
Member	A beneficiary who is enrolled in a CalOptima Program.
Pharmacy	An area, place or premises licensed by the State Board of Pharmacy in which the profession of pharmacy is practiced and where Prescriptions are compounded and dispensed, and for the purpose of this policy, the licensed dispensing area of a community clinic.
Pharmacy Benefit Manager (PBM)	An entity that provides pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1

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INSTRUCTIONS FOR COMPLETING A SUSPECTED FRAUD OR ABUSE REFERRAL FORM

To submit a request to investigate suspected fraud or abuse, please complete a CalOptima Suspected Fraud or Abuse Referral Form. Examples of fraud or abuse are listed on the Suspected Fraud or Abuse Referral Form. These are examples only. The list does not represent every situation in which fraud or abuse can take place. Therefore, CalOptima has provided an "Other" category for the requestor to describe the suspected fraud or abuse to be investigated.

Please note there is a section on the form to complete for reporting suspected fraud and abuse by a "Member" and/or "Provider."

Complete all applicable sections of the form. It is very important to complete the form in it's entirety to effectively investigate the referral.

If desired, requestor may remain anonymous; however, it should be understood that if the requestor does not provide his/her name and telephone number, the Compliance Supervisor of FWA will be unable to contact him/her for clarification of any of the information submitted that may prevent completion of the investigation.

Submit the completed form and attach supporting documents to CalOptima's Office of Compliance via one of the following methods:

1. Email: fraud@caloptima.org
2. U.S. Mail: CalOptima
   Office of Compliance
   505 City Parkway West
   Orange, CA 92868
3. Fax: 1-~~714-481-6457~~657-900-1605

ALL CORRESPONDENCE SHOULD BE MARKED AS "CONFIDENTIAL"

Correspondence will be received by the Office of Compliance, Special Investigations Unit (SIU) for review. Completed CalOptima Suspected Fraud or Abuse Referral Forms, and accompanying documentation may be sent directly to the Supervisor of FWA (Fraud, Waste, and Abuse) if the requestor wishes that the information only be opened by the Supervisor of FWA. Correspondence should be mailed to:

CalOptima
Supervisor of FWA
505 City Parkway West
Orange, CA 92868

CORRESPONDENCE SHOULD BE MARKED:
"CONFIDENTIAL: TO BE OPENED BY SUPERVISOR of FWA ONLY."

For additional information, or instructions on completing this form please call CalOptima's Office of Compliance, Special Investigations Unit (SIU) at: 1-714-246-8790.

- see next page -

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SUSPECTED FRAUD OR ABUSE REFERRAL FORM

REFERRAL INFORMATION		
Date: _____		Notice involves suspected fraud or abuse by a:
Referred by: Name: _____	Title: _____	☐ Member
Dept.: _____	Phone#: _____	☐ Provider

MEMBER	PROVIDER
CalOptima Program: ☐ Medi-Cal ☐ OneCare ☐ PACE ☐ OneCare Connect	Provider Name:
Member Name:	Type of provider:
Member ID:	Provider ID #:
Address:	Address:
City: Zip:	City: Zip:
Date of service if applicable:	Date of service if applicable:
	Member ID, if applicable: If multiple Members are involved, please attach a list.
Suspected fraud or abuse: ☐ Using another individual's identity or documentation of Medi-Cal eligibility to obtain covered services (unless such person is an authorized representative who is presenting such information to obtain covered services on behalf of a member). ☐ Selling, loaning, or giving a member's identity or documentation of eligibility (Medi-Cal, OneCare, OneCare Connect or PACE) to obtain covered services (other than to a family member to obtain covered services on behalf of a Member). ☐ Making an unsubstantiated declaration of eligibility. ☐ Using a covered service for purposes other than the purposes for which it was prescribed including use of such covered service by an individual other than the member for whom the covered service was prescribed or provided. ☐ Failing to report other health coverage. ☐ Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive covered services. ☐ Other (please specify) _____	**Suspected fraud or abuse**: ☐ Unsubstantiated declaration of eligibility to participate in the CalOptima program. ☐ Submission of claims for covered services that are: ☐ Substantially and demonstrably in excess of any individual's usual charges for such covered services. ☐ Not actually provided to the member for which the claim is submitted. ☐ In excess of the quantity that is medically necessary; ☐ Billed using a code that would result in greater payment than the code that reflects the covered service. ☐ Already included in capitation rate. ☐ Submitted for payment to both CalOptima and another third party payer without full disclosure. ☐ Charging a member in excess of allowable co-payments and deductibles for covered services. ☐ Billing a member for covered services without obtaining written consent to bill for such services. ☐ Failure to disclose conflict of interest. ☐ Receiving, soliciting, or offering a kickback, bribe, or rebate to refer or fail to refer a member. ☐ Failure to register billing intermediary with the Department of Health Care Services (DHCS). ☐ False certification of medical necessity. ☐ Attributing a diagnosis code to a member that does not reflect the member's medical condition for the purpose of obtaining higher reimbursement.

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SUSPECTED FRAUD OR ABUSE REFERRAL FORM

	☐ False or inaccurate Minimum Standards or credentialing information. ☐ Submitting reports that contain unsubstantiated data, data that is inconsistent with records, or has been altered in a manner that is inconsistent with policies, contracts, statutes, or regulations. ☐ Other (please specify) _____

DOCUMENTATION (PLEASE ATTACH):

- ☐ Claims data
- ☐ Medical records
- ☐ Complaint, appeal, or grievance
- ☐ UM reports
- ☐ Audit
- ☐ Other (please specify) _____

Please provide a brief explanation of how the documentation provided supports concerns of fraudulent activity:
_____

Please provide the root cause of this suspected fraudulent activity: _____

OTHER RELEVANT INFORMATION (PLEASE ATTACH):

Are there any prior suspected fraud or abuse issues by this member, provider, pharmacy, other: _____

1. ☐ No
   ☐ Yes. Please describe:

2. If yes, what was the outcome?

Please submit this form with all pertinent documentation to the OFFICE OF COMPLIANCE SPECIAL INVESTIGATIONS UNIT (SIU). The Office of Compliance, SIU shall report as appropriate to local and state entities. If you do not receive an acknowledgement of receipt of this form within five (5) working days, please contact the Supervisor of FWA at 1-714-246-8790.

This section to be completed by Compliance:

Compliance Tracking No. _____ Date Acknowledgement Sent: _____

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INSTRUCTIONS FOR COMPLETING A SUSPECTED FRAUD OR ABUSE REFERRAL FORM

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Please note there is a section on the form to complete for reporting suspected fraud and abuse by a "Member" and/or "Provider."

Complete all applicable sections of the form. It is very important to complete the form in it's entirety to effectively investigate the referral.

If desired, requestor may remain anonymous; however, it should be understood that if the requestor does not provide his/her name and telephone number, the Compliance Supervisor of FWA will be unable to contact him/her for clarification of any of the information submitted that may prevent completion of the investigation.

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505 City Parkway West
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SUSPECTED FRAUD OR ABUSE REFERRAL FORM

REFERRAL INFORMATION		
Date: _____		Notice involves suspected fraud or abuse by a:
Referred by: Name: _____	Title: _____	☐ Member
Dept.: _____	Phone#: _____	☐ Provider

MEMBER	PROVIDER
CalOptima Program: ☐ Medi-Cal ☐ OneCare ☐ PACE ☐ OneCare Connect	Provider Name:
Member Name:	Type of provider:
Member ID:	Provider ID #:
Address:	Address:
City: Zip:	City: Zip:
Date of service if applicable:	Date of service if applicable:
	Member ID, if applicable: If multiple Members are involved, please attach a list.
Suspected fraud or abuse: ☐ Using another individual's identity or documentation of Medi-Cal eligibility to obtain covered services (unless such person is an authorized representative who is presenting such information to obtain covered services on behalf of a member). ☐ Selling, loaning, or giving a member's identity or documentation of eligibility (Medi-Cal, OneCare, OneCare Connect or PACE) to obtain covered services (other than to a family member to obtain covered services on behalf of a Member). ☐ Making an unsubstantiated declaration of eligibility. ☐ Using a covered service for purposes other than the purposes for which it was prescribed including use of such covered service by an individual other than the member for whom the covered service was prescribed or provided. ☐ Failing to report other health coverage. ☐ Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive covered services. ☐ Other (please specify) _____	**Suspected fraud or abuse**: ☐ Unsubstantiated declaration of eligibility to participate in the CalOptima program. ☐ Submission of claims for covered services that are: ☐ Substantially and demonstrably in excess of any individual's usual charges for such covered services. ☐ Not actually provided to the member for which the claim is submitted. ☐ In excess of the quantity that is medically necessary; ☐ Billed using a code that would result in greater payment than the code that reflects the covered service. ☐ Already included in capitation rate. ☐ Submitted for payment to both CalOptima and another third party payer without full disclosure. ☐ Charging a member in excess of allowable co-payments and deductibles for covered services. ☐ Billing a member for covered services without obtaining written consent to bill for such services. ☐ Failure to disclose conflict of interest. ☐ Receiving, soliciting, or offering a kickback, bribe, or rebate to refer or fail to refer a member. ☐ Failure to register billing intermediary with the Department of Health Care Services (DHCS). ☐ False certification of medical necessity. ☐ Attributing a diagnosis code to a member that does not reflect the member's medical condition for the purpose of obtaining higher reimbursement.

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DOCUMENTATION (PLEASE ATTACH):

- ☐ Claims data
- ☐ Medical records
- ☐ Complaint, appeal, or grievance
- ☐ UM reports
- ☐ Audit
- ☐ Other (please specify) _____

Please provide a brief explanation of how the documentation provided supports concerns of fraudulent activity:
_____

Please provide the root cause of this suspected fraudulent activity: _____

OTHER RELEVANT INFORMATION (PLEASE ATTACH):

Are there any prior suspected fraud or abuse issues by this member, provider, pharmacy, other: _____

1. ☐ No
   ☐ Yes. Please describe:

2. If yes, what was the outcome?

Please submit this form with all pertinent documentation to the OFFICE OF COMPLIANCE SPECIAL INVESTIGATIONS UNIT (SIU). The Office of Compliance, SIU shall report as appropriate to local and state entities. If you do not receive an acknowledgement of receipt of this form within five (5) working days, please contact the Supervisor of FWA at 1-714-246-8790.

This section to be completed by Compliance:

Compliance Tracking No. _____ Date Acknowledgement Sent: _____

~~Policy #: HH.1107Δ~~
~~Title: **Fraud, Waste and Abuse Investigation and Reporting**~~
~~Department: Office of Compliance~~
~~Section: Fraud, Waste, and Abuse Special Investigations Unit~~

~~CEO Approval: Michael Schrader~~

~~Effective Date: 09/01/04~~
~~Last Review Date: 06/01/16~~12/01/16
~~Last Revised Date: 06/01/16~~12/01/16

~~Applicable to: Medi-Cal~~
~~OneCare~~
~~OneCare Connect~~
~~PACE~~

Policy #: HH.1107Δ
Title: **Fraud, Waste, and Abuse Investigation and Reporting**

Department: Office of Compliance
Section: Fraud, Waste, and Abuse – Special Investigations Unit

CEO Approval: Michael Schrader

Effective Date: 09/01/04
Last Review Date: 12/01/16
Last Revised Date: 12/01/16

Applicable to:
☒ Medi-Cal
☒ OneCare
☒ OneCare Connect
☒ PACE

I. PURPOSE

~~To~~ This policy establish~~es~~ a process to investigate and report suspected Fraud, Waste, or Abuse (FWA) in a CalOptima program by a Member, Provider, Practitioner, a CalOptima Employee, First Tier, Downstream and Related Entities (FDR~~'~~s), Billing Intermediary, and CalOptima's Health Network, in accordance with federal and state regulations.

~~**CalOptima employee~~Employee~~, a Member, or a First Tier, Downstream or Related Entity (FDR), in accordance with federal and state regulations.**~~

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~

~~Term~~	~~Definition~~
~~Abuse~~	~~Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.~~
~~Centers for Medicare & Medicaid Services (CMS)~~	~~The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.~~
~~Compliance Committee~~	~~The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Executive Director of Compliance; and Executive Director of Human Resources.~~
~~Compliance Program~~	~~The program (including, without limitation, this Compliance Plan, Code of Conduct and Policies and Procedures and Procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Member, Employees and FDRs comply with applicable law and ethical standards.~~

~~Term~~	~~Definition~~
~~Covered Service~~	~~Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), or other services as authorized by the Board of Directors, which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.~~ ~~OneCare:~~ ~~Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Center of Medicare & Medicaid Services (CMS) Contract.~~ ~~OneCare Connect:~~ ~~Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).~~ ~~PACE:~~ ~~Items and services provided by CalOptima under the provisions of Welfare & Institutions Code section 14132, except those services specifically excluded under the CalOptima PACE Program Agreement, Exhibit E, Attachment 1, Section 26.~~
~~Credible aAllegation of Fraud~~	~~Credible allegation of fraud. A credible allegation of fraud may be an allegation, which has been verified by the State, from any source, including but not limited to the following: (1) Fraud hotline complaints. (2) Claims data mining. (3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.~~
~~Department of Health Care Services (DHCS)~~	~~The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.~~
~~Downstream Entity~~	~~Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.~~
~~Employee~~	~~Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.~~

~~Term~~	~~Definition~~
~~First Tier, Downstream, and Related Entities (FDR)~~	~~First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortiums, and Health Maintenance Organizations.~~
~~First Tier Entity~~	~~Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.~~
~~Fraud~~	~~Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. §Section 1347).~~
~~Health Insurance Portability and Accountability Act (HIPAA)~~	~~The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.~~
~~Health Network~~	~~The contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.~~
~~Medically Necessary or Medical Necessity~~	~~Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.~~
~~Medical Record~~	~~Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.~~
~~Member~~	~~A beneficiary who is enrolled in a CalOptima Program.A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.~~
~~Pharmacy Benefit Manager (PBM)~~	~~An entity that provides pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.The entity that performs certain functions and tasks including, but not limited to, Pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.~~

~~Term~~	~~Definition~~
~~Provider~~	~~A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.~~
~~Related Entity~~	~~Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.~~
~~Waste~~	~~The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.~~

~~III.~~II. POLICY

A. CalOptima maintains a zero tolerance policy toward FWA by any CalOptima ~~employee~~ Employee, or FDRs.

B. CalOptima and its FDRs shall comply with applicable statutory, regulatory, other requirements, sub-regulatory guidance, and contractual commitments related to the delivery of ~~covered~~ Covered ~~Medi-Cal~~ Sservices, which include, but are not limited to, federal and state False Claims Acts, Anti-Kickback statutes, prohibitions on inducements to beneficiaries, Health Insurance Portability and Accountability Act (HIPAA), and other applicable statutes.

C. CalOptima ~~employees~~ Employees and its FDRs are expected and required to promptly report suspected violations of any statute, regulations, or guidelines applicable to any CalOptima program. CalOptima maintains a strict policy of non-retaliation and non-retribution toward ~~employees~~ Employees and its FDRs who make such reports in good faith. CalOptima Employees and its FDRs are protected from retaliation under Title 31, United State Code, Section 3730(h), for False Claims Act complaints, as well as any other anti-retaliation protections.

D. This policy is reviewed annually to ensure relevancy and accuracy, ensuring that CalOptima's FWA program are in alignment with industry best practices.

E. CalOptima shall establish a process for timely and reasonable investigation and reporting of suspected FWA in accordance with this policy.

F. CalOptima's Office of Compliance shall coordinate all activities associated with the investigation and reporting of suspected FWA.

G. CalOptima's Office of Compliance shall maintain a system for the review of suspect claims to detect and prevent FWA, in accordance with federal and state regulations, and to identify resulting overpayments for recoupment in accordance with CalOptima Policy HH.5000Δ: Provider Overpayment Investigation and Determination.

H. CalOptima shall cooperate with the Department of Health Care Services (DHCS), Centers for Medicare & Medicaid (CMS), and law enforcement agencies related to any ~~Fraud, Waste and Abuse~~FWA investigations, or audits.

I. CalOptima shall conduct a preliminary investigation of any allegation of suspected FWA and shall report suspected FWA to the appropriate agency, in accordance with its c~~C~~ontracts with DHCS and/or CMS, and this policy.

J. Upon determination of validity of the allegation, CalOptima shall refer ~~report~~ suspected FWA to DHCS and/or CMS for further investigation, as appropriate.

K. CalOptima's Office of Compliance shall maintain a database and a uniform filing system to maintain suspected FWA referrals, including reports, investigations, and correspondence, in accordance with CalOptima's Compliance Program.

L. CalOptima's Office of Compliance shall develop data and other supporting evidence for a FWA investigation, consult with Legal Counsel, and function as the liaison between CalOptima and DHCS, appropriate state Medical Boards, the State Board of Pharmacy, other licensing entities, law enforcement, prosecuting agencies as appropriate, and other relevant entities.

M. CalOptima's Office of Compliance shall ensure appropriate confidentiality of case files, or other documentation relating to any investigation of a suspected FWA case.

N. CalOptima's Office of Compliance shall report the status and results of all suspected FWA investigations to CalOptima's Compliance Committee.

O. CalOptima shall fully coordinate and cooperate with DHCS, CMS and other law enforcement agencies related to any FWA investigations or audits to support health oversight matters.

III. ~~IV.~~ PROCEDURE

A. Reporting:

1. CalOptima shall provide a method for CalOptima E~~e~~mployees, FDRs, and Members to anonymously report suspected FWA to the Office of Compliance. CalOptima E~~e~~mployees and its FDRs may call the Compliance and Ethics Hotline at (877) 837-4417 to anonymously report concerns regarding Fraud, Waste, and Abuse.

2. A CalOptima E~~e~~mployee who detects suspected FWA shall complete a Suspected Fraud or Abuse Referral Form and transmit it to the Office of Compliance.

3. An FDR with a contractual obligation to report suspected FWA shall notify CalOptima of suspected FWA, in accordance with the terms and conditions of its c~~C~~ontract and this policy.

4. CalOptima's Office of Compliance shall investigate and report suspected FWA, in accordance with this policy.

5. CalOptima shall report to DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by CalOptima E~~e~~mployees, FDRs, or Members. CalOptima shall conduct, complete and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within ten (10) business days of the date CalOptima first became aware of, or is in notice of such activity.

6. For investigations involving One-Care, One-Care Connect, or PACE programs, CalOptima shall report to CMS via the NBI MEDIC all cases of suspected fraud and/or abuse where there is reason to believe that an incident of F~~f~~raud and/or A~~a~~buse has occurred by CalOptima E~~e~~mployees, FDRs, or Members. CalOptima shall conduct, complete and report to CMS, the results of a preliminary investigation of the suspected F~~f~~raud and/or A~~a~~buse within thirty (30) business days of the date CalOptima first became aware of, or is in notice of such activity.

7. Referrals to DHCS and NBI MEDIC, where Special Investigation Unit (SIU) detection activities results in a reason to believe suspected F~~f~~raud or A~~a~~buse has occurred and requires further investigation by DHCS, shall be sent on the Form MC609-Confidential Report form. The MC609 form and attachments submitted to DHCS must at a minimum include:

   a. Number of complaints of F~~f~~raud and A~~a~~buse submitted that warranted preliminary investigation;

   b. For each complaint which warranted a preliminary investigation:

      i. Name and/or SSN or CIN;

      ii. Source of Complaint;

      iii. Type of P~~p~~rovider;

      iv. Nature of complaint;

      v. Approximate dollars involved if known; and

      vi. Legal and administrative disposition of the case.

   c. For investigations involving the Medi-Cal program, the referral shall be submitted on a Medi-Cal Complaint Report (MC 609) that can be sent to DHCS via secure e-mail, secure facsimile, Federal Express with Tracking number or certified mail, in accordance with the instructions provided in Exhibit E of CalOptima's contract with the Department of Health Care Services for Medi-Cal.

   d. For investigations involving the One-Care, One-Care Connect, or -PACE programs, the referral shall be submitted on a Part D/MEDIC Complaint form that can be sent to CMS contractor, NBI MEDIC, via secure e-mail, secure facsimile, FedEx with Tracking Number, or certified mail. For investigations involving One-Care, One-Care Connect, or PACE program where the allegation is exclusively a compromised identification, the referral to NBI MEDIC shall be submitted on a MEDIC ID compromised form. CalOptima shall submit applicable police reports, investigation documentation (background, interviews, ~~etc~~etc.), member information, Provider enrollment data, confirmation of services, list items or services furnished by Provider, pharmaceutical data, and any other pertinent information.

~~A.~~B. Investigation:

1. Upon detection of suspected FWA, the Office of Compliance shall review the suspected activity using data from reports, including, but not limited to, the following:

a. CalOptima's Compliance and Ethics Hotline, or other reporting mechanisms;~~laims data;~~

b. Claims data history~~Encounter data~~;

c. Encounter Data~~Medical Records~~;

d. Member and Provider ~~Complaints~~complaints, ~~A~~appeals, and ~~Grievance~~ grievance reviews;

e. Medical record audits~~Utilization Management~~ ~~Management~~ ~~reports~~;

f. Pharmacy data;

g. Utilization Management Reports~~Audits~~;

h. Provider utilization profiles;

i. Monitoring and auditing activities ~~Member utilization profiles~~;

j. Monitoring external health care FWA cases and determining if CalOptima's FWA program can be strengthened with information gleaned from the case activity; and/or~~Geographic and demographic studies;~~

~~k.~~ Internal and external survey~~, reviews~~, reviews, and audits.~~Evaluation of a Provider's Member capacity; and~~

~~l.~~k. ~~Interviews.~~

2. For investigations involving the CalOptima Medi-Cal program, CalOptima shall complete the preliminary investigation, including the review of listed and other documents. CalOptima shall conduct, complete and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within ten (10) business days of the date CalOptima first became aware of, or is in notice of such activity.

3. For investigations involving the One~~-~~Care, One Care Connect, ~~and~~or Program of All-Inclusive Care for the Elderly (PACE) programs, ~~lines of business,~~ CalOptima shall complete the preliminary investigation, including the review of listed and other documents. CalOptima shall conduct, complete and report to the CMS National Benefit Integrity Medicare Drug Integrity Contractor~~contractor,~~ (NBI MEDIC) ~~(National Benefit Integrity Medicare Drug Integrity Contractor)~~, the results of a preliminary investigation of the suspected fraud and/or abuse within thirty (30) business days of the date CalOptima first became aware of, or is in notice of such activity.

4. For CalOptima E~~e~~mployee conduct investigations that involve potential FWA, a referral to SIU should be made by the CalOptima staff involved in the initial E~~e~~mployee conduct investigation. Each referral is considered on a case~~-~~ by~~--~~case basis. The referral to SIU for E~~e~~mployee conduct investigations will authorize the SIU to have primary responsibility of the E~~e~~mployee conduct investigation as it relates to potential FWA.

~~2.~~

~~3.~~5. When included on the FWA Referral Form, or when the FWA Investigator is able to determine the probable root cause of the suspected FWA, the information will be documented in the Fraud Tracking Database. Additionally, the FWA Investigator will track and trend on the root causes as part of the FWA Trend Analysis on a quarterly basis to the Compliance Committee, when there are root causes that have been identified and able to be trended.

6. For the Medi-Cal Program, and ~~I~~in accordance with CalOptima Policies HH.2005Δ: Corrective Actions Plans, HH.2002Δ: Sanctions, GA.8021: Employee Conduct and GA.8022: Progressive Discipline, CalOptima shall issue corrective actions to E~~e~~mployees, and its FDRs related to validated instances of FWA. Corrective actions will be monitored by the Compliance Committee, or the Human Resources Department ~~of Human Resources~~, as appropriate. Corrective actions may include financial sanctions, regulatory reporting, performance improvement plans, or termination. If the validated instance of FWA is determined to be criminal in nature, correction action may also include a referral to law enforcement. Should such corrective action need to be issued, CalOptima Office of Compliance will initiate review and discussion at the first Compliance Committee following the date of identification of the suspected FWA, the date of report to DHCS, or the date of FWA substantiation by DHCS subsequent to the report.

7. For ~~investigations involving~~ the One-Care, One-Care Connect, ~~and~~ or PACE ~~lines of business~~programs, and~~,~~ in accordance with CalOptima Policies ~~MA.9104~~HH.2005Δ: Corrective Actions Plans, ~~MA.9105~~HH.2002Δ: Sanctions, GA.8021: Employee Conduct and GA.8022: Progressive Discipline, CalOptima shall issue corrective actions to employees, and its FDRs related to validated instances of FWA. Corrective actions will be monitored by the Compliance Committee, or the Human Resources Department ~~of Human Resources~~, as appropriate. Corrective actions may include financial sanctions, regulatory reporting, performance improvement plans, or termination, as appropriate. If the validated instance of FWA is determined to be criminal in nature, corrective action may also include a referral to law enforcement. Should such corrective action need to be issued, CalOptima Office of Compliance will initiate review and discussion at the first Compliance Committee following the date of identification of the suspected FWA, the date of report to CMS, or the date of FWA substantiation by CMS subsequent to the report.

8. For investigations involving situations when DHCS notifies the CalOptima that a ~~c~~Credible ~~a~~Allegation of ~~f~~Fraud has been found against a provider relating to the provision of Fee-For-Service (FFS) Medi-Cal services and that provider is also part of the CalOptima network, CalOptima must take one (1) or more of the following options and submit supporting documentation to DHCS~~.~~:

   a. Terminate the P~~p~~rovider from its network;

   b. Temporarily suspend the P~~p~~rovider from its network pending resolution of the F~~f~~raud allegation;

   c. Temporarily suspend payment to the P~~p~~rovider pending resolution of the F~~f~~raud allegation; and/or

   d. Conduct additional monitoring including audits of the P~~p~~rovider's claims history and future claims submissions for appropriate billing.

~~4.~~

~~5.~~9. The following is a list of potential FWA classifications for Member and provider Fraud and Abuse Program, along with some examples of potential detection criteria that may be used to detect these types of suspected FWA:

MEMBER FRAUD OR PROGRAM ABUSE		**DETECTION CRITERIA Including but not limited to:**
M01	Using another individual's identity or documentation of Medi-Cal eligibility to obtain Covered Services	Members with multiple areas of service; members who attempt more than one PCP; reports of members who are hiding assets or income
M02	Selling, loaning, or giving a member's identity or documentation of Medi-Cal eligibility to obtain services	Members with multiple areas of service; members who attempt more than one PCP; reports of members who are hiding assets or income
M03	Making an unsubstantiated declaration of eligibility	Members with multiple areas of service; members who attempt more than one PCP; reports of members who are hiding assets or income
M04	Using a Covered Service for purposes other than the purpose for which it was described including use of such Covered Service	Selling a covered wheelchair; selling medications; abusing prescription medications
M05	Failing to report other health coverage.	Payments by OHI
M06	Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive Covered Services.	Hotline reports; internal reports; reports by Health Networks
M07	Other (please specify)	Any source
M08	Member Pharmacy Utilization	PBM reports; data analytics; claims data; encounter data; FWA software
M09	Doctor Shopping	PBM reports; data analytics; claims data; encounter data; FWA software
M10	Altered Prescription	Provider report; DEA report; pharmacy report; PBM reports; data analytics; claims data; encounter data; FWA software

PROVIDER FRAUD OR PROGRAM ABUSE		**DETECTION CRITERIA Including but not limited to:**
P01	Unsubstantiated declaration of eligibility to participate in the CalOptima program	Provider information not able to be verified during credentialing or contracting process; providers on the excluded provider list
P02	Submission of claims for Covered Services that are substantially and demonstrably in excess of any individual's usual charges for such Covered Services	PBM reports; data analytics; claims data; encounter data; FWA software
P03	Submission of claims for Covered Services that are not actually provided to the member for which the claim is submitted	PBM reports; data analytics; claims data; encounter data; FWA software; verification survey; hotline

PROVIDER FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P04	Submission of claims for Covered Services that are in excess of the quantity that is Medically Necessary	PBM reports; data analytics; claims data; encounter data; FWA software
P05	Submission of claims for Covered Services that are that are billed using a code that would result in great payment than the code that reflects the covered services	PBM reports; data analytics; claims data; encounter data; FWA software
P06	Submission of claims for Covered Services that is already included in the capitation rate	PBM reports; data analytics; claims data; encounter data; FWA software
P07	Submission of claims for Covered Services that are submitted for payment to both CalOptima and another third party payer without full disclosure	PBM reports; data analytics; claims data; encounter data; FWA software; payment by OHI
P08	Charging a member in excess of allowable co-payments and deductibles for Covered Services	Member report; hotline report; oversight audits
P09	Billing a member for Covered Services without obtaining written consent to bill for such service	Member report; hotline report; oversight audits
P10	Failure to disclose conflict of interest	Hotline; credentialing or contracting process
P11	Receiving, soliciting, or offering a kickback, bribe or rebate to refer or fail to refer a member	Hotline report; oversight report
P12	Failure to register billing intermediary with the Department of Health Care Services	Oversight audit; report by regulatory body; hotline
P13	False certification of Medical Necessity	Medical record review; claims data; encounter data; FWA software
P14	Attributing a diagnosis code to a member that does not reflect the member's medical condition for the purpose of obtaining higher reimbursement	Medical record review; claims data; encounter data; FWA software
P15	False or inaccurate Minimum Standards or credentialing information	Hotline; credentialing or contracting process
P16	Submitting reports that contain unsubstantiated data, data that is inconsistent with records, or has been altered in a manner that is inconsistent with policies, contracts, statues or regulations	Medical record review; claims data; encounter data; FWA software
P17	Other (please specify)	Any source
P18	Provider Pharmacy Utilization	PBM reports; data analytics; claims data; encounter data; FWA software

PROVIDER FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P19	Billing Medi-Cal Member for Services	Member report; hotline report; oversight audits
P20	Durable Medical Equipment- Covered Services that are not actually provided to beneficiary	Member report; hotline report; oversight audits; verification survey

EMPLOYEE FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
E01	Use of a ~~m~~Member's identity or documentation of Medi-Cal eligibility to obtain services	Employees obtaining services on a ~~m~~Member's account. Hotline report. Data analytics. Referrals to SIU.
E02	Use of a ~~m~~Member's identity or documentation of Medi-Cal eligibility to obtain a gain.	Employees obtaining unjust enrichment, funds, or other gain by selling ~~m~~Member's account information. Hotline report.
E03	Employee assistance to providers with the submission of claims for Covered Services that are not actually provided to the ~~m~~Member for which the claim is submitted.	Employees obtaining unjust enrichment, funds, or other gain from provider by using ~~m~~Member's account information to assist in the submission of false claims. Hotline report. Referrals to SIU.
E04	Employee deceptively accessing company confidential information for purpose of a gain.	Employees obtaining unjust enrichment, funds, or other gain from another by deceptive and unauthorized accessing of information. Hotline Service. Data Analytics. Referrals to SIU.

~~6.~~10. CalOptima Special Investigation Unit (SIU) shall enter a~~A~~ll documentation related to any suspected FWA case ~~must be entered~~ into the Fraud Tracking Database as soon as practicable and document ~~Documentation of~~ the final disposition is t~~o be documented~~ as soon as practicable, once the case has been determined to be closed.

~~7.~~11. Compliance Action/Outcomes may include but are not limited to:

C01	Contract amendment
C02	Corrective action plan
C03	Education
C04	Focused Audit
C05	Investigation
C06	Monitoring
C07	New Policy
C08	Policy Revision
C09	Prepayment Review
C10	Process Review
C100	Referred to CalOptima Legal
C101	No Fraud Folder Created
C102	Criminal Filing- Pending
C11	Criminal Filing- Conviction
C111	Criminal Filing- Exonerated
C12	Non-Criminal Action Taken

C13	Does not meet prosecutorial guidelines
C14	Technical issues- resolved
C15	Insufficient evidence of fraud
C16	Allegations/Violation confirmed: Warning Letter Issued
C18	Allegations/Violation confirmed: Administrative Action
C19	Allegations/Violation confirmed: Warning Letter & Administrative Action
C20	Administrative Error
C21	Administrative Action
C22	Unable to establish violation of the Medi-Cal Program
C23	Medi-Cal Usage Minimal
C24	DHS Referred to Other Agency
C26	Criminal Filing
C98	No Action Taken
C99	Other: (Explain)

~~B. Reporting:~~

~~1. CalOptima shall provide a method for CalOptima employees, FDRs, and Members to anonymously report suspected FWA to the Office of Compliance. CalOptima employees and its FDRs may call the Compliance and Ethics Hotline at (877) 837-4417 to anonymously report concerns regarding Fraud, Waste, and Abuse.~~

~~2. CalOptima employee who detects suspected FWA shall complete a Suspected Fraud or Abuse Referral Form and transmit it to the Office of Compliance.~~

~~3. An FDR with a contractual obligation to report suspected FWA shall notify CalOptima of suspected FWA, in accordance with the terms and conditions of its Contract and this policy.~~

~~4. CalOptima's Office of Compliance shall investigate and report suspected FWA, in accordance with this policy.~~

~~CalOptima shall report to DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by CalOptima employees, FDRs, or Members. CalOptima shall conduct, complete and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within ten (10) business days of the date CalOptima first became aware of, or is in notice of such activity.~~

~~5. For investigations involving One Care, One Care Connect, andor PACE lines of businessprograms, CalOptima shall report to CMS via the National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by CalOptima employees, FDRs, or Members. CalOptima shall conduct, complete and report to CMS, the results of a preliminary investigation of the suspected fraud and/or abuse within thirty (30) business days of the date CalOptima first became aware of, or is in notice of such activity.~~

~~6. Referrals to DHCS and NBI MEDIC, where Special Investigation Unit (SIU) detection activities results in a reason to believe suspected fraud or abuse has occurred and requires further investigation by DHCS, shall be sent on the Form MC609 Confidential Report form. The MC609 form and attachments submitted to DHCS must at a minimum include:~~

~~a. Number of complaints of fraud and abuse submitted that warranted preliminary investigation;~~

~~b. For each complaint which warranted a preliminary investigation:~~

~~i. Name and/or SSN or CIN;~~

~~ii. Source of Complaint;~~

~~iii. Type of provider;~~

~~iv. Nature of complaint;~~

~~v. Approximate dollars involved if known;~~

~~vi. Legal and administrative disposition of the case.~~

~~For investigations the Medi-Cal program, T~~the referral shall be submitted on a Medi-Cal Complaint Report (MC 609) that can be sent to DHCS via secure e-mail (Iron Port), secure facsimile, Federal Express with Tracking number or certified mail, in accordance with the instructions provided in Exhibit E of CalOptima's contract with the Department of Health Care Services for Medi-Cal.~~;~~

~~c. For investigations involving One Care, One Care Connect, or and PACE lines of businessprograms, the referral shall be submitted on a Part D/MEDIC Complaint form that can be sent to CMS contractor, NBI MEDIC, via secure e-mail (Iron Port), secure facsimile, Federal Express with Tracking Number, or certified mail. For investigations involving One Care, One Care Connect, andor PACE lines of business program where the allegation is exclusively a compromised identification, the referral to NBI MEDIC shall be submitted on a MEDIC ID Ccompromised form.~~

~~d. CalOptima shall submit applicable police reports, investigation documentation (background, interviews, etc), member information, Provider enrollment data, confirmation of services, list items or services furnished by Provider, pharmaceutical data, and any other pertinent information.~~

~~V.~~IV. ATTACHMENTS

A. Suspected Fraud or Abuse Referral Form (English)
B. Suspected Fraud or Abuse Referral Form (Spanish)
C. Suspected Fraud or Abuse Referral Form (Vietnamese)
D. Suspected Fraud or Abuse Referral Form (Korean)
E. Suspected Fraud or Abuse Referral Form (Chinese)
F. Suspected Fraud or Abuse Referral Form (Farsi)
G. Suspected Fraud or Abuse Referral Form (Arabic)
H. Form MC609 - Confidential Medi-Cal Complaint Report form
I. CalOptima Referral to MEDIC
~~H.~~J. CalOptima Referral to MEDIC ID Compromised

~~VI.~~V. REFERENCES

A. California Business and Professions Code, §4040
B. CalOptima Compliance ~~Program~~Plan
C. CalOptima Contract for Health Care Services
D. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
E. CalOptima Contract with the Department of Health Care Services (DHCS) for ~~C.~~ Medi-~~C~~Cal
F. CalOptima PACE Program Agreement
~~Contract for Centers for Medicare & Medicaid Services for OneCare~~
~~Three-Way Agreement with the Department of Health Care Service and Centers for Medicare & Medicaid Services for OneCare Connect~~
~~D.~~G. CalOptima Policy HH.1105Δ: Fraud, Waste and Abuse Detection
~~E.~~H. CalOptima Policy HH.2002Δ: Sanction
I. CalOptima Policy HH.2005Δ: Corrective Action Plan
~~F.~~J. CalOptima Policy HH.5000Δ: Provider Overpayment Investigation and Determination
K. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Service (DHCS) for Cal MediConnect
~~G. Contract for Health Care Services~~
~~H.~~L. Medi-Cal Managed Care Division (MMCD) All Plan Letter 03-011: Fraud Referral Procedure to Audits and Investigations (AI)
~~I. Title 42, Code of Federal Regulations, §455.2~~
~~Title 31, United State Code, §3730(h), for False Claims Act complaints~~
~~CalOptima Policy MA.9105: Sanctions~~
~~CalOptima Policy MA.9104: Corrective Action Plan~~
M. ~~CMS Medicare Prescription Drug Benefit Manual~~Medicare Managed Care Manual, ~~Chapter 9 – Part D Program to Control Fraud and Abuse~~Chapters 9 and 21
~~Contract for Centers for Medicare and Medicaid~~
~~Title 42, Code of Federal Regulations, § 455.2~~
N. Title 31, United States Code, § 3730(h), for False Claims Act complaints
O. Title 42, Code of Federal Regulations, § 455.2
~~Welfare and Institutions Code, §14043.1(a)~~
P. All Plan Letter (APL) 15-026

~~J.~~

~~VII.~~VI. REGULATORY AGENCY APPROVALS

A. 08/01/16: Department of Health Care Services

~~VIII.~~VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY
~~IX.~~

~~Version~~	~~Version Date~~	~~Policy Number~~	~~Policy Title~~
~~Effective~~	~~09/01/04~~	~~HH.1107~~	~~Fraud and Abuse Investigation and Reporting~~
~~Revised~~	~~01/01/08~~	~~HH.1107~~	~~Fraud, Waste and Abuse Investigation and Reporting~~
~~Revised~~	~~12/01/09~~	~~HH.1107~~	~~Fraud, Waste and Abuse Investigation and Reporting~~
~~Revised~~	~~02/01/13~~	~~HH.1107~~	~~Fraud, Waste and Abuse Investigation and Reporting~~
~~Revised~~	~~07/01/14~~	~~HH.1107~~	~~Fraud, Waste and Abuse Investigation and Reporting~~
~~Revised~~	~~09/01/15~~	~~HH.1107~~	~~Fraud, Waste and Abuse Investigation and Reporting~~
~~Revised~~	~~06/01/16~~	~~HH.1107~~	~~Fraud, Waste, and Abuse Investigation and Reporting~~
~~Revised~~	~~12/01/16~~	~~HH.1107Δ~~	~~Fraud, Waste, and Abuse Investigation and Reporting~~

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	09/01/2004	HH.1107	Fraud and Abuse Investigation and Reporting	Medi-Cal
Effective	01/01/2007	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare
Revised	01/01/2008	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	09/01/2008	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare
Revised	12/01/2009	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	12/01/2010	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare
Revised	02/01/2013	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	02/01/2013	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare
Revised	07/01/2014	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	12/01/2014	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare OneCare Connect
Revised	09/01/2015	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	09/01/2015	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare OneCare Connect PACE

~~Version~~	~~Version Date~~	~~Policy Number~~	~~Policy Title~~	
Revised	06/01/2016	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal
Revised	12/01/2016	HH.1107Δ	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9108	Fraud, Waste, and Abuse Investigation and Reporting	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Executive Director of Compliance; and Executive Director of Human Resources.
Compliance Program	The program (including, without limitation, this Compliance Plan, Code of Conduct and Policies and Procedures and Procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Member, Employees and FDRs comply with applicable law and ethical standards.
Covered Service	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), or other services as authorized by the Board of Directors, which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Center of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way contract with the

Term	Definition
	Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS). PACE: Items and services provided by CalOptima under the provisions of Welfare & Institutions Code section 14132, except those services specifically excluded under the CalOptima PACE Program Agreement, Exhibit E, Attachment 1, Section 26.
Credible Allegation of Fraud	Credible allegation of fraud. A credible allegation of fraud may be an allegation, which has been verified by the State, from any source, including but not limited to the following: (1) Fraud hotline complaints. (2) Claims data mining. (3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortiums, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347).
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Health Network	The contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").

Term	Definition
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Member	A beneficiary who is enrolled in a CalOptima Program.
Pharmacy Benefit Manager (PBM)	An entity that provides pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1

Policy #:	HH.1107Δ
Title:	**Fraud, Waste, and Abuse Investigation and Reporting**
Department:	Office of Compliance
Section:	Fraud, Waste, and Abuse – Special Investigations Unit
CEO Approval:	Michael Schrader _____
Effective Date:	09/01/04
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy establishes a process to investigate and report suspected Fraud, Waste, or Abuse (FWA) in a CalOptima program by a Member, Provider, Practitioner, a CalOptima Employee, First Tier, Downstream and Related Entities (FDRs), Billing Intermediary, and CalOptima's Health Network, in accordance with federal and state regulations.

II. POLICY

A. CalOptima maintains a zero tolerance policy toward FWA by any CalOptima Employee, or FDRs.

B. CalOptima and its FDRs shall comply with applicable statutory, regulatory, other requirements, sub-regulatory guidance, and contractual commitments related to the delivery of Covered Services, which include, but are not limited to, federal and state False Claims Acts, Anti-Kickback statutes, prohibitions on inducements to beneficiaries, Health Insurance Portability and Accountability Act (HIPAA), and other applicable statutes.

C. CalOptima Employees and its FDRs are expected and required to promptly report suspected violations of any statute, regulations, or guidelines applicable to any CalOptima program. CalOptima maintains a strict policy of non-retaliation and non-retribution toward Employees and its FDRs who make such reports in good faith. CalOptima Employees and its FDRs are protected from retaliation under Title 31, United State Code, Section 3730(h), for False Claims Act complaints, as well as any other anti-retaliation protections.

D. This policy is reviewed annually to ensure relevancy and accuracy, ensuring that CalOptima's FWA program are in alignment with industry best practices.

E. CalOptima shall establish a process for timely and reasonable investigation and reporting of suspected FWA in accordance with this policy.

F. CalOptima's Office of Compliance shall coordinate all activities associated with the investigation and reporting of suspected FWA.

G. CalOptima's Office of Compliance shall maintain a system for the review of suspect claims to detect and prevent FWA, in accordance with federal and state regulations, and to identify resulting

overpayments for recoupment in accordance with CalOptima Policy HH.5000Δ: Provider Overpayment Investigation and Determination.

H. CalOptima shall cooperate with the Department of Health Care Services (DHCS), Centers for Medicare & Medicaid (CMS), and law enforcement agencies related to any FWA investigations, or audits.

I. CalOptima shall conduct a preliminary investigation of any allegation of suspected FWA and shall report suspected FWA to the appropriate agency, in accordance with its contracts with DHCS and/or CMS, and this policy.

J. Upon determination of validity of the allegation, CalOptima shall refer suspected FWA to DHCS and/or CMS for further investigation, as appropriate.

K. CalOptima's Office of Compliance shall maintain a database and a uniform filing system to maintain suspected FWA referrals, including reports, investigations, and correspondence, in accordance with CalOptima's Compliance Program.

L. CalOptima's Office of Compliance shall develop data and other supporting evidence for a FWA investigation, consult with Legal Counsel, and function as the liaison between CalOptima and DHCS, appropriate state Medical Boards, the State Board of Pharmacy, other licensing entities, law enforcement, prosecuting agencies as appropriate, and other relevant entities.

M. CalOptima's Office of Compliance shall ensure appropriate confidentiality of case files, or other documentation relating to any investigation of a suspected FWA case.

N. CalOptima's Office of Compliance shall report the status and results of all suspected FWA investigations to CalOptima's Compliance Committee.

O. CalOptima shall fully coordinate and cooperate with DHCS, CMS and other law enforcement agencies related to any FWA investigations or audits to support health oversight matters.

III. PROCEDURE

A. Reporting:

1. CalOptima shall provide a method for CalOptima Employees, FDRs, and Members to anonymously report suspected FWA to the Office of Compliance. CalOptima Employees and its FDRs may call the Compliance and Ethics Hotline at (877) 837-4417 to anonymously report concerns regarding Fraud, Waste, and Abuse.

2. A CalOptima Employee who detects suspected FWA shall complete a Suspected Fraud or Abuse Referral Form and transmit it to the Office of Compliance.

3. An FDR with a contractual obligation to report suspected FWA shall notify CalOptima of suspected FWA, in accordance with the terms and conditions of its contract and this policy.

4. CalOptima's Office of Compliance shall investigate and report suspected FWA, in accordance with this policy.

5. CalOptima shall report to DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by CalOptima Employees, FDRs, or Members. CalOptima shall conduct, complete and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within ten (10) business days of the date CalOptima first became aware of, or is in notice of such activity.

6. For investigations involving OneCare, OneCare Connect, or PACE programs, CalOptima shall report to CMS via the NBI MEDIC all cases of suspected fraud and/or abuse where there is reason to believe that an incident of Fraud and/or Abuse has occurred by CalOptima Employees, FDRs, or Members. CalOptima shall conduct, complete and report to CMS, the results of a preliminary investigation of the suspected Fraud and/or Abuse within thirty (30) business days of the date CalOptima first became aware of, or is in notice of such activity.

7. Referrals to DHCS and NBI MEDIC, where Special Investigation Unit (SIU) detection activities results in a reason to believe suspected Fraud or Abuse has occurred and requires further investigation by DHCS, shall be sent on the Form MC609-Confidential Report form. The MC609 form and attachments submitted to DHCS must at a minimum include:

    a. Number of complaints of Fraud and Abuse submitted that warranted preliminary investigation;

    b. For each complaint which warranted a preliminary investigation:

        i. Name and/or SSN or CIN;

        ii. Source of Complaint;

        iii. Type of Provider;

        iv. Nature of complaint;

        v. Approximate dollars involved if known; and

        vi. Legal and administrative disposition of the case.

    c. For investigations involving the Medi-Cal program, the referral shall be submitted on a Medi-Cal Complaint Report (MC 609) that can be sent to DHCS via secure e-mail, secure facsimile, Federal Express with Tracking number or certified mail, in accordance with the instructions provided in Exhibit E of CalOptima's contract with the Department of Health Care Services for Medi-Cal.

    d. For investigations involving the OneCare, OneCare Connect, or PACE programs, the referral shall be submitted on a Part D/MEDIC Complaint form that can be sent to CMS contractor, NBI MEDIC, via secure e-mail, secure facsimile, FedEx with Tracking Number, or certified mail. For investigations involving OneCare, OneCare Connect, or PACE program where the allegation is exclusively a compromised identification, the referral to NBI MEDIC shall be submitted on a MEDIC ID compromised form. CalOptima shall submit applicable police reports, investigation documentation (background, interviews, etc.), member information, Provider enrollment data, confirmation of services, list items or services furnished by Provider, pharmaceutical data, and any other pertinent information.

B. Investigation:

1. Upon detection of suspected FWA, the Office of Compliance shall review the suspected activity using data from reports, including, but not limited to, the following:

   a. CalOptima's Compliance and Ethics Hotline, or other reporting mechanisms;

   b. Claims data history;

   c. Encounter Data;

   d. Member and Provider complaints, appeals, and grievance reviews;

   e. Medical record audits;

   f. Pharmacy data;

   g. Utilization Management Reports;

   h. Provider utilization profiles;

   i. Monitoring and auditing activities;

   j. Monitoring external health care FWA cases and determining if CalOptima's FWA program can be strengthened with information gleaned from the case activity; and/or

   k. Internal and external survey, reviews, and audits.

2. For investigations involving the CalOptima Medi-Cal program, CalOptima shall complete the preliminary investigation, including the review of listed and other documents. CalOptima shall conduct, complete and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within ten (10) business days of the date CalOptima first became aware of, or is in notice of such activity.

3. For investigations involving the OneCare, One Care Connect, or Program of All-Inclusive Care for the Elderly (PACE) programs, CalOptima shall complete the preliminary investigation, including the review of listed and other documents. CalOptima shall conduct, complete and report to the CMS National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC), the results of a preliminary investigation of the suspected fraud and/or abuse within thirty (30) business days of the date CalOptima first became aware of, or is in notice of such activity.

4. For CalOptima Employee conduct investigations that involve potential FWA, a referral to SIU should be made by the CalOptima staff involved in the initial Employee conduct investigation. Each referral is considered on a case- by-case basis. The referral to SIU for Employee conduct investigations will authorize the SIU to have primary responsibility of the Employee conduct investigation as it relates to potential FWA.

5. When included on the FWA Referral Form, or when the FWA Investigator is able to determine the probable root cause of the suspected FWA, the information will be documented in the Fraud Tracking Database. Additionally, the FWA Investigator will track and trend on the root causes as part of the FWA Trend Analysis on a quarterly basis to the Compliance Committee, when there are root causes that have been identified and able to be trended.

6. For the Medi-Cal Program, and in accordance with CalOptima Policies HH.2005Δ: Corrective Actions Plans, HH.2002Δ: Sanctions, GA.8021: Employee Conduct and GA.8022: Progressive Discipline, CalOptima shall issue corrective actions to Employees, and its FDRs related to validated instances of FWA. Corrective actions will be monitored by the Compliance Committee, or the Human Resources Department, as appropriate. Corrective actions may include financial sanctions, regulatory reporting, performance improvement plans, or termination. If the validated instance of FWA is determined to be criminal in nature, correction action may also include a referral to law enforcement. Should such corrective action need to be issued, CalOptima Office of Compliance will initiate review and discussion at the first Compliance Committee following the date of identification of the suspected FWA, the date of report to DHCS, or the date of FWA substantiation by DHCS subsequent to the report.

7. For the OneCare, OneCare Connect, or PACE programs, and in accordance with CalOptima Policies HH.2005Δ: Corrective Actions Plans, HH.2002Δ: Sanctions, GA.8021: Employee Conduct and GA.8022: Progressive Discipline, CalOptima shall issue corrective actions to employees, and its FDRs related to validated instances of FWA. Corrective actions will be monitored by the Compliance Committee, or the Human Resources Department, as appropriate. Corrective actions may include financial sanctions, regulatory reporting, performance improvement plans, or termination, as appropriate. If the validated instance of FWA is determined to be criminal in nature, corrective action may also include a referral to law enforcement. Should such corrective action need to be issued, CalOptima Office of Compliance will initiate review and discussion at the first Compliance Committee following the date of identification of the suspected FWA, the date of report to CMS, or the date of FWA substantiation by CMS subsequent to the report.

8. For investigations involving situations when DHCS notifies the CalOptima that a Credible Allegation of Fraud has been found against a provider relating to the provision of Fee-For-Service (FFS) Medi-Cal services and that provider is also part of the CalOptima network, CalOptima must take one (1) or more of the following options and submit supporting documentation to DHCS:

    a. Terminate the Provider from its network;

    b. Temporarily suspend the Provider from its network pending resolution of the Fraud allegation;

    c. Temporarily suspend payment to the Provider pending resolution of the Fraud allegation; and/or

    d. Conduct additional monitoring including audits of the Provider’s claims history and future claims submissions for appropriate billing.

9. The following is a list of potential FWA classifications for Member and provider Fraud and Abuse Program, along with some examples of potential detection criteria that may be used to detect these types of suspected FWA:

MEMBER FRAUD OR PROGRAM ABUSE		**DETECTION CRITERIA Including but not limited to:**
M01	Using another individual's identity or documentation of Medi-Cal eligibility to obtain Covered Services	Members with multiple areas of service; members who attempt more than one PCP; reports of members who are hiding assets or income
M02	Selling, loaning, or giving a member's identity or documentation of Medi-Cal eligibility to obtain services	Members with multiple areas of service; members who attempt more than one PCP; reports of members who are hiding assets or income
M03	Making an unsubstantiated declaration of eligibility	Members with multiple areas of service; members who attempt more than one PCP; reports of members who are hiding assets or income
M04	Using a Covered Service for purposes other than the purpose for which it was described including use of such Covered Service	Selling a covered wheelchair; selling medications; abusing prescription medications
M05	Failing to report other health coverage.	Payments by OHI
M06	Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive Covered Services.	Hotline reports; internal reports; reports by Health Networks
M07	Other (please specify)	Any source
M08	Member Pharmacy Utilization	PBM reports; data analytics; claims data; encounter data; FWA software
M09	Doctor Shopping	PBM reports; data analytics; claims data; encounter data; FWA software
M10	Altered Prescription	Provider report; DEA report; pharmacy report; PBM reports; data analytics; claims data; encounter data; FWA software

PROVIDER FRAUD OR PROGRAM ABUSE		**DETECTION CRITERIA Including but not limited to:**
P01	Unsubstantiated declaration of eligibility to participate in the CalOptima program	Provider information not able to be verified during credentialing or contracting process; providers on the excluded provider list
P02	Submission of claims for Covered Services that are substantially and demonstrably in excess of any individual's usual charges for such Covered Services	PBM reports; data analytics; claims data; encounter data; FWA software
P03	Submission of claims for Covered Services that are not actually provided to the member for which the claim is submitted	PBM reports; data analytics; claims data; encounter data; FWA software; verification survey; hotline

PROVIDER FRAUD OR PROGRAM ABUSE		**DETECTION CRITERIA Including but not limited to:**
P04	Submission of claims for Covered Services that are in excess of the quantity that is Medically Necessary	PBM reports; data analytics; claims data; encounter data; FWA software
P05	Submission of claims for Covered Services that are that are billed using a code that would result in great payment than the code that reflects the covered services	PBM reports; data analytics; claims data; encounter data; FWA software
P06	Submission of claims for Covered Services that is already included in the capitation rate	PBM reports; data analytics; claims data; encounter data; FWA software
P07	Submission of claims for Covered Services that are submitted for payment to both CalOptima and another third party payer without full disclosure	PBM reports; data analytics; claims data; encounter data; FWA software; payment by OHI
P08	Charging a member in excess of allowable co-payments and deductibles for Covered Services	Member report; hotline report; oversight audits
P09	Billing a member for Covered Services without obtaining written consent to bill for such service	Member report; hotline report; oversight audits
P10	Failure to disclose conflict of interest	Hotline; credentialing or contracting process
P11	Receiving, soliciting, or offering a kickback, bribe or rebate to refer or fail to refer a member	Hotline report; oversight report
P12	Failure to register billing intermediary with the Department of Health Care Services	Oversight audit; report by regulatory body; hotline
P13	False certification of Medical Necessity	Medical record review; claims data; encounter data; FWA software
P14	Attributing a diagnosis code to a member that does not reflect the member's medical condition for the purpose of obtaining higher reimbursement	Medical record review; claims data; encounter data; FWA software
P15	False or inaccurate Minimum Standards or credentialing information	Hotline; credentialing or contracting process
P16	Submitting reports that contain unsubstantiated data, data that is inconsistent with records, or has been altered in a manner that is inconsistent with policies, contracts, statues or regulations	Medical record review; claims data; encounter data; FWA software
P17	Other (please specify)	Any source
P18	Provider Pharmacy Utilization	PBM reports; data analytics; claims data; encounter data; FWA software

PROVIDER FRAUD OR PROGRAM ABUSE		**DETECTION CRITERIA Including but not limited to:**
P19	Billing Medi-Cal Member for Services	Member report; hotline report; oversight audits
P20	Durable Medical Equipment- Covered Services that are not actually provided to beneficiary	Member report; hotline report; oversight audits; verification survey

EMPLOYEE FRAUD OR PROGRAM ABUSE		**DETECTION CRITERIA Including but not limited to:**
E01	Use of a Member's identity or documentation of Medi-Cal eligibility to obtain services	Employees obtaining services on a Member's account. Hotline report. Data analytics. Referrals to SIU.
E02	Use of a Member's identity or documentation of Medi-Cal eligibility to obtain a gain.	Employees obtaining unjust enrichment, funds, or other gain by selling Member's account information. Hotline report.
E03	Employee assistance to providers with the submission of claims for Covered Services that are not actually provided to the Member for which the claim is submitted.	Employees obtaining unjust enrichment, funds, or other gain from provider by using Member's account information to assist in the submission of false claims. Hotline report. Referrals to SIU.
E04	Employee deceptively accessing company confidential information for purpose of a gain.	Employees obtaining unjust enrichment, funds, or other gain from another by deceptive and unauthorized accessing of information. Hotline Service. Data Analytics. Referrals to SIU.

10. CalOptima Special Investigation Unit (SIU) shall enter all documentation related to any suspected FWA case into the Fraud Tracking Database as soon as practicable and document the final disposition is t as soon as practicable, once the case has been determined to be closed.

11. Compliance Action/Outcomes may include but are not limited to:

C01	Contract amendment
C02	Corrective action plan
C03	Education
C04	Focused Audit
C05	Investigation
C06	Monitoring
C07	New Policy
C08	Policy Revision
C09	Prepayment Review
C10	Process Review
C100	Referred to CalOptima Legal
C101	No Fraud Folder Created
C102	Criminal Filing- Pending
C11	Criminal Filing- Conviction
C111	Criminal Filing- Exonerated
C12	Non-Criminal Action Taken
C13	Does not meet prosecutorial guidelines

C14	Technical issues- resolved
C15	Insufficient evidence of fraud
C16	Allegations/Violation confirmed: Warning Letter Issued
C18	Allegations/Violation confirmed: Administrative Action
C19	Allegations/Violation confirmed: Warning Letter & Administrative Action
C20	Administrative Error
C21	Administrative Action
C22	Unable to establish violation of the Medi-Cal Program
C23	Medi-Cal Usage Minimal
C24	DHS Referred to Other Agency
C26	Criminal Filing
C98	No Action Taken
C99	Other: (Explain)

IV. ATTACHMENTS

A. Suspected Fraud or Abuse Referral Form (English)
B. Suspected Fraud or Abuse Referral Form (Spanish)
C. Suspected Fraud or Abuse Referral Form (Vietnamese)
D. Suspected Fraud or Abuse Referral Form (Korean)
E. Suspected Fraud or Abuse Referral Form (Chinese)
F. Suspected Fraud or Abuse Referral Form (Farsi)
G. Suspected Fraud or Abuse Referral Form (Arabic)
H. Form MC609 - Confidential Medi-Cal Complaint Report form
I. CalOptima Referral to MEDIC
J. CalOptima Referral to MEDIC ID Compromised

V. REFERENCES

A. California Business and Professions Code, §4040
B. CalOptima Compliance Plan
C. CalOptima Contract for Health Care Services
D. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
E. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
F. CalOptima PACE Program Agreement
G. CalOptima Policy HH.1105Δ: Fraud, Waste and Abuse Detection
H. CalOptima Policy HH.2002Δ: Sanction
I. CalOptima Policy HH.2005Δ: Corrective Action Plan
J. CalOptima Policy HH.5000Δ: Provider Overpayment Investigation and Determination
K. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Service (DHCS) for Cal MediConnect
L. Medi-Cal Managed Care Division (MMCD) All Plan Letter 03-011: Fraud Referral Procedure to Audits and Investigations (AI)
M. Medicare Managed Care Manual, Chapters 9 and 21
N. Title 31, United States Code, § 3730(h), for False Claims Act complaints
O. Title 42, Code of Federal Regulations, § 455.2
P. Welfare and Institutions Code, §14043.1(a)All Plan Letter (APL) 15-026

VI. REGULATORY AGENCY APPROVALS

A. 08/01/16: Department of Health Care Services

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	09/01/2004	HH.1107	Fraud and Abuse Investigation and Reporting	Medi-Cal
Effective	01/01/2007	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare
Revised	01/01/2008	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	09/01/2008	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare
Revised	12/01/2009	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	12/01/2010	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare
Revised	02/01/2013	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	02/01/2013	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare
Revised	07/01/2014	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	12/01/2014	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare OneCare Connect
Revised	09/01/2015	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	09/01/2015	MA.9108	Fraud, Waste and Abuse Investigation and Reporting	OneCare OneCare Connect PACE
Revised	06/01/2016	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal
Revised	12/01/2016	HH.1107Δ	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9108	Fraud, Waste, and Abuse Investigation and Reporting	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Executive Director of Compliance; and Executive Director of Human Resources.
Compliance Program	The program (including, without limitation, this Compliance Plan, Code of Conduct and Policies and Procedures and Procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Member, Employees and FDRs comply with applicable law and ethical standards.
Covered Service	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), or other services as authorized by the Board of Directors, which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. <u>OneCare</u>: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Center of Medicare & Medicaid Services (CMS) Contract. <u>OneCare Connect</u>: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way contract with the

Term	Definition
	Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS). PACE: Items and services provided by CalOptima under the provisions of Welfare & Institutions Code section 14132, except those services specifically excluded under the CalOptima PACE Program Agreement, Exhibit E, Attachment 1, Section 26.
Credible Allegation of Fraud	Credible allegation of fraud. A credible allegation of fraud may be an allegation, which has been verified by the State, from any source, including but not limited to the following: (1) Fraud hotline complaints. (2) Claims data mining. (3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortiums, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347).
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Health Network	The contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").

Term	Definition
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Member	A beneficiary who is enrolled in a CalOptima Program.
Pharmacy Benefit Manager (PBM)	An entity that provides pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1

CONFIDENTIAL

INSTRUCTIONS FOR COMPLETING A SUSPECTED FRAUD OR ABUSE REFERRAL FORM

To submit a request to investigate suspected fraud or abuse, please complete a CalOptima Suspected Fraud or Abuse Referral Form. Examples of fraud or abuse are listed on the Suspected Fraud or Abuse Referral Form. These are examples only. The list does not represent every situation in which fraud or abuse can take place. Therefore, CalOptima has provided an "Other" category for the requestor to describe the suspected fraud or abuse to be investigated.

Please note there is a section on the form to complete for reporting suspected fraud and abuse by a "Member" and/or "Provider."

Complete all applicable sections of the form. It is very important to complete the form in it's entirety to effectively investigate the referral.

If desired, requestor may remain anonymous; however, it should be understood that if the requestor does not provide his/her name and telephone number, the Compliance Supervisor of FWA will be unable to contact him/her for clarification of any of the information submitted that may prevent completion of the investigation.

Submit the completed form and attach supporting documents to CalOptima's Office of Compliance via one of the following methods:

1. Email: fraud@caloptima.org
2. U.S. Mail: CalOptima
   Office of Compliance
   505 City Parkway West
   Orange, CA 92868
3. Fax: 1-~~714-481-6457~~657-900-1605

ALL CORRESPONDENCE SHOULD BE MARKED AS "CONFIDENTIAL"

Correspondence will be received by the Office of Compliance, Special Investigations Unit (SIU) for review. Completed CalOptima Suspected Fraud or Abuse Referral Forms, and accompanying documentation may be sent directly to the Supervisor of FWA (Fraud, Waste, and Abuse) if the requestor wishes that the information only be opened by the Supervisor of FWA. Correspondence should be mailed to:

CalOptima
Supervisor of FWA
505 City Parkway West
Orange, CA 92868

CORRESPONDENCE SHOULD BE MARKED:
"CONFIDENTIAL: TO BE OPENED BY SUPERVISOR of FWA ONLY."

For additional information, or instructions on completing this form please call CalOptima's Office of Compliance, Special Investigations Unit (SIU) at: 1-714-246-8790.

- see next page -

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SUSPECTED FRAUD OR ABUSE REFERRAL FORM

REFERRAL INFORMATION		
Date: _____		Notice involves suspected fraud or abuse by a:
Referred by: Name: _____	Title: _____	☐ Member
Dept.: _____	Phone#: _____	☐ Provider

MEMBER	PROVIDER
CalOptima Program: ☐ Medi-Cal ☐ OneCare ☐ PACE ☐ OneCare Connect	Provider Name:
Member Name:	Type of provider:
Member ID:	Provider ID #:
Address:	Address:
City: Zip:	City: Zip:
Date of service if applicable:	Date of service if applicable:
	Member ID, if applicable: If multiple Members are involved, please attach a list.
Suspected fraud or abuse: ☐ Using another individual's identity or documentation of Medi-Cal eligibility to obtain covered services (unless such person is an authorized representative who is presenting such information to obtain covered services on behalf of a member). ☐ Selling, loaning, or giving a member's identity or documentation of eligibility (Medi-Cal, OneCare, OneCare Connect or PACE) to obtain covered services (other than to a family member to obtain covered services on behalf of a Member). ☐ Making an unsubstantiated declaration of eligibility. ☐ Using a covered service for purposes other than the purposes for which it was prescribed including use of such covered service by an individual other than the member for whom the covered service was prescribed or provided. ☐ Failing to report other health coverage. ☐ Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive covered services. ☐ Other (please specify) _____	**Suspected fraud or abuse**: ☐ Unsubstantiated declaration of eligibility to participate in the CalOptima program. ☐ Submission of claims for covered services that are: ☐ Substantially and demonstrably in excess of any individual's usual charges for such covered services. ☐ Not actually provided to the member for which the claim is submitted. ☐ In excess of the quantity that is medically necessary; ☐ Billed using a code that would result in greater payment than the code that reflects the covered service. ☐ Already included in capitation rate. ☐ Submitted for payment to both CalOptima and another third party payer without full disclosure. ☐ Charging a member in excess of allowable co-payments and deductibles for covered services. ☐ Billing a member for covered services without obtaining written consent to bill for such services. ☐ Failure to disclose conflict of interest. ☐ Receiving, soliciting, or offering a kickback, bribe, or rebate to refer or fail to refer a member. ☐ Failure to register billing intermediary with the Department of Health Care Services (DHCS). ☐ False certification of medical necessity. ☐ Attributing a diagnosis code to a member that does not reflect the member's medical condition for the purpose of obtaining higher reimbursement.

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SUSPECTED FRAUD OR ABUSE REFERRAL FORM

	☐ False or inaccurate Minimum Standards or credentialing information. ☐ Submitting reports that contain unsubstantiated data, data that is inconsistent with records, or has been altered in a manner that is inconsistent with policies, contracts, statutes, or regulations. ☐ Other (please specify) _____

DOCUMENTATION (PLEASE ATTACH):

- ☐ Claims data
- ☐ Medical records
- ☐ Complaint, appeal, or grievance
- ☐ UM reports
- ☐ Audit
- ☐ Other (please specify) _____

Please provide a brief explanation of how the documentation provided supports concerns of fraudulent activity:
_____

Please provide the root cause of this suspected fraudulent activity: _____

OTHER RELEVANT INFORMATION (PLEASE ATTACH):

Are there any prior suspected fraud or abuse issues by this member, provider, pharmacy, other: _____

1. ☐ No
   ☐ Yes. Please describe:

2. If yes, what was the outcome?

Please submit this form with all pertinent documentation to the OFFICE OF COMPLIANCE SPECIAL INVESTIGATIONS UNIT (SIU). The Office of Compliance, SIU shall report as appropriate to local and state entities. If you do not receive an acknowledgement of receipt of this form within five (5) working days, please contact the Supervisor of FWA at 1-714-246-8790.

This section to be completed by Compliance:

Compliance Tracking No. _____ Date Acknowledgement Sent: _____

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INSTRUCTIONS FOR COMPLETING A SUSPECTED FRAUD OR ABUSE REFERRAL FORM

To submit a request to investigate suspected fraud or abuse, please complete a CalOptima Suspected Fraud or Abuse Referral Form. Examples of fraud or abuse are listed on the Suspected Fraud or Abuse Referral Form. These are examples only. The list does not represent every situation in which fraud or abuse can take place. Therefore, CalOptima has provided an "Other" category for the requestor to describe the suspected fraud or abuse to be investigated.

Please note there is a section on the form to complete for reporting suspected fraud and abuse by a "Member" and/or "Provider."

Complete all applicable sections of the form. It is very important to complete the form in it's entirety to effectively investigate the referral.

If desired, requestor may remain anonymous; however, it should be understood that if the requestor does not provide his/her name and telephone number, the Compliance Supervisor of FWA will be unable to contact him/her for clarification of any of the information submitted that may prevent completion of the investigation.

Submit the completed form and attach supporting documents to CalOptima's Office of Compliance via one of the following methods:

1. Email: fraud@caloptima.org
2. U.S. Mail: CalOptima
   Office of Compliance
   505 City Parkway West
   Orange, CA 92868
3. Fax: 1-657-900-1605

ALL CORRESPONDENCE SHOULD BE MARKED AS "CONFIDENTIAL"

Correspondence will be received by the Office of Compliance, Special Investigations Unit (SIU) for review. Completed CalOptima Suspected Fraud or Abuse Referral Forms, and accompanying documentation may be sent directly to the Supervisor of FWA (Fraud, Waste, and Abuse) if the requestor wishes that the information only be opened by the Supervisor of FWA. Correspondence should be mailed to:

CalOptima
Supervisor of FWA
505 City Parkway West
Orange, CA 92868

CORRESPONDENCE SHOULD BE MARKED:
"CONFIDENTIAL: TO BE OPENED BY SUPERVISOR of FWA ONLY."

For additional information, or instructions on completing this form please call CalOptima's Office of Compliance, Special Investigations Unit (SIU) at: 1-714-246-8790.

- see next page -

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SUSPECTED FRAUD OR ABUSE REFERRAL FORM

REFERRAL INFORMATION		
Date: _____		Notice involves suspected fraud or abuse by a:
Referred by: Name: _____	Title: _____	☐ Member
Dept.: _____	Phone#: _____	☐ Provider

MEMBER	PROVIDER
CalOptima Program: ☐ Medi-Cal ☐ OneCare ☐ PACE ☐ OneCare Connect	Provider Name:
Member Name:	Type of provider:
Member ID:	Provider ID #:
Address:	Address:
City: Zip:	City: Zip:
Date of service if applicable:	Date of service if applicable:
	Member ID, if applicable: If multiple Members are involved, please attach a list.
Suspected fraud or abuse: ☐ Using another individual's identity or documentation of Medi-Cal eligibility to obtain covered services (unless such person is an authorized representative who is presenting such information to obtain covered services on behalf of a member). ☐ Selling, loaning, or giving a member's identity or documentation of eligibility (Medi-Cal, OneCare, OneCare Connect or PACE) to obtain covered services (other than to a family member to obtain covered services on behalf of a Member). ☐ Making an unsubstantiated declaration of eligibility. ☐ Using a covered service for purposes other than the purposes for which it was prescribed including use of such covered service by an individual other than the member for whom the covered service was prescribed or provided. ☐ Failing to report other health coverage. ☐ Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive covered services. ☐ Other (please specify) _____	**Suspected fraud or abuse**: ☐ Unsubstantiated declaration of eligibility to participate in the CalOptima program. ☐ Submission of claims for covered services that are: ☐ Substantially and demonstrably in excess of any individual's usual charges for such covered services. ☐ Not actually provided to the member for which the claim is submitted. ☐ In excess of the quantity that is medically necessary; ☐ Billed using a code that would result in greater payment than the code that reflects the covered service. ☐ Already included in capitation rate. ☐ Submitted for payment to both CalOptima and another third party payer without full disclosure. ☐ Charging a member in excess of allowable co-payments and deductibles for covered services. ☐ Billing a member for covered services without obtaining written consent to bill for such services. ☐ Failure to disclose conflict of interest. ☐ Receiving, soliciting, or offering a kickback, bribe, or rebate to refer or fail to refer a member. ☐ Failure to register billing intermediary with the Department of Health Care Services (DHCS). ☐ False certification of medical necessity. ☐ Attributing a diagnosis code to a member that does not reflect the member's medical condition for the purpose of obtaining higher reimbursement.

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SUSPECTED FRAUD OR ABUSE REFERRAL FORM

	☐ False or inaccurate Minimum Standards or credentialing information. ☐ Submitting reports that contain unsubstantiated data, data that is inconsistent with records, or has been altered in a manner that is inconsistent with policies, contracts, statutes, or regulations. ☐ Other (please specify) _____

DOCUMENTATION (PLEASE ATTACH):

- ☐ Claims data
- ☐ Medical records
- ☐ Complaint, appeal, or grievance
- ☐ UM reports
- ☐ Audit
- ☐ Other (please specify) _____

Please provide a brief explanation of how the documentation provided supports concerns of fraudulent activity:
_____

Please provide the root cause of this suspected fraudulent activity: _____

OTHER RELEVANT INFORMATION (PLEASE ATTACH):

Are there any prior suspected fraud or abuse issues by this member, provider, pharmacy, other: _____

1. ☐ No
   ☐ Yes. Please describe:

2. If yes, what was the outcome?

Please submit this form with all pertinent documentation to the OFFICE OF COMPLIANCE SPECIAL INVESTIGATIONS UNIT (SIU). The Office of Compliance, SIU shall report as appropriate to local and state entities. If you do not receive an acknowledgement of receipt of this form within five (5) working days, please contact the Supervisor of FWA at 1-714-246-8790.

This section to be completed by Compliance:

Compliance Tracking No. _____ Date Acknowledgement Sent: _____

CONFIDENTIAL MEDI-CAL COMPLAINT REPORT

FOR DHS STAFF ONLY
P.I. number
Case number

FOR COUNTY STAFF ONLY	
CalOptima Case number:	
CIN#	

Name of person reporting complaint			Telephone number
Address (number, street)	City	ZIP code	
Medi-Cal beneficiary name		Date of birth	Social security number
Address (number, street)	City	ZIP code	Telephone number
Provider name			Provider number
Address (number, street)	City	ZIP code	Telephone number
Violation			Type code

Details of complaint

Complaint taken by	Date
Address	Telephone number

FOR DHS STAFF USE ONLY

Supporting Documents

☐ MEDS _____ Date: _____

☐ CDR _____ Date: _____

☐ CLETS _____ Date: _____

☐ Other _____ Date: _____

_____ Date: _____

Action Taken

☐ P.I. Closed _____ Date: _____

☐ P.I. Referred to: _____ Date: _____

☐ Case opened _____ Date: _____

Assigned to: _____

Supervisor: _____

National Benefit Integrity MEDIC Complaint Form

Instruction: The purpose of this form is to report complaints of fraud, waste, and abuse in the Medicare Parts C & D Programs. A representative from Health Integrity may contact you upon receipt of this complaint, so please be sure to furnish sufficient contact information. **To ensure compliance with all applicable laws, do not send Protected Health Information (PHI) via email.**

Date of Referral: _____

Please designate as a Part C or Part D issue:

- ◯ Medicare Advantage Issue (Part C)
- ◯ Prescription Drug Benefit Issue (Part D)
- ◯ Both Part C and Part D Issue

Complainant Contact Information:

Name: _____ Phone: _____ Fax: _____
Email: _____

Submitted By (Select One):

Plan Name/Contract #: _____
Plan Tracking #: _____
Parent Organization: _____ on behalf of
(Plan Name(s)/Contract #): _____
Pharmacy Benefit Manager: _____ on behalf of
(Plan Name(s)/Contract #): _____

Address: _____ City: _____ State: Zip: _____

Beneficiary Contact Information:

Name: _____ Phone: _____ HICN#:_____
Address: _____ City: _____ State Zip:_____
Date of Birth: _____ Primary language (if other than English):_____
Medicare Plan Name: _____ Member ID#:_____

Description of Subject/Suspects of Fraud:

Name: _____ Tax ID (TIN): _____ NPI: _____
DEA#: _____ Medicare Provider #: _____
Business: _____ Phone: _____
Address:_____ City: _____ State:_____ Zip:_____
Please describe type of business or physician specialty: _____

Complaint Details:

Period of Review: _____

Potential **MEDICARE** program exposure:

Part C program exposure: Billed $ Paid $
Part D program exposure: Billed $ Paid $

Is law enforcement involved? ◯ No ◯ Yes(include agency contact):

Was information from PLATO utilized for this complaint? ◯ No ◯ Yes

Note: Please enter description of findings/allegations on next page.

To ensure compliance with all applicable laws, do not send Protected Health Information(PHI) via email.

Please fax this form to 410-819-8698, email to NBIMEDICComplaints@healthintegrity.org, call 877-7SAFERX, or mail to Health Integrity, 24864 Marlboro Avenue, Easton, MD 21601-2732, Attn: NBI MEDIC

Description of Findings/Allegations: (Please provide a detailed description of the nature of the fraud issue including the following: description of fraudulent activity; CPT codes involved; states where the fraud activity took place; description of individuals and/or businesses involved in the alleged illegal activity; dates that the fraud occurred; names and contact information for victims; and copies of documentation regarding the fraudulent activity including letters, advertising, etc.):

To ensure compliance with all applicable laws, do not send Protected Health Information (PHI) via email.

NBI MEDIC Compromised ID Report Form

Instruction: The purpose of this form is to report compromised Health Insurance Claim Numbers (HICNs), prescribing provider identifiers, or dispensing provider identifiers in the Medicare Parts C & D programs. Health Integrity may contact you upon receipt of this report, so please be sure to furnish sufficient contact information. Please supply one compromised subject per form. To ensure compliance with all applicable laws, please do not send Protected Health Information (PHI) via email.

Please fax this form to 410-819-8698, Attn: Health Integrity; National BI MEDIC, Complaints Manager, or email it as an encrypted attachment to NBIMEDICComplaints@healthintegrity.org.

Submitter Contact Information

Name: _____ Phone: _____ Fax: _____

Organization: _____ Email: _____

Address: _____ City: _____State: _____ Zip:_____

Compromised ID Information:

Type of entity: ◯ Beneficiary ◯ Prescriber/Provider ◯ Pharmacy

Description of identifier which has been compromised (e.g., HICN, DEA, NPI, NCPDP):_____

Identifier(s) which has been compromised: _____

Name of entity or individual: _____

Address of entity or individual:_____ City: _____ State:_____ Zip:_____

Type of Issue: ◯ Part C Issue ◯ Part D Issue ◯ Part C & D Issue

Report Details:

Please provide any information regarding how the number was compromised, subjects involved, etc. This may include a description of how the theft occurred, dates that the fraud occurred, description of individuals and/or businesses involved in the alleged activity, names and contact information for victims, and copies of documentation regarding the fraudulent activity including letters, advertising, attestations, affidavits, verification forms, etc. (enter details on page 2).

Policy #:	HH.3000Δ
Title:	**Notice of Privacy Practices**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/03
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy~~o defines~~ identifies the ~~process~~ required content of ~~by which CalOptima shall provide Members with a copy of the~~ CalOptima's Notice of Privacy Practices (NPP) and the process by which the NPP is distributed to CalOptima Members.

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~
~~Disclosure:~~	~~Has the meaning given such term in sectionin 160.103 of Title in 45, Code of Federal Regulations Section 160.103 including the following: . Tthe release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.~~
~~Health Care Operations:~~	~~Has the meaning in 42 Code of Federal Regulations Section 164.501, including: Aactivities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.~~
~~Health Maintenance Organization:~~	~~A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.~~
~~Member:~~	~~An enrollee beneficiary of a CalOptima program.~~
~~Notice of Privacy Practices (NPP):~~	~~Notice provided to a Member that describes Cal Optima's practices in the Use and Disclosure of Protected Health Information, Member Rrights, and CalOptima legal duties with respect to Protected Health Information.~~
~~Payment:~~	~~Has the meaning in 42 Code of Federal Regulations Section 164.501, including: Aactivities carried out by CalOptima including:~~ ~~— Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities;~~ ~~— Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or~~

	justification of charges; and, Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Protected Health Information (PHI):	Has the meaning given such term in Section 160.103 of Title in 45, Code of Federal Regulations Section 160.103, including the following: . Iindividually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: The past, present, or future physical or mental health or condition of a Member; The provision of health care to a Member; or Past, present, or future Payment for the provision of health care to a Member.
Required by Law:	Has the meaning in 45 Code of Federal Regulations (CFR) Section 164.103 which specifies a mandate contained Mandated in law that compels an and compelling a covered entity (provider, health plan, or clearinghouse) to make a uUse or Disclosure of PHI and that is enforceable in a court of competent jurisdictionlaw and which are permissible grounds for a covered entity to Use of Disclose PHI under 45 CFR Section 164.512(a) when relevant requirements are met.
Threshold Languages:	Medi-Cal: Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA). OneCare, OneCare Connect, PACE: The non-English native language of a group served by the CMS Program as specified in annual guidance to Contractors on specific translation requirements for their service areas.As specified in annual guidance to Contractors on specific translation requirements for their service areas.
Treatment:	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: Aactivities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use of PHI:	Has the meaning given such term in Section 160.103 of Title in 45, Code of Federal Regulations Section 160.103, including the following:. tThe sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

III. POLICY

A. CalOptima shall provide each Member with a copy of the NPP upon enrollment.

~~B. CalOptima shall revise and distribute the NPP to all Members within sixty (60) calendar days after a material change in:~~

~~1. The Use or Disclosures of Protected Health Information (PHI) by CalOptima;~~

~~2. The Member's rights regarding PHI; or~~

~~3. The legal requirements for handling PHI.~~

II. POLICY

A. CalOptima M~~m~~embers have the right to adequate notice of the Uses and Disclosures of Protected Health Information (PHI) that may be made by CalOptima and of the Members' rights and CalOptima's legal duties with respect to PHI. ~~CalOptima shall provide eacha Member with a copy of the NPP upon enrollment.~~

B. CalOptima provides information that directs Members on the process to file complaints with CalOptima and its regulators and will not retaliate against Members who file complaints when they believe their privacy rights have been violated in accordance with CalOptima Policy HH.3012Δ: Non-Retaliation on Reporting Violations.

CalOptima provides the NPP to Members as required by law including, providing the NPP upon enrollment and providing notice upon material revisions of the NPP on its website.

~~CalOptima shall revise and distribute the NPP to all Members within sixty (60) calendar days after a material change in:~~

~~The Use or DisclosuresDisclosure of Protected Health Information (PHI) by CalOptima;~~

~~TheA Member's rights regarding PHI; or~~

~~The legal requirements for handling PHI.~~

C.

~~IV.~~III. PROCEDURE

~~A. The NPP shall be made available to anyone, upon request, by calling or writing to the CalOptima Customer Service Department. CalOptima's Customer Service Department shall make the NPP available in Threshold Languages to anyone by mail, in person, or through the CalOptima website.~~

~~B.~~A. The content of the NPP shall be written in plain language, and contain the following elements:

1. Mandated header;

2. Description and one (1) example each, of the types of Use and Disclosures that CalOptima is permitted under state and federal regulations for the purposes of Treatment, Payment, and Health Care Operations. If a Use or Disclosure for any purpose described in paragraphs (b)(1)(ii)(A) or (B) of 45 CFR Section 164.520 is prohibited or material limited by other applicable law, the description of such use or disclosure must reflect the more stringent law as defined in 45 CFR Section 160.202.~~, or as otherwise Required by Law~~;

3. A description of the types of Uses and Disclosures that require an authorization under Section 164.504(a)(2)-(a)(4), a ~~S~~statement that other Use and Disclosures not described in this notice will ~~may~~ be made only with the Member's written authorization, and a statement that the Member may revoke ~~this~~ such authorization as provided by Section 164.508(b)(5);

~~4. Statement to address, as applicable:~~

~~a. Appointment reminders and information on Treatment alternatives or other health-related benefits and services; or~~

~~b. Disclosure of the Member's PHI to a group health plan, insurance issuer, or Health Maintenance Organization (HMO).~~

~~5.~~4. Statement to describe the Member's rights concerning his or her PHI, how to exercise these rights, and restrictions on such rights, that shall include information on:

a. Restrictions concerning certain Use and Disclosures of PHI, and provision that CalOptima is not required to agree to those restrictions, except in case of a disclosure restricted under Section 164.522(a)(1)(iv) and in accordance with CalOptima Policy HH.3007Δ: Member Right to Request Restrictions on Use and Disclosure of Protected Health Information;

b. Right to receive confidential communications of PHI, in accordance with CalOptima Policy HH.3008Δ: Member Right to Request Confidential Communications;

c. Right to inspect and copy PHI, in accordance with CalOptima Policy HH.3001Δ: Member Access to Designated Record Set;

d. Right to request amendment to PHI, in accordance with CalOptima Policy HH.3004Δ: Member Request to Amend Record;

e. Right to receive accounting of Disclosures, with certain exceptions, in accordance with CalOptima Policy HH.3005Δ: Member Request for an Accounting of Disclosures; and

f. Right to receive a paper copy of the NPP, in accordance with this policy.

~~6.~~5. ~~S~~Statement specifically describing CalOptima's duties and rights under the privacy rule, including:

a. A statement that CalOptima is required by law ~~The responsibility~~ to maintain the privacy of the Member's PHI , to provide individuals with notice of its legal duties and privacy practices with respect to PHI, and to notify affected Members following a breach of

unsecured PHI, and in accordance with CalOptima policies, which shall include processes to ensure internal protection of:

~~i.~~ Verbal (i.e., when talking to individuals on the telephone or in person about a Member), and written information, in accordance with CalOptima policies HH.3003Δ: Verification of Identity for Disclosures of Protected Health Information, HH.3009Δ: Access by Member's Authorized Representative, HH.3016Δ: Guidelines for Handling Protected Health Information Offsite, and HH.3019Δ: De-identification of Protected Health Information ~~and HH.3021: Disclosure of Information to Family Members or Friends Involved in Member Care; and~~.

i.

~~ii. Electronic information, pursuant to CalOptima Policies: HH.3014Δ: Use of Electronic Mail with Protected Health Information, GA.5005a: Use of Technology Resources, GA.5005b: Email and Internet Use, and GA.5005c: Laptop Loaner Policy.~~

b. The responsibility to abide by the terms of the NPP currently in effect;

c. Reserve our right to make changes to the terms of the NPP when we make changes to our privacy practices~~The right to change the terms of the NPP, and to make new notice provisions effective for PHI that CalOptima maintains~~; and

d. A description of how CalOptima provides Members with a revised NPP.

~~7.~~6. Statement that the Member may file a complaint as part of their privacy rights, and without ~~any~~ retaliation ~~in accordance with CalOptima's non-retaliation policy, complain~~ to CalOptima's Customer Service Department or Privacy Officer, the California Department of Health Care Services (DHCS), and the United States Department of Health and Human Services (HHS) if the Member believes his or her privacy rights have been violated, and include contact title and telephone number for filing the complaint with CalOptima or to get further information concerning the notice. The contact information should include:

a. CalOptima Privacy Officer
CalOptima
505 City Parkway West
Orange, CA 92868
Telephone: (888) 587-8088;

b. CalOptima Customer Service Department
Telephone: (714) 246-8500
Toll-free: (888) 587-8088
TDD/TTY: (800) 735-2929;

~~a.~~c. Privacy Officer
c/o: Office of HIPAA Compliance
Department of Health Care Services
P.O. Box 997413, MS 4722
Sacramento, CA 95899-7413
Email: privacyofficer@dhcs.ca.gov

Telephone: (916) 445-4646
Fax: (916) 440-7680;

~~b.~~d. Information Security Officer
DHCS Information Security Office
P.O. Box 997413, MS 6400
Sacramento, CA 95899-7413
Email: iso@dhcs.ca.gov
Fax: (916) 440-5537
Telephone: ITSD Service Desk
(916) 440-7000 or (800) 579-0874; and

~~c.~~e. Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Voice Phone (800) 368-1019
FAX (415) 437-8329
TDD (800) 537-7697
Email: OCRComplaint@hhs.gov

~~8.~~7. Effective date of the notice.

~~C.~~B. The NPP shall be made available to anyone, upon request, by calling or writing to the CalOptima Customer Service Department. CalOptima's Customer Service Department shall make the NPP available in Threshold Languages to anyone by mail, in person, or through the CalOptima website. CalOptima shall distribute the NPP by:

1. Ensuring initial distribution by mail to all ~~enrollees~~Members, prior to April 2003;

2. Including copies in all new enrollment packets, effective April 2003;

3. Posting a copy in the Customer Service Department lobby in Threshold languages;

4. Posting the NPP on the CalOptima website; ~~and~~

   a. Upon a material change to the NPP, CalOptima shall prominently post the change or the revised NPP on the CalOptima website by the effective date of the material change to the notice.

5. Providing a revised NPP, or information about the material change and how to obtain the revised NPP, in the next annual mailing to Members; and

~~5.~~6. Notifying all Members at least once every three (3) years that a copy of the NPP is available upon request, or may be obtained on the CalOptima website at www.caloptima.org.

~~D.~~C. Documentation and Retention:

1. CalOptima shall document compliance with this policy, and retain copies of the notices issued for a period of ~~six~~ ten (~~6~~10) years from the effective date of the notice.

~~V.~~IV. ATTACHMENTS

A. Notice of Privacy Practices

~~VI.~~V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~B.~~D. CalOptima ~~Contract with the Department of Health Care Services (DHCS) for PACE~~PACE Program Agreement
~~C.~~E. CalOptima Policy AA.1000: Glossary of Terms
F. CalOptima Policy CMC.1001: Glossary of Terms
~~D.~~G. CalOptima Policy MA.1001: Glossary of Terms
~~E.~~H. CalOptima Policy GA.5005a: Use of Technology Resources
~~F.~~I. CalOptima Policy GA.5005b: Email and Internet Use
~~G.~~J. CalOptima Policy GA.5005c: Laptop Loaner Policy
K. CalOptima Policy HH.3001Δ: Member Access to Designated Record Set
~~H.~~L. CalOptima Policy HH.3012Δ: Non-Retaliation on Reporting Violations
~~I.~~M. CalOptima Policy HH.3003Δ: Verification of Identity for Disclosure of Protected Health Information
~~J.~~N. CalOptima Policy HH.3004Δ: Member Request to Amend Record
~~K.~~O. CalOptima Policy HH.3005Δ: Member Request for an Accounting of Disclosures
~~L.~~P. CalOptima Policy HH.3007Δ: Member Right to Request Restrictions on Use and Disclosure of Protected Health Information
~~M.~~Q. CalOptima Policy HH.3008Δ: Member Right to Request Confidential Communications
~~N.~~R. CalOptima Policy HH.3009Δ: Access by Member's Authorized Representative
~~O.~~S. CalOptima Policy HH.3014Δ: Use of Electronic Mail with Protected Health Information
~~P.~~T. CalOptima Policy HH.3016Δ: Guidelines for Handling Protected Health Information Offsite
~~Q.~~U. CalOptima Policy HH.3019Δ: De-identification of Protected Health Information
~~R. CalOptima Policy HH.3021: Disclosure of Information to Family Members or Friends Involved in Member Care~~
~~S.~~V. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~CalOptima Compliance Plan~~
~~T.~~W. MMCD All Plan Letter 06001: Notice of Privacy Practices and Notification of Breaches
~~U. NCQA Standard RR5 Privacy and Confidentiality: Element A: Adopting Written Policies, Factor 1 – 2014~~NCQA Standard MED5 Privacy and Confidentiality: Element A: Adopting Written Policies, Factor 1-2017
X.

Y. Title 45, Code of Federal Regulations (C.F.R.), ~~Section~~ §164.105(c)(2)
~~V.~~Z. Title 45, Code of Federal Regulations (C.F.R.), ~~Section~~ §164.520~~, Notice of Privacy Practices for Protected Health Information~~
~~W.~~AA. Title 45, Code of Federal Regulations (C.F.R.), ~~Section~~ §164.530(g)~~, Administrative Requirements~~

~~VII.~~VI. REGULATORY AGENCY APPROVALS

None to Date

~~VIII.~~VII. BOARD ACTIONS

None to Date

~~IX.~~VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3000	Notice of Privacy Practices	Medi-Cal
Effective	06/01/2005	MA.9202	Notice of Privacy Practices	OneCare
Revised	07/01/2007	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	02/01/2008	MA.9202	Notice of Privacy Practices	OneCare
Revised	04/01/2009	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	01/01/2011	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	01/01/2013	HH.3000Δ	Notice of Privacy Practices	Medi-Cal OneCare
Revised	01/01/2014	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	05/01/2014	MA.9202	Notice of Privacy Practices	OneCare
Revised	11/01/2014	MA.9202	Notice of Privacy Practices	OneCare
Revised	09/01/2015	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	09/01/2015	MA.9202	Notice of Privacy Practices	OneCare OneCare Connect PACE
Revised`	12/01/2016	HH.3000Δ	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE

Version	Date	Policy Number	Policy Title	Line(s) of Business
Retired	12/01/2016	MA.9202	Notice of Privacy Practices	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Health Care Operations	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Maintenance Organization	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Member	An enrollee-beneficiary of a CalOptima program.
Notice of Privacy Practices (NPP)	Notice provided to a Member that describes Cal Optima's practices in the Use and Disclosure of Protected Health Information, Member rights, and CalOptima legal duties with respect to Protected Health Information.
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: **1.** Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; **2.** Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and, **3.** Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Protected Health Information (PHI)	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

Term	Definition
Required by Law	Has the meaning in 45 Code of Federal Regulations (CFR) Section 164.103 which specifies a mandate contained in law that compels an entity to make a Use or Disclosure of PHI and that is enforceable in a court of law and which are permissible grounds for a covered entity to Use of Disclose PHI under 45 CFR Section 164.512(a) when relevant requirements are met.
Threshold Languages	Medi-Cal: Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA). OneCare, OneCare Connect, PACE: The non-English native language of a group served by the CMS Program as specified in annual guidance to Contractors on specific translation requirements for their service areas.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

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Policy #:	HH.3000Δ
Title:	**Notice of Privacy Practices**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/03
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy identifies the required content of CalOptima's Notice of Privacy Practices (NPP) and the process by which the NPP is distributed to CalOptima Members.

II. POLICY

A. CalOptima Members have the right to adequate notice of the Uses and Disclosures of Protected Health Information (PHI) that may be made by CalOptima and of the Members' rights and CalOptima's legal duties with respect to PHI.

B. CalOptima provides information that directs Members on the process to file complaints with CalOptima and its regulators and will not retaliate against Members who file complaints when they believe their privacy rights have been violated in accordance with CalOptima Policy HH.3012Δ: Non-Retaliation on Reporting Violations.

C. CalOptima provides the NPP to Members as required by law including, providing the NPP upon enrollment and providing notice upon material revisions of the NPP on its website.

III. PROCEDURE

A. The content of the NPP shall be written in plain language, and contain the following elements:

1. Mandated header;

2. Description and one (1) example each, of the types of Use and Disclosures that CalOptima is permitted under state and federal regulations for the purposes of Treatment, Payment, and Health Care Operations. If a Use or Disclosure for any purpose described in paragraphs (b)(1)(ii)(A) or (B) of 45 CFR Section 164.520 is prohibited or material limited by other applicable law, the description of such use or disclosure must reflect the more stringent law as defined in 45 CFR Section 160.202.;

3. A description of the types of Uses and Disclosures that require an authorization under Section 164.504(a)(2)-(a)(4), a statement that other Use and Disclosures not described in this notice will be made only with the Member's written authorization, and a statement that the Member may revoke such authorization as provided by Section 164.508(b)(5);

4. Statement to describe the Member's rights concerning his or her PHI, how to exercise these rights, and restrictions on such rights, that shall include information on:

    a. Restrictions concerning certain Use and Disclosures of PHI, and provision that CalOptima is not required to agree to those restrictions, except in case of a disclosure restricted under Section 164.522(a)(1)(iv) and in accordance with CalOptima Policy HH.3007Δ: Member Right to Request Restrictions on Use and Disclosure of Protected Health Information;

    b. Right to receive confidential communications of PHI, in accordance with CalOptima Policy HH.3008Δ: Member Right to Request Confidential Communications;

    c. Right to inspect and copy PHI, in accordance with CalOptima Policy HH.3001Δ: Member Access to Designated Record Set;

    d. Right to request amendment to PHI, in accordance with CalOptima Policy HH.3004Δ: Member Request to Amend Record;

    e. Right to receive accounting of Disclosures, with certain exceptions, in accordance with CalOptima Policy HH.3005Δ: Member Request for an Accounting of Disclosures; and

    f. Right to receive a paper copy of the NPP, in accordance with this policy.

5. Statement specifically describing CalOptima's duties and rights under the privacy rule, including:

    a. A statement that CalOptima is required by law to maintain the privacy of the Member's PHI , to provide individuals with notice of its legal duties and privacy practices with respect to PHI, and to notify affected Members following a breach of unsecured PHI, and in accordance with CalOptima policies, which shall include processes to ensure internal protection of:

        i. Verbal (i.e., when talking to individuals on the telephone or in person about a Member), and written information, in accordance with CalOptima policies HH.3003Δ: Verification of Identity for Disclosures of Protected Health Information, HH.3009Δ: Access by Member's Authorized Representative, HH.3016Δ: Guidelines for Handling Protected Health Information Offsite, and HH.3019Δ: De-identification of Protected Health Information.

    b. The responsibility to abide by the terms of the NPP currently in effect;

    c. Reserve our right to make changes to the terms of the NPP when we make changes to our privacy practices; and

    d. A description of how CalOptima provides Members with a revised NPP.

6. Statement that the Member may file a complaint as part of their privacy rights, and without retaliation, to CalOptima's Customer Service Department or Privacy Officer, the California Department of Health Care Services (DHCS), and the United States Department of Health and Human Services (HHS) if the Member believes his or her privacy rights have been violated,

and include contact title and telephone number for filing the complaint with CalOptima or to get further information concerning the notice. The contact information should include:

a. CalOptima Privacy Officer
CalOptima
505 City Parkway West
Orange, CA 92868
Telephone: (888) 587-8088;

b. CalOptima Customer Service Department
Telephone: (714) 246-8500
Toll-free: (888) 587-8088
TDD/TTY: (800) 735-2929;

c. Privacy Officer
c/o: Office of HIPAA Compliance
Department of Health Care Services
P.O. Box 997413, MS 4722
Sacramento, CA 95899-7413
Email: privacyofficer@dhcs.ca.gov
Telephone: (916) 445-4646
Fax: (916) 440-7680;

d. Information Security Officer
DHCS Information Security Office
P.O. Box 997413, MS 6400
Sacramento, CA 95899-7413
Email: iso@dhcs.ca.gov
Fax: (916) 440-5537
Telephone: ITSD Service Desk
(916) 440-7000 or (800) 579-0874; and

e. Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Voice Phone (800) 368-1019
FAX (415) 437-8329
TDD (800) 537-7697
Email: OCRComplaint@hhs.gov

7. Effective date of the notice.

B. The NPP shall be made available to anyone, upon request, by calling or writing to the CalOptima Customer Service Department. CalOptima's Customer Service Department shall make the NPP available in Threshold Languages to anyone by mail, in person, or through the CalOptima website. CalOptima shall distribute the NPP by:

1. Ensuring initial distribution by mail to all Members, prior to April 2003;

2. Including copies in all new enrollment packets, effective April 2003;

3. Posting a copy in the Customer Service Department lobby in Threshold languages;

4. Posting the NPP on the CalOptima website;

   a. Upon a material change to the NPP, CalOptima shall prominently post the change or the revised NPP on the CalOptima website by the effective date of the material change to the notice.

5. Providing a revised NPP, or information about the material change and how to obtain the revised NPP, in the next annual mailing to Members; and

6. Notifying all Members at least once every three (3) years that a copy of the NPP is available upon request, or may be obtained on the CalOptima website at www.caloptima.org.

C. Documentation and Retention:

1. CalOptima shall document compliance with this policy, and retain copies of the notices issued for a period of ten (10) years from the effective date of the notice.

IV. ATTACHMENTS

A. Notice of Privacy Practices

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy AA.1000: Glossary of Terms
F. CalOptima Policy CMC.1001: Glossary of Terms
G. CalOptima Policy MA.1001: Glossary of Terms
H. CalOptima Policy GA.5005a: Use of Technology Resources
I. CalOptima Policy GA.5005b: Email and Internet Use
J. CalOptima Policy GA.5005c: Laptop Loaner Policy
K. CalOptima Policy HH.3001Δ: Member Access to Designated Record Set
L. CalOptima Policy HH.3012Δ: Non-Retaliation on Reporting Violations
M. CalOptima Policy HH.3003Δ: Verification of Identity for Disclosure of Protected Health Information
N. CalOptima Policy HH.3004Δ: Member Request to Amend Record
O. CalOptima Policy HH.3005Δ: Member Request for an Accounting of Disclosures
P. CalOptima Policy HH.3007Δ: Member Right to Request Restrictions on Use and Disclosure of Protected Health Information
Q. CalOptima Policy HH.3008Δ: Member Right to Request Confidential Communications
R. CalOptima Policy HH.3009Δ: Access by Member's Authorized Representative
S. CalOptima Policy HH.3014Δ: Use of Electronic Mail with Protected Health Information

T. CalOptima Policy HH.3016Δ: Guidelines for Handling Protected Health Information Offsite
U. CalOptima Policy HH.3019Δ: De-identification of Protected Health Information
V. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnectMMCD All Plan Letter 06001: Notice of Privacy Practices and Notification of Breaches
W. NCQA Standard MED5 Privacy and Confidentiality: Element A: Adopting Written Policies, Factor 1-2017
X. Title 45, Code of Federal Regulations (C.F.R.), §164.105(c)(2)
Y. Title 45, Code of Federal Regulations (C.F.R.), §164.520
Z. Title 45, Code of Federal Regulations (C.F.R.), §164.530(g)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3000	Notice of Privacy Practices	Medi-Cal
Effective	06/01/2005	MA.9202	Notice of Privacy Practices	OneCare
Revised	07/01/2007	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	02/01/2008	MA.9202	Notice of Privacy Practices	OneCare
Revised	04/01/2009	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	01/01/2011	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	01/01/2013	HH.3000Δ	Notice of Privacy Practices	Medi-Cal OneCare
Revised	01/01/2014	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	05/01/2014	MA.9202	Notice of Privacy Practices	OneCare
Revised	11/01/2014	MA.9202	Notice of Privacy Practices	OneCare
Revised	09/01/2015	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	09/01/2015	MA.9202	Notice of Privacy Practices	OneCare OneCare Connect PACE

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised`	12/01/2016	HH.3000Δ	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9202	Notice of Privacy Practices	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Health Care Operations	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Maintenance Organization	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Member	An enrollee-beneficiary of a CalOptima program.
Notice of Privacy Practices (NPP)	Notice provided to a Member that describes Cal Optima's practices in the Use and Disclosure of Protected Health Information, Member rights, and CalOptima legal duties with respect to Protected Health Information.
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: **1.** Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; **2.** Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and, **3.** Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Protected Health Information (PHI)	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

Term	Definition
Required by Law	Has the meaning in 45 Code of Federal Regulations (CFR) Section 164.103 which specifies a mandate contained in law that compels an entity to make a Use or Disclosure of PHI and that is enforceable in a court of law and which are permissible grounds for a covered entity to Use of Disclose PHI under 45 CFR Section 164.512(a) when relevant requirements are met.
Threshold Languages	Medi-Cal: Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA). OneCare, OneCare Connect, PACE: The non-English native language of a group served by the CMS Program as specified in annual guidance to Contractors on specific translation requirements for their service areas.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

1

Placeholder for:

HH.3000Δ: Notice of Privacy Practices,

Attachment A: Notice of Privacy Practices (NPP)

Status: Pending internal approval.

~~Policy #: MA.9203~~
~~Title: **Member Access to Designated Record Set**~~
~~Department: Office of Compliance~~
~~Section: Health Insurance Portability and Accountability Act (HIPAA)~~
~~CEO Approval: Michael Schrader~~

~~Effective Date: 8/1/05~~
~~Last Review Date: 9/1/15~~
~~Last Revised Date: 9/1/15~~

~~This policy shall apply to the following CalOptima line of business (LOB):~~
- ~~OneCare~~
- ~~OneCare Connect~~
- ~~PACE~~

~~Policy #: HH.3001~~

~~Title: **Member Access to Designated Record Set**~~
~~Department: Office of Compliance~~
~~Section: Health Insurance Portability and Accountability Act (HIPAA)~~
~~CEO Approval: Michael Schrader~~

~~Effective Date: 4/1/03~~
~~Review Date: 9/1/15~~
~~Revised Date: 9/1/15~~
~~Policy #:~~ HH.3001Δ
Title: **Member Access to Designated Record Set**
Department: Office of Compliance
Section: ~~Health Insurance Portability and Accountability Act (HIPAA~~Privacy~~)~~

CEO Approval: Michael Schrader

Effective Date: 04/01/03
Last Review Date: 12/01/16
Last Revised Date: 12/01/16

Applicable to:
☒ Medi-Cal
☒ OneCare
☒ OneCare Connect
☒ PACE

I. PURPOSE

This policy~~o~~ defines the Designated Record Set (DRS) that contains Protected Health Information (PHI) for a Member, maintained by CalOptima and the conditions under which the Member may access, inspect, or obtain a copy of his or her PHI in the DRS.

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~
~~Authorized Representative~~	~~Any individual authorized by a Member, or under state law, to act on his or her behalf in obtaining an Organization Determination or in dealing with any level of the Appeal process. An Authorized Representative is subject to the rules described in Title 20 of the Code of Federal Regulations, Part 404, Subpart R, unless otherwise stated in the Medicare Managed Care Manual (Use form CMS-1696 for Claims Adjudication or Claim Appeals process)Has the meaning given suchto the term Personal Representative in section 164.502(g) of title 45 CFR of Title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.~~
~~Business Associate~~	~~Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who:~~ ~~1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; orOn behalf of a covered entity or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs, or assists in the performance of:~~ ~~a. A function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or~~ ~~b. Any other function or activity regulated by this subchapter; or~~ ~~Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of~~

Term	Definition
	such covered entity or arrangement, to the person.Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the services involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. A person that offers a personal health record to one or more individuals on behalf of a covered entity. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate. 2.
Designated Record Set	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. A group of records maintained by or for a covered entity that is: The medical records and billing records about individuals maintained by or for a covered health care provider; The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or Used, in whole or in part, by or for the covered entity to make decisions about individuals. The term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity. by or for CalOptima that includes enrollment, Payment, claims adjudication, and case or medical management record system(s) used by or maintained for the agency, or used, in whole or in part, by or for CalOptima to make decisions about the Member. The DRS excludes patient identifiable data used for administrative, regulatory, Health Care Operations and Payment/financial purpose; employment records held by CalOptima in its role as employer.

Term	Definition
Disclosure	Has the meaning in in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information. Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner orof information outside of the entity holding the information.
FACETS™	Licensed software product that supports administrative, claims processing and adjudication, membership data, and other information needs of managed care organizations.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including aActivities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Network (HN)	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG)physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	An enrollee beneficiary of a CalOptima program.
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: - Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; - Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and, - Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.Activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.

~~Term~~	~~Definition~~
~~Protected Health Information (PHI)~~	~~Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.~~ ~~This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to:~~ ~~The past, present, or future physical or mental health or condition of a Member;~~ ~~The provision of health care to a Member; or~~ ~~Past, present, or future Payment for the provision of health care to a Member. Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.~~ ~~This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to:~~ ~~1. Past, present, or future Payment for the provision of health care to a Member.~~ ~~2. The provision of health care to a Member; or~~ ~~3. The past, present, or future physical or mental health or condition of a Member.~~
~~Provider~~	~~A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.~~
~~Research~~	~~Systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.~~
~~Treatment~~	~~Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.Activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.~~

~~Term~~	~~Definition~~
~~Use of PHI~~	~~Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. The sharing, employment, application, utilization, examination, or analysis of the PIIIPHI within an entity that maintains such information.~~

~~III.~~II. POLICY

A. Members shall have the right to access, inspect, or obtain a copy of ~~his or her~~their PHI in the DRS for as long as CalOptima maintains the PHI record.

B. CalOptima shall grant a Member's Authorized Representative access to a Member's PHI, in accordance with CalOptima P~~p~~olicies ~~, MA.9212~~HH.3009Δ: Access by Member's Authorized Representative and ~~MA.9219~~HH.3015Δ: Authorization for Release of Protected Health Information.

C. Any person with knowledge of a violation or potential violation of this policy shall report such information to the Privacy Officer directly or through the CalOptima Compliance and Ethics Hotline at 1-877-837-4417.

~~IV.~~III. PROCEDURE

A. ~~Request~~Requests for access to inspect or obtain a copy ~~a~~of DRS:

1. A Member shall submit a written request for access to inspect or copy the DRS by submitting the Individual Request for Access to Personal Health Information form, to the Office of Compliance.

2. The DRS does not include ~~copies of~~complete copies of~~-~~ records created and/or maintained by ~~other~~ Providers other than CalOptima. If a ~~m~~Member wants such records, they are advised to contact their doctor or clinic.~~.~~

3. CalOptima shall process a request to inspect or obtain copies of the DRS within thirty (30) calendar days after receipt of ~~the~~a written request. If necessary, a thirty (30) calendar day extension may be used to retrieve data located off-site.

~~3.~~
a. For extensions, CalOptima must provide the ~~m~~Member a written statement of the reasons for the delay and the date by which it may complete its action (within the thirty (30) calendar day period) and it may only have one (1) extension.

~~1.~~4. The Office of Compliance shall notify the Member, in writing, of the determination on the request. ~~-~~The notice ~~will~~shall contain the information set forth in Section ~~IV~~III.E. of this policy.

~~2.~~5. Verification of Member identification requesting access to inspect or copy the DRS:

a. If the Member makes such request in person to the Customer Service Department, ~~the~~ Customer Service staff shall:

i. Request identification (e.g., Member ID card or a letter from CalOptima~~)~~), or ask to verify the Member's date of birth or address based on ~~CalOptima Claims System~~FACETS™ data; and

ii. Provide the Member with a copy of the Individual Request for Access to Personal Health Information form for the Member to complete.

~~iii.~~b. If the Member request is received by mail, the Office of Compliance staff shall accept the completed form as being from the Member unless there is an error in the information included on the request form that requires additional verification from the requestor.

~~3.~~6. The Office of Compliance shall accept the request from the Member as valid, provided all information on the request is complete and accurate. ~~-~~All requests shall include, as applicable:

a. An Authorization for Use or Disclosure of Protected Health Information form, as applicable, for disclosure of a ~~m~~Member's PHI to a third party;

b. An Individual Request for Access to Personal Health Information form;

c. A written request that provides sufficient information as necessary to identify the specific PHI sought;

d. Documentation that verifies the identity of the Member, in accordance with CalOptima ~~Policy MA.9205P~~policy HH.3003Δ: Verification of Identity for Disclosure of Protected Health Information.

7. The Office of Compliance shall review the request, determine if Member access is appropriate, and which parts of the DRS the Member cannot access.

8. The Office of Compliance shall deny Member access to the following:

a. Psychotherapy notes;

~~a.~~b. PHI compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; or

~~b.~~ PHI obtained from someone other than a Provider under a promise of confidentiality, and ~~-~~the access requested would be reasonably likely to reveal the source of the information.~~; or~~

c. ~~PHI covered under the Clinical Laboratory Improvements Act (CLIA).~~

9. CalOptima may deny access without the right of the Member to request review by a CalOptima designated licensed health care professional, under the following conditions:

a. PHI as set forth in Section II~~I~~V.A.8. of this policy; or

b. When the PHI is used for Research and Treatment, CalOptima may temporarily suspend ~~—~~access, provided:

i. The Member agreed to the denial of access when consenting to participate in the Research and Treatment; and

~~ii. The Provider informed the Member that the right to access shall be reinstated upon completion of the Research. , or~~

~~10. CalOptima may deny access, with the right of the Member to request review by a CalOptima designated licensed health care professional, under the following conditions:~~

~~a.~~ c. -A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the Member or another person;

~~b.~~ d.- The PHI makes reference to another person other than the Member, unless that person is a Provider, and a licensed health care professional ~~determines~~has determined, in his or her professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or

~~c.~~ e. -The Authorized Representative requests for access, and a licensed ~~healthcare~~health care professional has determined, in his or her professional judgment, that the provision of access to such Authorized Representative is reasonably likely to cause substantial harm to the individual or another person.

10. If the denial is based on any of the reasons as stated in Section IV. A. 9. c-e, ~~the~~a ~~m~~Member can request to have the denial reviewed by another licensed health care professional by submitting a written request to the CalOptima Privacy Officer ~~AT~~at 505 City Parkway West, Orange, CA 92868~~.~~.

11. The Office of Compliance shall route the request to the department(s) or Business Associate responsible for creating or maintaining the requested record(s).

12. The responsible department or Business Associate ~~shall~~~~must~~shall send a copy of the requested PHI to the Office of Compliance within fourteen (14) calendar days of receiving the request.

B. The following departments within CalOptima shall have responsibility for the DRS, as follows:

1. Customer Service Department;

2. Finance Department;

3. Information Systems (IS);

4. Claims Administration;

5. Case Management:

a. Prior Authorization records only; or

b. Case or Medical Management records only.

6. Pharmacy:

a. Prior Authorization records only.

7. Multipurpose Senior Services Program (MSSP):

a. Prior Authorization records only.

8. Long Term Care (LTC):

a. Case or Medical Management Records.

C. Department staff ~~shallshould~~shall consult ~~with~~ the Privacy Officer if there is any doubt about the appropriateness of releasing the PHI to the Member.

D. If CalOptima does not maintain the PHI that is the subject of the Member's request for access, and CalOptima knows where the requested information is maintained, CalOptima shall inform the Member of the entity to whom the Member may direct such request.

E. Notification to Member:

1. The Office of Compliance shall notify the Member regarding the record request as follows:

a. Approved: If CalOptima approves the Member's request, CalOptima shall provide the Member with the records requested, in accordance with the format and method designated on the Individual Request for Access to Personal Health Information Form within thirty (30) calendar days after receipt of the request, but no later than sixty (60) calendar days if an extension is needed~~.~~

b. Denied: If CalOptima denies the Member's request, CalOptima shall send a letter to the Member ~~within the required timeframes~~ within thirty (30) calendar days after receipt of the request, but no later than sixty (60) calendar days if an extension is needed, informing the Member of the decision, the reason for denial, and instructions on Member's appeal rights to have the materials reviewed, if applicable. The denial notice shall ~~would include~~include a description of how ~~the~~a ~~m~~Member may complain to CalOptima or OCR and ~~include~~ contact information for how to file a complaint with CalOptima.

F. Documentation~~:~~

1. The Office of Compliance shall retain a record of the ~~request~~requests and related letters, including a copy of ~~the~~ information released to the Member, for ten (10) years from the date of the release.

G. The following table summarizes the content of CalOptima's DRS:

~~Designated Record Set~~DRS Content	Source	Media Type For Member
Enrollment Records Enrollment Form from Member	Customer Service	Paper Form
Auto-Assignment ~~& Physician Medical Group~~and Health Network changes	IS	Print out/report from ~~CalOptima Claims System~~FACETS™ Excluded: Customer Service Notes
Payment Records (1) Eligibility Records	IS	Print out/report from ~~CalOptima Claims System~~FACETS™
(2) Claims Records	Claims	Paper copy from microfiche Print out/report from ~~CalOptima Claims System~~FACETS™
(3)~~-~~ Prior, current and retrospective Authorization Records (ARF/PA request and attachments*, notice of action (NOA) letters)	Care Coordination	Print out/report from ~~CalOptima Claims System,~~ FACETS™, clinical systems. Paper copy from ARF/PA File, shared drive, or CD-rom.
	Pharmacy	Paper copy Summary- Pharmacy Benefit Manager (PBM) data files
	MSSP	Paper copy Print out/report from MSSP ~~data base~~database
*Note: Excludes ~~medical records~~Medical Records created and maintained by Providers.	LTC	Paper copy, Print out/report from LTC database
Case or Medical Management Record Entries in Care Management Data Systems including contacts with Member or other coordination activities used in making decisions about the Member.	Care Coordination	Paper copy Summary reports from clinical systems and ~~database~~data base files. Excludes: Case or Medical Management notes created by Providers or Health Networks.

~~Designated Record Set~~DRS Content	Source	Media Type For Member
Excluded: Patient-identifiable data used for administrative, regulatory, Health Care Operations and Payment/financial purpose; employment records held by CalOptima in its role as employer.		Examples include protocols, practice guidelines, accreditation reports, best practice guidelines, public health records, statistical reports, MDS Report, ~~and~~ patient identifiable data reviewed for quality assurance.

~~V.~~IV. ATTACHMENTS

A. Authorization for Use or Disclosure of Protected Health Information
~~A.~~B. Individual Instruction Sheet for CalOptima HIPAA Authorization for Release of Protected Health Information Form
~~B.~~C. Individual Request for Access to Personal Health Information
~~C.~~D. Letter: Denial of Access-Subject to review
~~D.~~E. Letter: Denial of Access-Not Subject to review

~~VI.~~V. REFERENCES

~~A.~~

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima ~~Contract with the Department of Health Care Services (DHCS) for PACE~~PACE Program Agreement
~~B. California Health and Safety Code, Section §123110~~
~~C.~~E. CalOptima Notice of Privacy Practices
~~D. CalOptima Privacy Program~~
~~E. CalOptima Policy AA.1000: Glossary of Terms~~
~~F. CalOptima Policy CMC.1001: Glossary of Terms~~
~~G.~~ CalOptima Policy ~~MA.1001: Glossary of Terms~~
~~H.~~F. ~~CalOptima Policy MA.9205~~HH.3003Δ: Verification of Identity for Disclosure of Protected Health Information
~~I.~~G. CalOptima Policy ~~MA.9212~~HH.3009Δ: Access by Member's Authorized Representative
~~J.~~H. CalOptima Policy ~~MA.9219~~HH.3015Δ: Authorization for Release of Protected Health Information (PHI)
~~K.~~I. CalOptima ~~Compliance Plan~~Privacy Program
J. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
K. NCQA Standard ~~RR5~~MED5 Privacy and Confidentiality: Element A: Adopting Written Policies, Factor 2 – 201~~4~~7
L. Title 45, Code of Federal Regulations (C.F.R.), §164.501
~~L.~~M. Title 45, Code of Federal Regulations (C.F.R.), ~~Section~~ §164.524 ~~Access of Individuals to Protected Health Information~~
N. Title 45, Code of Federal Regulations (C.F.R.), ~~Section~~ §164.~~524,~~530 ~~Administrative Requirements,~~ (j)(2)

~~M. Implementation specification: Retention period~~

~~VII.~~VI. REGULATORY AGENCY APPROVALS

None to Date

~~VIII.~~VII. BOARD ACTIONS

None to Date

~~IX.~~VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3001	Member Access to Designated Record Set	Medi-Cal
Effective	08/01/2005	MA.9203	Member Access to Designated Record Set	OneCare
Revised	04/01/2007	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	07/01/2008	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	09/01/2008	MA.9203	Member Access to Designated Record Set	OneCare
Revised	07/01/2011	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	07/01/2011	MA.9203	Member Access to Designated Record Set	OneCare
Revised	01/01/2013	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	01/01/2014	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	06/01/2014	MA.9203	Member Access to Designated Record Set	OneCare
Revised	11/01/2014	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	11/01/2014	MA.9203	Member Access to Designated Record Set	OneCare
Revised	09/01/2015	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	09/01/2015	MA.9203	Member Access to Designated Record Set	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3001Δ	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE

Version	Date	Policy Number	Policy Title	Line(s) of Business
Retired	12/01/2016	MA.9203	Member Access to Designated Record Set	OneCare OneCare Connect PACE

~~Version~~	~~Version Date~~	~~Policy Number~~	~~Policy Title~~
~~Original Date~~Effective	~~08~~04/01/2005~~2003~~	~~MA.9203~~HH.3001	~~Member Access to Designated Record Set~~
~~Revision Date 1~~Revised	~~04/01/2007~~	~~HH.3001~~	~~Member Access to Designated Record Set~~
~~Revised~~Revision Date ~~1~~2	~~09~~07/01/2008	~~MA.9203~~HH.3001	~~Member Access to Designated Record Set~~
~~Revised~~Revision Date ~~2~~3	~~07/01/2011~~	~~MA.9203~~HH.3001	~~Member Access to Designated Record Set~~
~~Revised~~Revision Date ~~2~~4	~~01/01/2013~~	~~HH.3001~~	~~Member Access to Designated Record Set~~
~~Revised~~Revision Date ~~3~~5	~~06~~01/01/2014	~~MA.9203~~HH.3001	~~Member Access to Designated Record Set~~
~~Revised~~Revision Date ~~4~~6	~~11/01/2014~~	~~MA.9203~~HH.3001	~~Member Access to Designated Record Set~~
~~Revised~~Revision Date ~~5~~ 7	~~09/01/2015~~	~~MA.9203~~HH.3001	~~Member Access to Designated Record Set~~

IX. GLOSSARY

Term	Definition
Authorized Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.

Term	Definition
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.

Term	Definition
Designated Record Set	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. A group of records maintained by or for a covered entity that is: 1. The medical records and billing records about individuals maintained by or for a covered health care provider; 2. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or 3. Used, in whole or in part, by or for the covered entity to make decisions about individuals. The term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
FACETS™	Licensed software product that supports administrative, claims processing and adjudication, membership data, and other information needs of managed care organizations.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	An enrollee-beneficiary of a CalOptima program.

Term	Definition
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Research	Systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

1

Policy #:	HH.3001Δ
Title:	**Member Access to Designated Record Set**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/03
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy defines the Designated Record Set (DRS) that contains Protected Health Information (PHI) for a Member, maintained by CalOptima and the conditions under which the Member may access, inspect, or obtain a copy of his or her PHI in the DRS.

II. POLICY

A. Members shall have the right to access, inspect, or obtain a copy of their PHI in the DRS for as long as CalOptima maintains the PHI record.

B. CalOptima shall grant a Member's Authorized Representative access to a Member's PHI, in accordance with CalOptima Policies HH.3009Δ: Access by Member's Authorized Representative and HH.3015Δ: Authorization for Release of Protected Health Information.

C. Any person with knowledge of a violation or potential violation of this policy shall report such information to the Privacy Officer directly or through the CalOptima Compliance and Ethics Hotline at 1-877-837-4417.

III. PROCEDURE

A. Requests for access to inspect or obtain a copy of DRS:

1. A Member shall submit a written request for access to inspect or copy the DRS by submitting the Individual Request for Access to Personal Health Information form, to the Office of Compliance.

2. The DRS does not include complete copies of records created and/or maintained by Providers other than CalOptima. If a Member wants such records, they are advised to contact their doctor or clinic.

3. CalOptima shall process a request to inspect or obtain copies of the DRS within thirty (30) calendar days after receipt of a written request. If necessary, a thirty (30) calendar day extension may be used to retrieve data located off-site.

a. For extensions, CalOptima must provide the Member a written statement of the reasons for the delay and the date by which it may complete its action (within the thirty (30) calendar day period) and it may only have one (1) extension.

4. The Office of Compliance shall notify the Member, in writing, of the determination on the request. The notice shall contain the information set forth in Section III.E. of this policy.

5. Verification of Member identification requesting access to inspect or copy the DRS:

   a. If the Member makes such request in person to the Customer Service Department, Customer Service staff shall:

      i. Request identification (e.g., Member ID card or a letter from CalOptima), or ask to verify the Member's date of birth or address based on FACETS™ data; and

      ii. Provide the Member with a copy of the Individual Request for Access to Personal Health Information form for the Member to complete.

   b. If the Member request is received by mail, the Office of Compliance staff shall accept the completed form as being from the Member unless there is an error in the information included on the request form that requires additional verification from the requestor.

6. The Office of Compliance shall accept the request from the Member as valid, provided all information on the request is complete and accurate. All requests shall include, as applicable:

   a. An Authorization for Use or Disclosure of Protected Health Information form, as applicable, for disclosure of a Member's PHI to a third party;

   b. An Individual Request for Access to Personal Health Information form;

   c. A written request that provides sufficient information as necessary to identify the specific PHI sought;

   d. Documentation that verifies the identity of the Member, in accordance with CalOptima Policy HH.3003Δ: Verification of Identity for Disclosure of Protected Health Information.

7. The Office of Compliance shall review the request, determine if Member access is appropriate, and which parts of the DRS the Member cannot access.

8. The Office of Compliance shall deny Member access to the following:

   a. Psychotherapy notes;

   b. PHI compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; or

   c. PHI obtained from someone other than a Provider under a promise of confidentiality, and the access requested would be reasonably likely to reveal the source of the information.

9. CalOptima may deny access without the right of the Member to request review by a CalOptima designated licensed health care professional, under the following conditions:

    a. PHI as set forth in Section III.A.8. of this policy; or

    b. When the PHI is used for Research and Treatment, CalOptima may temporarily suspend access, provided:

        i. The Member agreed to the denial of access when consenting to participate in the Research and Treatment; and

    c. A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the Member or another person;

    d. The PHI makes reference to another person other than the Member, unless that person is a Provider, and a licensed health care professional has determined, in his or her professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or

    e. The Authorized Representative requests for access, and a licensed health care professional has determined, in his or her professional judgment, that the provision of access to such Authorized Representative is reasonably likely to cause substantial harm to the individual or another person.

10. If the denial is based on any of the reasons as stated in Section IV. A. 9. c-e, a Member can request to have the denial reviewed by another licensed health care professional by submitting a written request to the CalOptima Privacy Officer at 505 City Parkway West, Orange, CA 92868.

11. The Office of Compliance shall route the request to the department(s) or Business Associate responsible for creating or maintaining the requested record(s).

12. The responsible department or Business Associate shall send a copy of the requested PHI to the Office of Compliance within fourteen (14) calendar days of receiving the request.

B. The following departments within CalOptima shall have responsibility for the DRS, as follows:

1. Customer Service Department;

2. Finance Department;

3. Information Systems (IS);

4. Claims Administration;

5. Case Management:

    a. Prior Authorization records only; or

b. Case or Medical Management records only.

6. Pharmacy:

a. Prior Authorization records only.

7. Multipurpose Senior Services Program (MSSP):

a. Prior Authorization records only.

8. Long Term Care (LTC):

a. Case or Medical Management Records.

C. Department staff shall consult the Privacy Officer if there is any doubt about the appropriateness of releasing the PHI to the Member.

D. If CalOptima does not maintain the PHI that is the subject of the Member's request for access, and CalOptima knows where the requested information is maintained, CalOptima shall inform the Member of the entity to whom the Member may direct such request.

E. Notification to Member:

1. The Office of Compliance shall notify the Member regarding the record request as follows:

a. Approved: If CalOptima approves the Member's request, CalOptima shall provide the Member with the records requested, in accordance with the format and method designated on the Individual Request for Access to Personal Health Information Form within thirty (30) calendar days after receipt of the request, but no later than sixty (60) calendar days if an extension is needed

b. Denied: If CalOptima denies the Member's request, CalOptima shall send a letter to the Member within thirty (30) calendar days after receipt of the request, but no later than sixty (60) calendar days if an extension is needed, informing the Member of the decision, the reason for denial, and instructions on Member's appeal rights to have the materials reviewed, if applicable. The denial notice shall include a description of how a Member may complain to CalOptima or OCR and contact information for how to file a complaint with CalOptima.

F. Documentation

1. The Office of Compliance shall retain a record of the requests and related letters, including a copy of information released to the Member, for ten (10) years from the date of the release.

G. The following table summarizes the content of CalOptima's DRS:

DRS Content	Source	Media Type For Member

DRS Content	Source	Media Type For Member
Enrollment Records Enrollment Form from Member	Customer Service	Paper Form
Auto-Assignment and Health Network changes	IS	Print out/report from FACETS™ Excluded: Customer Service Notes
Payment Records (1) Eligibility Records	IS	Print out/report from FACETS™
(2) Claims Records	Claims	Paper copy from microfiche Print out/report from FACETS™
(3) Prior, current and retrospective Authorization Records (ARF/PA request and attachments*, notice of action (NOA) letters)	Care Coordination	Print out/report from FACETS™, clinical systems. Paper copy from ARF/PA File, shared drive, or CD-rom.
	Pharmacy	Paper copy Summary- Pharmacy Benefit Manager (PBM) data files
	MSSP	Paper copy Print out/report from MSSP database
*Note: Excludes Medical Records created and maintained by Providers.	LTC	Paper copy, Print out/report from LTC database
Case or Medical Management Record Entries in Care Management Data Systems including contacts with Member or other coordination activities used in making decisions about the Member.	Care Coordination	Paper copy Summary reports from clinical systems and data base files. Excludes: Case or Medical Management notes created by Providers or Health Networks.
Excluded: Patient-identifiable data used for administrative, regulatory, Health Care Operations and Payment/financial purpose; employment records held by CalOptima in its role as employer.		Examples include protocols, practice guidelines, accreditation reports, best practice guidelines, public health records, statistical reports, MDS Report, patient identifiable data reviewed for quality assurance.

IV. ATTACHMENTS

A. Authorization for Use or Disclosure of Protected Health Information
B. Individual Instruction Sheet for CalOptima HIPAA Authorization for Release of Protected Health Information Form

C. Individual Request for Access to Personal Health Information
D. Letter: Denial of Access-Subject to review
E. Letter: Denial of Access-Not Subject to review

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Notice of Privacy Practices
F. CalOptima Policy HH.3003Δ: Verification of Identity for Disclosure of Protected Health Information
G. CalOptima Policy HH.3009Δ: Access by Member's Authorized Representative
H. CalOptima Policy HH.3015Δ: Authorization for Release of Protected Health Information (PHI)
I. CalOptima Privacy Program
J. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
K. NCQA Standard MED5 Privacy and Confidentiality: Element A: Adopting Written Policies, Factor 2 – 2017
L. Title 45, Code of Federal Regulations (C.F.R.), §164.501
M. Title 45, Code of Federal Regulations (C.F.R.), §164.524
N. Title 45, Code of Federal Regulations (C.F.R.), §164.530(j)(2)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3001	Member Access to Designated Record Set	Medi-Cal
Effective	08/01/2005	MA.9203	Member Access to Designated Record Set	OneCare
Revised	04/01/2007	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	07/01/2008	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	09/01/2008	MA.9203	Member Access to Designated Record Set	OneCare
Revised	07/01/2011	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	07/01/2011	MA.9203	Member Access to Designated Record Set	OneCare

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	01/01/2013	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	01/01/2014	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	06/01/2014	MA.9203	Member Access to Designated Record Set	OneCare
Revised	11/01/2014	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	11/01/2014	MA.9203	Member Access to Designated Record Set	OneCare
Revised	09/01/2015	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	09/01/2015	MA.9203	Member Access to Designated Record Set	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3001Δ	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9203	Member Access to Designated Record Set	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Authorized Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.

Term	Definition
Designated Record Set	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. A group of records maintained by or for a covered entity that is: 1. The medical records and billing records about individuals maintained by or for a covered health care provider; 2. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or 3. Used, in whole or in part, by or for the covered entity to make decisions about individuals. The term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
FACETS™	Licensed software product that supports administrative, claims processing and adjudication, membership data, and other information needs of managed care organizations.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	An enrollee-beneficiary of a CalOptima program.
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.

Term	Definition
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Research	Systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

1

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

HIPAA privacy regulations require you to complete this form to authorize CalOptima to release your Protected Health Information (PHI) to another person or entity. Please complete, sign, and return the form to CalOptima.

SECTION A: MEMBER AUTHORIZING RELEASE OF PHI

Name of Member: _____

Member CIN: _____

Address: _____

Phone No.: _____ Member date of birth: _____

SECTION B: PERSON OR ORGANIZATION AUTHORIZED TO RECEIVE THIS INFORMATION

Please enter the person(s) or organization who will receive member's protected health information. This information may be disclosed to, and used by, the following person(s) or organization(s). The representative receiving the information must be 18 years of age or older.

Name (enter first and last name[s]): _____

Relationship to Member: _____

Address: _____

Phone No.: _____

SECTION C: INFORMATION THAT CAN BE RELEASED

I allow the following information to be released by CalOptima (Check only one box):

- ☐ **My complete member file,** including **health information** (e.g. diagnosis, test results, treatment history, health care services, claims status and history, provider name(s)); **financial information** pertaining to your health condition and/or insurance coverage (e.g. claims history); and **personal information** (e.g., name, address, date of birth, and member ID). **(*This authorization doesn't include certain sensitive information unless it is specifically approved below.*) OR**
- ☐ **Only limited information** may be disclosed (check all applicable boxes below):

Limited information		
☐ Billing	☐ Medical records (excludes psychotherapy notes)	☐ Referral
☐ Claims & payment	☐ Physician and hospital affiliations	☐ Other:
☐ Diagnosis and procedure	☐ Pre-certification & pre-authorization	

I also approve the release of the following types of **sensitive information** by CalOptima (check all boxes that apply to you):

Sensitive information		
☐ Mental health (including psychotherapy notes)	☐ Genetic testing	☐ Other:
☐ Abuse (sexual/physical/mental/elder)	☐ HIV or AIDS	
☐ Alcohol/substance abuse	☐ Sexually transmitted illness	

SECTION D: PURPOSE OF THIS AUTHORIZATION

This protected health information is being disclosed for the following purpose(s). Please select all that apply:

- ☐ At the request of the Member
- ☐ I have been designated by the patient as his/her representative
- ☐ Other (please specify):

_____

SECTION E: EXPIRATION DATE OF AUTHORIZATION

This authorization will expire on the earlier of **(Please choose only one box):**

- ☐ _____ **[INSERT DATE OF EXPIRATION]: OR**
- ☐ Upon the following event (which must relate to the member or to the purpose of the disclosure being authorized): _____

SECTION F: REVIEW AND APPROVAL

- I understand that I have the right to withdraw this authorization, in writing, at any time by sending written notification to: CalOptima, ATTN: Customer Service Department.
- I also understand that my revocation is not effective to the extent that the persons I have authorized to disclose my protected health information have acted in reliance upon this authorization prior to receipt of the revocation.
- I understand my authorization to release this information will not affect my eligibility or enrollment status, or any treatment or benefit payment decisions. I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy laws.
- I release CalOptima from any liability associated with releasing this information to the person/agency named above. I understand that I may have the right under federal or state law to inspect or copy the protected health information to be disclosed.
- I understand I have the right to refuse to sign this authorization.
- If this authorization is signed by a personal representative, please provide representative documentation as required by state law (i.e., HealthCare Power of Attorney, Health Care Surrogate, Living Will or Guardianship papers).

By signing below, I acknowledge receiving a copy of this authorization.

_____

Signature of Member **Date**

If Personal Representative:

Name of Personal Representative:

_____

Legal Relationship to Member:

_____

Signature of Authorized Representative: _____ Date: _____

Sign and mail or deliver to: **CalOptima Customer Service Department**
505 City Parkway West
Orange, CA 92868

~~AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)~~

~~The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.~~

~~Date of Request: _____ Telephone Number: _____~~

~~Member Name: _____ Member CIN: _____~~

~~AUTHORIZATION:~~

~~I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.~~

~~Describe the health information that will be used or disclosed under this authorization (please be specific): _____~~

_____

_____

~~Person or organization authorized to received the health information: _____~~

~~Describe each purpose of the requested use or disclosure (please be specific): _____~~

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: _____

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that the health information used or disclosed as a result of my signing this authorization may not be further used or disclosed by the recipient unless another authorization is obtained from me or unless such use or disclosure is specifically permitted or required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Personal Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Authorized Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative

(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

HIPAA privacy regulations require you to complete this form to authorize CalOptima to release your Protected Health Information (PHI) to another person or entity. Please complete, sign, and return the form to CalOptima.

SECTION A: MEMBER AUTHORIZING RELEASE OF PHI

Name of Member: _____

Member CIN: _____

Address:_____

Phone No.:_____ Member date of birth:_____

SECTION B: PERSON OR ORGANIZATION AUTHORIZED TO RECEIVE THIS INFORMATION

Please enter the person(s) or organization who will receive member's protected health information. This information may be disclosed to, and used by, the following person(s) or organization(s). The representative receiving the information must be 18 years of age or older.

Name (enter first and last name[s]):_____

Relationship to Member:_____

Address:_____

Phone No.:_____

SECTION C: INFORMATION THAT CAN BE RELEASED

I allow the following information to be released by CalOptima (Check only one box):

- ☐ **My complete member file,** including **health information** (e.g. diagnosis, test results, treatment history, health care services, claims status and history, provider name(s)); **financial information** pertaining to your health condition and/or insurance coverage (e.g. claims history); and **personal information** (e.g., name, address, date of birth, and member ID). **(*This authorization doesn't include certain sensitive information unless it is specifically approved below.*)** **OR**
- ☐ **Only limited information** may be disclosed (check all applicable boxes below):

Limited information		
☐ Billing	☐ Medical records (excludes psychotherapy notes)	☐ Referral
☐ Claims & payment	☐ Physician and hospital affiliations	☐ Other:
☐ Diagnosis and procedure	☐ Pre-certification & pre-authorization	

I also approve the release of the following types of **sensitive information** by CalOptima (check all boxes that apply to you):

Sensitive information		
☐ Mental health (including psychotherapy notes)	☐ Genetic testing	☐ Other:
☐ Abuse (sexual/physical/mental/elder)	☐ HIV or AIDS	
☐ Alcohol/substance abuse	☐ Sexually transmitted illness	

SECTION D: PURPOSE OF THIS AUTHORIZATION

This protected health information is being disclosed for the following purpose(s). Please select all that apply:

- ☐ At the request of the Member
- ☐ I have been designated by the patient as his/her representative
- ☐ Other (please specify):

_____
___

SECTION E: EXPIRATION DATE OF AUTHORIZATION

This authorization will expire on the earlier of **(Please choose only one box):**

- ☐ _____ **[INSERT DATE OF EXPIRATION]: OR**
- ☐ Upon the following event (which must relate to the member or to the purpose of the disclosure being authorized):_____

SECTION F: REVIEW AND APPROVAL

- I understand that I have the right to withdraw this authorization, in writing, at any time by sending written notification to: CalOptima, ATTN: Customer Service Department.
- I also understand that my revocation is not effective to the extent that the persons I have authorized to disclose my protected health information have acted in reliance upon this authorization prior to receipt of the revocation.
- I understand my authorization to release this information will not affect my eligibility or enrollment status, or any treatment or benefit payment decisions. I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy laws.
- I release CalOptima from any liability associated with releasing this information to the person/agency named above. I understand that I may have the right under federal or state law to inspect or copy the protected health information to be disclosed.
- I understand I have the right to refuse to sign this authorization.
- If this authorization is signed by a personal representative, please provide representative documentation as required by state law (i.e., HealthCare Power of Attorney, Health Care Surrogate, Living Will or Guardianship papers).

By signing below, I acknowledge receiving a copy of this authorization.

_____ _____

Signature of Member **Date**

If Personal Representative:

Name of Personal Representative:

_____

Legal Relationship to Member:

_____

Signature of Authorized Representative: _____ Date: _____

Sign and mail or deliver to:	**CalOptima Customer Service Department** **505 City Parkway West** **Orange, CA 92868**

Individual Request for Access to Personal Health Information (PHI)

As required by the California Welfare and Institutions code and the Federal Health Insurance Portability and Accountability Act (HIPAA), members have the right of access to inspect and obtain a copy of their health information contained in a Designated Record Set (DRS). CalOptima members, past and current, can request copies of their individual Protected Health Information (PHI).

CalOptima will act upon this request within 30 calendar days from the date CalOptima receives this request or within 60 calendar days from the date CalOptima receives the request if the requested information that is produced by CalOptima is not maintained or accessible to CalOptima on-site. CalOptima will either inform you of the acceptance of the request and provide you with the requested access or provide a written denial explaining the reasons for the denial and whether you are entitled to have the denial reviewed.

To Request a Copy of Your Medical Records:

1. Please complete the entire form including your full legal name, your 8-digit CalOptima issued CIN number, your date of birth (DOB) and the best telephone number we can reach you at. Please print legibly.

2. Please be advised that in order to process your request, a valid photo ID with signature must be included with your request form. If the form is signed by a member's authorized representative, then the authorized representative must provide legal documentation that he/she is authorized to act on the member's behalf.

3. Please select only the records necessary to fulfill your need. If you are unsure of what you need, please contact CalOptima Customer Service at (888) 587-8088 for assistance.

4. Please note that CalOptima members who were assigned to a health network (e.g. Monarch, AltaMed, etc.) during any portion of the date range requested, should also consult their health network. CalOptima does not maintain or have access to records compiled by Health Networks, Hospitals or Physicians Offices.

5. If you have any questions or concerns regarding your request for access to your personal health information, please contact CalOptima Customer Service toll free at (888) 587-8088.

6. Medical records may be picked up onsite at the CalOptima Office or sent via electronic mail or certified postal mail. ~~CalOptima will provide your Personal Health Information (PHI) by pick-up, mail or email. PHI~~ Requests for records to be faxed are subject to approval by CalOptima. ~~may also be faxed upon approval~~. Records sent via e-mail ~~emails containing PHI are~~ will be sent secure (encrypted) to the e-mail address provided to CalOptima; ~~with encryption~~; however, CalOptima shall not be held responsible for loss of PHI on personal email accounts.

Individual Request for Access to Personal Health Information (PHI)

Member Name: _____ CalOptima CIN#: _____
Please Print (Last, First, MI)

Telephone: ( ) _____ DOB: _____
(mm/dd/yyyy)

Please indicate specifically the information to which you are requesting access:

☐ Medical Claims Records
☐ Medical Authorization Request
☐ Care Management Records
☐ Pharmacy Claims Records
☐ Pharmacy Prior Authorization (PA)
☐ Notice of Action
☐ State Hearing Statement
☐ Enrollment Form
☐ Other, please explain: _____

Please specify date range needed:

__/__/____ to __/__/____
(mm/dd/yyyy) *(mm/dd/yyyy)*

Please indicate the reason for this request: _____

_____

Delivery Method Requested (select one):

☐ On-site at CalOptima Customer Service ☐ Email: _____
☐ Mail: _____
Street/Unit *City* *State* *Zip*
☐ Fax *(Upon approval)*: _____

CalOptima may charge a fee of $0.10 per page, and any postage fees if you ask for the records to be mailed to you. I hereby authorize CalOptima to release the requested medical records to myself.

Member Signature: _____ Date: _____
(mm/dd/yyyy)

For Authorized Representative or Legal Guardian Use Only

Name: _____ Relationship to Member: _____
Please Print

Signature: _____ Date: _____
(mm/dd/yyyy)

Please submit the completed request form to CalOptima in person or by mail, fax or email.

CalOptima
Attn: Office of Compliance
505 City Parkway West
Orange, CA 92868
Email: privacy@caloptima.org • Fax: (714) 481-6457

Individual Request for Access to Personal Health Information (PHI)

As required by the California Welfare and Institutions code and the Federal Health Insurance Portability and Accountability Act (HIPAA), members have the right of access to inspect and obtain a copy of their health information contained in a Designated Record Set (DRS). CalOptima members, past and current, can request copies of their individual Protected Health Information (PHI).

CalOptima will act upon this request within 30 calendar days from the date CalOptima receives this request or within 60 calendar days from the date CalOptima receives the request if the requested information that is produced by CalOptima is not maintained or accessible to CalOptima on-site. CalOptima will either inform you of the acceptance of the request and provide you with the requested access or provide a written denial explaining the reasons for the denial and whether you are entitled to have the denial reviewed.

To Request a Copy of Your Medical Records:

1. Please complete the entire form including your full legal name, your 8-digit CalOptima issued CIN number, your date of birth (DOB) and the best telephone number we can reach you at. Please print legibly.

2. Please be advised that in order to process your request, a valid photo ID with signature must be included with your request form. If the form is signed by a member's authorized representative, then the authorized representative must provide legal documentation that he/she is authorized to act on the member's behalf.

3. Please select only the records necessary to fulfill your need. If you are unsure of what you need, please contact CalOptima Customer Service at (888) 587-8088 for assistance.

4. Please note that CalOptima members who were assigned to a health network (e.g. Monarch, AltaMed, etc.) during any portion of the date range requested, should also consult their health network. CalOptima does not maintain or have access to records compiled by Health Networks, Hospitals or Physicians Offices.

5. If you have any questions or concerns regarding your request for access to your personal health information, please contact CalOptima Customer Service toll free at (888) 587-8088.

6. Medical records may be picked up onsite at the CalOptima Office or sent via electronic mail or certified postal mail. Requests for records to be faxed are subject to approval by CalOptima. Records sent via e-mail will be sent secure (encrypted) to the e-mail address provided to CalOptima; however, CalOptima shall not be held responsible for loss of PHI on personal email accounts.

Individual Request for Access to Personal Health Information (PHI)

Member Name: _____ CalOptima CIN#: _____
Please Print (Last, First, MI)

Telephone: ( ) _____ DOB: _____
(mm/dd/yyyy)

Please indicate specifically the information to which you are requesting access:

☐ Medical Claims Records
☐ Medical Authorization Request
☐ Care Management Records
☐ Pharmacy Claims Records
☐ Pharmacy Prior Authorization (PA)
☐ Notice of Action
☐ State Hearing Statement
☐ Enrollment Form
☐ Other, please explain: _____

Please specify date range needed:

__/__/____ to __/__/____
(mm/dd/yyyy) *(mm/dd/yyyy)*

Please indicate the reason for this request: _____

_____

Delivery Method Requested (select one):

☐ On-site at CalOptima Customer Service ☐ Email: _____
☐ Mail: _____
Street/Unit *City* *State* *Zip*
☐ Fax *(Upon approval)*: _____

CalOptima may charge a fee of $0.10 per page, and any postage fees if you ask for the records to be mailed to you. I hereby authorize CalOptima to release the requested medical records to myself.

Member Signature: _____ Date: _____
(mm/dd/yyyy)

For Authorized Representative or Legal Guardian Use Only

Name: _____ Relationship to Member: _____
Please Print

Signature: _____ Date: _____
(mm/dd/yyyy)

Please submit the completed request form to CalOptima in person or by mail, fax or email.

CalOptima
Attn: Office of Compliance
505 City Parkway West
Orange, CA 92868
Email: privacy@caloptima.org • Fax: (714) 481-6457

[DATE]

[NAME]
[ADDRESS]
[CITY], [STATE] [ZIP]

Member Name:
Member CIN:

Re: Response to Request for Access to Protected Health Information (PHI)

Dear [NAME]:

CalOptima has received your request for access to Protected Health Information (PHI) dated [DATE], regarding the above named member. A licensed healthcare professional has reviewed this request, and has denied access to the information. Under federal law, we are not required to provide the information because [REASON].

If you wish to have the denial reviewed by another licensed health care professional, you may submit a written request for review. This request should be submitted to:

CalOptima Privacy Officer
505 City Parkway West
Orange, CA, 92868

Should you have any questions regarding this denial, you may contact the Office of Compliance at CalOptima by calling [Number].

For more information about your privacy rights, please refer to your copy of the CalOptima Notice of Privacy Practices. It is also available on our website at www.caloptima.org, or from CalOptima's Customer Service Department by calling **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday from 8 a.m. to 5:30 p.m. Members with hearing or speech impairments can call our TDD line at **1-714-246-8523**. We have staff who speak your language.

If you believe your privacy rights have been violated, you may file a complaint with CalOptima or with the secretary of the Department of Health and Human Services. To file a complaint with CalOptima, contact CalOptima's Customer Service Department at 1-714-246-8500.

CalOptima cannot take away your health care benefits or do anything to hurt you in any way if you choose to file a complaint or use any of your privacy rights.

Sincerely,

Privacy Officer

CalOptima

[DATE]

[NAME]
[ADDRESS]
[CITY], [STATE] [ZIP]

Member Name:
Member CIN:

Re: Response to Request for Access to Protected Health Information (PHI)

Dear [NAME]:

CalOptima has received your request for access to Protected Health Information (PHI) dated [DATE] regarding the above named member. A licensed healthcare professional has reviewed this request and denied access to the information. Under federal law, we are not required to provide the information because [REASON].

This denial is final and is not subject to review according to federal law.

Should you have any questions regarding this denial, you may contact the Office of Compliance at CalOptima by calling [Number].

For more information about your privacy rights, please refer to your copy of the CalOptima Notice of Privacy Practices. It is also available on our website at www.caloptima.org, or from CalOptima's Customer Service Department by calling **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday from 8 a.m. to 5:30 p.m. Members with hearing or speech impairments can call our TDD line at **1-714-246-8523**. We have staff who speak your language.

If you believe your privacy rights have been violated, you may file a complaint with CalOptima or with the secretary of the Department of Health and Human Services. To file a complaint with CalOptima, contact CalOptima's Customer Service Department at 1-714-246-8500.

CalOptima cannot take away your health care benefits or do anything to hurt you in any way if you choose to file a complaint or use any of your privacy rights.

Sincerely,

Privacy Officer
CalOptima

~~CEO Approval:~~ ~~Michael Schrader~~ _____

~~Effective Date:~~ ~~04/01/03~~
~~Last Review Date:~~ ~~7/1/1612/01/16~~
~~Last Revised Date~~ ~~9/1/1512/01/15~~

CalOptima
A Public Agency
Better. Together.

Policy #: HH.3002Δ
Title: **Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls**
Department: Office of Compliance
Section: ~~Health Insurance Portability and Accountability Act (HIPAA)~~Privacy

CEO Approval: Michael Schrader _____

Effective Date: 04/01/03
Last Review Date: 12/01/16
Last Revised Date: 12/01/16

Applicable to:
☒ Medi-Cal
☒ OneCare
☒ OneCare Connect
☒ PACE

I. PURPOSE

This policy~~o~~ describes the conditions under which CalOptima shall control access to, request, Use, or Disclose Protected Health Information (PHI) to ensure that the data used is the Minimum Necessary to fulfill the request or carry out the required function.

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~

~~Term~~	~~Definition~~
~~Business Associate:~~	~~Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who:~~ ~~On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or~~ ~~Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.~~ ~~A covered entity may be a business associate of another covered entity.~~ ~~Business associate includes:~~ ~~A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information.~~ ~~A person that offers a personal health record to one or more individuals on behalf of a covered entity.~~ ~~A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.~~ ~~Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who:~~ ~~1. On behalf of a covered entity or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs, or assists in the performance of:~~ ~~a. A function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or~~ ~~b. Any other function or activity regulated by this subchapter; or~~ ~~2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such~~

Term	Definition
CalOptima Workforce	This includes .Employee or Employees ("Employee" or "Employees") which means any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
Capitation Payments:	The monthly amount paid to a Health Network by CalOptima for the delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender.
Covered Entity:	A health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by Title 45, Code of Federal Regulations, Part 160.
Designee:	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disclosure:	Has the meaning in in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information. Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Encounter:	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member, regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
FACETS:	Licensed software product that supports administrative, claims processing and adjudication, membership data, and other information needs of managed care organizations.
Health Care Operations:	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including: activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.Activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Network:	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.

~~Term~~	~~Definition~~
~~Member:~~	~~An enrollee beneficiary of a CalOptima program.~~
~~Minimum Necessary:~~	~~The principle that a covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment or Health Care Operations.~~
~~Payment:~~	~~Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including:~~ ~~Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities;~~ ~~Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and,~~ ~~3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.~~Activities carried out by CalOptima including: ~~A. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities;~~ ~~B. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and~~ ~~C. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.~~

Term	Definition
Protected Health Information (PHI):	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: - The past, present, or future physical or mental health or condition of a Member; - The provision of health care to a Member; or - Past, present, or future Payment for the provision of health care to a Member.Has the meaning given such term in Section 160.103 of Title 45, Code of - Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. - - This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider:	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Required by Law	Has the meaning in 45 Code of Federal Regulations (CFR) Section 164.103 which specifies a mandate contained in law that compels an entity to make a Use or Disclosure of PHI and that is enforceable in a court of law and which are permissible grounds for a covered entity to Use of Disclose PHI under 45 CFR Section 164.512(a) when relevant requirements are met.
Treatment:	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.Activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.

~~Term~~	~~Definition~~
~~Use of PHI:~~	~~Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. The sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.~~

II. POLICY

A. CalOptima employees shall make every reasonable effort to control unauthorized access to, and to only request, Disclose, or Use the Minimum Necessary data to complete Health Care Operations or to carry out any request for Member health-related information related to those activities which are for purposes directly connected with the administration of CalOptima programs. ~~or the Medi-Cal program.~~

B. CalOptima employees shall not divulge the Medi-Cal status of a Member without the prior approval of the Department of Health Care Services (DHCS), except for Treatment, Payment, and Health Care Operations.

~~B. , or as Required by Law.~~

C. Minimum Necessary shall apply to all PHI that CalOptima receives or creates.

D. Minimum Necessary policy shall not apply to:

1. Disclosures to, ~~or Use~~or requests by, a health care Provider for Treatment;

2. Disclosures made to the Member who is the subject of the information;

3. Disclosures made pursuant to authorization by the Member;

4. Disclosures to the Department of Health and Human Services (HHS), when Disclosure of information is required under the Privacy Rule for enforcement purposes;

~~4.~~5. Uses or Disclosures that are required for compliance with HIPAA regulatory requirements; and

~~5.~~6. Other Uses or Disclosures that are required by Law.

~~IV.~~III. PROCEDURE

A. Minimum Necessary Use of PHI

1. CalOptima shall limit staff access to a Member's PHI to those employees who need to Use the data to carry out their specific job-related duties, including those related to Treatment, Payment, and Health Care Operations.

2. The respective department directors, or ~~manager~~ their Designee, shall determine access to electronic and paper data files. ~~-~~The department director shall assign an employee specific access level for computer systems. The CalOptima Information Systems Applications Management Department shall manage password control.

3. Within CalOptima, the following departments shall require and maintain the indicated levels of access to PHI on a routine basis to appropriately accomplish their duties and responsibilities:

Department	FACETS ™ Member Eligibility	FACETS ™ Customer Service	FACETS ™ Claims	FACETS ™ Finance/Cap	FACETS ™ Accounts Payable	FACETS ™ G&A	FACETS ™ ~~CalOptima Claims System~~ UM/CM	Department Level Hard Copy Databases	Clinical Support Systems
Care Coordination, MSSP, and Medical Management	P	C	P		P	C	C	Selective	C
Claims Administration	P	C	C	P			P	All	
Customer Service	C	C	P			P	P-Sel	Selective	
Fiscal Services	P		P	C	C		P-Sel	Selective	
Provider/Encounter	P		P	P			P	Selective	
Grievance & Appeals Resolution Services (GARS)	P	C	P			C	C	All	
Office of Compliance	P	P	P				P	Selective	
Government Affairs-Regulatory	P	P	P				P	Selective	
Legal Affairs	P	P	P		P	P	P	All	
Executive Office	P	P	P	P	P	P	P		
KEY:	C= View & Access P= View Only								

	Selective= Restricted to certain department staff P-Sel= UM Inquiry View only

4. The respective department director or ~~manager~~ Designee may grant access to other job categories on a specific "need-to-know" basis, and shall restrict access to Minimum Necessary data to complete the work activity.

B. Minimum Disclosure of PHI

1. All routine Disclosures for Payment and Health Care Operations shall contain only the PHI data necessary to complete the Health Care Operations or Payment process.

2. CalOptima shall control unauthorized access to PHI in paper form as follows:

a. CalOptima employees shall not leave PHI in paper form unattended at any time, unless it is locked in a file cabinet, file room, desk, or office. Unattended means that the information is not under observation by an employee authorized to access such information.

b. An authorized CalOptima employee shall escort a visitor through an area where PHI is contained, and shall keep PHI out of sight while a visitor is in the area, unless the visitor is authorized to view the PHI.

c. CalOptima employees shall dispose of PHI through ~~confidential~~ a Business Associate~~means, including, but not limited to,~~ by shredding or pulverizing.

d. CalOptima employees shall not remove PHI from the CalOptima premises, except for routine business purposes or with the express written permission of DHCS, or CMS.

e. Facsimile containing PHI

i. CalOptima employees shall not leave an incoming or outgoing facsimile containing PHI unattended.

ii. CalOptima shall house facsimile machines in a secure area.

iii. An outgoing facsimile shall contain a confidentiality statement notifying an individual receiving a facsimile in error to destroy the facsimile.

iv. CalOptima employees shall verify a facsimile number prior to sending the facsimile.

f. Mail containing PHI

i. CalOptima employees shall send mail that contains PHI only by a secure method(s).

ii. CalOptima shall send a mailing that contains PHI of two thousand five hundred (2,500) Members or more by a secure, bonded courier with signature required on the receipt.

iii. CalOptima employees shall encrypt all electronic media sent by mail.

3. CalOptima shall control unauthorized access to PHI in oral form as follows:

   a. CalOptima employees shall not discuss PHI in public areas.

   b. CalOptima employees shall not discuss PHI with unauthorized person(s).

4. Routine recurring Disclosures, or requests for PHI, include:

   a. Membership, Capitation Payments, and Encounter reporting with contracted Health Networks.

   b. Payment of claims for services provided to Members.

   c. Coordination of care between CalOptima and the Health Care Agency (HCA), Regional Center of Orange County (RCOC), Health Networks, and Providers.

   d. Complying with regulatory reporting requirements and oversight activities.

   e. Requests for PHI to carry out peer review or other Quality Improvement (QI) activities.

   ~~e.~~f. Business owners responsible for recurring ~~d~~Disclosures or requests for PHI pertaining to the above activities should ensure such PHI requested is limited to the information reasonably necessary to accomplish the stated purpose for ~~the~~ which the request is made.

C. Review of Non-routine Disclosures or Requests for PHI

1. All requests for non-routine Disclosures of PHI shall be routed to the Privacy Officer, or his or her ~~designee~~Designee, for review.

2. The Privacy Officer, or ~~his or her~~their Designee, shall review all non-routine Disclosures or requests on an individual basis to determine that the PHI requested is limited to the information reasonably necessary to accomplish the stated purpose for which the request is made. Criteria to determine PHI which may be provided in a non-routine Disclosure or request for PHI is detailed in CalOptima Policy ~~Refer to~~ HH.3001Δ: Member Access to Designated Record Set ~~for the criteria to determine what PHI may be provided in a non-routine Disclosure or request for PHI~~.

D. Criteria for Reviewing Non-routine Requests for PHI Disclosures

1. The requestor(s) clearly states the purpose for which the PHI is requested.

2. All requested information is reasonably necessary to meet the need stated on the request.

3. When applicable, the requestor(s) submits valid authorization with the request for the PHI, in accordance with CalOptima Policy ~~MA.9219~~HH.3015Δ: Authorization for Release of Protected Health Information.

4. The Disclosure is consistent with CalOptima ~~policy, MA.9202~~Policy HH.3000Δ: Notice of Privacy Practices.

5. Requests may be accepted as the Minimum Necessary for the stated purpose when requested under the following conditions:

   a. A professional who is a member of CalOptima's Workforce or Business Associate requests the information in order to provide a professional service to CalOptima, and the requestor represents that the request is the Minimum Necessary information for the stated purpose; or

   b. Another Covered Entity requests the information.

E. The Privacy Officer, or ~~his or her~~their Designee, shall make a determination on the request, and authorize or deny the request for the release of the PHI, in whole or part, based on the above criteria and relevant California law including, but not limited to, those related to:

1. Elder abuse;

2. Persons with Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS);

3. Family planning;

4. Immunization status; and

5. Child Health and Disability Prevention Program (CHDP) screening, including blood, lead, substance abuse, mental health, and developmental disabilities.

F. Knowledge of a violation or potential violation of this policy shall be reported directly to the Office of Compliance or the CalOptima Compliance and Ethics Hotline 1-877-837-4417.

G. Documentation:

~~G.~~

1. CalOptima shall record all Disclosures pursuant to the standard Disclosure tracking procedure, in accordance with CalOptima Policy ~~MA.9210~~HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information (PHI).

~~V.~~IV. ATTACHMENTS

Not Applicable

V. REFERENCES

~~California Welfare and Institutions Code, Sections §§14100.2 (a) and 10850~~
A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima ~~Contract with the Department of Health Care Services (DHCS) for PACE~~PACE Program Agreement
~~A. CalOptima Policy AA.1000: Glossary of Terms~~
~~B. CalOptima Policy CMC.1001: Glossary of Terms~~
~~C.~~D. CalOptima Policy ~~MA.9202~~HH.3000Δ: Notice of Privacy Practices
~~D.~~E. CalOptima Policy ~~MA.9210~~HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information (PHI)
~~E.~~F. CalOptima Policy ~~MA.9219~~HH.3015Δ: Authorization for Release of Protected Health Information
~~F. CalOptima Privacy Program, 2007~~
G. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~G. Workgroup for Electronic Data Interchange (WEDI) – Strategic National Implementation Process (SNIP) Security and Privacy Workgroup Privacy Policies and Procedures White Paper, http://www.wedi.org/cmsUploads/pdfUpload/WhitePaper/pub/ACFA092.pdf~~
~~H. CalOptima Compliance Plan~~
~~HIPAA Patient Privacy Compliance Guide, Atlantic Information Services, Inc.~~
H.
~~NCQA Standard RR5 Privacy and Confidentiality: Element A: Adopting Written Policies, Factor 6 & Element B: Physical and Electric Access, Factor 5 – 2014~~
I. ~~Title 42, Code of Federal Regulations, Section §~~431.00 et seq.Title 45, Code of Federal Regulations, §164.501
J. Title 45, Code of Federal Regulations, ~~Section~~ §164.502(b)~~, Uses and Disclosures of PHI~~
K. Title 45, Code of Federal Regulations, ~~Section~~ §164.514(d)~~, Other Requirements Related to Uses and Disclosures of PHI~~

VI. REGULATORY AGENCY APPROVALS

A. 06/12/14: Department of Health Care Services

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/01/2005	MA.9204	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	OneCare
Revised	04/01/2007	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal
Revised	02/01/2008	MA.9204	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	OneCare
Revised	01/01/2009	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal
Revised	07/01/2011	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal
Revised	07/01/2011	MA.9204	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	OneCare
Revised	01/01/2013	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal OneCare
Revised	01/01/2014	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal OneCare
Revised	04/01/2014	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	06/01/2014	MA.9204	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	OneCare
Revised	11/01/2014	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal
Revised	11/01/2014	MA.9204	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	OneCare
Revised	09/01/2015	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal
Revised	09/01/2015	MA.9204	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3002Δ	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9204	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	OneCare OneCare Connect PACE

~~VIII.~~

~~Version~~	~~Version Date~~	~~Policy Number~~	~~Policy Title~~
~~Original DateEffective~~	~~04/01/2003~~	~~HH.3002~~	~~Minimum Necessary Uses and Disclosure of Protected Health Information~~
~~OriginalRevision Date 1ed~~	~~0604/01/20052007~~	~~MA.9204HH.3002~~	~~Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls~~

~~Version~~	~~Version Date~~	~~Policy Number~~	~~Policy Title~~
~~Revised~~Revision Date 12	~~02/01/2008~~01/2009	~~MA.9204~~HH.3002	~~Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls~~
~~Revised~~Revision Date 23	~~07/01/2011~~	~~MA.9204~~HH.3002	~~Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls~~
~~Revised~~Revision Date 4	~~01/01/2013~~	~~HH.3002~~	~~Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls~~
~~Revised~~Revision Date 35	~~06~~01/01/2014	~~MA.9204~~HH.3002	~~Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls~~
~~Revised~~Revision Date 6	~~04/01/2014~~	~~HH.3002~~	~~Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls~~
~~Revised~~Revision Date 47	~~11/01/2014~~	~~MA.9204~~HH.3002	~~Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls~~
~~Revised~~Revision Date 58	~~09/01/2015~~	~~MA.9204~~HH.3002	~~Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls~~
~~Revised~~Revision Date 9	~~07/01/2016~~12/01/2016	~~HH.3002~~	~~Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls~~

IX. GLOSSARY

Term	Definition
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.
CalOptima Workforce	This includes any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
Capitation Payments	The monthly amount paid to a Health Network by CalOptima for the delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender.

Term	Definition
Covered Entity	A health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by Title 45, Code of Federal Regulations, Part 160.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disclosure	Has the meaning in in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member, regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
FACETS	Licensed software product that supports administrative, claims processing and adjudication, membership data, and other information needs of managed care organizations.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including: activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	An enrollee-beneficiary of a CalOptima program.
Minimum Necessary	The principle that a covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment or Health Care Operations.

Term	Definition
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Protected Health Information (PHI)	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Required by Law	Has the meaning in 45 Code of Federal Regulations (CFR) Section 164.103 which specifies a mandate contained in law that compels an entity to make a Use or Disclosure of PHI and that is enforceable in a court of law and which are permissible grounds for a covered entity to Use of Disclose PHI under 45 CFR Section 164.512(a) when relevant requirements are met.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

1

Policy #:	HH.3002Δ
Title:	**Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/03
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy describes the conditions under which CalOptima shall control access to, request, Use, or Disclose Protected Health Information (PHI) to ensure that the data used is the Minimum Necessary to fulfill the request or carry out the required function.

II. POLICY

A. CalOptima employees shall make every reasonable effort to control unauthorized access to, and to only request, Disclose, or Use the Minimum Necessary data to complete Health Care Operations or to carry out any request for Member health-related information related to those activities which are for purposes directly connected with the administration of CalOptima programs.

B. CalOptima employees shall not divulge the Medi-Cal status of a Member without the prior approval of the Department of Health Care Services (DHCS), except for Treatment, Payment, and Health Care Operations.

C. Minimum Necessary shall apply to all PHI that CalOptima receives or creates.

D. Minimum Necessary policy shall not apply to:

1. Disclosures to, or requests by, a health care Provider for Treatment;

2. Disclosures made to the Member who is the subject of the information;

3. Disclosures made pursuant to authorization by the Member;

4. Disclosures to the Department of Health and Human Services (HHS), when Disclosure of information is required under the Privacy Rule for enforcement purposes;

5. Uses or Disclosures that are required for compliance with HIPAA regulatory requirements; and

6. Other Uses or Disclosures that are required by Law.

III. PROCEDURE

A. Minimum Necessary Use of PHI

1. CalOptima shall limit staff access to a Member's PHI to those employees who need to Use the data to carry out their specific job-related duties, including those related to Treatment, Payment, and Health Care Operations.

2. The respective department directors, or their Designee, shall determine access to electronic and paper data files. The department director shall assign an employee specific access level for computer systems. The CalOptima Information Systems Applications Management Department shall manage password control.

3. Within CalOptima, the following departments shall require and maintain the indicated levels of access to PHI on a routine basis to appropriately accomplish their duties and responsibilities:

Department	**FACETS™ Member Eligibility**	**FACETS™ Customer Service**	**FACETS™ Claims**	**FACETS™ Finance/Cap**	**FACETS™ Accounts Payable**	**FACETS™ G&A**	**FACETS™ UM/CM**	**Department Level Hard Copy Databases**	**Clinical Support Systems**
Care Coordination, MSSP, and Medical Management	P	C	P		P	C	C	Selective	C
Claims Administration	P	C	C	P			P	All	
Customer Service	C	C	P			P	P-Sel	Selective	
Fiscal Services	P		P	C	C		P-Sel	Selective	
Provider/Encounter	P		P	P			P	Selective	
Grievance & Appeals Resolution Services (GARS)	P	C	P			C	C	All	
Office of Compliance	P	P	P				P	Selective	
Government Affairs-Regulatory	P	P	P				P	Selective	
Legal Affairs	P	P	P		P	P	P	All	
Executive Office	P	P	P	P	P	P	P		

KEY:	C= View & Access P= View Only Selective= Restricted to certain department staff P-Sel= UM Inquiry View only

4. The respective department director or Designee may grant access to other job categories on a specific "need-to-know" basis, and shall restrict access to Minimum Necessary data to complete the work activity.

B. Minimum Disclosure of PHI

1. All routine Disclosures for Payment and Health Care Operations shall contain only the PHI data necessary to complete the Health Care Operations or Payment process.

2. CalOptima shall control unauthorized access to PHI in paper form as follows:

a. CalOptima employees shall not leave PHI in paper form unattended at any time, unless it is locked in a file cabinet, file room, desk, or office. Unattended means that the information is not under observation by an employee authorized to access such information.

b. An authorized CalOptima employee shall escort a visitor through an area where PHI is contained, and shall keep PHI out of sight while a visitor is in the area, unless the visitor is authorized to view the PHI.

c. CalOptima employees shall dispose of PHI through a Business Associate by shredding or pulverizing.

d. CalOptima employees shall not remove PHI from the CalOptima premises, except for routine business purposes or with the express written permission of DHCS, or CMS.

e. Facsimile containing PHI

i. CalOptima employees shall not leave an incoming or outgoing facsimile containing PHI unattended.

ii. CalOptima shall house facsimile machines in a secure area.

iii. An outgoing facsimile shall contain a confidentiality statement notifying an individual receiving a facsimile in error to destroy the facsimile.

iv. CalOptima employees shall verify a facsimile number prior to sending the facsimile.

f. Mail containing PHI

i. CalOptima employees shall send mail that contains PHI only by a secure method(s).

ii. CalOptima shall send a mailing that contains PHI of two thousand five hundred (2,500) Members or more by a secure, bonded courier with signature required on the receipt.

iii. CalOptima employees shall encrypt all electronic media sent by mail.

3. CalOptima shall control unauthorized access to PHI in oral form as follows:

   a. CalOptima employees shall not discuss PHI in public areas.

   b. CalOptima employees shall not discuss PHI with unauthorized person(s).

4. Routine recurring Disclosures, or requests for PHI, include:

   a. Membership, Capitation Payments, and Encounter reporting with contracted Health Networks.

   b. Payment of claims for services provided to Members.

   c. Coordination of care between CalOptima and the Health Care Agency (HCA), Regional Center of Orange County (RCOC), Health Networks, and Providers.

   d. Complying with regulatory reporting requirements and oversight activities.

   e. Requests for PHI to carry out peer review or other Quality Improvement (QI) activities.

   f. Business owners responsible for recurring Disclosures or requests for PHI pertaining to the above activities should ensure such PHI requested is limited to the information reasonably necessary to accomplish the stated purpose for which the request is made.

C. Review of Non-routine Disclosures or Requests for PHI

1. All requests for non-routine Disclosures of PHI shall be routed to the Privacy Officer, or his or her Designee, for review.

2. The Privacy Officer, or their Designee, shall review all non-routine Disclosures or requests on an individual basis to determine that the PHI requested is limited to the information reasonably necessary to accomplish the stated purpose for which the request is made. Criteria to determine PHI which may be provided in a non-routine Disclosure or request for PHI is detailed in CalOptima Policy HH.3001Δ: Member Access to Designated Record Set.

D. Criteria for Reviewing Non-routine Requests for PHI Disclosures

1. The requestor(s) clearly states the purpose for which the PHI is requested.

2. All requested information is reasonably necessary to meet the need stated on the request.

3. When applicable, the requestor(s) submits valid authorization with the request for the PHI, in accordance with CalOptima Policy HH.3015Δ: Authorization for Release of Protected Health Information.

4. The Disclosure is consistent with CalOptima Policy HH.3000Δ: Notice of Privacy Practices.

5. Requests may be accepted as the Minimum Necessary for the stated purpose when requested under the following conditions:

   a. A professional who is a member of CalOptima's Workforce or Business Associate requests the information in order to provide a professional service to CalOptima, and the requestor represents that the request is the Minimum Necessary information for the stated purpose; or

   b. Another Covered Entity requests the information.

E. The Privacy Officer, or their Designee, shall make a determination on the request, and authorize or deny the request for the release of the PHI, in whole or part, based on the above criteria and relevant California law including, but not limited to, those related to:

1. Elder abuse;

2. Persons with Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS);

3. Family planning;

4. Immunization status; and

5. Child Health and Disability Prevention Program (CHDP) screening, including blood, lead, substance abuse, mental health, and developmental disabilities.

F. Knowledge of a violation or potential violation of this policy shall be reported directly to the Office of Compliance or the CalOptima Compliance and Ethics Hotline 1-877-837-4417.

G. Documentation:

1. CalOptima shall record all Disclosures pursuant to the standard Disclosure tracking procedure, in accordance with CalOptima Policy HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information (PHI).

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima PACE Program Agreement
D. CalOptima Policy HH.3000Δ: Notice of Privacy Practices

E. CalOptima Policy HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information (PHI)
F. CalOptima Policy HH.3015Δ: Authorization for Release of Protected Health Information
G. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
H. HIPAA Patient Privacy Compliance Guide, Atlantic Information Services, Inc.
I. Title 45, Code of Federal Regulations, §164.501
J. Title 45, Code of Federal Regulations, §164.502(b)
K. Title 45, Code of Federal Regulations, §164.514(d)

VI. REGULATORY AGENCY APPROVALS

A. 06/12/14: Department of Health Care Services

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information	Medi-Cal
Effective	06/01/2005	MA.9204	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	OneCare
Revised	04/01/2007	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal
Revised	02/01/2008	MA.9204	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	OneCare
Revised	01/01/2009	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	07/01/2011	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal
Revised	07/01/2011	MA.9204	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	OneCare
Revised	01/01/2013	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal OneCare
Revised	01/01/2014	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal OneCare
Revised	04/01/2014	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal
Revised	06/01/2014	MA.9204	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	OneCare
Revised	11/01/2014	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal
Revised	11/01/2014	MA.9204	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	OneCare
Revised	09/01/2015	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	09/01/2015	MA.9204	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3002Δ	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9204	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.
CalOptima Workforce	This includes any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
Capitation Payments	The monthly amount paid to a Health Network by CalOptima for the delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender.

Term	Definition
Covered Entity	A health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by Title 45, Code of Federal Regulations, Part 160.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disclosure	Has the meaning in in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member, regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
FACETS	Licensed software product that supports administrative, claims processing and adjudication, membership data, and other information needs of managed care organizations.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including: activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	An enrollee-beneficiary of a CalOptima program.
Minimum Necessary	The principle that a covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment or Health Care Operations.
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.

Term	Definition
Protected Health Information (PHI)	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Required by Law	Has the meaning in 45 Code of Federal Regulations (CFR) Section 164.103 which specifies a mandate contained in law that compels an entity to make a Use or Disclosure of PHI and that is enforceable in a court of law and which are permissible grounds for a covered entity to Use of Disclose PHI under 45 CFR Section 164.512(a) when relevant requirements are met.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

1

~~Policy #: HH.3003~~
~~Title: **Verification of Protected**~~
~~Department: Office of Com~~
~~Section: Health Insura~~
~~Accountabilit~~
~~CEO Approval: Michael~~

~~Effective Date: 4/03~~

~~Effective Date: 76/1/1605~~
~~Last Review Date:~~
~~Last Revised Date:~~

Policy #: HH.3003Δ
Title: **Verification of Identity for Disclosure of Protected Health Information**

Department: Office of Compliance
Section: ~~Health Insurance Portability and Accountability Act (HIPAA)~~Privacy

CEO Approval: Michael Schrader

Effective Date: 04/01/03
Last Review Date: 12/01/16
Last Revised Date: 12/01/16

Applicable to:
☒ Medi-Cal
☒ OneCare
☒ OneCare Connect
☒ PACE

~~Last Revised Date: 9/1/15~~

~~9/1/15~~

~~Policy #:~~	~~HH.3003~~MA.9205Δ		
~~I.~~ ~~itle:~~	~~II.~~ ~~Verification of Identity for Disclosure of Protected Health Information~~	~~III.~~ ~~Revised Date:~~	~~IV.~~ ~~12/01/16~~
olicy #:	HH.3003Δ		
itle:	Verification of Identification for Disclosure of Protected Health Information	evised Date:	12/01/16

I. PURPOSE

This policy~~o~~ defines the steps necessary for verification of identity of a person requesting Protected Health Information (PHI) prior to Disclosure.

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~
~~Authorized Representative:~~	~~Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.Has the meaning given such term in section 164.502(g) 45 CFR of title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.~~
~~Disclosure:~~	~~Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.~~
~~FACETS™:~~	~~Licensed software product that supports administrative, claims processing and adjudication, membership data, and other information needs of managed care organizations.~~

Term	Definition
Health Care Operations:	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.Activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contact and health benefits, management and administration activities customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Insurance Portability and Accountability Act (HIPAA):)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Member:	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.A beneficiary who is enrolled in a CalOptima Program.An enrollee beneficiary of a CalOptima Program.

~~Term~~	~~Definition~~
~~Payment:~~	~~Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including:~~ ~~Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities;~~ ~~Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and~~ ~~Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.Activities carried out by CalOptima including:~~ ~~1.Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities;~~ ~~2.Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and~~ ~~3.Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.~~

~~Term~~	~~Definition~~
~~Protected Health Information (PHI):~~	~~Has the meaning given such term in Section~~section ~~160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.~~ ~~This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to:~~ ~~1. Past, present, or future Payment for the provision of health care to a Member.~~ ~~2. The provision of health care to a Member; or~~ ~~The past, present, or future physical or mental health or condition of a Member.;~~ ~~The provision of health care to a mMember; or~~ ~~3. Past, present, or future Payment for the provision of health care to a Member.~~
~~Treatment:~~	~~Has the meaning in 42 Code of Federal Regulations Section 164.501, including: a~~Activities ~~undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.~~

~~III.~~II. POLICY

A. CalOptima, and its programs, shall take necessary reasonable steps to verify the identity and legal authority of a person requesting Disclosure of PHI.

~~IV.~~III. PROCEDURE

A. Verification of a Member:

1. Telephone: ~~-~~A person representing him or herself to be a Member can be verified using the following method:

a. Demographic information that is confirmed in FACETS™ (Member number, address, or date of birth);

b. The use of confirming data in the system such as prior entries regarding services; or

c. The Member is known to CalOptima staff from prior contact.

2. In person: ~~-~~A person representing him or herself to be a Member can be verified by:

a. Presentation of identification~~,~~ such as a driver's license, ~~membership~~Membership card, or other materials~~,~~ such as letters from public agencies or CalOptima, addressed to the Member;

b. Verbal statements of address, date of birth, ~~or~~ or other data confirmed in FACETS™; or

c. The Member is known to CalOptima staff from prior contact.

3. Written request:~~-~~ A person representing~~-~~ him or herself to be a Member in a written request can be verified by:

a. Submitting a copy of a government issued identification, such as a driver's license, a state issued identification (ID) card, or a passport; or

~~c.~~ b. A written request or authorization form with a notarized signature.

B. Verification of a Member's Authorized Representative:

1. Telephone and in person:~~-~~ An Authorized Representative shall provide information to identify his or her relationship to the minor, dependent adult, or deceased Member.~~-~~ Accepted documents include:

a. Legal documents: Executed power of attorney, proof of guardianship, medical power of attorney, certified letter of conservatorship, executor of will, letters testamentary, or letters of administration, or if the Member is deceased and the Authorized Representative is the next of kin or other family member, accepted documentation may be the Authorized Representative's birth certificate and drivers license; or

b. A valid written authorization signed by the Member ~~(signature must either be notarized o~~ a copy of a government issued identification must accompany the authorization) or the court.

2. ~~-~~Written request made by an Authorized Representative: An Authorized Representative shall include legal documentation with his or her written request to verify that he or she is the parent,

conservator, guardian, executor of a decedent's will, or have medical decision making-authority for the individual, along with a ~~notarized signature~~ government issued identification of the Authorized Representative.

~~2.~~3. Documentation of the Authorized Representative's known relationship shall be documented in FACETS™ and the documentation provided by the Authorized Representative shall be saved in the Customer Service Department shared files.

~~3.~~4. CalOptima shall grant a Member's Authorized Representative access to a Member's PHI~~,~~ in accordance with ~~CalOptima~~the following CalOptima policies:~~,~~ HH.3001Δ: Member Access to Designated Record Set, HH.3009Δ: Access by Member's Authorized Representative, and HH.3015Δ: Authorization for Release of Protected Health Information.

C. Verification of a Disclosure requested by a family member, relative, close friend of the Member, or any other person identified by the Member:

1. Member is available: ~~-~~If the Member is available on the telephone or in person, CalOptima staff shall obtain the Member's consent before disclosing the PHI~~,~~ or based on the circumstances~~,~~ if it is inferred that the Member was given the opportunity to object and did not object to the Disclosure. Documentation of the Disclosure is required as follows:

   a. CalOptima staff shall document that the Member was present and verbally agreed to the Disclosure; or

   b. The circumstances that led the CalOptima staff to believe that the Member agreed to or did not object to the ~~Disclosured~~Disclosure of PHI to the family member, relative, close friend of the Member, or any other person identified by the Member.

2. Member is not available: ~~-~~If there in an emergency~~,~~ or if the Member is incapacitated, CalOptima staff may use their professional judgment to determine whether the Disclosure of PHI is in the best interest of the Member. Staff may only disclose the PHI that is relevant to the person's involvement in the Member's care~~,~~ and shall document the emergency that supported the Disclosure of PHI to the family member, relative, close friend of the Member, or any other person identified by the Member.

   ~~2.~~a. CalOptima staff shall adhere to applicable state and federal regulations regarding minimum necessary uses and disclosures of PHI, as well as CalOptima Policy HH.3002Δ: Minimum Necessary Uses and Disclosures of Protected Health Information and Document Controls.

D. Written Requests for PHI:

1. A written request for copies of PHI may be accepted as valid, provided all information on the request is complete and accurate~~,~~ based on CalOptima data, subject to the verification requirements above.

2. A request from a Member's Authorized Representative shall include either the appropriate legal documentation or written authorization from the Member to release the PHI, (signature must either be notarized or a copy of a government issued identification must accompany the authorization), unless otherwise permitted ~~under Treatment, Payment, Health Care Operations, or laws~~ in accordance with the following CalOptima Policies HH.3011Δ: Use and Disclosure for Treatment, Payment and Health Care Operations, and HH.3010Δ: Protected Health Information Disclosures Required by Law.

3. Deceased Member: The PHI of a deceased Member is subject to the federal HIPAA privacy provisions for as long as CalOptima maintains the PHI. An Authorized Representative with legal authority to act on behalf of a deceased Member or their estate may request the Member's PHI.

4. CalOptima shall verify the legal authority of a public official or person acting on behalf of a public official through a review of:

   a. ~~Documentations~~Documentation, statements, or presentations that, upon initial review, meet the applicable requirements for a Disclosure of PHI;

   b. Presentation of an agency identification badge, other official credentials, or other proof of government authority;

   c. Other evidence or documentation from an agency~~, that~~ which establishes that the person is acting on behalf of the public official, such as a contract for services, memorandum of understanding, or purchase order;

   d. A written statement of ~~the~~ legal authority under which the information is requested;

   e. If a written statement ~~would be~~is impracticable, an oral statement of such legal authority; or

   f. A request that is made pursuant to a warrant, subpoena, order, or other legal process issued by a grand jury or a judicial or administrative tribunal that is presumed to constitute legal authority.

E. CalOptima staff may rely on the exercise of professional judgment in making a Disclosure to avert a serious threat to the health and safety of ~~the~~a Member or others.

~~V.~~IV. ATTACHMENTS

A. Authorization for Use or Disclosure of Protected Health Information

~~A.~~B. Individual Instruction Sheet for CalOptima HIPAA Authorization for Release of Protected Health Information Form

~~VI.~~V. REFERENCES

~~A. California Health and Safety Code Section 123105.11(e) Definition of Representative~~

~~B. CalOptima Notice of Privacy Practices CalOptima Policy AA.1000: Glossary of Terms~~

~~CalOptima Policy CMC.1001: Glossary of Terms~~

A. CalOptima Compliance Plan

B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage

C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal

D. CalOptima ~~Contract with the Department of Health Care Services (DHCS) for PACE~~ PACE Program Agreement

~~CalOptima Policy AA.1000: Glossary of Terms~~

~~C.~~E. CalOptima Policy CMC.1001: Glossary of Terms

F. CalOptima Policy HH.3001Δ: Member Access to Designated Record Set

~~D.~~G. CalOptima Policy HH.3002Δ: Minimum Necessary Uses and Disclosures of Protected Health Information and Document Controls

~~E.~~H. CalOptima Policy HH.3009Δ: Access by Member's Authorized Representative

~~F.~~I. CalOptima Policy HH.3010Δ: Protected Health Information Disclosures Required by Law

~~G.~~J. CalOptima Policy HH.3011Δ: Use and Disclosure for Treatment, Payment and Health Care Operations

~~H.~~K. CalOptima Policy HH.3015Δ: Authorization for Release of Protected Health Information

L. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect

~~I. Guide to Medical Privacy and HIPAA, 2002 Medical Records Privacy Requirements~~

~~J. HIPAA Patient Privacy Compliance Guide, 2002, Section 1500 Other Requirements Related to Use and Disclosure of PHI~~

~~K.~~M. Title 45, Code of Federal Regulations (C.F.R), ~~Section~~ §164.514 ~~(~~h)

~~L.~~N. Title 45, Code of Federal Regulations (C.F.R), §164.510(b)

~~M. CalOptima Policy CMC.1001: Glossary of Terms~~

~~CalOptima Policy MA. 9202: Notice of Privacy Practices~~

~~CalOptima Policy MA.9203: Member Access to Designated Record Set~~

~~CalOptima Policy MA.9212: Access by Member's Authorized Representative~~

~~CalOptima Policy MA.9213: Protected Health Information Disclosures Required by Law~~

~~CalOptima Policy MA.9214: Use and Disclosure for Treatment, Payment, and Health Care Operations~~

~~CalOptima Policy MA.9219: Authorization for Release of Protected Health Information~~

~~VII.~~VI. REGULATORY AGENCY APPROVALS

None to Date

~~VIII.~~VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/2003	HH.3003	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal
Effective	06/01/2005	MA.9205	Verification of Identity for Disclosure of Protected Health Information	OneCare
Revised	04/01/2007	HH.3003	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2009	HH.3003	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2009	MA.9205	Verification of Identity for Disclosure of Protected Health Information	OneCare
Revised	12/01/2011	HH.3003	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2013	HH.3003Δ	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal OneCare
Revised	05/01/2014	MA.9205	Verification of Identity for Disclosure of Protected Health Information	OneCare
Revised	09/01/2014	HH.3003	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal
Revised	09/01/2015	HH.3003	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal

~~Policy #:~~ ~~HH.3003~~MA.9205Δ

~~I.~~	~~II.~~	~~III.~~	~~IV.~~
~~itle:~~	~~Verification of Identity for Disclosure of Protected Health Information~~	~~Revised Date:~~	~~12/01/156~~

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olicy #: 3003Δ

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itle: fication of Identification for Disclosure of Protected Health Information

evised Date: ~~1~~2/01/16

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	09/01/2015	MA.9205	Verification of Identity for Disclosure of Protected Health Information	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3003Δ	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9205	Verification of Identity for Disclosure of Protected Health Information	OneCare OneCare Connect PACE

~~IX.~~

~~Version~~	~~Version Date~~	~~Policy Number~~	~~Policy Title~~
~~Original Date~~	~~04/2003~~06/01/2005	~~HH.3003~~MA.9205	~~Verification of Identity for Disclosure of Protected Health Information~~
~~Revision Date 1~~	~~04/01/2007~~	~~HH.3003~~	~~Verification of Identity for Disclosure of Protected Health Information~~
~~Revision Date 2~~1	~~01/01/2009~~	~~HH.3003~~MA.9205	~~Verification of Identity for Disclosure of Protected Health Information~~
~~Revision Date 3~~	~~12/01/2011~~	~~HH.3003~~	~~Verification of Identity for Disclosure of Protected Health Information~~
~~Revision Date 4~~	~~01/01/2013~~	~~HH.3003~~	~~Verification of Identity for Disclosure of Protected Health Information~~
~~Revision Date 5~~2	~~09~~05/01/2014	~~HH.3003~~MA.9205	~~Verification of Identity for Disclosure of Protected Health Information~~
~~Revision Date 6~~3	~~09/01/2015~~	~~HH.3003~~MA.9205	~~Verification of Identity for Disclosure of Protected Health Information~~

IX. GLOSSARY

Term	Definition
Authorized Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
FACETS	Licensed software product that supports administrative, claims processing and adjudication, membership data, and other information needs of managed care organizations.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, as amended.
Member	A beneficiary who is enrolled in a CalOptima Program.

Term	**Definition**
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Protected Health Information (PHI)	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.

Policy #:	HH.3003Δ
Title:	**Verification of Identity for Disclosure of Protected Health Information**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/03
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy defines the steps necessary for verification of identity of a person requesting Protected Health Information (PHI) prior to Disclosure.

II. POLICY

A. CalOptima, and its programs, shall take necessary reasonable steps to verify the identity and legal authority of a person requesting Disclosure of PHI.

III. PROCEDURE

A. Verification of a Member:

1. Telephone: A person representing him or herself to be a Member can be verified using the following method:

   a. Demographic information that is confirmed in FACETS™ (Member number, address, or date of birth);

   b. The use of confirming data in the system such as prior entries regarding services; or

   c. The Member is known to CalOptima staff from prior contact.

2. In person: A person representing him or herself to be a Member can be verified by:

   a. Presentation of identification such as a driver's license, Membership card, or other materials such as letters from public agencies or CalOptima, addressed to the Member;

   b. Verbal statements of address, date of birth, or other data confirmed in FACETS™; or

   c. The Member is known to CalOptima staff from prior contact.

3. Written request: A person representing him or herself to be a Member in a written request can be verified by:

a. Submitting a copy of a government issued identification, such as a driver's license, a state issued identification (ID) card, or a passport; or

b. A written request or authorization form with a notarized signature.

B. Verification of a Member's Authorized Representative:

1. Telephone and in person: An Authorized Representative shall provide information to identify his or her relationship to the minor, dependent adult, or deceased Member. Accepted documents include:

a. Legal documents: Executed power of attorney, proof of guardianship, medical power of attorney, certified letter of conservatorship, executor of will, letters testamentary, or letters of administration, or if the Member is deceased and the Authorized Representative is the next of kin or other family member, accepted documentation may be the Authorized Representative's birth certificate and drivers license; or

b. A valid written authorization signed by the Member (a copy of a government issued identification must accompany the authorization) or the court.

2. Written request made by an Authorized Representative: An Authorized Representative shall include legal documentation with his or her written request to verify that he or she is the parent, conservator, guardian, executor of a decedent's will, or have medical decision making-authority for the individual, along with a government issued identification of the Authorized Representative.

3. Documentation of the Authorized Representative's known relationship shall be documented in FACETS™ and the documentation provided by the Authorized Representative shall be saved in the Customer Service Department shared files.

4. CalOptima shall grant a Member's Authorized Representative access to a Member's PHI in accordance with the following CalOptima policies: HH.3001Δ: Member Access to Designated Record Set, HH.3009Δ: Access by Member's Authorized Representative, and HH.3015Δ: Authorization for Release of Protected Health Information.

C. Verification of a Disclosure requested by a family member, relative, close friend of the Member, or any other person identified by the Member:

1. Member is available: If the Member is available on the telephone or in person, CalOptima staff shall obtain the Member's consent before disclosing the PHI or based on the circumstances if it is inferred that the Member was given the opportunity to object and did not object to the Disclosure. Documentation of the Disclosure is required as follows:

a. CalOptima staff shall document that the Member was present and verbally agreed to the Disclosure; or

b. The circumstances that led the CalOptima staff to believe that the Member agreed to or did not object to the Disclosure of PHI to the family member, relative, close friend of the Member, or any other person identified by the Member.

2. Member is not available: If there in an emergency or if the Member is incapacitated, CalOptima staff may use their professional judgment to determine whether the Disclosure of PHI is in the best interest of the Member. Staff may only disclose the PHI that is relevant to the person's involvement in the Member's care and shall document the emergency that supported the Disclosure of PHI to the family member, relative, close friend of the Member, or any other person identified by the Member.

    a. CalOptima staff shall adhere to applicable state and federal regulations regarding minimum necessary uses and disclosures of PHI, as well as CalOptima Policy HH.3002Δ: Minimum Necessary Uses and Disclosures of Protected Health Information and Document Controls.

D. Written Requests for PHI:

1. A written request for copies of PHI may be accepted as valid, provided all information on the request is complete and accurate based on CalOptima data, subject to the verification requirements above.

2. A request from a Member's Authorized Representative shall include either the appropriate legal documentation or written authorization from the Member to release the PHI, (signature must either be notarized or a copy of a government issued identification must accompany the authorization), unless otherwise permitted in accordance with the following CalOptima Policies HH.3011Δ: Use and Disclosure for Treatment, Payment and Health Care Operations, and HH.3010Δ: Protected Health Information Disclosures Required by Law.

3. Deceased Member: The PHI of a deceased Member is subject to the federal HIPAA privacy provisions for as long as CalOptima maintains the PHI. An Authorized Representative with legal authority to act on behalf of a deceased Member or their estate may request the Member's PHI.

4. CalOptima shall verify the legal authority of a public official or person acting on behalf of a public official through a review of:

    a. Documentation, statements, or presentations that, upon initial review, meet the applicable requirements for a Disclosure of PHI;

    b. Presentation of an agency identification badge, other official credentials, or other proof of government authority;

    c. Other evidence or documentation from an agency which establishes that the person is acting on behalf of the public official, such as a contract for services, memorandum of understanding, or purchase order;

    d. A written statement of legal authority under which the information is requested;

    e. If a written statement is impracticable, an oral statement of such legal authority; or

    f. A request that is made pursuant to a warrant, subpoena, order, or other legal process issued by a grand jury or a judicial or administrative tribunal that is presumed to constitute legal authority.

E. CalOptima staff may rely on the exercise of professional judgment in making a Disclosure to avert a serious threat to the health and safety of a Member or others.

IV. ATTACHMENTS

A. Authorization for Use or Disclosure of Protected Health Information
B. Individual Instruction Sheet for CalOptima HIPAA Authorization for Release of Protected Health Information Form

V. REFERENCES

A. CalOptima Policy HH.3001Δ: Member Access to Designated Record Set
B. CalOptima Policy HH.3002Δ: Minimum Necessary Uses and Disclosures of Protected Health Information and Document Controls
C. CalOptima Policy HH.3009Δ: Access by Member's Authorized Representative
D. CalOptima Policy HH.3010Δ: Protected Health Information Disclosures Required by Law
E. CalOptima Policy HH.3011Δ: Use and Disclosure for Treatment, Payment and Health Care Operations
F. CalOptima Policy HH.3015Δ: Authorization for Release of Protected Health Information
G. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
H. Title 45, Code of Federal Regulations (C.F.R), §164.514(h)
I. Title 45, Code of Federal Regulations (C.F.R), §164.510(b)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/2003	HH.3003	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal
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Revised	01/01/2009	HH.3003	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	01/01/2009	MA.9205	Verification of Identity for Disclosure of Protected Health Information	OneCare
Revised	12/01/2011	HH.3003	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2013	HH.3003Δ	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal OneCare
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Revised	09/01/2015	MA.9205	Verification of Identity for Disclosure of Protected Health Information	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3003Δ	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9205	Verification of Identity for Disclosure of Protected Health Information	OneCare OneCare Connect PACE

IX. GLOSSARY

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Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
FACETS	Licensed software product that supports administrative, claims processing and adjudication, membership data, and other information needs of managed care organizations.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, as amended.
Member	A beneficiary who is enrolled in a CalOptima Program.
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.

Term	Definition
Protected Health Information (PHI)	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.

1

Reviewed by VC 10/20/16
Reviewed by MKC 10/26/16
Revised Readability Level 5.9 Powers, Sumner, Kearl (Gunning Fog) by MKC 10/26/16

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

HIPAA privacy regulations require you to complete this form to authorize CalOptima to release your ~~P~~protected ~~H~~health i~~I~~nformation (PHI) to another person or entity. ~~-~~Please complete, sign, and return the form to CalOptima. Please be advised that in order to process your request, a copy of a valid photo identification (ID) with signature must be included with your request form.

SECTION A: MEMBER AUTHORIZING RELEASE OF PHI

Name of Member:
_____

Member CIN: _____
_____

Address~~:~~ ~~–~~:
_____

Phone ~~No.~~: _____ Member ~~d~~Date of ~~b~~Birth:
~~—~~ _____

SECTION B: PERSON OR ORGANIZATION AUTHORIZED TO RECEIVE THIS INFORMATION

Please enter the person(s) or organization who will receive member's protected health information. This information may be disclosed to, and used by, the following person(s) or organization(s). The representative receiving the information must be 18 years of age or older.

Name (enter first and last name[s]): _____

Relationship to Member: _____

Address: _____ ~~-~~
_____

Phone ~~No.~~: _____

SECTION C: INFORMATION THAT CAN BE RELEASED

I allow the following information to be released by CalOptima (c~~C~~heck only one box):

- ☐ **My complete member file,** including **health information** (e.g. diagnosis, test results, treatment history, health care services, claims status and history, provider name[~~(s)~~]); **financial information** pertaining to ~~your~~my health condition and/or insurance coverage (e.g. claims history); and **personal information** (e.g., name, address, date of birth, and member ID). ***(This authorization does no~~'~~t include certain sensitive information unless it is specifically approved below.)*** **OR**
- ☐ **Only limited information** may be disclosed (check all applicable boxes below):

Limited information		
☐ Billing	☐ Medical records (excludes psychotherapy notes)	☐ Referral
☐ Claims &and payment	☐ Physician and hospital affiliations	☐ Other:
☐ Diagnosis and procedure	☐ Pre-certification &and pre-authorization	

I also approve the release of the following types of **sensitive information** by CalOptima (check all boxes that apply to you):

Sensitive information		
☐ Mental health (including psychotherapy notes)	☐ Genetic testing	☐ Other:
☐ Abuse (sexual/physical/mental/elder)	☐ HIV or AIDS	
☐ Alcohol/substance abuse	☐ Sexually transmitted illness	

SECTION D: PURPOSE OF THIS AUTHORIZATION

This protected health information is being disclosed for the following purpose(s). Please select all that apply:

☐ At the request of the m-Member
☐ I have been designated by the patient as his/her representative
☐ Other (please specify):

_____
_____
_____

SECTION E: EXPIRATION DATE OF AUTHORIZATION

This authorization will expire on the earlier of **(pPlease choose only one box):**

☐ _____ **[INSERT DATE OF EXPIRATION]: OR**
☐ Upon the following event (which must relate to the member or to the purpose of the disclosure being authorized): _____

SECTION F: REVIEW AND APPROVAL

- I understand that I have the right to withdraw this authorization, in writing, at any time by sending written notification to: -CalOptima, ATTNttn: Customer Service Department.
- I also understand that my revocation is not effective to the extent that the persons I have authorized to disclose my protected health information have acted in reliance upon this authorization prior to receipt of the revocation.
- I understand my authorization to release this information will not affect my eligibility or enrollment status, or any treatment or benefit payment decisions. I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy laws.
- I release CalOptima from any liability associated with releasing this information to the person/agency named above. I understand that I may have the right under federal or state law to inspect or copy the protected health information to be disclosed.
- I understand I have the right to refuse to sign this authorization.
- If this authorization is signed by a personal representative, please provide representative documentation as required by state law (i.e., Hhealth Ccare Ppower of Aattorney, Hhealth Ccare Ssurrogate, lLiving Wwill or Gguardianship papers).

By signing below, I acknowledge receiving a copy of this authorization.

Signature of Member **Date**

If Personal Representative:

Name of Personal Representative:

Legal Relationship to Member:

Signature of Authorized Representative: Date:

Sign and mail or deliver- to: **CalOptima**
Customer Service Department
505 City Parkway West
Orange, CA 92868
Fax: (714) 481-6457

~~**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)**~~

~~The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.~~

~~Date of Request:~~ ~~Telephone Number:~~

~~Member Name:~~ ~~Member CIN:~~

~~AUTHORIZATION:~~

~~I, , hereby authorize CalOptima, to use or disclose my health information as described below.~~

~~Describe the health information that will be used or disclosed under this authorization (please be specific):~~

~~Person or organization authorized to received the health information:~~

~~Describe each purpose of the requested use or disclosure (please be specific):~~

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: _____

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that the health information used or disclosed as a result of my signing this authorization may not be further used or disclosed by the recipient unless another authorization is obtained from me or unless such use or disclosure is specifically permitted or required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Personal Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Authorized Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative

(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

HIPAA privacy regulations require you to complete this form to authorize CalOptima to release your protected health information (PHI) to another person or entity. Please complete, sign, and return the form to CalOptima. Please be advised that in order to process your request, a copy of a valid photo identification (ID) with signature must be included with your request form.

SECTION A: MEMBER AUTHORIZING RELEASE OF PHI

Name of Member: _____

Member CIN: _____

Address: _____

Phone: _____ Member Date of Birth: _____

SECTION B: PERSON OR ORGANIZATION AUTHORIZED TO RECEIVE THIS INFORMATION

Please enter the person(s) or organization who will receive member's protected health information. This information may be disclosed to, and used by, the following person(s) or organization(s). The representative receiving the information must be 18 years of age or older.

Name (enter first and last name[s]):_____

Relationship to Member:_____

Address:_____

Phone: _____

SECTION C: INFORMATION THAT CAN BE RELEASED

I allow the following information to be released by CalOptima (check only one box):

☐ **My complete member file,** including **health information** (e.g. diagnosis, test results, treatment history, health care services, claims status and history, provider name[s]); **financial information** pertaining to my health condition and/or insurance coverage (e.g. claims history); and **personal information** (e.g., name, address, date of birth, and member ID). **(*This authorization does not include certain sensitive information unless it is specifically approved below.*) OR**

☐ **Only limited information** may be disclosed (check all applicable boxes below):

Limited information		
☐ Billing	☐ Medical records (excludes psychotherapy notes)	☐ Referral
☐ Claims and payment	☐ Physician and hospital affiliations	☐ Other:
☐ Diagnosis and procedure	☐ Pre-certification and pre-authorization	

I also approve the release of the following types of **sensitive information** by CalOptima (check all boxes that apply to you):

Sensitive information		
☐ Mental health (including psychotherapy notes)	☐ Genetic testing	☐ Other:
☐ Abuse (sexual/physical/mental/elder)	☐ HIV or AIDS	
☐ Alcohol/substance abuse	☐ Sexually transmitted illness	

SECTION D: PURPOSE OF THIS AUTHORIZATION

This protected health information is being disclosed for the following purpose(s). Please select all that apply:

- ☐ At the request of the member
- ☐ I have been designated by the patient as his/her representative
- ☐ Other (please specify):_____
  _____

SECTION E: EXPIRATION DATE OF AUTHORIZATION

This authorization will expire on the earlier of **(please choose only one box):**

- ☐ _____ **[INSERT DATE OF EXPIRATION]: OR**
- ☐ Upon the following event (which must relate to the member or to the purpose of the disclosure being authorized):_____

SECTION F: REVIEW AND APPROVAL

- I understand that I have the right to withdraw this authorization, in writing, at any time by sending written notification to: CalOptima, Attn: Customer Service Department.
- I also understand that my revocation is not effective to the extent that the persons I have authorized to disclose my protected health information have acted in reliance upon this authorization prior to receipt of the revocation.
- I understand my authorization to release this information will not affect my eligibility or enrollment status, or any treatment or benefit payment decisions. I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy laws.
- I release CalOptima from any liability associated with releasing this information to the person/agency named above. I understand that I may have the right under federal or state law to inspect or copy the protected health information to be disclosed.
- I understand I have the right to refuse to sign this authorization.
- If this authorization is signed by a personal representative, please provide representative documentation as required by state law (i.e., health care power of attorney, health care surrogate, living will or guardianship papers).

By signing below, I acknowledge receiving a copy of this authorization.

_____ _____

Signature of Member **Date**

If Personal Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Authorized Representative: _____ Date: _____

Sign and mail or deliver to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868
Fax: (714) 481-6457

Policy #:	HH.3004Δ
Title:	**Member Request to Amend Records**
Department:	Office of Compliance
Section:	Privacy~~Health Insurance Portability and Accountability Act (HIPAA)~~
CEO Approval:	Michael Schrader
Effective Date:	04/01/03
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy~~o~~ defines the process by which Members may request amendments to their Protected Health Information (PHI) maintained in the Designated Record Set (DRS) by CalOptima or its Business Associate(s).

~~II. DEFINITION~~

~~Term~~	~~Definition~~
~~Business Associate~~	~~Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. A person or entity who:~~ ~~1. On behalf of a covered entity or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs or assists in the performance of:~~ ~~a. A function or activity involving the use of disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing benefit management, practice management, and repricing; or~~ ~~b. Any other function or activity regulated by this subchapter; or~~ ~~2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the services involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.~~
~~Complaint~~	~~An oral or written expression indicating dissatisfaction with any aspect of the CalOptima program.~~
~~Designated Record Set~~	~~A group of records maintained by or for Cal Optima that includes enrollment, Payment, claims adjudication, and case or medical management~~

	record system(s) used by or maintained for the agency, or used, in whole or in part, by or for CalOptima to make decisions about the Member. The DRS excludes patient-identifiable data used for administrative, regulatory, Health Care Operations and Payment/financial purpose; employment records held by CalOptima in its role as employer.
Disclosure	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Protected Health Information (PHI)	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form of medium. This information indentifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and related to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member, or 3. Past, present, or future Payment for the provision of health care to a Member.

Term	**Definition**

Term	Definition
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: 3. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. A person that offers a personal health record to one or more individuals on behalf of a covered entity. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: On behalf of a covered entity or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs or assists in the performance of: A function or activity involving the use of disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing benefit management, practice management, and repricing; or Any other function or activity regulated by this subchapter; or Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates,

Term	Definition
Complaint	Any expression of dissatisfaction to CalOptima, a Provider, or the Quality Improvement Organization (QIO) by a Member made orally or in writing. A Complaint may include concerns about the operations of Providers or Cal Optima such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, respect paid to Members, and claims regarding the right of a Member to receive services or receive payment for services previously rendered. A Complaint may also involve CalOptima's refusal to provide services to which a Member believes he or she is entitled. A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.
Designated Record Set	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. A group of records maintained by or for a covered entity that is: - The medical records and billing records about individuals maintained by or for a covered health care provider; - The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or - Used, in whole or in part, by or for the covered entity to make decisions about individuals. The term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.A group of records maintained by or for Cal Optima that includes enrollment, Payment, claims adjudication, and case or medical management record system(s) used by or maintained for the agency, or used, in whole or in part, by or for CalOptima to make decisions about the Member. The DRS excludes patient identifiable data used for administrative, regulatory, Health Care Operations and Payment/financial purpose; employment records held by CalOptima in its role as employer.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information. Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Health Network (HN)	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.

~~Term~~	~~Definition~~
~~Medical Record~~	~~A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term "Medical Record" is used both for the physical folder for each individual patient and for the body. Information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.~~
~~Member (Global)~~	~~An enrollee-beneficiary of a CalOptima program.~~
~~Protected Health Information (PHI)~~	~~Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.~~ ~~Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form of medium.~~ ~~This information indentifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and related to:~~ ~~• The past, present, or future physical or mental health or condition of a Member;~~ ~~• The provision of health care to a Member, or~~ ~~• Past, present, or future Payment for the provision of health care to a Member.~~

~~III.~~II. POLICY

A. CalOptima shall honor a Member's right to request an amendment or correction to his or her PHI, if the Member feels that the information is incomplete or inaccurate. -The Member has the right to request an amendment of his or her PHI for as long as CalOptima or a Business Associate maintains such PHI in the Designated Record Set (DRS). ~~per CalOptima's Record Retention Schedule and CalOptima Ppolicy MA.9106/HH.2022Δ Record Retention and Access .~~

B. CalOptima shall retain the right to approve or deny a Member's request for an amendment or correction to his or her PHI.

~~IV.~~III. PROCEDURE

A. The Privacy Officer, or his or her ~~d~~Designee, ~~Office of Compliance~~ shall be responsible for receiving, processing, and responding to requests for amendments to PHI.

B. All Member requests for amendments to protected or other health information shall be in writing and directed to the Office of Compliance.

C. Members shall document the reason(s) to support the amendment request.

D. CalOptima shall review a request from a Member who is enrolled in a Health Network (HN) in coordination with the Member's Health Network or Business Associate, as appropriate.

E. As applicable, ~~T~~the Privacy Officer, or his or her ~~d~~Designee ~~Office of Compliance~~ shall refer the request to a designated health care professional or the department responsible for maintaining the DRS in question on a case-by-case basis.

F. ~~F.~~ CalOptima may deny a Member's request to amend PHI that:

1. Is not created by CalOptima, unless the originator is no longer available to act on the request;

2. Is not part of the Member's DRS (Note: CalOptima does not create or maintain clinical Medical Records for Members);

3. Is not accessible to the Member due to federal or state laws do not permit it; or

4. Is accurate and complete.

G. The ~~Office of~~ Privacy Officer, or his or her ~~d~~Designee, ~~Compliance~~ shall inform the Member in writing no later than sixty (60) calendar days after receipt of the request if the amendment is approved.

1. If CalOptima is unable to act on the amendment within the time specified in Section III~~V~~.G. of this policy, CalOptima may extend the allotted period for action by no more than thirty (30) calendar days.

~~H. CalOptima shall not extend the allotted period for action by more than thirty (30) calendar days.~~

~~I.~~H. If CalOptima extends the period for action, the Privacy Officer, or his or her designee ~~Office of Compliance~~ shall within thirty (30) calendar days after receipt of the request, provide the Member with a written statement of the reasons for the delay, and the date by which CalOptima shall complete the action on the request.

~~J.~~I. If CalOptima approves the request for amendment, the Privacy Officer, or his or her D~~d~~esignee ~~Office of Compliance~~ shall:

1. Make the appropriate amendment, or arrange to have the appropriate department make the amendment;

2. Inform the Member in a timely manner, as specified in Section III~~V~~.G. ~~of~~ this policy, that the amendment has been approved, and obtain the Member's identification and agreement to have CalOptima notify the relevant person(s) with which the amendment needs to be shared; and

3. Within a reasonable time frame, make reasonable efforts to provide the amendment to:

   a. Persons identified by the Member as having received PHI about the Member and needing the amendment; and

   b. Persons, including Business Associates that CalOptima knows to have the PHI that is the subject of the amendment, and that may have relied on, or may could forseeably rely, on the information to the detriment of the Member, using the Notification of Amendment to Protected Health Information form.

K.J. Amendment Request is Denied

1. CalOptima shall permit the Member to subject a written statement disagreeing with the denial of all or part of a requested amendment and the basis of such disagreement. If CalOptima denies If CalOptima denies the request for amendment, the Privacy Officer, or his or her designee Office of Compliance shall provide the Member with a timely written denial, in accordance with Section IIIV.G. of this policy letter that contains:

   a. The basis for the denial;

   b. Information on a Member's right to submit a written statement of disagreement with the denial, and how the Member may file such a statement;

   c. A description of how the Member may file a Complaint with CalOptima, in accordance with CalOptima Policies HH.1102: CalOptima Member Complaint, and HH.1103: CalOptima Health Network Member Complaint, CMC.9001: Member Complaint Process, and; MA.9001 Complaint Process;.

   d. A description of how the Member may file a Complaint to the Secretary of Health and Human Services; and

   e. The following statement: -"If we denied your request to change your Protected Health Information (PHI), in whole or in part, you may submit a "Statement of Disagreement". If you do not submit a "Statement of Disagreement", you may ask us to include your change request and our denial along with all future disclosures of the information that you wanted change.If the Member does not submit a statement of disagreement, the Member may request CalOptima to provide the Member's request for amendment and the denial with any future Disclosure of the Protected Health Information that is the subject of the amendment request."

2. If the Member provides a statement of disagreement, CalOptima may prepare a written rebuttal to the Member's statement of disagreement.

3. CalOptima shall provide the Member with a copy of the rebuttal.

4. CalOptima shall append or otherwise link the following to the DRS or the PHI that is the subject of the disputed amendment:

a. The Member's request for amendment;

b. The denial of the request;

c. The Member's statement of disagreement, if any; and

d. CalOptima's rebuttal, if any.

5. Any subsequent Disclosures of the PHI to which a Member's written disagreement relates shall include the following:

a. The appended material as described in Section III~~V~~.K.4; or

b. An accurate summary of any such information.

6. CalOptima may transmit subsequent Disclosures separately from a standard transaction if the standard transaction does not allow the transmission of the amendment information.

7. If the Member has not submitted a written statement of disagreement, CalOptima shall include the Member's request for amendment and CalOptima's denial, or an accurate summary of such information, with any subsequent Disclosure of the PHI only if the individual has requested such action.

~~L.~~K. CalOptima shall retain a copy of a Member's request and the outcome of the review for ~~six~~ ten (10~~6~~) years from the receipt of the request.

~~V.~~IV. ATTACHMENTS

A. Member Request to Amend Protected Health Information
B. Notification of Amendment to Protected Health Information
C. Response to Request to Amend Protected Health Information
D. Statement of Disagreement/Request to include Amendment Request and Denial with Future Disclosures

~~VI.~~V. REFERENCES

~~A. 2002 WEDI – SNIP Security and Privacy Workgroup Privacy Policies and Procedures~~
~~B. AHIMA Practice Brief: Patient Access and Amendment to Health Records, 2002~~
A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima ~~Contract with the Department of Health Care Services (DHCS) for PACE~~PACE Program Agreement
A. CalOptima Notice of Privacy Practices
~~C.~~B. CalOptima Policy CMC.9001: Member Complaint Process

~~D. CalOptima Policy AA.1000: Glossary of Terms~~
~~E. CalOptima Policy CMC.1001: Glossary of Terms~~
~~F.~~C. CalOptima Policy HH.1102: CalOptima Member Complaint
D. CalOptima Policy HH.1103: CalOptima Health Network Member Complaint
~~G.~~E. CalOptima Policy HH.2022Δ Record Retention and Access
F. CalOptima Policy HH.3000Δ: Notice of Privacy Practice
~~H.~~G. CalOptima Policy MA.9001: Complaint Process
~~I.~~H. CalOptima Privacy Program~~, 2006~~
I. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
J. HIPAA Patient Privacy Compliance Guide, 1340: The Right of Individuals to Amend PHI
K. The California Patient Privacy Manual, California Health Care Association, 2002, Chapter 3, Patient Rights
~~L. NCQA Standard RR5 MED5 Privacy and Confidentiality: Element A: Adopting Written Policies, Factor 4 – 2014~~7
~~M.~~L. Title 45, Code of Federal Regulations (C.F.R), ~~Section~~ §164.501 ~~Definitions Required by Law~~
~~N. Title 45, Code of Federal Regulations, Section §164.524 Access of Individuals to Protected Health Information~~
M. Title 45, Code of Federal Regulations (C.F.R), ~~Section164~~§164.526
~~O. Amendment of Personal Health Information~~

~~VII.~~VI. REGULATORY AGENCY APPROVALS

None to Date

~~VIII.~~VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3004	Member Request to Amend Record	Medi-Cal
Effective	06/01/2005	MA.9207	Member Request to Amend Record	OneCare
Revised	04/01/2007	HH.3004	Member Request to Amend Record	Medi-Cal
Revised	01/01/2008	HH.3004	Member Request to Amend Record	Medi-Cal
Revised	02/01/2008	MA.9207	Member Request to Amend Record	OneCare
Revised	07/01/2011	HH.3004	Member Request to Amend Record	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	07/01/2011	MA.9207	Member Request to Amend Record	OneCare
Revised	01/01/2013	HH.3004Δ	Member Request to Amend Record	Medi-Cal OneCare
Revised	01/01/2014	HH.3004Δ	Member Request to Amend Record	Medi-Cal OneCare
Revised	11/01/2014	HH.3004	Member Request to Amend Record	Medi-Cal
Revised	11/01/2014	MA.9207	Member Request to Amend Record	OneCare
Revised	09/01/2015	HH.3004	Member Request to Amend Record	Medi-Cal
Revised	09/01/2015	MA.9207	Member Request to Amend Record	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3004Δ	Member Request to Amend Record	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9207	Member Request to Amend Record	OneCare OneCare Connect PACE

~~**IX.**~~

~~Version~~	~~Version Date~~	~~Policy Number~~	~~Policy Title~~
~~Original Date~~	~~04/01/2003~~	~~HH.3004~~	~~Member Request to Amend Record~~
~~Revision Date 1~~	~~04/01/2007~~	~~HH.3004~~	~~Member Request to Amend Record~~
~~Revision Date 2~~	~~01/01/2008~~	~~HH.3004~~	~~Member Request to Amend Record~~
~~Revision Date 3~~	~~07/01/2011~~	~~HH.3004~~	~~Member Request to Amend Record~~
~~Revision Date 4~~	~~01/01/2013~~	~~HH.3004~~	~~Member Request to Amend Record~~
~~Revision Date 5~~	~~01/01/2014~~	~~HH.3004~~	~~Member Request to Amend Record~~
~~Revision Date 6~~	~~11/01/2014~~	~~HH.3004~~	~~Member Request to Amend Record~~
~~Revision Date 7~~	~~09/01/2015~~	~~HH.3004~~	~~Member Request to Amend Record~~

IX. GLOSSARY

Term	Definition
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.
Complaint	Any expression of dissatisfaction to CalOptima, a Provider, or the Quality Improvement Organization (QIO) by a Member made orally or in writing. A Complaint may include concerns about the operations of Providers or Cal Optima such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, respect paid to Members, and claims regarding the right of a Member to receive services or receive payment for services previously rendered. A Complaint may also involve CalOptima's refusal to provide services to which a Member believes he or she is entitled. A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.
Designated	Has the meaning given such term in Section 164.501 of Title 45, Code of

Term	Definition
Record Set	Federal Regulations. A group of records maintained by or for a covered entity that is: 1. The medical records and billing records about individuals maintained by or for a covered health care provider; 2. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or 3. Used, in whole or in part, by or for the covered entity to make decisions about individuals. The term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information. .
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Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term "Medical Record" is used both for the physical folder for each individual patient and for the body. Information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	An enrollee- of a CalOptima Program.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information indentifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and related to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member, or

Term	Definition
	3. Past, present, or future Payment for the provision of health care to a Member.

Policy #:	HH.3004Δ
Title:	**Member Request to Amend Records**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/03
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy defines the process by which Members may request amendments to their Protected Health Information (PHI) maintained in the Designated Record Set (DRS) by CalOptima or its Business Associate(s).

II. POLICY

A. CalOptima shall honor a Member's right to request an amendment or correction to his or her PHI, if the Member feels that the information is incomplete or inaccurate. The Member has the right to request an amendment of his or her PHI for as long as CalOptima or a Business Associate maintains such PHI in the Designated Record Set (DRS).

B. CalOptima shall retain the right to approve or deny a Member's request for an amendment or correction to his or her PHI.

III. PROCEDURE

A. The Privacy Officer, or his or her Designee, shall be responsible for receiving, processing, and responding to requests for amendments to PHI.

B. All Member requests for amendments to protected or other health information shall be in writing and directed to the Office of Compliance.

C. Members shall document the reason(s) to support the amendment request.

D. CalOptima shall review a request from a Member who is enrolled in a Health Network (HN) in coordination with the Member's Health Network or Business Associate, as appropriate.

E. As applicable, the Privacy Officer, or his or her Designee shall refer the request to a designated health care professional or the department responsible for maintaining the DRS in question on a case-by-case basis.

F. CalOptima may deny a Member's request to amend PHI that:

1. Is not created by CalOptima, unless the originator is no longer available to act on the request;

2. Is not part of the Member's DRS (Note: CalOptima does not create or maintain clinical Medical Records for Members);

3. Is not accessible to the Member due to federal or state laws do not permit it; or

4. Is accurate and complete.

G. The Privacy Officer, or his or her Designee, shall inform the Member in writing no later than sixty (60) calendar days after receipt of the request if the amendment is approved.

1. If CalOptima is unable to act on the amendment within the time specified in Section III.G. of this policy, CalOptima may extend the allotted period for action by no more than thirty (30) calendar days.

H. If CalOptima extends the period for action, the Privacy Officer, or his or her designee shall within thirty (30) calendar days after receipt of the request, provide the Member with a written statement of the reasons for the delay, and the date by which CalOptima shall complete the action on the request.

I. If CalOptima approves the request for amendment, the Privacy Officer, or his or her Designee shall:

1. Make the appropriate amendment, or arrange to have the appropriate department make the amendment;

2. Inform the Member in a timely manner, as specified in Section III.G. of this policy, that the amendment has been approved, and obtain the Member's identification and agreement to have CalOptima notify the relevant person(s) with which the amendment needs to be shared; and

3. Within a reasonable time frame, make reasonable efforts to provide the amendment to:

a. Persons identified by the Member as having received PHI about the Member and needing the amendment; and

b. Persons, including Business Associates that CalOptima knows to have the PHI that is the subject of the amendment and that may have relied, or could forseeably rely, on the information to the detriment of the Member, using the Notification of Amendment to Protected Health Information form.

J. Amendment Request is Denied

1. CalOptima shall permit the Member to subject a written statement disagreeing with the denial of all or part of a requested amendment and the basis of such disagreement. If CalOptima denies the request for amendment, the Privacy Officer, or his or her designee shall provide the Member with a timely written denial, in accordance with Section III.G. of this policy letter that contains:

a. The basis for the denial;

b. Information on a Member's right to submit a written statement of disagreement with the denial, and how the Member may file such a statement;

c. A description of how the Member may file a Complaint with CalOptima, in accordance with CalOptima Policies HH.1102: CalOptima Member Complaint, HH.1103: CalOptima Health Network Member Complaint, CMC.9001: Member Complaint Process, and MA.9001 Complaint Process;

d. A description of how the Member may file a Complaint to the Secretary of Health and Human Services; and

e. The following statement: "If we denied your request to change your Protected Health Information (PHI), in whole or in part, you may submit a "Statement of Disagreement". If you do not submit a "Statement of Disagreement", you may ask us to include your change request and our denial along with all future disclosures of the information that you wanted change."

2. If the Member provides a statement of disagreement, CalOptima may prepare a written rebuttal to the Member's statement of disagreement.

3. CalOptima shall provide the Member with a copy of the rebuttal.

4. CalOptima shall append or otherwise link the following to the DRS or the PHI that is the subject of the disputed amendment:

a. The Member's request for amendment;

b. The denial of the request;

c. The Member's statement of disagreement, if any; and

d. CalOptima's rebuttal, if any.

5. Any subsequent Disclosures of the PHI to which a Member's written disagreement relates shall include the following:

a. The appended material as described in Section III.K.4; or

b. An accurate summary of any such information.

6. CalOptima may transmit subsequent Disclosures separately from a standard transaction if the standard transaction does not allow the transmission of the amendment information.

7. If the Member has not submitted a written statement of disagreement, CalOptima shall include the Member's request for amendment and CalOptima's denial, or an accurate summary of such information, with any subsequent Disclosure of the PHI only if the individual has requested such action.

K. CalOptima shall retain a copy of a Member's request and the outcome of the review for ten (10) years from the receipt of the request.

IV. ATTACHMENTS

A. Member Request to Amend Protected Health Information
B. Notification of Amendment to Protected Health Information
C. Response to Request to Amend Protected Health Information
D. Statement of Disagreement/Request to include Amendment Request and Denial with Future Disclosures

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
A. CalOptima Notice of Privacy Practices
B. CalOptima Policy CMC.9001: Member Complaint Process
C. CalOptima Policy HH.1102: CalOptima Member Complaint
D. CalOptima Policy HH.1103: CalOptima Health Network Member Complaint
E. CalOptima Policy HH.2022Δ Record Retention and Access
F. CalOptima Policy HH.3000Δ: Notice of Privacy Practice
G. CalOptima Policy MA.9001: Complaint Process
H. CalOptima Privacy Program
I. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
J. HIPAA Patient Privacy Compliance Guide, 1340: The Right of Individuals to Amend PHI
K. The California Patient Privacy Manual, California Health Care Association, 2002, Chapter 3, Patient Rights
L. Title 45, Code of Federal Regulations (C.F.R), §164.501
M. Title 45, Code of Federal Regulations (C.F.R), §164.526

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3004	Member Request to Amend Record	Medi-Cal
Effective	06/01/2005	MA.9207	Member Request to Amend Record	OneCare
Revised	04/01/2007	HH.3004	Member Request to Amend Record	Medi-Cal
Revised	01/01/2008	HH.3004	Member Request to Amend Record	Medi-Cal
Revised	02/01/2008	MA.9207	Member Request to Amend Record	OneCare

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	07/01/2011	HH.3004	Member Request to Amend Record	Medi-Cal
Revised	07/01/2011	MA.9207	Member Request to Amend Record	OneCare
Revised	01/01/2013	HH.3004Δ	Member Request to Amend Record	Medi-Cal OneCare
Revised	01/01/2014	HH.3004Δ	Member Request to Amend Record	Medi-Cal OneCare
Revised	11/01/2014	HH.3004	Member Request to Amend Record	Medi-Cal
Revised	11/01/2014	MA.9207	Member Request to Amend Record	OneCare
Revised	09/01/2015	HH.3004	Member Request to Amend Record	Medi-Cal
Revised	09/01/2015	MA.9207	Member Request to Amend Record	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3004Δ	Member Request to Amend Record	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9207	Member Request to Amend Record	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.
Complaint	Any expression of dissatisfaction to CalOptima, a Provider, or the Quality Improvement Organization (QIO) by a Member made orally or in writing. A Complaint may include concerns about the operations of Providers or Cal Optima such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, respect paid to Members, and claims regarding the right of a Member to receive services or receive payment for services previously rendered. A Complaint may also involve CalOptima's refusal to provide services to which a Member believes he or she is entitled. A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.
Designated Record Set	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. A group of records maintained by or for a covered entity that is:

Term	Definition
	1. The medical records and billing records about individuals maintained by or for a covered health care provider; 2. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or 3. Used, in whole or in part, by or for the covered entity to make decisions about individuals. The term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information. .
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term "Medical Record" is used both for the physical folder for each individual patient and for the body. Information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	An enrollee- of a CalOptima Program.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information indentifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and related to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member, or 3. Past, present, or future Payment for the provision of health care to a Member.

1

Member Request to Amend Protected Health Information (PHI)

Date of Request: _____

Member Name: _____ Date of Birth: _____

Member CIN: _____ Telephone Number: _____

Please tell us what Protected Health Information (PHI) or record you would like CalOptima to change:

_____

_____

_____

Please tell us why you would like this change. You must give a reason:

_____

_____

_____

NOTIFICATION:

CalOptima must notify you within 60 calendar days if the changes were made as you requested or tell you that more time is needed (up to 30 calendar extra days) to decide. Please tell us where to send you a letter:

Address: _____ Apt #:_____

City: _____ State: _____ Zip Code: _____

If CalOptima decides to change the record as you requested, the change will be sent to any person who received the information before it was changed. Please tell us if there are any such persons who need the changed information.

☐ No
☐ Yes Please list the person's names and addresses:

_____ _____

_____ _____

_____ _____

We will also send the change to other persons that we know received the information before it was changed if they relied, or might in the future rely, on the information. Do you agree to this?

☐ No
☐ Yes

Continue on page 2.

RESTRICTIONS:

CalOptima does not have to change your record if:

- CalOptima did not create the information.
- The information in the record is accurate and complete.
- You do not have the legal right to access the Protected Health Information (PHI) you want changed.
- The Protected Health Information (PHI) you want changed is not part of the information kept by CalOptima (Member Designated Record Set; this includes enrollment information, billing records and records containing your Protected Health Information (PHI) that are used by us to make decisions about you.).

YOUR RIGHTS:

For more information about your privacy rights, please refer to your copy of the CalOptima Notice of Privacy Practices. It is also on our website: www.caloptima.org, or you can call the CalOptima's Customer Service Department at **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday from 8 a.m. to 5:30 p.m. Members with hearing or speech impairments can call our TDD line at **1-714-246-8523**. We have staff who can speak your language.

If you believe your privacy rights have been violated, you may file a complaint with CalOptima or with the secretary of the Department of Health and Human Services. To file a complaint with CalOptima, contact CalOptima Customer Service Department at 1-714-246-8500.

CalOptima cannot take away your health care benefits or do anything to hurt you in any way if you choose to file a complaint or use any of the privacy rights in this Notice.

SIGNATURE:

Member Signature: _____

If Authorized Representative (please include appropriate documentation):

Print Name: _____ Relationship to Member: _____

SUBMIT TO CALOPTIMA:

When you have finished filling out this form, please send it to CalOptima:

Office of Compliance
505 City Parkway West
Orange, CA 92868

Or, bring it to the Customer Service Department at CalOptima's offices located at 505 City Parkway West, Orange, CA 92868.

[DATE]

[NAME]
[ADRESS]
[CITY], [STATE] [ZIP]

Re: Notification of Amendment to Protected Health Information (PHI)

Dear [NAME]:

CalOptima has received your request to Amend your Protected Health Information (PHI) dated [DATE]. This letter is to notify you that CalOptima has approved the following changes to your PHI based on your request:

CalOptima will begin to notify the person(s) in need of the amendment based on your request.
[If member agreed] CalOptima will also send the change to other persons that we know received the information before it was changed, if they relied, or might in the future rely on, the information.

[IF APPLICABLE]
The part of the change that we will not make is:

If we denied your request to change your Protected Health Information (PHI), in whole or in part, you may submit a "Statement of Disagreement". If you do not submit a "Statement of Disagreement", you may ask us to include your change request and our denial along with all future disclosures of the information that you wanted change.

If you want to submit a "Statement of Disagreement" please write "Statement of Disagreement" on the top then mail or deliver the request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

If you want to include your change request and our denial along with future disclosures of the information you wanted changed, please mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

For more information about your privacy rights, please refer to your copy of the CalOptima Notice of Privacy Practices. It is also available on our website: www.caloptima.org, or from the Customer Service Department at CalOptima by calling **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through

Friday from 8 a.m. to 5:30 p.m. Members with hearing or speech impairments can call our TDD line at **1-714-246-8523**. We have staff who speak your language.

If you believe your privacy rights have been violated, you may file a complaint with CalOptima or with the secretary of the Department of Health and Human Services. To file a complaint with CalOptima, contact CalOptima Customer Service Department at 1-714-246-8500.

CalOptima cannot take away your health care benefits or do anything to hurt you in any way if you choose to file a complaint or use any of the privacy rights in this Notice.

Please feel free to contact me at 1-714-246-[XXXX], if you have any questions regarding the information contained in this letter.

Sincerely,

Privacy Officer
CalOptima

Encl.: Member Request to Amend Protected Health Information (PHI)

[DATE]

[NAME]
[ADRESS]
[CITY], [STATE] [ZIP]

Re: Response to Request to Amend Protected Health Information (PHI)

Dear [NAME]:

CalOptima has received your request to Amend your Protected Health Information (PHI) dated [DATE].

☐ We need more time to process your request. We will send you response to your request by [DATE].
☐ We will make the changes as requested and will notify the person(s) you designated of the change.
☐ We will make the change that you requested, but only in part, and will notify the person(s) you designated of the change. The part of the change that we shall make is: _____
_____
_____
_____

The part of the change that we will not make is:

See the box checked below for the reason we will not make part of the change you requested:

We will not make the change as you requested because:
☐ You did not include a reason to support your request.
☐ The information we have is accurate and complete.
☐ We did not create the information you want changed, and you did not give us a reasonable basis to believe that the origination of the information is no longer available to act on your request to change information
☐ The information you want changed is not information you have the right to access.
☐ The information you want changed is not part of the Designated Record Set (this includes: enrollment information, Billing records, and records containing your Protected Health Information PHI that are used by us to make decisions about you).
☐ Other: _____
_____

If we denied your request to change your Protected Health Information (PHI), in whole or in part, you may submit a “Statement of Disagreement”. If you do not submit a “Statement of Disagreement”, you may ask us to include your change request and our denial along with all future disclosures of the information that you wanted change.

If you want to submit a “Statement of Disagreement” please write “Statement of Disagreement” on the top then mail or deliver the request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

If you want to include your change request and our denial along with future disclosures of the information you wanted changed, please mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

For more information about your privacy rights, please refer to your copy of the CalOptima Notice of Privacy Practices. It is also available on our website: www.caloptima.org, or from the Customer Service Department at CalOptima by calling **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday from 8 a.m. to 5:30 p.m. Members with hearing or speech impairments can call our TDD line at **1-714-246-8523**. We have staff who speak your language.

If you believe your privacy rights have been violated, you may file a complaint with CalOptima or with the secretary of the Department of Health and Human Services. To file a complaint with CalOptima, contact CalOptima Customer Service Department at 1-714-246-8500.

CalOptima cannot take away your health care benefits or do anything to hurt you in any way if you choose to file a complaint or use any of the privacy rights in this Notice.

Sincerely,

Privacy Officer
CalOptima

Statement of Disagreement
Request to Include Amendment Request and Denial with Future Disclosures

Date of Request: _____

Member Name: _____ Date of Birth: _____

Member CIN: _____ Telephone Number: _____

I understand that CalOptima denied my request to change my Protected Health Information (PHI). My request was dated: _____.

Choose only one (1) box below:

I understand that CalOptima may prepare a rebuttal to my Statement of Disagreement. A "rebuttal" is a statement of why CalOptima thinks my Statement of Disagreement is not accepted. If CalOptima prepares a written rebuttal, I will receive a copy.

☐ I want to file this "Statement of Disagreement".
I disagree with the denial because: _____
_____
_____
_____

☐ I do not want to file a "Statement of Disagreement" but I would like CalOptima to include my change request and the denial with all future disclosures of the information that have to do with my change request.

YOUR RIGHTS:

For more information about your privacy rights, please refer to your copy of the CalOptima Notice of Privacy Practices. A copy can be found on our website: www.caloptima.org, or from CalOptima's Customer Service Department by calling **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday from 8 a.m. to 5:30 p.m. Members with hearing or speech impairments can call our TDD line at **1-714-246-8523**. We have staff who can speak your language.

If you believe your privacy rights have been violated, you may file a complaint with CalOptima or with the secretary of the Department of Health and Human Services. To file a complaint with CalOptima, contact CalOptima Customer Service Department at 1-714-246-8500. CalOptima cannot take away your health care benefits or do anything to hurt you in any way if you choose to file a complaint or use any of the privacy rights in this Notice.

SIGNATURE:

Member Signature: _____

If Authorized Representative (please include legal documentation):

Print Name: _____ Relationship to Member: _____

Policy #:	HH.3005Δ
Title:	**Member Request for Accounting of Disclosures**
Department:	Office of Compliance
Section:	~~Health Insurance Portability and Accountability Act (HIPAA)~~Privacy
CEO Approval:	Michael Schrader
Effective Date:	04/01/03
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

~~To~~ This policy define~~s~~ the scope of a Member's right to request an accounting of ~~all~~ Disclosures made by CalOptima of the Member's Protected Health Information (PHI) created or maintained in a Designated Record Set (DRS) by CalOptima or its Business ~~Associates~~Associates.

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~

~~Business Associate~~	~~Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who:~~ ~~On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or~~ ~~Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.~~ ~~A covered entity may be a business associate of another covered entity.~~ ~~Business associate includes:~~ ~~A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information.~~ ~~A person that offers a personal health record to one or more individuals on behalf of a covered entity.~~ ~~A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.~~ ~~Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. A person or entity who:~~ ~~1. On behalf of a covered entity or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs or assists in the performance of:~~ ~~a. A function or activity involving the use of disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing benefit~~

~~Designated Record Set (DRS)~~	~~Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. A group of records maintained by or for a covered entity that is:~~ ~~- The medical records and billing records about individuals maintained by or for a covered health care provider;~~ ~~- The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or~~ ~~- Used, in whole or in part, by or for the covered entity to make decisions about individuals.~~ ~~The term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.A group of records maintained by or for CalOptima that includes enrollment, Payment, claims adjudication, and case or medical management record system(s) used by or maintained for the agency, or used, in whole or in part, by or for CalOptima to make decisions about the Member. The DRS excludes patient identifiable data used for administrative, regulatory, Health Care Operations and Payment/financial purpose; employment records held by CalOptima in its role as employer.~~
~~Disclosure~~	~~Has the meaning in in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information. Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.~~
~~Health Care Operations~~	~~Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including aActivities including quality assessment and improvement activities, care management, professional review, compliance audits, health insurance underwriting, premium rating and other activities related to a contact and health benefits, management and administration activities customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.~~
~~Health Network~~	~~A Physician Hospital Consortium (PHC), physician groupPhysician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.~~
~~Limited Data Set~~	~~Protected Health Information (PHI) that uses the indirect identifiers (State, town or city, zip codes, dates of service, birth, and death) and excludes direct identifiers of the Member or the Member's relatives, employers, or household members.~~

~~Member~~	~~A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.~~An enrollee beneficiary of ~~a CalOptima program.~~
~~Payment~~	~~Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including:~~ ~~- Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities;~~ ~~- Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and,~~ ~~- Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.~~Activities carried out by CalOptima including: ~~1. Determination eligibility, risk adjustments based on the Member health status and demographics, billing claims management, and collection activities;~~ ~~2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification or charges; and~~ ~~3. Utilization review activities including pre-certification, pre-authorization, concurrent, or retrospective review of services.~~

~~Protected Health Information (PHI)~~	~~Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.~~ ~~This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to:~~ ~~- The past, present, or future physical or mental health or condition of a Member;~~ ~~- The provision of health care to a Member; or~~ ~~- Past, present, or future Payment for the provision of health care to a Member. Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form of medium.~~ ~~-~~ ~~- This information indentifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and related to:~~ ~~1. The past, present, or future physical or mental health or condition of a Member;~~ ~~2. The provision of health care to a Member, or~~ ~~3. Past, present, or future Payment for the provision of health care to a Member.~~
~~Provider~~	~~A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Physician Medical Group, or other person or institution who furnishes Covered Services.~~
~~Use of PHI~~	~~Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. The sharing, employment, application, utilization, examination, or analysis of the fill within an entity that maintains such information.~~

~~III.~~II. POLICY

A. Upon a Member's request, CalOptima shall provide an accounting of PHI Disclosures released for a time period not to exceed six (6) years and not prior to April 14, 2003.

1. Disclosures Excepted from Accounting

~~a. CalOptima is not required to provide an accounting of Disclosures if the information was:~~

~~i.~~a. Used to provide Member care, Payment for services, or Health Care Operations, including but not limited to, ~~Disclosure~~disclosures to Providers, clearinghouses, and Business Associates;

~~ii.~~b. Provided to the Member;

~~iii.~~c. Provided to national security or intelligence;

~~iv.~~d. Provided to correctional facilities or law enforcement officials;

~~v.~~e. Made ~~in accordance with~~ pursuant to a Member's Authorization to Disclose;

~~vi.~~f. Part of a Limited ~~Date~~Data Set; or

~~vii.~~g. Incidental to another permissible Use or Disclosure.

B. ~~-~~The Office of Compliance shall track all other Disclosures of PHI not mentioned in Section II~~I~~.A., in accordance with CalOptima Policy ~~HH.3006~~MA.9210HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information ~~(PHI).~~

C. Disclosure of PHI is not limited to hard-copy information~~,~~ and may include any information disclosed by other means, such as verbally, electronic data release, or by facsimile.

D. CalOptima shall temporarily suspend a Member's right to receive an accounting of Disclosures to a health oversight agency or law enforcement official if:

1. CalOptima receives a written statement from such agency or official that an accounting to the ~~-~~Member would be reasonably likely to impede the agency's activities, and specifying the time ~~-~~for which such a suspension is required; or

2. A health oversight agency or law enforcement official provides ~~a~~an verbal statement to CalOptima, in which case CalOptima shall:

   a. Document the statement, including the identity of the agency or official making the ~~-~~statement;

   b. Temporarily suspend the Member's right to an accounting of Disclosures subject to the ~~-~~statement; and

   c. Limit the temporary suspension to no longer than thirty (30) calendar days from the date of ~~-~~the oral statement, unless CalOptima receives a written request for suspension.

~~IV.~~III. PROCEDURE

A. A Member may request an accounting of Disclosures of his or her PHI that CalOptima ~~-~~released, ~~for a period of time less than~~in the six (6) years prior to ~~from~~ the date of the request (or lesser time if requested), by submitting ~~-~~a Request for an Accounting of Disclosures ~~form~~Form to the Customer Service Department.

B. The Customer Service Department shall:

1. Provide the Member with a Request for an Accounting of Disclosures ~~form~~Form by U.S. mail or in person at the CalOptima office; and

2. Assist the Member in completing the form, if necessary.

C. CalOptima's Customer Service Department shall forward all requests to the ~~Office of Compliance~~Privacy Officer or Designee who shall process the request.

D. CalOptima shall review a Member's request for an accounting of ~~Disclosures~~Disclosure from Members enrolled in a Health Network in coordination with the Health Network or other Business Associate, as appropriate.

E. A written account of the Disclosures shall include:

1. Disclosures of PHI that occurred during the six (6) years, or shorter time period as designated on the Member's request, prior to the date of the request for an accounting;

a. The date of the Disclosure;

b. The name of the entity or ~~and address of the~~ person ~~or entity~~ who received the PHI, and if known, the address of such entity or person;

c. A brief description of the PHI ~~released~~ Disclosed; and

d. A brief statement of the purpose ~~for~~ of the ~~information~~Disclosure that reasonably informs the individual of the basis for the Disclosure, or in lieu of such statement, a copy of a written request for a disclosure.~~, or, instead of a statement, a copy of the written request for the information; and~~

~~e.~~ F. CalOptima shall provide the information required by Section ~~IV~~II.E.~~1-4~~ for the first disclosure and the frequency, periodicity, or number of Disclosures made during the accounting period requested by the Member and the date of the last such Disclosure during the accounting period requested by the Member. If multiple requests were made by the same individual or entity, the list will include the frequency, periodicity, number of times the information was released and the date of the last release during the period requested by the Member.

~~F.~~G. The Office of Compliance shall act on the Member's request, and:

1. Provide the Member with the PHI accounting within sixty (60) calendar days after the date of request; or

2. If the PHI accounting will not be prepared within the sixty (60) calendar days, communicate to the Member:

   a. The reasons why the PHI accounting will not be prepared within sixty (60) ~~-~~calendar days;

   b. The date in which the PHI accounting will be prepared; and

   c. Complete the request within an additional thirty (30) calendar days after the ~~-~~expiration of ~~-~~the initial sixty (60) calendar days.

~~G.~~H. Documentation

1. The Office of Compliance shall document the request in the Office of Compliance tracking database~~, which~~ that shall include, but not be limited to:

   a. Date of request;

   b. Name of person who processed the request; and

   c. Date the accounting was released to Member.

2. The Office of Compliance shall maintain a copy of the PHI accounting provided to the Member for ~~six (6~~ten (10) years from the date the request is received.

~~H.~~I. CalOptima shall provide the Member with the first request for an accounting in any twelve (12) month period at no charge. CalOptima may charge the Member a reasonable, cost-based fee for each future request within the twelve (12) month period, provided that CalOptima informs the Member in advance of the fee, and offers the Member a chance to withdraw or modify the request to avoid or reduce the fee.

~~I. Any person with knowledge of a violation or potential violation of this policy shall report such information directly to the Office of Compliance or through the CalOptima Compliance and Ethics Hotline at 1-877-837-4417.~~

~~V.~~IV. ATTACHMENTS

A. Request for an Accounting of Disclosures Form
B. Response to Request for Accounting of Disclosures

~~VI.~~V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima ~~Contract with the Department of Health Care Services (DHCS) for PACE~~PACE Program Agreement
~~A. CalOptima Policy AA.1000: Glossary of Terms~~

~~B. CalOptima Policy CMC.1001: Glossary of Terms~~
~~C. CalOptima Policy IS~~MA.1001: Glossary of Terms
~~D.~~E. CalOptima Policy HH.3006Δ~~:~~: Tracking ~~and Reporting~~ Disclosures of Protected Health Information ~~(PHI)~~
~~E.~~F. CalOptima Privacy Program
G. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~F.~~H. Guide to Medical Privacy and HIPAA, Thompson Publishing Group, 2002, Section 400-Medical Records Privacy Requirements
~~G. NCQA Standard RR5 Privacy and Confidentiality: Element A: Adopting Written Policies, Factor 5 – 2014~~NCQA Standard MED5 Privacy and Confidentiality: Element A: Adopting Written Policies for Privacy and Confidentiality, Factor 5
~~H. The California Patient Privacy Manual, California Health care Association, 2002, Chapter 3- Patient Rights~~
I. Title 45~~,~~ Code of Federal Regulations (C.F.R), ~~Section~~ §164.528
~~I. , Accounting of Disclosures of Protected Health Information.~~

~~VII.~~VI. REGULATORY AGENCY APPROVALS

None to Date

~~VIII.~~VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY
~~IX.~~

~~Version~~	~~Version Date~~	~~Policy Number~~	~~Policy Title~~
~~Original Date~~Effective	~~04~~06/01/2003~~2005~~	~~HH.3005~~MA.9209	~~Member Request for an Accounting of Disclosures~~
~~Revision Date 1~~	~~04/01/2007~~	~~HH.3005~~	~~Member Request for an Accounting of Disclosures~~
~~Revision Date 2~~1Revised	~~01~~02/01/2008	~~HH.3005~~MA.9209	~~Member Request for an Accounting of Disclosures~~
~~Revised~~Revision Date ~~3~~2	~~07/01/2011~~	~~HH.3005~~MA.9209	~~Member Request for an Accounting of Disclosures~~
~~Revised~~Revision Date ~~4~~	~~01/01/2013~~	~~HH.3005~~	~~Member Request for an Accounting of Disclosures~~
~~Revised~~Revision Date ~~5~~3	~~01~~06/01/2014	~~HH.3005~~MA.9209	~~Member Request for an Accounting of Disclosures~~
~~Revised~~Revision Date ~~6~~4	~~11/01/2014~~	~~HH.3005~~MA.9209	~~Member Request for an Accounting of Disclosures~~
~~Revised~~Revision Date ~~7~~5	~~09/01/2015~~	~~HH.3005~~MA.9209	~~Member Request for an Accounting of Disclosures~~

~~Version~~	~~Version Date~~	~~Policy Number~~	~~Policy Title~~

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Effective	06/01/2005	MA.9209	Member Request for Accounting of Disclosures	OneCare
Revised	04/01/2007	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Revised	01/01/2008	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Revised	02/01/2008	MA.9209	Member Request for Accounting of Disclosures	OneCare
Revised	07/01/2011	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Revised	07/01/2011	MA.9209	Member Request for Accounting of Disclosures	OneCare
Revised	01/01/2013	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal OneCare
Revised	01/01/2014	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal OneCare
Revised	06/01/2014	MA.9209	Member Request for Accounting of Disclosures	OneCare
Revised	11/01/2014	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Revised	11/01/2014	MA.9209	Member Request for Accounting of Disclosures	OneCare
Revised	09/01/2015	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Revised	09/01/2015	MA.9209	Member Request for Accounting of Disclosures	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3005Δ	Member Request for Accounting of Disclosures	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9209	Member Request for Accounting of Disclosures	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: • On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or • Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: • A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. • A person that offers a personal health record to one or more individuals on behalf of a covered entity. • A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.

Designated Record Set (DRS)	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. A group of records maintained by or for a covered entity that is: • The medical records and billing records about individuals maintained by or for a covered health care provider; • The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or • Used, in whole or in part, by or for the covered entity to make decisions about individuals. The term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.
Disclosure	Has the meaning in in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance audits, health insurance underwriting, premium rating and other activities related to a contact and health benefits, management and administration activities customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Limited Data Set	Protected Health Information (PHI) that uses the indirect identifiers (State, town or city, zip codes, dates of service, birth, and death) and excludes direct identifiers of the Member or the Member's relatives, employers, or household members.
Member	An enrollee-beneficiary of a CalOptima program.
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and, 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.

Protected Health Information (PHI)	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Physician Medical Group, or other person or institution who furnishes Covered Services.
Use	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

Policy #:	HH.3005Δ
Title:	**Member Request for Accounting of Disclosures**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/03
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy defines the scope of a Member's right to request an accounting of Disclosures made by CalOptima of the Member's Protected Health Information (PHI) created or maintained in a Designated Record Set (DRS) by CalOptima or its Business Associates.

II. POLICY

A. Upon a Member's request, CalOptima shall provide an accounting of PHI Disclosures released for a time period not to exceed six (6) years and not prior to April 14, 2003.

1. Disclosures Excepted from Accounting

a. Used to provide Member care, Payment for services, or Health Care Operations, including but not limited to, disclosures to Providers, clearinghouses, and Business Associates;

b. Provided to the Member;

c. Provided to national security or intelligence;

d. Provided to correctional facilities or law enforcement officials;

e. Made pursuant to a Member's Authorization to Disclose;

f. Part of a Limited Data Set; or

g. Incidental to another permissible Use or Disclosure.

B. The Office of Compliance shall track all other Disclosures of PHI not mentioned in Section II.A., in accordance with CalOptima Policy HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information.

C. Disclosure of PHI is not limited to hard-copy information and may include any information disclosed by other means, such as verbally, electronic data release, or by facsimile.

D. CalOptima shall temporarily suspend a Member's right to receive an accounting of Disclosures to a health oversight agency or law enforcement official if:

1. CalOptima receives a written statement from such agency or official that an accounting to the Member would be reasonably likely to impede the agency's activities, and specifying the time for which such a suspension is required; or

2. A health oversight agency or law enforcement official provides an verbal statement to CalOptima, in which case CalOptima shall:

   a. Document the statement, including the identity of the agency or official making the statement;

   b. Temporarily suspend the Member's right to an accounting of Disclosures subject to the statement; and

   c. Limit the temporary suspension to no longer than thirty (30) calendar days from the date of the oral statement, unless CalOptima receives a written request for suspension.

III. PROCEDURE

A. A Member may request an accounting of Disclosures of his or her PHI that CalOptima released, in the six (6) years prior to the date of the request (or lesser time if requested), by submitting a Request for an Accounting of Disclosures Form to the Customer Service Department.

B. The Customer Service Department shall:

   1. Provide the Member with a Request for an Accounting of Disclosures Form by U.S. mail or in person at the CalOptima office; and

   2. Assist the Member in completing the form, if necessary.

C. CalOptima's Customer Service Department shall forward all requests to the Privacy Officer or Designee who shall process the request.

D. CalOptima shall review a Member's request for an accounting of Disclosure from Members enrolled in a Health Network in coordination with the Health Network or other Business Associate, as appropriate.

E. A written account of the Disclosures shall include:

   1. Disclosures of PHI that occurred during the six (6) years, or shorter time period as designated on the Member's request, prior to the date of the request for an accounting;

      a. The date of the Disclosure;

      b. The name of the entity or person who received the PHI, and if known, the address of such entity or person;

      c. A brief description of the PHI Disclosed; and

d. A brief statement of the purpose of the Disclosure that reasonably informs the individual of the basis for the Disclosure, or in lieu of such statement, a copy of a written request for a disclosure.

F. CalOptima shall provide the information required by Section III.E. for the first disclosure and the frequency, periodicity, or number of Disclosures made during the accounting period requested by the Member and the date of the last such Disclosure during the accounting period requested by the Member. If multiple requests were made by the same individual or entity, the list will include the frequency, periodicity, number of times the information was released and the date of the last release during the period requested by the Member.

G. The Office of Compliance shall act on the Member's request, and:

1. Provide the Member with the PHI accounting within sixty (60) calendar days after the date of request; or

2. If the PHI accounting will not be prepared within the sixty (60) calendar days, communicate to the Member:

a. The reasons why the PHI accounting will not be prepared within sixty (60) calendar days;

b. The date in which the PHI accounting will be prepared; and

c. Complete the request within an additional thirty (30) calendar days after the expiration of the initial sixty (60) calendar days.

H. Documentation

1. The Office of Compliance shall document the request in the Office of Compliance tracking database that shall include, but not be limited to:

a. Date of request;

b. Name of person who processed the request; and

c. Date the accounting was released to Member.

2. The Office of Compliance shall maintain a copy of the PHI accounting provided to the Member for ten (10) years from the date the request is received.

I. CalOptima shall provide the Member with the first request for an accounting in any twelve (12) month period at no charge. CalOptima may charge the Member a reasonable, cost-based fee for each future request within the twelve (12) month period, provided that CalOptima informs the Member in advance of the fee, and offers the Member a chance to withdraw or modify the request to avoid or reduce the fee.

IV. ATTACHMENTS

A. Request for an Accounting of Disclosures Form
B. Response to Request for Accounting of Disclosures

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy HH.3006Δ: Tracking Disclosures of Protected Health Information
F. CalOptima Privacy Program
G. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
H. Guide to Medical Privacy and HIPAA, Thompson Publishing Group, 2002, Section 400-Medical Records Privacy Requirements
I. Title 45, Code of Federal Regulations (C.F.R), §164.528

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Effective	06/01/2005	MA.9209	Member Request for Accounting of Disclosures	OneCare
Revised	04/01/2007	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Revised	01/01/2008	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Revised	02/01/2008	MA.9209	Member Request for Accounting of Disclosures	OneCare
Revised	07/01/2011	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Revised	07/01/2011	MA.9209	Member Request for Accounting of Disclosures	OneCare
Revised	01/01/2013	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal OneCare
Revised	01/01/2014	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal OneCare
Revised	06/01/2014	MA.9209	Member Request for Accounting of Disclosures	OneCare
Revised	11/01/2014	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	11/01/2014	MA.9209	Member Request for Accounting of Disclosures	OneCare
Revised	09/01/2015	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Revised	09/01/2015	MA.9209	Member Request for Accounting of Disclosures	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3005Δ	Member Request for Accounting of Disclosures	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9209	Member Request for Accounting of Disclosures	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: • On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or • Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: • A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. • A person that offers a personal health record to one or more individuals on behalf of a covered entity. • A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.

Designated Record Set (DRS)	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. A group of records maintained by or for a covered entity that is: • The medical records and billing records about individuals maintained by or for a covered health care provider; • The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or • Used, in whole or in part, by or for the covered entity to make decisions about individuals. The term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.
Disclosure	Has the meaning in in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance audits, health insurance underwriting, premium rating and other activities related to a contact and health benefits, management and administration activities customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Limited Data Set	Protected Health Information (PHI) that uses the indirect identifiers (State, town or city, zip codes, dates of service, birth, and death) and excludes direct identifiers of the Member or the Member's relatives, employers, or household members.
Member	An enrollee-beneficiary of a CalOptima program.
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and, 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.

Protected Health Information (PHI)	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Physician Medical Group, or other person or institution who furnishes Covered Services.
Use	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

1

Request for an Accounting of Disclosures Form

Date of Request: _____

Member Name: _____ Date of Birth: _____

Member CIN: _____ Telephone Number: _____

I would like an accounting or record of how my Protected Health Information (PHI) was disclosed by CalOptima, as required by federal regulations. I understand that CalOptima does not have to tell me about the following types of disclosures:

1. Disclosures for purposes of Treatment, Payment and Health Care Operations.
2. Disclosures to me or authorized by me to another person(s).
3. Disclosures to persons involved in my care.
4. Disclosures to State or Federal health oversight agencies
5. Disclosures made prior to April 14, 2003.

I also understand that my right to a record of some, or all disclosures, may be suspended by the government under limited circumstances.

I understand that CalOptima must give me the record of disclosures within 60 calendar days, or give notice to me that an extra 30 calendar days (or less) is needed to prepare it.

I understand I am allowed one (1) free record or accounting of disclosures for every 12-month period. I may be charged a fee if I request more than one accounting of disclosures within the same 12-month period.

For more information about your privacy rights, please visit our website at www.caloptima.org or call CalOptima's Customer Service Department toll-free at 1-888-587-8088. Members with hearing or speech impairments can call our TDD line at 1-714-246-8523. We have staff who can speak your language.

I would like a record of disclosures that covers the following time period:

From: _____ To: _____
Note: The time period may not be longer than six (6) years, and may not include dates before April 14, 2003.

I would like the record of disclosures in the following form:

☐ On paper, to the following address:

Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

☐ Electronically, sent through a secure e-mail to: _____

Member Signature: _____

If Authorized Representative, please complete the section below and provide documentation:

Print Name: _____ Relationship to Member: _____

[date]

VIA ELECTRONIC MAIL

[name]
[address]
[city], CA [zip]

Re: Request for Accounting of Disclosures

Dear Mr./Ms. [insert last name]:

We received your request for an accounting of disclosures of your Protected Health Information (PHI) form on [date]. Your form indicates that you requested an accounting of disclosures for [date range]. [Our records show the following PHI disclosures have been made:] Our records show that your PHI was not disclosed for purposes other than the ones listed below, which describes the information that health care organizations are not required to release under the Health Insurance Portability and Accountability Act (HIPAA) regulation.

CalOptima is not required to provide you with an accounting of the following types of disclosures:

1. Disclosures for purposes of Treatment, Payment and Health Care Operations.
2. Disclosures to me or authorized by me to another person(s).
3. Disclosures to persons involved in my care.
4. Disclosures to State or Federal health oversight agency.
5. Disclosures made prior to April 14, 2003.

A copy of your Request for an Accounting of Disclosures Form is enclosed.

Please feel free to contact me at (714) 246-[XXXX], if you have any questions regarding the information contained in this letter.

Sincerely,

Compliance Analyst
Office of Compliance

Encl.: Accounting of Disclosures Form

Policy #:	MA.9210
Title:	**Tracking and Reporting Disclosures of Protected Health Information**
Department:	Office of Compliance
Section:	Health Insurance Portability and Accountability Act (HIPAA)
CEO Approval:	Michael Schrader
Effective Date:	4/1/03
Last Review Date:	9/1/15
Last Revised Date	9/1/15

This policy shall apply to the following CalOptima lines of business (LOB):

- OneCare
- OneCare Connect
- PACE

Medi-Cal

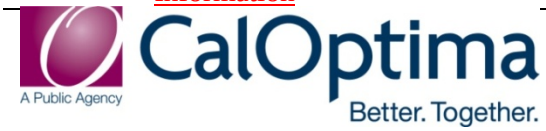
Policy #:	HH.3006
Title:	**Tracking and Reporting Disclosures of Protected Health Information**
Department:	Office of Compliance
Section:	Health Insurance Portability and Accountability Act (HIPAA)
CEO Approval:	Michael Schrader
Effective Date:	4/1/03
Last Review Date:	7/1/16
Last Revised Date:	9/1/15

~~Poli~~ ~~cy #:~~ ~~HH.3006MA.9210~~

~~Tracking and Reporting Disclosures of Protected Health Information (PHI)~~

~~Title:~~ ~~Revised Date:~~ ~~912/01/165~~

Policy #: HH.3006Δ
Title: Tracking and Reporting Disclosures of Protected Health Information Revised Date: 12/01/16



Policy #: HH.3006Δ
Title: **Tracking and Reporting Disclosures of Protected Health Information**

Department: Office of Compliance
Section: ~~Health Insurance Portability and Accountability Act (HIPAA)~~Privacy

CEO Approval: Michael Schrader

Effective Date: 04/01/03
Last Review Date: 12/01/16
Last Revised Date: 12/01/16

Applicable to:
☒ Medi-Cal
☒ OneCare
☒ OneCare Connect
☒ PACE

I. PURPOSE

This policy~~o~~ defines the process by which CalOptima shall track and report Disclosures of a Member's Protected Health Information (PHI).

~~II. DEFINITION~~

~~DEFINITIONS~~

~~Term~~	~~Definition~~

~~Term~~	~~Definition~~
~~Authorized Representative:~~	~~Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.Has the meaning given such term in section 164.502 (g) 45 CFR of titles 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of un-emancipated minors.~~
~~Department of Health Care Services (DHCS)~~	~~The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.The single State Department responsible for administration of the Medi-Cal Program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.~~

~~Poli~~ ~~HH.3006MA.9210~~

~~cy #:~~

~~Tracking and Reporting Disclosures of Protected Health Information (PHI)~~

~~Title:~~ ~~Revised Date:~~ ~~912/01/165~~

Policy #: HH.3006Δ

Title: Tracking and Reporting Disclosures of Protected Health Information Revised Date: 12/01/16

~~Term~~	~~Definition~~
~~Designated Record Set (DRS)):~~	~~Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. A group of records maintained by or for a covered entity that is:~~ ~~The medical records and billing records about individuals maintained by or for a covered health care provider;~~ ~~The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or~~ ~~Used, in whole or in part, by or for the covered entity to make decisions about individuals.~~ ~~The term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity~~A group of records maintained by or for CalOptima that includes enrollment, Payment, claims adjudication, and case or medical management record system(s) used by or maintained for the agency, or used, in whole or in part, by or for CalOptima to make decisions about the Member. The DRS excludes patient-identifiable data used for administrative, regulatory, Health Care Operations and Payment/financial purpose; employment records held by CalOptima in its role as employer.
~~Designee~~	~~A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.~~
~~Disclosure:~~	~~Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.~~Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.

~~Poli cy #:~~ ~~HH.3006~~MA.9210

~~Tracking and Reporting Disclosures of Protected Health Information (PHI)~~

~~Title:~~ ~~Revised Date:~~ ~~912~~/01/~~165~~

Policy #: HH.3006Δ

Title: Tracking and Reporting Disclosures of Protected Health Information Revised Date: 12/01/16

~~Term~~	~~Definition~~
~~Health Care Operations:~~	~~Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.~~Activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities customer services, resolution of internal grievances, business planning, and development activities related to compliance with the privacy rule.
~~Medical Record:~~	~~A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term "Medical Record" is used both for the physical folder for each individual patient and for the body of information which compromises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.~~
~~Member~~	~~A beneficiary who is enrolled in a CalOptima Program.An enrollee beneficiary of a CalOptima program.~~

Term	Definition
Payment:	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: • Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; • Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and, • Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.Activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.

~~Term~~	~~Definition~~
~~Protected Health Information (PHI)):~~	~~Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.~~ ~~Has the meaning given such term in Section~~section ~~160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or~~of ~~medium.~~ ~~This information identifies the individual or there is~~ a ~~reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to:~~ ~~1. The past, present, or future physical or mental health or condition of a Member;~~ ~~2. The provision of health care to a Member; or~~ ~~3. Past, present, or future Payment for the provision of health care to a Member.~~
~~Treatment:~~	~~Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.~~Activities ~~undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's~~Member's ~~health care benefits.~~

~~HH.~~II. POLICY

A. CalOptima shall maintain a tracking process for all oral, written, facsimile, electronic, or other form of Disclosures of PHI that is not related to Treatment, Payment, or Health Care Operations,

to the Member or when the Member authorized Disclosure, or other functions specified in this policy.

B. CalOptima shall maintain a tracking process for all requests for a Member's PHI, other than a request for Medical Records, and shall report this information, as applicable, to the Department of Health Care Services (DHCS) monthly.

C. CalOptima shall maintain a tracking process for the entities, other than those within CalOptima's treatment network, to which CalOptima discloses Member names and addresses, and shall report this information, as applicable, to DHCS annually.

~~IV.~~III. PROCEDURE

A. The following categories of Disclosures are not required to be included on the report when a Member requests an accounting of the Disclosure made of his or her PHI as defined in the Designated Record Set (DRS):

1. Used to carry out activities related to Treatment, Payment, or Health Care Operations;

2. Disclosed to the Member, or Member's Authorized Representative, or authorized by the Member;

3. Incidental Disclosures;

4. Disclosures made prior to April 14, 2003;

5. For national security or intelligence purposes; and

6. Disclosure of PHI directly relevant to an individual's involvement in a Member's care, (e.g., family member, other relative, or a close personal friend of the Member, or any other person identified by the Member).

B. Any other Disclosure shall be recorded and reported to the Privacy Officer, his or her Designee~~, or the Office of Compliance~~. CalOptima shall track routine disclosures which may include, but are not limited to:~~The following list is the most common types of routine Disclosures that shall be tracked:~~

1. Disclosures ~~R~~required by law;

2. For health oversight activities;

3. Required for public health activities;

4. About victims of abuse, neglect, or domestic violence;

5. To coroners or medical examiners;

6. To funeral directors;

7. For organ, eye or tissue donation; and

8. To avert a serious threat to health or safety.

C. Tracking Routine Recurring Disclosures

1. Departments that Disclose PHI on a regular basis to the same agency ~~or entity~~ shall maintain a current log with the following elements included in hard copy or in an electronic spreadsheet:

   a. Date of initial Disclosure;

   b. Name of person or organization receiving the PHI;

   c. Address, if known;

   d. Brief description of information Disclosed; and

   e. Brief statement of purpose and the frequency of Disclosure.

2. Disclosure reports for recurring Disclosures shall be summarized to include the above stated information with the number of times the information was Disclosed and the date of the last Disclosure.

D. Tracking Non-Recurring Disclosures

1. The Office of Compliance shall enter any Disclosure made that is not included in the routine recurring Disclosures reported and entered into the Office of Compliance PHI Tracking Database for tracking and reporting purposes.

2. The following information shall be reported:

   a. Member name and Identification number;

b. Date of the Disclosure;

c. Name of organization or person who received information, and their address, if known;

d. Brief description of information Disclosed;

e. Brief statement of the purpose for the Disclosure;

f. Name of the person making the Disclosure; and

g. Department of the person making the report.

3. The report for non-recurring routine type of Disclosures may be submitted on a Reporting Non-Routine Disclosures of Protected Health Information (PHI) Form or e-mailed with the above information to the Office of Compliance within three (3) business days of making the routine Disclosure.

E. Documentation: The Office of Compliance shall:

1. Enter in the Office of Compliance Tracking Database the Disclosure reports from other departments and those Disclosures reviewed by the Privacy Officer, or his or her Designee.

2. Maintain a log of all requests from Members for accounting of Disclosures, including the following information:

a. Date request received;

b. Name of Member or Member's Authorized Representative requesting the accounting;

c. Member Identification number;

d. Date range requested;

e. Name of staff person handling the request; and

f. Date the report was provided to the Member.

3. Retain the request and a copy of the report given to the Member for six (6) years from the date CalOptima received the request.

F. Tracking and Reporting Requests for PHI other than a ~~Request~~Rrequest for Medical Records

1. The Office of Compliance shall track all requests for a Member's PHI, other than a request for Medical Records or other requests allowed by law.

2. The Regulatory Affairs and Compliance Department shall report this information, as applicable, to DHCS on a monthly basis.~~.~~

G. Tracking and Reporting of Entities Outside of the treatment network to which CalOptima Discloses Member names and addresses

1. Each Department shall track the entities outside the CalOptima treatment network to which CalOptima discloses Member names and addresses, and report this information to the Office of Compliance annually. An entity outside the CalOptima treatment network shall include any person, organization, or agency that CalOptima contracts with for non-medical services.

2. The Regulatory Affairs Department shall report this information ~~annually to DHCS,~~ as applicable.

~~V.~~IV. ATTACHMENTS

A. Reporting Non-Routine Disclosures of Protected Health Information (PHI) Form

~~VI.~~V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal (Exhibit E, Attachment 2 Program Terms and Conditions, Provision 22)
D. CalOptima ~~Contract with the Department of Health Care Services (DHCS) for~~ PACEPACE Program Agreement
~~A.~~E. CalOptima Policy AA.1000: Glossary of Terms
~~B.~~F. CalOptima Policy CMC.1001: Glossary of Terms
~~C.~~G. CalOptima ~~Contract with the Department~~Policy MA.1001: Glossary of ~~Health Care Services (DHCS)~~Terms
~~D.~~H. CalOptima Privacy Program
~~E. CalOptima Compliance Program~~
~~F. CalOptima Privacy Program CalOptima Contract with the Department of Health Care Services (DHCS)~~
I. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect

~~G. Guide to Medical Privacy and HIPAA, Section 400: Medical Records Privacy Requirements, Thompson Publishing Group, 2002~~

~~H.~~J. Title 45, Code of Federal Regulations, ~~Section §~~164.528~~, Accounting of Disclosures of Protected Health Information~~

~~I.~~K. Volume 65, Federal Register, Number 250

~~VII.~~VI. REGULATORY AGENCY APPROVALS

None to Date

~~VIII.~~VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/2003	HH.3006	Tracking Disclosures of PHI	Medi-Cal
Revised	04/01/2007	HH.3006	Tracking Disclosures of PHI	Medi-Cal
Revised	01/01/2008	HH.3006	Tracking Disclosures of PHI	Medi-Cal
Effective	02/02/2008	MA.9210	Tracking and Reporting Disclosures of Protected Health Information (PHI)	OneCare
Revised	01/01/2010	HH.3006	Tracking and Reporting Disclosures of Protected Health Information	Medi-Cal
Revised	01/01/2010	MA.9210	Tracking and Reporting Disclosures of Protected Health Information (PHI)	OneCare
Revised	04/01/2013	HH.3006	Tracking and Reporting Disclosures of Protected Health Information	Medi-Cal
Revised	02/01/2014	MA.9210	Tracking and Reporting Disclosures of Protected Health Information (PHI)	OneCare
Revised	09/01/2014	HH.3006	Tracking and Reporting Disclosures of Protected Health Information	Medi-Cal

~~Poli~~ ~~HH.3006~~MA.9210

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~~y #:~~

~~Tracking and Reporting Disclosures of Protected Health Information (PHI)~~

~~Title:~~ ~~Revised Date:~~ ~~912/01/165~~

Policy #: HH.3006Δ

Title: Tracking and Reporting Disclosures of Protected Health Information Revised Date: 12/01/16

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	09/01/2014	MA.9210	Tracking and Reporting Disclosures of Protected Health Information (PHI)	OneCare
Revised	09/01/2015	HH.3006	Tracking and Reporting Disclosures of Protected Health Information	Medi-Cal
Revised	09/01/2015	MA.9210	Tracking and Reporting Disclosures of Protected Health Information (PHI)	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3006Δ	Tracking and Reporting Disclosures of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9210	Tracking and Reporting Disclosures of Protected Health Information (PHI)	OneCare OneCare Connect PACE

~~**IX.**~~

~~Version~~	~~Version Date~~	~~Policy Number~~	~~Policy Title~~
~~Original Date~~	~~04/2003~~02/02/2008	~~HH.3006~~MA.9210	~~Tracking and Reporting Disclosures of Protected Health Information (PHI)~~
~~Revision Date 1~~	~~04/01/2007~~	~~HH.3006~~	~~Tracking Disclosures of PHI~~
~~Revision Date 2~~	~~01/01/2008~~	~~HH.3006~~	~~Tracking Disclosures of PHI~~
~~Revision Date 3~~1	~~01/01/2010~~	~~HH.3006~~MA.9210	~~Tracking and Reporting Disclosures of Protected Health Information (PHI)~~
~~Revision Date 4~~2	~~04~~02/01/2013~~2014~~	~~HH.3006~~MA.9210	~~Tracking and Reporting Disclosures of Protected Health Information (PHI)~~
~~Revision Date 5~~3	~~09/01/2014~~	~~HH.3006~~MA.9210	~~Tracking and Reporting Disclosures of Protected Health Information (PHI)~~
~~Revision Date 6~~4	~~09/01/2015~~	~~HH.3006~~MA.9210	~~Tracking and Reporting Disclosures of Protected Health Information (PHI)~~

~~Poli cy #:~~ ~~HH.3006~~MA.9210

~~Tracking and Reporting Disclosures of Protected Health Information (PHI)~~

~~Title:~~ ~~Revised Date: 912/01/165~~

Policy #: HH.3006Δ
Title: Tracking and Reporting Disclosures of Protected Health Information Revised Date: 12/01/16

IX. GLOSSARY

Term	Definition
Authorized Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Designated Record Set (DRS)	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. A group of records maintained by or for a covered entity that is: 1. The medical records and billing records about individuals maintained by or for a covered health care provider; 2. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or 3. Used, in whole or in part, by or for the covered entity to make decisions about individuals. The term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal

~~Poli cy #: HH.3006MA.9210~~

~~Title: Tracking and Reporting Disclosures of Protected Health Information (PHI)~~ ~~Revised Date: 912/01/165~~

Policy #: HH.3006Δ
Title: Tracking and Reporting Disclosures of Protected Health Information Revised Date: 12/01/16

Term	Definition
	grievances, business planning, and development and activities related to compliance with the privacy rule.
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term "Medical Record" is used both for the physical folder for each individual patient and for the body of information which compromises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	A beneficiary who is enrolled in a CalOptima Program.
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the

Term	Definition
	provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.

Policy #:	HH.3006Δ
Title:	**Tracking and Reporting Disclosures of Protected Health Information**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/03
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy defines the process by which CalOptima shall track and report Disclosures of a Member's Protected Health Information (PHI).

II. POLICY

A. CalOptima shall maintain a tracking process for all oral, written, facsimile, electronic, or other form of Disclosures of PHI that is not related to Treatment, Payment, or Health Care Operations, to the Member or when the Member authorized Disclosure, or other functions specified in this policy.

B. CalOptima shall maintain a tracking process for all requests for a Member's PHI, other than a request for Medical Records, and shall report this information, as applicable, to the Department of Health Care Services (DHCS) monthly.

C. CalOptima shall maintain a tracking process for the entities, other than those within CalOptima's treatment network, to which CalOptima discloses Member names and addresses, and shall report this information, as applicable, to DHCS annually.

III. PROCEDURE

A. The following categories of Disclosures are not required to be included on the report when a Member requests an accounting of the Disclosure made of his or her PHI as defined in the Designated Record Set (DRS):

1. Used to carry out activities related to Treatment, Payment, or Health Care Operations;

2. Disclosed to the Member, or Member's Authorized Representative, or authorized by the Member;

3. Incidental Disclosures;

4. Disclosures made prior to April 14, 2003;

5. For national security or intelligence purposes; and

6. Disclosure of PHI directly relevant to an individual's involvement in a Member's care, (e.g., family member, other relative, or a close personal friend of the Member, or any other person identified by the Member).

B. Any other Disclosure shall be recorded and reported to the Privacy Officer, his or her Designee. CalOptima shall track routine disclosures which may include, but are not limited to:

1. Disclosures required by law;

2. For health oversight activities;

3. Required for public health activities;

4. About victims of abuse, neglect, or domestic violence;

5. To coroners or medical examiners;

6. To funeral directors;

7. For organ, eye or tissue donation; and

8. To avert a serious threat to health or safety.

C. Tracking Routine Recurring Disclosures

1. Departments that Disclose PHI on a regular basis to the same agency shall maintain a current log with the following elements included in hard copy or in an electronic spreadsheet:

a. Date of initial Disclosure;

b. Name of person or organization receiving the PHI;

c. Address, if known;

d. Brief description of information Disclosed; and

e. Brief statement of purpose and the frequency of Disclosure.

2. Disclosure reports for recurring Disclosures shall be summarized to include the above stated information with the number of times the information was Disclosed and the date of the last Disclosure.

D. Tracking Non-Recurring Disclosures

1. The Office of Compliance shall enter any Disclosure made that is not included in the routine recurring Disclosures reported and entered into the Office of Compliance PHI Tracking Database for tracking and reporting purposes.

2. The following information shall be reported:

    a. Member name and Identification number;

    b. Date of the Disclosure;

    c. Name of organization or person who received information, and their address, if known;

    d. Brief description of information Disclosed;

    e. Brief statement of the purpose for the Disclosure;

    f. Name of the person making the Disclosure; and

    g. Department of the person making the report.

3. The report for non-recurring routine type of Disclosures may be submitted on a Reporting Non-Routine Disclosures of Protected Health Information (PHI) Form or emailed with the above information to the Office of Compliance within three (3) business days of making the routine Disclosure.

E. Documentation: The Office of Compliance shall:

1. Enter in the Office of Compliance Tracking Database the Disclosure reports from other departments and those Disclosures reviewed by the Privacy Officer, or his or her Designee.

2. Maintain a log of all requests from Members for accounting of Disclosures, including the following information:

    a. Date request received;

    b. Name of Member or Member's Authorized Representative requesting the accounting;

    c. Member Identification number;

    d. Date range requested;

    e. Name of staff person handling the request; and

    f. Date the report was provided to the Member.

3. Retain the request and a copy of the report given to the Member for six (6) years from the date CalOptima received the request.

F. Tracking and Reporting Requests for PHI other than a Request for Medical Records

1. The Office of Compliance shall track all requests for a Member's PHI, other than a request for Medical Records or other requests allowed by law.

2. The Regulatory Affairs and Compliance Department shall report this information, as applicable, to DHCS on a monthly basis.

G. Tracking and Reporting of Entities Outside of the treatment network to which CalOptima Discloses Member names and addresses

1. Each Department shall track the entities outside the CalOptima treatment network to which CalOptima discloses Member names and addresses, and report this information to the Office of Compliance annually. An entity outside the CalOptima treatment network shall include any person, organization, or agency that CalOptima contracts with for non-medical services.

2. The Regulatory Affairs Department shall report this information as applicable.

IV. ATTACHMENTS

A. Reporting Non-Routine Disclosures of Protected Health Information (PHI) Form

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal (Exhibit E, Attachment 2 Program Terms and Conditions, Provision 22)
D. CalOptima PACE Program Agreement
E. CalOptima Policy AA.1000: Glossary of Terms
F. CalOptima Policy CMC.1001: Glossary of Terms
G. CalOptima Policy MA.1001: Glossary of Terms
H. CalOptima Privacy Program
I. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
J. Title 45, Code of Federal Regulations, §164.528
K. Volume 65, Federal Register, Number 250

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/2003	HH.3006	Tracking Disclosures of PHI	Medi-Cal
Revised	04/01/2007	HH.3006	Tracking Disclosures of PHI	Medi-Cal
Revised	01/01/2008	HH.3006	Tracking Disclosures of PHI	Medi-Cal
Effective	02/02/2008	MA.9210	Tracking and Reporting Disclosures of Protected Health Information (PHI)	OneCare
Revised	01/01/2010	HH.3006	Tracking and Reporting Disclosures of Protected Health Information	Medi-Cal
Revised	01/01/2010	MA.9210	Tracking and Reporting Disclosures of Protected Health Information (PHI)	OneCare
Revised	04/01/2013	HH.3006	Tracking and Reporting Disclosures of Protected Health Information	Medi-Cal
Revised	02/01/2014	MA.9210	Tracking and Reporting Disclosures of Protected Health Information (PHI)	OneCare
Revised	09/01/2014	HH.3006	Tracking and Reporting Disclosures of Protected Health Information	Medi-Cal
Revised	09/01/2014	MA.9210	Tracking and Reporting Disclosures of Protected Health Information (PHI)	OneCare
Revised	09/01/2015	HH.3006	Tracking and Reporting Disclosures of Protected Health Information	Medi-Cal
Revised	09/01/2015	MA.9210	Tracking and Reporting Disclosures of Protected Health Information (PHI)	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3006Δ	Tracking and Reporting Disclosures of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9210	Tracking and Reporting Disclosures of Protected Health Information (PHI)	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Authorized Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Designated Record Set (DRS)	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. A group of records maintained by or for a covered entity that is: 1. The medical records and billing records about individuals maintained by or for a covered health care provider; 2. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or 3. Used, in whole or in part, by or for the covered entity to make decisions about individuals. The term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term "Medical Record" is used both for the physical folder for each individual patient and for the body of information which compromises the total of each patient's health history. Medical records

Term	Definition
	are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	A beneficiary who is enrolled in a CalOptima Program.
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.

1

Reporting Non-Routine Disclosures of PHI

Date of Report: _____

Name of person filing report: _____

Date of Disclosure: _____

Name of organization/person that received the PHI: _____

Brief description of content of Disclosure: _____

_____

_____

_____

_____

Purpose of Disclosure: _____

_____

_____

Name of person who Disclosed information: _____

Note: the above information may be submitted via an e-mail as long as all data is included in the body of the e-mail.

FOR USE BY OFFICE OF COMPLIANCE

Date entered in FACETS™: _____

Staff name that entered data: _____

Policy #:	HH.3007Δ
Title:	**Member Rights to Request Restrictions on Use and Disclosure of Protected Health Information**
Department:	Office of Compliance
Section:	~~Health Insurance Portability and Accountability Act (HIPAA)~~Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/03
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy~~o~~ describes the process by which a Member may request CalOptima to restrict the Use and Disclosure of his or her Protected Health Information (PHI), and how CalOptima shall process such requests in accordance with applicable statutory, regulatory, and contractual requirements.

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~
~~Authorized Representative~~	~~Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.Has the meaning given such term in section 164.502(g) 45 CFR of title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.~~

Term	Definition
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: — On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or — Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: — A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. — A person that offers a personal health record to one or more individuals on behalf of a covered entity. — A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of a covered entity or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs or assists in the performance of: a. A function or activity involving the use of disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing benefit management, practice management, and repricing; or b. Any other function or activity regulated by this subchapter; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the services involves the disclosure of individually identifiable health

~~Term~~	~~Definition~~
~~Disclosure~~	~~Has the meaning in in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information. Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.~~
~~Emergency Services~~	~~Covered Services furnished by Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.~~
~~Health Care Operations~~	~~Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.~~
~~Member~~	~~An enrollee beneficiary of a CalOptima program.A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.~~
~~Payment~~	~~Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including:~~ ~~- Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities;~~ ~~- Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and,~~ ~~- Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.~~

~~Term~~	~~Definition~~
~~Protected Health Information~~	~~Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.~~ ~~This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to:~~ ~~— The past, present, or future physical or mental health or condition of a Member;~~ ~~— The provision of health care to a Member; or~~ ~~— Past, present, or future Payment for the provision of health care to a Member. All individually identifiable health information that is transmitted electronically, maintained in any electric medium, or transmitted or maintained in other form of medium.~~ ~~—~~ ~~— This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to:~~ ~~—~~ ~~1. The past, present, or future physical or mental health or condition of a Member;~~ ~~—~~ ~~2. The provision of health care to a Member; or~~ ~~—~~ ~~3. Past, present, or future Payment for the provision of health care to a Member.~~
~~Provider~~	~~A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Physician Group, or other person or institution who furnishes Covered Services.~~
~~Required by Law~~	~~Has the meaning in 45 Code of Federal Regulations (CFR) Section 164.103 which specifies a mandate contained in law that compels an entity to make a Use or Disclosure of PHI and that is enforceable in a court of law and which are permissible grounds for a covered entity to Use of Disclose PHI under 45 CFR Section 164.512(a) when relevant requirements are met. Mandated in law and compelling a covered entity (provider, health plan, or clearinghouse) to make a use or disclosure of Protected Health Information (Pill) and that is enforceable in a court of competent jurisdiction.~~
~~Use of PHI~~	~~Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. The sharing, employment application, utilization, examination, or analysis of PHI within an entity that maintains such information.~~

~~HH.~~II. POLICY

A. ~~CalOptima must permit a Member to request restrictions of Uses and Disclosures of PHI for Treatment, Payment and Health Care Operations and disclosures permitted under Title 45, Code of Federal Regulations, Section 164.510(b).~~ CalOptima must permit a Member to request restrictions of Uses and Disclosures of PHI for Treatment, Payment and Health Care Operations and disclosures permitted under Title 45, Code of Federal Regulations, Section 164.51-(b). ~~may use or disclose PHI, provided that the Member is informed in advance of the Use or Disclosure and has the opportunity to agree to or prohibit or restrict the Use or Disclosure.~~ A Member may request CalOptima, in writing or orally, to restrict the Use and/or Disclosure of his or her PHI.

1. CalOptima retains the right to approve or deny such request.

B. CalOptima ~~must~~ may agree to the Member's request to restrict Disclosure of PHI about the Member if:

~~The Disclosure is for the purpose of carrying out Payment or Health Care Operations and is not otherwise required by law; and~~

~~B.~~1. The PHI pertains solely to a health care item or service for which the Member, or person other than the health plan on behalf of the Member, has paid the covered entity in full. If the law requires the disclosure, CalOptima does not have to agree to the Member's restriction.

C. If CalOptima approves a Member's request to restrict the Use and Disclosure of the Member's PHI, CalOptima shall not be subject to such restrictions if:

1. Disclosure is required by Law;

2. The restricted PHI is needed:

   a. By a treating Provider;

   b. For public health activities;

   c. To report abuse, neglect, domestic violence, and activities related to criminal acts; or

   d. By a coroner.

3. The Member requires Emergency Services; or

4. The Disclosure is among those defined in Title 45, Code of Federal Regulations, Sections 164.512 and 164.522.

D. CalOptima shall not Use and Disclose PHI covered by an agreed upon restriction in violation of that restriction. ~~-~~CalOptima cannot take back what was used or disclosed prior to approving the

restriction request, but will limit the ~~u~~Use or D~~d~~isclosure in accordance with an agreed upon restriction in the future.

~~4.~~

~~IV.~~III. PROCEDURE

A. Requests for restrictions on Use and Disclosure:

1. The Member or a Member's Authorized Representative shall submit a written request to restrict either the Use and/or Disclosure of the Member's PHI to the CalOptima Office of Compliance. The request must include:

   a. Request to Restrict Information on Use and Disclosure of Protected Health Information form;

   b. The PHI that is to be restricted;

   c. Whether the Member wants to restrict the Use, Disclosure, or both; and

   d. To whom the limitations apply (e.g., Disclosures to a spouse);

2. CalOptima shall discuss the request with a Member or a Member's Authorized Representative to ensure that such restrictions are in the Member's best interest.

3. CalOptima will remind the Member that CalOptima:

   a. Retains the right to approve or deny such request;

   b. May release the restricted PHI in emergency situations;

   c. May release the restricted PHI if Required by Law; and

   d. May terminate the agreement to restrict PHI.

4. CalOptima shall review a Member's request to restrict Use and Disclosure of PHI in coordination with Business Associates, as appropriate.

5. CalOptima will document the restriction, if any.

6. CalOptima shall notify the Member of the decision to approve or deny the Member's request within thirty (30) calendar days of receipt of the request, using the Response to Request for Restriction on Use and Disclosure of PHI form.

B. Terminating a Restriction

1. CalOptima may terminate its agreement to a restriction of Use and Disclosure under the following circumstances:

a. The Member agrees to, or requests, the termination in writing to CalOptima.

b. The Member agrees verbally to the termination, and the verbal agreement is documented by CalOptima; or

c. CalOptima notifies the Member that it shall terminate its agreement to the restriction(s), except that such termination is only effective with respect to PHI created or received after the individual has been notified of the termination, except as provided in Section III.B.I of this policy.

C. The Office of Compliance shall retain copies of all requests and related notices on file for ten (10) years from the date the request is received by CalOptima or the date when the restriction was last in effect, whichever is later.

~~V.~~IV. ATTACHMENTS

A. Request for Restriction on Use and Disclosure of Protected Health Information
B. Response to Request for Restriction on Use and Disclosure of Protected Health Information
C. Termination of Restriction

~~VI.~~V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima ~~Contract with the Department of Health Care Services (DHCS) for PACE~~PACE Program Agreement
~~A. CalOptima Policy AA.1000: Glossary of Terms~~
~~B. CalOptima Policy CMC.1001: Glossary of Terms~~
~~C.~~E. CalOptima Policy HH.3000Δ: Notice of Privacy Practices
~~D.~~F. CalOptima Policy IS.1001: Glossary of Terms
~~E.~~G. CalOptima Privacy Program
H. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~F.~~I. HIPAA Patient Privacy Compliance Guide, Atlantic Information Services, Inc., Section 400-Medical Records Privacy Requirements
~~G.~~J. Privacy & Security Policies and Procedures: A Resource Document, WEDI, 2002
~~H.~~K. NCQA Standard ~~RR5~~ MED5 Privacy and Confidentiality: Element A: Adopting Written Policies, Factor 3 – 2017~~4~~
~~I.~~L. Title 45, Code of Federal Regulations, ~~Section~~ §164.512 ~~Uses and Disclosures for which an Authorization or Opportunity to Agree or Object is not Required~~
~~J.~~M. Title 45, Code of Federal Regulations, ~~Section~~ §164.522 ~~Rights to Request Privacy Protection for Protected Health Information~~

~~VII.~~VI. REGULATORY AGENCY APPROVALS

None to Date

VIII.VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3007	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal
Effective	06/01/2005	MA.9206	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	OneCare
Revised	07/01/2007	HH.3007	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2009	MA.9206	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	OneCare
Revised	07/01/2011	HH.3007	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal
Revised	07/01/2011	MA.9206	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	OneCare
Revised	01/01/2013	HH.3007Δ	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal OneCare
Revised	01/01/2014	HH.3007	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal
Revised	05/01/2014	MA.9206	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	OneCare
Revised	11/01/2014	HH.3007	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	11/01/2014	MA.9206	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	OneCare
Revised	09/01/2015	HH.3007	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal
Revised	09/01/2015	MA.9206	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3007Δ	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9206	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	OneCare OneCare Connect PACE

~~IX.~~

~~Version~~	~~Version Date~~	~~Policy Number~~	~~Policy Title~~
~~Original Date~~Effective	~~04/01/2003~~	~~HH.3007~~	~~Member Right to Request Restrictions on Use and Disclosure of Protected Health Information~~
~~Revision Date 1~~Revised	~~07/01/2007~~	~~HH.3007~~	~~Member Right to Request Restrictions on Use and Disclosure of Protected Health Information~~
~~Revised~~Revision Date 2	~~07/01/2011~~	~~HH.3007~~	~~Member Right to Request Restrictions on Use and Disclosure of Protected Health Information~~
~~Revised~~Revision Date 3	~~01/01/2013~~	~~HH.3007~~	~~Member Right to Request Restrictions on Use and Disclosure of Protected Health Information~~
~~Revised~~Revision Date 4	~~01/01/2014~~	~~HH.3007~~	~~Member Right to Request Restrictions on Use and Disclosure of Protected Health Information~~
~~Revised~~Revision Date 5	~~11/01/2014~~	~~HH.3007~~	~~Member Right to Request Restrictions on Use and Disclosure of Protected Health Information~~
~~Revised~~Revision Date 6	~~09/01/2015~~	~~HH.3007~~	~~Member Right to Request Restrictions on Use and Disclosure of Protected Health Information~~

IX. GLOSSARY

Term	Definition
Authorized Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.

Term	Definition
Disclosure	Has the meaning in in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Emergency Services	Covered Services furnished by Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Member	An enrollee-beneficiary of a CalOptima program.
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and, Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Protected Health Information	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Physician Group, or other person or institution who furnishes Covered Services.

Term	Definition
Required by Law	Has the meaning in 45 Code of Federal Regulations (CFR) Section 164.103 which specifies a mandate contained in law that compels an entity to make a Use or Disclosure of PHI and that is enforceable in a court of law and which are permissible grounds for a covered entity to Use of Disclose PHI under 45 CFR Section 164.512(a) when relevant requirements are met.
Use	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

1

Policy #:	HH.3007Δ
Title:	**Member Rights to Request Restrictions on Use and Disclosure of Protected Health Information**
Department:	Office of Compliance
Section:	Privacy

CEO Approval: Michael Schrader _____

Effective Date:	04/01/03
Last Review Date:	12/01/16
Last Revised Date:	12/01/16

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE

I. PURPOSE

This policy describes the process by which a Member may request CalOptima to restrict the Use and Disclosure of his or her Protected Health Information (PHI), and how CalOptima shall process such requests in accordance with applicable statutory, regulatory, and contractual requirements.

II. POLICY

A. CalOptima must permit a Member to request restrictions of Uses and Disclosures of PHI for Treatment, Payment and Health Care Operations and disclosures permitted under Title 45, Code of Federal Regulations, Section 164.51-(b). A Member may request CalOptima, in writing or orally, to restrict the Use and/or Disclosure of his or her PHI.

1. CalOptima retains the right to approve or deny such request.

B. CalOptima may agree to the Member's request to restrict Disclosure of PHI about the Member if:

1. The PHI pertains solely to a health care item or service for which the Member, or person other than the health plan on behalf of the Member, has paid the covered entity in full. If the law requires the disclosure, CalOptima does not have to agree to the Member's restriction.

C. If CalOptima approves a Member's request to restrict the Use and Disclosure of the Member's PHI, CalOptima shall not be subject to such restrictions if:

1. Disclosure is required by Law;

2. The restricted PHI is needed:

a. By a treating Provider;

b. For public health activities;

c. To report abuse, neglect, domestic violence, and activities related to criminal acts; or

d. By a coroner.

3. The Member requires Emergency Services; or

4. The Disclosure is among those defined in Title 45, Code of Federal Regulations, Sections 164.512 and 164.522.

D. CalOptima shall not Use and Disclose PHI covered by an agreed upon restriction in violation of that restriction. CalOptima cannot take back what was used or disclosed prior to approving the restriction request, but will limit the Use or Disclosure in accordance with an agreed upon restriction in the future.

III. PROCEDURE

A. Requests for restrictions on Use and Disclosure:

1. The Member or a Member's Authorized Representative shall submit a written request to restrict either the Use and/or Disclosure of the Member's PHI to the CalOptima Office of Compliance. The request must include:

a. Request to Restrict Information on Use and Disclosure of Protected Health Information form;

b. The PHI that is to be restricted;

c. Whether the Member wants to restrict the Use, Disclosure, or both; and

d. To whom the limitations apply (e.g., Disclosures to a spouse);

2. CalOptima shall discuss the request with a Member or a Member's Authorized Representative to ensure that such restrictions are in the Member's best interest.

3. CalOptima will remind the Member that CalOptima:

a. Retains the right to approve or deny such request;

b. May release the restricted PHI in emergency situations;

c. May release the restricted PHI if Required by Law; and

d. May terminate the agreement to restrict PHI.

4. CalOptima shall review a Member's request to restrict Use and Disclosure of PHI in coordination with Business Associates, as appropriate.

5. CalOptima will document the restriction, if any.

6. CalOptima shall notify the Member of the decision to approve or deny the Member's request within thirty (30) calendar days of receipt of the request, using the Response to Request for Restriction on Use and Disclosure of PHI form.

B. Terminating a Restriction

1. CalOptima may terminate its agreement to a restriction of Use and Disclosure under the following circumstances:

   a. The Member agrees to, or requests, the termination in writing to CalOptima.

   b. The Member agrees verbally to the termination, and the verbal agreement is documented by CalOptima; or

   c. CalOptima notifies the Member that it shall terminate its agreement to the restriction(s), except that such termination is only effective with respect to PHI created or received after the individual has been notified of the termination, except as provided in Section III.B.I of this policy.

C. The Office of Compliance shall retain copies of all requests and related notices on file for ten (10) years from the date the request is received by CalOptima or the date when the restriction was last in effect, whichever is later.

IV. ATTACHMENTS

A. Request for Restriction on Use and Disclosure of Protected Health Information
B. Response to Request for Restriction on Use and Disclosure of Protected Health Information
C. Termination of Restriction

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy HH.3000Δ: Notice of Privacy Practices
F. CalOptima Policy IS.1001: Glossary of Terms
G. CalOptima Privacy Program
H. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
I. HIPAA Patient Privacy Compliance Guide, Atlantic Information Services, Inc., Section 400-Medical Records Privacy Requirements
J. Privacy & Security Policies and Procedures: A Resource Document, WEDI, 2002
K. NCQA Standard MED5 Privacy and Confidentiality: Element A: Adopting Written Policies, Factor 3 – 2017
L. Title 45, Code of Federal Regulations, §164.512
M. Title 45, Code of Federal Regulations, §164.522

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3007	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal
Effective	06/01/2005	MA.9206	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	OneCare
Revised	07/01/2007	HH.3007	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2009	MA.9206	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	OneCare
Revised	07/01/2011	HH.3007	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal
Revised	07/01/2011	MA.9206	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	OneCare
Revised	01/01/2013	HH.3007Δ	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal OneCare
Revised	01/01/2014	HH.3007	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal
Revised	05/01/2014	MA.9206	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	OneCare

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	11/01/2014	HH.3007	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal
Revised	11/01/2014	MA.9206	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	OneCare
Revised	09/01/2015	HH.3007	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal
Revised	09/01/2015	MA.9206	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3007Δ	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9206	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Authorized Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.

Term	Definition
Disclosure	Has the meaning in in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Emergency Services	Covered Services furnished by Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Member	An enrollee-beneficiary of a CalOptima program.
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and, Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Protected Health Information	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Physician Group, or other person or institution who furnishes Covered Services.

Term	Definition
Required by Law	Has the meaning in 45 Code of Federal Regulations (CFR) Section 164.103 which specifies a mandate contained in law that compels an entity to make a Use or Disclosure of PHI and that is enforceable in a court of law and which are permissible grounds for a covered entity to Use of Disclose PHI under 45 CFR Section 164.512(a) when relevant requirements are met.
Use	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

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Request for Restriction on Use and Disclosure of Protected Health Information (PHI)

Date of Request: _____

Member Name: _____ Date of Birth: _____

Member CIN: _____ Telephone Number: _____

I understand that CalOptima may use or disclose (release) my Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. CalOptima may also release information to someone involved in my care or the payment for my care, such as a family member or friend.

I understand that CalOptima does not have to agree to my request.

I request a restriction on CalOptima's Use and Disclosure of Protected Health Information (PHI).
The information I want limited is:

_____

_____

_____

_____

I want to limit CalOptima's:

☐ Use of this Information
☐ Disclosure of this information
☐ Both the use and disclosure of this information

I want the limits to apply to the following person/entity (For example: spouse): _____

REQUIRED USES AND DISCLOSURES:

Even if CalOptima agrees to the restriction, the information may still be shared under the following circumstances:

- During medical emergency if the restricted information is needed to provide emergency treatment. However, if the information is disclosed during an emergency, CalOptima will tell the recipient not to use or disclose it for any other purpose.
- For health agency oversight activities
- For uses or disclosures otherwise required by law
- If a restriction is agreed to, the termination in writing
- I orally agree to the termination and the oral agreement is documented
- CalOptima informs me that it is terminating the agreement. In this case, the termination is only effective for PHI created or received by CalOptima after I am notified of the termination.

Continue on page 2.

YOUR RIGHTS:

For more information about your privacy rights, please refer to your copy of the CalOptima Notice of Privacy Practices. A copy can be found on our website: www.caloptima.org, or from CalOptima's Customer Service Department by calling **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday from 8 a.m. to 5:30 p.m. Members with hearing or speech impairments can call our TDD line at 1-714-246-8523. We have staff who can speak your language.

If you believe your privacy rights have been violated, you may file a complaint with CalOptima or with the secretary of the Department of Health and Human Services. To file a complaint with CalOptima, contact CalOptima Customer Service Department at 1-714-246-8500 or write to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

CalOptima cannot take away your health care benefits or do anything to hurt you in any way if you choose to file a complaint or use any of the privacy rights in this Notice.

SIGNATURE:

Member Signature: _____

If Authorized Representative (please include legal documentation):

Print Name: _____ Relationship to Member: _____

[DATE]

[NAME]
[ADDRESS]
[CITY], [STATE] [ZIP]

Re: Response to Request for Restriction on Use and Disclosure of Protected Health Information (PHI)

Dear [NAME]:

CalOptima has received your Request for Restriction on Use and Disclosure of Protected Health Information (PHI) dated [DATE].

☐ CalOptima agrees to the restriction you requested
☐ CalOptima does not agree to the restriction you requested
☐ Other: _____

Even if CalOptima agrees to the restriction, the information may still be shared under the following circumstances:

- During medical emergency if the restricted information is needed to provide emergency treatment. However, if the information is disclosed during an emergency CalOptima will tell the recipient not to use or disclose it for any other purpose.
- For health agency oversight activities
- For uses or disclosures otherwise required by law
- If a restriction is agreed to, the termination in writing
- I orally agree to the termination and the oral agreement is documented
- CalOptima informs me that it is terminating the agreement. In this case, the termination is only effective for PHI created or received by CalOptima after I am notified of the termination.

For more information about your privacy rights, please refer to your copy of the CalOptima Notice of Privacy Practices. It is also available on our website: www.caloptima.org, or from the Customer Service Department at CalOptima by calling **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday from 8 a.m. to 5:30 p.m. Members with hearing or speech impairments can call our TDD line at **1-714-246-8523**. We have staff who speak your language.

If you believe your privacy rights have been violated, you may file a complaint with CalOptima or with the secretary of the Department of Health and Human Services. To file a complaint with CalOptima, contact CalOptima Customer Service Department at 1-714-246-8500 or write to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

CalOptima cannot take away your health care benefits or do anything to hurt you in any way if you choose to file a complaint or use any of the privacy rights in this Notice.

Sincerely,

Privacy Officer
CalOptima Office of Compliance

Termination of Restriction Form

Date: _____ Date of Birth: _____

Member Name: _____ Member CIN: _____

The member named above requested a restriction on the Use and Disclosure of Protected Health Information (PHI) dated [DATE].

☐ The member requests the restriction to be terminated

Member Signature: _____

If Authorized Representative (please include legal documentation):

Print Name: _____ Relationship to Member: _____

☐ The member agrees to the termination of the restriction.

Member Signature: _____

If Authorized Representative (please include legal documentation):

Print Name: _____ Relationship to Member: _____

☐ The member agreed orally to the termination.

Signature of CalOptima Representative who received the oral agreement:

_____

☐ CalOptima is informing you that the agreement is terminated. The termination is effective only with respect to Protected Health Information (PHI) created or received by us after you received this notification.

For more information about your privacy rights, please refer to your copy of the CalOptima Notice of Privacy Practices. A copy can be found on our website: www.caloptima.org, or from CalOptima's Customer Service Department by calling **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday from 8 a.m. to 5:30 p.m. Members with hearing or speech impairments can call our TDD line at **1-714-246-8523**. We have staff who can speak your language.

If you believe your privacy rights have been violated, you may file a complaint with CalOptima or with the secretary of the Department of Health and Human Services. To file a complaint with CalOptima, contact CalOptima Customer Service Department at 1-714-246-8500. To file a complaint with CalOptima, contact CalOptima Customer Service Department at 1-714-246-8500 or write to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

CalOptima cannot take away your health care benefits, or do anything to hurt you in any way if you choose to file a complaint or use any of the privacy rights in this Notice.

Sincerely,

Privacy Officer
CalOptima

Policy #:	HH.3008Δ
Title:	**Member Right to Request Confidential Communications**
Department:	Office of Compliance
Section:	~~Health Insurance Portability and Accountability Act (HIPAA)~~Privacy
CEO Approval:	Michael Schrader
Effective Date:	04/01/03
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This~~e~~ policy describes the process by which a Member may request to receive Confidential Communications from CalOptima regarding Protected Health Information (PHI).

~~II. DEFINITIONS~~

~~III.~~II. POLICY

A. CalOptima shall permit ~~m~~Members to request and shall ~~-~~accommodate a reasonable written request to receive communications of PHI by alternative means or at alternative locations when there is a risk of personal danger to the Member~~,~~ if PHI is communicated by telephone or mail to the Member's home, by CalOptima.

~~IV.~~III. PROCEDURE

A. A Member shall complete and submit a Request for Restriction on Manner/Method of Confidential Communications Form ~~to~~ in person to CalOptima's Customer Service Department ~~in person~~ or by mail to:

Attention: ~~Customer Service Department~~Office of Compliance
CalOptima
505 City Parkway West
Orange, CA 92868

B. CalOptima's Customer Service Department may assist the Member, or the Member's Authorized Representative, in completing the Request for Restriction on Manner/Method of Confidential Communications Form.

C. CalOptima shall only grant a request for Confidential Communications in cases in which the Member:

a.1. Clearly states that the disclosure of all or part of that information could endanger the Member by receiving CalOptima information at home; and

b.2. Provides an alternate address or method of contact for communications.

D. The Privacy Officer, or his or her Designee, shall review all written requests for Confidential Communications and shall be responsible for coordinating the review, logistics of implementing the request, and the response to the Member.

E. The Privacy Officer, or his or her Designee, shall coordinate requests from Members who are enrolled in a Health Network with the Health Network, or other Business Associates, as appropriate.

F. The Privacy Officer, or his or her Designee, shall notify the Member of the decision regarding the request for Confidential communications within thirty (30) calendar days of the receipt of the request.

G. If the Privacy Officer, or his or her Designee, -approves the request, he or she shall notify the following departments of the Member's Confidential Cecommunications status:

Department	**Potential Communication Materials Subject to Confidential Treatment**
Customer Service	Newsletters, notices regarding preventive health visits, enrollment, Health Network options, or other mass or individual Member mailings, including surveys.
Grievance and Appeals Resolutions	Communication regarding follow-ups or investigation of a Member, Health Network, or Provider complaints.
Care Coordination, Multipurpose Senior Services Program (MSSP), Long Term Care (LTC)	Any care management, disease interventions, notices of actions, or other communications involving contact with the Member.
Pharmacy	Any notice of actions (NOAs), clinical pharmacy issues, or other direct contact with the Member.

H. If the Privacy Officer, or his or her Designee, approves the request, he or she shall notify the Information Services (IS) Department, whereby IS shall flag the Member's record on FACETS™ to indicate a Confidential Communication status.

V.IV. ATTACHMENTS

A. Request for Restriction on Manner/Method of Confidential Communications Form

VI.V. REFERENCES

A. California Patient Privacy Manual, California Health Care Association, Chapter 3: Patient Rights, 2002
B. CalOptima Compliance Plan

C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima ~~Contract with the Department of Health Care Services (DHCS) for PACE~~PACE Program Agreement
~~B. CalOptima Policy AA.1000: Glossary of Terms~~
~~C. CalOptima Policy CMC.1001: Glossary of Terms~~
~~D.~~F. CalOptima Policy HH.3000Δ: Notice of Privacy Practices
~~E.~~G. CalOptima Privacy Program
H. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~F.~~I. Title 45, Code of Federal Regulations (C.F.R), ~~Sections~~ §§164.502(h) and 164.522(b)(1)(2)~~California Patient Privacy Manual, California Health Care Association, Chapter 3: Patient Rights, 2002~~
~~G.~~J. WEDI – SNIP Security and Privacy Workgroup Privacy Policies and Procedures, Individual Rights-Request Confidential Communications, 2002

~~VII.~~VI. REGULATORY AGENCY APPROVALS

A. 07/02/13: Department of Health Care Services (DHCS)
B. 03/19/12: Department of Health Care Services (DHCS)

~~VIII.~~VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3008	Member Right to Request Confidential Communications	Medi-Cal
Effective	06/01/2005	MA.9211	Member Right to Request Confidential Communications	OneCare
Revised	04/01/2007	HH.3008	Member Right to Request Confidential Communications	Medi-Cal
Revised	04/01/2007	MA.9211	Member Right to Request Confidential Communications	OneCare
Revised	02/01/2008	HH.3008	Member Right to Request Confidential Communications	Medi-Cal
Revised	02/01/2012	HH.3008	Member Right to Request Confidential Communications	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	02/01/2012	MA.9211	Member Right to Request Confidential Communications	OneCare
Revised	02/01/2013	HH.3008Δ	Member Right to Request Confidential Communications	Medi-Cal OneCare
Revised	02/01/2014	MA.9211	Member Right to Request Confidential Communications	OneCare
Revised	06/01/2014	MA.9211	Member Right to Request Confidential Communications	OneCare
Revised	09/01/2014	MA.9211	Member Right to Request Confidential Communications	OneCare
Revised	09/01/2015	HH.3008	Member Right to Request Confidential Communications	Medi-Cal
Revised	09/01/2015	MA.9211	Member Right to Request Confidential Communications	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3008	Member Right to Request Confidential Communications	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9211	Member Right to Request Confidential Communications	OneCare OneCare Connect PACE

~~IX.~~

~~Version~~	~~Version Date~~	~~Policy Number~~	~~Policy Title~~
~~Original Date~~	~~04/01/2003~~	~~HH.3008~~	~~Member Right to Request Confidential Communications~~
~~Revision Date 1~~	~~04/01/2007~~	~~HH.3008~~	~~Member Right to Request Confidential Communications~~
~~Revision Date 2~~	~~02/01/2008~~	~~HH.3008~~	~~Member Right to Request Confidential Communications~~
~~Revision Date 3~~	~~02/01/2012~~	~~HH.3008~~	~~Member Right to Request Confidential Communications~~
~~Revision Date 4~~	~~02/01/2013~~	~~HH.3008 Δ~~	~~Member Right to Request Confidential Communications~~
~~Revision Date 5~~	~~09/01/2015~~	~~HH.3008~~	~~Member Right to Request Confidential Communications~~

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IX. GLOSSARY

Term	Definition
Authorized Representative	Has the meaning given such term in section 164.502(g) 45 CFR of title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.

Term	Definition
Business Associates	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.~~Has the meaning given such term in section 160.103 of title 45, Code of Federal Regulations. A person or entity who:~~ ~~On behalf of a covered entity or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs, or assists in the performance of:~~ ~~A function or activity involving the use of disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or~~ ~~Any other function or activity regulated by this subchapter; or~~

Term	Definition
Confidential Communications	The provision of communications of Protected Health Information (PHI) by alternative means or at alternative locations based upon a Member's reasonable request.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
FACETS	Licensed software product that supports administrative, claims processing and adjudication, membership data, and other information needs of managed care organizations.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Protected Health Information (PHI)	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

1

Policy #:	HH.3008Δ
Title:	**Member Right to Request Confidential Communications**
Department:	Office of Compliance
Section:	Privacy

CEO Approval: Michael Schrader _____

Effective Date:	04/01/03
Last Review Date:	12/01/16
Last Revised Date:	12/01/16

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE

I. PURPOSE

This policy describes the process by which a Member may request to receive Confidential Communications from CalOptima regarding Protected Health Information (PHI).

II. POLICY

A. CalOptima shall permit Members to request and shall accommodate a reasonable written request to receive communications of PHI by alternative means or at alternative locations when there is a risk of personal danger to the Member if PHI is communicated by telephone or mail to the Member's home, by CalOptima.

III. PROCEDURE

A. A Member shall complete and submit a Request for Restriction on Manner/Method of Confidential Communications Form in person to CalOptima's Customer Service Department or by mail to:

Attention: Office of Compliance
CalOptima
505 City Parkway West
Orange, CA 92868

B. CalOptima's Customer Service Department may assist the Member, or the Member's Authorized Representative, in completing the Request for Restriction on Manner/Method of Confidential Communications Form.

C. CalOptima shall only grant a request for Confidential Communications in cases in which the Member:

1. Clearly states that the disclosure of all or part of that information could endanger the Member by receiving CalOptima information at home; and

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D. The Privacy Officer, or his or her Designee, shall review all written requests for Confidential Communications and shall be responsible for coordinating the review, logistics of implementing the request, and the response to the Member.

E. The Privacy Officer, or his or her Designee, shall coordinate requests from Members who are enrolled in a Health Network with the Health Network, or other Business Associates, as appropriate.

F. The Privacy Officer, or his or her Designee, shall notify the Member of the decision regarding the request for Confidential communications within thirty (30) calendar days of the receipt of the request.

G. If the Privacy Officer, or his or her Designee, approves the request, he or she shall notify the following departments of the Member's Confidential Communications status:

Department	**Potential Communication Materials Subject to Confidential Treatment**
Customer Service	Newsletters, notices regarding preventive health visits, enrollment, Health Network options, or other mass or individual Member mailings, including surveys.
Grievance and Appeals Resolutions	Communication regarding follow-ups or investigation of a Member, Health Network, or Provider complaints.
Care Coordination, Multipurpose Senior Services Program (MSSP), Long Term Care (LTC)	Any care management, disease interventions, notices of actions, or other communications involving contact with the Member.
Pharmacy	Any notice of actions (NOAs), clinical pharmacy issues, or other direct contact with the Member.

H. If the Privacy Officer, or his or her Designee, approves the request, he or she shall notify the Information Services (IS) Department, whereby IS shall flag the Member's record on FACETS™ to indicate a Confidential Communication status.

IV. ATTACHMENTS

A. Request for Restriction on Manner/Method of Confidential Communications Form

V. REFERENCES

A. California Patient Privacy Manual, California Health Care Association, Chapter 3: Patient Rights, 2002
B. CalOptima Compliance Plan
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima PACE Program Agreement
F. CalOptima Policy HH.3000Δ: Notice of Privacy Practices
G. CalOptima Privacy Program
H. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect

I. Title 45, Code of Federal Regulations (C.F.R), §§164.502(h) and 164.522(b)(1)(2)WEDI – SNIP Security and Privacy Workgroup Privacy Policies and Procedures, Individual Rights-Request Confidential Communications, 2002

VI. REGULATORY AGENCY APPROVALS

A. 07/02/13: Department of Health Care Services (DHCS)
B. 03/19/12: Department of Health Care Services (DHCS)

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3008	Member Right to Request Confidential Communications	Medi-Cal
Effective	06/01/2005	MA.9211	Member Right to Request Confidential Communications	OneCare
Revised	04/01/2007	HH.3008	Member Right to Request Confidential Communications	Medi-Cal
Revised	04/01/2007	MA.9211	Member Right to Request Confidential Communications	OneCare
Revised	02/01/2008	HH.3008	Member Right to Request Confidential Communications	Medi-Cal
Revised	02/01/2012	HH.3008	Member Right to Request Confidential Communications	Medi-Cal
Revised	02/01/2012	MA.9211	Member Right to Request Confidential Communications	OneCare
Revised	02/01/2013	HH.3008Δ	Member Right to Request Confidential Communications	Medi-Cal OneCare
Revised	02/01/2014	MA.9211	Member Right to Request Confidential Communications	OneCare
Revised	06/01/2014	MA.9211	Member Right to Request Confidential Communications	OneCare
Revised	09/01/2014	MA.9211	Member Right to Request Confidential Communications	OneCare

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	09/01/2015	HH.3008	Member Right to Request Confidential Communications	Medi-Cal
Revised	09/01/2015	MA.9211	Member Right to Request Confidential Communications	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3008	Member Right to Request Confidential Communications	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9211	Member Right to Request Confidential Communications	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Authorized Representative	Has the meaning given such term in section 164.502(g) 45 CFR of title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Business Associates	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.
Confidential Communications	The provision of communications of Protected Health Information (PHI) by alternative means or at alternative locations based upon a Member's reasonable request.

Term	Definition
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
FACETS	Licensed software product that supports administrative, claims processing and adjudication, membership data, and other information needs of managed care organizations.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Protected Health Information (PHI)	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

1

Request for Restriction on Manner/Method of Confidential Communications Form

Date of Request: _____

Member Name: _____ Date of Birth: _____

Member CIN: _____ Telephone Number: _____

You may request to receive confidential communications of Protected Health Information (PHI) by different ways or to a different address. For instance, you may not want your health records or your member information to go to your home where a family member might see it.

We will agree to these requests when there is a risk of personal harm to you because of Protected Health Information (PHI) sent from CalOptima.

☐ **I request that CalOptima not to send any communications regarding my Protected Health Information (PHI) to the address or telephone number of record on enrollment information due to the danger to myself.**

The other address or method of reaching me is (you must provide an alternate address in order for CalOptima to accommodate your request for Confidential Communication):

Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

YOUR RIGHTS:

For more information about your privacy rights, please refer to your copy of the CalOptima Notice of Privacy Practices. A copy can be found on our website: www.caloptima.org, or from CalOptima's Customer Service Department by calling **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday from 8 a.m. to 5:30 p.m. Members with hearing or speech impairments can call our TDD line at **1-714-246-8523**. We have staff who can speak your language.

If you believe your privacy rights have been violated, you may file a complaint with CalOptima or with the secretary of the Department of Health and Human Services. To file a complaint with CalOptima, contact CalOptima Customer Service Department at 1-714-246-8500 or write to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

CalOptima cannot take away your health care benefits, or do anything to hurt you in any way if you choose to file a complaint or use any of the privacy rights in this Notice.

SIGNATURE:

Member Signature: _____

If Authorized Representative (please include legal documentation):

Print Name: _____ Relationship to Member: _____

Policy #:	HH.3009Δ
Title:	**Access by Member's Authorized Representative**
Department:	Office of Compliance
Section:	~~Health Insurance Portability and Accountability Act (HIPAA)~~Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/03
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy defines the parameters for recognizing a Member's Authorized Representative as having the right to access the Member's Protected Health Information (PHI).

~~II. DEFINITIONS~~

~~Term~~	~~Definitions~~
~~Authorized Representative:~~	~~Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.Has the meaning given such term in section 164.502(g) 45 CFR of Title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of un-emancipated minors.~~
~~Member~~	~~A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the Cal Optima program. a beneficiary who is enrolled in a CalOptima Program.An enrollee beneficiary of a CalOptima program.~~
~~Protected Health Information (PHI)):~~	~~Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or~~

~~Term~~	~~Definitions~~
	~~medium.~~ ~~Has the meaning given such term in Sectionsection 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form orof medium.~~ ~~This information identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal OptimaCalOptima or Business Associates and relates to:~~ ~~1. The past, present, or future physical or mental health or condition of a Member;~~ ~~2. The provision of health care to a Member; or~~ ~~3. Past, present, or future Payment for the provision of health care to a Member.~~
~~Treatment~~	~~Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.Activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.~~

~~III.~~II. POLICY

A. CalOptima shall ~~recognize~~ treat a Member's Authorized Representative as the Member him/herself with respect to the Member's PHI.

~~A.~~B. CalOptima shall adhere to applicable state and federal regulations when identifying Authorized Representatives and disclosing PHI to those individuals.

~~IV.~~III. PROCEDURE

A. CalOptima must recognize an individual as a Member's Authorized Representative (to the extent the PHI is relevant to the personal representation) as follows:

If the Member is:	The Member's Authorized Representative is:
An adult or an emancipated minor	A person with legal authority to make health care decisions on behalf of the Member. Examples: ▪ Health care power of attorney ▪ Court appointed legal guardian
An unemancipated minor	A parent, guardian, or other person acting *in loco parentis* with legal authority to make health care decision on behalf of the minor child. Exceptions: ▪ For special sensitive services, that California law allows minors age twelve (12) or older to give consent for Treatment. ▪ Court has appointed someone other than the parent ▪ Parent agrees to the confidential relationship between the minor and a physician. ▪ Suspected abuse by parent or guardian
A decedent	A person with legal authority to act on behalf of the decedent or the estate, not restricted to health care decisions. Examples: ▪ Executor or Administrator of the estate ▪ Durable power of attorney for health care

B. CalOptima shall treat an Authorized Representatives as the Member and with the same rights as the Member including, without limitation, the Member's rights to access, accounting and amendment of their PHI.

C. CalOptima shall grant a Member's Authorized Representative access to a Member's PHI, in accordance with CalOptima Policy HH.3003Δ: Verification of Identity for Disclosures of Protected Health Information.

~~A.~~D. CalOptima recognizes that a parent, guardian, or other person acting *in loco parentis* has the authority to act on behalf of the Member who is an unemancipated minor with regard to PHI, subject to the limitations set forth in Section IV.~~B~~ E of this policy.

~~B.~~E. If a minor, age twelve (12) years and older, consents on his or her own behalf for the following services, without parental consent, PHI related to these services cannot be released to the parent or the Member's Authorized Representative without specific authorization from the minor Member under California law:

1. Pregnancy test, prenatal care, or birth control;

2. Testing or treatment for sexual disease, including the Human Immunodeficiency Virus (HIV);

3. Mental health treatment or counseling;

4. Rape or sexual assault; and

5. Alcohol or substance abuse treatment.

~~C.~~F. CalOptima may exercise professional judgment~~,~~ and refuse to accept an individual as an Authorized Representative, if CalOptima believes:

1. A Member has been, or may be subjected to, domestic violence, abuse, or neglect; or

2. A Member's life may be endangered by the individual identified as the Authorized Representative.

~~D. Individuals who must be recognized as the Member's Authorized Representative:~~

~~**If the Member is:**~~	~~**The Member's Authorized Representative is:**~~
~~An adult or an emancipated minor~~	~~A person with legal authority to make health care decisions on behalf of the Member.~~ ~~Examples:~~ ~~▪ Health care power of attorney~~ ~~▪ Court appointed legal guardian~~ ~~▪ General power of attorney~~
~~An unemancipated minor~~	~~A parent, guardian, or other person acting *in loco parentis* with legal authority to make health care decision on behalf of the minor child.~~ ~~Exceptions:~~ ~~▪ For special sensitive services, that California law allows minors age twelve (12) or older to give consent for Treatment.~~ ~~▪ Court has appointed someone other than the parent~~ ~~▪ Parent agrees to the confidential relationship between the minor and a physician.~~ ~~▪ Suspected abuse by parent or guardian~~
~~A decedent~~	~~A person with legal authority to act on behalf of the decedent or the estate, not restricted to health care decisions.~~ ~~Examples:~~ ~~▪ Executor or Administrator of the estate~~

If the Member is:	The Member's Authorized Representative is:
	• Durable power of attorney for health care

E. CalOptima shall grant a Member's Authorized Representative access to a Member's PHI, in accordance with CalOptima Policy HH.3003Δ: Verification of Identity for Disclosures of Protected Health Information.

V.IV. ATTACHMENTS

Not Applicable

VI.V. REFERENCES

A. California Family Code, Sections 6920-6929
B. California Patient Privacy Manual, California Health Carecare Association, 2002
C. CalOptima Compliance Plan
D. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
E. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B.F. CalOptima Contract with the Department of Health Care Services (DHCS) for PACEPACE Program Agreement
C. CalOptima Policy AA.1000: Glossary of Terms
D.G. CalOptima Policy HH.3000ΔHH.3000: Notices of Privacy Practices
E.H. CalOptima Policy HH.3003ΔHH.3003: Verification of Identity for Disclosures of Protected Health Information
F.I. CalOptima Privacy Program
J. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Office of Civil Rights, Standards for Privacy of Individually Identifiable Health Information, Personal Representatives, 2002
H.K. Title 45, Code of Federal Regulations (C.F.R), Section §164.502(g), Standard: Authorized Representative

VII.VI. REGULATORY AGENCY APPROVALS

A. 07/02/13: Department of Health Care Services
B. 03/19/12: Department of Managed Health Care

None to Date

VIII.VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/2003	HH.3009	Access by Member's Authorized Representative	Medi-Cal
Effective	06/01/2005	MA.9212	Access by Member's Authorized Representative	OneCare
Revised	04/01/2007	HH.3009	Access by Member's Authorized Representative	Medi-Cal
Revised	04/01/2007	MA.9212	Access by Member's Authorized Representative	OneCare
Revised	02/01/2008	HH.3009	Access by Member's Authorized Representative	Medi-Cal
Revised	02/01/2008	MA.9212	Access by Member's Authorized Representative	OneCare
Revised	02/01/2012	HH.3009	Access by Member's Authorized Representative	Medi-Cal
Revised	02/01/2012	MA.9212	Access by Member's Authorized Representative	OneCare
Revised	02/01/2013	HH.3009Δ	Access by Member's Authorized Representative	Medi-Cal OneCare
Revised	02/01/2014	MA.9212	Access by Member's Authorized Representative	OneCare
Revised	04/01/2014	HH.3009	Access by Member's Authorized Representative	Medi-Cal
Revised	09/01/2014	MA.9212	Access by Member's Authorized Representative	OneCare
Revised	09/01/2015	HH.3009	Access by Member's Authorized Representative	Medi-Cal
Revised	09/01/2015	MA.9212	Access by Member's Authorized Representative	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3009	Access by Member's Authorized Representative	Medi-Cal OneCare OneCare Connect
Retired	12/01/2016	MA.9212	Access by Member's Authorized Representative	OneCare OneCare Connect PACE

~~IX.~~

~~Poli cy #: HH.3009MA. 9212~~

~~Title: Access by Member's Authorized Representative Revised Date: 9120/1/1516~~

Policy #: HH.3009Δ
Title: Access by Member's Authorized Representative Revised Date: 12/01/16

~~Version~~	~~Version Date~~	~~Policy Number~~	~~Policy Title~~
~~Original DateEffective~~	~~04/200306/01/2005~~	~~HH.3009MA.9212~~	~~Access by Member's Authorized Representative~~
~~Revision Date Revised1~~	~~04/01/2007~~	~~HH.3009MA.9212~~	~~Access by Member's Authorized Representative~~
~~RevisedRevision Date 2~~	~~02/01/2008~~	~~HH.3009MA.9212~~	~~Access by Member's Authorized Representative~~
~~RevisedRevision Date 3~~	~~02/01/2012~~	~~HH.3009MA.9212~~	~~Access by Member's Authorized Representative~~
~~RevisedRevision Date 4~~	~~02/01/2013~~	~~HH.3009ΔMA.9212~~	~~Access by Member's Authorized Representative~~
~~RevisedRevision Date 5~~	~~0402/01/2014~~	~~HH.3009MA.9212~~	~~Access by Member's Authorized Representative~~
~~RevisedRevision Date 6~~	~~09/01/2014~~	~~MA.9212~~	~~Access by Member's Authorized Representative~~
~~RevisedRevision Date 67~~	~~09/01/2015~~	~~HH.3009MA.9212~~	~~Access by Member's Authorized Representative~~
~~Revised~~	~~12/01/2016~~	~~HH.3009~~	~~Access by Member's Authorized Representative~~

IX. GLOSSARY

Term	Definition
Authorized Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.
Member	A beneficiary who is enrolled in a CalOptima Program.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.

Policy #:	HH.3009Δ
Title:	**Access by Member's Authorized Representative**
Department:	Office of Compliance
Section:	Privacy

CEO Approval: Michael Schrader _____

Effective Date:	04/01/03
Last Review Date:	12/01/16
Last Revised Date:	12/01/16

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE

I. PURPOSE

This policy defines the parameters for recognizing a Member's Authorized Representative as having the right to access the Member's Protected Health Information (PHI).

II. POLICY

A. CalOptima shall treat a Member's Authorized Representative as the Member him/herself with respect to the Member's PHI.

B. CalOptima shall adhere to applicable state and federal regulations when identifying Authorized Representatives and disclosing PHI to those individuals.

III. PROCEDURE

A. CalOptima must recognize an individual as a Member's Authorized Representative (to the extent the PHI is relevant to the personal representation) as follows:

If the Member is:	The Member's Authorized Representative is:
An adult or an emancipated minor	A person with legal authority to make health care decisions on behalf of the Member. Examples: ▪ Health care power of attorney ▪ Court appointed legal guardian

If the Member is:	The Member's Authorized Representative is:
An unemancipated minor	A parent, guardian, or other person acting *in loco parenti*s with legal authority to make health care decision on behalf of the minor child. Exceptions: ▪ For special sensitive services, that California law allows minors age twelve (12) or older to give consent for Treatment. ▪ Court has appointed someone other than the parent ▪ Parent agrees to the confidential relationship between the minor and a physician. ▪ Suspected abuse by parent or guardian
A decedent	A person with legal authority to act on behalf of the decedent or the estate, not restricted to health care decisions. Examples: ▪ Executor or Administrator of the estate ▪ Durable power of attorney for health care

B. CalOptima shall treat an Authorized Representatives as the Member and with the same rights as the Member including, without limitation, the Member's rights to access, accounting and amendment of their PHI.

C. CalOptima shall grant a Member's Authorized Representative access to a Member's PHI, in accordance with CalOptima Policy HH.3003Δ: Verification of Identity for Disclosures of Protected Health Information.

D. CalOptima recognizes that a parent, guardian, or other person acting *in loco parentis* has the authority to act on behalf of the Member who is an unemancipated minor with regard to PHI, subject to the limitations set forth in Section IV.E of this policy.

E. If a minor, age twelve (12) years and older, consents on his or her own behalf for the following services, without parental consent, PHI related to these services cannot be released to the parent or the Member's Authorized Representative without specific authorization from the minor Member under California law:

1. Pregnancy test, prenatal care, or birth control;

2. Testing or treatment for sexual disease, including the Human Immunodeficiency Virus (HIV);

3. Mental health treatment or counseling;

4. Rape or sexual assault; and

5. Alcohol or substance abuse treatment.

F. CalOptima may exercise professional judgment and refuse to accept an individual as an Authorized Representative, if CalOptima believes:

1. A Member has been, or may be subjected to, domestic violence, abuse, or neglect; or

2. A Member's life may be endangered by the individual identified as the Authorized Representative.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. California Family Code, Sections 6920-6929
B. California Patient Privacy Manual, California Health care Association, 2002
C. CalOptima Compliance Plan
D. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
E. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
F. CalOptima PACE Program Agreement
G. CalOptima Policy HH.3000Δ: Notices of Privacy Practices
H. CalOptima Policy HH.3003Δ: Verification of Identity for Disclosures of Protected Health Information
I. CalOptima Privacy Program
J. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
K. Title 45, Code of Federal Regulations (C.F.R), §164.502(g)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/2003	HH.3009	Access by Member's Authorized Representative	Medi-Cal
Effective	06/01/2005	MA.9212	Access by Member's Authorized Representative	OneCare
Revised	04/01/2007	HH.3009	Access by Member's Authorized Representative	Medi-Cal
Revised	04/01/2007	MA.9212	Access by Member's Authorized Representative	OneCare
Revised	02/01/2008	HH.3009	Access by Member's Authorized Representative	Medi-Cal
Revised	02/01/2008	MA.9212	Access by Member's Authorized Representative	OneCare

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	02/01/2012	HH.3009	Access by Member's Authorized Representative	Medi-Cal
Revised	02/01/2012	MA.9212	Access by Member's Authorized Representative	OneCare
Revised	02/01/2013	HH.3009Δ	Access by Member's Authorized Representative	Medi-Cal OneCare
Revised	02/01/2014	MA.9212	Access by Member's Authorized Representative	OneCare
Revised	04/01/2014	HH.3009	Access by Member's Authorized Representative	Medi-Cal
Revised	09/01/2014	MA.9212	Access by Member's Authorized Representative	OneCare
Revised	09/01/2015	HH.3009	Access by Member's Authorized Representative	Medi-Cal
Revised	09/01/2015	MA.9212	Access by Member's Authorized Representative	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3009	Access by Member's Authorized Representative	Medi-Cal OneCare OneCare Connect
Retired	12/01/2016	MA.9212	Access by Member's Authorized Representative	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Authorized Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.
Member	A beneficiary who is enrolled in a CalOptima Program.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.

~~Medi-Cal~~
~~CalOptima~~
~~A Public Agency~~
~~Better. Together.~~

~~Policy #: HH.3010~~
~~Title: **Protected Health Information Disclosures Required by Law**~~
~~Dept: Office of Compliance~~
~~Section: Health Insurance Portability and Accountability Act (HIPAA)~~
~~CEO Approval: Michael Schrader~~

~~Effective Date: 64/1/0503~~
~~Last Review Date: 9/1/15~~
~~Last Revised Date: 9/1/15~~

~~This policy shall apply to the following CalOptima line of business (LOB):~~
- ~~OneCare~~
- ~~OneCare Connect~~
- ~~PACE~~

CalOptima
A Public Agency
Better. Together.

Policy #: HH.3010Δ
Title: **Protected Health Information Disclosures Required by Law**
Department: Office of Compliance
Section: ~~Health Insurance Portability and Accountability Act (HIPAA)~~Privacy

CEO Approval: Michael Schrader

Effective Date: 04/01/03
Last Review Date: 12/01/16
Last Revised Date: 12/01/16

Applicable to:
☒ Medi-Cal
☒ OneCare
☒ OneCare Connect
☒ PACE

I. PURPOSE

This policy~~o~~ describes the manner in which CalOptima ~~-~~Uses and Discloses Protected Health Information (PHI) as permitted~~-~~ by the Health Insurance Portability and Accountability Act (HIPAA) and ~~-~~as required by law.

~~II. DEFINITION~~

~~Term~~	~~Definition~~
~~Authorized Representative:~~	~~Medicare: Any individual authorized by a Member, or under state law, to act on his or her behalf in obtaining an Organization Determination or in dealing with any level of the Appeal process. An Authorized Representative is subject to the rules described in Title 20 of the Code of Federal Regulations, Part 404, Subpart R, unless otherwise stated in the Medicare Managed Care Manual (Use form CMS-1696 for Claims Adjudication or Claim Appeals process).~~ ~~Medi-Cal Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults~~

	or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.Has the meaning given such term in section 164.502(g) 45 CFR of title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Centers for Medicare & MedicaidDepartment of Health Care Services (DHCS):	The federal agency within the United StatesCalifornia Department of Health and HumanCare Services (DHHS) , the State agency that administers that Federal Medicare program and works in partnership with state governments to administeroversees California's Medicaid programs.program, known as Medi-Cal.
Disclosure:	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Health Insurance Portability and Accountability Act (HIPAA):	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information as subsequently amended.
Member:	An enrollee beneficiary of a CalOptima program.
Minimum Necessary:	The principle that a covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclose, or request for Treatment, Payment, or Health Care Operations.
Protected Health Information (PHI):	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form of medium. This information identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a

	~~Member.~~
~~Use of PHI:~~	~~Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information~~Has the ~~meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. The sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.~~

~~III.~~II. POLICY

A. CalOptima may not Use or Disclose PHI, except, as permitted or required by HIPAA.

B. CalOptima shall disclose PHI:

1. To the Member when requested under, and as required by, the Member's access and accounting rights set forth in 45 CFR Sections 164.524 and 164.528(i); or

2. When required by the Secretary of the Department of Health and Human Services (HHS) to investigate or determine CalOptima's Compliance with HIPAA.

C. CalOptima may U~~u~~se or D~~d~~isclose PHI to the extent that such Use or Disclosure is required by law and the Use or Disclosure is limited to the relevant requirements of such law and complies with HIPAA requirements specifically related to such Uses or Disclosures as provided in 45 CFR Section 164.512(a)(2).

D. CalOptima shall comply with the Welfare and Institutions Code Section 14100.2 and Title 22 CCR Section 51009 in making permitted Uses or Disclosures required by law under 45 CFR Section 164.512(a). Compliance with these laws extends beyond Member PHI and includes all confidential M~~m~~ember information (e.g. the fact that the Member is a Medi-Cal/Medicare recipient). In the event that CalOptima makes a Use or Disclosure required by law, it must first determine that the Use or Disclosure is for the purpose directly connected with the administration of the Medi-Cal/Medicare program.

E. Except for Uses and Disclosures described under Section III.B ~~above~~., Uses and Disclosures of Member PHI sought, demanded or otherwise requested by any non-Member party by any means including through subpoenas, document requests, court orders, informal inquiries, etc. that fall within this policy shall be immediately referred to CalOptima's legal counsel for review and handling.

~~IV.~~III. PROCEDURE

A. HIPAA required Uses and Disclosures

1. Member requests involving the Use or Disclosure of PHI under the Member's HIPAA access and accounting rights shall be governed by CalOptima Policies ~~MA.9203~~HH.3001Δ: Member Access to Designated Record Set and ~~MA.9209~~HH.3005Δ: Member Request for an Accounting of Disclosures.

2. If CalOptima receives a request from Department of Health and Human Services (DHHS) for Member PHI to investigate or determine CalOptima's compliance with HIPAA, such requests

or demands shall be immediately referred to CalOptima's Privacy Officer. CalOptima's Privacy Officer shall notify CalOptima's legal counsel of such requests and seek guidance in order to comply with such requests.

B. Permitted Uses and Disclosures required by Law~~:~~

1. CalOptima shall comply with requirements to maintain the confidentiality of all types of information concerning a Member which information shall not be open for examination except as directly connected with the administration of ~~the~~ CalOptima ~~CalOptima~~Medi-Cal ~~~~programs.

2. Purposes directly connected to the administration of the ~~CalOptima~~Medi-Cal~~CalOptima's~~ program encompasses those administrative activities and responsibilities in which the Centers for Medicare and Medicaid (CMS) and/or the Department of Health Care Services (DHCS) and CalOptima are required to engage in order to ensure effective program operations including, without limitation:

   a. Establishing eligibility and methods of reimbursement;

   b. Determining the amount of medical assistance;

   ~~b.~~c. ~~p~~Providing services;

   ~~c.~~d. ~~Providing services; conducting~~Conducting or assisting in investigations, prosecution or civil or criminal proceedings related to the administration of ~~the CalOptima~~Medi-Cal CalOptima's program; and

   ~~d.~~e. Conducting or assisting a legislative investigation or audit related to the administration of the ~~CalOptima~~Medi-Cal~~CalOptima's~~ program.

3. CalOptima may disclose Member confidential information including PHI and other identifying information, without the Member's Authorization, only if and to the extent that CalOptima first determines that the Disclosure is directly related to the administration of the ~~CalOptima~~Medi-Cal~~CalOptima's~~ programs and is otherwise permitted under Welfare & Institutions Code Section 14100.2 and Title 22 CCR 51009 and meets the following requirements, as applicable to the Use or Disclosure:
   ~~3.~~

   a. In the course of any judicial proceeding, in response to a court order, provided that the PHI disclosed is limited to that specifically authorized~~authorized~~ by the court order.

   b. In the course of any administrative proceeding, in response to an order of an administrative tribunal, provided that the PHI disclosed is limited to that specifically authorized~~authorized~~ by the administrative tribunal order.

   c. In response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal if:

      i. In connection with a state civil action or proceeding and certain administrative proceedings, the party seeking the PHI by civil subpoena duces tecum has complied with the service and notice requirements of California Code of Civil Procedure

Section 1985.3, which requires actual notice to the individual. In such cases, CalOptima shall examine the subpoena for compliance with Section 1987.3; or

ii. In cases where Section 1985.3 is not applicable, CalOptima has received satisfactory assurance as defined by HIPAA from the party seeking the PHI that it has notified the Member that is the subject of the PHI, with enough information about the litigation or proceeding so that the Member can raise an objection to the court or administrative tribunal; and the time for the Member to raise an objection with the court or tribunal has expired, and that there were no objections or all objections were resolved by the court of administrative tribunal, and the PHI requested is consistent with that resolution. In such cases, CalOptima review the written statement and accompanying documentation submitted by the party seeking the PHI to determine compliance with these requirements; or

iii. CalOptima receives satisfactory assurance from the party seeking the PHI that the parties to the dispute or proceeding have agreed to a qualified protective order, within the meaning of 45 CFR 164.512(e), and have presented it to the court or administrative tribunal, **or** the party seeking the PHI provides proof that a qualified protective order, within the meaning of 45 CFR 164.512(e), has been issued by the court or administrative tribunal. In such cases, CalOptima shall review the written statement and accompanying documentation submitted by the party seeking the PHI to determine compliance with these requirements.

d. In compliance with and as limited by the relevant requirements of an administrative request, including an administrative subpoena or summons, a civil or an authorized investigative demand, or similar process authorized under law, provided that:

i. The information sought is relevant and material to a legitimate law enforcement inquiry;

ii. The request is specific, and limited in scope to the extent reasonable for which the information is sought; and

iii. De-identified information could not reasonably be used.

e. In compliance with, and as limited by, the relevant requirements of a court-ordered search warrant or a grand jury subpoena;

f. For other law enforcement purposes such as~~-~~:

i. Limited information for identification and location purposes;

ii. A law enforcement official's request for information related to victims of a crime;

iii. About a person who has died to alert law enforcement of the death if the death is suspected to have resulted from criminal conduct; and

iv. To report crimes in emergencies.

~~iv.~~

v. Disclosures under this Section shall comply with the applicable provisions of 42 CFR Section 164.512(f)(2) and any relevant State laws that are more protective of the individual.

g. Disclosures about victims of abuse, neglect, or domestic violence are addressed in CalOptima Ppolicies GG.1320: Elder or Dependent Adult Abuse Reporting and GG.1706: Child Abuse Report.

h. Other circumstances when specifically required by law provided that such Uses and Disclosures are in compliance with such law and limited to the relevant requirements of such law.

4. State and Federal laws governing Uses and Disclosures required by law including those related to Disclosure of PHI to law enforcement are complex and may implicate multiple laws relevant to the particular circumstances. In responding to any requests, demands, orders or requests under Section IIIV.B.3., CalOptima shall also comply with State and Federal laws governing special protected categories of PHI including mental health and developmental disability information, HIV test results, substance abuse records and psychotherapy notes.

5. CalOptima shall also comply with other State requirements relevant to the release of PHI in the context of civil and criminal State and Federal proceedings or to law enforcement.

6. All Uses and Disclosures of Member PHI and/or other confidential information sought, demanded or otherwise requested by any non-Member party shall be immediately referred to CalOptima's legal counsel for review and handling.

7. All Uses and Disclosures made under this Policy shall be referred to the Privacy Officer and shall be recorded in accordance with CalOptima Policy MA.9210HH.3006Δ: Tracking Disclosures of Protected Health Information.

V.IV. ATTACHMENTS

Not Applicable

VI.V. REFERENCES

A. California Code of Civil Procedure Section 1985.3 & Section 1987.3
B. CalOptima Compliance Plan
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima Contract with the Department of Health Care Services (DHCS) for PACEPACE Program Agreement
B.F. CalOptima Compliance PlanPolicy AA.1000: Glossary of Terms
G. CalOptima Policy HH.3001Δ: Member Access to Designated Record Set
H. CalOptima Policy HH.3005Δ: Member Request for an Accounting of Disclosures
C.I. CalOptima Policy GG.1320: Elder or Dependent Adult Abuse Reporting
D. CalOptima Policy AA.1000: Glossary of Terms
E. CalOptima Policy CMC.1001: Glossary of Terms
F.J. CalOptima Policy GG.1706: Child Abuse Report

~~G.~~ CalOptima Policy ~~MA.1001: Glossary of Terms~~
~~H. CalOptima Policy MA.9203: Member Access to Designated Record Set~~
~~I. CalOptima Policy MA.9205: Member Request for an Accounting of Disclosures~~
~~J.~~K.~~CalOptima Policy MA.9210~~HH.3006Δ: Tracking Disclosures of Protected Health Information
L. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~K.~~M. Civil Code ~~Section~~ §56.30(b)
~~L.~~N. Title 22, California Code of Regulations (C.C.R.), ~~Section~~ §51009
~~M.~~O. Title 45, Code of Federal Regulations, §~~Sections~~ §164.501; 164.502(a), (b); ~~Section~~ 164.512(a), (c), (e) and (f); 1654.524 and 164.528(i) or (ii)
~~N.~~P. Welfare & Institutions Code, ~~Section~~ §14100.2

~~VII.~~VI. REGULATORY AGENCY APPROVALS

None to Date

~~VIII.~~VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3010	Protected Health Information Disclosures Required by Law	Medi-Cal
Effective	06/01/2005	MA.9213	Protected Health Information Disclosures Required by Law	OneCare
Revised	07/01/2007	HH.3010	Protected Health Information Disclosures Required by Law	Medi-Cal
Revised	07/01/2007	MA.9213	Protected Health Information Disclosures Required by Law	OneCare
Revised	01/01/2008	MA.9213	Protected Health Information Disclosures Required by Law	OneCare
Revised	11/01/2012	MA.9213	Protected Health Information Disclosures Required by Law	OneCare
Revised	09/01/2014	MA.9213	Protected Health Information Disclosures Required by Law	OneCare
Revised	09/01/2015	HH.3010	Protected Health Information Disclosures Required by Law	Medi-Cal
Revised	09/01/2015	MA.9213	Protected Health Information Disclosures Required by Law	OneCare OneCare Connect PACE

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	12/01/2016	HH.3010Δ	Protected Health Information Disclosures Required by Law	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9213	Protected Health Information Disclosures Required by Law	OneCare OneCare Connect PACE

~~**IX.**~~

~~**Version**~~	~~**Version Date**~~	~~**Policy Number**~~	~~**Policy Title**~~
~~Original Date~~	~~0604/01/20052003~~	~~MA.9213HH.3010~~	~~Protected Health Information Disclosures Required by Law~~
~~Revision Date 1~~	~~07/01/2007~~	~~MA.9213HH.3010~~	~~Protected Health Information Disclosures Required by Law~~
~~Revision Date 2~~	~~01/01/2008~~	~~MA.9213~~	~~Protected Health Information Disclosures Required by Law~~
~~Revision Date 3~~	~~11/01/2012~~	~~MA.9213~~	~~Protected Health Information Disclosures Required by Law~~
~~Revision Date 4~~	~~09/01/2014~~	~~MA.9213~~	~~Protected Health Information Disclosures Required by Law~~
~~Revision Date 52~~	~~09/01/2015~~	~~MA.9213HH.3010~~	~~Protected Health Information Disclosures Required by Law~~

IX. GLOSSARY

Term	Definition
Authorized Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information..
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information as subsequently amended.
Member	An enrollee-beneficiary of a CalOptima Program.
Minimum Necessary	The principle that a covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclose, or request for Treatment, Payment, or Health Care Operations.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information

Policy #:	HH.3010Δ
Title:	**Protected Health Information Disclosures Required by Law**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/03
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy describes the manner in which CalOptima Uses and Discloses Protected Health Information (PHI) as permitted by the Health Insurance Portability and Accountability Act (HIPAA) and as required by law.

II. POLICY

A. CalOptima may not Use or Disclose PHI, except, as permitted or required by HIPAA.

B. CalOptima shall disclose PHI:

1. To the Member when requested under, and as required by, the Member's access and accounting rights set forth in 45 CFR Sections 164.524 and 164.528(i); or

2. When required by the Secretary of the Department of Health and Human Services (HHS) to investigate or determine CalOptima's Compliance with HIPAA.

C. CalOptima may Use or Disclose PHI to the extent that such Use or Disclosure is required by law and the Use or Disclosure is limited to the relevant requirements of such law and complies with HIPAA requirements specifically related to such Uses or Disclosures as provided in 45 CFR Section 164.512(a)(2).

D. CalOptima shall comply with the Welfare and Institutions Code Section 14100.2 and Title 22 CCR Section 51009 in making permitted Uses or Disclosures required by law under 45 CFR Section 164.512(a). Compliance with these laws extends beyond Member PHI and includes all confidential Member information (e.g. the fact that the Member is a Medi-Cal/Medicare recipient). In the event that CalOptima makes a Use or Disclosure required by law, it must first determine that the Use or Disclosure is for the purpose directly connected with the administration of the Medi-Cal/Medicare program.

E. Except for Uses and Disclosures described under Section III.B., Uses and Disclosures of Member PHI sought, demanded or otherwise requested by any non-Member party by any means including through subpoenas, document requests, court orders, informal inquiries, etc. that fall within this policy shall be immediately referred to CalOptima's legal counsel for review and handling.

III. PROCEDURE

A. HIPAA required Uses and Disclosures

1. Member requests involving the Use or Disclosure of PHI under the Member's HIPAA access and accounting rights shall be governed by CalOptima Policies HH.3001Δ: Member Access to Designated Record Set and HH.3005Δ: Member Request for an Accounting of Disclosures.

2. If CalOptima receives a request from Department of Health and Human Services (DHHS) for Member PHI to investigate or determine CalOptima's compliance with HIPAA, such requests or demands shall be immediately referred to CalOptima's Privacy Officer. CalOptima's Privacy Officer shall notify CalOptima's legal counsel of such requests and seek guidance in order to comply with such requests.

B. Permitted Uses and Disclosures required by Law

1. CalOptima shall comply with requirements to maintain the confidentiality of all types of information concerning a Member which information shall not be open for examination except as directly connected with the administration of CalOptima programs.

2. Purposes directly connected to the administration of the CalOptima's program encompasses those administrative activities and responsibilities in which the Centers for Medicare and Medicaid (CMS) and/or the Department of Health Care Services (DHCS) and CalOptima are required to engage in order to ensure effective program operations including, without limitation:

   a. Establishing eligibility and methods of reimbursement;

   b. Determining the amount of medical assistance;

   c. Providing services;

   d. Conducting or assisting in investigations, prosecution or civil or criminal proceedings related to the administration of CalOptima's program; and

   e. Conducting or assisting a legislative investigation or audit related to the administration of the CalOptima's program.

3. CalOptima may disclose Member confidential information including PHI and other identifying information, without the Member's Authorization, only if and to the extent that CalOptima first determines that the Disclosure is directly related to the administration of the CalOptima's programs and is otherwise permitted under Welfare & Institutions Code Section 14100.2 and Title 22 CCR 51009 and meets the following requirements, as applicable to the Use or Disclosure:

   a. In the course of any judicial proceeding, in response to a court order, provided that the PHI disclosed is limited to that specifically authorized by the court order.

   b. In the course of any administrative proceeding, in response to an order of an administrative tribunal, provided that the PHI disclosed is limited to that specifically authorized by the administrative tribunal order.

c. In response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal if:

i. In connection with a state civil action or proceeding and certain administrative proceedings, the party seeking the PHI by civil subpoena duces tecum has complied with the service and notice requirements of California Code of Civil Procedure Section 1985.3, which requires actual notice to the individual. In such cases, CalOptima shall examine the subpoena for compliance with Section 1987.3; or

ii. In cases where Section 1985.3 is not applicable, CalOptima has received satisfactory assurance as defined by HIPAA from the party seeking the PHI that it has notified the Member that is the subject of the PHI, with enough information about the litigation or proceeding so that the Member can raise an objection to the court or administrative tribunal; and the time for the Member to raise an objection with the court or tribunal has expired, and that there were no objections or all objections were resolved by the court of administrative tribunal, and the PHI requested is consistent with that resolution. In such cases, CalOptima review the written statement and accompanying documentation submitted by the party seeking the PHI to determine compliance with these requirements; or

iii. CalOptima receives satisfactory assurance from the party seeking the PHI that the parties to the dispute or proceeding have agreed to a qualified protective order, within the meaning of 45 CFR 164.512(e), and have presented it to the court or administrative tribunal, **or** the party seeking the PHI provides proof that a qualified protective order, within the meaning of 45 CFR 164.512(e), has been issued by the court or administrative tribunal. In such cases, CalOptima shall review the written statement and accompanying documentation submitted by the party seeking the PHI to determine compliance with these requirements.

d. In compliance with and as limited by the relevant requirements of an administrative request, including an administrative subpoena or summons, a civil or an authorized investigative demand, or similar process authorized under law, provided that:

i. The information sought is relevant and material to a legitimate law enforcement inquiry;

ii. The request is specific, and limited in scope to the extent reasonable for which the information is sought; and

iii. De-identified information could not reasonably be used.

e. In compliance with, and as limited by, the relevant requirements of a court-ordered search warrant or a grand jury subpoena;

f. For other law enforcement purposes such as:

i. Limited information for identification and location purposes;

ii. A law enforcement official's request for information related to victims of a crime;

iii. About a person who has died to alert law enforcement of the death if the death is suspected to have resulted from criminal conduct; and

iv. To report crimes in emergencies.

v. Disclosures under this Section shall comply with the applicable provisions of 42 CFR Section 164.512(f)(2) and any relevant State laws that are more protective of the individual.

g. Disclosures about victims of abuse, neglect, or domestic violence are addressed in CalOptima Policies GG.1320: Elder or Dependent Adult Abuse Reporting and GG.1706: Child Abuse Report.

h. Other circumstances when specifically required by law provided that such Uses and Disclosures are in compliance with such law and limited to the relevant requirements of such law.

4. State and Federal laws governing Uses and Disclosures required by law including those related to Disclosure of PHI to law enforcement are complex and may implicate multiple laws relevant to the particular circumstances. In responding to any requests, demands, orders or requests under Section III.B.3., CalOptima shall also comply with State and Federal laws governing special protected categories of PHI including mental health and developmental disability information, HIV test results, substance abuse records and psychotherapy notes.

5. CalOptima shall also comply with other State requirements relevant to the release of PHI in the context of civil and criminal State and Federal proceedings or to law enforcement.

6. All Uses and Disclosures of Member PHI and/or other confidential information sought, demanded or otherwise requested by any non-Member party shall be immediately referred to CalOptima's legal counsel for review and handling.

7. All Uses and Disclosures made under this Policy shall be referred to the Privacy Officer and shall be recorded in accordance with CalOptima Policy HH.3006Δ: Tracking Disclosures of Protected Health Information.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. California Code of Civil Procedure Section 1985.3 & Section 1987.3
B. CalOptima Compliance Plan
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima PACE Program Agreement
F. CalOptima Policy AA.1000: Glossary of Terms
G. CalOptima Policy HH.3001Δ: Member Access to Designated Record Set

H. CalOptima Policy HH.3005Δ: Member Request for an Accounting of Disclosures
I. CalOptima Policy GG.1320: Elder or Dependent Adult Abuse Reporting
J. CalOptima Policy GG.1706: Child Abuse Report
K. CalOptima Policy HH.3006Δ: Tracking Disclosures of Protected Health Information
L. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
M. Civil Code §56.30(b)
N. Title 22, California Code of Regulations (C.C.R.), §51009
O. Title 45, Code of Federal Regulations, §§164.501; 164.502(a), (b); 164.512(a), (c), (e) and (f); 1654.524 and 164.528(i) or (ii)
P. Welfare & Institutions Code, §14100.2

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3010	Protected Health Information Disclosures Required by Law	Medi-Cal
Effective	06/01/2005	MA.9213	Protected Health Information Disclosures Required by Law	OneCare
Revised	07/01/2007	HH.3010	Protected Health Information Disclosures Required by Law	Medi-Cal
Revised	07/01/2007	MA.9213	Protected Health Information Disclosures Required by Law	OneCare
Revised	01/01/2008	MA.9213	Protected Health Information Disclosures Required by Law	OneCare
Revised	11/01/2012	MA.9213	Protected Health Information Disclosures Required by Law	OneCare
Revised	09/01/2014	MA.9213	Protected Health Information Disclosures Required by Law	OneCare
Revised	09/01/2015	HH.3010	Protected Health Information Disclosures Required by Law	Medi-Cal
Revised	09/01/2015	MA.9213	Protected Health Information Disclosures Required by Law	OneCare OneCare Connect PACE

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	12/01/2016	HH.3010Δ	Protected Health Information Disclosures Required by Law	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9213	Protected Health Information Disclosures Required by Law	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Authorized Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information..
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information as subsequently amended.
Member	An enrollee-beneficiary of a CalOptima Program.
Minimum Necessary	The principle that a covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclose, or request for Treatment, Payment, or Health Care Operations.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

Term	Definition
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information

1

Policy #:	HH.3011Δ
Title:	**Use and Disclosure of PHI for Treatment, Payment, and ~~and~~ Health Care Operations~~, and for Research~~**
Department:	Office of Compliance
Section:	~~Health Insurance Portability and Accountability Act (HIPAA)~~Privacy
CEO Approval:	Michael Schrader
Effective Date:	04/01/03
Last Review Date:	~~9/1/15~~12/01/16
Last Revised Date:	~~9/1/15~~12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy~~o defines~~ describes the requirements for the Use and Disclosure of Member PHI for Treatment, Payment, and Health Care Operations.~~he general guidelines for the Use or Disclosure of Protected Health Information (PHI) for Treatment, Payment, or Health Care Operations, and, to describe the conditions under which CalOptima may Use or Disclose PHI for Research.to describe the conditions under which CalOptima may Use or Disclose PHI for Research.~~

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~
~~Authorization~~	~~Has the meaning given such term in 45 CFR Section 164.508 and other federal and state laws imposing more stringent authorization requirements for the Use and Disclosure of Member PHI e.g. Welfare & Institution Code Ssection 14100.2.~~
~~Authorized Representative:~~	~~Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.Has the meaning given such term in section 164.502(g) 45 CFR of Title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of un-emancipated minors.~~

~~Term~~	~~Definition~~
~~Care Coordination:~~	~~Case management provided to Members who are at moderate risk, but still have an acute or chronic medical condition that requires assessment and coordination of resources in order to maintain the Members in the least restrictive setting.~~
~~Case Management:~~	~~A collaborative process~~systematic approach to coordination of care for a ~~Member with special needs and/or complex medical conditions that includes the elements~~ of assessment, care planning, facilitation, and ~~advocacy for options~~intervention monitoring, ~~and services to meet a Member's health needs through communication and available resources to promote quality cost effective outcomes~~documentation.~~.~~

~~Term~~	~~Definition~~
~~Covered Service:~~	~~Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.~~ ~~OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract~~ ~~One Care Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the three-way agreement with the Department of Health Care Services and Centers for Medicare & Medicaid Services (CMS).~~ ~~PACE: Those items and services provided by CalOptima under the provisions of Welfare & Institutions Code section 14132 except those services specifically excluded under the contract with the Department of Health Care Services.Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.~~
~~Credentialing:~~	~~The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.~~
~~De-identified Information:~~	~~Health information that does not identify a Member and does not provide a reasonable basis to believe that the information can be used to identify a Member.~~
~~Department of Health Care Services (DHCS):~~	~~The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.~~

~~Term~~	~~Definition~~
~~Disclosure:~~	~~Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.~~Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
~~Durable Medical Equipment (DME):~~	~~Walkers, wheelchairs, canes, crutches, helmets and other equipment that could be used by one (1) person and used again by another person (i.e., not single use equipment).~~
~~Grievance:~~	~~Any Complaint, other than one involving an Organization Determination, expressing dissatisfaction with any aspect of CalOptima's, a Health Network's, or a Provider's operations, activities, or behavior, regardless of any request for remedial action.An oral or written expression of dissatisfaction, including any Complaint, dispute, request for reconsideration, or Appeal made by a Member.~~
~~Health Care Operations:~~	~~Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including: a~~Activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities customer services, resolution of internal grievances, business planning, and development activities related to compliance with the privacy rule.
~~Health Network:~~	~~A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.~~
~~Limited Data Set:~~	~~Protected Health Information (PHI) that uses the indirect identifiers (State, town or city, zip codes, dates of service, birth, and death) and excludes direct identifiers of the Member or the Member's relatives, employers, or household members.~~
~~Long Term Care (LTC):~~	~~A variety of services that help Members with health or personal needs and activities of daily living over a period of time. Long Term Care (LTC) may be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.~~
~~Medically Necessary or Medical Necessity:~~	~~Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable~~Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.~~.~~

~~Term~~	~~Definition~~
~~Medical Record:~~	~~Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.~~ ~~A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.~~
~~Member:~~	~~An enrollee beneficiary of a CalOptima program.~~
~~Minimum Necessary:~~	~~The principle that a covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment or Health Care Operations.~~
~~Payment:~~	~~Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including:~~ ~~Activities carried out by CalOptima including:~~ ~~1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities;~~ ~~2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and~~ ~~3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.~~

~~Term~~	~~Definition~~
~~Protected Health Information (PHI):~~	~~Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.~~ ~~Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.~~ ~~This information identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to:~~ ~~1. The past, present, or future physical or mental health or condition of a Member;~~ ~~2. The provision of health care to a Member; or~~ ~~3. Past, present, or future Payment for the provision of health care to a Member.~~
~~Provider:~~	~~A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, Physician Medical Group, or other person or institution that furnishes Covered Services.~~
~~Research:~~	~~Systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalized knowledge.~~
~~Treatment:~~	~~Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.~~Activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
~~Use of PHI:~~	~~Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.~~Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. The sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

~~III.~~II. POLICY

~~A.~~ CalOptima shall maintain the privacy of PHI in compliance with all federal and state laws when using or disclosing PHI for Treatment, Payment, and ~~and~~ Health Care Operations~~, and Research~~, including applying the Minimum Necessary standard, when applicable. ~~CalOptima shall release Member's PHI for Research purposes only with written authorization from the Member.~~

~~B.~~A.

~~C.~~B. Unless otherwise prohibited by other state or federal law~~Except as otherwise required by law~~, CalOptima may use or disclose PHI pertaining to a Member to perform functions, activities, or services for the purposes directly related to the administration of the CalOptima program.

~~D. CalOptima shall release Member's PHI for Research purposes only with written authorization from the Member.~~

~~E. CalOptima may release Minimum Necessary health information, without authorization by the Member, by removing all identifiers with respect to the individual Member, his or her relatives, employers, and household Members from the Protected Health Information (PHI), in accordance with CalOptima Policy HH.3019~~MA.9221~~: De-identification of Protected Health Information.~~

C. CalOptima may Use and Disclose a Member's PHI without a Member's Authorization for Treatment, Payment or Health Care Operations in compliance with HIPAA and other federal and state laws to the extent that they are more protective of the Member's privacy.

D. Uses and Disclosures pursuant to a valid Member Authorization do not need to be tracked pursuant to CalOptima Policy HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information.

III. ~~IV.~~ PROCEDURE

A. CalOptima may Use and Disclose PHI for its own Treatment purposes and may Disclose PHI for the Treatment purposes of a health care provider.~~CalOptima may use or disclose PHI without a Member's prior authorization under the following circumstances~~:

1. Treatment

a. Activities undertaken by designated staff on behalf of a Member that includes:

i. Direct and indirect provision of health care;

ii. Coordination and management of health care and related services;

iii. Referral to and consultation between health care Providers; and

iv. Coordination with third parties for services related to the management of the Member's health care benefits.

b. Examples of Treatment activities include, but are not limited to:

i. Disclosing a Member's PHI to facilitate Long Term Care (LTC) placement;

ii. Referral for home health care, physical therapy, obtaining Durable Medical Equipment (DME) or medical supplies; and

iii. Providing medical information when referring the Member for consultations with other Providers.

~~B.~~2. Health Care Operations

~~1.~~a. CalOptima may Use and Disclose PHI for its own Health Care Operations. CalOptima may only Disclose PHI to another Covered Entity for the Health Care Operations of the other Covered Entity if~~Activities related to functions necessary to administer the CalOptima program and to support the core function of Treatment and Payment include, but are not limited to~~:

~~a.~~i. Each party has or had a relationship with the Member who is the subject of the PHI being requested~~Establishing eligibility and methods of reimbursement~~;

~~b.~~ii. The PHI pertains to such relationship~~Determining the amount of medical assistance~~;

iii. The Disclosure is for the following limited purposes: ~~Providing services for a Member;~~

(a) Quality assessment and improvement activities;

(b) Patient safety activities;

(c) Population-based activities;

(d) Credentialing and peer review;

(e) Evaluations of health care performance training programs; and

~~c.~~(f) Health care fraud and abuse detection and compliance as described in 45 CFR Section 164.506(c)(4) and where consistent with the administration of the Medi-Cal program.

~~d. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the CalOptima program;~~

~~e. Conducting or assisting a legislative investigation or audit related to the administration of the CalOptima program;~~

~~f. The submission of aggregated Member data to the Department of Health Care Services (DHCS);~~

~~g. Conducting quality assessment and improvement activities, including outcomes evaluation, and development of clinical guidelines and related functions that do not include Treatment;~~

~~h. Population-based activities relating to improving health or reducing health care costs;~~

~~i. Contacts with health care Providers and Members with information about Treatment alternatives;~~

~~j. Case Management and Care Coordination;~~

~~k. Reviewing the competence or qualifications of health care professionals, evaluating Provider and Health Network performance;~~

~~l. Training health care and non-health care professionals;~~

~~m. Accreditation, certification, licensing, or Credentialing activities;~~

~~n. Professional review, compliance and audits, health insurance underwriting, premium rating;~~

~~o. Underwriting and other activities relating to:~~

~~i. The creation, renewal, or replacement of a contract of health insurance or health benefits; and~~

~~ii. Ceding, securing, or placing a contract for reinsurance or risk relating to health care claims, including stop-loss and excess of loss insurance.~~

~~p. Conducting or arranging for medical review, legal and auditing services, including fraud and abuse detection and compliance programs;~~

~~q. Business planning and development, such as:~~

~~i. Conducting cost-management and planning analyses related to managing and operating the agency, including formulary development and administration; and~~

~~ii. Development or improvement of methods of Payment or coverage policies.~~

~~r. Business management and general administrative activities, including those related to implementing and complying with the privacy rule and other administrative simplification rules, customer services resolution of internal Grievances, sale or transfer of assets, creating de-identified health information or a Limited Data Set, and fundraising for the benefit for the agency.~~

~~C.~~3. Payment

~~1.~~a. CalOptima may Use and Disclose PHI for its own Payment activities and may Disclose PHI to another Covered Entity or health care provider for the payment activities of the entity that receives the information for CalOptima health care programs. The Minimum Necessary Rule applies to Uses and Discloses for Payment activities.~~Activities necessary for CalOptima to ensure a Member has access to and that a Provider receives payment for Medically Necessary Covered Services, including~~:

~~a.~~i. Determination of eligibility and to fulfill responsibility for coverage and provision of health benefits under agency programs;

~~b.~~ii. Reimbursement for provision of health care services and coordination of benefits with other health coverage;

~~c.~~iii. Risk adjustments based on Member health status and demographics, billing, claims management, and collection activities;

~~d.~~iv. Review of health care services regarding Medical Necessity, coverage under a health plan and appropriateness of care or justification of charges;

~~e.~~v. Utilization review activities including precertification, preauthorization, and concurrent and retrospective review of services;

~~f.~~vi. Disclosure to consumer reporting agencies of any of the following PHI relating to collection of premiums or reimbursement:

a) Name and address;

b) Date of birth;

c) Social Security Number;

d) Payment History;

e) Account number; or

~~f)~~ Name and address of CalOptima.

~~D. Uses and Disclosures for Research Purposes: Member Authorization~~

~~1. Authorization for release of PHI for Research purposes must include the following elements:~~

~~a. A description of the information to be Used or Disclosed that identifies the information in a specific and meaningful manner;~~

~~b. The name or other specific identification of the person(s), or class of persons, authorized to make the requested Use or Disclosure;~~

~~c. The name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested Use or Disclosure;~~

~~d. A description of each purpose of the requested Use or Disclosure;~~

~~e. A statement that the authorization does not expire or state that the authorization continues until the "end of the Research study";~~

~~f. Signature of the Member and the date, or if signed by Member's Authorized Representative, a description of the Authorized Representative's relationship to the Member;~~

~~g. Statement that further Disclosure of the PHI is prohibited unless another authorization is obtained from the Member (California Civil Code 56.10(c)); and~~

~~h. Additional elements that apply if authorization is requested by CalOptima:~~

~~i. A statement that CalOptima will not condition Treatment or Payment on the Member signing the authorization request;~~

~~ii. A statement that the Member can refuse to sign the authorization;~~

~~iii. A statement that the Member is entitled to a copy of the signed authorization; and~~

~~iv. As applicable, a statement if a Disclosure will result in either direct or indirect Payment to CalOptima from the receiver of the PHI.~~

~~E. Use and Disclosure for Research: De-identification of PHI~~

~~1. Identifiers shall be removed prior to the release of PHI containing individual identifying health data for Research~~ The following processes may be used to determine that PHI has been de-identified to protect the confidentiality of the Member, in accordance with CalOptima Policy HH.3019MA.9221HH.3019Δ: De-identification of Protected Health Information.

f)

~~a. Qualified Reviewer~~

~~i. A person with appropriate knowledge of, and experience with, generally accepted statistical and scientific principles and methods for rendering information not individually identifiable determines that the risk is very small that the information could be used, alone or in combination with other reasonably available information, by an anticipated recipient to identify an individual who is a subject of the information.~~

~~ii. There is documentation on the methods used by the person, and results of the analysis that justifies the determination that the information has been de-identified appropriately.~~

~~b. Removal of Specific Identifiers~~

~~i. The De-identification of PHI will include the removal of the following identifiers:~~

~~1) Name(s);~~

~~2) Social Security number;~~

~~3) Geographic subdivisions smaller than a state including:~~

~~a) Address;~~

~~b) City;~~

~~c) County;~~

~~d) Precinct;~~

~~e) Zip code or equivalent geocode;~~

~~4) Telephone number(s);~~

~~5) Facsimile number(s);~~

~~6) E-mail address;~~

~~7) Medical Record number;~~

~~8) Health plan beneficiary number;~~

~~9) All elements of dates (except year) for dates related to an individual:~~

~~a) Birth date;~~

~~b) Admission date;~~

~~c) Discharge date;~~

~~d) Date of death;~~

~~e) All ages over eighty-nine (89) years;~~

~~f) All elements of dates (including year) indicative of age, except an aggregated single category of ninety (90) or older is permissible;~~

~~10) Account number;~~

~~11) Certificate or license number;~~

~~12) Vehicle identifiers, serial numbers, and license plate number;~~

~~13) Device identifiers and serial numbers;~~

~~14) Web Universal Resource Locators (URLs);~~

~~15) Internet Protocol (IP) address numbers;~~

~~16) Biometric identifiers, voice, and fingerprints;~~

~~17) Full face photographs and comparable images; and~~

~~18) Any other unique identifying number, characteristic, or code.~~

~~ii. There is no actual knowledge that the information could be used alone, or in combination with other information, to identify an individual who is a subject of the information.~~

~~F. Re-identification of information~~

~~1. A code or other means of record identification may be assigned, provided:~~

~~a. The code is not derived from or related to information about the individual that would allow the individual to be identified, i.e., the last four digits of a social security number; and~~

~~b. The code is only used by CalOptima to re-identify the data, and the code is not released for Use by another person or entity.~~

~~V.~~IV. ATTACHMENTS

Not Applicable

~~VI.~~V. REFERENCES

~~A. California Welfare and Institutions Code, section 14100.2 (a)~~
A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~B.~~D. CalOptima ~~Contract with the Department of Health Care Services (DHCS) for PACE~~PACE Program Agreement~~CalOptima Compliance Plan~~~~Contract with the Department of Health Care Services (DHCS)~~
~~C. CalOptima Policy CMC.1001: Glossary of Terms~~
~~D. CalOptima Policy MA.1001~~AA.1000~~: Glossary of Terms~~
E. CalOptima Policy HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information
F. CalOptima Policy HH.3019Δ: De-identification of Protected Health Information
~~E.~~G. CalOptima Privacy Program
~~F.~~H. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~HIPAA Patient Privacy Compliance Guide, Atlantic Information Services, Inc. 2003~~

~~G. Office of Civil Rights, Standards for Privacy of Individually Identifiable Health Information Guidelines~~
~~H.~~I. Title 42 Code of Federal Regulations, ~~section~~ §431.00 et seq.
J. Title 45, Code of Federal Regulations, ~~Section~~ §§ 164.501, 164.502(b), and 164.506~~, Uses and Disclosures to Carry out Treatment, Payment, or Health Care Operations Title 45, Code of Federal Regulations (C.F.R), Section §164.512(i)~~
K. Title 22, California Code of Regulations, §51009
~~I.~~L. Welfare and Institutions Code, §14100.2 (a)

~~VII.~~VI. REGULATORY AGENCY APPROVALS

None to Date

~~VIII.~~VII. BOARD ACTIONS

None to Date

~~IX.~~VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal
Effective	04/01/2003	HH.3017	Use or Disclosure of Protected Health Information for Research	Medi-Cal
Effective	06/01/2005	MA.9214	Use and Disclosure for Treatment, Payment, and Health Care Operations	OneCare
Effective	06/01/2005	MA.9215	Use or Disclosure of Protected Health Information for Research	OneCare
Revised	04/01/2007	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal
Revised	04/01/2007	HH.3017	Use or Disclosure of Protected Health Information for Research	Medi-Cal
Revised	01/01/2008	HH.3017	Use or Disclosure of Protected Health Information for Research	Medi-Cal
Revised	02/01/2008	MA.9214	Use and Disclosure for Treatment, Payment, and Health Care Operations	OneCare
Revised	02/01/2008	MA.9215	Use or Disclosure of Protected Health Information for Research	OneCare

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	01/01/2010	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal
Revised	12/01/2012	HH.3017	Use or Disclosure of Protected Health Information for Research	Medi-Cal
Revised	04/01/2013	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal
Revised	04/01/14	HH.3017	Use or Disclosure of Protected Health Information for Research	Medi-Cal
Revised	09/01/2014	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal
Revised	09/01/2014	MA.9214	Use and Disclosure for Treatment, Payment, and Health Care Operations	OneCare
Revised	09/01/2014	MA.9215	Use or Disclosure of Protected Health Information for Research	OneCare
Revised	09/01/2015	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal
Revised	09/01/2015	HH.3017	Use or Disclosure of Protected Health Information for Research	Medi-Cal
Revised	09/01/2015	MA.9214	Use and Disclosure for Treatment, Payment, and Health Care Operations	OneCare OneCare Connect PACE
Revised	09/01/2015	MA.9215	Use or Disclosure of Protected Health Information for Research	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	HH.3017	Use or Disclosure of Protected Health Information for Research	Medi-Cal
Retired	12/01/2016	MA.9214	Use and Disclosure for Treatment, Payment, and Health Care Operations	OneCare OneCare Connect PACE
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IX. GLOSSARY

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De-identified Information	Health information that does not identify a Member and does not provide a reasonable basis to believe that the information can be used to identify a Member.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.

Term	Definition
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Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Limited Data Set	Protected Health Information (PHI) that uses the indirect identifiers (State, town or city, zip codes, dates of service, birth, and death) and excludes direct identifiers of the Member or the Member's relatives, employers, or household members.
Long Term Care (LTC)	A variety of services that help Members with health or personal needs and activities of daily living over a period of time. Long Term Care (LTC) may be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	An enrollee-beneficiary of a CalOptima program.
Minimum Necessary	The principle that a covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment or Health Care Operations.

Term	Definition
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, Physician Medical Group, or other person or institution that furnishes Covered Services.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

1

Policy #:	HH.3011Δ
Title:	**Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader
Effective Date:	04/01/03
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy describes the requirements for the Use and Disclosure of Member PHI for Treatment, Payment, and Health Care Operations.

II. POLICY

A. CalOptima shall maintain the privacy of PHI in compliance with all federal and state laws when using or disclosing PHI for Treatment, Payment, and Health Care Operations, including applying the Minimum Necessary standard, when applicable.

B. Unless otherwise prohibited by other state or federal law, CalOptima may use or disclose PHI pertaining to a Member to perform functions, activities, or services for the purposes directly related to the administration of the CalOptima program.

C. CalOptima may Use and Disclose a Member's PHI without a Member's Authorization for Treatment, Payment or Health Care Operations in compliance with HIPAA and other federal and state laws to the extent that they are more protective of the Member's privacy.

D. Uses and Disclosures pursuant to a valid Member Authorization do not need to be tracked pursuant to CalOptima Policy HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information.

III. PROCEDURE

A. CalOptima may Use and Disclose PHI for its own Treatment purposes and may Disclose PHI for the Treatment purposes of a health care provider.:

1. Treatment

a. Activities undertaken by designated staff on behalf of a Member that includes:

i. Direct and indirect provision of health care;

ii. Coordination and management of health care and related services;

iii. Referral to and consultation between health care Providers; and

iv. Coordination with third parties for services related to the management of the Member's health care benefits.

b. Examples of Treatment activities include, but are not limited to:

i. Disclosing a Member's PHI to facilitate Long Term Care (LTC) placement;

ii. Referral for home health care, physical therapy, obtaining Durable Medical Equipment (DME) or medical supplies; and

iii. Providing medical information when referring the Member for consultations with other Providers.

2. Health Care Operations

a. CalOptima may Use and Disclose PHI for its own Health Care Operations. CalOptima may only Disclose PHI to another Covered Entity for the Health Care Operations of the other Covered Entity if:

i. Each party has or had a relationship with the Member who is the subject of the PHI being requested;

ii. The PHI pertains to such relationship;

iii. The Disclosure is for the following limited purposes:

(a) Quality assessment and improvement activities;

(b) Patient safety activities;

(c) Population-based activities;

(d) Credentialing and peer review;

(e) Evaluations of health care performance training programs; and

(f) Health care fraud and abuse detection and compliance as described in 45 CFR Section 164.506(c)(4) and where consistent with the administration of the Medi-Cal program.

3. Payment

a. CalOptima may Use and Disclose PHI for its own Payment activities and may Disclose PHI to another Covered Entity or health care provider for the payment activities of the entity that

receives the information for CalOptima health care programs. The Minimum Necessary Rule applies to Uses and Discloses for Payment activities.:

i. Determination of eligibility and to fulfill responsibility for coverage and provision of health benefits under agency programs;

ii. Reimbursement for provision of health care services and coordination of benefits with other health coverage;

iii. Risk adjustments based on Member health status and demographics, billing, claims management, and collection activities;

iv. Review of health care services regarding Medical Necessity, coverage under a health plan and appropriateness of care or justification of charges;

v. Utilization review activities including precertification, preauthorization, and concurrent and retrospective review of services;

vi. Disclosure to consumer reporting agencies of any of the following PHI relating to collection of premiums or reimbursement:

a) Name and address;

b) Date of birth;

c) Social Security Number;

d) Payment History;

e) Account number; or

f) Name and address of CalOptima.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information
F. CalOptima Policy HH.3019Δ: De-identification of Protected Health Information
G. CalOptima Privacy Program
H. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect

I. Title 42 Code of Federal Regulations, §431.00 et seq.
J. Title 45, Code of Federal Regulations, §§ 164.501, 164.502(b), and 164.506
K. Title 22, California Code of Regulations, §51009
L. Welfare and Institutions Code, §14100.2 (a)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal
Effective	04/01/2003	HH.3017	Use or Disclosure of Protected Health Information for Research	Medi-Cal
Effective	06/01/2005	MA.9214	Use and Disclosure for Treatment, Payment, and Health Care Operations	OneCare
Effective	06/01/2005	MA.9215	Use or Disclosure of Protected Health Information for Research	OneCare
Revised	04/01/2007	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal
Revised	04/01/2007	HH.3017	Use or Disclosure of Protected Health Information for Research	Medi-Cal
Revised	01/01/2008	HH.3017	Use or Disclosure of Protected Health Information for Research	Medi-Cal
Revised	02/01/2008	MA.9214	Use and Disclosure for Treatment, Payment, and Health Care Operations	OneCare
Revised	02/01/2008	MA.9215	Use or Disclosure of Protected Health Information for Research	OneCare
Revised	01/01/2010	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	12/01/2012	HH.3017	Use or Disclosure of Protected Health Information for Research	Medi-Cal
Revised	04/01/2013	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal
Revised	04/01/14	HH.3017	Use or Disclosure of Protected Health Information for Research	Medi-Cal
Revised	09/01/2014	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal
Revised	09/01/2014	MA.9214	Use and Disclosure for Treatment, Payment, and Health Care Operations	OneCare
Revised	09/01/2014	MA.9215	Use or Disclosure of Protected Health Information for Research	OneCare
Revised	09/01/2015	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal
Revised	09/01/2015	HH.3017	Use or Disclosure of Protected Health Information for Research	Medi-Cal
Revised	09/01/2015	MA.9214	Use and Disclosure for Treatment, Payment, and Health Care Operations	OneCare OneCare Connect PACE
Revised	09/01/2015	MA.9215	Use or Disclosure of Protected Health Information for Research	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	HH.3017	Use or Disclosure of Protected Health Information for Research	Medi-Cal
Retired	12/01/2016	MA.9214	Use and Disclosure for Treatment, Payment, and Health Care Operations	OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9215	Use or Disclosure of Protected Health Information for Research	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Authorization	Has the meaning given such term in 45 CFR Section 164.508 and other federal and state laws imposing more stringent authorization requirements for the Use and Disclosure of Member PHI e.g. Welfare & Institution Code section 14100.2.
Authorized Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.
Covered Service:	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract One Care Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the three-way agreement with the Department of Health Care Services and Centers for Medicare & Medicaid Services (CMS). PACE: Those items and services provided by CalOptima under the provisions of Welfare & Institutions Code section 14132 except those services specifically excluded under the contract with the Department of Health Care Services.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services
De-identified Information	Health information that does not identify a Member and does not provide a reasonable basis to believe that the information can be used to identify a Member.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.

Term	Definition
Durable Medical Equipment (DME)	Walkers, wheelchairs, canes, crutches, helmets and other equipment that could be used by one (1) person and used again by another person (i.e., not single use equipment).
Grievance	An oral or written expression of dissatisfaction, including any Complaint, dispute, request for reconsideration, or Appeal made by a Member.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including: activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities customer services, resolution of internal grievances, business planning, and development activities related to compliance with the privacy rule.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Limited Data Set	Protected Health Information (PHI) that uses the indirect identifiers (State, town or city, zip codes, dates of service, birth, and death) and excludes direct identifiers of the Member or the Member's relatives, employers, or household members.
Long Term Care (LTC)	A variety of services that help Members with health or personal needs and activities of daily living over a period of time. Long Term Care (LTC) may be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	An enrollee-beneficiary of a CalOptima program.
Minimum Necessary	The principle that a covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment or Health Care Operations.

Term	Definition
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, Physician Medical Group, or other person or institution that furnishes Covered Services.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

1

Policy #:	HH.3014Δ
Title:	**Use of Electronic Mail with Protected Health Information**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader
Effective Date:	04/01/03
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

~~This policy shall apply to the following CalOptima line of business (LOB):~~

- ~~OneCare~~
- ~~OneCare Connect~~
- ~~PACE~~

I. PURPOSE

This policy~~o~~ describes CalOptima's procedures related to the use of electronic mail (e-mail) to send information containing Protected Health Information (PHI).~~defines CalOptima's procedures for the use of electronic mail (eE-mail) containing Protected Health Information (PHI) between CalOptima and its Business Associates.~~

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~
~~Breach~~	~~Has the meaning in 45, Code of Federal Regulations Section 164.402. The acquisition, access, use, or disclosure of protected health information in a manner not permitted under subpart E of~~

	~~this part which compromises the security or privacy of the protected health information.~~ ~~(1) Breach excludes:~~ ~~(i) Any unintentional acquisition, access, or use of protected health information by a workforce member or person acting under the authority of a covered entity or a business associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under subpart E of this part.~~ ~~(ii) Any inadvertent disclosure by a person who is authorized to access protected health information at a covered entity or business associate to another person authorized to access protected health information at the same covered entity or business associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under subpart E of this part.~~ ~~(iii) A disclosure of protected health information where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information~~
~~Business Associate:~~	~~Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who:~~ ~~On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or~~ ~~Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of~~

	~~such covered entity or arrangement, to the person.~~ ~~A covered entity may be a business associate of another covered entity.~~ ~~Business associate includes:~~ ~~A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information.~~ ~~A person that offers a personal health record to one or more individuals on behalf of a covered entity.~~ ~~1. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate~~Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: On behalf of a covered entity or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs, or assists in the performance of: ~~a. A function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or~~ ~~b. Any other function or activity regulated by this subchapter; or~~ ~~**2.** Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the services involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.~~
~~Disclosure:~~	~~Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.~~Has the meaning given such term in section 160.103 of Title 45,

	~~Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.~~
~~Encryption:~~	~~The use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without use of a confidential process or key or a method of converting an original message of regular text into encoded or unreadable text that is eventually decrypted into plan comprehensible text.~~
~~Health Network~~	~~The contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").A Physician Hospital Consortium (PHC), Physician Medical Group, physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with Cal Optima to provide Covered Services to Members assigned to that Health Network.~~
~~Minimum Necessary:~~	~~The principle that a covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment or Health Care Operations.~~
~~Personally Identifiable Information~~	~~PII is —any information about an individual maintained by an agency, including (1) any information that can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.l~~
~~Protected Health Information (PHI):~~PHI)	~~Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.~~ ~~Individually identifiable health information~~Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. ~~Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.~~ ~~This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to:~~ ~~1. The past, present, or future physical or mental health or condition of a Member;~~

	~~2. The provision of health care to a Member; or~~ ~~3. Past, present, or future Payment for the provision of health care to a Member.~~
~~Security Incident~~	~~Has the meaning in 45 Code of Federal Regulations Section 164.304. The attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.~~
~~Unsecured PHI/PI~~	~~Has the meaning in 45 Code of Federal Regulations Section 164.402. Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.~~
~~Use of PHI:~~	~~Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information~~Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. The sharing, employment, application, utilization, examination, or analysis of the Pill~~PHI within an entity that maintains such information.~~

~~III.~~II. POLICY

A. CalOptima~~, and~~ its ~~FDRs~~Business Associates, and FDRs shall send ~~email~~E-mail containing PHI as follows:

1. Internal e-mail

   a. E-mail sent within CalOptima's mail system may contain PHI that is limited to the Use and Disclosure of the Minimum Necessary data to complete the required message, in accordance with CalOptima Policy ~~MA.9204~~HH.3002Δ: Minimum Necessary Use and Disclosure of Protected Health Information.

   b. PHI (e.g., Member name, Social Security number, Client Index Number [CIN]) shall not be included in the subject line of the ~~e-mail~~E-Mail.

2. External e-mail sent on the Internet

   a. E-mail that CalOptima, or a Business Associate, sends to~~ ~~an external entity via the open Internet shall not contain PHI unless the e-mail or attachment has been encrypted to prevent anyone, other than the intended receiver, from reading the contents.

   b. E-mail that CalOptima or a Business Associate sends to an outside entity may contain PHI that is limited to the Use and Disclosure of the Minimum Necessary data to complete the required message, in accordance with CalOptima Policy ~~MA.9204~~HH.3002Δ: Minimum Necessary Use and Disclosure of Protected Health Information.

c. PHI (e.g., Member name, Social Security number, Client Index Number [CIN]) shall not be included in the subject line of the e-mail.

B. CalOptima staff shall follow instructions for use of e-mail as set forth in CalOptima Policy GA.5005b: ~~Email~~E-mail and Internet Use.

~~IV.~~III. PROCEDURE

A. Communications via ~~e~~E-mail sent through the open Internet requires ~~Encryption~~encryption to prevent unauthorized access to ~~the~~ PHI and in accordance with CalOptima Policy IS.1202: EPHI Technical Safeguards – Data Controls.

B. CalOptima employees and Business Associates shall immediately report any suspected or known Security Incidents, Breaches of Unsecured PHI/PI and/or other unauthorized access, Use or Disclosure of PHI/PI~~Breach of data security, Intrusion, or unauthorized Use or Disclosure of PHI~~ to the CalOptima Privacy Officer, or his or her Designee, in accordance with CalOptima policy ~~MA.9222~~HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI~~a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information~~.

C. CalOptima employees shall not save or store data files in an electronic format that contain PHI on public or private computers, unencrypted personal removable storage devices, personal cloud storage and/or personal email accounts in accordance with CalOptima Policy HH.3016Δ: Guidelines for Handling Protected Health Information (PHI) Offsite.

~~V.~~IV. ATTACHMENTS

Not Applicable

~~VI.~~V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Contract with the Department of Health Care Services (DHCS) for PACE
~~A. CalOptima Compliance Plan with the Department of Health Care Services (DHCS)~~
~~B.~~E. CalOptima Policy ~~MA.1001~~AA.1000: Glossary of Terms
F. CalOptima Policy GA.5005a: use of Technology Resources CalOptima Policy
G. CalOptima Policy GA.5005b: ~~Email~~E-mail and Internet Use
~~C.~~H. CalOptima Policy HH.3016Δ: Guidelines for Handling Protected Health Information (PHI) Offsite
~~D.~~I. CalOptima Policy ~~MA. 9204~~HH.3002Δ: Minimum Necessary Use and Disclosure of Protected Health Information
J. CalOptima ~~Policy MA.9222P~~policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI~~a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information~~
K. CalOptima Policy IS.1202: EPHI Technical Safeguards – Data Controls

L. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~E. Department of Health Care Services (DHCS) contract~~

~~VII.~~VI. REGULATORY AGENCY APPROVALS

~~None to Date~~

A. ~~-~~07/16/10: Department of Health Care Services
B. 09/17/09: Department of Health Care Services

~~VIII.~~VII. BOARD ACTIONS

None to Date

~~IX.~~VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Effective	06/01/2005	MA.9218	Use of Electronic Mail with Protected Health Information	OneCare
Revised	04/01/2007	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	01/01/2008	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	02/01/2008	MA.9218	Use of Electronic Mail with Protected Health Information	OneCare
Revised	01/01/2009	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	06/01/2010	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	06/01/2010	MA.9218	Use of Electronic Mail with Protected Health Information	OneCare
Revised	01/01/2011	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	01/01/2011	MA.9218	Use of Electronic Mail with Protected Health Information	OneCare

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	04/01/2013	HH.3014Δ	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare
Revised	02/01/2014	MA.9218	Use of Electronic Mail with Protected Health Information	OneCare
Revised	05/01/2014	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	09/01/2014	MA.9218	Use of Electronic Mail with Protected Health Information	OneCare
Revised	09/01/2015	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	09/01/2015	MA.9218	Use of Electronic Mail with Protected Health Information	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9218	Use of Electronic Mail with Protected Health Information	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Breach	Has the meaning in 45, Code of Federal Regulations Section 164.402. The acquisition, access, use, or disclosure of protected health information in a manner not permitted under subpart E of this part which compromises the security or privacy of the protected health information. (1) Breach excludes: (i) Any unintentional acquisition, access, or use of protected health information by a workforce member or person acting under the authority of a covered entity or a business associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under subpart E of this part. (ii) Any inadvertent disclosure by a person who is authorized to access protected health information at a covered entity or business associate to another person authorized to access protected health information at the same covered entity or business associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under subpart E of this part. (iii) A disclosure of protected health information where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.

Term	Definition
	A covered entity may be a business associate of another covered entity. Business associate includes: • A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. • A person that offers a personal health record to one or more individuals on behalf of a covered entity. **1.** A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Encryption	The use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without use of a confidential process or key or a method of converting an original message of regular text into encoded or unreadable text that is eventually decrypted into plan comprehensible text.
Health Network	The contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").
Minimum Necessary	The principle that a covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment or Health Care Operations.
Personally Identifiable Information	PII is —any information about an individual maintained by an agency, including (1) any information that can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.‖

Term	Definition
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. Individually identifiable health information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Security Incident	Has the meaning in 45 Code of Federal Regulations Section 164.304. The attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
Unsecured PHI/PI	Has the meaning in 45 Code of Federal Regulations Section 164.402. Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information

Policy #:	HH.3014Δ
Title:	**Use of Electronic Mail with Protected Health Information**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/03
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy describes CalOptima's procedures related to the use of electronic mail (e-mail) to send information containing Protected Health Information (PHI).

II. POLICY

A. CalOptima, its Business Associates, and FDRs shall send E-mail containing PHI as follows:

1. Internal e-mail

   a. E-mail sent within CalOptima's mail system may contain PHI that is limited to the Use and Disclosure of the Minimum Necessary data to complete the required message, in accordance with CalOptima Policy HH.3002Δ: Minimum Necessary Use and Disclosure of Protected Health Information.

   b. PHI (e.g., Member name, Social Security number, Client Index Number [CIN]) shall not be included in the subject line of the E-Mail.

2. External e-mail sent on the Internet

   a. E-mail that CalOptima, or a Business Associate, sends to an external entity via the open Internet shall not contain PHI unless the e-mail or attachment has been encrypted to prevent anyone, other than the intended receiver, from reading the contents.

   b. E-mail that CalOptima or a Business Associate sends to an outside entity may contain PHI that is limited to the Use and Disclosure of the Minimum Necessary data to complete the required message, in accordance with CalOptima Policy HH.3002Δ: Minimum Necessary Use and Disclosure of Protected Health Information.

   c. PHI (e.g., Member name, Social Security number, Client Index Number [CIN]) shall not be included in the subject line of the e-mail.

B. CalOptima staff shall follow instructions for use of e-mail as set forth in CalOptima Policy GA.5005b: E-mail and Internet Use.

III. PROCEDURE

A. Communications via E-mail sent through the open Internet requires encryption to prevent unauthorized access to PHI and in accordance with CalOptima Policy IS.1202: EPHI Technical Safeguards – Data Controls.

B. CalOptima employees and Business Associates shall immediately report any suspected or known Security Incidents, Breaches of Unsecured PHI/PI and/or other unauthorized access, Use or Disclosure of PHI/PI to the CalOptima Privacy Officer, or his or her Designee, in accordance with CalOptima policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI.

C. CalOptima employees shall not save or store data files in an electronic format that contain PHI on public or private computers, unencrypted personal removable storage devices, personal cloud storage and/or personal email accounts in accordance with CalOptima Policy HH.3016Δ: Guidelines for Handling Protected Health Information (PHI) Offsite.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Contract with the Department of Health Care Services (DHCS) for PACE
E. CalOptima Policy AA.1000: Glossary of Terms
F. CalOptima Policy GA.5005a: use of Technology Resources CalOptima Policy
G. CalOptima Policy GA.5005b: E-mail and Internet Use
H. CalOptima Policy HH.3016Δ: Guidelines for Handling Protected Health Information (PHI) Offsite
I. CalOptima Policy HH.3002Δ: Minimum Necessary Use and Disclosure of Protected Health Information
J. CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI
K. CalOptima Policy IS.1202: EPHI Technical Safeguards – Data Controls
L. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect

VI. REGULATORY AGENCY APPROVALS

A. 07/16/10: Department of Health Care Services
B. 09/17/09: Department of Health Care Services

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Effective	06/01/2005	MA.9218	Use of Electronic Mail with Protected Health Information	OneCare
Revised	04/01/2007	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	01/01/2008	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	02/01/2008	MA.9218	Use of Electronic Mail with Protected Health Information	OneCare
Revised	01/01/2009	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
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Revised	04/01/2013	HH.3014Δ	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare
Revised	02/01/2014	MA.9218	Use of Electronic Mail with Protected Health Information	OneCare
Revised	05/01/2014	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	09/01/2014	MA.9218	Use of Electronic Mail with Protected Health Information	OneCare
Revised	09/01/2015	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	09/01/2015	MA.9218	Use of Electronic Mail with Protected Health Information	OneCare OneCare Connect PACE

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	12/01/2016	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9218	Use of Electronic Mail with Protected Health Information	OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Breach	Has the meaning in 45, Code of Federal Regulations Section 164.402. The acquisition, access, use, or disclosure of protected health information in a manner not permitted under subpart E of this part which compromises the security or privacy of the protected health information. (1) Breach excludes: (i) Any unintentional acquisition, access, or use of protected health information by a workforce member or person acting under the authority of a covered entity or a business associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under subpart E of this part. (ii) Any inadvertent disclosure by a person who is authorized to access protected health information at a covered entity or business associate to another person authorized to access protected health information at the same covered entity or business associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under subpart E of this part. (iii) A disclosure of protected health information where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.

Term	Definition
	A covered entity may be a business associate of another covered entity. Business associate includes: • A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. • A person that offers a personal health record to one or more individuals on behalf of a covered entity. **1.** A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Encryption	The use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without use of a confidential process or key or a method of converting an original message of regular text into encoded or unreadable text that is eventually decrypted into plan comprehensible text.
Health Network	The contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").
Minimum Necessary	The principle that a covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment or Health Care Operations.
Personally Identifiable Information	PII is ―any information about an individual maintained by an agency, including (1) any information that can be used to distinguish or trace an individual‘s identity, such as name, social security number, date and place of birth, mother‘s maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.‖

Term	Definition
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. Individually identifiable health information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Security Incident	Has the meaning in 45 Code of Federal Regulations Section 164.304. The attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
Unsecured PHI/PI	Has the meaning in 45 Code of Federal Regulations Section 164.402. Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information

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Policy #:	HH.3015Δ
Title:	**Member Authorization for the Use and Disclosure of Protected Health Information**
Department:	Office of Compliance
Section:	~~Health Insurance Portability and Accountability Act (HIPAA)~~Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/03
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

~~To identify the scope and content of authorizations as it relates to Use and Disclosure of Protected Health Information (PHI).~~

~~To~~This policy describes the circumstances and process for obtaining a Member's (or from their Personal Representative) Authorization for the Use and Disclosure of Member Protected Health Information (PHI).~~To determine when it is appropriate to obtain an authorization for release of Mmember Protected Health Information (PHI), whether the mMember uses CalOptima's HIPAA Authorization for Release of PHI or provides a non-CalOptima HIPAA authorization form. A valid written authorization is required for use or disclosure of PHI except where the use or disclosure is otherwise required or permitted. All uses and disclosures made pursuant to an authorization must be consistent with the authorization.~~

~~II.~~ ~~DEFINITIONS~~

~~Term~~	~~Definition~~
~~Authorization~~	~~Has the meaning given such term in 45 CFR Section 164.508 and other federal and state laws imposing more stringent authorization requirements for the Use and Disclosure of Member PHI e.g. Welfare & Institution Code Section 14100.2.~~
~~Authorized Representative~~	~~Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.Has the meaning given such term in section 164.502(g) 45 CFR of title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.~~
~~De-identified Information~~	~~Health information that does not identify a Member and does not provide a reasonable basis to believe that the information can be used to identify a Member.~~

Term	Definition
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including aActivities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.

Term	Definition
Marketing	Has the meaning given such term in 45, Code of Federal Regulations Section 164.501. (1) Except as provided in paragraph (2) of this definition, marketing means to make a communication about a product or service that encourages recipients of the communication to purchase or use the product or service. (2) Marketing does not include a communication made: (i) To provide refill reminders or otherwise communicate about a drug or biologic that is currently being prescribed for the individual, only if any financial remuneration received by the covered entity in exchange for making the communication is reasonably related to the covered entity's cost of making the communication. (ii) For the following treatment and health care operations purposes, except where thecovered entity receives financial remuneration in exchange for making the communication: (A) For treatment of an individual by a health care provider, including case management or care coordination for the individual, or to direct or recommend alternative treatments, therapies, health care providers, or settings of care to theindividual; (B) To describe a health-related product or service (or payment for such product or service) that is provided by, or included in a plan of benefits of, the covered entitymaking the communication, including communications about: the entities participating in a health care provider network or health plan network; replacement of, or enhancements to, a health plan; and health-related products or services available only to a health plan enrollee that add value to, but are not part of, a plan of benefits; or (C) For case management or care coordination, contacting of individuals with information about treatment alternatives, and related functions to the extent these activities do not fall within the definition of treatment.
Member (Global)	A beneficiary who is enrolled in a CalOptima Program.An enrollee or beneficiary of a CalOptima program. A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Minimum Necessary	The principle that a covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment or Health Care Operations.

~~Term~~	~~Definition~~
~~Payment~~	~~Activities carried out by CalOptima including:~~ ~~• Determination eligibility, risk adjustments based on the Member health status and demographics, billing claims management, and collection activities;~~ ~~• Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification or charges; and~~ ~~• Utilization review activities including pre-certification, pre-authorization, concurrent, or retrospective review of services.~~
~~Protected Health Information (PHI)~~	~~Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.~~ ~~Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.~~ ~~This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to:~~ ~~1. The past, present, or future physical or mental health or condition of a Member;~~ ~~2. The provision of health care to a Member; or~~ ~~3. Past, present, or future Payment for the provision of health care to a Member.~~
~~Provider~~	~~A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.~~
~~Treatment~~	~~Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.~~Activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
~~Use of PHI~~	~~Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information~~Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. The sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

II. POLICY

A valid written authorization is required for use or disclosure of PHI except where the use or disclosure is otherwise required or permitted. All uses and disclosures made pursuant to an authorization must be consistent with the authorization.

A. CalOptima shall obtain written authorization from a Member prior to the Use or Disclosure of PHI for purposes other than Treatment, Payment, or Health Care Operations, unless otherwise permitted or required under the privacy standards. shall only Use or Disclose a Member's PHI pursuant to a written Authorization from the Member or the Member's Authorized Representative unless otherwise permitted or required by HIPAA and other applicable federal and state laws. may use and disclose Member's PHI only pursuant to a written Authorization of the Member or the Member's Authorized Representative with the following exceptions

:

for Treatment, Payment or Health Care Operations

as mandated or permitted by public policy

for certain research purposes

de-identified PHI or limited data sets

certain highly sensitive records which require disclosure-specific written authorization

B. CalOptima will not condition treatment, payment, enrollment, or benefits eligibility on an individual granting an aAuthorization.

A valid written authorization shall be required for use or disclosure of PHI, except where the use or disclosure is otherwise required or permitted. All uses and disclosures made pursuant to an authorization must be consistent with the authorization.

CalOptima shall obtain written authorization from the Member for the Use or Disclosure of PHI to a close personal friend, family member, or other individual involved in the Member's care, in accordance with CalOptima Policy HH.3021: Disclosure of Information to Family or Friends Involved in Member Care. CalOptima may Use or Disclose PHI to a Member's family member or close personal friend, or other person identified by the Member, if the Member or Authorized Representative is present and gives permission to the Disclosure.

CalOptima may Use or Disclose PHI to a Member's family member or friend, or other person identified by the Member, pursuant to a written authorization executed by the Member or Authorized Representative.

D. The authorization must be completed and must be signed by the person with authority to authorize use or disclosure of PHI, i.e. the Member or Authorized Representative.

C. CalOptima shall obtain, review and confirm that it has a valid Authorization from the Member or the Member's Authorized Representative in accordance with HIPAA and other applicable federal and state laws and this policy prior to a Use or Disclosure that requires an Authorization.

D. CalOptima may Use and Disclosure a Member's PHI in the following circumstances without a Member's Authorization in the following circumstances: for Treatment, Payment or Health Care Operations in compliance with HIPAA and other federal and state laws to the extent that they are more protective of the Member's privacy.

E. Uses and Disclosures involving Member PHI that has been properly "De-Identified" pursuant to the requirements in 45 CFR Section 164.514 do not require a Member's Authorization.

III. PROCEDURE

~~Authorization requests initiated by CalOptima shall be limited to the Minimum Necessary to accomplish the purpose for which the Use or Disclosure is described on the authorization form.~~

A. All valid authorizations shall contain ~~the following~~ specified core elements and requirements in accordance with 45 CFR §Section 164.508(c). Attachment A is CalOptima's Authorization Form for Release of PHI and contains the required elements in compliance with 45 CFR §Section 164.508(c):

1. A description of the information to be Used or Disclosed;
2. The name of the person or organization that will Use or Disclose the PHI;
3. The name of the person or organization that will receive the PHI;
4. A description of the purpose for which the PHI will be used (except for requests by Member, which can indicate "at Member's request" without further explanation);
5. The expiration date or event;
6. Statement that further Use or Disclosure of the PHI is prohibited unless another authorization is obtained from the Member or such Use or Disclosure is specifically required or permitted by law.
7. A statement that the Member has the right to revoke the authorization in writing and any exceptions to this right;
8. Member's signature and the date (if signed by Member Personal Representative, state relationship); and
9. Additional elements that apply if authorization is requested by CalOptima;
    a. A statement that CalOptima will not condition Treatment or Payment on the Member signing the authorization request;
    b. A statement that the Member can refuse to sign the authorization;

c. A statement that the Member is entitled to a copy of the signed authorization. A copy of the signed authorization must be given to the Member; or

d. A statement when any Disclosure will result in either direct or indirect Payment to CalOptima from the receiver of the PHI.

B. The Authorization must be completed and must be signed by the person with authority to authorize use or disclosure of PHI, i.e. the Member or Authorized Representative.

~~B. CalOptima shall obtain authorization from the Member for any use or Disclosure~~ Disclosure of ~~psychotherapy notes except in the following situations:~~

~~1. Use by the originator of the psychotherapy notes for Treatment;~~

~~2. Use or Disclosure by a covered entity's own training program for students, trainees, or practitioners in mental health, under supervision, to improve skills;~~

~~3. Use by a Provider for purposes of diagnosis or Treatment of the Member;~~

~~4. Use or Disclosure by a covered entity to defend itself in a legal action or other proceeding brought by the Member; or~~

~~5. Evaluation or oversight of the practitioner creating the psychotherapy notes.~~

C. All Uses and Disclosures made pursuant to an Authorization must be consistent with the Authorization.

~~C.~~D. Authorization shall be obtained from the Member for any Use or Disclosure of PHI for Marketing, except when:

1. Face-to-face communication is made by CalOptima to the Member; or

2. A promotional gift of nominal value is provided by CalOptima.

~~D.~~E. An ~~authorization~~ Authorization shall be considered invalid if the document submitted contains any of the following defects:

1. The expiration date has passed or the expiration date is known by CalOptima to have passed;

2. The authorization does not contain all the required elements;

3. The authorization is known by CalOptima to have been revoked;

4. The authorization is combined with any other document in a manner that is not permitted under the privacy standard; or

5. The authorization contains material information known by CalOptima to be false.

~~E.~~F. CalOptima staff shall verify the identity of the Authorized Representative in accordance with CalOptima Policy HH.3003Δ: Verification of Identity for Disclosures of Protected Health Information.

~~Research-related treatment may be dependent upon the Member signing an Authorization for Use or Disclosure of PHI under certain circumstances.~~

~~Circumstance under which services may be dependent upon the Member's signing Authorization for Use or Disclosure of PHI includes research-related treatment.~~

G. Revocation of Authorization

1. A Member may revoke an authorization at any time by writing to CalOptima and requesting that the authorization be revoked.

2. The revocation will not apply to those Uses or Disclosures made with reliance on the authorization prior to the receiving the request to revoke the authorization.

~~H. Authorizations for Multipurpose Senior Services Program (MSSP):~~

~~1. The MSSP unit shall follow the standards for obtaining authorizations for all Disclosures as required by contract with the Department of Aging, including the use of the MSSP authorization from provided by the Department of Aging.~~

~~2. Documentation for MSSP:~~

~~1. Copies of all signed authorizations are maintained in the MSSP record for the Member.~~

~~2. Disclosures that are not specifically authorized by the Member and are not part of Payment or Health Care Operations will be reported to the Office of Compliance for tracking purposes per CalOptima Policy HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information.~~

~~I.~~H. All signed authorization and revocation notices are retained on file for ~~six~~ ten (~~6~~10) years from the date the documents are received by CalOptima.

~~Upon receipt of a signed authorization form or a revocation notice, CalOptima shall forward a copy of the authorization form or revocation notice to the Member for his or her records.~~

~~K.~~ CalOptima ~~will~~shall mail a HIPAA Authorization for Release of Information form to ~~individuals~~Members requesting disclosure of PHI when such ~~a release~~ form is required by HIPAA privacy regulations. ~~***Refer to Attachment A: HIPAA Authorization for Release of Health Information Form and Attachment B: Individual InstructionSheet for CalOptima HIPAA Authorization for Release of Protected Health Information Form.***~~

~~I.~~

1. L. Upon receipt of signed and completed form via fax or mail, the CalOptima Privacy Officer or Designee shall review, approve or deny, and will disclose requested information when appropriate, per the signed form.
1.

K. CalOptima shall obtain authorization from the Member for any use or Disclosure of psychotherapy notes except in the following situations:

1. Use by the originator of the psychotherapy notes for Treatment;

2. Use or Disclosure by a covered entity's own training program for students, trainees, or practitioners in mental health, under supervision, to improve skills;

3. Use by a Provider for purposes of diagnosis or Treatment of the Member;

4. Use or Disclosure by a covered entity to defend itself in a legal action or other proceeding brought by the Member; or

5. Evaluation or oversight of the practitioner creating the psychotherapy notes.

M. Requests to release information submitted using a non-CalOptima authorization form:.

a.If a an individualMember submits a completed HIPAA Release of Information form other than the CalOptima specific authorization form, the form will be forwarded to the HIPAA Privacy Officer for review and approval.
b.CalOptima may not disclose PHI pursuant to an authorization form without ensuring that it meets the HIPAA privacy requirements and is confirmed by the HIPAA Privacy Office or Designee..
c.HIPAA Privacy Officer willshall ensure that the non-CalOptima HIPAA Release of Information form complies with the HIPAA requirements for authorizations to disclose patient information or records in accordancewith 45 CFR §164.508(c) HIPAA. ***Refer to Attachment C- HIPAA Authorization Compliance Review Form.***
d.HIPAA Privacy Officer willshall instruct staff if the submitted non-CalOptima form is valid to disclose PHI or ifindividual must complete the CalOptima specific HIPAA Authorization to Release Information form prior to CalOptima disclosing requesting information.

IV. ATTACHMENTS

A. Attachment A: CalOptima HIPAA Authorization for ReleaseUse or Disclosure of Protected Health Information
A.
B. B. Attachment B: Individual Instruction Sheet for CalOptima HIPAA Authorization for Release of Protected Health Information Form
C. C. Attachment C: HIPAA Authorization Checklist

V. REFERENCES

~~A. California Civil Code 56.10(c)~~
~~B. California Civil Code 56.104~~
A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Contract with the Department of Health Care Services (DHCS) for PACE
~~C. CalOptima Policy AA.1000: Glossary of Terms~~
E. CalOptima Policy HH.3003Δ: Verification of Identity for Disclosures of Protected Health Information
~~D.~~F. CalOptima Policy HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information
~~E. CalOptima Policy HH.3003: Verification of Identity for Disclosures of Protected Health Information~~
~~F.~~G. CalOptima Policy HH.3021Δ: Disclosure of Information to Family or Friends Involved in Member Care
H. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~G. Multipurpose Senior Services Program Standards, California Department of Aging~~
~~H.~~I. NCQA Standard ~~RR5~~ MED5 Privacy and Confidentiality: Factor B – 201~~7~~4
J. Title 45, Code of Federal Regulations, ~~Section~~ §§ 164.502(a)(iv), 164.506(a), and 164.508, 164.51~~1~~2
~~Welfare & Institutions Code § 14100.2~~~~Uses and Disclosures for which an Authorization is Required~~
K.
L. California Civil Code §§ 56.10(c) and 56.104
M. Code of California Regulations Title 22, §51009
~~Title 45, Code of Federal Regulations, Section §164.512~~
~~Uses and disclosures for which an authorization or opportunity to agree or object is not required.~~

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Effective	06/01/2005	MA.9219	Authorization for Release of Protected Health Information (PHI)	OneCare

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	04/01/2007	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	01/01/2008	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	02/01/2008	MA.9219	Authorization for Release of Protected Health Information (PHI)	OneCare
Revised	09/01/2009	HH.3021	Disclosure of Information to Family Members or Friends Involved in Member Care	Medi-Cal
Revised	09/01/2009	MA.9224	Disclosure of Information to Family Members or Friends Involved in Member Care	OneCare
Revised	01/01/2010	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	01/01/2011	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	01/01/2013	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	05/01/2013	MA.9219	Authorization for Release of Protected Health Information (PHI)	OneCare
Revised	05/01/2013	MA.9224	Disclosure of Information to Family Members or Friends Involved in Member Care	OneCare
Revised	08/01/2013	HH.3021	Disclosure of Information to Family Members or Friends Involved in Member Care	Medi-Cal
Revised	01/01/2014	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	06/01/2014	MA.9219	Authorization for Release of Protected Health Information (PHI)	OneCare

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	09/01/2014	MA.9224	Disclosure of Information to Family Members or Friends Involved in Member Care	OneCare
Revised	11/01/2014	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	11/01/2014	MA.9219	Authorization for Release of Protected Health Information (PHI)	OneCare
Revised	09/01/2015	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	09/01/2015	HH.3021	Disclosure of Information to Family Members or Friends Involved in Member Care	Medi-Cal
Revised	09/01/2015	MA.9219	Authorization for Release of Protected Health Information (PHI)	OneCare OneCare Connect PACE
Revised	09/01/2015	MA.9224	Disclosure of Information to Family Members or Friends Involved in Member Care	OneCare OneCare Connect PACE
Retired	12/01/2016	HH.3021	Disclosure of Information to Family Members or Friends Involved in Member Care	Medi-Cal
Retired	12/01/2016	MA.9219	Authorization for Release of Protected Health Information (PHI)	OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9224	Disclosure of Information to Family Members or Friends Involved in Member Care	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3015Δ	Authorization for Release of Protected Health Information (PHI)	Medi-Cal OneCare OneCare Connect PACE

~~Version~~	~~Version Date~~	~~Policy Number~~	~~Policy Title~~
~~Original Date~~	~~04/01/2003~~	~~HH.3015~~	~~Authorization for Release of Protected Health Information (PHI)~~

~~Version~~	~~Version Date~~	~~Policy Number~~	~~Policy Title~~
~~Revision Date 1~~	~~04/01/2007~~	~~HH.3015~~	~~Authorization for Release of Protected Health Information (PHI)~~
~~Revision Date 2~~	~~01/01/2008~~	~~HH.3015~~	~~Authorization for Release of Protected Health Information (PHI)~~
~~Revision Date 3~~	~~01/01/2010~~	~~HH.3015~~	~~Authorization for Release of Protected Health Information (PHI)~~
~~Revision Date 4~~	~~01/01/2011~~	~~HH.3015~~	~~Authorization for Release of Protected Health Information (PHI)~~
~~Revision Date 5~~	~~01/01/2013~~	~~HH.3015~~	~~Authorization for Release of Protected Health Information (PHI)~~
~~Revision Date 6~~	~~01/01/2014~~	~~HH.3015~~	~~Authorization for Release of Protected Health Information (PHI)~~
~~Revision Date 7~~	~~11/01/2014~~	~~HH.3015~~	~~Authorization for Release of Protected Health Information (PHI)~~
~~Revision Date 8~~	~~09/01/2015~~	~~HH.3015~~	~~Authorization for Release of Protected Health Information (PHI)~~
~~Revised~~	~~12/01/2016~~	~~HH.3015Δ~~	~~Member Authorization for the Use and Disclosure of Protected Health Information~~

IX. GLOSSARY

Term	Definition
Authorization	Has the meaning given such term in 45 CFR Section 164.508 and other federal and state laws imposing more stringent authorization requirements for the Use and Disclosure of Member PHI e.g. Welfare & Institution Code Section 14100.2.
Authorized Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.
De-identified Information	Health information that does not identify a Member and does not provide a reasonable basis to believe that the information can be used to identify a Member.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.

Term	Definition
Marketing	Has the meaning given such term in 45, Code of Federal Regulations Section 164.501. 1. Except as provided in paragraph (2) of this definition, marketing means to make a communication about a product or service that encourages recipients of the communication to purchase or use the product or service. 2. Marketing does not include a communication made: i. To provide refill reminders or otherwise communicate about a drug or biologic that is currently being prescribed for the individual, only if any financial remuneration received by the covered entity in exchange for making the communication is reasonably related to the covered entity's cost of making the communication. ii. For the following treatment and health care operations purposes, except where thecovered entity receives financial remuneration in exchange for making the communication: a. For treatment of an individual by a health care provider, including case management or care coordination for the individual, or to direct or recommend alternative treatments, therapies, health care providers, or settings of care to theindividual; b. To describe a health-related product or service (or payment for such product or service) that is provided by, or included in a plan of benefits of, the covered entitymaking the communication, including communications about: the entities participating in a health care provider network or health plan network; replacement of, or enhancements to, a health plan; and health-related products or services available only to a health plan enrollee that add value to, but are not part of, a plan of benefits; or c. For case management or care coordination, contacting of individuals with information about treatment alternatives, and related functions to the extent these activities do not fall within the definition of treatment.
Member	A beneficiary who is enrolled in a CalOptima Program.
Minimum Necessary	The principle that a covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment or Health Care Operations.

Term	Definition
Payment	Activities carried out by CalOptima including: 1. Determination eligibility, risk adjustments based on the Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification or charges; and 3. Utilization review activities including pre-certification, pre-authorization, concurrent, or retrospective review of services.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information

1

Policy #:	HH.3015Δ
Title:	**Member Authorization for the Use and Disclosure of Protected Health Information**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/03
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy describes the circumstances and process for obtaining a Member's (or from their Personal Representative) Authorization for the Use and Disclosure of Member Protected Health Information (PHI).

II. POLICY

A. CalOptima shall only Use or Disclose a Member's PHI pursuant to a written Authorization from the Member or the Member's Authorized Representative unless otherwise permitted or required by HIPAA and other applicable federal and state laws.

B. CalOptima will not condition treatment, payment, enrollment, or benefits eligibility on an individual granting an Authorization.

C. CalOptima shall obtain, review and confirm that it has a valid Authorization from the Member or the Member's Authorized Representative in accordance with HIPAA and other applicable federal and state laws and this policy prior to a Use or Disclosure that requires an Authorization.

D. CalOptima may Use and Disclosure a Member's PHI in the following circumstances without a Member's Authorization in the following circumstances: for Treatment, Payment or Health Care Operations in compliance with HIPAA and other federal and state laws to the extent that they are more protective of the Member's privacy.

E. Uses and Disclosures involving Member PHI that has been properly "De-Identified" pursuant to the requirements in 45 CFR Section 164.514 do not require a Member's Authorization.

III. PROCEDURE

A. All valid authorizations shall contain specified core elements and requirements in accordance with 45 CFR Section 164.508(c). Attachment A is CalOptima's Authorization Form for Release of PHI and contains the required elements in compliance with 45 CFR Section 164.508(c):

1. A description of the information to be Used or Disclosed;

2. The name of the person or organization that will Use or Disclose the PHI;

3. The name of the person or organization that will receive the PHI;

4. A description of the purpose for which the PHI will be used (except for requests by Member, which can indicate "at Member's request" without further explanation);

5. The expiration date or event;

6. Statement that further Use or Disclosure of the PHI is prohibited unless another authorization is obtained from the Member or such Use or Disclosure is specifically required or permitted by law.

7. A statement that the Member has the right to revoke the authorization in writing and any exceptions to this right;

8. Member's signature and the date (if signed by Member Personal Representative, state relationship); and

9. Additional elements that apply if authorization is requested by CalOptima;

   a. A statement that CalOptima will not condition Treatment or Payment on the Member signing the authorization request;

   b. A statement that the Member can refuse to sign the authorization;

   c. A statement that the Member is entitled to a copy of the signed authorization. A copy of the signed authorization must be given to the Member; or

   d. A statement when any Disclosure will result in either direct or indirect Payment to CalOptima from the receiver of the PHI.

B. The Authorization must be completed and must be signed by the person with authority to authorize use or disclosure of PHI, i.e. the Member or Authorized Representative.

C. All Uses and Disclosures made pursuant to an Authorization must be consistent with the Authorization.

D. Authorization shall be obtained from the Member for any Use or Disclosure of PHI for Marketing, except when:

1. Face-to-face communication is made by CalOptima to the Member; or

2. A promotional gift of nominal value is provided by CalOptima.

E. An Authorization shall be considered invalid if the document submitted contains any of the following defects:

1. The expiration date has passed or the expiration date is known by CalOptima to have passed;

2. The authorization does not contain all the required elements;

3. The authorization is known by CalOptima to have been revoked;

4. The authorization is combined with any other document in a manner that is not permitted under the privacy standard; or

5. The authorization contains material information known by CalOptima to be false.

F. CalOptima staff shall verify the identity of the Authorized Representative in accordance with CalOptima Policy HH.3003Δ: Verification of Identity for Disclosures of Protected Health Information.

G. Revocation of Authorization

1. A Member may revoke an authorization at any time by writing to CalOptima and requesting that the authorization be revoked.

2. The revocation will not apply to those Uses or Disclosures made with reliance on the authorization prior to the receiving the request to revoke the authorization.

H. All signed authorization and revocation notices are retained on file for ten (10) years from the date the documents are received by CalOptima.

I. CalOptima shall mail a HIPAA Authorization for Release of Information form to Members requesting disclosure of PHI when such form is required by HIPAA privacy regulations.

1. Upon receipt of signed and completed form via fax or mail, the CalOptima Privacy Officer or Designee shall review, approve or deny, and disclose requested information when appropriate, per the signed form.

K. CalOptima shall obtain authorization from the Member for any use or Disclosure of psychotherapy notes except in the following situations:

1. Use by the originator of the psychotherapy notes for Treatment;

2. Use or Disclosure by a covered entity's own training program for students, trainees, or practitioners in mental health, under supervision, to improve skills;

3. Use by a Provider for purposes of diagnosis or Treatment of the Member;

4. Use or Disclosure by a covered entity to defend itself in a legal action or other proceeding brought by the Member; or

5. Evaluation or oversight of the practitioner creating the psychotherapy notes.

IV. ATTACHMENTS

A. CalOptima HIPAA Authorization for Release of Protected Health Information
B. Individual Instruction Sheet for CalOptima HIPAA Authorization for Release of Protected Health Information Form
C. HIPAA Authorization Checklist

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Contract with the Department of Health Care Services (DHCS) for PACE
E. CalOptima Policy HH.3003Δ: Verification of Identity for Disclosures of Protected Health Information
F. CalOptima Policy HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information
G. CalOptima Policy HH.3021Δ: Disclosure of Information to Family or Friends Involved in Member Care
H. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
I. NCQA Standard MED5 Privacy and Confidentiality: Factor B – 2017
J. Title 45, Code of Federal Regulations, §§ 164.502(a)(iv), 164.506(a), and 164.508, 164.512
K. Welfare & Institutions Code § 14100.2
L. California Civil Code §§ 56.10(c) and 56.104
M. Code of California Regulations Title 22, §51009

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
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Revised	12/01/2016	HH.3015Δ	Authorization for Release of Protected Health Information (PHI)	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Authorization	Has the meaning given such term in 45 CFR Section 164.508 and other federal and state laws imposing more stringent authorization requirements for the Use and Disclosure of Member PHI e.g. Welfare & Institution Code Section 14100.2.
Authorized Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.
De-identified Information	Health information that does not identify a Member and does not provide a reasonable basis to believe that the information can be used to identify a Member.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.
Marketing	Has the meaning given such term in 45, Code of Federal Regulations Section 164.501. 1. Except as provided in paragraph (2) of this definition, marketing means to make a communication about a product or service that encourages recipients of the communication to purchase or use the product or service. 2. Marketing does not include a communication made: i. To provide refill reminders or otherwise communicate about a drug or biologic that is currently being prescribed for the individual, only if any financial remuneration received by the covered entity in exchange for making the communication is reasonably related to the covered entity's cost of making the communication. ii. For the following treatment and health care operations purposes, except where thecovered entity receives financial remuneration in exchange for making the communication:

Term	Definition
	a. For treatment of an individual by a health care provider, including case management or care coordination for the individual, or to direct or recommend alternative treatments, therapies, health care providers, or settings of care to theindividual; b. To describe a health-related product or service (or payment for such product or service) that is provided by, or included in a plan of benefits of, the covered entitymaking the communication, including communications about: the entities participating in a health care provider network or health plan network; replacement of, or enhancements to, a health plan; and health-related products or services available only to a health plan enrollee that add value to, but are not part of, a plan of benefits; or c. For case management or care coordination, contacting of individuals with information about treatment alternatives, and related functions to the extent these activities do not fall within the definition of treatment.
Member	A beneficiary who is enrolled in a CalOptima Program.
Minimum Necessary	The principle that a covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment or Health Care Operations.
Payment	Activities carried out by CalOptima including: 1. Determination eligibility, risk adjustments based on the Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification or charges; and 3. Utilization review activities including pre-certification, pre-authorization, concurrent, or retrospective review of services.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.

Term	Definition
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information

1

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

HIPAA privacy regulations require you to complete this form to authorize CalOptima to release your Protected Health Information (PHI) to another person or entity. Please complete, sign, and return the form to CalOptima.

SECTION A: MEMBER AUTHORIZING RELEASE OF PHI

Name of Member: _____

Member CIN: _____

Address: _____

Phone No.: _____ Member date of birth: _____

SECTION B: PERSON OR ORGANIZATION AUTHORIZED TO RECEIVE THIS INFORMATION

Please enter the person(s) or organization who will receive member's protected health information. This information may be disclosed to, and used by, the following person(s) or organization(s). The representative receiving the information must be 18 years of age or older.

Name (enter first and last name[s]): _____

Relationship to Member: _____

Address: _____

Phone No.: _____

SECTION C: INFORMATION THAT CAN BE RELEASED

I allow the following information to be released by CalOptima (Check only one box):

- ☐ **My complete member file,** including **health information** (e.g. diagnosis, test results, treatment history, health care services, claims status and history, provider name(s)); **financial information** pertaining to your health condition and/or insurance coverage (e.g. claims history); and **personal information** (e.g., name, address, date of birth, and member ID). **(*This authorization doesn't include certain sensitive information unless it is specifically approved below.*) OR**
- ☐ **Only limited information** may be disclosed (check all applicable boxes below):

Limited information		
☐ Billing	☐ Medical records (excludes psychotherapy notes)	☐ Referral
☐ Claims & payment	☐ Physician and hospital affiliations	☐ Other:
☐ Diagnosis and procedure	☐ Pre-certification & pre-authorization	

I also approve the release of the following types of **sensitive information** by CalOptima (check all boxes that apply to you):

Sensitive information		
☐ Mental health (including psychotherapy notes)	☐ Genetic testing	☐ Other:
☐ Abuse (sexual/physical/mental/elder)	☐ HIV or AIDS	
☐ Alcohol/substance abuse	☐ Sexually transmitted illness	

SECTION D: PURPOSE OF THIS AUTHORIZATION

This protected health information is being disclosed for the following purpose(s). Please select all that apply:

- ☐ At the request of the Member
- ☐ I have been designated by the patient as his/her representative
- ☐ Other (please specify):

_____

SECTION E: EXPIRATION DATE OF AUTHORIZATION

This authorization will expire on the earlier of **(Please choose only one box):**

- ☐ _____ **[INSERT DATE OF EXPIRATION]: OR**
- ☐ Upon the following event (which must relate to the member or to the purpose of the disclosure being authorized): _____

SECTION F: REVIEW AND APPROVAL

- I understand that I have the right to withdraw this authorization, in writing, at any time by sending written notification to: CalOptima, ATTN: Customer Service Department.
- I also understand that my revocation is not effective to the extent that the persons I have authorized to disclose my protected health information have acted in reliance upon this authorization prior to receipt of the revocation.
- I understand my authorization to release this information will not affect my eligibility or enrollment status, or any treatment or benefit payment decisions. I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy laws.
- I release CalOptima from any liability associated with releasing this information to the person/agency named above. I understand that I may have the right under federal or state law to inspect or copy the protected health information to be disclosed.
- I understand I have the right to refuse to sign this authorization.
- If this authorization is signed by a personal representative, please provide representative documentation as required by state law (i.e., HealthCare Power of Attorney, Health Care Surrogate, Living Will or Guardianship papers).

By signing below, I acknowledge receiving a copy of this authorization.

_____

Signature of Member **Date**

If Personal Representative:

Name of Personal Representative:

_____

Legal Relationship to Member:

_____

Signature of Authorized Representative: _____ Date: _____

Sign and mail or deliver to: **CalOptima Customer Service Department**
505 City Parkway West
Orange, CA 92868

~~AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)~~

~~The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.~~

~~Date of Request: _____ Telephone Number: _____~~

~~Member Name: _____ Member CIN: _____~~

~~AUTHORIZATION:~~

~~I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.~~

~~Describe the health information that will be used or disclosed under this authorization (please be specific): _____~~

_____

_____

~~Person or organization authorized to received the health information: _____~~

~~Describe each purpose of the requested use or disclosure (please be specific): _____~~

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: _____

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that the health information used or disclosed as a result of my signing this authorization may not be further used or disclosed by the recipient unless another authorization is obtained from me or unless such use or disclosure is specifically permitted or required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Personal Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Authorized Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative

(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

HIPAA privacy regulations require you to complete this form to authorize CalOptima to release your Protected Health Information (PHI) to another person or entity. Please complete, sign, and return the form to CalOptima.

SECTION A: MEMBER AUTHORIZING RELEASE OF PHI

Name of Member: _____

Member CIN: _____

Address:_____

Phone No.:_____ Member date of birth:_____

SECTION B: PERSON OR ORGANIZATION AUTHORIZED TO RECEIVE THIS INFORMATION

Please enter the person(s) or organization who will receive member's protected health information. This information may be disclosed to, and used by, the following person(s) or organization(s). The representative receiving the information must be 18 years of age or older.

Name (enter first and last name[s]):_____

Relationship to Member:_____

Address:_____

Phone No.:_____

SECTION C: INFORMATION THAT CAN BE RELEASED

I allow the following information to be released by CalOptima (Check only one box):

- ☐ **My complete member file,** including **health information** (e.g. diagnosis, test results, treatment history, health care services, claims status and history, provider name(s)); **financial information** pertaining to your health condition and/or insurance coverage (e.g. claims history); and **personal information** (e.g., name, address, date of birth, and member ID). **(*This authorization doesn't include certain sensitive information unless it is specifically approved below.*)** **OR**
- ☐ **Only limited information** may be disclosed (check all applicable boxes below):

Limited information		
☐ Billing	☐ Medical records (excludes psychotherapy notes)	☐ Referral
☐ Claims & payment	☐ Physician and hospital affiliations	☐ Other:
☐ Diagnosis and procedure	☐ Pre-certification & pre-authorization	

I also approve the release of the following types of **sensitive information** by CalOptima (check all boxes that apply to you):

Sensitive information		
☐ Mental health (including psychotherapy notes)	☐ Genetic testing	☐ Other:
☐ Abuse (sexual/physical/mental/elder)	☐ HIV or AIDS	
☐ Alcohol/substance abuse	☐ Sexually transmitted illness	

SECTION D: PURPOSE OF THIS AUTHORIZATION

This protected health information is being disclosed for the following purpose(s). Please select all that apply:

- ☐ At the request of the Member
- ☐ I have been designated by the patient as his/her representative
- ☐ Other (please specify):

_____
___

SECTION E: EXPIRATION DATE OF AUTHORIZATION

This authorization will expire on the earlier of **(Please choose only one box):**

- ☐ _____ **[INSERT DATE OF EXPIRATION]: OR**
- ☐ Upon the following event (which must relate to the member or to the purpose of the disclosure being authorized):_____

SECTION F: REVIEW AND APPROVAL

- I understand that I have the right to withdraw this authorization, in writing, at any time by sending written notification to: CalOptima, ATTN: Customer Service Department.
- I also understand that my revocation is not effective to the extent that the persons I have authorized to disclose my protected health information have acted in reliance upon this authorization prior to receipt of the revocation.
- I understand my authorization to release this information will not affect my eligibility or enrollment status, or any treatment or benefit payment decisions. I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy laws.
- I release CalOptima from any liability associated with releasing this information to the person/agency named above. I understand that I may have the right under federal or state law to inspect or copy the protected health information to be disclosed.
- I understand I have the right to refuse to sign this authorization.
- If this authorization is signed by a personal representative, please provide representative documentation as required by state law (i.e., HealthCare Power of Attorney, Health Care Surrogate, Living Will or Guardianship papers).

By signing below, I acknowledge receiving a copy of this authorization.

_____ _____

Signature of Member **Date**

If Personal Representative:

Name of Personal Representative:

_____

Legal Relationship to Member:

_____

Signature of Authorized Representative: _____ Date: _____

Sign and mail or deliver to:	**CalOptima Customer Service Department** **505 City Parkway West** **Orange, CA 92868**

Instruction Sheet for CalOptima HIPAA Authorization for Release of Protected Health Information

SECTION A: MEMBER AUTHORIZING RELEASE

This section applies to the member who is asking for the release of his or her information to another person or organization. Please complete all items of information in this section.

SECTION B: PERSON OR ORGANIZATION AUTHORIZED TO RECEIVE THIS INFORMATION

Please enter the name(s) of the person(s) or organization(s) that you are authorizing to access your PHI and act on your behalf. For example, if you are authorizing your spouse, adult children, or any other individual to act on your behalf, enter his/her name in these spaces. If you are authorizing an organization (such as a broker, law firm, insurance agency, etc.) to act on your behalf, enter the specific name of the organization in these spaces. **Examples include:** ***"Dr. John Smith" or "Mary Doe (spouse)."*** Indicate how the person(s) or organization(s) relate to you (for example, spouse, adult children, etc.) and provide their phone number.

SECTION C: INFORMATION THAT CAN BE RELEASED

This section tells us what information you would like us to release: all or some.

- For "**all of my information**," check the **first** box
- For "**only limited information**," check the second box, and under "**Limited information**" please check all boxes below that apply to you.
- The topics under "**sensitive information**" may be very personal or sensitive to you. If you wish to approve the release of this type of information, check the box(es) that apply to you.

SECTION D: PURPOSE OF THIS AUTHORIZATION

Select the reason(s) you've asked for the release of your information. If you have a specific reason, please fill in under "**Other**" and indicate the reason. For example, if you only want the person(s) or organization(s) you are authorizing to receive your protected health information and act on your behalf to handle a claims appeal for you, you would enter ***"To appeal a claim determination"*** or something similar in that block.

SECTION E: EXPIRATION DATE OF AUTHORIZATION

Check the first box if you want the authorization to end on a certain date. Enter in the date of expiration. Check the second box if you wish for the authorization to expire on a certain event, for example, "***one year from my signature date***."

SECTION F: REVIEW AND APPROVAL

If you are the member, sign your name and enter the date you signed the form.

If you are the member's personal representative, sign your name, enter the date you signed the form and indicate your representative relationship. You **must** also provide us with a copy of the legal documentation indicating you are the authorized representative of the member.

- Examples of legal documents:
    - **Health Care, General or Durable Power of Attorney** – this document gives someone you trust the legal power to act on your behalf and make health care decisions for you.
    - **Legal Guardianship** – this is when the court appoints someone to care for another person.
    - **Conservatorship** – this happens when the court appoints a responsible person to make decisions for someone who can't make responsible decisions for him/herself.
    - **Executor of Estate** – this type of document would be used when the person who is being represented has died.

Please keep a copy of the form for your records.

Attachment C: HIPAA Authorization Checklist

The following checklist is utilized to assess the validity of the authorization submitted with requests for release of information on a **non-CalOptima** HIPAA Authorization for Release of Information. The authorization must contain the following core elements and required statements.

#	**Requirements for Authorization to Disclose Patient Health Information or Records (45 CFR**	✓
1	Authorization provides a description of the patient's protected health information to be used or disclosed that identifies the information in a specific and meaningful	
2	Authorization identifies CalOptima as authorized to make the disclosure.	
3	Authorization identifies the name or organization authorized to whom CalOptima may make the disclosure.	
4	Authorization identifies the purpose of the disclosure. The statement "at the request of the patient" is a sufficient description of the purpose when a patient initiates the authorization and does not, or elects not to, provide a statement of the purpose.	
5	Authorization identifies an expiration date or an expiration event that relates to the patient or the purpose of the use or disclosure.	
6	Authorization contains the signature of the patient or patient's authorized legal representative.	
7	If signed by an authorized legal representative, the authorization identifies the relationship of that person to the patient.	
8	Authorization includes the date on which the authorization is signed.	
9	Authorization contains a statement informing the patient regarding the right to revoke the authorization in writing and a description how to do so.	
10	Authorization contains a statement informing the patient about the organization's ability or inability to condition treatment, payment, enrollment or eligibility for benefits.	
11	Authorization contains a statement informing the patient about the potential for information to be redisclosed and no longer protected by the state or federal privacy rule.	
12	Authorization is written in plain language	

~~Last Revised Date: 9/1/15~~

Policy #: HH.3016Δ
Title: **Guidelines for Handling Protected Health Information Offsite**
Department: Office of Compliance
Section: Privacy

CEO Approval: Michael Schrader _____

Effective Date: 04/03
Last Review Date: 12/01/16
Last Revised Date: 12/01/16

Applicable to:
☒ Medi-Cal
☒ OneCare
☒ OneCare Connect
☒ PACE

~~This policy shall apply to the following CalOptima line of business (LOB):~~
- ~~OneCare~~
- ~~OneCare Connect~~
- ~~PACE~~

I. PURPOSE

This policy~~o~~ describes the process for handling Protected Health Information (PHI) created, accessed, or taken offsite from CalOptima offices.

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~
~~Access Controls:~~	~~Controls that identify and authenticate a user to allow access to confidential information and Protected Health Information (PHI) based on a business need to know. Access Controls~~

	~~protect the computer systems from unauthorized access as well as determine the type of access a user is entitled to have.~~
~~Breach:~~	~~Has the meaning in 45, Code of Federal Regulations Section 164.402.~~ ~~Breach means tThe acquisition, access, use, or disclosure of protected health information in a manner not permitted under subpart E of this part which compromises the security or privacy of the protected health information.~~ ~~(1) Breach excludes:~~ ~~(i) Any unintentional acquisition, access, or use of protected health information by a workforce member or person acting under the authority of a covered entity or a business associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under subpart E of this part.~~ ~~(ii) Any inadvertent disclosure by a person who is authorized to access protected health information at a covered entity or business associate to another person authorized to access protected health information at the same covered entity or business associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under subpart E of this part.~~ ~~(iii) A disclosure of protected health information where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information~~An unauthorized disclosure of Protected Health Information (PHI) that violates either federal or state laws (HIPAA Privacy Rule and State Information Practices Act of 1977) or PHI that has been reasonably believed to have been acquired by an unauthorized person. A breach may be paper or electronic.
~~Business Associate:~~	~~Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who:~~ ~~On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such~~

~~covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or~~

~~Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.~~

~~A covered entity may be a business associate of another covered entity.~~

~~Business associate includes:~~

~~A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information.~~

~~A person that offers a personal health record to one or more individuals on behalf of a covered entity.~~

~~1. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate~~Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations.
~~A person or entity who: On behalf of a covered entity or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs, or assists in the performance of:~~

~~a. A function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or~~

	~~b. Any other function or activity regulated by this subchapter; or~~ ~~2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the services involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.~~
~~Designee:~~	~~A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.~~
~~Disclosure:~~	~~Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.~~Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
~~EPHI~~	~~Has the meaning in 45, Code of Federal Regulations Section 160.103,~~ ~~individually identifiable health information transmitted by electronic media ormedia or maintained in electronic media,~~
~~Health Insurance Portability and Accountability Act (HIPAA)~~	~~The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.~~
~~Intrusion~~	~~The act of wrongfully (without authorization) entering upon, seizing, or taking possession of computerized data that compromises the security, confidentiality, or integrity of personal information maintained by CalOptima or its Business Associates.~~
~~Long Term Care (LTC):~~	~~A variety of services that help Members with health or personal needs and activities of daily living over a period of time. Long Term Care (LTC) may be provided at home, in the community or in various types of facilities, including nursing homes and assisted living facilities.~~
~~Medical Record:~~	~~A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical~~

	~~history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.~~
~~Member:~~	~~An enrollee-beneficiary of a CalOptima program.~~
~~Minimum Necessary:~~	~~The principle that covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment or Health Care Operations.~~
~~Prior Authorization:~~	~~A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures.~~
~~Personally Identifiable Information~~	~~PII is — any information about an individual maintained by an agency, including (1) any information that can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.‖~~
~~Protected Health Information (PHI):~~	~~Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.~~~~Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form of medium.~~ ~~Individually identifiable health information~~ ~~This information identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual.~~ ~~The information was created or received by CalOptima or Business Associates and relates to:~~ ~~1. The past, present, or future physical or mental health or condition of a Member;~~ ~~2. The provision of health care to a Member; or~~ ~~3. Past, present, or future Payment for the provision of health care to a Member.~~
~~Security Incident~~	~~Has the meaning in 45 Code of Federal Regulations Section 164.304. The attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or~~

	~~interference with system operations in an information system.~~
~~Unsecured PHI/PI~~	~~Has the meaning in 45 Code of Federal Regulations Section 164.402. Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.~~
~~Use of PHI:~~	~~Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. The sharing, employment, application, utilization, examination, or analysis of the Pill~~ PHI ~~within an entity that maintains such information.~~

~~III.~~II. POLICY

A. CalOptima employees shall exercise ~~reasonable~~ precautions according to the regulations and standards set by HIPAA and CalOptima Policies when ~~in~~ handling PHI or E-PHI created, accessed, or taken off site from the main office.

~~IV.~~III. PROCEDURE

A. General guidelines

1. Staff shall~~-~~ adhere to Minimum Necessary requirements ~~exercise professional judgment in~~ when viewing, documenting, and/or recording information ~~the Minimum Necessary data when reviewing~~during ~~a~~such reviews of ~~Medical Records~~medical records in facilities ~~for purposes of certification or re-certification of Member's need for admission or continuing stays as inpatients for acute or Long Term Care (LTC) services.~~

2. Staff shall collect all data relative to a Member, whether by interview, observation, or review of documents, in a setting that provides reasonable privacy and protects the information from unauthorized Disclosure.

3. Staff shall protect all physical documents that contain Member PHI from the view or access by an unauthorized person during transport from and to the office through use of:

   a. Binders; and/or

   b. Folders or other protective cover~~;~~,and/~~-~~or

   c. Locked in trunk of the vehicle; or~~.~~

   ~~c.~~d. Personal possession of Member PHI such that it is in sight at all times~~Remain in possession and within sight at all times.~~

4. Staff shall not leave any paper ~~-~~documents containing PHI ~~including assessment forms, Prior Authorizations~~Authorization, or other data collection forms including, without limitation, audit or other data collection forms unattended in areas accessible by an unauthorized person~~-~~.

5. Staff shall not store confidential, personal, or sensitive information unattended in vehicles at any time.

6. Staff shall not store confidential, personal, or sensitive information unattended in baggage, at any time, during travel.

7. Staff shall not save or store data files in an electronic format that contain PHI on public or private computers, ~~including data files that are accessed through the Internet via electronic mail or webmail.~~unencrypted personal removable storage devices, personal cloud storage and/or personal email accounts.

~~7.~~8. Staff shall not use mobile devices of any kind to take and save photos of information and/or images containing PHI. ~~pictures of data containing PHI.~~

~~8.~~9. Staff shall maintain physical control of CalOptima laptops, cell phones, tablets, USB drives, and all other mobile devices at all times.

~~9.~~10. Staff shall only use CalOptima-issued encrypted storage devices to store files containing PHI~~encrypt all portable storage devices or files (i.e., USB drives, writeable CDs/DVDs, etc.) that contain PHI~~, in accordance with CalOptima Policy GA.5005a: Use of Technology Resources.

~~10.~~11. Staff shall shred PHI documents or files prior to disposal. If necessary, staff shall return documents or files to the main office for disposal.

B. Use of Personal Computer (PC) from remote locations

1. Employees granted access to CalOptima's networks ~~IS~~ are required to adhere to the following procedures:

   a. Maintain the C~~c~~onfidentiality of his or her user sign-on identification code and password;

   b. Keep the PC secure at all times and do not leave it unattended during travel to, or working offsite at, public places (e.g. hospitals, Long Term Care (LTC) facilities, conferences, etc.)~~when in public places, including, but not limited to, hospitals, LTC facilities, or other Member or agency locations~~;

   c. Log off the CalOptima network or lock computer when the PC will be left inactive or unattended; and

   d. Ensure that passwords or operating instructions for accessing the CalOptima systems are not stored with the computer.

C. CalOptima employees and ~~its,~~ Business Associates, ~~-~~First Tier, Downstream and Related Entities (FDRs) shall report any Security Incidents, Breaches of Unsecured PHI/PI and/or other unauthorized access, Use or Disclosure of PHI/PI~~unauthorized Use or Disclosure of PHI, any Breach of data security, or Intrusion~~ immediately after discovery during a ~~work week~~workweek to the CalOptima Privacy Officer, ~~or his or her Designee,~~ in accordance with CalOptima Policy ~~MA.9222:~~ HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other unauthorized Use or Disclosure of PHI/PI~~of a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information~~.

~~V.~~IV. ATTACHMENTS

Not Applicable

~~VI.~~V. REFERENCES

~~Health Administrative Manual~~
A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~A.~~D. CalOptima PACE Program Agreement~~CalOptima Compliance Plan~~~~Policy AA.1000: Glossary of Terms~~
~~B.~~E. CalOptima Policy GA.5005a: Use of Technology Resources
F. CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other unauthorized Use or Disclosure of PHI/PI~~Reporting an Unauthorized Use or Disclosure of Protected Health Information or Breach of Data Security or Intrusion~~
G. CalOptima Policy IS.1102 Electronic Media and Hardware Controls
H. CalOptima Policy IS.1201 EPHI Technical Safeguards -- Access Controls
I. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~OneCare Policy MA.9222: Reporting an Unauthorized Use or Disclosure of Protected Health Information or Breach of Data, Security, or Intrusion~~
~~C.~~ CMS Missive, Privacy, and Security of Beneficiary Information, D~~d~~ated June 9, 2006
~~D.~~J. ~~Health Administrative Manual, Section 6-1050.3~~
~~E.~~K. Health Administrative Manual
~~F. CalOptima Policy MA.1001: Glossary of Terms~~
~~G. CalOptima Policy MA.9222: Reporting of a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information~~
~~H.~~L. Title 45, Code of Federal Regulations, ~~Section~~§-164.103 ~~Definitions~~
~~I.~~M. Title 45, Code of Federal Regulations, §164.502(b) ~~Standard: Minimum Necessary~~
~~J.~~ Title 45, Code of Federal Regulations, §164.530(c)(1) ~~Standard: Safeguards~~
N. ~~Title 45, Code of Federal Regulations, Section 164.103 Definitions~~
~~CalOptima Policy IS.1102 Electronic Media and Hardware Controls~~
~~K. CalOptima Policy IS.1201 EPHI Technical Safeguards -- Access Controls~~

~~VII.~~VI. REGULATORY APPROVALS

~~None to Date~~

A. 7/16/10: ————Department of Health Care Services
B. 9/21/09: ————Department of Health Care Services

~~VIII.~~VII. BOARD ACTIONS

None to Date

~~IX.~~VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/2003	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Effective	06/01/2005	MA.9220	Guidelines for Handling Protected Health Information (PHI) Offsite	OneCare
Revised	04/01/2007	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Revised	04/01/2007	MA.9220	Guidelines for Handling Protected Health Information (PHI) Offsite	OneCare
Revised	01/01/2009	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Revised	01/01/2009	MA.9220	Guidelines for Handling Protected Health Information (PHI) Offsite	OneCare
Revised	06/01/2010	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Revised	04/01/2013	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Revised	09/01/2014	MA.9220	Guidelines for Handling Protected Health Information (PHI) Offsite	OneCare
Revised	09/01/2015	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Revised	09/01/2015	MA.9220	Guidelines for Handling Protected Health Information (PHI) Offsite	OneCare OneCare Connect PACE

Poli~~cy~~ #:	~~MA.9220~~HH.3016Δ		
Title:	Guidelines for Handling Protected Health Information (PHI) Offsite	~~Revised~~ Date:	~~9/1/15~~12/01/16

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	12/01/2016	HH.3016Δ	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9220	Guidelines for Handling Protected Health Information (PHI) Offsite	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Access Controls	Controls that identify and authenticate a user to allow access to confidential information and Protected Health Information (PHI) based on a business need to know. Access Controls protect the computer systems from unauthorized access as well as determine the type of access a user is entitled to have.
Breach	Has the meaning in 45, Code of Federal Regulations Section 164.402. The acquisition, access, use, or disclosure of protected health information in a manner not permitted under subpart E of this part which compromises the security or privacy of the protected health information. Breach excludes: 1. Any unintentional acquisition, access, or use of protected health information by a workforce member or person acting under the authority of a covered entity or a business associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under subpart E of this part. 2. Any inadvertent disclosure by a person who is authorized to access protected health information at a covered entity or business associate to another person authorized to access protected health information at the same covered entity or business associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under subpart E of this part. 3. A disclosure of protected health information where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or

Term	Definition
	for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
EPHI	Has the meaning in 45, Code of Federal Regulations Section 160.103, individually identifiable health information transmitted by electronic media or maintained in electronic media,
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Intrusion	The act of wrongfully (without authorization) entering upon, seizing, or taking possession of computerized data that compromises the security, confidentiality, or integrity of personal information maintained by CalOptima or its Business Associates.
Long Term Care (LTC)	A variety of services that help Members with health or personal needs and activities of daily living over a period of time. Long Term Care (LTC) may be provided at home, in the community or in various types of facilities, including nursing homes and assisted living facilities.
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	An enrollee-beneficiary of a CalOptima program.

Term	Definition
Minimum Necessary	The principle that covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment or Health Care Operations.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures.
Personally Identifiable Information	PII is —any information about an individual maintained by an agency, including (1) any information that can be used to distinguish or trace an individual‘s identity, such as name, social security number, date and place of birth, mother‘s maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.‖
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. Individually identifiable health information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Security Incident	Has the meaning in 45 Code of Federal Regulations Section 164.304. The attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
Unsecured PHI/PI	Has the meaning in 45 Code of Federal Regulations Section 164.402. Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

Policy #:	HH.3016Δ
Title:	**Guidelines for Handling Protected Health Information Offsite**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/03
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy describes the process for handling Protected Health Information (PHI) created, accessed, or taken offsite from CalOptima offices.

II. POLICY

A. CalOptima employees shall exercise precautions according to the regulations and standards set by HIPAA and CalOptima Policies when handling PHI or E-PHI created, accessed, or taken off site from the main office.

III. PROCEDURE

A. General guidelines

1. Staff shall adhere to Minimum Necessary requirements when viewing, documenting, and/or recording information during such reviews of medical records in facilities

2. Staff shall collect all data relative to a Member, whether by interview, observation, or review of documents, in a setting that provides reasonable privacy and protects the information from unauthorized Disclosure.

3. Staff shall protect all physical documents that contain Member PHI from the view or access by an unauthorized person during transport from and to the office through use of:

   a. Binders; and/or

   b. Folders or other protective cover,and/or

   c. Locked in trunk of the vehicle; or

   d. Personal possession of Member PHI such that it is in sight at all times.

4. Staff shall not leave any paper documents containing PHI, or other data collection forms including, without limitation, audit or other data collection forms unattended in areas accessible by an unauthorized person.

5. Staff shall not store confidential, personal, or sensitive information unattended in vehicles at any time.

6. Staff shall not store confidential, personal, or sensitive information unattended in baggage, at any time, during travel.

7. Staff shall not save or store data files in an electronic format that contain PHI on public or private computers, unencrypted personal removable storage devices, personal cloud storage and/or personal email accounts.

8. Staff shall not use mobile devices of any kind to take and save photos of information and/or images containing PHI..

9. Staff shall maintain physical control of CalOptima laptops, cell phones, tablets, USB drives, and all other mobile devices at all times.

10. Staff shall only use CalOptima-issued encrypted storage devices to store files containing PHI, in accordance with CalOptima Policy GA.5005a: Use of Technology Resources.

11. Staff shall shred PHI documents or files prior to disposal. If necessary, staff shall return documents or files to the main office for disposal.

B. Use of Personal Computer (PC) from remote locations

1. Employees granted access to CalOptima's networks are required to adhere to the following procedures:

a. Maintain the Confidentiality of his or her user sign-on identification code and password;

b. Keep the PC secure at all times and do not leave it unattended during travel to, or working offsite at, public places (e.g. hospitals, Long Term Care (LTC) facilities, conferences, etc.);

c. Log off the CalOptima network or lock computer when the PC will be left inactive or unattended; and

d. Ensure that passwords or operating instructions for accessing the CalOptima systems are not stored with the computer.

C. CalOptima employees and Business Associates, First Tier, Downstream and Related Entities (FDRs) shall report any Security Incidents, Breaches of Unsecured PHI/PI and/or other unauthorized access, Use or Disclosure of PHI/PI immediately after discovery during a workweek to the CalOptima Privacy Officer, in accordance with CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other unauthorized Use or Disclosure of PHI/PI.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy GA.5005a: Use of Technology Resources
F. CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other unauthorized Use or Disclosure of PHI/PI
G. CalOptima Policy IS.1102 Electronic Media and Hardware Controls
H. CalOptima Policy IS.1201 EPHI Technical Safeguards -- Access Controls
I. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
J. CMS Missive, Privacy, and Security of Beneficiary Information, Dated June 9, 2006
K. Health Administrative Manual
L. Title 45, Code of Federal Regulations, §164.103
M. Title 45, Code of Federal Regulations, §164.502(b)
Title 45, Code of Federal Regulations, §164.530(c)(1)

VI. REGULATORY APPROVALS

A. 7/16/10: Department of Health Care Services
B. 9/21/09: Department of Health Care Services

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/2003	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Effective	06/01/2005	MA.9220	Guidelines for Handling Protected Health Information (PHI) Offsite	OneCare
Revised	04/01/2007	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Revised	04/01/2007	MA.9220	Guidelines for Handling Protected Health Information (PHI) Offsite	OneCare
Revised	01/01/2009	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Revised	01/01/2009	MA.9220	Guidelines for Handling Protected Health Information (PHI) Offsite	OneCare

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	06/01/2010	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Revised	04/01/2013	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Revised	09/01/2014	MA.9220	Guidelines for Handling Protected Health Information (PHI) Offsite	OneCare
Revised	09/01/2015	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Revised	09/01/2015	MA.9220	Guidelines for Handling Protected Health Information (PHI) Offsite	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3016Δ	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9220	Guidelines for Handling Protected Health Information (PHI) Offsite	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Access Controls	Controls that identify and authenticate a user to allow access to confidential information and Protected Health Information (PHI) based on a business need to know. Access Controls protect the computer systems from unauthorized access as well as determine the type of access a user is entitled to have.
Breach	Has the meaning in 45, Code of Federal Regulations Section 164.402. The acquisition, access, use, or disclosure of protected health information in a manner not permitted under subpart E of this part which compromises the security or privacy of the protected health information. Breach excludes: 1. Any unintentional acquisition, access, or use of protected health information by a workforce member or person acting under the authority of a covered entity or a business associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under subpart E of this part. 2. Any inadvertent disclosure by a person who is authorized to access protected health information at a covered entity or business associate to another person authorized to access protected health information at the same covered entity or business associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under subpart E of this part. 3. A disclosure of protected health information where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or

Term	Definition
	for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
EPHI	Has the meaning in 45, Code of Federal Regulations Section 160.103, individually identifiable health information transmitted by electronic media or maintained in electronic media,
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Intrusion	The act of wrongfully (without authorization) entering upon, seizing, or taking possession of computerized data that compromises the security, confidentiality, or integrity of personal information maintained by CalOptima or its Business Associates.
Long Term Care (LTC)	A variety of services that help Members with health or personal needs and activities of daily living over a period of time. Long Term Care (LTC) may be provided at home, in the community or in various types of facilities, including nursing homes and assisted living facilities.
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	An enrollee-beneficiary of a CalOptima program.

Term	Definition
Minimum Necessary	The principle that covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment or Health Care Operations.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures.
Personally Identifiable Information	PII is ―any information about an individual maintained by an agency, including (1) any information that can be used to distinguish or trace an individual‘s identity, such as name, social security number, date and place of birth, mother‘s maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.‖
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. Individually identifiable health information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Security Incident	Has the meaning in 45 Code of Federal Regulations Section 164.304. The attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
Unsecured PHI/PI	Has the meaning in 45 Code of Federal Regulations Section 164.402. Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

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Policy #:	HH.3019Δ
Title:	**De-identification of Protected Health Information**
Department:	Office of Compliance
Section:	~~Health Insurance Portability and Accountability Act (HIPAA)~~Privacy
CEO Approval:	Michael Schrader
Effective Date:	04/01/03
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy~~o~~ describes the processes CalOptima must undertake, in accordance with HIPAA, to De-Identify Protected Health Information (PHI).~~identifiers that shall be removed prior to the release of Protected Health Information (PHI) containing individual identifying health data for Research or other purposes.~~

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~

Term	Definition
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: — On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or — Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: — A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. — A person that offers a personal health record to one or more individuals on behalf of a covered entity. — A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.
De-identified Information	Health information that does not identify a Member and does not provide a reasonable basis to believe that the information can be used to identify a Member.
Disclosure:	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information. Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.

Term	Definition
Health Care Operations	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Member:	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program. A beneficiary who is enrolled in a CalOptima Program.An enrollee beneficiary of a CalOptima program.
Medical Record:	A medical records, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term "Medical Record" is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Minimum Necessary:	The principle that covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment or Health Care Operations.

Term	Definition
Protected Health Information (PHI):	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: — The past, present, or future physical or mental health or condition of a Member; — The provision of health care to a Member; or — Past, present, or future Payment for the provision of health care to a Member.Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form of medium. This information identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Research:	Systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.
Use	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

HI.II. POLICY

A. CalOptima is permitted to:

1. Use PHI to create information that is not individually identifiable health information; and

2. Disclose PHI to a Business Associate to create information that is not individually identifiable health information.CalOptima may Disclose Minimum Necessary health information without authorization by the Member by removing all identifiers with respect to the individual Member, his or her relatives, employers, and household members from the PHI.

B. CalOptima requires that a Qualified Reviewer process (Expert Reviewer Method) or Removal of Specific Identifier process (Safe Harbor Method), in accordance with this Policy and HIPAA, be used to De-Identify Member data. CalOptima shall also ensure that any identifiers indicating the Member's status as a recipient of public assistance are also removed from the data.

C. CalOptima's creation of De-Identified health information is considered part of Health Care Operations. –If CalOptima uses a third party to De-Identify, such party must comply with this pPolicy and must be a qualified to do so as a Business Associate and subject to a Business Associate Agreement.

D. Health information that does not identify a Member and with respect to which there is no reasonable basis to believe that the information can be used to identify a Member through the De-Identification processes outlined in this Policy and HIPAA is not individually identifiable health information.

A.E. CalOptima shall not authorize Business Associates to De-Identify member data and/or Use or Disclose De-Identified data unless the Business Associate's underlying services provided to CalOptima are expressly related to such purposes.

IV.III. PROCEDURE

A. The Office of Compliance shall use (or validate the use of) one of the following processes when CalOptima De-Identifies health information:

A. The Office of Compliance may use any of the following processes to determine if PHI has been De-identified to protect the confidentiality of the Member.

1. Qualified Reviewer

   a. The Qualified Reviewer must be Aa person with appropriate knowledge of, and experience with, generally accepted statistical and scientific principles and methods for rendering information not individually identifiable.

   b. The Qualified Reviewer shall::

      i. Applying such principles and methods must determine that the risk is very small that the information could be used, alone or in combination with other reasonably available information, by an anticipated recipient to identify an individual who is a subject of the informationDetermine if the risk is minimal, meaning the information can be used, alone or in combination with other reasonable available information, by an anticipated recipient to identify an individual who is a subject of the information; and

      ii. Must document the methods and Document the methods used and results of the analysis, which justify the determination that the information has been De-identified appropriately.

2. Removal of Specific Identifiers

   a. CalOptima or its designated Business Associate must remove all of the following identifiers. The removal of identifiers must be consistent with the level required by HIPAA

regulations (45 CFR Section of 164.514(a)) and Office for Civil Rights (OCR) guidance.~~The De-identification of PHI includes the removal of the following identifiers:~~

i. Name;

ii. Social Security number;

iii. Geographic subdivisions smaller than a state including:

a) Address;

b) City;

c) County;

d) Precinct; and

e) Zip code or equivalent geocode;

iv. Telephone numbers;

v. Facsimile numbers;

vi. E-mail address;

vii. Medical Record number;

viii. Health plan beneficiary number;

ix. All elements of dates (except year) for dates related to an individual:

a) Birth date;

b) Admission date;

c) Discharge date;

d) Date of death;

e) All ages over eighty-nine (89) years; and

f) All elements of dates (including year) indicative of age, except an aggregated single category of “ninety (90) years or older” is permissible.

x. Account number;

xi. Certificate or license number;

xii. Vehicle identifiers, serial numbers, and license plate number;

xiii. Device identifiers and serial numbers;

xiv. Web Universal Resource Locators (URLs);

xv. Internet Protocol (IP) address numbers;

xvi. -Biometric identifiers, voice, and finger prints;

xvii. ~~Full~~. Full face photographs and comparable images; and

xviii. Any other unique identifying number, characteristic, or code.

b. There is no actual knowledge that the information could be used alone or in combination with other information to identify an individual who is a subject of the information.

~~b.~~c. CalOptima shall also ensure that any other identifiers reflecting or indicating the Member's status as a recipient of public assistance are also removed from the data and that the remaining data cannot be used alone or in combination to identify the Member's status as a recipient of public assistance.

3. Re-identification of information

a. A code or other means of record identification may be assigned if:

i. The code is not derived from or related to information about the individual that would allow the individual to be identified (i.e., the first four digits of a social security number).

ii. The code is only used by CalOptima to re-identify the data and the code is not released for use by another person or entity.

~~V.~~IV. ATTACHMENTS

Not Applicable

~~VI.~~V. REFERENCES

~~A. CalOptima Policy AA.1000: Glossary of Terms~~
A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Contract with the Department of Health Care Services (DHCS) for PACE
~~B.~~E. CalOptima Policy AA.1000: Glossary of Terms
F. CalOptima Policy MA.1001: Glossary of Terms
~~C.~~G. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~HIPAA Patient Privacy~~

~~Compliance Guide, Atlantic Information Services, Inc, 2002, Patient Health Information and Research, pp. 2000-39-41~~

~~D.~~H. Department of Health and Human Services, Office of Civil Rights "Guidance Regarding Methods for De-Identification of Protected Health Information in Accordance with the HIPAA Privacy Rule" (November 26, 2012); http://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/index.html

~~E.~~I. Title 45, Code of Federal Regulations (C.F.R), ~~§Section §~~ 164.50~~1~~, 164.502 and 164.514 ~~Definitions Required by Law~~

~~Title 45, Code of Federal Regulations, Section §§ 164.502 and 164.514~~

~~Department of Health and Human Services, Office of Civil Rights "Guidance Regarding Methods for De-Identification of Protected Health Information in Accordance with the HIPAA Privacy Rule" (November 26, 2012); http://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/index.html~~

~~F. Standard: De-Identification of Protected Health Information~~

~~VII.~~VI. REGULATORY AGENCY APPROVALS

None to Date

~~VIII.~~VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/2003	HH.3019	De-identification of Protected Health Information	Medi-Cal
Effective	06/01/2005	MA.9221	De-identification of Protected Health Information	OneCare
Revised	04/01/2007	HH.3019	De-identification of Protected Health Information	Medi-Cal
Revised	02/01/2008	MA.9221	De-identification of Protected Health Information	OneCare
Revised	08/01/2011	HH.3019	De-identification of Protected Health Information	Medi-Cal
Revised	04/01/2013	HH.3019	De-identification of Protected Health Information	Medi-Cal
Revised	09/01/2014	MA.9221	De-identification of Protected Health Information	OneCare
Revised	09/01/2015	HH.3019	De-identification of Protected Health Information	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	09/01/2015	MA.9221	De-identification of Protected Health Information	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3019Δ	De-identification of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9221	De-identification of Protected Health Information	OneCare OneCare Connect PACE

~~**IX.**~~

~~Version~~	~~Version Date~~	~~Policy Number~~	~~Policy Title~~
~~Original Date~~	~~04/2003~~06/01/2005	~~HH.3019~~MA.9221	~~De-identification of Protected Health Information~~
~~Revision Date 1~~	~~04~~02/01/~~2007~~2008	~~HH.3019~~MA.9221	~~De-identification of Protected Health Information~~
~~Revision Date 2~~	~~08~~09/01/~~2011~~2014	~~HH.3019~~MA.9221	~~De-identification of Protected Health Information~~
~~Revision Date 3~~	~~04/01/2013~~	~~HH.3019~~	~~De-identification of Protected Health Information~~
~~Revision Date 4~~3	~~09/01/2015~~	~~HH.3019~~MA.9221	~~De-identification of Protected Health Information~~

IX. GLOSSARY

Term	Definition
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.
De-identified Information	Health information that does not identify a Member and does not provide a reasonable basis to believe that the information can be used to identify a Member.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.

Term	Definition
Health Care Operations	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Member	A beneficiary who is enrolled in a CalOptima Program.
Medical Record	A medical records, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term "Medical Record" is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Research	Systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.
Use	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

1

Policy #:	HH.3019Δ
Title:	**De-identification of Protected Health Information**
Department:	Office of Compliance
Section:	Privacy

CEO Approval: Michael Schrader _____

Effective Date:	04/01/03
Last Review Date:	12/01/16
Last Revised Date:	12/01/16

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE

I. PURPOSE

This policy describes the processes CalOptima must undertake, in accordance with HIPAA, to De-Identify Protected Health Information (PHI).

II. POLICY

A. CalOptima is permitted to:

1. Use PHI to create information that is not individually identifiable health information; and

2. Disclose PHI to a Business Associate to create information that is not individually identifiable health information.

B. CalOptima requires that a Qualified Reviewer process (Expert Reviewer Method) or Removal of Specific Identifier process (Safe Harbor Method), in accordance with this Policy and HIPAA, be used to De-Identify Member data. CalOptima shall also ensure that any identifiers indicating the Member's status as a recipient of public assistance are also removed from the data.

C. CalOptima's creation of De-Identified health information is considered part of Health Care Operations. If CalOptima uses a third party to De-Identify, such party must comply with this policy and must be a qualified to do so as a Business Associate and subject to a Business Associate Agreement.

D. Health information that does not identify a Member and with respect to which there is no reasonable basis to believe that the information can be used to identify a Member through the De-Identification processes outlined in this Policy and HIPAA is not individually identifiable health information.

E. CalOptima shall not authorize Business Associates to De-Identify member data and/or Use or Disclose De-Identified data unless the Business Associate's underlying services provided to CalOptima are expressly related to such purposes.

III. PROCEDURE

A. The Office of Compliance shall use (or validate the use of) one of the following processes when CalOptima De-Identifies health information:

1. Qualified Reviewer

    a. The Qualified Reviewer must be a person with appropriate knowledge of, and experience with, generally accepted statistical and scientific principles and methods for rendering information not individually identifiable.

    b. The Qualified Reviewer:

        i. Applying such principles and methods must determine that the risk is very small that the information could be used, alone or in combination with other reasonably available information, by an anticipated recipient to identify an individual who is a subject of the information; and

        ii. Must document the methods and results of the analysis, which justify the determination that the information has been De-identified appropriately.

2. Removal of Specific Identifiers

    a. CalOptima or its designated Business Associate must remove all of the following identifiers. The removal of identifiers must be consistent with the level required by HIPAA regulations (45 CFR Section of 164.514(a)) and Office for Civil Rights (OCR) guidance.

        i. Name;

        ii. Social Security number;

        iii. Geographic subdivisions smaller than a state including:

            a) Address;

            b) City;

            c) County;

            d) Precinct; and

            e) Zip code or equivalent geocode;

        iv. Telephone numbers;

        v. Facsimile numbers;

        vi. E-mail address;

        vii. Medical Record number;

        viii. Health plan beneficiary number;

        ix. All elements of dates (except year) for dates related to an individual:

a) Birth date;

b) Admission date;

c) Discharge date;

d) Date of death;

e) All ages over eighty-nine (89) years; and

f) All elements of dates (including year) indicative of age, except an aggregated single category of "ninety (90) years or older" is permissible.

x. Account number;

xi. Certificate or license number;

xii. Vehicle identifiers, serial numbers, and license plate number;

xiii. Device identifiers and serial numbers;

xiv. Web Universal Resource Locators (URLs);

xv. Internet Protocol (IP) address numbers;

xvi. Biometric identifiers, voice, and finger prints;

xvii. Full face photographs and comparable images; and

xviii. Any other unique identifying number, characteristic, or code.

b. There is no actual knowledge that the information could be used alone or in combination with other information to identify an individual who is a subject of the information.

c. CalOptima shall also ensure that any other identifiers reflecting or indicating the Member's status as a recipient of public assistance are also removed from the data and that the remaining data cannot be used alone or in combination to identify the Member's status as a recipient of public assistance.

3. Re-identification of information

a. A code or other means of record identification may be assigned if:

i. The code is not derived from or related to information about the individual that would allow the individual to be identified (i.e., the first four digits of a social security number).

ii. The code is only used by CalOptima to re-identify the data and the code is not released for use by another person or entity.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Contract with the Department of Health Care Services (DHCS) for PACE
E. CalOptima Policy AA.1000: Glossary of Terms
F. CalOptima Policy MA.1001: Glossary of Terms
G. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
H. Department of Health and Human Services, Office of Civil Rights "Guidance Regarding Methods for De-Identification of Protected Health Information in Accordance with the HIPAA Privacy Rule" (November 26, 2012); http://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/index.html
I. Title 45, Code of Federal Regulations (C.F.R), §§ 164.50, 164.502 and 164.514

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/2003	HH.3019	De-identification of Protected Health Information	Medi-Cal
Effective	06/01/2005	MA.9221	De-identification of Protected Health Information	OneCare
Revised	04/01/2007	HH.3019	De-identification of Protected Health Information	Medi-Cal
Revised	02/01/2008	MA.9221	De-identification of Protected Health Information	OneCare
Revised	08/01/2011	HH.3019	De-identification of Protected Health Information	Medi-Cal
Revised	04/01/2013	HH.3019	De-identification of Protected Health Information	Medi-Cal
Revised	09/01/2014	MA.9221	De-identification of Protected Health Information	OneCare

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	09/01/2015	HH.3019	De-identification of Protected Health Information	Medi-Cal
Revised	09/01/2015	MA.9221	De-identification of Protected Health Information	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3019Δ	De-identification of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9221	De-identification of Protected Health Information	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.
De-identified Information	Health information that does not identify a Member and does not provide a reasonable basis to believe that the information can be used to identify a Member.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.

Term	Definition
Health Care Operations	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Member	A beneficiary who is enrolled in a CalOptima Program.
Medical Record	A medical records, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term "Medical Record" is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Research	Systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.
Use	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

1

Policy #:	HH.3020Δ
Title:	**Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI**
Department:	Office of Compliance
Section:	~~Health Insurance Portability and Accountability Act (HIPAA)~~Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	07/01/07
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy describes CalOptima's policies and procedures for reporting Security Incidents, Breaches of Unsecured PHI/PI and/or other unauthorized access, Use or Disclosure of PHI/PI to its regulators and providing notice to affected Members and media of Breaches of Unsecured PHI in accordance with contractual and regulatory requirements. ~~This policyo describe outlines CalOptima's policy onprocess for mitigatingon of any Breach of data security, Intrusion, or unauthorized Use or Disclosure of Protected Health Information (PHI). CalOptima shall report the process for notifying the Department of Health Care Services (DHCS), the California Department of Aging (CDA), the Department of Health and Human Services (HHS), and Affected Members of anany Breach of data security, Intrusion, or unauthorized Use or Disclosure of Protected Health Information (PHI) to the , Department of Health Care Services (DHCS), the Department of Health and Human Services (HHS) and other applicable regulatory agencies. This policy also) and describes CalOptima's processthe procedure for notifying individuals whose unsecured PHI has been compromised by such a Bbreach, as well asincluding the notifyingication to the media of breaches affecting five hundred (500) or more individuals, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)~~

~~**DEFINITIONS**~~

~~**Term**~~	~~**Definition**~~
~~Breach~~	~~Has the meaning in 45, Code of Federal Regulations Section 164.402~~ ~~Breach means the acquisition, access, use, or disclosure of protected health information in a manner not permitted under subpart E of this part which compromises the security or privacy of the protected health information.~~

	(1) Breach excludes: (i) Any unintentional acquisition, access, or use of protected health information by a workforce member or person acting under the authority of a covered entity or a business associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under subpart E of this part. (ii) Any inadvertent disclosure by a person who is authorized to access protected health information at a covered entity or business associate to another person authorized to access protected health information at the same covered entity or business associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under subpart E of this part. (iii) A disclosure of protected health information where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.An unauthorized disclosure of protected health information (PHI) that violates either federal or state laws (HIPAA Privacy Rule and State Information Practices Act of 1977) or PHI that has been reasonably believed to have been acquired by an unauthorized person. A breach may be paper or electronic.
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of

	~~protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.~~ ~~A covered entity may be a business associate of another covered entity.~~ ~~Business associate includes:~~ ~~A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information.~~ ~~A person that offers a personal health record to one or more individuals on behalf of a covered entity.~~ ~~1. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: On behalf of a covered entity or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs, or assists in the performance of:~~ ~~a. A function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or~~ ~~b. Any other function or activity regulated by this subchapter; or~~ ~~2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the services involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.~~
~~Corrective Action Plan (CAP)~~	~~A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other~~

	requirements identified by CalOptima and its regulators. A plan delineating specific and identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the State, or designated representatives. Health Networks and Providers may be required to complete CAPs to ensure that they are in compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements identified by CalOptima and its regulators.
Covered Entity	A health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by Title 45, Code of Federal Regulations, Part 160.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Employee	See below for definition of Workforce mMember.
EPHI	Has the meaning in 45, Code of Federal Regulations Section 160.103 individually identifiable health information transmitted by electronic media or maintained in electronic media,
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Intrusion	The act of wrongfully (without authorization) entering upon, seizing, or taking possession of computerized data that compromises the security, confidentiality, or integrity of personal information maintained by CalOptima or its Business Associates.
Member	An enrollee beneficiary of a CalOptima program.A Medi-Cal eligible

	beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Personally Identifiable Information	PII is —any information about an individual maintained by an agency, including (1) any information that can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.‖
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Security Incident	Has the meaning in 45 Code of Federal Regulations Section 164.304. tThe attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
Unsecured PHI/PI	Has the meaning in 45 Code of Federal Regulations Section 164.402. : means pProtected hHealth iInformation that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.
Use of PHI	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. The sharing, employment, application, utilization, examination, or

	analysis of the PHI within an entity that maintains such information.
Workforce Member	Has the meaning in 45, Code of Federal Regulations Section 160.103 including: employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity or business associate, is under the direct control of such covered entity or business associate, whether or not they are paid by the covered entity or business associate.

II. POLICY

A. CalOptima shall report Security Incidents, Breaches of Unsecured PHI or other Unauthorized access, Use or Disclosure of PHI/PI to regulators as required by its regulatory contracts and applicable state and federal laws.CalOptima shall report any Breach of data security, Intrusion, or unauthorized Use or Disclosure of Protected Health Information (PHI) to the Department of Health Care Services (DHCS), the Department of Health and Human Services (HHS) and other applicable regulatory agencies.

As a Covered Entity, CalOptima and its Business Associates shall have Administrative, Physical, and Technical Safeguards in place that reasonably protect the Confidentiality, Integrity, and Availability of PHI, both electronic (EPHI) and non-electronic, in accordance with applicable state and federal regulations, Health Insurance Portability and Accountability Act (HIPAA), and CalOptima privacy and security policies.

A.B. CalOptima employees cEmployees and its Business Associates shall immediately report any suspected or known Security Incidents, Breaches of Unsecured PHI/PI and/or other unauthorized access, Use or Disclosure of PHI/PIBreach of data security, Intrusion, or unauthorized Use or Disclosure of PHI to the CalOptima Privacy Officer, or Designee, in accordance with this policy.

B. Examples of Reportable Security Incidents are: Breaches include, but are not limited to:

1. Lost or Sstolen unencrypted electronic devices that contain PHI or PIelectronic devices that contain PHI;

2. Posting PHI or PI on social mediaA Covered Entity that wrongfully Uses or Discloses PHI;

3. E-mailing or saving EPHI to personal accounts and/or publicly accessible accountsPHI from CalOptima that is posted on a public website by a disgruntled employee;

4. E-mailing EPHI that is not encryptedElectronic mail containing PHI that is sent unencrypted and is intercepted by an unintended third party;

~~5. Downloading EPHI to a portable device in violation of CalOptima's policies (e.g. without express authority and required safeguards (encryption))Lost or Stolen Prior Authorization forms that are left in an employee's automobile;~~

~~6. Faxes or e-mails that contain CalOptima PHI are misdirected to an unintended third party due to the use of incorrect fax numbers or e-mailsPHI that is wrongfully sent by facsimile to an unintended recipient; and~~

~~7. Theft of paper records with CalOptima PHI from an Employee's vehicleRecords containing PHI sent by courier service that are lost or stolen.~~

~~C. CalOptima shall notify DHCS, of the discovery of a suspected or known Breach of data security, Intrusion, or unauthorized Use or Disclosure of PHI, in accordance with this policy,, with the exception of an HMO.~~

~~D. CalOptimaAn HMO A HMO shall directly report to DHCS , and CalOptima any Breach of data security, Intrusion, or unauthorized Use or Disclosure of PHI, involving a CalOptima Member, in accordance with this policy.~~

~~E. CalOptima shall notify the CDA of a suspected or known Breach of data security, intrusion, or unauthorized Use or Disclosure of PHI affecting Multipurpose Senior Services Program (MSSP) Members in accordance with this policy. Notification to the CDA shall be in addition to notification to DHCS.~~

~~F.~~C. Business Associates shall notify CalOptima of discovery of any known or suspected Security Incidents, Breaches of Unsecured PHI/PI and/or other unauthorized access, Use or Disclosure of PHI/PI~~Breach of data security, Intrusion, or unauthorized Use or Disclosure of PHI. , who shall notify DHCS within the timeframe specified in the DHCS contract and Section IV.B.1 of this policy.~~ Business Associates shall submit a written report to CalOptima of a suspected or known Security Incidents, Breaches of Unsecured PHI/PI and/or other unauthorized access, Use or Disclosure of PHI/PI~~Breach, Intrusion, or unauthorized Use or Disclosure of PHI~~, in accordance with this policy.

~~G.~~ CalOptima shall investigate such a Security Incident, Breach of Unsecured PHI/PI and/or other unauthorized access, Use or Disclosure of PHI/PI~~Breach, Intrusion, or unauthorized Use or Disclosure of PHI~~ and provide a written report of the investigation to DHCS in accordance with this policy.

~~H.~~D.

~~I. CalOptima shall provide a written report of the investigation to the CDA of a suspected or known Breach, Intrusion, or unauthorized Use or Disclosure of PHI affecting MSSP Members. A written report to the CDA shall be in addition to the written report to DHCS.~~

~~J.~~E. CalOptima shall notify individual Members whose unsecured PHI has been or believed to have been accessed, acquired, Used, or Disclosed as a result of a Breach by a Covered Entity, which compromises the security or privacy of the PHI. ~~Such notice shall be made without unreasonable~~

~~delay and no later than sixty (60) calendar days from the date of discovery of the Breach, in accordance with Section IV.B.1 of this policy.~~

~~K. CalOptima shall notify the HHS of Breaches of PHI involving five-hundred (500) or more Members concurrently with notification to Affected Members. For breaches of PHI involving less than five-hundred (500) Members, CalOptima shall submit a log to the HHS no later than sixty (60) calendar days after the end of each calendar year.~~

~~L.~~F. CalOptima shall take appropriate actions to mitigate any harmful effect known to be caused by a Breach of Unsecured PHI/PI in accordance with CalOptima Policies~~A Covered Entity shall take prompt corrective action to mitigate any risks or damages caused by a Breach, to the extent possible.~~. ~~, in accordance with CalOptima Policy HH.3013: Mitigation.~~

~~M.~~G. Business Associates shall comply with CalOptima Business Associate Agreement reporting and notice requirements when a Security Incident or Breach of Unsecured PHI/PI or other unauthorized access, Use or Disclosure of PHI involves DHCS and/or CalOptima PHI/PI. ~~CalOptima, HMOs, and Business Associates shall follow the notification requirements for affected Members of the CalOptima Program~~ as required by applicable regulatory agencies. ~~in, accordance with CalOptima Policy HF.9020: Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Heath Information.~~

~~N. CalOptima, HMOs, Physician Medical Groups and Business Associates shall follow the notification requirements for affected Members of the OneCare Program, in accordance with OneCare Policy MA.9222: Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Heath Information.~~

III. PROCEDURE

A. Discovery

1. CalOptima ~~employees~~Employees, Health Networks, with the exception of a HMO, ~~,~~ and Business Associates shall report any Security Incidents, Breaches of Unsecured PHI/PI and/or other unauthorized access, Use or Disclosure of PHI/PI ~~Breach of data security, Intrusion, or unauthorized Use or Disclosure of PHI~~ immediately after discovery ~~during the business day~~ to the CalOptima Privacy Officer, or Designee by telephone, fax or email Privacy@CalOptima.org.~~.~~

a. ~~a.~~ Examples of Reportable Security Incidents or Breaches are:

i. Lost or stolen unencrypted electronic devices that contain PHI or PI;

ii. Posting PHI or PI on social media;

iii. E-mailing or saving EPHI to personal accounts and/or publicly accessible accounts; ;

iv. E-mailing EPHI that is not encrypted;

v. Downloading EPHI to a portable device in violation of CalOptima's policies (e.g. without express authority and required safeguards (encryption));

vi. Faxes or e-mails that contain CalOptima PHI are misdirected to an unintended third party due to the use of incorrect fax numbers or e-mails; and

vii. Theft of paper records with CalOptima PHI from an e~~E~~mployee's vehicle.

~~2. If the initial discovery occurs during non-business hours, CalOptima employees and Business Associates shall report the initial discovery to CalOptima's Customer Service Department~~

~~If the Business Associate is an HMO that has a direct contract with Medi-Cal, the HMO shall directly and immediately report to DHCS the discovery of any suspected or known Breach of data security, Intrusion, or unauthorized Use or Disclosure of PHI involving a CalOptima Member. The HMO shall send a copy of the report to CalOptima's Privacy Officer, or Designee, immediately after notification to DHCS, in accordance with Section IV.B.1 of this policy.~~

B. The CalOptima Privacy Officer or Designee shall notify and report the discovery of any known or suspected Breach of data security, Intrusion, or unauthorized Use or Disclosure of PHI to DHCS, in accordance with the following guidelines:

1. Notification to DHCS:

a. EPHI: The CalOptima Privacy Officer or Designee shall notify DHCS immediately after the discovery, in accordance with Sections III~~V~~.B.1.b. and III~~V~~.B.1.c. of this policy, as applicable.

b. PHI in non-electronic form: ~~-~~The CalOptima Privacy Officer or Designee shall notify DHCS within twenty-four (24) hours after the initial discovery, in accordance with Section III~~V~~.B.1.c. of this policy.

c. The CalOptima Privacy Officer or Designee shall notify the DHCS Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer by electronic mail or facsimile, and by telephone, as required.

~~d. If the incident is discovered during non-business hours and involves EPHI, the CalOptima Privacy Officer or Designee shall notify DHCS immediately by calling the DHCS ITSD Help Desk at 1-916-440-7000.~~

2. ~~Business Associates shall notify CalOptima of discovery of any known or suspected~~ Security ~~Incidents, Breaches of Unsecured PHI/PI and/or other unauthorized access, Use or Disclosure of PHI/PIBreach of data security, Intrusion, or unauthorized Use or Disclosure of PHI, who shall contact DHCS immediately, as specified in the DHCS contract and Section IV.B of this policy.~~ Business Associates shall submit a written report directly to the CalOptima Privacy Officer or

Designee within ~~three (3) business days~~forty-eight (48) hours after the initial discovery. The written report shall contain the elements specified in the DHCS Privacy Incident Report Form ~~Section IV.B.4.b of this policy~~. CalOptima shall investigate the incident and report directly to DHCS, in accordance with Section III~~V~~.B. of this policy.

3. If the Business Associate is an HMO that has a direct contract with Medi-Cal, the HMO shall report its discovery of a Breach directly to DHCS if it involves a CalOptima Member. The HMO shall simultaneously copy the report to the CalOptima Privacy Officer or Designee by electronic mail to ~~HN~~ReportingPrivacy@caloptima.org. The HMO Privacy Officer shall report the Breach as it pertains to CalOptima Members to DHCS using the guidelines in Section III~~V~~.B. of this policy.

4. Investigation and written report to DHCS:

   a. The CalOptima Privacy Officer or Designee shall investigate the Breach, Intrusion, or unauthorized Use or Disclosure of PHI, and provide an interim written report of the investigation to the DHCS Privacy Officer, the DHCS Contract Manager, and the DHCS Information Security Officer within seventy-two (72) hours after the initial discovery.

   b. Within ten (10) working days of the initial discovery, CalOptima Privacy Officer or Designee shall submit a complete investigation report to the DHCS Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer.

C. CalOptima shall complete the investigative report for DHCS by using ~~use~~ the DHCS Privacy Incident Report Form.

~~c. , which include but not limited to the following:~~

~~d.~~

~~i. The date of the incident, when the incident was discovered, and when DHCS was notified of the incident;~~

~~ii.~~

~~iii. A complete description of the incident, including:~~

~~iv.~~

~~1) The data elements involved and the extent of the data involved in the Breach;~~
~~2)~~
~~3) The primary job function of the person known or reasonably believed to have improperly Used or Disclosed PHI;~~
~~4)~~
~~5) A description of where the PHI is believed to have been improperly transmitted, sent, or utilized;~~
~~6)~~
~~7) The cause or probable cause of the incident;~~
~~8)~~
~~9) The impact of the incident including, but not limited to, potential misuse of data or identity theft;~~

~~10)~~

~~11) If California Civil Code sections 1798.39 and 1798.82, Title 13 of the American Recovery and Reinvestment Act of 2009, or any other federal or state laws requiring individual notifications of Breaches are triggered;~~

~~12) The steps taken to reduce the harmful effects (mitigation); and~~

~~13) A Corrective Action Plan (CAP) that describes how CalOptima will prevent reoccurrence of this incident in the future.~~

~~C. The CalOptima Privacy Officer or Designee shall notify and report the discovery of a suspected Breach of data security, Intrusion, or unauthorized Use or Disclosure of PHI affecting MSSP Members to the CDA in accordance with the following guidelines:~~

~~1. Notification to the CDA: The CalOptima Privacy Officer or Designee shall notify CDA within twenty-four (24) hours after the initial discovery. CalOptima's Privacy Officer or Designee shall notify the CDA MSSP Operations Manager and CDA MSSP Branch Chief by electronic mail.~~

~~2. Written Report to the CDA:~~

~~a. The CalOptima Privacy Officer or Designee shall investigate the Breach, Intrusion, or unauthorized Use or Disclosure of PHI, and provide a written report of the investigation to the CDA within five (5) business days after the initial discovery. The written report shall be emailed to the CDA MSSP Operations Manager, the CDA MSSP Branch Chief, and the CDA Information Security Officer.~~

~~b. CalOptima shall use the CDA Incident Report Form.~~

D. CalOptima shall notify Members whose unsecured ePHI has been or is believed to have been accessed, acquired, Used, or Disclosed as a result of a Breach which compromises the security or privacy of the PHI. All notifications shall be provided without unreasonable delay and no later than sixty (60) calendar days after the date of discovery, which is the first day the breach is known by a Covered Entity, or would have been known by exercising reasonable diligence. CalOptima shall provide notification as specified below.

1. CalOptima shall write the notification in plain language and include, to the extent possible:

   a. A brief description of what occurred, including the date of the Breach and the date of the discovery of the Breach, if known;

   b. A description of the types of unsecured PHI that were involved in the Breach (e.g., full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information involved);

c. Any steps Members should take to protect themselves from potential harm resulting from the Breach;

d. A brief description of what the Covered Entity is doing to investigate the Breach, to mitigate harm to Members, and to protect against any further Breaches; and

e. Contact procedures for M~~m~~embers to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, website, or postal address.

2. CalOptima shall provide notification in the following form:

a. CalOptima shall send written notification by first-class mail to the Member at the last known address or by electronic mail if the Member has agreed to receive notice by electronic mail. CalOptima may provide notification in one (1) or more mailings as information is available.

i. If the Member is deceased, CalOptima shall provide written notification by first-class mail to either the next of kin or personal representative of the M~~m~~ember, if contact information is known.

ii. If current contact information is unavailable for fewer than ten (10) Members, CalOptima may provide a substitute notice by an alternative form of written notice, telephone, or other means.

iii. If current contact information is unavailable for ten (10) or more Members, CalOptima shall provide a substitute notice by a readily visible posting on the homepage of CalOptima's Website for ninety (90) calendar days or by a readily visible notice in a major print or broadcast media. The notice shall include a toll-free telephone number that remains active for at least ninety (90) calendar days for Members to obtain information regarding the Breach.

~~b.~~ If CalOptima deems a Breach incident to require urgency because of a possible imminent misuse of unsecured PHI, CalOptima may provide Breach notification to Members by telephone or other means, in addition to written notice.

~~c.~~b.

~~d. For a Breach of unsecured PHI affecting more than five hundred (500) Members, CalOptima shall notify and ensure publication of the Breach by prominent media outlets serving Orange County, in addition to providing individual written notices.~~

E. The CalOptima Privacy Officer or Designee shall notify the Secretary of HHS immediately following the discovery of a Breach of unsecured PHI as follows:

1. For Breaches of unsecured PHI involving five hundred (500) or more Members, the CalOptima Privacy Officer shall provide notification to the Secretary of HHS. ~~concurrently with notifications provided to Affected Members.~~

2. For Breaches of unsecured PHI involving less than five hundred (500) Members, the CalOptima Privacy Officer shall submit a log of such Breaches for the preceding calendar year, no later than sixty (60) calendar days after the end of each calendar year.

F. ~~F.~~ For a Breach of unsecured PHI affecting more than five hundred (500) individuals,~~-~~ CalOptima shall ~~–~~notify prominent media outlets serving Orange County, in addition to providing individual written notices without unreasonable delay, but no later than sixty (60) calendar days from the date of discovery.

IV. ATTACHMENTS

A. DHCS Privacy Incident Report Form
~~B. CDA Incident Report Form~~

V. REFERENCES

A. CalOptima Business Associates Agreement
B. CalOptima Compliance Plan
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~CalOptima Contract with the Department of Health Care Services (DHCS) for PACE~~ PACE Program Agreement
~~A. CalOptima Contract with the Department of Health Care Services (DHCS)~~
~~B. CalOptima Contract for Health Care Services~~
~~C. CalOptima Business Associates Agreement~~
~~D.~~E. ~~CalOptima Policy AA.1000: Glossary of Terms~~
~~E. CalOptima Policy IS.1001: Glossary of Terms~~
~~F. CalOptima Policy HH.3013: Mitigation~~
~~G.~~F. CalOptima Privacy Program
G. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
H. MMCD All Plan Letter 06001: HIPAA Requirements: Notice of Privacy Practices and Notification of Breaches
I. MMCD All Plan Letter 06005: Protected Health Information (PHI) and Notification of Breaches
J. CDA Program Memorandum PM 07-18(P): Protection of Information Assets
~~K. NCQA Standard RR5 Privacy and Confidentiality: Element F: Accountability and Responsibility, Factor 1-3 – 2014~~

K. Health Information and Technology for Economic and Clinical Health Act ("HITECH Act")Title 13, American Recovery and Reinvestment Act of 2009
L. Title 45, Code of Federal Regulations §164.400 et seq
M. Title 45, Code of Federal Regulations §164.502 Uses and Disclosures of PHI
N. Title 45, Code of Federal Regulations §164.514
N.O. Title 42 United State Code (U.S.C) Section 17932(h) Other Requirements Related to Uses and Disclosures of PHI

VI. REGULATORY AGENCY APPROVALS

A. 07/22/13: Department of Health Care Services

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3013	Mitigation	Medi-Cal
Effective	06/01/2005	MA.9217	Mitigation	OneCare
Revised	04/01/2007	HH.3013	Mitigation	Medi-Cal
Effective	07/01/2007	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Effective	08/01/2007	MA.9222	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	OneCare
Revised	02/01/2008	MA.9217	Mitigation	OneCare
Revised	01/01/2010	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2010	MA.9222	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	OneCare

Poli~~-~~cy #: HH.3020Δ

Title: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other U~~u~~nauthorized Use or Disclosure of PHI/PI~~Reporting of a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information~~

- Revised Date: 12~~9~~/01/15~~6~~

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	09/01/2011	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	09/01/2011	MA.9222	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	OneCare
Revised	11/01/2011	HH.3013	Mitigation	Medi-Cal
Revised	12/01/2012	HH.3013	Mitigation	Medi-Cal
Revised	12/01/2012	MA.9217	Mitigation	OneCare
Revised	01/01/2013	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	12/01/2013	HH.3013	Mitigation	Medi-Cal
Revised	01/01/2014	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2014	MA.9217	Mitigation	OneCare
Revised	06/01/2014	MA.9222	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	OneCare
Revised	11/01/2014	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	11/01/2014	HH.3013	Mitigation	Medi-Cal
Revised	09/01/2015	HH.3013	Mitigation	Medi-Cal
Revised	09/01/2015	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal

Poli~~-~~cy #:	HH.3020Δ		
Title:	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other U~~u~~nauthorized Use or Disclosure of PHI/PI~~Reporting of a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information~~	- Revised Date:	12~~9~~/01/15~~6~~

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	09/01/2015	MA.9217	Mitigation	OneCare OneCare Connect PACE
Revised	09/01/2015	MA.9222	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3020Δ	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9222	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	OneCare OneCare Connect PACE

~~Version~~	~~Version Date~~	~~Policy Number~~	~~Policy Title~~
~~Original Date~~	~~07/01/2007~~	~~HH.3020~~	~~Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information~~
~~Revision Date 1~~	~~01/01/2010~~	~~HH.3020~~	~~Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information~~
~~Revision Date 2~~	~~09/01/2011~~	~~HH.3020~~	~~Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information~~
~~Revision Date 3~~	~~01/01/2013~~	~~HH.3020~~	~~Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information~~
~~Revision Date 4~~	~~01/01/2014~~	~~HH.3020~~	~~Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information~~
~~Revision Date 5~~	~~11/01/2014~~	~~HH.3020~~	~~Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information~~
~~Revision Date 6~~	~~09/01/2015~~	~~HH.3020~~	~~Reporting a Breach of Data Security, Intrusion,~~

Poli~~-~~cy #:	HH.3020Δ		
Title:	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other U~~u~~nauthorized Use or Disclosure of PHI/PI~~Reporting of a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information~~	~~-~~ Revised Date:	12~~9~~/01/15~~5~~6

~~**Version**~~	~~**Version Date**~~	~~**Policy Number**~~	~~**Policy Title**~~
			~~or Unauthorized Use or Disclosure of Protected Health Information~~

1

IX. GLOSSARY

Term	Definition
Breach	Has the meaning in 45, Code of Federal Regulations Section 164.402. Breach means the acquisition, access, use, or disclosure of protected health information in a manner not permitted under subpart E of this part which compromises the security or privacy of the protected health information. (1) Breach excludes: (i) Any unintentional acquisition, access, or use of protected health information by a workforce member or person acting under the authority of a covered entity or a business associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under subpart E of this part. (ii) Any inadvertent disclosure by a person who is authorized to access protected health information at a covered entity or business associate to another person authorized to access protected health information at the same covered entity or business associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under subpart E of this part. (iii) A disclosure of protected health information where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of

Term	Definition
	such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Covered Entity	A health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by Title 45, Code of Federal Regulations, Part 160.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Employee	See below for definition of Workforce Member.
EPHI	Has the meaning in 45, Code of Federal Regulations Section 160.103 individually identifiable health information transmitted by electronic media or maintained in electronic media,

Term	Definition
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Intrusion	The act of wrongfully (without authorization) entering upon, seizing, or taking possession of computerized data that compromises the security, confidentiality, or integrity of personal information maintained by CalOptima or its Business Associates.
Member	An enrollee-beneficiary of a CalOptima program.
Personally Identifiable Information	PII is ―any information about an individual maintained by an agency, including (1) any information that can be used to distinguish or trace an individual‘s identity, such as name, social security number, date and place of birth, mother‘s maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.‖
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Security Incident	Has the meaning in 45 Code of Federal Regulations Section 164.304. The attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

Term	Definition
Unsecured PHI/PI	Has the meaning in 45 Code of Federal Regulations Section 164.402. Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.
Workforce Member	Has the meaning in 45, Code of Federal Regulations Section 160.103 including: employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity or business associate, is under the direct control of such covered entity or business associate, whether or not they are paid by the covered entity or business associate.

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Policy #:	HH.3020Δ
Title:	**Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	07/01/07
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy describes CalOptima's policies and procedures for reporting Security Incidents, Breaches of Unsecured PHI/PI and/or other unauthorized access, Use or Disclosure of PHI/PI to its regulators and providing notice to affected Members and media of Breaches of Unsecured PHI in accordance with contractual and regulatory requirements.

II. POLICY

A. CalOptima shall report Security Incidents, Breaches of Unsecured PHI or other Unauthorized access, Use or Disclosure of PHI/PI to regulators as required by its regulatory contracts and applicable state and federal laws.

B. CalOptima employees shall immediately report any suspected or known Security Incidents, Breaches of Unsecured PHI/PI and/or other unauthorized access, Use or Disclosure of PHI/PI to the CalOptima Privacy Officer, or Designee, in accordance with this policy.

C. Business Associates shall notify CalOptima of discovery of any known or suspected Security Incidents, Breaches of Unsecured PHI/PI and/or other unauthorized access, Use or Disclosure of PHI/PI. Business Associates shall submit a written report to CalOptima of a suspected or known Security Incidents, Breaches of Unsecured PHI/PI and/or other unauthorized access, Use or Disclosure of PHI/PI, in accordance with this policy.

D. CalOptima shall investigate such a Security Incident, Breach of Unsecured PHI/PI and/or other unauthorized access, Use or Disclosure of PHI/PI and provide a written report of the investigation to DHCS in accordance with this policy.

E. CalOptima shall notify individual Members whose unsecured PHI has been or believed to have been accessed, acquired, Used, or Disclosed as a result of a Breach by a Covered Entity, which compromises the security or privacy of the PHI.

F. CalOptima shall take appropriate actions to mitigate any harmful effect known to be caused by a Breach of Unsecured PHI/PI in accordance with CalOptima Policies.

G. Business Associates shall comply with CalOptima Business Associate Agreement reporting and notice requirements when a Security Incident or Breach of Unsecured PHI/PI or other unauthorized access, Use or Disclosure of PHI involves DHCS and/or CalOptima PHI/PI.

III. PROCEDURE

A. Discovery

1. CalOptima Employees, Health Networks, with the exception of a HMO, and Business Associates shall report any Security Incidents, Breaches of Unsecured PHI/PI and/or other unauthorized access, Use or Disclosure of PHI/PI immediately after discovery to the CalOptima Privacy Officer, or Designee by telephone, fax or email Privacy@CalOptima.org.

a. Examples of Reportable Security Incidents or Breaches are:

i. Lost or stolen unencrypted electronic devices that contain PHI or PI;

ii. Posting PHI or PI on social media;

iii. E-mailing or saving EPHI to personal accounts and/or publicly accessible accounts; ;

iv. E-mailing EPHI that is not encrypted;

v. Downloading EPHI to a portable device in violation of CalOptima's policies (e.g. without express authority and required safeguards (encryption));

vi. Faxes or e-mails that contain CalOptima PHI are misdirected to an unintended third party due to the use of incorrect fax numbers or e-mails; and

vii. Theft of paper records with CalOptima PHI from an employee's vehicle.

B. The CalOptima Privacy Officer or Designee shall notify and report the discovery of any known or suspected Breach of data security, Intrusion, or unauthorized Use or Disclosure of PHI to DHCS, in accordance with the following guidelines:

1. Notification to DHCS:

a. EPHI: The CalOptima Privacy Officer or Designee shall notify DHCS immediately after the discovery, in accordance with Sections III.B.1.b. and III.B.1.c. of this policy, as applicable.

b. PHI in non-electronic form: The CalOptima Privacy Officer or Designee shall notify DHCS within twenty-four (24) hours after the initial discovery, in accordance with Section III.B.1.c. of this policy.

c. The CalOptima Privacy Officer or Designee shall notify the DHCS Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer by electronic mail or facsimile, and by telephone, as required.

2. Business Associates shall submit a written report directly to the CalOptima Privacy Officer or Designee within forty–eight (48) hours after the initial discovery. The written report shall contain the elements specified in the DHCS Privacy Incident Report Form. CalOptima shall investigate the incident and report directly to DHCS, in accordance with Section III.B. of this policy.

3. If the Business Associate is an HMO that has a direct contract with Medi-Cal, the HMO shall report its discovery of a Breach directly to DHCS if it involves a CalOptima Member. The HMO shall simultaneously copy the report to the CalOptima Privacy Officer or Designee by electronic mail to Privacy@caloptima.org. The HMO Privacy Officer shall report the Breach as it pertains to CalOptima Members to DHCS using the guidelines in Section III.B. of this policy.

4. Investigation and written report to DHCS:

a. The CalOptima Privacy Officer or Designee shall investigate the Breach, Intrusion, or unauthorized Use or Disclosure of PHI, and provide an interim written report of the investigation to the DHCS Privacy Officer, the DHCS Contract Manager, and the DHCS Information Security Officer within seventy-two (72) hours after the initial discovery.

b. Within ten (10) working days of the initial discovery, CalOptima Privacy Officer or Designee shall submit a complete investigation report to the DHCS Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer.

C. CalOptima shall complete the investigative report for DHCS by using the DHCS Privacy Incident Report Form.

D. CalOptima shall notify Members whose unsecured ePHI has been or is believed to have been accessed, acquired, Used, or Disclosed as a result of a Breach which compromises the security or privacy of the PHI. All notifications shall be provided without unreasonable delay and no later than sixty (60) calendar days after the date of discovery, which is the first day the breach is known by a Covered Entity, or would have been known by exercising reasonable diligence. CalOptima shall provide notification as specified below.

1. CalOptima shall write the notification in plain language and include, to the extent possible:

a. A brief description of what occurred, including the date of the Breach and the date of the discovery of the Breach, if known;

b. A description of the types of unsecured PHI that were involved in the Breach (e.g., full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information involved);

c. Any steps Members should take to protect themselves from potential harm resulting from the Breach;

d. A brief description of what the Covered Entity is doing to investigate the Breach, to mitigate harm to Members, and to protect against any further Breaches; and

e. Contact procedures for Members to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, website, or postal address.

2. CalOptima shall provide notification in the following form:

a. CalOptima shall send written notification by first-class mail to the Member at the last known address or by electronic mail if the Member has agreed to receive notice by electronic mail. CalOptima may provide notification in one (1) or more mailings as information is available.

i. If the Member is deceased, CalOptima shall provide written notification by first-class mail to either the next of kin or personal representative of the Member, if contact information is known.

ii. If current contact information is unavailable for fewer than ten (10) Members, CalOptima may provide a substitute notice by an alternative form of written notice, telephone, or other means.

iii. If current contact information is unavailable for ten (10) or more Members, CalOptima shall provide a substitute notice by a readily visible posting on the homepage of CalOptima's Website for ninety (90) calendar days or by a readily visible notice in a major print or broadcast media. The notice shall include a toll-free telephone number that remains active for at least ninety (90) calendar days for Members to obtain information regarding the Breach.

b. If CalOptima deems a Breach incident to require urgency because of a possible imminent misuse of unsecured PHI, CalOptima may provide Breach notification to Members by telephone or other means, in addition to written notice.

E. The CalOptima Privacy Officer or Designee shall notify the Secretary of HHS immediately following the discovery of a Breach of unsecured PHI as follows:

1. For Breaches of unsecured PHI involving five hundred (500) or more Members, the CalOptima Privacy Officer shall provide notification to the Secretary of HHS.

2. For Breaches of unsecured PHI involving less than five hundred (500) Members, the CalOptima Privacy Officer shall submit a log of such Breaches for the preceding calendar year, no later than sixty (60) calendar days after the end of each calendar year.

F. For a Breach of unsecured PHI affecting more than five hundred (500) individuals, CalOptima shall notify prominent media outlets serving Orange County, in addition to providing individual written notices without unreasonable delay, but no later than sixty (60) calendar days from the date of discovery.

IV. ATTACHMENTS

A. DHCS Privacy Incident Report Form

V. REFERENCES

A. CalOptima Business Associates Agreement
B. CalOptima Compliance Plan
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima PACE Program Agreement
F. CalOptima Privacy Program
G. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
H. MMCD All Plan Letter 06001: HIPAA Requirements: Notice of Privacy Practices and Notification of Breaches
I. MMCD All Plan Letter 06005: Protected Health Information (PHI) and Notification of Breaches
J. CDA Program Memorandum PM 07-18(P): Protection of Information Assets
K. Health Information and Technology for Economic and Clinical Health Act ("HITECH Act")
L. Title 45, Code of Federal Regulations §164.400 et seq
M. Title 45, Code of Federal Regulations §164.502
N. Title 45, Code of Federal Regulations §164.514
O. Title 42 United State Code (U.S.C) Section 17932(h)

VI. REGULATORY AGENCY APPROVALS

A. 07/22/13: Department of Health Care Services

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3013	Mitigation	Medi-Cal
Effective	06/01/2005	MA.9217	Mitigation	OneCare
Revised	04/01/2007	HH.3013	Mitigation	Medi-Cal
Effective	07/01/2007	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	08/01/2007	MA.9222	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	OneCare
Revised	02/01/2008	MA.9217	Mitigation	OneCare
Revised	01/01/2010	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2010	MA.9222	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	OneCare
Revised	09/01/2011	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	09/01/2011	MA.9222	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	OneCare
Revised	11/01/2011	HH.3013	Mitigation	Medi-Cal
Revised	12/01/2012	HH.3013	Mitigation	Medi-Cal
Revised	12/01/2012	MA.9217	Mitigation	OneCare
Revised	01/01/2013	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	12/01/2013	HH.3013	Mitigation	Medi-Cal
Revised	01/01/2014	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2014	MA.9217	Mitigation	OneCare
Revised	06/01/2014	MA.9222	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	OneCare

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	11/01/2014	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	11/01/2014	HH.3013	Mitigation	Medi-Cal
Revised	09/01/2015	HH.3013	Mitigation	Medi-Cal
Revised	09/01/2015	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	09/01/2015	MA.9217	Mitigation	OneCare OneCare Connect PACE
Revised	09/01/2015	MA.9222	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3020Δ	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9222	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Breach	Has the meaning in 45, Code of Federal Regulations Section 164.402. Breach means the acquisition, access, use, or disclosure of protected health information in a manner not permitted under subpart E of this part which compromises the security or privacy of the protected health information. (1) Breach excludes: (i) Any unintentional acquisition, access, or use of protected health information by a workforce member or person acting under the authority of a covered entity or a business associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under subpart E of this part. (ii) Any inadvertent disclosure by a person who is authorized to access protected health information at a covered entity or business associate to another person authorized to access protected health information at the same covered entity or business associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under subpart E of this part. (iii) A disclosure of protected health information where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such

Term	Definition
	covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.
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Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Employee	See below for definition of Workforce Member.
EPHI	Has the meaning in 45, Code of Federal Regulations Section 160.103 individually identifiable health information transmitted by electronic media or maintained in electronic media,
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.

Term	Definition
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Intrusion	The act of wrongfully (without authorization) entering upon, seizing, or taking possession of computerized data that compromises the security, confidentiality, or integrity of personal information maintained by CalOptima or its Business Associates.
Member	An enrollee-beneficiary of a CalOptima program.
Personally Identifiable Information	PII is ―any information about an individual maintained by an agency, including (1) any information that can be used to distinguish or trace an individual‘s identity, such as name, social security number, date and place of birth, mother‘s maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.‖
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Security Incident	Has the meaning in 45 Code of Federal Regulations Section 164.304. The attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
Unsecured PHI/PI	Has the meaning in 45 Code of Federal Regulations Section 164.402. Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

Term	Definition
Workforce Member	Has the meaning in 45, Code of Federal Regulations Section 160.103 including: employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity or business associate, is under the direct control of such covered entity or business associate, whether or not they are paid by the covered entity or business associate.

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PRIVACY INCIDENT REPORT (PIR)

The information reported in this form will be strictly confidential. The information reported in this form will be used to review your determination of whether a breach has occurred.

*☐ = Required items within 72 hours of discovery, to the extent known

† = US Health and Human Services (HHS) required information

1. SUMMARY OF PRIVACY INCIDENT *† (Please include location of the Privacy Incident, how the Privacy Incident occurred, and any information regarding the type of media and protected health information involved in the Privacy Incident.)

2. BASIC INFRMATION *†

DHCS Privacy Incident case number (this will be assigned after initial report):

Reporting entity's Privacy Incident case number (if applicable):

Date of most recent updates (today's date):

Reporting entity:	Type of Entity:	HIPAA Covered Entity?

Return completed form to: privacyofficer@dhcs.ca.gov or fax to: (916) 440-7680

The type of contract the reporting entity has with DHCS?

Entity that caused Privacy Incident:

HIPAA Covered Entity?

Reporting entity's relationship with the entity that caused the Privacy Incident:

Date(s) of Privacy Incident: **Dates(s) of discovery:** **Date of notice to DHCS:**

Number of individuals affected by Privacy Incident:

What was the primary job function of the person(s) known, or reasonably believed, to have improperly sent, used, accessed, or disclosed PHI/PI (include employer/employee status, and any other pertinent information)?

What was the primary job function of the person(s) who viewed or (accidentally) obtained PHI/PI (include employer, employee status, other health plan member, and any other pertinent information)?

Additional basic information:

Was this incident a Violation of your Policies and Procedures?

If yes, please explain:

Return completed form to: privacyofficer@dhcs.ca.gov or fax to: (916) 440-7680

3. CONTACT INFORMATION *†

Reporting entity's contact's name:

Reporting entity's contact's e-mail:

Reporting entity's contact's telephone number:

Was this incident reported to any other entities/persons(s):

If the answer to the above questions is 'yes', then list the contact information of the entity/person the report was filed with:

4. PROTECTED HEALTH INFORMATION (PHI)/PERSONALLY IDENTIFIABLE (PI)*

Does the information disclosed in the Privacy Incident provide a reasonable basis to believe it can be used to identify an individual?

Does the information disclosed in the Privacy Incident relate to the past, present, or future physical or mental health, or condition of an individual?

Does the information involved in the Privacy Incident relate to the payment or provision of health care to an individual?

5. TYPE OF PRIVACY INCIDENT *†

- ☐ Improper Disposal
- ☐ Theft
- ☐ Loss
- ☐ Unauthorized Disclosure
- ☐ Mis-Sent
- ☐ Hacking/IT Incident
- ☐ Unauthorized Use/Access
- ☐ Unknown
- ☐ Other

If other, please explain:

6. TYPE OF PROTECTED INFORMATION INVOLVED *†

DEMOGRAPHIC INFORMATION

- ☐ First Name or Initial
- ☐ Last Name
- ☐ Address/Zip
- ☐ CIN or Medi-Cal #
- Date of Birth
- ☐ Social Security Number
- ☐ Driver's License
- ☐ Membership #
- ☐ Health Plan Name
- ☐ User Name/Email Address with Password
- ☐ Other

Return completed form to: privacyofficer@dhcs.ca.gov or fax to: (916) 440-7680

If other type of protected information, please explain:

FINANCIAL INFORMATION

☐ Credit Card / Bank Acct# ☐ Claims Information ☐ Other

If other, please explain:

CLINICAL INFORMATION

☐ Diagnosis / Condition ☐ Medications ☐ Psychotherapy notes

☐ Mental Health Data ☐ Lab Results ☐ Substance Use / Alcohol Data

☐ Other

If other, please explain:

Please list all the data elements originally obtained from DHCS:

Please list all the data elements originally obtained from or verified by the Social Security Administration:

7. LOCATION OF INFORMATION DISCLOSED IN PRIVACY INCIDENT *†

☐ Laptop ☐ Network Server ☐ Desktop Computer

☐ Portable Electronic Device Email ☐ Electronic Record

☐ Paper Data ☐ Smart Phone ☐ Hard Drive

☐ CD / DVD ☐ PDA ☐ Tape / DLT / DASD

☐ USB Thumb Drive Fax ☐ Other

If other, please explain: if network server please provide the name of the server and who owns it:

Return completed form to: privacyofficer@dhcs.ca.gov or fax to: (916) 440-7680

8. APPLICABLE SAFEGUARDS IN PLACE PRIOR TO PRIVACY INCIDENT *†

☐ Strong Authentication ☐ Packet Filtering ☐ Anti-Virus Software

☐ Secure Browser Sessions ☐ Biometrics ☐ Encrypted Wireless

☐ Physical Security ☐ Firewalls ☐ Logical Access Control

☐ Data Leak Protection ☐ Encrypted ☐ Intrusion Detection

Was staff involved in Privacy Incident trained in HIPAA information Security and Privacy within the past year?

Additional information regarding safeguards:

9. MALICIOUS CODE/MALWARE TYPE

☐ Worm ☐ Buffer Overflow ☐ Virus

☐ Trojan ☐ Denial of Service (DOS) ☐ Other

If other, please explain:

10. DATA AND RECOVERY *

Were any DHCS systems involved?

Was data encrypted per NIST standards?

Was data recovered?

If data was recovered, specify what, when, and who has it now:

If not recovered, explain (still missing/shredded/under investigation):

Discuss the impact of Privacy Incident (potential misuse of data, identity theft, etc.):

Return completed form to: privacyofficer@dhcs.ca.gov or fax to: (916) 440-7680

11. DHCS PROGRAM DATA

How many DHCS Program beneficiaries' PHI or PI were impacted by the Privacy Incident? *

Did this Privacy Incident involve a minor (<18 yrs.)?

Was PHI or PI in question utilized in the administration of the Medi-Cal Program?

12. SUPPLEMENTARY DESCRIPTION OF PRIVACY INCIDENT † (Please include any supplementary information regarding the Privacy Incident)

13. ACTIONS TAKEN IN RESPONSE TO PRIVACY INCIDENT †

Describe mitigation plan and status (if necessary attach separately):

Investigation status (i.e. completed, estimated completion date, etc.):

Status of member notification letter (if applicable):

Describe Corrective Action Plan (CAP) and status (attach CAP separately if needed):

Note: A CAP is implemented in an attempt to prevent this type of Privacy Incident from reoccurring.

Return completed form to: privacyofficer@dhcs.ca.gov or fax to: (916) 440-7680

Enter the CAP completion/implementation date (Or the date it is scheduled):

14. BREACH DEFINITIONS AND EXCEPTIONS

Did Privacy Incident fall under one of the three exclusions?

If an exclusion, please explain circumstances.

15. BREACH DETERMINATION †

Has your entity determined this to be a Federal Breach?

Has your entity determined this to be a State Breach?

An incident is presumed to be a breach. If you have evidence under 45 CFR 164.402(2)(1)(i),(ii),(iii),(iv), please provide the evidence and the HIPAA provision that applies to find that a breach does not exist below.

This may be submitted in a seperate document. If this is the case please enter "Attached" below.

16. BREACH REPORTING (if applicable) †

Date of Federal breach reporting to OCR (if applicable).

If you did not enter a date above, remember that it is your responsibility to report breaches as required by Federal regulation.

Date of State breach reporting to Attorney General's office (if applicable).

If you did not enter a date above, remember that it is your responsibility to report breaches as required by State Law.

Return completed form to: privacyofficer@dhcs.ca.gov or fax to: (916) 440-7680

Policy #: HH.2002Δ
Title: **Sanctions**
Department: Office of Compliance
Section: Regulatory Affairs & Compliance

CEO Approval: Michael Schrader

Effective Date: 10/01/98
Last Review Date: ~~09/01/15~~12/01/16
Last Revised Date: ~~09/01/15~~12/01/16

Applicable to:
☒ Medi-Cal
☒ OneCare
☒ OneCare Connect
☒ PACE

I. PURPOSE

This policy ~~To~~ describes ~~p~~ the process by which CalOptima shall ~~to~~ impose Sanctions on a First Tier, Downstream, or Related Entity (FDR) ~~to~~to enforce effective correction of noncompliance with statutory, regulatory, contractual, or CalOptima policy requirements, ~~or~~ Fraud, Waste, and Abuse, or the FDR's failure to satisfactorily implement corrective actions.~~romotes First Tier, Downstream, and Related Entity (FDR) , Downstream and Related Entity (FDR) compliance with statutory, regulatory, contractual, CalOptima policies,y and other requirements related to CalOptima programs and by to describeing the process in which CalOptima shall issue and apply Sanctions and penalties.~~

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~
~~Abuse~~	~~A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima programs, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima programs.~~
~~Centers for Medicare & Medicaid Services (CMS)~~	~~The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.~~
~~Compliance Committee~~	~~The CalOptima committee that consists of executive officers, leadership of key operating divisions, and legal counsel that implements and oversees CalOptima's Compliance Program.~~
~~Compliance Program~~	~~The program including, without limitation, the Compliance Plan, Code of Conduct, and CalOptima policies, developed and adopted by CalOptima to promote, monitor, and ensure that CalOptima's operations and practices and the practices of its Board members, employees, contractors, and providers comply with applicable law and ethical standards.~~
~~Corrective Action Plan (CAP)~~	~~A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima,~~

~~Term~~	~~Definition~~
	~~regulating bodies, or designated representatives. Delegates may be required to complete CAPs to ensure they are in compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements identified by CalOptima and its regulators.~~
~~Covered Service~~	~~A health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by Title 45, Code of Federal Regulations, Part 160.~~
~~Department of Health Care Services (DHCS)~~	~~The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California). DHCS is generally referred to as the state in this document.~~
~~Department of Managed Health Care (DMHC)~~	~~The state department charged with overseeing health care service plans licensed under the Knox-Keene Health Care Services Plan Act of 1975.~~
~~Downstream Entity~~	~~Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.~~
~~Encounter~~	~~Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.~~
~~First Tier Entity~~	~~Any party that enters into a written arrangement with CalOptima to provide administrative services or health care services to a Medicare or Medicaid eligible individual under the CalOptima program.~~
~~First Tier, Downstream, and Related Entities (FDR)~~	~~FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.~~
~~Fraud~~	~~An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, and Welfare and Institutions Code section 14043.1(i).~~
~~Member~~	~~A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.~~
~~Related Entity~~	~~Any entity that is related to CalOptima by common ownership or control and:~~ ~~1. Performs some of the management functions under contract or delegation;~~ ~~2. Furnishes services to Medicare or Medicaid enrollees under an oral or written agreement; or~~

~~Term~~	~~Definition~~
	~~3. Leases real property or sells materials to CalOptima at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.~~
~~Sanction~~	~~Action taken by CalOptima including, without limitations, restrictions, monetary fines, termination or a combination thereof, based on a FDR failure to comply with statutory, regulatory, contractual, CalOptima policy, or other requirements related to CalOptima programs.~~
~~Waste~~	~~Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to CalOptima Programs. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.~~

~~III.~~II. POLICY

A. CalOptima, through the Compliance Committee, may impose Sanctions against a~~n~~n~~sn~~ ~~FDR~~FDR if it fails to comply with statutory, regulatory, contractual, CalOptima polic~~y~~y~~y~~, and other requirements related to CalOptima programs. The Compliance Committee shall approve and oversee Sanctions.

B. CalOptima may impose Sanctions against a~~n~~n ~~FDR~~FDR immediately following the ~~FDR~~FDR's failure to comply with statutory, regulatory, contractual, CalOptima policy, or other requirements related to CalOptima programs, with or without a Corrective Action Plan (CAP) requirement.

C. If required by CalOptima, a~~n~~n ~~FDR~~FDR must submit a CAP response to CalOptima in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan. CalOptima may also impose Sanctions if a~~n~~n ~~FDR~~FDR fails to submit, remediate, or implement a CAP response, or take corrective action under any approved CAP in the time or manner required by CalOptima.

D. The extent of the Sanction shall be commensurate with the severity of the deficiency identified as it relates to the risk posed to the CalOptima Member(s), as well as other financial or accreditation exposure to CalOptima, and designed to correct the underlying issue and prevent future recurrence.

E. Sanctions include, but are not limited to, financial penalties, suspension of membership enrollment, de-delegation, and/or termination of contract. CalOptima retains the right to take termination action in addition to, and notwithstanding, the imposition of other S~~s~~anctions under this policy.

F. In the event a~~n~~n ~~FDR~~FDR fails to remediate its non-compliance in the time or manner required by CalOptima, CalOptima may impose additional and/or more severe S~~s~~anctions.

~~IV.~~III. PROCEDURE

A. Basis for Sanctions

1. CalOptima may impose Sanctions or take any other action against a~~n~~n FDR~~FDR~~ based on the identification of deficient performance or non-compliance of ~~an FDR~~an FDR. ~~-~~Non-compliance may be established through ~~any of the following or other means~~and may include, but is not limited to:

~~a.~~ Findings from performance reviews and/or delegation oversight activities, in accordance with CalOptima Policy ~~HH.2004: Performance Reviews;~~GG.1619Δ: Delegation Oversight;

~~b.~~a.

~~c. Findings from delegation oversight activities, in accordance with CalOptima Policy GG.1619: Delegation Oversight;~~

b. Findings from r~~R~~egulatory reviews; including but not limited to the Department of Health Care Services (DHCS), the Department of Managed Health Care (DMHC), and the Centers for Medicare & Medicaid Services (CMS) audits;

c. Findings from Provider and Member complaints and surveys;

~~e. Failing to function in the best interest of a Member including, but not limited to, inappropriately withholding Covered Services from a Member or failing to maintain Member access to Covered Services;~~

~~Failing to meet performance and quality requirements;~~

~~Failing to furnish Covered Services in the scope or manner required by the CalOptima contract or agreement;~~

~~Engaging in acts of prohibited discrimination;~~

~~f.~~e. Engaging in F~~f~~raud, W~~w~~aste, or A~~a~~buse as specified in CalOptima Policy~~y~~ HH.1105Δ: Fraud, Waste and Abuse Detection;

~~g.~~f. Failing to report data or other information in the time or manner required by CalOptima including, but not limited to, Encounter data;

g. Engaging in any prohibited Marketing Activities, as specified in CalOptima Policy MA.2001: Marketing Materials Standards;

h. Failing to have the required amounts and types of financial reserves or to meet financial solvency requirements;

i. Failing to comply with the CalOptima Compliance Program and investigations including, but not limited to, CalOptima's Code of Conduct and policies;

j. Breaching any covenant, condition, or term of the contract or agreement including, but not limited to, failing to perform contracted duties and responsibilities in the time or manner required by CalOptima~~, or cooperate with investigations~~;

~~j.~~

k. Failing to submit, remediate, or implement a CAP response, or take corrective action under any approved CAP response in the time or manner required by CalOptima; and

l. Failing to comply with any other review of statutory, regulatory, contractual, CalOptima policy and other requirements related to a CalOptima policy.

B. Determining Sanction

1. CalOptima's Compliance Committee shall review findings of ann FDRFDR's deficient performance, or non-compliance, as provided by CalOptima's Delegation Audit & Oversight Committee (AOC) or and in accordance with CalOptima Ppolicies, GG.1619Δ: Delegation Oversight and HH.2004: Performance Reviews.

2. The CalOptima Compliance Committee has the authority to authorize and implement all Sanctions, and shall oversee and monitor all Sanctions imposed.

3. The Compliance Committee shall determine the severity of the Sanction based upon findings of deficient performance or non-compliance. Sanctions will vary in severity based on the extent and type of finding. Actions that are determined to endanger a Member or prevent access to Covered Services will be reviewed and acted upon immediately, by the Office of Compliance. Sanctions shall be designed to correct the underlyingunderlying issue and prevent future occurrence. Sanctions imposed may include, but not be limited to, termination of the contract between the FDR FDR and CalOptima.

3.4. The Compliance Committee shall consult with the Legal Department on the imposition of Sanctions including, but not limited to, contract terminations, as necessary and appropriate.

C. Types of Sanctions

1. Sanctions may include any of the following:

   a. Financial penalties defined in the contract;

   b. Enrollment freeze - Auto Assignment,; Member -selection, or both;

   c. De-delegation of delegated function(s);

   ~~Financial responsibility to pay a consultant or contractor, as determined by CalOptima, to work with the non-compliant organization to bring it into compliance;~~As determined by CalOptima, The requirement to engage and pay for an external auditor or other consultant acceptable to, and approved by, CalOptima, in order to correct the identified deficiency(eies), non-compliance, or FWA to CalOptima's satisfaction;~~.Tthe financial responsibility equal to the cost of payment for consultingant/contractorr services to bring the non-compliant organization into compliance;~~

   d. ~~All consultant/contractor services shall be approved by CalOptima.~~

   e. Termination of the contract, or agreement, with the non-compliant organization;

   f. Forfeiture of FDRFDR Financial Security;

   g. Capitation deduction; and/or

   h. Any other action CalOptima deems appropriate and reasonable.

2. Monetary Sanctions are imposed independently, and are in addition to any other sums owed to CalOptima, such as refunding of overpayments. Parties with pending monetary Sanctions are responsible for paying monetary Ssanctions in the time and manner required by CalOptima.

D. Notification of Sanction

1. CalOptima shall notify a~~n~~n ~~FDR~~FDR, in writing. Such notice shall:

a. Detail the findings of non-compliance;

b. Reference the applicable statutory, regulatory, contractual, CalOptima policies,~~y~~ or other requirements that are the basis of the findings;

c. Provide detailed information describing the Sanction;

d. Identify timeframes by which the ~~FDR~~FDR ~~-~~shall be required to achieve compliance, as applicable;

e. Inform the ~~FDR~~FDR that CalOptima may impose additional Sanctions if compliance is not achieved in the manner and timeframe specified; and

f. Provide notice of the ~~FDR~~FDR's right to file a C~~c~~omplaint, in accordance with CalOptima policy.

E. The Compliance Committee shall oversee and monitor the ~~FDR~~FDR's response to the Sanctions letter.

~~V.~~IV. ATTACHMENTS

Not Applicable

~~VI.~~V. REFERENCES

A. CalOptima Code of Conduct
B. CalOptima Compliance Plan
~~A.~~C. CalOptima Contract with the ~~Department of Health Care Services~~ Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima Health Network Service Agreement
F. CalOptima ~~Contract with the Department of Health Care Services (DHCS) for PACE~~PACE Program Agreement
~~Contract for Health Care Services~~
~~B. Title 22, California Code of Regulations, Section 51301 et. seq.~~
~~C. CalOptima Policy AA.1000: Glossary of Terms~~
~~D.~~G. CalOptima Policy GG.1619Δ: Delegation Oversight
~~E.~~H. CalOptima Policy HH.1105Δ: Fraud and Abuse Detection
~~F. CalOptima Policy HH.2004: Performance Reviews~~
~~G.~~I. CalOptima Policy HH.2005Δ: Corrective Action Plan
~~H. CalOptima Policy CMC.1001: Glossary of Terms~~
~~CalOptima Policy MA.1001: Glossary of Terms~~
~~I.~~J. CalOptima Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~J. CalOptima Compliance Plan~~

K. ~~CalOptima Code of Conduct~~Medicare Managed Care Manual, Chapters 9 and 21
~~Contract for Health Care Services~~
~~-~~
~~-~~
L. Title 22, California Code of Regulations (C.C.R.), ~~Section~~§~~-~~51301 et. seq.
~~K.~~M. Title 42, Code of Federal Regulations (C.F.R.), §455.2
N. Title 18, United States Code (U.S.C), ~~Section~~ §1347
~~-~~Welfare and Institutions Code, §14043.1(a)~~Title 42, Code of Federal Regulations (C.F.R.), §455.2~~
~~L.~~O. ~~Welfare and Institutions Code, §14043.1(i)~~

~~VII.~~VI. REGULATORY AGENCY APPROVALS

None to Date

~~VIII.~~VII. ~~-~~BOARD ACTIONS

None to Date

~~IX.~~VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	10/01/1998	HH.2002	Health Network Sanctions	Medi-Cal
Revised	10/01/2002	HH.2002	Health Network Sanctions	Medi-Cal
Revised	07/01/2004	HH.2002	Health Network Sanctions	Medi-Cal
Effective	08/01/2005	MA.9105	Contracted Provider Sanctions	OneCare
Revised	01/01/2008	HH.2002	Health Network Sanction	Medi-Cal
Revised	08/01/2008	MA.9105	Contracted Provider Sanctions	OneCare
Revised	04/01/2013	HH.2002Δ	Health Network Sanction	Medi-Cal OneCare
Revised	04/01/2014	MA.9105	Sanctions	OneCare
Revised	09/01/2015	HH.2002	Sanctions	Medi-Cal
Revised	09/01/2015	MA.9105	Sanctions	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2002Δ	Sanctions	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2015	MA.9105	Sanctions	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Audit & Oversight Committee	A subcommittee of the Compliance Committee chaired by the Director of Audit and Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's departments as provided for in the AOC charter.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers that Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Executive Director of Compliance; and Executive Director of Human Resources.
Compliance Program	The program (including, without limitation, this Compliance Plan, Code of Conduct and Policies and Procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Member, Employees and FDRs comply with applicable law and ethical standards.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services, or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
~~Covered Service~~	~~A health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by Title 45, Code of Federal Regulations, Part 160.~~
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.

Term	Definition
Department of Managed Health Care (DMHC)	The California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code, Sections 1340 *et seq.*
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
FDR	First Tier, Downstream or Related Entity, as separately defined herein.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C Section 1347).
Member	A beneficiary who is enrolled in a CalOptima Program.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Sanction	An action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Policy #:	HH.2002Δ
Title:	**Sanctions**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	Michael Schrader
Effective Date:	10/01/98
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy describes the process by which CalOptima shall impose Sanctions on a First Tier, Downstream, or Related Entity (FDR) to enforce effective correction of noncompliance with statutory, regulatory, contractual, or CalOptima policy requirements, Fraud, Waste, and Abuse, or the FDR's failure to satisfactorily implement corrective actions.

II. POLICY

A. CalOptima, through the Compliance Committee, may impose Sanctions against an FDR if it fails to comply with statutory, regulatory, contractual, CalOptima policy, and other requirements related to CalOptima programs. The Compliance Committee shall approve and oversee Sanctions.

B. CalOptima may impose Sanctions against an FDR immediately following the FDR's failure to comply with statutory, regulatory, contractual, CalOptima policy, or other requirements related to CalOptima programs, with or without a Corrective Action Plan (CAP) requirement.

C. If required by CalOptima, an FDR must submit a CAP response to CalOptima in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan. CalOptima may also impose Sanctions if an FDR fails to submit, remediate, or implement a CAP response, or take corrective action under any approved CAP in the time or manner required by CalOptima.

D. The extent of the Sanction shall be commensurate with the severity of the deficiency identified as it relates to the risk posed to the CalOptima Member(s), as well as other financial or accreditation exposure to CalOptima, and designed to correct the underlying issue and prevent future recurrence.

E. Sanctions include, but are not limited to, financial penalties, suspension of membership enrollment, de-delegation, and/or termination of contract. CalOptima retains the right to take termination action in addition to, and notwithstanding, the imposition of other Sanctions under this policy.

F. In the event an FDR fails to remediate its non-compliance in the time or manner required by CalOptima, CalOptima may impose additional and/or more severe Sanctions.

III. PROCEDURE

A. Basis for Sanctions

1. CalOptima may impose Sanctions or take any other action against an FDR based on the identification of deficient performance or non-compliance of an FDR. Non-compliance may be established through and may include, but is not limited to:

    a. Findings from performance reviews and/or delegation oversight activities, in accordance with CalOptima Policy GG.1619Δ: Delegation Oversight;

    b. Findings from regulatory reviews; including but not limited to the Department of Health Care Services (DHCS), the Department of Managed Health Care (DMHC), and the Centers for Medicare & Medicaid Services (CMS) audits;

    c. Findings from Provider and Member complaints and surveys;

    e. Engaging in Fraud, Waste, or Abuse as specified in CalOptima Policy HH.1105Δ: Fraud, Waste and Abuse Detection;

    f. Failing to report data or other information in the time or manner required by CalOptima including, but not limited to, Encounter data;

    g. Engaging in any prohibited Marketing Activities, as specified in CalOptima Policy MA.2001: Marketing Materials Standards;

    h. Failing to have the required amounts and types of financial reserves or to meet financial solvency requirements;

    i. Failing to comply with the CalOptima Compliance Program and investigations including, but not limited to, CalOptima's Code of Conduct and policies;

    j. Breaching any covenant, condition, or term of the contract or agreement including, but not limited to, failing to perform contracted duties and responsibilities in the time or manner required by CalOptima;

    k. Failing to submit, remediate, or implement a CAP response, or take corrective action under any approved CAP response in the time or manner required by CalOptima; and

    l. Failing to comply with any other review of statutory, regulatory, contractual, CalOptima policy and other requirements related to a CalOptima policy.

B. Determining Sanction

1. CalOptima's Compliance Committee shall review findings of an FDR's deficient performance, or non-compliance, as provided by CalOptima's Audit & Oversight Committee (AOC) and in accordance with CalOptima Policy GG.1619Δ: Delegation Oversight.

2. The CalOptima Compliance Committee has the authority to authorize and implement all Sanctions, and shall oversee and monitor all Sanctions imposed.

3. The Compliance Committee shall determine the severity of the Sanction based upon findings of deficient performance or non-compliance. Sanctions will vary in severity based on the extent and type of finding. Actions that are determined to endanger a Member or prevent access to Covered Services will be reviewed and acted upon immediately, by the Office of Compliance.

Sanctions shall be designed to correct the underlying issue and prevent future occurrence. Sanctions imposed may include, but not be limited to, termination of the contract between the FDR and CalOptima.

4. The Compliance Committee shall consult with the Legal Department on the imposition of Sanctions including, but not limited to, contract terminations, as necessary and appropriate.

C. Types of Sanctions

1. Sanctions may include any of the following:

   a. Financial penalties defined in the contract;

   b. Enrollment freeze - Auto Assignment, Member selection, or both;

   c. De-delegation of delegated function(s);

   d. The requirement to engage and pay for an external auditor or other consultant acceptable to, and approved by CalOptima, in order to correct the identified deficiency(ies), non-compliance, or FWA to CalOptima's satisfaction;

   e. Termination of the contract, or agreement, with the non-compliant organization;

   f. Forfeiture of FDR Financial Security;

   g. Capitation deduction; and/or

   h. Any other action CalOptima deems appropriate and reasonable.

2. Monetary Sanctions are imposed independently, and are in addition to any other sums owed to CalOptima, such as refunding of overpayments. Parties with pending monetary Sanctions are responsible for paying monetary Sanctions in the time and manner required by CalOptima.

D. Notification of Sanction

1. CalOptima shall notify an FDR, in writing. Such notice shall:

   a. Detail the findings of non-compliance;

   b. Reference the applicable statutory, regulatory, contractual, CalOptima policies, or other requirements that are the basis of the findings;

   c. Provide detailed information describing the Sanction;

   d. Identify timeframes by which the FDR shall be required to achieve compliance, as applicable;

   e. Inform the FDR that CalOptima may impose additional Sanctions if compliance is not achieved in the manner and timeframe specified; and

   f. Provide notice of the FDR's right to file a Complaint, in accordance with CalOptima policy.

E. The Compliance Committee shall oversee and monitor the FDR's response to the Sanctions letter.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Code of Conduct
B. CalOptima Compliance Plan
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima Health Network Service Agreement
F. CalOptima PACE Program Agreement
G. CalOptima Policy GG.1619Δ: Delegation Oversight
H. CalOptima Policy HH.1105Δ: Fraud and Abuse Detection
I. CalOptima Policy HH.2005Δ: Corrective Action Plan
J. CalOptima Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
K. Medicare Managed Care Manual, Chapters 9 and 21
L. Title 22, California Code of Regulations (C.C.R.), §51301 et. seq.
M. Title 42, Code of Federal Regulations (C.F.R.), §455.2
N. Title 18, United States Code (U.S.C), §1347
O. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	10/01/1998	HH.2002	Health Network Sanctions	Medi-Cal
Revised	10/01/2002	HH.2002	Health Network Sanctions	Medi-Cal
Revised	07/01/2004	HH.2002	Health Network Sanctions	Medi-Cal
Effective	08/01/2005	MA.9105	Contracted Provider Sanctions	OneCare
Revised	01/01/2008	HH.2002	Health Network Sanction	Medi-Cal
Revised	08/01/2008	MA.9105	Contracted Provider Sanctions	OneCare
Revised	04/01/2013	HH.2002Δ	Health Network Sanction	Medi-Cal OneCare
Revised	04/01/2014	MA.9105	Sanctions	OneCare
Revised	09/01/2015	HH.2002	Sanctions	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	09/01/2015	MA.9105	Sanctions	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2002Δ	Sanctions	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2015	MA.9105	Sanctions	OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Audit & Oversight Committee	A subcommittee of the Compliance Committee chaired by the Director of Audit and Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's departments as provided for in the AOC charter.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers that Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Executive Director of Compliance; and Executive Director of Human Resources.
Compliance Program	The program (including, without limitation, this Compliance Plan, Code of Conduct and Policies and Procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Member, Employees and FDRs comply with applicable law and ethical standards.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services, or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Department of Managed Health Care (DMHC)	The California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code, Sections 1340 *et seq*.

Term	Definition
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
FDR	First Tier, Downstream or Related Entity, as separately defined herein.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C Section 1347).
Member	A beneficiary who is enrolled in a CalOptima Program.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Sanction	An action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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~~Policy #: HH.2005~~
~~Title: **Corrective Action Plan**~~
~~Department: Office of Compliance~~
~~Section: Compliance~~

~~CEO Approval: Michael Schrader~~

~~Effective Date: 11/01/98~~
~~Last Review Date: 09/01/15~~
~~Last Revised Date: 09/01/15~~

Policy #: HH.2005Δ
Title: **Corrective Action Plan**
Department: Office of Compliance
Section: Regulatory Affairs & Compliance

CEO Approval: Michael Schrader

Effective Date: 11/01/98
Last Review Date: 12/01/16
Last Revised Date: 12/01/16

Applicable to:
☒ Medi-Cal
☒ OneCare
☒ OneCare Connect
☒ PACE

I. PURPOSE

This policy~~o~~ defines the requirements for CalOptima and its First Tier~~, Downstream and Related Entities (FDRs)~~, Downstream, and Related Entities (FDRs) for development and submission of an Immediate Corrective Action Plan (ICAP) or Corrective Action Plan (CAP) for areas of non-compliant performance, as identified by CalOptima's Office of Compliance.

~~II. DEFINITIONS~~

~~**Term**~~	~~**Definition**~~
~~Corrective Action Plan (CAP)~~	~~A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, regulating bodies, or designated representatives. Delegates may be required to complete CAPs to ensure they are in compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements identified by CalOptima and its regulators.~~
~~Designee~~	~~A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.~~
~~Downstream Entity~~	~~Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.~~
~~First Tier, Downstream, and Related Entities~~	~~Delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.~~

~~(FDRs)~~	
~~First Tier Entity~~	~~Any party that enters into a written arrangement with CalOptima to provide administrative services or health care services to a Medicare or Medicaid eligible individual under the CalOptima program.~~
~~Immediate Corrective Action Plan (ICAP)~~	~~An ICAP is the result of non-compliance with specific requirements that has the potential to cause significant member harm. Significant member harm exists if the non-compliance resulted in the failure to provide medical items, services or prescription drugs, causing financial distress, or posing a threat to member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.~~
~~Related Entity~~	~~Any entity that is related to CalOptima by common ownership or control and:~~ ~~1. Performs some of the management functions under contract or delegation;~~ ~~2. Furnishes services to Medicare or Medicaid/Medi-Cal enrollees under an oral or written agreement; or~~ ~~3. Leases real property or sells materials to CalOptima at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.~~
~~Sanction~~	~~Action taken by CalOptima including, without limitations, restrictions, monetary fines, termination or a combination thereof, based on a FDR failure to comply with statutory, regulatory, contractual, CalOptima policy, or other requirements related to CalOptima programs.~~

~~HH.~~II. POLICY

A. CalOptima's Office of Compliance shall conduct A~~a~~uditing, operational M~~m~~onitoring, and investigations of internal CalOptima departments and its ~~FDR's~~ FDRs to ensure compliance with statutory, regulatory, contractual, CalOptima polic~~iesyy~~, and other requirements related to CalOptima programs.

B. CalOptima's Office of Compliance may require that an internal department, or ~~FDR~~FDR, develop an ICAP, or CAP, response based on the identified area(s) of non-compliance.

C. CalOptima's Office of Compliance shall require that CalOptima internal departments and ~~CalOptima's FDRs~~FDRs to bring ~~its~~ their operations into full compliance with statutory, regulatory, contractual, CalOptima polic~~ies,y,y~~ and other requirements, which CalOptima, or its regulators, have identified as non-compliant, within timeframes established by CalOptima's Office of Compliance.

D. An internal department, or ~~FDR~~FDR, shall develop, submit, and take corrective action under an approved ICAP, or CAP, response in the time and manner required by CalOptima's Office of Compliance.

1. Failure by the internal department to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima polic~~iesyy~~, or other requirements to ~~the~~ CalOptima's Office of Compliance's ICAP, or CAP, request shall lead to further action, ~~in accordance with CalOptima Ppolicy GA.8022: Progressive Discipline.~~

2. Failure by an FDRan FDR to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima policiesyy, or other requirements to the CalOptima's Office of Compliance's ICAP, or CAP, request shall lead to further action, in accordance with CalOptima Ppolicy HH.2002Δ: Sanctions. CalOptima may impose Sanctions for the underlying non-compliant performance that gave rise to the ICAP-, or CAP, request, or the failure to develop, submit, and meet the requirements of the ICAP, or CAP, request.

IV.III. PROCEDURE

A. Basis for an ICAP or CAP

1. 1. CalOptima's Office of Compliance shall routinely Mmonitor performance metrics, conduct routine or focused Aaudits, and conduct ongoing Mmonitoring and investigations of reported non-compliance for internal departments, or FDRs FDRs, through a variety of mechanisms, including but not limited to performance and quality related metrics.

   a. CalOptima's Office of Compliance may issue an ICAP/CAP request as a result of Aaudits conducted by federal and state regulatory agencies, including, but not limited to the Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS), and the Department of Managed Health Care (DMHC).

   b. CalOptima's Office of Compliance may issue an ICAP/CAP -request as a result of an ICAP/CAP request, or other corrective action, that CalOptima receives from a federal or state regulatory agency that is directly related to the operations of First Tier Entityan FDR.

1.2. In the event that the CalOptima's Office of Compliance determines an internal department, or FDRFDR, , has failed to comply with statutory, regulatory, contractual, CalOptima policiesyy, or other requirements, the Office of Compliance may request issue an ICAP, or CAP request, -to address the issue problem. CalOptima's Office of Compliance shall coordinate its efforts with CalOptima's Human Resources Department in the event that an ICAP or CAP potentially warrants Employee disciplinary action.

B. ICAP and CAP Issuance and Requirements

1. CalOptima's Office of Compliance shall utilize a standardized ICAP, or CAP, request template.

2. Non-compliance with specific requirements that have the potential to cause significant Member harm, or place CalOptima's accreditation, participation and/or contractual status with regulatory agencies in jeopardy will require an ICAP response.

   a. If the finding requires an ICAP request, as determined by CalOptima's Office of Compliance, the internal department, or FDR FDR, is required to cease non-compliant activities within two (2) business days of receiving the ICAP request.

   b. The internal department, or FDR FDR, shall provide a written response, within three (3) business days of receiving ofan ICAP request, detailing how it will mitigate and prevent further non-compliance. Following the acceptance of the ICAP response, the internal department, or FDRFDR,, is required to resolve the issue in a manner and timeframe as deemed appropriate by CalOptima's Office of Compliance.

3. A CAP request is the result of ~~a~~ material non-compliance with specific requirements that does not rise to the level of an ICAP request.

   a. The internal department, or ~~FDR~~FDR, is required to respond to the CAP request within fourteen (14) ~~business~~ calendar days. Following the acceptance of the CAP response, the internal department, or ~~FDR~~FDR, ~~,~~ is required to resolve the issue in a manner and timeframe ~~as~~ deemed appropriate by CalOptima's Office of Compliance.

4. An ICAP, or CAP, response shall include the following elements:

   a. A root cause analysis of the deficiency which may include a description of the policies and procedures, staffing, training, and systems that failed;

   b. Steps taken to resolve the deficiency;

   c. Steps taken to avoid reoccurrence;

   d. Method for implementation and completion of ICAP ~~request~~response, or CAP ~~reques~~responset~~;~~

   e. Individual(s) responsible for implementation of the ICAP response, or CAP ~~reques~~responset~~;~~ ~~and~~

   f. An attestation by the internal department, or ~~FDR~~ FDR, conveying a plan to remedy its identified deficiencies; and~~.~~

   g. ICAP response, or CAP~~, request~~ response completion date(s), as applicable.

C. ~~Inadequate~~ Unacceptable Resolution to an ICAP or CAP

1. If the internal department's, or ~~FDR's~~FDR's, resolution to the deficiency is ~~inadequate~~unacceptable, or the internal department, or ~~FDR~~ FDR, fails to respond, CalOptima's Office of Compliance shall issue a ~~letter~~ written notice to the internal department's Chief, or the ~~FDR's~~ FDR's Chief Executive Officer (CEO), or ~~his or her~~their Designee, which shall include:

   a. A summary of previous outreach and required action(s);

   b. ~~How it was determined~~Evidence~~An explanation~~ of why that the resolution was not ~~adequate~~ acceptable, or a response was not received;

   c. A revised ~~resolution~~ response timeline of two (2) business days for an ICAP;

      i. Extensions to this timeline may be authorized on a case-by-case basis by the Compliance Officer, or his/her D~~d~~esignee.

   d. A revised response timeline of five (5) business days for a CAP;

      ~~i.~~ Extensions to this timeline may be authorized on a case-by-case basis by the Compliance Officer, or his/her D~~d~~esignee.

      i.

~~c.~~e. Reiteration of consequences – specific to nature of issue and degree of completeness~~-~~ in accordance with CalOptima Policy ~~policies GA.8022: Progressive Discipline or~~ HH.2002Δ: Sanctions; and

~~d.~~f. Referral to the ~~Delegation~~ Audit & Oversight Committee and the ~~/or~~ Compliance Committee.

D. ~~Adequate~~ Acceptable Resolution with ICAP or CAP Requirements

1. An internal department's, or FDR's, ICAP or CAP response may be accepted once all requirements outlined in Section III.B.4. of this policy are fulfilled. If an ICAP or CAP response requires Monitoring, or a focused Audit, the ICAP or CAP response shall not be closed until the remediation(s) implemented have been validated by the Office of Compliance and demonstrate that the issue will not recur.

   a. An internal department's, or FDR's, ICAP, or CAP, response may be accepted and closed in tandem, if Monitoring, or a focused Audit, is not required.

~~1.~~2. If the internal department's, or ~~FDR's~~FDR's, resolution to the deficiency is deemed ~~adequate~~ acceptable by the ~~Executive Director of~~ Compliance Officer, or ~~his or her~~their Designee, CalOptima's Office of Compliance may issue ~~an~~ a written notification of acceptance ~~letter~~, which shall include:

   a. An acknowledgement of acceptance;

   b. A description of follow up actions, which shall include, but is not limited to:

      i. Submission of finalized documentation; and/or

      ii. Focused A~~a~~udit, as described in S~~s~~ection ~~IV~~III.E. of this policy; and/or

      iii. Monitoring, as deemed appropriate by CalOptima's Office of Compliance, and as described in S~~s~~ection III~~V~~.F. of this policy.

~~2.~~3. If the internal department's, or ~~FDR's~~ FDR's, resolution to the deficiency is accepted and deemed sufficient by the ~~Executive Director of~~ Compliance Officer, or ~~his or her~~their Designee, CalOptima's Office of Compliance shall issue a written notification of closure, ~~letter~~ which shall include:

   a. An acknowledgement of closure;

   b. ~~An~~ The effective date of closure; and

   c. Consequences of repeat deficiencies.

E. Focused Audits

1. CalOptima's Office of Compliance may conduct a focused A~~a~~udit of an internal department, or ~~FDR~~FDR, to confirm implementation of the accepted ICAP, or CAP, ~~remediation~~response.

2. CalOptima's Office of Compliance shall notify the internal department, or ~~FDR~~FDR, of the scope, Aaudit period, and Aaudit deliverables that shall be required to complete the Aaudit.

3. CalOptima's Office of Compliance may continue to Mmonitor, or Aaudit, an internal department's, or ~~FDR's~~FDR's, performance of ~~critical~~ issues and/or functions related to the ICAP, or CAP, request.

F. Monitoring Period

1. CalOptima's Office of Compliance may conduct Mmonitoring of the internal department's, or ~~FDR's~~FDR's, resolution to ~~determine if it is adequate~~ confirm implementation of the accepted ICAP, or CAP, response.

2. CalOptima's Office of Compliance shall Mmonitor the internal department's, or ~~FDR's~~FDR's, resolution for a predetermined timeframe, as established by CalOptima's Office of Compliance.

3. CalOptima's Office of Compliance shall notify the internal department, or ~~F~~FDR~~DR~~, of the scope, Mmonitoring period, and deliverables that shall be required to complete the Mmonitoring.

4. CalOptima's Office of Compliance may continue to Mmonitor, or Aaudit, an internal department's, or ~~FDR's~~FDR's, performance of ~~critical~~ issues and/or functions related to the ICAP, or CAP, request.

G. Failure to Maintain Adequate Resolution

1. If during the Mmonitoring period, or the focused Aaudit, the internal department, or ~~FDR~~FDR, fails to maintain the remedies in place, CalOptima's Office of Compliance shall issue the internal department, or ~~FDR~~FDR, an ICAP request.

2. The internal department, or ~~FDR~~FDR, shall be required to resolve the issue within ~~three~~ two (~~3~~2) business days from the re-issuance of the finding.

~~\~~

~~—~~Extensions to this timeline may be authorized on a case-by-case basis by the Compliance Officer, or his/her D~~d~~esignee.

a.

3. The ICAP request shall require the information as described in S~~s~~ection III~~V~~.B.4. of this policy.

H. ICAP and CAP Tracking and Reporting

1. CalOptima's Office of Compliance shall track all CAP and ICAP requests issued utilizing a ~~CAP request tracker~~standardized tool.

~~_____~~

2. CalOptima's Office of Compliance shall report the status of a~~A~~ll CAP/ICAP ~~-~~requests ~~shall be reported~~ to the ~~Delegation~~ Audit & Oversight Committee and the ~~/or~~ Compliance Committee.

3. If CalOptima's internal department, or ~~FDR~~FDR, has repeat deficiencies, the issue(s) shall be reported to the Audit &~~Delegation~~ Oversight Committee and~~/or~~ the Compliance Committee by the Office of Compliance for further action.

~~V.~~IV. ATTACHMENTS

A. ICAP/CAP Request Template

~~VI.~~V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
~~A.~~ CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C.
~~Contract for Health Care Services~~
~~B.~~D. ~~Contract for Health Care Services~~CalOptima Health Network Service Agreement
E. CalOptima PACE Agreement
~~C.~~F. CalOptima Policy AA.1000: Glossary of Terms
~~D.~~G. CalOptima Policy HH.2002Δ: Sanctions
H. ~~CalOptima Policy GA.8022: Progressive Discipline~~CalOptima Policy MA.1001: Glossary of Terms
I. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
H. Medicare Managed Care Manual, Chapters 9 and 21
I. Title 22, California Code of Regulations (C.C.R.), §51301 et. seq.
~~Contract for Health Care Services~~

~~VII.~~VI. REGULATORY AGENCY APPROVALS

None to Date

~~VIII.~~VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	11/01/1998	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	10/01/2002	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Effective	08/01/2005	MA.9104	Corrective Action Plan	OneCare
Revised	06/01/2007	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	08/01/2008	MA.9104	Corrective Action Plan	OneCare
Revised	04/01/2013	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare
Revised	04/01/2014	MA.9104	Corrective Action Plan	OneCare
Revised	12/01/2014	MA.9104	Corrective Action Plan	Cal MediConnect OneCare PACE
Revised	09/01/2015	HH.2005	Corrective Action Plan	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	09/01/2015	MA.9104	Corrective Action Plan	OneCare OneCare Connect PACE
~~Retired~~	~~12/01/2016~~	~~MA.9104~~	~~Corrective Action Plan~~	~~OneCare~~ ~~OneCare Connect~~ ~~PACE~~
Revised	12/01/2016	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9104	Corrective Action Plan	OneCare OneCare Connect PACE

~~Version~~	~~Version Date~~	~~Policy Number~~	~~Policy Title~~
~~Original Date~~	~~11/01/1998~~	~~HH.2005~~	~~Health Network Corrective Action Plan~~
~~Revised Revision Date 1~~	~~10/2002~~	~~HH.2005~~	~~Health Network Corrective Action Plan~~
~~Revised Revision Date 2~~	~~06/01/2007~~	~~HH.2005~~	~~Health Network Corrective Action Plan~~
~~Revised Revision Date 3~~	~~04/01/2013~~	~~HH.2005Δ~~	~~Corrective Action Plan~~
~~Revised Revision Date 4~~	~~09/01/2015~~	~~HH.2005~~	~~Corrective Action Plan~~
~~Revised~~	~~12/01/2016~~	~~HH.2005Δ~~	~~Corrective Action Plan~~

IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Audit & Oversight Committee	A subcommittee of the Compliance Committee chaired by the Director of Audit and Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's departments as provided for in the AOC charter.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), or designated representatives. First Tier ~~Entitys~~Entities and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
~~Corrective Action Plan (CAP) Request~~	
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Immediate Corrective Action Plan (ICAP)	An ICAP is the result of non-compliance with specific requirements that has the potential to cause significant member harm. Significant member harm exists if the non-compliance resulted in the failure to provide medical items, services or prescription drugs, causing financial distress, or posing a threat to member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Immediate Corrective Action Plan (ICAP) Request	The result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Member	An enrollee-beneficiary of a CalOptima program.

Term	Definition
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective
Sanction	An action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on a First Tier Entity's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.

Policy #:	HH.2005Δ
Title:	**Corrective Action Plan**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	Michael Schrader_____
Effective Date:	11/01/98
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy defines the requirements for CalOptima and its First Tier, Downstream, and Related Entities (FDRs) for development and submission of an Immediate Corrective Action Plan (ICAP) or Corrective Action Plan (CAP) for areas of non-compliant performance, as identified by CalOptima's Office of Compliance.

II. POLICY

A. CalOptima's Office of Compliance shall conduct Auditing, operational Monitoring, and investigations of internal CalOptima departments and its FDRs to ensure compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements related to CalOptima programs.

B. CalOptima's Office of Compliance may require that an internal department, or FDR, develop an ICAP, or CAP, response based on the identified area(s) of non-compliance.

C. CalOptima's Office of Compliance shall require that CalOptima internal departments and FDRs to bring their operations into full compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements, which CalOptima, or its regulators, have identified as non-compliant, within timeframes established by CalOptima's Office of Compliance.

D. An internal department, or FDR, shall develop, submit, and take corrective action under an approved ICAP, or CAP, response in the time and manner required by CalOptima's Office of Compliance.

1. Failure by the internal department to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima policy, or other requirements to CalOptima's Office of Compliance's ICAP, or CAP, request shall lead to further action,

2. Failure by an FDR to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima policy, or other requirements to CalOptima's Office of Compliance's ICAP, or CAP, request shall lead to further action, in accordance with CalOptima Policy HH.2002Δ: Sanctions. CalOptima may impose Sanctions for the underlying non-compliant performance that gave rise to the ICAP, or CAP, request, or the failure to develop, submit, and meet the requirements of the ICAP, or CAP, request.

III. PROCEDURE

A. Basis for an ICAP or CAP

1. CalOptima's Office of Compliance shall routinely Monitor performance metrics, conduct routine or focused Audits, and conduct ongoing Monitoring and investigations of reported non-compliance for internal departments, or FDRs, through a variety of mechanisms.

    a. CalOptima's Office of Compliance may issue an ICAP/CAP request as a result of Audits conducted by federal and state regulatory agencies, including, but not limited to the Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS), and the Department of Managed Health Care (DMHC).

    b. CalOptima's Office of Compliance may issue an ICAP/CAP request as a result of an ICAP/CAP request, or other corrective action, that CalOptima receives from a federal or state regulatory agency that is directly related to the operations of an FDR.

2. In the event that CalOptima's Office of Compliance determines an internal department, or FDR, has failed to comply with statutory, regulatory, contractual, CalOptima policy, or other requirements, the Office of Compliance may issue an ICAP, or CAP request, to address the problem. CalOptima's Office of Compliance shall coordinate its efforts with CalOptima's Human Resources Department in the event that an ICAP or CAP potentially warrants Employee disciplinary action.

B. ICAP and CAP Issuance and Requirements

1. CalOptima's Office of Compliance shall utilize a standardized ICAP, or CAP, request template.

2. Non-compliance with specific requirements that have the potential to cause significant Member harm, or place CalOptima's accreditation, participation and/or contractual status with regulatory agencies in jeopardy will require an ICAP response.

    a. If the finding requires an ICAP request, as determined by CalOptima's Office of Compliance, the internal department, or FDR, is required to cease non-compliant activities within two (2) business days of receiving the ICAP request.

    b. The internal department, or FDR, shall provide a written response, within three (3) business days of receiving an ICAP request, detailing how it will mitigate and prevent further non-compliance. Following the acceptance of the ICAP response, the internal department, or FDR, is required to resolve the issue in a manner and timeframe deemed appropriate by CalOptima's Office of Compliance.

3. A CAP request is the result of material non-compliance with specific requirements that does not rise to the level of an ICAP request.

    a. The internal department, or FDR, is required to respond to the CAP request within fourteen (14) calendar days. Following the acceptance of the CAP response, the internal department, or FDR, is required to resolve the issue in a manner and timeframe deemed appropriate by CalOptima's Office of Compliance.

4. An ICAP, or CAP, response shall include the following elements:

a. A root cause analysis of the deficiency which may include a description of the policies and procedures, staffing, training, and systems that failed;

b. Steps taken to resolve the deficiency;

c. Steps taken to avoid reoccurrence;

d. Method for implementation and completion of ICAP response, or CAP response;

e. Individual(s) responsible for implementation of the ICAP response, or CAP response;

f. An attestation by the internal department, or FDR, conveying a plan to remedy its identified deficiencies; and

g. ICAP response, or CAP response completion date(s), as applicable.

C. Unacceptable Resolution to an ICAP or CAP

1. If the internal department's, or FDR's, resolution to the deficiency is unacceptable, or the internal department, or FDR, fails to respond, CalOptima's Office of Compliance shall issue a written notice to the internal department's Chief, or the FDR's Chief Executive Officer (CEO), or their Designee, which shall include:

a. A summary of previous outreach and required action(s);

b. An explanation of why that the resolution was not acceptable, or a response was not received;

c. A revised response timeline of two (2) business days for an ICAP;

i. Extensions to this timeline may be authorized on a case-by-case basis by the Compliance Officer, or his/her Designee.

d. A revised response timeline of five (5) business days for a CAP;

i. Extensions to this timeline may be authorized on a case-by-case basis by the Compliance Officer, or his/her Designee.

e. Reiteration of consequences – specific to nature of issue and degree of completeness in accordance with CalOptima Policy HH.2002Δ: Sanctions; and

f. Referral to the Audit & Oversight Committee and the Compliance Committee.

D. Acceptable Resolution with ICAP or CAP Requirements

1. An internal department's, or FDR's, ICAP or CAP response may be accepted once all requirements outlined in Section III.B.4. of this policy are fulfilled. If an ICAP or CAP response requires Monitoring, or a focused Audit, the ICAP or CAP response shall not be closed until the remediation(s) implemented have been validated by the Office of Compliance and demonstrate that the issue will not recur.

a. An internal department's, or FDR's, ICAP, or CAP, response may be accepted and closed in tandem, if Monitoring, or a focused Audit, is not required.

2. If the internal department's, or FDR's, resolution to the deficiency is deemed acceptable by the Compliance Officer, or their Designee, CalOptima's Office of Compliance may issue a written notification of acceptance, which shall include:

   a. An acknowledgement of acceptance;

   b. A description of follow up actions, which shall include, but is not limited to:

      i. Submission of finalized documentation; and/or

      ii. Focused Audit, as described in Section III.E. of this policy; and/or

      iii. Monitoring, as deemed appropriate by CalOptima's Office of Compliance, and as described in Section III.F. of this policy.

3. If the internal department's, or FDR's, resolution to the deficiency is accepted and deemed sufficient by the Compliance Officer, or their Designee, CalOptima's Office of Compliance shall issue a written notification of closure, which shall include:

   a. An acknowledgement of closure;

   b. The effective date of closure; and

   c. Consequences of repeat deficiencies.

E. Focused Audits

1. CalOptima's Office of Compliance may conduct a focused Audit of an internal department, or FDR, to confirm implementation of the accepted ICAP, or CAP, response.

2. CalOptima's Office of Compliance shall notify the internal department, or FDR, of the scope, Audit period, and Audit deliverables that shall be required to complete the Audit.

3. CalOptima's Office of Compliance may continue to Monitor, or Audit, an internal department's, or FDR's, performance of issues and/or functions related to the ICAP, or CAP, request.

F. Monitoring Period

1. CalOptima's Office of Compliance may conduct Monitoring of the internal department's, or FDR's, resolution to confirm implementation of the accepted ICAP, or CAP, response.

2. CalOptima's Office of Compliance shall Monitor the internal department's, or FDR's, resolution for a predetermined timeframe, as established by CalOptima's Office of Compliance.

3. CalOptima's Office of Compliance shall notify the internal department, or FDR, of the scope, Monitoring period, and deliverables that shall be required to complete the Monitoring.

4. CalOptima's Office of Compliance may continue to Monitor, or Audit, an internal department's, or FDR's, performance of issues and/or functions related to the ICAP, or CAP, request.

G. Failure to Maintain Adequate Resolution

1. If during the Monitoring period, or the focused Audit, the internal department, or FDR, fails to maintain the remedies in place, CalOptima's Office of Compliance shall issue the internal department, or FDR, an ICAP request.

2. The internal department, or FDR, shall be required to resolve the issue within two (2) business days from the re-issuance of the finding.

   a. Extensions to this timeline may be authorized on a case-by-case basis by the Compliance Officer, or his/her Designee.

3. The ICAP request shall require the information as described in Section III.B.4. of this policy.

H. ICAP and CAP Tracking and Reporting

1. CalOptima's Office of Compliance shall track all CAP and ICAP requests issued utilizing a standardized tool.

2. CalOptima's Office of Compliance shall report the status of all CAP/ICAP requests to the Audit & Oversight Committee and the Compliance Committee.

3. If CalOptima's internal department, or FDR, has repeat deficiencies, the issue(s) shall be reported to the Audit & Oversight Committee and the Compliance Committee by the Office of Compliance for further action.

IV. ATTACHMENTS

A. ICAP/CAP Request Template

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Agreement
E. CalOptima Policy AA.1000: Glossary of Terms
F. CalOptima Policy HH.2002Δ: Sanctions
G. CalOptima Policy MA.1001: Glossary of Terms
H. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
H. Medicare Managed Care Manual, Chapters 9 and 21
I. Title 22, California Code of Regulations (C.C.R.), §51301 et. seq.

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	11/01/1998	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	10/01/2002	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Effective	08/01/2005	MA.9104	Corrective Action Plan	OneCare
Revised	06/01/2007	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	08/01/2008	MA.9104	Corrective Action Plan	OneCare
Revised	04/01/2013	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare
Revised	04/01/2014	MA.9104	Corrective Action Plan	OneCare
Revised	12/01/2014	MA.9104	Corrective Action Plan	Cal MediConnect OneCare PACE
Revised	09/01/2015	HH.2005	Corrective Action Plan	Medi-Cal
Revised	09/01/2015	MA.9104	Corrective Action Plan	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9104	Corrective Action Plan	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Audit & Oversight Committee	A subcommittee of the Compliance Committee chaired by the Director of Audit and Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's departments as provided for in the AOC charter.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), or designated representatives. First Tier Entities and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Immediate Corrective Action Plan (ICAP)	An ICAP is the result of non-compliance with specific requirements that has the potential to cause significant member harm. Significant member harm exists if the non-compliance resulted in the failure to provide medical items, services or prescription drugs, causing financial distress, or posing a threat to member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Immediate Corrective Action Plan (ICAP) Request	The result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Member	An enrollee-beneficiary of a CalOptima program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective

Term	Definition
Sanction	An action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on a First Tier Entity's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.

1

~~CalOptima Office Of Compliance~~
~~Responsible Party (CalOptima or Delegated Entity)~~

Corrective Action Plan (CAP):
Non-Compliance Investigations

~~NOTE~~Instructions: ~~CalOptima's Office of Compliance is responsible for completing all cells in blue.~~ The R~~r~~esponsible P~~p~~arty (CalOptima or Delegated Entity) must provide a response to all cells in white, including: (1) a response (in black font) to each of the four ~~(4)~~ questions under CAP Response (2) Identification of the responsible person including all contact information, (3) Implementation date, actual or planned, and (4) CAP Attestation.

~~is required to complete all cells in white.~~CalOptima's Office of Compliance is responsible for completing all cells in blue.

Responsible Party (CalOptima or Delegated Entity)		**Case #**	
		CAP Type: Immediate (ICAP) or Standard (CAP) ~~(ICAP/CAP)~~	
Department (if applicable)		**Date CAP Sent by CalOptima**	
Date of Incident		**Date CAP Due to CalOptima**	
Investigator Name		**CAP Submitted By**	
Line of Business		**Date CAP Submitted**	

CAP #	Background/Deficiency	CAP Response (Responsible Party: Black, CalOptima: Red)	Responsible Person/Contact Information	~~Due Date to~~ Implementation Date	CAP ~~Closed Date~~Status
1	**Background:** **Applicable References and Standards:** **Findings and Actions~~Deficiency~~:**	**1) What is the root cause of the deficiency?** **2) What step(s) have been taken to resolve the deficiency?** **3) What control(s) have been implemented to ensure this deficiency does not reoccur?**			

~~CalOptima Office Of Compliance~~
~~Responsible Party (CalOptima or Delegated Entity)~~

Corrective Action Plan (CAP):
Non-Compliance Investigations

~~NOTE~~Instructions: ~~CalOptima's Office of Compliance is responsible for completing all cells in blue.~~ The Rresponsible Ppparty (CalOptima or Delegated Entity) must provide a response to all cells in white, including: (1) a response (in black font) to each of the four ~~(4)~~ questions under CAP Response (2) Identification of the responsible person including all contact information, (3) Implementation date, actual or planned, and (4) CAP Attestation.

~~is required to complete all cells in white.~~CalOptima's Office of Compliance is responsible for completing all cells in blue.

		4) How will CAP be measured and monitored to close CAP?			
Monitoring Method(s) and Result				**Monitoring ~~Date~~Status**	

CAP #	Background/Deficiency	CAP Response~~:~~ (Responsible Party: Black, CalOptima: Red)	Responsible Person/Contact Information	~~Due Date to~~ Implementation Date	CAP ~~Closed Date~~Status
2	**Background:** **Applicable References and Standards:** **Findings and Actions:** **~~Deficiency:~~**	**1) What is the root cause of the deficiency?** **2) What step(s) have been taken to resolve the deficiency?** **3) What control(s) have been implemented to ensure this deficiency does not reoccur?**			

~~CalOptima Office Of Compliance~~
~~Responsible Party (CalOptima or Delegated Entity)~~

Corrective Action Plan (CAP):
Non-Compliance Investigations

~~NOTE~~Instructions: ~~CalOptima's Office of Compliance is responsible for completing all cells in blue.~~ The R~~r~~esponsible P~~p~~arty (CalOptima or Delegated Entity) must provide a response to all cells in white, including: (1) a response (in black font) to each of the four ~~(4)~~ questions under CAP Response (2) Identification of the responsible person including all contact information, (3) Implementation date, actual or planned, and (4) CAP Attestation.

~~is required to complete all cells in white.~~CalOptima's Office of Compliance is responsible for completing all cells in blue.

		4) How will CAP be measured and monitored to close CAP?			
Monitoring Method(s) and Result				**Monitoring ~~Date~~Status**	

CAP Attestation:

I, _____ [NAME/TITLE] hereby have the authority to attest that the CAP(s), and subsequent remediation, as stated above, accurately reflect _____ [BUSINESS OWNER/DELEGATE] plan to remediate and execute the above referenced area(s) of non compliance.

Generated by:
(Responsible Party) _____ _____ _____
Name, Title Signature Date

Approved by: _____ _____
(CalOptima) _____ Name, Title Signature Date

Corrective Action Plan (CAP):
Non-Compliance Investigations

Instructions: The Responsible Party (CalOptima or Delegated Entity) must provide a response to all cells in white, including: (1) a response (in black font) to each of the four questions under CAP Response (2) Identification of the responsible person including all contact information, (3) Implementation date, actual or planned, and (4) CAP Attestation.

CalOptima's Office of Compliance is responsible for completing all cells in blue.

Responsible Party (CalOptima or Delegated Entity)		**Case #**	
		CAP Type: Immediate (ICAP) or Standard (CAP)	
Department (if applicable)		**Date CAP Sent by CalOptima**	
Date of Incident		**Date CAP Due to CalOptima**	
Investigator Name		**CAP Submitted By**	
Line of Business		**Date CAP Submitted**	

CAP #	Background/Deficiency	CAP Response (Responsible Party: Black, CalOptima: Red)	Responsible Person/Contact Information	Implementation Date	CAP Status
1	**Background:** **Applicable References and Standards:** **Findings and Actions:**	**1) What is the root cause of the deficiency?** **2) What step(s) have been taken to resolve the deficiency?** **3) What control(s) have been implemented to ensure this deficiency does not reoccur?**			

Corrective Action Plan (CAP):
Non-Compliance Investigations

Instructions: The Responsible Party (CalOptima or Delegated Entity) must provide a response to all cells in white, including: (1) a response (in black font) to each of the four questions under CAP Response (2) Identification of the responsible person including all contact information, (3) Implementation date, actual or planned, and (4) CAP Attestation.

CalOptima's Office of Compliance is responsible for completing all cells in blue.

		4) How will CAP be measured and monitored to close CAP?			
Monitoring Method(s) and Result				**Monitoring Status**	

CAP #	Background/Deficiency	CAP Response (Responsible Party: Black, CalOptima: Red)	Responsible Person/Contact Information	Implementation Date	CAP Status
2	**Background:** **Applicable References and Standards:** **Findings and Actions:**	**1) What is the root cause of the deficiency?** **2) What step(s) have been taken to resolve the deficiency?** **3) What control(s) have been implemented to ensure this deficiency does not reoccur?**			

Corrective Action Plan (CAP):
Non-Compliance Investigations

Instructions: The Responsible Party (CalOptima or Delegated Entity) must provide a response to all cells in white, including: (1) a response (in black font) to each of the four questions under CAP Response (2) Identification of the responsible person including all contact information, (3) Implementation date, actual or planned, and (4) CAP Attestation.

CalOptima's Office of Compliance is responsible for completing all cells in blue.

		4) How will CAP be measured and monitored to close CAP?			
Monitoring Method(s) and Result				**Monitoring Status**	

CAP Attestation:

I, _____ [NAME/TITLE] hereby have the authority to attest that the CAP(s), and subsequent remediation, as stated above, accurately reflect _____ [BUSINESS OWNER/DELEGATE] plan to remediate and execute the above referenced area(s) of non compliance.

Generated by:
(Responsible Party) _____ _____
Name, Title Signature Date

Approved by:
(CalOptima) _____ _____
Name, Title Signature Date

Policy #:	HH.2007Δ
Title:	**Compliance Committee**
Department:	Office of Compliance
Section:	Regulatory Affairs &Compliance
CEO Approval:	Michael Schrader _____
Effective Date:	09/01/15
Last Review Date:	~~DATE~~12/01/16
Last Revised Date:	~~DATE~~12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy describes the role and responsibility of CalOptima's Compliance Committee in ensuring and enforcing compliance with ethical standards, regulatory requirements, contractual obligations~~establish a process in which the Executive Director of Compliance~~Compliance Officer~~Officer~~ shall report results at least quarterly to the Compliance Committee and Board of Directors. Reporting shall ensure and enforce the compliance of with~~ethical standards, contractual requirements, applicable federal and state statutes, regulations~~, the Compliance Program including the Fraud, Waste, and Abuse (FWA) Plan~~,~~ and Code of Conduct ~~(COC)~~, and CalOptima policies.

II. POLICY

A. The Compliance Committee shall oversee compliance efforts in accordance with the Compliance Program, including theCompliance Plan, Fraud, Waste, and Abuse (FWA) Plan, ~~Code of Conduct (COC)~~Code of Conduct, all applicable state and federal regulations, policies and procedures, and federal and state contracts.

B. The Compliance Committee shall recommend and monitor, in collaboration with the Office of Compliance, the development of internal processes and procedures to implement and support the Compliance Plan, Code of Conduct, the FWA Plan, and adherence to relevant statutory, regulatory and contractual obligations.

~~B.~~C. The Office of Compliance shall provide summary updates of all issued Corrective Action Plan(s) (CAPs) to t~~T~~he ~~Office of Compliance and~~ Audit &~~Delegation~~ Oversight Committee (~~D~~AOC) and Compliance Committee ~~Compliance Committee, Executive Department, and Board of Directorsshall recommend corrective action(s), as appropriate,to the Executive Director of ComplianceCompliance Officer~~Officerand ~~Compliance Committee for approval, implementation, monitoring and shallevaluatione of the effectiveness of the Corrective Action Plan (CAP).~~for review. The Compliance Committee shall Monitor and report on the effectiveness of issued CAPs.

~~C. The Compliance Committee shall recommend and monitor, in collaboration with the Office of Compliance~~Executive Department, Board of Directors, and the Audit & Oversight Department, the ~~development of internal processes and procedures to implement and thatsupport the Compliance Plan, Code of Conduct, the FWA Plan, and adherence to relevant statutory, regulatory and contractual obligations.~~

III. PROCEDURE

A. Compliance Committee Organization

1. The ~~Executive Director of Compliance~~Compliance Officer shall serve as Chairperson of the Compliance Committee.

2. The Directors of Medicare Regulatory Affairs & Compliance and Medi-Cal Regulatory Affairs &Compliance shall serve as Co-Vice Chairpersons and are considered the Chairperson Designees.

~~3. The Compliance Committee shall consists of executive officers, leadership staff of key operating divisions, and legal counsel that implements and oversees CalOptima's Compliance Program.~~

3. Each member of the Compliance Committee is a voting member. Voting members may appoint a Designee, when deemed appropriate. The Designee ~~shall~~ mayserve as a ~~1~~subject matter expert at the Compliance Committee meeting; however, the Designee will~~would~~ not have voting rights unless approved in advance by the ~~Executive Director of Compliance~~Compliance Officer.

~~4.~~

~~For purposes of voting, a quorum shall consist of fifty-one percent (51%) of the Compliance Committee members. In the absence of a quorum, the meeting may proceed; however, any issues requiring a vote shall be deferred until the next regular meeting. If an action by the Compliance Committee is critical, a vote may be taken by the Chairperson, or his, or her Designee, outside of the meeting by phone, electronic mail or via documented votes. Action will be documented and made part of the minutes.~~

~~5.~~4. At the request of the Chairperson of the Compliance Committee, CalOptima Eemployees may be requested to attend a Compliance Committee meeting, on an ad-hoc basis~~, at the request of the Chairperson~~. Attendance may be warranted to support discussion items at the Compliance Committee meeting and/or to provide~~mote~~ clarification for the voting members.

~~6.~~5. A~~ll a~~ctivities of the Compliance Committee, to the extent not deemed~~shall be considered~~ privileged and confidential, shall be ~~and not subject to~~ disclosable~~ure~~.

B. Compliance Committee Meetings

1. The Compliance Committee ~~and Board of Directors~~ shall meet at least on a quarterly basis, or more frequently as significant non-compliant and/or FWA issues are identified outside of the quarterly time period, as determined by the Compliance Officer. Annually, Compliance Committee members shall receive a calendar of meetings for the calendar year as well as a reporting matrix which includes all planned reports to be presented during scheduled Compliance Committee~~s~~ meetings.

2. A Committee binder is distributed to all meeting attendees prior to the Compliance Committee meeting. The Committee binder shall include, but is not limited to:

   a. Current meeting agenda;

   b. Final draft meeting minutes from the previous Compliance Committee for approval;

   c. Listing of open action items;

d. Submitted Compliance Committee reports;

e. Scheduled audit reports;

f. CAP monitoring;

g. Notices of Non-Compliance; and

h. Special reports, which may include, but not limited to, any reports not regularly presented to the Compliance Committee that may be of interest or concern, or is intermittent in nature.

3. Minutes of Compliance Committee meetings shall be maintained by the Office of Compliance in the normal course of business. ~~a confidential electronic and hard-copy file in the Office of Compliance department.~~

4. Ad-hoc Compliance Committee meetings may be held at the discretion of the Chairperson, as deemed appropriate.

~~5. For purposes of voting, a quorum shall consist of fifty-one percent (51%) of the Compliance Committee members. In the absence of a quorum, the meeting may proceed; however, any issues requiring a vote shall be deferred until the next regular meeting. If an action by the Compliance Committee is critical, a vote may be taken by the Chairperson, or his, or her Designee outside of the meeting by phone, electronic mail or via documented votes. Action will be documented and made part of the minutes.~~

C. Compliance Committee Responsibilities

1. The Compliance Committee responsibilities shall include, but are not limited to~~,~~:

a. Determine the appropriate strategy and/or approach~~Review and approve strategies~~ to promote compliance~~,and~~to prevent, detect, and correct ~~non-compliance~~potential violations, and to advise the ~~Executive Director of Compliance~~Compliance Officer accordingly;

b. Review and approve training related to Compliance and FWA and ~~. E~~ensure~~s~~ that training and education are effective and appropriately completed;

c. ~~Review and approve~~Assist with the creation and implementation of the Office of Compliance Annual Risk Assessment and of the compliance M~~m~~onitoring and A~~a~~uditing work plan;

d. Review and ~~approve~~ M~~m~~onitor the effectiveness of the Compliance Program, including M~~m~~onitoring key performance reports and metrics, evaluating business and administrative operations, and overseeing the creation, implementation, and development of ~~andaudit process(es), work plan(s), and implementation of appropriate~~ corrective and preventative action(s) to ensure they are prompt and effective;

e. ~~Enforce effective corrective actions and r~~Review overall effectiveness of the internal controls designed to ensure compliance with applicable regulations in daily operations;

f. Receive reports from the ~~Executive Director of Compliance~~Compliance Officer, on at least a quarterly basis, concerning the Compliance Program;

g. Review and approve recommendations of appropriate actions to ensure CalOptima is complying with the applicable laws, ~~and~~ regulations, and ethical standards;

h. Ensure legal counsel is consulted as appropriate and all applicable rights are preserved, including the attorney-client privilege;

i. Ensure CalOptima has a Compliance & Ethics h~~h~~otline and an Office of Compliance email address for CalOptima M~~m~~embers, ~~Board of Directors~~members of the Governing Body, E~~e~~mployees, ~~including~~ and FDRs, to ~~outreach for~~ask compliance questions and report potential issues regarding any CalOptima p~~P~~rogram. Inquiries may include, but are not limited to, non-compliance and potential FWA. Information presented shall be handled c~~c~~onfidentially (to the extent permitted by applicable law and circumstances) and may be submitted anonymously, if desired by the informant, without fear of retaliation in accordance with, CalOptima Policy HH.3012Δ:Non-Retaliation for Reporting Violations;

j. Ensure CalOptima has appropriate and current compliance policies and procedures,

k. Review and address reports of Monitoring and Auditing of areas in which ~~the Medi-Cal program~~CalOptima is at risk of program non-compliance and/or potential FWA, and ~~establish~~ ensure CAPs and ICAPs are implemented and M~~m~~onitored for effectiveness; ~~and~~

l. Provide~~s~~ regular and ad-hoc status reports of compliance with recommendations to the CalOptima Board of Directors; ~~.~~

m. Analyze applicable federal and state programs, including contractual, legal, and regulatory requirements, along with areas of risk, and coordinate with the ~~Executive Director of Compliance~~Compliance Officer to ensure the adequacy of the Compliance Program; and

~~l.~~n. Review the Office of Compliance's process for soliciting, evaluating, and responding to reports and disclosures within the Compliance Program.

2. In accordance with CalOptima Policy~~,~~ HH.2005Δ: Corrective Action Plan, the Compliance Committee in cooperation with ~~Delegation~~ Audit &Oversight Committee (~~DOC~~AOC) shall determine Sanctions, in accordance with CalOptima P~~p~~olicy HH.2002Δ: Sanctions, or other remedial actions, as appropriate, to ensure compliance.

3. The Compliance Committee, in collaboration with the ~~DOC~~AOC, shall evaluate the effectiveness of such corrective actions in collaboration with the appropriate CalOptima departments and shall make recommendations regarding ongoing monitoring activities to ensure continuing compliance.

D. The Compliance Committee Chairperson shall report to the Board of Directors on at least a quarterly basis. The report shall include a summary of compliance issues taken before the Compliance Committee, remedial action taken, and outcomes of such actions.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Code of Conduct
B. CalOptima Compliance Plan
C. CalOptima Compliance Committee Charter
D. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
E. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~A.~~F. CalOptima ~~Contract with the Department of Health Care Services (DHCS) for PACE~~PACE Program Agreement
~~B.~~G. CalOptima Policy HH.2005Δ: Corrective Action Plan
~~C.~~H. CalOptima Policy HH.2002Δ: Sanctions
~~D.~~I. CalOptima Policy HH.3012Δ:Non-Retaliation for Reporting Violations
J. CalOptima Policy: AA.~~1000~~11001: Glossary of Terms
A. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
B. Medicare Managed Care Manual, Chapters 9 and 21
C. Title 42, Code of Federal Regulations (C.F.R.), §455.2
~~E.~~K. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	08/01/2014	MA.9123	Compliance Committee	OneCare
Revised	12/01/2014	MA.9123	Compliance Committee	OneCare
Effective	09/01/2015	HH.2007	Compliance Committee	Medi-Cal
Revised	09/01/2015	MA.9123	Compliance Committee	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2007	Compliance Committee	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9123	Compliance Committee	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
~~Auditing~~Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications~~A formal, systematic, and disciplined approach designed to evaluate and improve the effectiveness of processes and related controls. Auditing is governed by professional standards, completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.~~
Code of Conduct ~~(COC)~~	The statement setting forth the principles and standards governing CalOptima's activities to which Board Members, Employees, FDRs, and agents of CalOptima are expected to adhere.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; ~~Executive Director of Compliance~~Compliance Officer; and Executive Director of Human Resources.
Compliance Program	The program (including, without limitation, ~~this~~ theCompliance Plan, Code of Conduct and Policies and Procedures ~~and Procedures~~) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Members, Employees and FDRs comply with applicable law and ethical standards.
Corrective Action Plan	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.

Term	Definition
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	Anyand all employees of CalOptima, includingall senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, ~~and~~ Health Maintenance Organizations, suppliers and consultants, including those that contract with CalOptima as well as those that are Downstream or Related Entities.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C Section 1347).
Governing Body	TheBoard ofDirectors ofCalOptima
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.~~An on-going process usually directed by management to ensure processes are working as intended. Monitoring is an effective detective control within a process and is typically completed by department staff and communicated to department management.~~
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Policy #:	HH.2007Δ
Title:	**Compliance Committee**
Department:	Office of Compliance
Section:	Regulatory Affairs &Compliance
CEO Approval:	Michael Schrader _____
Effective Date:	09/01/15
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy describes the role and responsibility of CalOptima's Compliance Committee in ensuring and enforcing compliance with ethical standards, regulatory requirements, contractual obligations, the Compliance Program including the Fraud, Waste, and Abuse (FWA) Plan and Code of Conduct, and CalOptima policies.

II. POLICY

A. The Compliance Committee shall oversee compliance efforts in accordance with the Compliance Program, including theCompliance Plan, Fraud, Waste, and Abuse (FWA) Plan, Code of Conduct, all applicable state and federal regulations, policies and procedures, and federal and state contracts.

B. The Compliance Committee shall recommend and monitor, in collaboration with the Office of Compliance, the development of internal processes and procedures to implement and support the Compliance Plan, Code of Conduct, the FWA Plan, and adherence to relevant statutory, regulatory and contractual obligations.

C. The Office of Compliance shall provide summary updates of all issued Corrective Action Plan(s) (CAPs) to the Audit & Oversight Committee (AOC) and Compliance Committee for review. The Compliance Committee shall Monitor and report on the effectiveness of issued CAPs.

III. PROCEDURE

A. Compliance Committee Organization

1. The Compliance Officer shall serve as Chairperson of the Compliance Committee.

2. The Directors of Medicare Regulatory Affairs & Compliance and Medi-Cal Regulatory Affairs &Compliance shall serve as Co-Vice Chairpersons and are considered the Chairperson Designees.

3. Each member of the Compliance Committee is a voting member. Voting members may appoint a Designee, when deemed appropriate. The Designee mayserve as a subject matter expert at the Compliance Committee meeting; however, the Designee will not have voting rights unless approved in advance by the Compliance Officer.

4. At the request of the Chairperson of the Compliance Committee, CalOptima Employees may be requested to attend a Compliance Committee meeting, on an ad-hoc basis. Attendance may be warranted to support discussion items at the Compliance Committee meeting and/or to provide clarification for the voting members.

5. Activities of the Compliance Committee, to the extent not deemed privileged and confidential, shall be disclosable.

B. Compliance Committee Meetings

1. The Compliance Committee shall meet at least on a quarterly basis, or more frequently as significant non-compliant and/or FWA issues are identified outside of the quarterly time period, as determined by the Compliance Officer. Annually, Compliance Committee members shall receive a calendar of meetings for the calendar year as well as a reporting matrix which includes all planned reports to be presented during scheduled Compliance Committee meetings.

2. A Committee binder is distributed to all meeting attendees prior to the Compliance Committee meeting. The Committee binder shall include, but is not limited to:

   a. Current meeting agenda;

   b. Final draft meeting minutes from the previous Compliance Committee for approval;

   c. Listing of open action items;

   d. Submitted Compliance Committee reports;

   e. Scheduled audit reports;

   f. CAP monitoring;

   g. Notices of Non-Compliance; and

   h. Special reports, which may include, but not limited to, any reports not regularly presented to the Compliance Committee that may be of interest or concern, or is intermittent in nature.

3. Minutes of Compliance Committee meetings shall be maintained by the Office of Compliance in the normal course of business.

4. Ad-hoc Compliance Committee meetings may be held at the discretion of the Chairperson, as deemed appropriate.

C. Compliance Committee Responsibilities

1. The Compliance Committee responsibilities shall include, but are not limited to:

   a. Determine the appropriate strategy and/or approach to promote compliance,to prevent, detect, and correct potential violations, and to advise the Compliance Officer accordingly;

   b. Review and approve training related to Compliance and FWA and ensure that training and education are effective and appropriately completed;

c. Assist with the creation and implementation of the Office of Compliance Annual Risk Assessment and of the compliance Monitoring and Auditing work plan;

d. Review and Monitor the effectiveness of the Compliance Program, including Monitoring key performance reports and metrics, evaluating business and administrative operations, and overseeing the creation, implementation, and development of corrective and preventative action(s) to ensure they are prompt and effective;

e. Review overall effectiveness of the internal controls designed to ensure compliance with applicable regulations in daily operations;

f. Receive reports from the Compliance Officer, on at least a quarterly basis, concerning the Compliance Program;

g. Review and approve recommendations of appropriate actions to ensure CalOptima is complying with the applicable laws, regulations, and ethical standards;

h. Ensure legal counsel is consulted as appropriate and all applicable rights are preserved, including the attorney-client privilege;

i. Ensure CalOptima has a Compliance & Ethics hotline and an Office of Compliance email address for CalOptima Members, members of the Governing Body, Employees, and FDRs, to ask compliance questions and report potential issues regarding any CalOptima program. Inquiries may include, but are not limited to, non-compliance and potential FWA. Information presented shall be handled confidentially (to the extent permitted by applicable law and circumstances) and may be submitted anonymously, if desired by the informant, without fear of retaliation in accordance with, CalOptima Policy HH.3012Δ:Non-Retaliation for Reporting Violations;

j. Ensure CalOptima has appropriate and current compliance policies and procedures,

k. Review and address reports of Monitoring and Auditing of areas in which CalOptima is at risk of program non-compliance and/or potential FWA, and ensure CAPs and ICAPs are implemented and Monitored for effectiveness;

l. Provide regular and ad-hoc status reports of compliance with recommendations to the CalOptima Board of Directors;

m. Analyze applicable federal and state programs, including contractual, legal, and regulatory requirements, along with areas of risk, and coordinate with the Compliance Officer to ensure the adequacy of the Compliance Program; and

n. Review the Office of Compliance's process for soliciting, evaluating, and responding to reports and disclosures within the Compliance Program.

2. In accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan, the Compliance Committee in cooperation with Audit &Oversight Committee (AOC) shall determine Sanctions, in accordance with CalOptima Policy HH.2002Δ: Sanctions, or other remedial actions, as appropriate, to ensure compliance.

3. The Compliance Committee, in collaboration with the AOC, shall evaluate the effectiveness of such corrective actions in collaboration with the appropriate CalOptima departments and shall make recommendations regarding ongoing monitoring activities to ensure continuing compliance.

D. The Compliance Committee Chairperson shall report to the Board of Directors on at least a quarterly basis. The report shall include a summary of compliance issues taken before the Compliance Committee, remedial action taken, and outcomes of such actions.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Code of Conduct
B. CalOptima Compliance Plan
C. CalOptima Compliance Committee Charter
D. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
E. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
F. CalOptima PACE Program Agreement
G. CalOptima Policy HH.2005Δ: Corrective Action Plan
H. CalOptima Policy HH.2002Δ: Sanctions
I. CalOptima Policy HH.3012Δ:Non-Retaliation for Reporting Violations
J. CalOptima Policy: AA.1001: Glossary of Terms
A. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
B. Medicare Managed Care Manual, Chapters 9 and 21
C. Title 42, Code of Federal Regulations (C.F.R.), §455.2
K. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	08/01/2014	MA.9123	Compliance Committee	OneCare
Revised	12/01/2014	MA.9123	Compliance Committee	OneCare
Effective	09/01/2015	HH.2007	Compliance Committee	Medi-Cal
Revised	09/01/2015	MA.9123	Compliance Committee	OneCare OneCare Connect PACE

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	12/01/2016	HH.2007	Compliance Committee	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9123	Compliance Committee	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications
Code of Conduct	The statement setting forth the principles and standards governing CalOptima's activities to which Board Members, Employees, FDRs, and agents of CalOptima are expected to adhere.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.
Compliance Program	The program (including, without limitation, theCompliance Plan, Code of Conduct and Policies and Procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Members, Employees and FDRs comply with applicable law and ethical standards.
Corrective Action Plan	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.

Term	Definition
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	Anyand all employees of CalOptima, includingall senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, Health Maintenance Organizations, suppliers and consultants, including those that contract with CalOptima as well as those that are Downstream or Related Entities.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C Section 1347).
Governing Body	TheBoard ofDirectors ofCalOptima
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1

Policy #: HH.2014Δ
Title: **Compliance Program**
Department: Office of Compliance
Section: Regulatory Affairs & Compliance

CEO Approval: Michael Schrader

Effective Date: 08/01/08
Last Review Date: 12/01/169/01/15
Last Revision Date: 12/01/169/01/15

Applicable to:
☒ Medi-Cal
☒ OneCare
☒ OneCare Connect
☒ PACE

I. PURPOSE

This policy establishes a Compliance Program to ensure and enforce compliance with ethical standards, contractual requirements, applicable federal and state statutes and regulations, and CalOptima policies.

II. DEFINITIONS

Term	Definition
Compliance Committee	The CalOptima committee that consists of executive officers, leadership of key operating divisions, and legal counsel that implements and oversees CalOptima's Compliance Program.
Compliance Program	The program including, without limitation, the Compliance Plan, Code of Conduct, and CalOptima policies, developed and adopted by CalOptima to promote, monitor, and ensure that CalOptima's operations and practices and the practices of its Board members, employees, contractors, and providers comply with applicable law and ethical standards.
Downstream Entity	Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
First Tier Entity	Any party that enters into a written arrangement with CalOptima to provide administrative services or health care services to a Medicare or Medicaid eligible individual under the CalOptima program.
First Tier, Downstream, and Related Entities (FDR)	FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United

	~~States Social Security Administration, who is enrolled in the CalOptima program.~~
~~Providers~~	~~A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Physician Medical Group, or other person or institution who furnishes Covered Services.~~
~~Related Entity~~	~~Any entity that is related to CalOptima by common ownership or control and:~~ ~~1. Performs some of the management functions under contract or delegation;~~ ~~2. Furnishes services to Medicare or Medicaid enrollees under an oral or written agreement; or~~ ~~3. Leases real property or sells materials to CalOptima at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.~~

~~III.~~II. POLICY

A. CalOptima shall establish a written Compliance Program, in accordance with this policy.

B. CalOptima's First Tier, Downstream and Related Entities (FDRs) shall, at a minimum, develop a written Compliance Program, in accordance with this policy.

C. CalOptima shall revise and update the Compliance Program, including the Compliance Plan, and all applicable CalOptima policies, as changes occur in CalOptima's needs, regulatory requirements, and applicable laws.

D. The CalOptima Board of Directors is responsible for overseeing the implementation and effectiveness of ~~shall review and approve~~ the Compliance Program, and approving the Compliance Plan and Code of Conduct.

~~D. , in accordance with this policy.~~

E. The Compliance Officer, in conjunction with the Compliance Committee, shall provide oversight, analysis, and continuous monitoring of compliance activities and shall provide a summary of such activities to the Board of Directors on a periodic basis.

F. The Compliance Officer, in conjunction with the Compliance Committee, may update and make minor, non-substantive revisions to the Compliance Plan without the need to obtain Board of Directors approval.

~~F.~~G. CalOptima Employees, members of the Governing Body, ~~The Board of Directors, employees,~~ and FDRs, shall comply with the Compliance Program.

~~IV.~~III. PROCEDURE

A. The Office of Compliance shall recommend revisions ~~modify~~ to the Compliance Plan, Code of Conduct, and related policies and procedures, as necessary, to maintain compliance with contractual requirements, applicable state and federal statutes and regulations, and CalOptima ~~policies~~operations, or as otherwise indicated to meet the needs of Members.

B. The ~~Executive Director of Compliance~~Compliance Officer shall submit recommended revisions to the Compliance Plan and ~~,~~ Code of Conduct, ~~and related policies and procedures~~ to the Compliance Committee for review and approval.

C. Upon the Compliance Committee's approval, the ~~Executive Director of Compliance~~Compliance Officer shall present substantive revisions to the ~~revised~~ Compliance Plan and/or Code of Conduct to the Board of Directors for approval and adoption into the Compliance Program. Minor non-substantive revisions, specifically the correction of typographical or formatting errors, to the Compliance Plan may be implemented without the need to obtain Board of Directors approval.~~.~~

~~V.~~IV. ATTACHMENTS

Not Applicable

~~A. CalOptima Compliance Plan~~

~~VI.~~V. REFERENCES

A. CalOptima Code of Conduct
B. CalOptima Compliance Plan
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima ~~Contract with the Department of Health Care Services (DHCS) for PACE~~ PACE Program Agreement
F. CalOptima Policy AA.1100: Glossary of Terms
G. CalOptima Policy CMC.1001: Glossary of Terms
~~A.~~H. CalOptima Policy MA.1001: Glossary of Terms
I. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
J. Medicare Managed Care Manual, Chapters 9 and 21
~~B.~~
~~C.~~K. Office of Inspector General Guidelines for Operating an Effective Compliance Program
~~D.~~L. Title 42, Code of Federal Regulations (C.F.R.), §§422.503, 423.504~~CalOptima Policy AA.1100: Glossary of Terms~~

~~VII.~~VI. REGULATORY AGENCY APPROVALS

A. 7/12/13: Department of Health Care Services

~~VIII.~~VII. BOARD ACTIONS

None to Date

~~IX.~~VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/01/2005	MA.9101	Compliance Program	OneCare
Effective	08/01/2008	HH.2014	Compliance Program	Medi-Cal
Revised	06/01/2013	HH.2014Δ	Compliance Program	Medi-Cal Healthy Families OneCare
Revised	06/01/2013	MA.9101	Compliance Program	OneCare
Revised	06/01/2014	MA.9101	Compliance Program	OneCare
Revised	09/01/2014	HH.2014	Compliance Program	Medi-Cal
Revised	09/01/2015	HH.2014	Compliance Program	Medi-Cal
Revised	09/01/2015	MA.9101	Compliance Program	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2014Δ	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9101	Compliance Program	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Code of Conduct	The statement setting forth the principles and standards governing CalOptima's activities to which CalOptima's Board of Directors, employees, contractors, and agents are required to adhere.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consists of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.
Compliance Program	The program (including, without limitation, the Compliance Plan, Code of Conduct, and Policies and Procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Members, Employees and FDRs comply with applicable law and ethical standards.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, Health Maintenance Organizations, suppliers and consultants, including those that directly contract with CalOptima as well as those that are Downstream or Related Entities-.
Governing Body	The Board of Directors of CalOptima
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

Policy #:	HH.2014Δ
Title:	**Compliance Program**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	Michael Schrader
Effective Date:	08/01/08
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy establishes a Compliance Program to ensure and enforce compliance with ethical standards, contractual requirements, applicable federal and state statutes and regulations, and CalOptima policies.

II. POLICY

A. CalOptima shall establish a written Compliance Program, in accordance with this policy.

B. CalOptima's First Tier, Downstream and Related Entities (FDRs) shall, at a minimum, develop a written Compliance Program, in accordance with this policy.

C. CalOptima shall revise and update the Compliance Program, including the Compliance Plan, and all applicable CalOptima policies, as changes occur in CalOptima's needs, regulatory requirements, and applicable laws.

D. The CalOptima Board of Directors is responsible for overseeing the implementation and effectiveness of the Compliance Program, and approving the Compliance Plan and Code of Conduct.

E. The Compliance Officer, in conjunction with the Compliance Committee, shall provide oversight, analysis, and continuous monitoring of compliance activities and shall provide a summary of such activities to the Board of Directors on a periodic basis.

F. The Compliance Officer, in conjunction with the Compliance Committee, may update and make minor, non-substantive revisions to the Compliance Plan without the need to obtain Board of Directors approval.

G. CalOptima Employees, members of the Governing Body, and FDRs, shall comply with the Compliance Program.

III. PROCEDURE

A. The Office of Compliance shall recommend revisions to the Compliance Plan, Code of Conduct, and related policies and procedures, as necessary, to maintain compliance with contractual

requirements, applicable state and federal statutes and regulations, and CalOptima operations, or as otherwise indicated to meet the needs of Members.

B. The Compliance Officer shall submit recommended revisions to the Compliance Plan and Code of Conduct, to the Compliance Committee for review and approval.

C. Upon the Compliance Committee's approval, the Compliance Officer shall present substantive revisions to the Compliance Plan and/or Code of Conduct to the Board of Directors for approval and adoption into the Compliance Program. Minor non-substantive revisions, specifically the correction of typographical or formatting errors, to the Compliance Plan may be implemented without the need to obtain Board of Directors approval.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Code of Conduct
B. CalOptima Compliance Plan
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima PACE Program Agreement
F. CalOptima Policy AA.1100: Glossary of Terms
G. CalOptima Policy CMC.1001: Glossary of Terms
H. CalOptima Policy MA.1001: Glossary of Terms
I. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
J. Medicare Managed Care Manual, Chapters 9 and 21
K. Office of Inspector General Guidelines for Operating an Effective Compliance Program
L. Title 42, Code of Federal Regulations (C.F.R.), §§422.503, 423.504

VI. REGULATORY AGENCY APPROVALS

A. 7/12/13: Department of Health Care Services

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/01/2005	MA.9101	Compliance Program	OneCare
Effective	08/01/2008	HH.2014	Compliance Program	Medi-Cal
Revised	06/01/2013	HH.2014Δ	Compliance Program	Medi-Cal Healthy Families OneCare
Revised	06/01/2013	MA.9101	Compliance Program	OneCare
Revised	06/01/2014	MA.9101	Compliance Program	OneCare

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	09/01/2014	HH.2014	Compliance Program	Medi-Cal
Revised	09/01/2015	HH.2014	Compliance Program	Medi-Cal
Revised	09/01/2015	MA.9101	Compliance Program	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2014Δ	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9101	Compliance Program	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Code of Conduct	The statement setting forth the principles and standards governing CalOptima's activities to which CalOptima's Board of Directors, employees, contractors, and agents are required to adhere.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consists of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.
Compliance Program	The program (including, without limitation, the Compliance Plan, Code of Conduct, and Policies and Procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Members, Employees and FDRs comply with applicable law and ethical standards.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, Health Maintenance Organizations, suppliers and consultants, including those that directly contract with CalOptima as well as those that are Downstream or Related Entities.
Governing Body	The Board of Directors of CalOptima
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

Policy #:	HH.2018Δ
Title:	**Compliance and Ethics Hotline**
Department:	Office of Compliance
Section:	Compliance
CEO Approval:	_____Michael Schrader _____
Effective Date:	04/01/12
Last Review Date:	~~09/01/15~~12/01/16
Last Revised Date:	~~09/01/15~~12/01/16
Applicable to:	▪ Medi-Cal ▪ OneCare ▪ OneCare Connect ▪ PACE

I. PURPOSE

~~_____~~This policy~~o~~ establish~~es~~ procedures whereby CalOptima shall receive, document, and manage calls made to ~~—~~CalOptima's C~~c~~ompliance and E~~e~~thics H~~h~~otline.

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~
~~Board Members~~	~~Members of the CalOptima Board of Directors.~~
~~Caller~~	~~Anyone who calls CalOptima's compliance and ethics hotline.~~
~~Complaint~~	~~An oral or written expression indicating dissatisfaction with any aspect of the CalOptima program. Any expression of dissatisfaction to a Medicare health plan, provider, facility or Quality Improvement Organization (QIO) by an enrollee made orally or in writing. This can include concerns about the operations of providers or Medicare health plans such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to enrollees, the claims regarding the right of the enrollee to receive services or receive payment for services previously rendered. It also includes a plan's refusal to provide services to which the enrollee believes he or she is entitled. A complaint could be either a grievance or an appeal, or a single complaint could include elements of both. Every complaint must be handled under the appropriate grievance and/or appeal process.~~
~~Corrective Action Plan (CAP)~~	~~A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, regulating bodies, or designated representatives. Delegates may be required to complete CAPs to ensure they are in compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements identified by CalOptima and its regulators.~~

~~Designee~~	~~A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.~~
~~Downstream Entity~~	~~Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.~~
~~Employee~~	~~Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.~~
~~First Tier, Downstream, and Related Entities (FDR)~~	~~FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, Health Maintenance Organizations, suppliers and consultants, including those that directly contract with CalOptima as well as those that are Downstream or Related Entities.~~~~FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.~~
~~First Tier Entity~~	~~Any party that enters into a written arrangement with CalOptima to provide administrative services or health care services to a Medicare or Medicaid eligible individual under the CalOptima program.~~
~~Immediate Corrective Action Plan (ICAP)~~	~~An ICAP is the result of non-compliance with specific requirements that has the potential to cause significant member harm. Significant member harm exists if the non-compliance resulted in the failure to provide medical items, services or prescription drugs, causing financial distress, or posing a threat to member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.~~
~~Member~~	~~A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the a CalOptima program~~Program~~.~~
~~Provider~~	~~A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services~~
~~Related Entity:~~	~~Any entity that is related to CalOptima by common ownership or control and:~~ ~~1. Performs some of the management functions under contract or delegation;~~ ~~2. Furnishes services to Medicare or Medicaid enrollees under an oral or written agreement; or~~ ~~3. Leases real property or sells materials to CalOptima at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.~~

~~III.~~II. POLICY

A. CalOptima maintains a confidential C~~c~~ompliance and E~~e~~thics H~~h~~otline at 1-877-837-4417, which Board Members, Employees, First Tier, Downstream and Related Entities (FDRs) and other persons may use, including on an anonymous basis, to report potential compliance issues to the organization. CalOptima will strive to maintain confidentiality, to the extent permitted under applicable laws.~~CalOptima's First Tier, Downstream and Related Entities (FDRs) shall develop a process for receiving, documenting, and managing calls made to the FDRs' hotline, in accordance with this policy~~.

B. CalOptima's FDRs shall develop a process not inconsistent with this policy for receiving, documenting, and managing calls made to the FDR's hotline. In addition, when FDRs train their employees on the FDR's reporting processes, such training shall emphasize that reports must be made to CalOptima, when appropriate.

~~B.~~C. CalOptima may contract with ~~A~~a third party vendor ~~contracted by CalOptima shall~~to:

1. Take and document all incoming calls to the C~~c~~ompliance and E~~e~~thics H~~h~~otline;

2. Secure all information provided by the Caller and log the information on an intake form; and

3. Send the intake information to the Office of Compliance within one (1) business day of the call.

~~C.~~D. All calls made to CalOptima's C~~c~~ompliance and E~~e~~thics H~~h~~otline (1-877-837-4417) shall be handled in a manner that protects the privacy of the Caller, either named or anonymous,~~,~~ to the extent permitted by applicable law and circumstances.~~.~~ ~~All~~ Each C~~c~~aller~~s~~ shall be asked if he or she would like to remain anonymous.

~~D.~~E. The Office of Compliance shall ~~investigate~~ review all calls made to CalOptima's C~~c~~ompliance and E~~e~~thics H~~h~~otline within three (3) business days of receipt and take timely appropriate action depending on the circumstances. CalOptima screens calls made to CalOptima's C~~c~~ompliance and E~~e~~thics H~~h~~otline in order to prioritize matters that require immediate investigation. The Office of Compliance shall initiate a reasonable inquiry as quickly as possible, but not later than two (2) weeks after receipt of the phone call.

~~E.~~F. Access to CalOptima's C~~c~~ompliance and E~~e~~thics H~~h~~otline is available to ~~callers~~ Callers twenty-four (24) hours per day, seven (7) days per week, by calling 1-877-837-4417.

~~F.~~G. Availability of CalOptima's C~~c~~ompliance and E~~e~~thics H~~h~~otline shall be publicized in Member, Provider, ~~employee~~Employee, and community communications.

~~G.~~H. CalOptima maintains a strict policy of non-retaliation and non-retribution towards an ~~employee~~ Employee who makes such reports in good faith, pursuant to CalOptima Policies HH.3012Δ: Non-Retaliation for Reporting Violations, and HH.2019Δ: Reporting Suspected Misconduct or Violation.

~~IV.~~III. PROCEDURE

A. Receipt and Documentation of Call

~~1. The third party vendor shall intake phone calls received on the compliance and ethics hotline and shall document all pertinent information, including the name, phone number, and location of the Caller, if the Caller is willing to provide that information.~~

~~2.~~1. The third party vendor will:

a. ~~The third party vendor shall i~~Intake phone calls received on the C~~c~~ompliance and E~~e~~thics H~~h~~otline and shall document all pertinent information, including the name, phone number, and location of the Caller, if the Caller is willing to provide that information.
~~a.~~

b. Document the nature of the concern and attempt to secure all identifiable information, such as name, location, specifics of the allegation, and any unique identifiers, such as the Client Index Number (CIN) or National Provider Number (NPI).

c. Ascertain whether the Caller wants a call back or email follow up after the investigation closes. If so, the third party vendor shall obtain a phone number or email for the call back/follow up.

d. Forward the call intake information to CalOptima's Office of Compliance for investigation within one (1) business day of the call.

~~3.~~2. The Office of Compliance shall assign a case number, create electronic and paper files, and refer the case to the ~~Executive Director of~~ Compliance Officer, or his or her Designee, for review within two (2) business days of receipt from the third party vendor.

B. Call Investigation

1. If the call concerns a general inquiry or a general c~~C~~omplaint about a CalOptima Provider or procedure, the ~~Executive Director of~~ Compliance Officer, or his or her Designee, shall route the call to the appropriate CalOptima department for follow-up.

2. If the call concerns allegations of ~~wrongdoing~~ suspected or detected non-compliance or potential FWA on the part of a CalOptima Member, ~~board~~ Board ~~member~~Member, Provider, or ~~employee~~Employee, the ~~Executive Director of~~ Compliance Officer, or his or her Designee, shall initiate an investigation into the allegations.

3. The Compliance Officer~~Executive Director of Compliance~~, or his or her Designee, shall review the case and determine if additional information is necessary to develop an investigative plan. If additional information is required, the ~~caller~~Caller, if identified, shall be contacted by the ~~Executive Director of~~ Compliance Officer, or his or her Designee, to obtain the additional information. If the ~~caller~~ Caller is anonymous, the ~~Executive Director of~~ Compliance Officer, or his or her Designee, shall evaluate the information provided, and determine if the investigation can proceed with the information at hand. If the investigation cannot proceed without additional information, the ~~Executive Director of~~ Compliance Officer, or his or her Designee, shall close the case and document the rationale for closure in the case file.

4. If the investigation proceeds, the ~~Executive Director of~~ Compliance Officer, or his or her Designee, shall review and investigate the case in accordance with CalOptima Ppolicies HH.2020Δ: Conducting Compliance Investigations or HH.1107Δ: Fraud, Waste and Abuse Investigation and Reporting.

5. The ~~Executive Director of~~ Compliance Officer, or his or her Designee, shall report any CalOptima Eemployee matters that appear to involve criminal liability or substantial civil liability to the Human Resources Department, Legal Affairs Department, and other appropriate department(s), depending on the circumstances. In consultation with the CalOptima Legal Counsel, the ~~Executive Director of~~ Compliance Officer may report potential criminal activity to the appropriate authority(ies).

6. The Office of Compliance may consult with CalOptima Legal Counsel, as necessary.

7. Once the preliminary investigation has been completed, and has been sufficiently documented with all relevant questions answered, the ~~Executive Director of Compliance~~Compliance Officer, or his or her Designee, shall determine whether the allegations should be referred to the appropriate regulatory enforcement branch for further investigation.

8. If preliminary investigation finds that there is no basis for the allegation, the ~~Executive Director of~~ Compliance Officer, or his or her Designee, shall close the case and document the rationale for such closure in the case file.

9. If the preliminary investigation finds that there is validity to the allegations made, the Office of Compliance shall forward the case file to the appropriate regulatory agency, in accordance with CalOptima Policy HH.1107Δ: Fraud, Waste, and Abuse Investigation and Reporting.

10. For cases that are not appropriate for referral to the State and/or Federal regulators, but involve behaviors that must be corrected, or remediated, an Immediate Corrective Action Plan (ICAP), Corrective Action Plan (CAP), other remedial action(s), or some other disciplinary measure consistent with CalOptima policies and procedures shall be required to be implemented by the parties involved. The ~~Executive Director of~~ Compliance Officer, or his or her Designee, shall be responsible for monitoring successful completion of any ICAP, CAP, or other disciplinary measures imposed on the parties involved, while maintaining the privacy and confidentiality of such parties, to the extent permitted by applicable law and circumstances.

~~10.~~11. CalOptima's Office of Compliance shall maintain databases of case files originating from the Ccompliance and Eethics Hhotline, including reports and documentation, in accordance with CalOptima's Compliance Program.

~~V.~~IV. ATTACHMENTS

Not Applicable

~~VI.~~V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage

~~A.~~C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~B. 31 United States Code, Section 3730(h) — Civil Actions for False Claims~~
~~C. Title 45, Code of Federal Regulations, Section 164.530 – Administrative Requirements~~
~~D. CalOptima Policy AA.1000: Glossary of Terms~~
~~E.~~D. CalOptima Policy HH.1107Δ: Fraud, Waste, and Abuse Investigation and Reporting
E. CalOptima Policy HH.2019 Δ: Reporting Suspected Misconduct or Violation
F. CalOptima Policy HH.2020Δ: Conducting Compliance Investigations
G. CalOptima Policy HH.3012 Δ: Non-Retaliation for Reporting Violations
H. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
I. Title 31 United States Code, Section 3730(h) — Civil Actions for False Claims
~~G.~~J. Title 45, Code of Federal Regulations, Section 164.530 – Administrative Requirements

~~VII.~~VI. REGULATORY AGENCY APPROVALS

None to Date

~~VIII.~~VII. BOARD ACTIONS

None to Date

~~IX.~~VIII. REVIEW/REVISION HISTORY

Version	~~Version~~ Date	Policy Number	Policy Title	Line(s) of Business
~~Original Date~~Effective	04/01/2012	HH.2018Δ	Compliance and Ethics Hotline	Medi-Cal OneCare
~~Revision Date 1~~Revised	03/01/2013	HH.2018Δ	Compliance and Ethics Hotline	Medi-Cal OneCare
Revised~~Revision Date 2~~	05/01/2014	HH.2018	Compliance and Ethics Hotline	Medi-Cal
Effective	05/01/2014	MA.9113	Compliance and Ethics Hotline	OneCare
Revised~~Revision Date 3~~	09/01/2015	HH.2018	Compliance and Ethics Hotline	Medi-Cal
Revised	09/01/2015	MA.9113	Compliance and Ethics Hotline	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2018Δ	Compliance and Ethics Hotline	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9113	Compliance and Ethics Hotline	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Board Members	Members of the CalOptima Board of Directors.
Caller	Anyone who calls CalOptima's compliance and ethics hotline.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, Health Maintenance Organizations, suppliers and consultants, including those that directly contract with CalOptima as well as those that are Downstream or Related Entities.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Immediate Corrective Action Plan (ICAP)	An ICAP is the result of non-compliance with specific requirements that has the potential to cause significant member harm. Significant member harm exists if the non-compliance resulted in the failure to provide medical items, services or prescription drugs, causing financial distress, or posing a threat to member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Member	A beneficiary who is enrolled in a CalOptima Program.

Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services
Related Entity:	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

1

Policy #:	HH.2018Δ
Title:	**Compliance and Ethics Hotline**
Department:	Office of Compliance
Section:	Compliance
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/12
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	▪ Medi-Cal ▪ OneCare ▪ OneCare Connect ▪ PACE

I. PURPOSE

This policy establishes procedures whereby CalOptima shall receive, document, and manage calls made to CalOptima's Compliance and Ethics Hotline.

II. POLICY

A. CalOptima maintains a confidential Compliance and Ethics Hotline at 1-877-837-4417, which Board Members, Employees, First Tier, Downstream and Related Entities (FDRs) and other persons may use, including on an anonymous basis, to report potential compliance issues to the organization. CalOptima will strive to maintain confidentiality, to the extent permitted under applicable laws..

B. CalOptima's FDRs shall develop a process not inconsistent with this policy for receiving, documenting, and managing calls made to the FDR's hotline. In addition, when FDRs train their employees on the FDR's reporting processes, such training shall emphasize that reports must be made to CalOptima, when appropriate.

C. CalOptima may contract with a third party vendor to:

1. Take and document all incoming calls to the Compliance and Ethics Hotline;

2. Secure all information provided by the Caller and log the information on an intake form; and

3. Send the intake information to the Office of Compliance within one (1) business day of the call.

D. All calls made to CalOptima's Compliance and Ethics Hotline (1-877-837-4417) shall be handled in a manner that protects the privacy of the Caller, either named or anonymous, to the extent permitted by applicable law and circumstances. Each Caller shall be asked if he or she would like to remain anonymous.

E. The Office of Compliance shall review all calls made to CalOptima's Compliance and Ethics Hotline within three (3) business days of receipt and take timely appropriate action depending on the circumstances. CalOptima screens calls made to CalOptima's Compliance and Ethics Hotline in order to prioritize matters that require immediate investigation. The Office of Compliance shall

initiate a reasonable inquiry as quickly as possible, but not later than two (2) weeks after receipt of the phone call.

F. Access to CalOptima's Compliance and Ethics Hotline is available to Callers twenty-four (24) hours per day, seven (7) days per week, by calling 1-877-837-4417.

G. Availability of CalOptima's Compliance and Ethics Hotline shall be publicized in Member, Provider, Employee, and community communications.

H. CalOptima maintains a strict policy of non-retaliation and non-retribution towards an Employee who makes such reports in good faith, pursuant to CalOptima Policies HH.3012Δ: Non-Retaliation for Reporting Violations, and HH.2019Δ: Reporting Suspected Misconduct or Violation.

III. PROCEDURE

A. Receipt and Documentation of Call

1. The third party vendor will:

   a. Intake phone calls received on the Compliance and Ethics Hotline and shall document all pertinent information, including the name, phone number, and location of the Caller, if the Caller is willing to provide that information.

   b. Document the nature of the concern and attempt to secure all identifiable information, such as name, location, specifics of the allegation, and any unique identifiers, such as the Client Index Number (CIN) or National Provider Number (NPI).

   c. Ascertain whether the Caller wants a call back or email follow up after the investigation closes. If so, the third party vendor shall obtain a phone number or email for the call back/follow up.

   d. Forward the call intake information to CalOptima's Office of Compliance for investigation within one (1) business day of the call.

2. The Office of Compliance shall assign a case number, create electronic and paper files, and refer the case to the Compliance Officer, or his or her Designee, for review within two (2) business days of receipt from the third party vendor.

B. Call Investigation

1. If the call concerns a general inquiry or a general complaint about a CalOptima Provider or procedure, the Compliance Officer, or his or her Designee, shall route the call to the appropriate CalOptima department for follow-up.

2. If the call concerns allegations of suspected or detected non-compliance or potential FWA on the part of a CalOptima Member, Board Member, Provider, or Employee, the Compliance Officer, or his or her Designee, shall initiate an investigation into the allegations.

3. The Compliance Officer, or his or her Designee, shall review the case and determine if additional information is necessary to develop an investigative plan. If additional information is

required, the Caller, if identified, shall be contacted by the Compliance Officer, or his or her Designee, to obtain the additional information. If the Caller is anonymous, the Compliance Officer, or his or her Designee, shall evaluate the information provided, and determine if the investigation can proceed with the information at hand. If the investigation cannot proceed without additional information, the Compliance Officer, or his or her Designee, shall close the case and document the rationale for closure in the case file.

4. If the investigation proceeds, the Compliance Officer, or his or her Designee, shall review and investigate the case in accordance with CalOptima Policies HH.2020Δ: Conducting Compliance Investigations or HH.1107Δ: Fraud, Waste and Abuse Investigation and Reporting.

5. The Compliance Officer, or his or her Designee, shall report any CalOptima Employee matters that appear to involve criminal liability or substantial civil liability to the Human Resources Department, Legal Affairs Department, and other appropriate department(s), depending on the circumstances. In consultation with the CalOptima Legal Counsel, the Compliance Officer may report potential criminal activity to the appropriate authority(ies).

6. The Office of Compliance may consult with CalOptima Legal Counsel, as necessary.

7. Once the preliminary investigation has been completed, and has been sufficiently documented with all relevant questions answered, the Compliance Officer, or his or her Designee, shall determine whether the allegations should be referred to the appropriate regulatory enforcement branch for further investigation.

8. If preliminary investigation finds that there is no basis for the allegation, the Compliance Officer, or his or her Designee, shall close the case and document the rationale for such closure in the case file.

9. If the preliminary investigation finds that there is validity to the allegations made, the Office of Compliance shall forward the case file to the appropriate regulatory agency, in accordance with CalOptima Policy HH.1107Δ: Fraud, Waste, and Abuse Investigation and Reporting.

10. For cases that are not appropriate for referral to the State and/or Federal regulators, but involve behaviors that must be corrected, or remediated, an Immediate Corrective Action Plan (ICAP), Corrective Action Plan (CAP), other remedial action(s), or some other disciplinary measure consistent with CalOptima policies and procedures shall be required to be implemented by the parties involved. The Compliance Officer, or his or her Designee, shall be responsible for monitoring successful completion of any ICAP, CAP, or other disciplinary measures imposed on the parties involved, while maintaining the privacy and confidentiality of such parties, to the extent permitted by applicable law and circumstances.

11. CalOptima's Office of Compliance shall maintain databases of case files originating from the Compliance and Ethics Hotline, including reports and documentation, in accordance with CalOptima's Compliance Program.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Policy HH.1107Δ: Fraud, Waste, and Abuse Investigation and Reporting
E. CalOptima Policy HH.2019Δ: Reporting Suspected Misconduct or Violation
F. CalOptima Policy HH.2020Δ: Conducting Compliance Investigations
G. CalOptima Policy HH.3012Δ: Non-Retaliation for Reporting Violations
H. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
I. Title 31 United States Code, Section 3730(h) — Civil Actions for False Claims
J. Title 45, Code of Federal Regulations, Section 164.530 – Administrative Requirements

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2012	HH.2018Δ	Compliance and Ethics Hotline	Medi-Cal OneCare
Revised	03/01/2013	HH.2018Δ	Compliance and Ethics Hotline	Medi-Cal OneCare
Revised	05/01/2014	HH.2018	Compliance and Ethics Hotline	Medi-Cal
Effective	05/01/2014	MA.9113	Compliance and Ethics Hotline	OneCare
Revised	09/01/2015	HH.2018	Compliance and Ethics Hotline	Medi-Cal
Revised	09/01/2015	MA.9113	Compliance and Ethics Hotline	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2018Δ	Compliance and Ethics Hotline	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9113	Compliance and Ethics Hotline	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Board Members	Members of the CalOptima Board of Directors.
Caller	Anyone who calls CalOptima's compliance and ethics hotline.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, Health Maintenance Organizations, suppliers and consultants, including those that directly contract with CalOptima as well as those that are Downstream or Related Entities.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Immediate Corrective Action Plan (ICAP)	An ICAP is the result of non-compliance with specific requirements that has the potential to cause significant member harm. Significant member harm exists if the non-compliance resulted in the failure to provide medical items, services or prescription drugs, causing financial distress, or posing a threat to member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Member	A beneficiary who is enrolled in a CalOptima Program.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services

Related Entity:	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

1

Policy #:	HH.2019Δ-~~A~~
Title:	**Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Policies ~~Misconduct or Violation~~**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/12
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy~~o~~ establishes a structure whereby CalOptima Governing Body, E~~e~~mployees, and First Tier, Downstream and Related Entities (FDRs) are able to report suspected misconduct or violations, in good faith, without fear of retaliation or retribution.

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~
~~Code of Conduct~~	~~The statement setting forth the principles and standards governing CalOptima's activities to which CalOptima's Board of Directors, employees, FDRs and agents are required to adhere.~~
~~Compliance Committee~~	~~The CalOptima committee that consists of executive officers, leadership of key operating divisions, and legal counsel that implements and oversees CalOptima's Compliance Program.~~
~~Designee~~	~~A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.~~
~~Downstream Entity~~	~~Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.~~
~~First Tier, Downstream, and Related Entities (FDR)~~	~~FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.~~
~~First Tier Entity~~	~~Any party that enters into a written arrangement with CalOptima to provide administrative services or health care services to a Medicare or Medicaid eligible individual under the CalOptima program.~~
~~Governing Body~~	~~For the purpose of this policy, the term Governing Body shall refer to the Board of Directors and all advisory committees.~~
~~Employee~~	~~For the purpose of this policy the term Employee shall refer to~~

	~~any full-time, intern, temporary, volunteer and any as-needed employee.~~
~~Member~~	~~A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.~~
~~Related Entity~~	~~Any entity that is related to CalOptima by common ownership or control and:~~ ~~1. Performs some of the management functions under contract or delegation;~~ ~~2. Furnishes services to Medicare or Medicaid enrollees under an oral or written agreement; or~~ ~~3. Leases real property or sells materials to CalOptima at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.~~

~~III.~~II. POLICY

A. CalOptima is committed to establishing a culture that promotes prevention, detection, and resolution of instances of conduct that do not conform to its organizational policies, its Code of Conduct, State and Federal laws or regulations, or program requirements of Federal and State health care programs.

B. All CalOptima Members, members of the Governing Body, Employees, and FDRs have the responsibility to promptly report in good faith any suspected Fraud, Waste, or Abuse, or suspected ~~violations, in good faith, of~~violations of any statute, regulation or guideline, ~~Fraud, Waste, or Abuse,~~ applicable to Federal and /or State health care programs, of the Code of Conduct, or of CalOptima's policies and procedures.

1. A member of the CalOptima Governing Body, Employee, or FDR may file a report, without fear of retaliation or retribution, by doing one (1) of the following:

   a. Notifying his or her immediate supervisor;

   b. Notifying the ~~Executive Director of Compliance~~Compliance Officer, or his or her Designee, or a member of management;

   c. Completing a Request for Compliance Action Form;

   d. Calling CalOptima's Compliance and Ethics Hotline~~compliance and ethics hotline~~; or

   e. ~~Reports can be made d~~Directly to CalOptima's Office of Compliance D~~d~~epartment via mail, facsimile, or email for confidential and/or anonymous reporting.

C. CalOptima is committed to a policy that encourages timely reporting of compliance concerns, and prohibits any action directed against a ~~-~~member of the Governing Body, Employee, or FDR for making such a report in good faith.

D. CalOptima policy strictly prohibits retaliation for reporting, in good faith, perceived or suspected violations of any statute, regulation or guideline, Fraud, Waste, or Abuse, applicable to Federal and /or State health care programs, of the Code of Conduct, or of CalOptima's policies and procedures, or for participation in an investigation of an alleged violation, in accordance with CalOptima Policy HH.3012Δ: Non-Retaliation for Reporting Violations.

E. Individuals cannot exempt themselves from the consequences of their own misconduct by self-reporting, although self-reporting may be taken into account when determining the appropriate course of action.

F. Any person who intentionally provides false information may be subject to disciplinary action.

~~IV.~~III. PROCEDURE

A. The Office of Compliance, in collaboration with the CalOptima management team, shall ensure awareness of the following compliance measures:

1. Open communication between Employees and their ~~-~~manager, or supervisor, ~~open communication~~ about any questions regarding compliance. Managers and supervisors shall respond to any inquiry and/or refer the question to appropriate personnel.

2. Management's "open door policy." ~~a~~All management personnel shall have an open door policy that allows an E~~e~~mployee to present any suspected violation.

3. All CalOptima Members, a member of the Governing Body, E~~e~~mployees, and FDRs are responsible for promptly reporting suspected violations, in good faith, of any statute, regulation, or guideline, Fraud, Waste, or Abuse, applicable to Federal and /or State health care programs, of the Code of Conduct, or of CalOptima's policies and procedures, or other instances of misconduct.

B. The Office of Compliance, in collaboration with the CalOptima management team, shall implement and publicize, in writing, compliance measures to, include, but not limited to:

1. CalOptima Employee Handbook;

2. CalOptima Code of Conduct; and

3. Compliance training.

C. Mechanisms for reporting suspected violations

1. A member of the CalOptima Governing Body, E~~e~~mployee, or FDR may:

   a. Report to a manager or supervisor: Concerns about business conduct in any department; and

   b. Managers or supervisors who receive such reports from Employees shall immediately report the information to the ~~Executive Director of Compliance~~Compliance Officer, or his or her Designee.

2. Call CalOptima's Compliance and Ethics Hotline

   a. CalOptima's Compliance and Ethics Hotline ~~compliance and ethics hotline~~ shall be accessible by calling 1-877-837-4417.

   b. CalOptima's Compliance and Ethics Hotline ~~compliance and ethics hotline~~ shall be accessible twenty-four (24) hours~~,~~ a day, seven (7) days a week.

   c. The caller may choose to remain anonymous.

   d. The Office of Compliance shall receive, document, and manage calls, in accordance with CalOptima Policy HH.2018Δ: Compliance and Ethics Hotline.

3. Request for a Compliance Action Form

   a. This form is available on the CalOptima Intranet (InfoNet) and CalOptima Website at www.caloptima.org; and

   b. Information received on the Request for Compliance Action Form shall be handled in the same manner as calls received on CalOptima's Compliance and Ethics Hotline~~compliance and ethics hotline~~, in accordance with CalOptima Policy HH.2018Δ: Compliance and Ethics Hotline.

4. Report to the ~~Executive Director of~~ Compliance Officer, or his or her Designee:

   a. The ~~Executive Director of~~ Compliance Officer can be reached at 1-657-235-6997, 7:30 a.m.-5 p.m. Pacific Standard Time (PST), Monday through Friday.

   b. Reports can be made directly to the ~~Executive Director of~~ Compliance Officer, in lieu of other reporting options.

   c. Any information received by the ~~Executive Director of~~ Compliance Officer, or his or her Designee, shall be handled in the same manner as calls received on CalOptima's Compliance and Ethics Hotline~~compliance and ethics Hotline~~, in accordance with CalOptima Policy HH.2018Δ: Compliance and Ethics Hotline.

5. Reports can be made directly to CalOptima's Office of Compliance ~~department~~ via mail, facsimile or email for confidential and/or anonymous reporting.

   a. Emails can be sent to compliance@caloptima.org~~HNreporting@caloptima.org~~. Faxes can be sent to 1-714-481-6457.

D. The ~~Executive Director of~~ Compliance Officer, or his or her Designee, is responsible for reviewing all reports of suspected violations. The ~~Executive Director of~~ Compliance Officer, or his or her Designee, shall maintain, to as great a degree as practical, the confidentiality of the identity of any Ee~~e~~mployee who submits a report of suspected violation, as allowed by law.

E. The ~~Executive Director of~~ Compliance Officer, or his or her Designee, shall conduct an investigation, in accordance with CalOptima Policy HH.2020Δ: Conducting ~~Internal~~ Compliance Investigations, and shall report findings to the Compliance Committee, ~~-~~ the Board of Directors, regulatory and/or law enforcement agency, as deemed appropriate.

~~V.~~IV. ATTACHMENTS

A. Request for Compliance Action Form

~~VI.~~V. REFERENCES

A. CalOptima Code of Conduct
~~A.~~B. CalOptima Compliance Plan
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima Contract with the Department of Health Care Services (DHCS) for PACE
~~B.~~ CalOptima Employee Handbook
~~C.~~F. ~~Title 45, Code of Federal Regulations, Section 164.530 – Administrative Requirements~~
~~CalOptima Policy AA.10100: Glossary of Terms~~
~~D. CalOptima Policy CMC.1001: Glossary of Terms~~
~~E.~~G. CalOptima Policy HH.2018Δ: Compliance and Ethics Hotline
~~F.~~ CalOptima Policy HH.3012Δ: Non-Retaliation for Reporting Violations
~~G.~~H. ~~CalOptima Policy HH.2018: Compliance and Ethics Hotline~~
I. CalOptima Policy HH.2020Δ: Conducting Compliance Investigations
~~CalOptima Policy MA.1001: Glossary of Terms~~
J. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
K. Medicare Managed Care Manual, Chapters 9 and 21
L. False Claims Act (FCA), (31, U.S.C., §§3729-3733)
~~H.~~M. Title 45, Code of Federal Regulations (C.F.R.), ~~Section~~ §164.530 ~~– Administrative Requirements~~ ~~CalOptima Policy HH.2020: Conducting Internal Investigations~~

~~VII.~~VI. REGULATORY AGENCY APPROVALS

None to Date

~~VIII.~~VII. BOARD ACTIONS

None to Date

~~IX.~~VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2012	HH.2019	Reporting Suspected Misconduct or Violations	Medi-Cal
Revised	03/01/2013	HH.2019Δ	Reporting Suspected Misconduct or Violations	Medi-Cal Healthy Families OneCare
Effective	06/01/2014	MA.9114	Reporting Suspected Misconduct or Violations	OneCare
Revised	09/01/2015	HH.2019	Reporting Suspected Misconduct or Violations	Medi-Cal
Revised	09/01/2015	MA.9114	Reporting Suspected Misconduct or Violations	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2019Δ	Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Policies	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9114	Reporting Suspected Misconduct or Violations	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Code of Conduct	The statement setting forth the principles and standards governing CalOptima's activities to which Board Members, Employees, FDRs, and agents of CalOptima are expected to adhere.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.

Term	Definition
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347).
Governing Body	The Board of Directors of CalOptima.
Member	A beneficiary who is enrolled in a CalOptima Program.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Policy #:	HH.2019Δ
Title:	**Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Policies**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/12
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy establishes a structure whereby CalOptima Governing Body, Employees, and First Tier, Downstream and Related Entities (FDRs) are able to report suspected misconduct or violations, in good faith, without fear of retaliation or retribution.

II. POLICY

A. CalOptima is committed to establishing a culture that promotes prevention, detection, and resolution of instances of conduct that do not conform to its organizational policies, its Code of Conduct, State and Federal laws or regulations, or program requirements of Federal and State health care programs.

B. All CalOptima Members, members of the Governing Body, Employees, and FDRs have the responsibility to promptly report in good faith any suspected Fraud, Waste, or Abuse, or suspected violations of any statute, regulation or guideline, applicable to Federal and /or State health care programs, of the Code of Conduct, or of CalOptima's policies and procedures.

1. A member of the CalOptima Governing Body, Employee, or FDR may file a report, without fear of retaliation or retribution, by doing one (1) of the following:

   a. Notifying his or her immediate supervisor;

   b. Notifying the Compliance Officer, or his or her Designee, or a member of management;

   c. Completing a Request for Compliance Action Form;

   d. Calling CalOptima's Compliance and Ethics Hotline; or

   e. Directly to CalOptima's Office of Compliance Department via mail, facsimile, or email for confidential and/or anonymous reporting.

C. CalOptima is committed to a policy that encourages timely reporting of compliance concerns, and prohibits any action directed against a member of the Governing Body, Employee, or FDR for making such a report in good faith.

D. CalOptima policy strictly prohibits retaliation for reporting, in good faith, perceived or suspected violations of any statute, regulation or guideline, Fraud, Waste, or Abuse, applicable to Federal and/or State health care programs, of the Code of Conduct, or of CalOptima's policies and procedures, or for participation in an investigation of an alleged violation, in accordance with CalOptima Policy HH.3012Δ: Non-Retaliation for Reporting Violations.

E. Individuals cannot exempt themselves from the consequences of their own misconduct by self-reporting, although self-reporting may be taken into account when determining the appropriate course of action.

F. Any person who intentionally provides false information may be subject to disciplinary action.

III. PROCEDURE

A. The Office of Compliance, in collaboration with the CalOptima management team, shall ensure awareness of the following compliance measures:

1. Open communication between Employees and their manager, or supervisor, about any questions regarding compliance. Managers and supervisors shall respond to any inquiry and/or refer the question to appropriate personnel.

2. Management's "open door policy." All management personnel shall have an open door policy that allows an Employee to present any suspected violation.

3. All CalOptima Members, a member of the Governing Body, Employees, and FDRs are responsible for promptly reporting suspected violations, in good faith, of any statute, regulation, or guideline, Fraud, Waste, or Abuse, applicable to Federal and /or State health care programs, of the Code of Conduct, or of CalOptima's policies and procedures, or other instances of misconduct.

B. The Office of Compliance, in collaboration with the CalOptima management team, shall implement and publicize, in writing, compliance measures to, include, but not limited to:

1. CalOptima Employee Handbook;

2. CalOptima Code of Conduct; and

3. Compliance training.

C. Mechanisms for reporting suspected violations

1. A member of the CalOptima Governing Body, Employee, or FDR may:

a. Report to a manager or supervisor: Concerns about business conduct in any department; and

b. Managers or supervisors who receive such reports from Employees shall immediately report the information to the Compliance Officer, or his or her Designee.

2. Call CalOptima's Compliance and Ethics Hotline

    a. CalOptima's Compliance and Ethics Hotline shall be accessible by calling 1-877-837-4417.

    b. CalOptima's Compliance and Ethics Hotline shall be accessible twenty-four (24) hours a day, seven (7) days a week.

    c. The caller may choose to remain anonymous.

    d. The Office of Compliance shall receive, document, and manage calls, in accordance with CalOptima Policy HH.2018Δ: Compliance and Ethics Hotline.

3. Request for a Compliance Action Form

    a. This form is available on the CalOptima Intranet (InfoNet) and CalOptima Website at www.caloptima.org; and

    b. Information received on the Request for Compliance Action Form shall be handled in the same manner as calls received on CalOptima's Compliance and Ethics Hotline, in accordance with CalOptima Policy HH.2018Δ: Compliance and Ethics Hotline.

4. Report to the Compliance Officer, or his or her Designee:

    a. The Compliance Officer can be reached at 1-657-235-6997, 7:30 a.m.-5 p.m. Pacific Standard Time (PST), Monday through Friday.

    b. Reports can be made directly to the Compliance Officer, in lieu of other reporting options.

    c. Any information received by the Compliance Officer, or his or her Designee, shall be handled in the same manner as calls received on CalOptima's Compliance and Ethics Hotline, in accordance with CalOptima Policy HH.2018Δ: Compliance and Ethics Hotline.

5. Reports can be made directly to CalOptima's Office of Compliance via mail, facsimile or email for confidential and/or anonymous reporting.

    a. Emails can be sent to compliance@caloptima.org. Faxes can be sent to 1-714-481-6457.

D. The Compliance Officer, or his or her Designee, is responsible for reviewing all reports of suspected violations. The Compliance Officer, or his or her Designee, shall maintain, to as great a degree as practical, the confidentiality of the identity of any Employee who submits a report of suspected violation, as allowed by law.

E. The Compliance Officer, or his or her Designee, shall conduct an investigation, in accordance with CalOptima Policy HH.2020Δ: Conducting Compliance Investigations, and shall report findings to the Compliance Committee, the Board of Directors, regulatory and/or law enforcement agency, as deemed appropriate.

IV. ATTACHMENTS

A. Request for Compliance Action Form

V. REFERENCES

A. CalOptima Code of Conduct
B. CalOptima Compliance Plan
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima Contract with the Department of Health Care Services (DHCS) for PACE
F. CalOptima Employee Handbook
G. CalOptima Policy HH.2018Δ: Compliance and Ethics Hotline
H. CalOptima Policy HH.3012Δ: Non-Retaliation for Reporting ViolationsCalOptima Policy HH.2020Δ: Conducting Compliance Investigations
I. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
J. Medicare Managed Care Manual, Chapters 9 and 21
K. False Claims Act (FCA), (31, U.S.C., §§3729-3733)
L. Title 45, Code of Federal Regulations (C.F.R.), §164.530

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2012	HH.2019	Reporting Suspected Misconduct or Violations	Medi-Cal
Revised	03/01/2013	HH.2019Δ	Reporting Suspected Misconduct or Violations	Medi-Cal Healthy Families OneCare
Effective	06/01/2014	MA.9114	Reporting Suspected Misconduct or Violations	OneCare
Revised	09/01/2015	HH.2019	Reporting Suspected Misconduct or Violations	Medi-Cal
Revised	09/01/2015	MA.9114	Reporting Suspected Misconduct or Violations	OneCare OneCare Connect PACE

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	12/01/2016	HH.2019Δ	Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Policies	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9114	Reporting Suspected Misconduct or Violations	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Code of Conduct	The statement setting forth the principles and standards governing CalOptima's activities to which Board Members, Employees, FDRs, and agents of CalOptima are expected to adhere.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347).
Governing Body	The Board of Directors of CalOptima.

Term	Definition
Member	A beneficiary who is enrolled in a CalOptima Program.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1

REQUEST FOR COMPLIANCE ACTION

Requestor must complete this Request for Compliance Action Form and include all documentation necessary to determine if alleged violation(s) justify further Compliance action.

SUBMISSION INSTRUCTIONS:
Requestor must submit the completed form to CalOptima via electronic mail at compliance@caloptima.org or via hard copy to CalOptima's Office of Compliance, Attn: Compliance Officer, 505 City Parkway West, Orange CA 92868

REQUESTOR'S NAME:	**ORGANIZATION:**
PHONE NUMBER:	**DEPT./TITLE:**
DATE OF INCIDENT:	**Line(s) of Business Impacted (if applicable):**

Explain in detail the suspected issue of non-compliance with statutory, regulatory, contractual, CalOptima policy or other requirements of the CalOptima program. Please attach another page if more room is needed.

Requestor Signature:	Date:

Select type of Compliance Action being requested:

☐ Investigation	☐ Corrective Action Plan (CAP)	☐ Sanction(s)	☐ Other _____

Basis of this request:

- ☐ Contract §: _____
- ☐ FDR Contract §: _____
- ☐ Business Associate Agreement: _____
- ☐ Statute/Regulation §: _____
- ☐ MMCD All Plan Letter (APL)/Policy Letter (PL): _____
- ☐ HPMS Memo/Dual Plan Letters (DPL): _____
- ☐ Operating Instruction Letter (OIL): _____
- ☐ CalOptima Policy: _____
- ☐ Regulatory Audit (e.g., CMS, DHCS, DMHC): _____
- ☐ Non-Contracted Entity: _____
- ☐ NCQA: _____
- ☐ Other: _____

FOR COMPLIANCE USE ONLY — DO NOT WRITE BELOW THIS LINE

Case #: _____

Received by: _____ **Date:** _____

Assigned to: _____ **Date:** _____

Preliminary Risk Level: ☐ High ☐ Medium ☐ Low

Compliance cannot act on a request for compliance action until it receives all supporting documentation regarding alleged violation(s) of CalOptima policy, contractual, statutory or regulatory requirements. However, potential fraud and abuse can be reported to the Compliance and Ethics Hotline at 1-877-837-4417.

REQUEST FOR COMPLIANCE ACTION

Requestor must complete this Request for Compliance Action Form and include all documentation necessary to determine if alleged violation(s) justify further Compliance action.

SUBMISSION INSTRUCTIONS:
Requestor must submit the completed form to CalOptima via electronic mail at compliance@caloptima.org or via hard copy to CalOptima's Office of Compliance, Attn: Compliance Officer, 505 City Parkway West, Orange CA 92868

REQUESTOR'S NAME:	**ORGANIZATION:**
PHONE NUMBER:	**DEPT./TITLE:**
DATE OF INCIDENT:	**Line(s) of Business Impacted (if applicable):**
Explain in detail the suspected issue of non-compliance with statutory, regulatory, contractual, CalOptima policy or other requirements of the CalOptima program. Please attach another page if more room is needed.	
Requestor Signature:	Date:

Select type of Compliance Action being requested:

☐ Investigation	☐ Corrective Action Plan (CAP)	☐ Sanction(s)	☐ Other _____

Basis of this request:

☐ Contract §: _____

☐ FDR Contract §: _____

☐ Business Associate Agreement: _____

☐ Statute/Regulation §: _____

☐ MMCD All Plan Letter (APL)/Policy Letter (PL): _____

☐ HPMS Memo/Dual Plan Letters (DPL): _____

☐ Operating Instruction Letter (OIL): _____

☐ CalOptima Policy: _____

☐ Regulatory Audit (e.g., CMS, DHCS, DMHC): _____

☐ Non-Contracted Entity: _____

☐ NCQA: _____

☐ Other: _____

FOR COMPLIANCE USE ONLY — DO NOT WRITE BELOW THIS LINE

Case #: _____

Received by: _____ **Date:** _____

Assigned to: _____ **Date:** _____

Preliminary Risk Level: ☐ High ☐ Medium ☐ Low

Compliance cannot act on a request for compliance action until it receives all supporting documentation regarding alleged violation(s) of CalOptima policy, contractual, statutory or regulatory requirements. However, potential fraud and abuse can be reported to the Compliance and Ethics Hotline at 1-877-837-4417.

Policy #:	HH.2020Δ
Title:	**Conducting Compliance Investigations**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	Michael Schrader
Effective Date:	12/01/12
Last Review Date	~~09/01/15~~ 12/01/16
Last Revised Date	~~09/01/15~~ 12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

~~To~~ This policy outlines ~~policies and procedures~~the process for conducting and overseeing compliance investigations or inquiries into allegations of violations of the CalOptima Code of Conduct, any statute, regulation, or guideline applicable to federal and/or state health care programs, or of CalOptima's policies and procedures.

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~
~~Compliance Committee~~	~~The CalOptima committee that consists of executive officers, managers of key operating divisions, and legal counsel that oversees implementation of CalOptima's Compliance Program.~~
~~Compliance Program~~	~~The program including, without limitation, the Compliance Plan, Code of Conduct, and CalOptima policies, developed and adopted by CalOptima to promote, monitor, and ensure that CalOptima's operations and practices and the practices of its Board members, employees, contractors, and providers comply with applicable law and ethical standards.~~
~~Designee~~	~~A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.~~
~~Downstream Entity~~	~~Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.~~
~~Employee~~	~~For the purposes of this policy the term employee shall refer to any full time, intern, temporary, volunteer and any as needed employee.~~
~~First Tier, Downstream, and Related Entities (FDR):~~	~~FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.~~

~~First Tier Entity~~	~~Any party that enters into a written arrangement with CalOptima to provide administrative services or health care services to a Medicare or Medicaid eligible individual under the CalOptima program.~~
~~Governing Body~~	~~For the purpose of this policy, the term governing body shall refer to the Board of Directors.~~
~~Compliance Program~~	~~The program including, without limitation, the Compliance Plan, Code of Conduct, and CalOptima policies, developed and adopted by CalOptima to promote, monitor, and ensure that CalOptima's operations and practices and the practices of its Board members, employees, contractors, and providers comply with applicable law and ethical standards.~~
~~Protected Health Information (PHI)~~	~~Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to:~~ ~~1. The past, present, or future physical or mental health or condition of a Member.~~ ~~2. The provision of health care to a Member; or~~ ~~3. Past, present, or future Payment for the provision of health care to a Member.~~
~~Related Entity~~	~~Any entity that is related to CalOptima by common ownership or control and:~~ ~~1. Performs some of the management functions under contract or delegation;~~ ~~2. Furnishes services to Medicare or Medicaid enrollees under an oral or written agreement; or~~ ~~3. Leases real property or sells materials to CalOptima at a cost of more than two thousand five hundred dollars ($2,500) during a contract period~~
~~Sanction~~	~~Action taken by CalOptima including, without limitations, restrictions, monetary fines, termination or a combination thereof, based on an FDR's failure to comply with statutory, regulatory, contractual, CalOptima policy, or other requirements related to CalOptima programs.~~

~~III.~~II. POLICY

~~A.~~ ~~A.~~ CalOptima's ~~employee~~Employees, Governing Body, and First Tier, Downstream and Related Entities (FDRs), have affirmative obligations under CalOptima's Compliance Program to report all violations and suspected violations of law, regulations and/or policies, the CalOptima Code of Conduct, and/or other compliance issues. CalOptima maintains various disclosure and reporting mechanisms (i.e., hotline) which allow such individuals to fulfill these obligations.

A.

1. CalOptima's Employees, Governing Body, and FDRs shall ~~C~~commence such preliminary investigations within the time frame identified in Section III.B.1.

B. CalOptima has a non-~~retaliation~~Retaliation policy regarding the reporting and investigating of incidents of non-compliance with applicable laws, regulations, the CalOptima Code of Conduct, and/or policies, or other compliance issues, ~~as stated in~~in accordance with CalOptima Policy HH.3012Δ: Non-Retaliation on Reporting Violations.

C. The ~~Executive Director of Compliance~~~~Compliance Officer~~Compliance Officer, or ~~his or her~~their Designee, is responsible for investigating potential non-compliance with applicable laws, regulations, the CalOptima Code of Conduct, and/or policies, or other compliance issues involving CalOptima, including its officers and ~~employee~~Employees, and refers matters to the Compliance Committee, as appropriate. Potential non-compliance with applicable laws, regulations, and/or policies, or other compliance issues, may be discovered through, for example, reports to CalOptima's Compliance and Ethics H~~h~~otline, ~~complaints~~complaints, routine monitoring, or regulatory audits.

D. The ~~Executive Director of Compliance~~~~Compliance Officer~~Compliance Officer, or ~~his or her~~their Designee, shall promptly conduct a preliminary review of potential incidents of ~~noncompliance~~non-compliance with applicable laws, regulations, the CalOptima Code of Conduct, and/or policies, or other compliance issues, to determine whether there is sufficient credible information and basis to warrant to a full compliance investigation of the matter. In conducting such preliminary review, the ~~Executive Director of Compliance~~Compliance Officer, or ~~his or her~~their ~~designee~~Designee, ~~-~~may refer the matter to another appropriate CalOptima department, including referrals to the Executive Director of Human Resources, who is responsible for investigations related to ~~employee~~Employee harassment and discrimination and related matters.

E. The Privacy Officer, or ~~his or her~~their Designee, in collaboration with the Security Officer, or their Designee, shall be responsible for investigations of potential violations of Protected Health Information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended, including implementing regulations, ~~and~~ the Health Information Technology for Economic and Clinical Health (HITECH) Act, and~~/or~~ applicable state privacy, security, and c~~C~~confidentiality laws.

F. Whenever there is credible evidence that suggests violation of criminal, civil, or administrative laws, the ~~Executive Director of Compliance~~Compliance Officer, or ~~his or her~~their ~~designee~~Designee, ~~shall~~~~may~~Designee, may consult with CalOptima's Legal Affairs Department, or independent legal counsel, ~~for~~, for further guidance regarding reports to law enforcement agencies or state or federal regulators, or other appropriate actions.

G. Whenever there is credible evidence that suggests Fraud, Waste, or Abuse, the ~~Executive Director of Compliance~~Compliance Officer, or ~~his or her~~their Designee, shall evaluate, investigate, and report the matter as appropriate, in accordance with CalOptima Policies HH.1105Δ: Fraud, Waste, and Abuse Detection ~~-~~and HH.1107Δ: Fraud, Waste, and Abuse Investigation and Reporting.

H. In conducting internal investigations, CalOptima ~~, including the Office of Compliance personnel,~~ shall respect the rights of all persons involved in the investigation, including those persons accused of non-compliance, in accordance with CalOptima Policy HH.3012Δ: Non-Retaliation on Reporting Violations. CalOptima strictly prohibits ~~retaliation~~Retaliation against ~~employee~~Employees for reporting compliance concerns, and/or participating in internal investigations.

~~IV.~~III. PROCEDURE

A. Preliminary Investigation

1. The ~~Executive Director of Compliance~~Compliance Officer, or ~~his or her~~their Designee, shall:

   a. Evaluate all incidents of potential ~~noncompliance~~non-compliance with applicable laws, regulations, and/or policies, the CalOptima Code of Conduct, or other compliance issues regardless of source;

   b. Determine whether there is sufficient information and basis to proceed with a full investigation of the incident/matter, or whether additional information is necessary;

   c. Determine whether the incident/matter is an inquiry, or is otherwise appropriate for referral to another CalOptima d~~D~~epartment, or whether it is a non-issue that warrants closure of the compliance matter;

   d. Determine whether the incident, if verified to be true, would necessitate a referral or report to one (1) or more of CalOptima's regulatory agencies, ~~(~~or such agency's designated contractor~~ e.g., DHCS Audits and Investigations, CMS MEDIC)~~.

   ~~d.~~e. If applicable, report the incident to Centers for Medicare & Medicaid Services (CMS) and/or the Department of Health Care Services (DHCS) in accordance with CalOptima Policy MA.9124: CMS Self-Disclosure.~~.~~

2. If the ~~Executive Director of Compliance~~~~Compliance Officer~~Compliance Officer, or ~~his or her~~their Designee, determines that a full investigation of the incident is appropriate, ~~then he or she~~they shall review whether CalOptima needs to take any preventative or corrective actions prior to the ~~Executive Director of Compliance~~~~Compliance Officer~~'s~~s~~Compliance Officer's, or ~~his or her~~their Designee's, completion of the full investigation, including, without limitation, preliminary reports to regulatory agencies, placement of ~~employee~~Employees on administrative leave, etc. The ~~Executive Director of Compliance~~Compliance Officer, or ~~his or her~~their Designee, may recommend the temporary or permanent cessation of internal activities that may be the cause of, or contribute to, the alleged non-compliance, as appropriate. The ~~Executive Director of Compliance~~Compliance Officer, or ~~his or her~~their Designee, may consult with CalOptima's Legal Affairs Department on such actions as needed.

3. The ~~Executive Director of Compliance~~Compliance Officer, or ~~his or her~~their Designee, shall determine if an investigation is warranted. The ~~Executive Director of Compliance~~Compliance Officer, or ~~his or her~~their Designee, shall establish the scope of the investigation, based on the following factors, to include, but ~~be~~ not be limited to:

   a. The availability of individuals who may be involved;

   b. The time frame of the alleged violations;

   c. Whether the alleged violations appear to be an isolated incident or pattern of improper conduct;

   d. Whether the alleged violations indicate a systemic or procedural deficiency in a department's operation; and

   e. The time requirements for conducting the investigation, including, any regulatory obligations for commencement and completion of the investigation.

4. Prior to initiating the investigation, the ~~Executive Director of Compliance~~Compliance Officer, or ~~his or her~~their Designee, shall fully explore and understand all the allegations and related issues raised in a complaint.

5. Based on the scope of the investigation, the ~~Executive Director of Compliance~~Compliance Officer, or ~~his or her~~their Designee, shall develop an investigative plan. The ~~Executive Director of Compliance~~Compliance Officer may delegate investigative activities, but retains ultimate supervision and responsibility for compliance investigations.

6. The ~~Executive Director of Compliance~~Compliance Officer shall assume responsibility for carrying out the investigation, or shall assign a qualified person to carry out the investigation, who is organizationally removed from any of the parties directly involved in the investigation.

B. Investigation

1. The ~~Executive Director of Compliance~~Compliance Officer, or ~~his or her~~their Designee, shall initiate the investigation (including gathering all documents, conducting interviews and obtaining other relevant evidence) promptly and generally no later than fourteen ~~two (2) weeks~~ (14) calendar days after the potential ~~noncompliance~~non-compliance was identified (and earlier if the regulatory requirement dictate such and/or if the matter requires more immediate resolution).

2. All communications, evidence, and reports shall be saved, logged, and sequentially numbered upon receipt by the ~~Executive Director of Compliance~~Compliance Officer, or ~~his or her~~their Designee, and ~~-~~maintained in the investigation case file.

3. All information gathered by the ~~Executive Director of Compliance~~Compliance Officer, or ~~his or her~~their Designee, during the investigation shall be held in confidence, in accordance with applicable state and federal law, except as specifically authorized by CalOptima policies and~~,~~ procedures, and applicable law.

4. The ~~Executive Director of Compliance~~Compliance Officer, or ~~his or her~~their Designee, shall:

   a. Conduct interviews, in person and in private, with one (1) interviewee at a time;

   b. Follow professional interview principles and techniques; and

   c. Ensure circumstance and content of the interview are supported by a witness for sensitive interviews.

5. The ~~Executive Director of Compliance~~Compliance Officer, or ~~his or her~~their Designee, shall have a full understanding of the relevant laws, regulations, and government guidance pertinent to the investigation before conducting the investigation, and may consult with CalOptima's Legal Affairs Department for legal guidance on the subject matter at issue.

6. Investigations shall be completed within a reasonable time period, and as expeditiously as possible, based on the circumstances, including, but not limited to, consideration of relevant statutory and/or regulatory requirements (e.g. overpayment disclosure and refunding requirements), the potential that the matter involves ~~fraud~~ Fraud or ~~abuse~~Abuse, and/or the potential for ongoing financial or other harm to CalOptima, any federal or state health care program, and/or any individual while the investigation is conducted.

7. The ~~Executive Director of Compliance~~Compliance Officer, or ~~his or her~~their Designee, shall review whether there are sufficient internal resources, or whether external resources are needed to conduct the investigation. If external resources are necessary, the ~~Executive Director of Compliance~~Compliance Officer, or ~~his or her~~their Designee, may consult with CalOptima's Legal Affairs Department to determine the best course of action.

C. Involvement of Legal Representation

1. Any member of a CalOptima Governing Body, ~~permanent or temporary employee~~Employee, or FDR who is the subject of an investigation is free to retain independent counsel. If a member of a CalOptima Governing Body, ~~employee~~Employee, or FDR is already represented by counsel, the ~~Executive Director of Compliance~~Compliance Officer, or ~~his or her~~their Designee, shall discuss ramifications with CalOptima's Legal Affairs Department before proceeding.

~~1.~~

2. If a member of a CalOptima Governing Body, ~~permanent or temporary employee~~Employee, or FDR is being interviewed, and requests the presence of an attorney, the interview shall be stopped, and the ~~Executive Director of Compliance~~Compliance Officer, or their Designee, shall notify CalOptima's Legal Affairs Department.

3. If the interview is with a member of a CalOptima Governing Body, ~~employee~~Employee, or FDR who is suspected of serious misconduct, CalOptima's Legal Affairs Department shall advise the member of a CalOptima Governing Body, ~~employee~~Employee, or FDR of the seriousness of the matter and CalOptima's policy to disclose the result of its investigation to other government agencies, including appropriate state and/or federal law enforcement agencies.

~~3.~~

D. Documenting and reporting findings of the investigation

1. For every interview, the ~~Executive Director of Compliance~~Compliance Officer, or ~~his or her~~their Designee, shall prepare a written interview report covering all the key points derived from that contact.

2. The ~~Executive Director of Compliance~~Compliance Officer, or ~~his or her~~their Designee, shall:

   a. Write the investigation report;

   b. File with the original written communication; and

   c. Include a summary of the individual's complaint, a chronology of events, the investigator's findings/conclusions, and, as appropriate, recommended actions with specific responsibilities assigned to managers to ensure implementation.

3. The ~~Executive Director of Compliance~~Compliance Officer, or ~~his or~~their Designee, shall review root cause analyses, corrective action plans, remediation plans, and future monitoring/auditing plans, as appropriate, to address verified incidents of ~~noncompliance~~non-compliance or deficiencies to ensure they do not recur in the future. The ~~Executive Director of Compliance~~Compliance Officer, or ~~his or her~~their Designee, may consult with the Compliance Committee, CalOptima Legal Affairs, Human Resources, or other parties, as necessary and appropriate, to develop these plans.

4. The ~~Executive Director of Compliance~~Compliance Officer, or ~~his or her~~their Designee, shall report the findings to the Compliance Committee, as appropriate, along with recommendations for final corrective action, in order to confirm completion of the investigative tasks. The Compliance Committee can determine if additional steps are necessary to complete the investigation.

5. The ~~Executive Director of Compliance~~Compliance Officer, or ~~his or her~~their Designee, shall distribute and report complete investigations to the Compliance Committee. No copies shall be provided to other parties, unless requested to do so and approved by the ~~Executive Director of Compliance~~Compliance Officer, or ~~his or her~~their Designee~~.~~.

6. If potential legal issues exist, the report shall be provided to CalOptima's Legal Affairs Department for appropriate action.

7. If the investigation and report have been requested or directed by CalOptima's Legal Affairs Department, the report should be marked "Attorney-Client Privilege" or "Attorney Work Product," as requested by CalOptima's Legal Affairs Department, and furnished only to CalOptima's Legal Affairs Department. Under those circumstances, it shall be the responsibility of CalOptima's Legal Affairs Department to report and advise management about the facts, circumstances, and alternative courses of action.

8. Upon review of the report ~~Once the report has been reviewed~~ by the Compliance Committee, the ~~Executive Director of Compliance~~Compliance Officer, or ~~his or her~~their Designee, shall act upon the findings and recommendations for corrective action measures and determine whether adverse actions should be taken against any parties, and if so, determine the Sanction itself. The ~~Executive Director of Compliance~~Compliance Officer, or ~~his or her~~their Designee, as appropriate, may consult with CalOptima's Legal Affairs Department in making the necessary decisions.

9. Before taking action on the results of an investigation, the ~~Executive Director of Compliance~~Compliance Officer, or ~~his or her~~their Designee, shall ensure that the complainant (if known) has received general feedback on the results of the investigation, but not the details of the investigation, or any specific action or decisions relating to any individual.

10. The ~~Executive Director of Compliance~~Compliance Officer, or ~~his or her~~their Designee, shall report the results of an investigation to the CalOptima Board of Directors and the Chief Executive Officer, as appropriate.

~~V.~~IV. ATTACHMENTS

Not Applicable

~~VI.~~V. REFERENCES

~~A. Health Insurance Portability and Accountability Act (HIPAA) of 1996~~
~~B. Health Information Technology for Economic and Clinical Health (HITECH) Act~~
A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal

D. CalOptima ~~Contract with the Department of Health Care Services (DHCS) for PACE~~PACE Program Agreement
~~C. CalOptima Policy AA.1000: Glossary of Terms~~
~~D.~~E. CalOptima Policy HH.1105Δ: Fraud, Waste, and Abuse Detection
~~E.~~F. CalOptima Policy HH.1107Δ: Fraud, Waste, and Abuse Investigation and Reporting
G. CalOptima Policy HH.3012Δ: Non-Retaliation on Reporting Violations
H. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~F.~~
I. Health Information Technology for Economic and Clinical Health (HITECH) Act
J. Health Insurance Portability and Accountability Act (HIPAA) of 1996, including implementing regulations
K. Medicare Managed Care Manual, Chapters 9 and 21
L. Title 42, Code of Federal Regulations (C.F.R.), §455.15
M. Title 42, Code of Federal Regulations (C.F.R.), §455.2
~~G.~~N. Welfare and Institutions Code, §14043.1(a)

~~VII.~~VI. REGULATORY AGENCY APPROVALS

None to Date

~~VIII.~~VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	12/01/2012	HH.2020	Conducting Internal Investigations	Medi-Cal
Revised	04/01/2014	HH.2020	Conducting Internal Investigations	Medi-Cal
Effective	11/01/2014	MA.9125	Conducting Internal Investigations	OneCare
Revised	09/01/2015	HH.2020	Conducting Internal Investigations	Medi-Cal
Revised	09/01/2015	MA.9125	Conducting Compliance Investigations	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2020Δ	Conducting Compliance Investigations	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9125	Conducting Compliance Investigations	OneCare OneCare Connect PACE

~~IX.~~

~~Version~~	~~Version Date~~	~~Policy Number~~	~~Policy Title~~	~~Line(s) of Business~~

Version	Version Date	Policy Number	Policy Title	Line(s) of Business
OriginalEffective Date	12/01/2012	HH.2020	Conducting Internal Investigations	
Revision Date 1Revised	04/01/2014	HH.2020	Conducting Internal Investigations	Medi-Cal
RevisedRevision Date 2	09/01/2015	HH.2020	Conducting Compliance Investigations	Medi-Cal
Revised	12/01/2016	HH.2020Δ	Conducting Compliance Investigations	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Abuse	A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima programs, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima programs. Or the intentional or careless act that causes harm or serious risk of harm to an older person or vulnerable adult, including: physical abuse, emotional abuse, sexual abuse, and exploitation, neglect, abandonment or self-neglect.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Code of Conduct	The statement setting forth the principles and standards governing CalOptima's activities to which Board Members, Employees, FDRs, and agents of CalOptima are expected to adhere.
~~Any expression of dissatisfaction to CalOptima, a Provider, or the Quality Improvement Organization (QIO) by a Member made orally or in writing. A Complaint may include concerns about the operations of Providers or CalOptima such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, respect paid to Members, and claims regarding the right of a Member to receive services or receive payment for services previously rendered. A Complaint may also involve CalOptima's refusal to provide services to which a Member believes he or she is entitled. A Complaint may be a Grievance or an Appeal, or a single Complaint could include~~	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; ~~Executive Director of Compliance~~Compliance Officer; and Executive Director of Human Resources.

Term	Definition
~~both.~~Compliance Committee	
Compliance Program	The program (including, without limitation, this Compliance Plan, Code of Conduct and Policies and Procedures and Procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Member, Employees and FDRs comply with applicable law and ethical standards.
Confidential	Entrusted with private or personal information that is confined to a person or group as opposed to the public.
Designee	A person selected or designated to carry out a duty or role. The assigned Designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDR):	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C Section 1347).
Governing Body	The Board of Directors of CalOptima.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 if HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.
Protected Health Information (PHI)	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member. 2. The provision of health care to a Member; or

Term	Definition
	3. Past, present, or future Payment for the provision of health care to a Member.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Retaliation	Includes, but not limited to, coercion, threats, intimidation, discrimination, and other forms of retaliatory action against individuals.
Sanction	An action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Policy #:	HH.2020Δ
Title:	**Conducting Compliance Investigations**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	Michael Schrader _____
Effective Date:	12/01/12
Last Review Date	12/01/16
Last Revised Date	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy outlines the process for conducting and overseeing compliance investigations or inquiries into allegations of violations of the CalOptima Code of Conduct, any statute, regulation, or guideline applicable to federal and/or state health care programs, or of CalOptima's policies and procedures.

II. POLICY

A. CalOptima's Employees, Governing Body, and First Tier, Downstream and Related Entities (FDRs), have affirmative obligations under CalOptima's Compliance Program to report all violations and suspected violations of law, regulations and/or policies, the CalOptima Code of Conduct, and/or other compliance issues. CalOptima maintains various disclosure and reporting mechanisms (i.e., hotline) which allow such individuals to fulfill these obligations.

1. CalOptima's Employees, Governing Body, and FDRs shall commence such preliminary investigations within the time frame identified in Section III.B.1.

B. CalOptima has a non-Retaliation policy regarding the reporting and investigating of incidents of non-compliance with applicable laws, regulations, the CalOptima Code of Conduct, and/or policies, or other compliance issues, in accordance with CalOptima Policy HH.3012Δ: Non-Retaliation on Reporting Violations.

C. The Compliance Officer, or their Designee, is responsible for investigating potential non-compliance with applicable laws, regulations, the CalOptima Code of Conduct, and/or policies, or other compliance issues involving CalOptima, including its officers and Employees, and refers matters to the Compliance Committee, as appropriate. Potential non-compliance with applicable laws, regulations, and/or policies, or other compliance issues, may be discovered through, for example, reports to CalOptima's Compliance and Ethics Hotline, complaints, routine monitoring, or regulatory audits.

D. The Compliance Officer, or their Designee, shall promptly conduct a preliminary review of potential incidents of non-compliance with applicable laws, regulations, the CalOptima Code of Conduct, and/or policies, or other compliance issues, to determine whether there is sufficient credible information and basis to warrant to a full compliance investigation of the matter. In conducting such preliminary review, the Compliance Officer, or their Designee, may refer the

matter to another appropriate CalOptima department, including referrals to the Executive Director of Human Resources, who is responsible for investigations related to Employee harassment and discrimination and related matters.

E. The Privacy Officer, or their Designee, in collaboration with the Security Officer, or their Designee, shall be responsible for investigations of potential violations of Protected Health Information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended, including implementing regulations, the Health Information Technology for Economic and Clinical Health (HITECH) Act, and applicable state privacy, security, and confidentiality laws.

F. Whenever there is credible evidence that suggests violation of criminal, civil, or administrative laws, the Compliance Officer, or their Designee, may consult with CalOptima's Legal Affairs Department, or independent legal counsel, for further guidance regarding reports to law enforcement agencies or state or federal regulators, or other appropriate actions.

G. Whenever there is credible evidence that suggests Fraud, Waste, or Abuse, the Compliance Officer, or their Designee, shall evaluate, investigate, and report the matter as appropriate, in accordance with CalOptima Policies HH.1105Δ: Fraud, Waste, and Abuse Detection and HH.1107Δ: Fraud, Waste, and Abuse Investigation and Reporting.

H. In conducting internal investigations, CalOptima shall respect the rights of all persons involved in the investigation, including those persons accused of non-compliance, in accordance with CalOptima Policy HH.3012Δ: Non-Retaliation on Reporting Violations. CalOptima strictly prohibits Retaliation against Employees for reporting compliance concerns, and/or participating in internal investigations.

III. PROCEDURE

A. Preliminary Investigation

1. The Compliance Officer, or their Designee, shall:

   a. Evaluate all incidents of potential non-compliance with applicable laws, regulations, and/or policies, the CalOptima Code of Conduct, or other compliance issues regardless of source;

   b. Determine whether there is sufficient information and basis to proceed with a full investigation of the incident/matter, or whether additional information is necessary;

   c. Determine whether the incident/matter is an inquiry, or is otherwise appropriate for referral to another CalOptima department, or whether it is a non-issue that warrants closure of the compliance matter;

   d. Determine whether the incident, if verified to be true, would necessitate a referral or report to one (1) or more of CalOptima's regulatory agencies, or such agency's designated contractor.

   e. If applicable, report the incident to Centers for Medicare & Medicaid Services (CMS) and/or the Department of Health Care Services (DHCS) in accordance with CalOptima Policy MA.9124: CMS Self-Disclosure.

2. If the Compliance Officer, or their Designee, determines that a full investigation of the incident is appropriate, they shall review whether CalOptima needs to take any preventative or corrective

actions prior to the Compliance Officer's, or their Designee's, completion of the full investigation, including, without limitation, preliminary reports to regulatory agencies, placement of Employees on administrative leave, etc. The Compliance Officer, or their Designee, may recommend the temporary or permanent cessation of internal activities that may be the cause of, or contribute to, the alleged non-compliance, as appropriate. The Compliance Officer, or their Designee, may consult with CalOptima's Legal Affairs Department on such actions as needed.

3. The Compliance Officer, or their Designee, shall determine if an investigation is warranted. The Compliance Officer, or their Designee, shall establish the scope of the investigation, based on the following factors, to include, but not be limited to:

   a. The availability of individuals who may be involved;

   b. The time frame of the alleged violations;

   c. Whether the alleged violations appear to be an isolated incident or pattern of improper conduct;

   d. Whether the alleged violations indicate a systemic or procedural deficiency in a department's operation; and

   e. The time requirements for conducting the investigation, including, any regulatory obligations for commencement and completion of the investigation.

4. Prior to initiating the investigation, the Compliance Officer, or their Designee, shall fully explore and understand all the allegations and related issues raised in a complaint.

5. Based on the scope of the investigation, the Compliance Officer, or their Designee, shall develop an investigative plan. The Compliance Officer may delegate investigative activities, but retains ultimate supervision and responsibility for compliance investigations.

6. The Compliance Officer shall assume responsibility for carrying out the investigation, or shall assign a qualified person to carry out the investigation, who is organizationally removed from any of the parties directly involved in the investigation.

B. Investigation

1. The Compliance Officer, or their Designee, shall initiate the investigation (including gathering all documents, conducting interviews and obtaining other relevant evidence) promptly and generally no later than fourteen (14) calendar days after the potential non-compliance was identified (and earlier if the regulatory requirement dictate such and/or if the matter requires more immediate resolution).

2. All communications, evidence, and reports shall be saved, logged, and sequentially numbered upon receipt by the Compliance Officer, or their Designee, and maintained in the investigation case file.

3. All information gathered by the Compliance Officer, or their Designee, during the investigation shall be held in confidence, in accordance with applicable state and federal law, except as specifically authorized by CalOptima policies and procedures, and applicable law.

4. The Compliance Officer, or their Designee, shall:

    a. Conduct interviews, in person and in private, with one (1) interviewee at a time;

    b. Follow professional interview principles and techniques; and

    c. Ensure circumstance and content of the interview are supported by a witness for sensitive interviews.

5. The Compliance Officer, or their Designee, shall have a full understanding of the relevant laws, regulations, and government guidance pertinent to the investigation before conducting the investigation, and may consult with CalOptima's Legal Affairs Department for legal guidance on the subject matter at issue.

6. Investigations shall be completed within a reasonable time period, and as expeditiously as possible, based on the circumstances, including, but not limited to, consideration of relevant statutory and/or regulatory requirements (e.g. overpayment disclosure and refunding requirements), the potential that the matter involves Fraud or Abuse, and/or the potential for ongoing financial or other harm to CalOptima, any federal or state health care program, and/or any individual while the investigation is conducted.

7. The Compliance Officer, or their Designee, shall review whether there are sufficient internal resources, or whether external resources are needed to conduct the investigation. If external resources are necessary, the Compliance Officer, or their Designee, may consult with CalOptima's Legal Affairs Department to determine the best course of action.

C. Involvement of Legal Representation

1. Any member of a CalOptima Governing Body, Employee, or FDR who is the subject of an investigation is free to retain independent counsel. If a member of a CalOptima Governing Body, Employee, or FDR is already represented by counsel, the Compliance Officer, or their Designee, shall discuss ramifications with CalOptima's Legal Affairs Department before proceeding.

2. If a member of a CalOptima Governing Body, Employee, or FDR is being interviewed, and requests the presence of an attorney, the interview shall be stopped, and the Compliance Officer, or their Designee, shall notify CalOptima's Legal Affairs Department.

3. If the interview is with a member of a CalOptima Governing Body, Employee, or FDR who is suspected of serious misconduct, CalOptima's Legal Affairs Department shall advise the member of a CalOptima Governing Body, Employee, or FDR of the seriousness of the matter and CalOptima's policy to disclose the result of its investigation to other government agencies, including appropriate state and/or federal law enforcement agencies.

D. Documenting and reporting findings of the investigation

1. For every interview, the Compliance Officer, or their Designee, shall prepare a written interview report covering all the key points derived from that contact.

2. The Compliance Officer, or their Designee, shall:

    a. Write the investigation report;

b. File with the original written communication; and

c. Include a summary of the individual's complaint, a chronology of events, the investigator's findings/conclusions, and, as appropriate, recommended actions with specific responsibilities assigned to managers to ensure implementation.

3. The Compliance Officer, or their Designee, shall review root cause analyses, corrective action plans, remediation plans, and future monitoring/auditing plans, as appropriate, to address verified incidents of non-compliance or deficiencies to ensure they do not recur in the future. The Compliance Officer, or their Designee, may consult with the Compliance Committee, CalOptima Legal Affairs, Human Resources, or other parties, as necessary and appropriate, to develop these plans.

4. The Compliance Officer, or their Designee, shall report the findings to the Compliance Committee, as appropriate, along with recommendations for final corrective action, in order to confirm completion of the investigative tasks. The Compliance Committee can determine if additional steps are necessary to complete the investigation.

5. The Compliance Officer, or their Designee, shall distribute and report complete investigations to the Compliance Committee. No copies shall be provided to other parties, unless requested to do so and approved by the Compliance Officer, or their Designee.

6. If potential legal issues exist, the report shall be provided to CalOptima's Legal Affairs Department for appropriate action.

7. If the investigation and report have been requested or directed by CalOptima's Legal Affairs Department, the report should be marked "Attorney-Client Privilege" or "Attorney Work Product," as requested by CalOptima's Legal Affairs Department, and furnished only to CalOptima's Legal Affairs Department. Under those circumstances, it shall be the responsibility of CalOptima's Legal Affairs Department to report and advise management about the facts, circumstances, and alternative courses of action.

8. Upon review of the report by the Compliance Committee, the Compliance Officer, or their Designee, shall act upon the findings and recommendations for corrective action measures and determine whether adverse actions should be taken against any parties, and if so, determine the Sanction itself. The Compliance Officer, or their Designee, as appropriate, may consult with CalOptima's Legal Affairs Department in making the necessary decisions.

9. Before taking action on the results of an investigation, the Compliance Officer, or their Designee, shall ensure that the complainant (if known) has received general feedback on the results of the investigation, but not the details of the investigation, or any specific action or decisions relating to any individual.

10. The Compliance Officer, or their Designee, shall report the results of an investigation to the CalOptima Board of Directors and the Chief Executive Officer, as appropriate.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy HH.1105Δ: Fraud, Waste, and Abuse Detection
F. CalOptima Policy HH.1107Δ: Fraud, Waste, and Abuse Investigation and Reporting
G. CalOptima Policy HH.3012Δ: Non-Retaliation on Reporting Violations
H. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
I. Health Information Technology for Economic and Clinical Health (HITECH) Act
J. Health Insurance Portability and Accountability Act (HIPAA) of 1996, including implementing regulations
K. Medicare Managed Care Manual, Chapters 9 and 21
L. Title 42, Code of Federal Regulations (C.F.R.), §455.15
M. Title 42, Code of Federal Regulations (C.F.R.), §455.2
N. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	12/01/2012	HH.2020	Conducting Internal Investigations	Medi-Cal
Revised	04/01/2014	HH.2020	Conducting Internal Investigations	Medi-Cal
Effective	11/01/2014	MA.9125	Conducting Internal Investigations	OneCare
Revised	09/01/2015	HH.2020	Conducting Internal Investigations	Medi-Cal
Revised	09/01/2015	MA.9125	Conducting Compliance Investigations	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2020Δ	Conducting Compliance Investigations	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9125	Conducting Compliance Investigations	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Abuse	A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima programs, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima programs. Or the intentional or careless act that causes harm or serious risk of harm to an older person or vulnerable adult, including: physical abuse, emotional abuse, sexual abuse, and exploitation, neglect, abandonment or self-neglect.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Code of Conduct	The statement setting forth the principles and standards governing CalOptima's activities to which Board Members, Employees, FDRs, and agents of CalOptima are expected to adhere.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.
Compliance Program	The program (including, without limitation, this Compliance Plan, Code of Conduct and Policies and Procedures and Procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Member, Employees and FDRs comply with applicable law and ethical standards.
Confidential	Entrusted with private or personal information that is confined to a person or group as opposed to the public.
Designee	A person selected or designated to carry out a duty or role. The assigned Designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDR):	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.

Term	Definition
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C Section 1347).
Governing Body	The Board of Directors of CalOptima.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 if HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.
Protected Health Information (PHI)	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member. 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Retaliation	Includes, but not limited to, coercion, threats, intimidation, discrimination, and other forms of retaliatory action against individuals.
Sanction	An action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1

Policy #: HH.2021
Title: **Exclusion Monitoring**
Department: Office of Compliance
Section: Regulatory Affairs & Compliance

CEO Approval: Michael Schrader

Effective Date: 05/01/12
Last Review Date: 12/01/16
Last Revised Date: 12/01/16

Applicable to:
☒ Medi-Cal
☒ OneCare
☒ OneCare Connect
☒ PACE

~~P~~
~~olicy #: HH.2021~~
~~Title: **Exclusion Monitoring**~~
~~Department: Office of Compliance~~
~~Section: Compliance~~

~~CEO Approval: Michael Schrader~~

~~Effective Date: 05/01/12~~
~~Last Review Date: 09/01/15~~
~~Last Revised Date: 09/01/15~~

I. PURPOSE

This policy~~o~~ establishes a process for verifying and monitoring the eligibility of an Eemployee (permanent, temporary, volunteer and as-needed employees), member of the Governing Body, First Tier, Downstream, and Related ~~entities~~ Entity (FDR~~s~~), and vendors ~~-~~to participate in CalOptima's federally-funded health care programs through state and federal exclusions and ineligible lists.

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~
~~Credentialing~~	~~The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.~~
~~Downstream Entity~~	~~Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.~~
~~First Tier, Downstream, and Related~~	~~FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.~~

~~Term~~	~~Definition~~
~~Entities (FDR)~~	
~~First Tier Entity~~	~~Any party that enters into a written arrangement with CalOptima to provide administrative services or health care services to a Medicare or Medicaid eligible individual under the CalOptima program.~~
~~Governing Body~~	~~For the purposes of this policy, the term governing body shall refer to the Board of Directors.~~
~~Member~~	~~A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.~~
~~Provider~~	~~A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.~~
~~Related Entity~~	~~Any entity that is related to CalOptima by common ownership or control and:~~ ~~1. Performs some of the management functions under contract or delegation;~~ ~~2. Furnishes services to Medicare or Medicaid enrollees under an oral or written agreement; or~~ ~~3. Leases real property or sells materials to CalOptima at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.~~

~~III.~~II. POLICY

A. CalOptima shall ensure all Eemployees, members of the Governing Body, FDRs, and vendors are eligible to participate in CalOptima's federally-funded health care programs, and shall be responsible for:

1. Requiring ~~Ensuring the~~ an Eemployee, member of the Governing Body, FDR, or vendor to disclose and report pending suspensions, exclusions or debarments~~has no knowledge of an impending exclusion~~, of the Eemployee, member of the Governing Body, or FDR;

2. Conducting the initial eligibility verification of an Eemployee, member of the Governing Body, FDR, and vendor prior to hiring, renewing, or entering in any new agreement with CalOptima, or issuing payment there to;

3. Performing eligibility verification of an Eemployee, member of the Governing Body, FDR, and vendor monthly thereafter; and

4. Maintaining ~~a~~ records of all initial and monthly verification.

B. CalOptima shall not employ individuals, or contract with individuals or entities, that ~~is~~are determined to be suspended, debarred, or excluded from participation in Federal or State health care programs.

~~:~~

C. CalOptima shall not reimburse or make payment to an individual or entity that is verified to be suspended, debarred, or excluded from participation in Federal or State health care programs.

~~:~~

D. CalOptima will take immediate appropriate actions, with the assistance of Legal Counsel, to terminate the employment of an individual, the contractual relationship with an FDR or vendor, or

the appointment of a member of the Governing Body, if such individual or entity is verified to be suspended, debarred, or excluded from participation in Federal or State health care programs.~~.~~

~~B.~~E. CalOptima shall utilize state and federal exclusion and ineligible list sources referenced in this policy to verify the eligibility of an Eemployee, member of the Governing Body, FDR or vendor and shall maintain a record of completion indicating, at minimum:

1. The date of verification;~~,~~
2. The exclusion and ineligible list source(s);~~,~~
3. Verification results;~~,~~ and
4. The name of the person who conducted the verification.

F. CalOptima is to refer to the chart below to determine the responsible departments that conduct initial and/or monthly exclusions checks thereafter.

~~C. In the event an Eemployee, member of the Governing Body, FDR, or vendor is identified on an exclusion list, CalOptima will immediately terminate and/or block for future payment. CalOptima shall deny payment and participation to an individual or entity, from any and all CalOptima programs.~~

Group	Prior to contracting/hire, CalOptima will verify through …	Monthly thereafter, CalOptima will verify through …
Employees ~~(excluding Board & Committee members)~~	Human Resources	Human Resources
Members of the Governing Body (Board of Directors)	Compliance	Compliance
CalOptima Committee~~'~~s	Compliance	Compliance
Pharmacy Prescriber Pharmacy Network Provider	PBM PBM	PBM PBM
FDRs (excluding Providers and Health Networks)	Purchasing	Compliance
Providers, Practitioners, Health Delivery Organizations (HDO's)	Quality/-Credentialing	Quality/ Credentialing
Health Networks	~~Audit & Oversight~~~~TBD (RAC proposing Contracting department)~~Contracting	Compliance
Medical Group Practice	~~TBD (RAC proposing Credentialing department)~~Contracting	~~TBD (RAC proposing~~ Quality/ Credentialing ~~department)~~

~~D.~~G. All CalOptima FDRs and vendors shall verify the eligibility of all its ~~e~~Eemployees and/or Ddownstream Eentities (as defined above) ~~and its FDRs and vendors~~ prior to hiring/contracting and monthly thereafter. The FDR and vendors shall maintain a record of completion indicating, at minimum:

1. Date of verification;

2. The exclusion and ineligible list source(s)~~;~~;

3. Verification results~~;~~, and

4. The name of the person who conducted the verification.

~~E.~~H. In the event an E~~e~~mployee, FDR or vendor has been identified in an exclusion list, the FDR or vendor must immediately terminate the E~~e~~mployee, FDR, or vendor and immediately notify CalOptima of the identified ineligible person/entity.

~~F.~~I. The Office of Compliance may A~~a~~udit CalOptima departments responsible for exclusion activities, as necessary.

~~IV.~~III. PROCEDURE

A. Monitoring Sources

1. As applicable, CalOptima shall use M~~m~~onitoring sources to retrieve verification and eligibility data, including, but not limited to:

   a. The General Services Administration's (GSA) System for Award Management (SAM) website;

   b. Medicare Exclusion Database (MED);

   c. Medi-Cal's Suspended and Ineligible (S&I) list;

   d. OIG Exclusions Database (OIG LEIE Database); and

   e. Other monitoring sources as identified in CalOptima Policy GG.1609Δ: Credentialing and Recredentialing.

B. Initial Verification

~~2.~~ 1. Prior to hiring an E~~e~~mployee or contracting with an FDR or vendor, the responsible Department identified in the chart in Section II.F. of this policy shall verify that the individual or entity is not Excluded by reviewing the monitoring sources listed in Section III.A.1. of this policy.~~Prior to hiring or contracting, the responsible department, as detailed in section III.C of this policy, shall verify against one (1) or more of the monitoring sources listed in this policy.~~

C. Monitoring

~~B.~~1. On a monthly basis, prior to publishing the next verification list update, the responsible department ~~shall~~ monitor E~~e~~mployees, FDRs, vendors and members of the Board by reviewing the monitoring sources listed in Section III.A.1. of this policy~~monitor exclusion and ineligible lists using one (1) or more of the monitoring sources listed in this policy, as applicable~~.

~~C.~~2. The responsible department shall deem an E~~e~~mployee, member of the Governing Body, FDR or vendor excluded or ineligible if identified on one (1) or more M~~m~~onitoring sources. ~~If~~

applicable, the Office of Compliance shall complete a CalOptima Provider Alert to notify all appropriate CalOptima departments of the excluded or ineligible individual or entity.

D. Actions Based on Discovery of Exclusion

~~D.~~1. In accordance with Title 42, Code of Federal Regulations, Section 1001.1901(b)~~-~~(1), CalOptima shall immediately suspend and halt payment for services for an ineligible or excluded Eemployee, member of the Governing Body, FDR, or vendor. The payment prohibition applies ~~to the excluded or ineligible Eemployee, member of the Governing Body, FDR, or vendor regardless of who submits the claim.~~ regardless of whether or not the Excluded individual or entity submits claims for reimbursement to, or the method of reimbursement by, Federal or State health care programs.

~~—~~CalOptima will take immediate appropriate actions, with the assistance of Legal Counsel, to terminate the employment of an individual, the contractual relationship with a FDR or vendor, or the appointment of a member of the Governing Body, if such person or entity is determined to be E~~E~~xcluded. In the event, that a specific FDR or vendor employee is identified as Excluded, the applicable contractual relationship will also be reviewed to determine whether it may continue with the removal of the Excluded employee.

2.

3. If CalOptima identifies an Excluded individual or entity after they are hired or contracted, the matter should be referred to the Office of Compliance for further investigation. As appropriate, CalOptima will engage in the service of Legal Counsel to take further action as appropriate.

~~E.~~4. CalOptima may recoup monies paid to the Eemployee, member of the Governing Body, FDR, or vendor while Eexcluded. Exclusion findings will be referred to the Office of Compliance for further action in accordance with CalOptima policy. As appropriate, CalOptima will engage in the service of Legal Counsel to take further action as appropriate.

E. FDRs

~~F.~~1. If CalOptima declines to include an FDR, or vendor, from participating in any CalOptima program, it shall notify the FDR, or vendor, in writing, noting the reason for denial. The FDR, or vendor, may contest the denial if they feel there is an error or inappropriate exclusion. If CalOptima determines that there is an inappropriate exclusion, correction shall be made, as stated in the Centers for Medicare & Medicaid Services (CMS) Center for Program Integrity Center for Medicare Letter issu~~dat~~ed June 29, 2011.

~~G.~~ 2. If the FDR, or vendor, has been re-instated by an excluding source listed on this policy, and is now in good standing and able to participate in CalOptima's federally-funded health care programs, the FDR or vendor may express interest in participating with CalOptima. CalOptima will require evidence to verify re-instated participation in CalOptima's federally-funded health care programs. In addition, the FDR, or vendor, will require re-processing through contracting and/or C~~c~~redentialing.

~~V.~~IV. ATTACHMENTS

Not Applicable

~~VI.~~V. REFERENCES

~~A. Balanced Budget Act of 1997~~
A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima ~~Contract with the Department of Health Care Services (DHCS) for PACE~~PACE Program Agreement
~~CalOptima Policy AA.1000: Glossary of Terms~~
E. CalOptima Policy GG.1609Δ: Credentialing and Recredentialing
~~CalOptima Policy MA.1001: Glossary of Terms~~
F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~B.~~ Department Health Care Services (DHCS) contract with CalOptima
~~C.~~G. ~~Health Insurance Portability and Accountability Act of 1996~~
H. Medicaid Program Integrity Manual, Revised 2011
I. Medicare Managed Care Manual, Chapters 9 and 21
J. Medicare Program Integrity Manual, Revised 2014
K. Sections 1128 and 156 of the Social Security Act
~~D.~~L. Title 42, Code of Federal Regulations (C.F.R.), ~~Section~~ §1001.1901
~~E.~~ Title 42, United States Code (-U.S.-C.), ~~ode section~~ §1320a-7(a)(1)(D), (a)(4)(c), 1320a-7(b)(8)
~~F.~~M. ~~Section 1128 and 156 of the Social Security Act~~
~~G.~~ Updated: OIG's Provider Self-Disclosure Protocol, Issued April 17, 2013
~~H. Health Insurance Portability and Accountability Act of 1996~~
~~I.~~N. ~~Balanced Budget Act of 1997~~
~~J. CMS: Center for Program Integrity Center for Medicare Letter, June 29, 2011~~
~~K.~~ Updated: Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs, Issued May 8, 2013
~~L.~~O. ~~Updated: OIG's Provider Self-Disclosure Protocol, Issued April 17, 2013~~
~~M. CalOptima Policy AA.1000: Glossary of Terms~~
~~N. CalOptima Policy GG.1609Δ: Credentialing and Recredentialing~~
~~O. CalOptima Compliance Program~~

~~VII.~~VI. REGULATORY AGENCY APPROVALS

None to Date

~~VIII.~~VII. BOARD ACTIONS

None to Date

~~IX.~~VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2012	HH.2021	Vendor Exclusion Monitoring and Audits	Medi-Cal
Revised	08/01/2013	HH.2021Δ	Vendor Exclusion Monitoring and Audits	Medi-Cal OneCare
Effective	05/01/2014	MA.9121	Exclusion Monitoring	OneCare
Revised	09/01/2015	HH.2021	Vendor Exclusion Monitoring and Audits	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	09/01/2015	MA.9121	Exclusion Monitoring	OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9121	Exclusion Monitoring	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2021	Vendor Exclusion Monitoring and Audits	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
Excluded	Suspension, exclusion, or debarment from participation in Federal and/or state health care programs.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Governing Body	The Board of Directors of CalOptima.
Member	A beneficiary who is enrolled in a CalOptima Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

Policy #:	HH.2021Δ
Title:	**Exclusion Monitoring**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	Michael Schrader _____
Effective Date:	05/01/12
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy establishes a process for verifying and monitoring the eligibility of an Employee (permanent, temporary, volunteer and as-needed employees), member of the Governing Body, First Tier, Downstream, and Related Entity (FDR), and vendors to participate in CalOptima's federally-funded health care programs through state and federal exclusions and ineligible lists.

II. POLICY

A. CalOptima shall ensure all Employees, members of the Governing Body, FDRs, and vendors are eligible to participate in CalOptima's federally-funded health care programs, and shall be responsible for:

1. Requiring an Employee, member of the Governing Body, FDR, or vendor to disclose and report pending suspensions, exclusions or debarments, of the Employee, member of the Governing Body, or FDR;

2. Conducting the initial eligibility verification of an Employee, member of the Governing Body, FDR, and vendor prior to hiring, renewing, or entering in any new agreement with CalOptima, or issuing payment there to;

3. Performing eligibility verification of an Employee, member of the Governing Body, FDR, and vendor monthly thereafter; and

4. Maintaining records of all initial and monthly verification.

B. CalOptima shall not employ individuals, or contract with individuals or entities, that are determined to be suspended, debarred, or excluded from participation in Federal or State health care programs.

C. CalOptima shall not reimburse or make payment to an individual or entity that is verified to be suspended, debarred, or excluded from participation in Federal or State health care programs.

D. CalOptima will take immediate appropriate actions, with the assistance of Legal Counsel, to terminate the employment of an individual, the contractual relationship with an FDR or vendor, or the appointment of a member of the Governing Body, if such individual or entity is verified to be suspended, debarred, or excluded from participation in Federal or State health care programs.

E. CalOptima shall utilize state and federal exclusion and ineligible list sources referenced in this policy to verify the eligibility of an Employee, member of the Governing Body, FDR or vendor and shall maintain a record of completion indicating, at minimum:

1. The date of verification;

2. The exclusion and ineligible list source(s);

3. Verification results; and

4. The name of the person who conducted the verification.

F. CalOptima is to refer to the chart below to determine the responsible departments that conduct initial and/or monthly exclusions checks thereafter.

Group	Prior to contracting/hire, CalOptima will verify through …	Monthly thereafter, CalOptima will verify through …
Employees	Human Resources	Human Resources
Members of the Governing Body (Board of Directors)	Compliance	Compliance
CalOptima Committees	Compliance	Compliance
Pharmacy Prescriber Pharmacy Network Provider	PBM PBM	PBM PBM
FDRs (excluding Providers and Health Networks)	Purchasing	Compliance
Providers, Practitioners, Health Delivery Organizations (HDOs)	Quality/Credentialing	Quality/Credentialing
Health Networks	Contracting	Compliance
Medical Group Practice	Contracting	Quality/Credentialing

G. All CalOptima FDRs and vendors shall verify the eligibility of all its Employees and/or Downstream Entities (as defined above) prior to hiring/contracting and monthly thereafter. The FDR and vendors shall maintain a record of completion indicating, at minimum:

1. Date of verification;

2. The exclusion and ineligible list source(s);

3. Verification results; and

4. The name of the person who conducted the verification.

H. In the event an Employee, FDR or vendor has been identified in an exclusion list, the FDR or vendor must immediately terminate the Employee, FDR, or vendor and immediately notify CalOptima of the identified ineligible person/entity.

I. The Office of Compliance may Audit CalOptima departments responsible for exclusion activities, as necessary.

III. PROCEDURE

A. Monitoring Sources

1. As applicable, CalOptima shall use Monitoring sources to retrieve verification and eligibility data, including, but not limited to:

   a. The General Services Administration's (GSA) System for Award Management (SAM) website;

   b. Medicare Exclusion Database (MED);

   c. Medi-Cal's Suspended and Ineligible (S&I) list;

   d. OIG Exclusions Database (OIG LEIE Database); and

   e. Other monitoring sources as identified in CalOptima Policy GG.1609Δ: Credentialing and Recredentialing.

B. Initial Verification

1. Prior to hiring an Employee or contracting with an FDR or vendor, the responsible Department identified in the chart in Section II.F. of this policy shall verify that the individual or entity is not Excluded by reviewing the monitoring sources listed in Section III.A.1. of this policy.

C. Monitoring

1. On a monthly basis, prior to publishing the next verification list update, the responsible department shall monitor Employees, FDRs, vendors and members of the Board by reviewing the monitoring sources listed in Section III.A.1. of this policy.

2. The responsible department shall deem an Employee, member of the Governing Body, FDR or vendor excluded or ineligible if identified on one (1) or more Monitoring sources. If applicable, the Office of Compliance shall complete a CalOptima Provider Alert to notify all appropriate CalOptima departments of the excluded or ineligible individual or entity.

D. Actions Based on Discovery of Exclusion

1. In accordance with Title 42, Code of Federal Regulations, Section 1001.1901(b)(1), CalOptima shall immediately suspend and halt payment for services for an ineligible or excluded Employee, member of the Governing Body, FDR, or vendor. The payment prohibition applies regardless of whether or not the Excluded individual or entity submits claims for reimbursement to, or the method of reimbursement by, Federal or State health care programs.

2. CalOptima will take immediate appropriate actions, with the assistance of Legal Counsel, to terminate the employment of an individual, the contractual relationship with a FDR or vendor, or the appointment of a member of the Governing Body, if such person or entity is determined to be Excluded. In the event, that a specific FDR or vendor employee is identified as Excluded, the applicable contractual relationship will also be reviewed to determine whether it may continue with the removal of the Excluded employee.

3. If CalOptima identifies an Excluded individual or entity after they are hired or contracted, the matter should be referred to the Office of Compliance for further investigation. As appropriate, CalOptima will engage in the service of Legal Counsel to take further action as appropriate.

4. CalOptima may recoup monies paid to the Employee, member of the Governing Body, FDR, or vendor while Excluded. Exclusion findings will be referred to the Office of Compliance for further action in accordance with CalOptima policy. As appropriate, CalOptima will engage in the service of Legal Counsel to take further action as appropriate.

E. FDRs

1. If CalOptima declines to include an FDR, or vendor, from participating in any CalOptima program, it shall notify the FDR, or vendor, in writing, noting the reason for denial. The FDR, or vendor, may contest the denial if they feel there is an error or inappropriate exclusion. If CalOptima determines that there is an inappropriate exclusion, correction shall be made, as stated in the Centers for Medicare & Medicaid Services (CMS) Center for Program Integrity Center for Medicare Letter issued June 29, 2011.

2. If the FDR, or vendor, has been re-instated by an excluding source listed on this policy, and is now in good standing and able to participate in CalOptima's federally-funded health care programs, the FDR or vendor may express interest in participating with CalOptima. CalOptima will require evidence to verify re-instated participation in CalOptima's federally-funded health care programs. In addition, the FDR, or vendor, will require re-processing through contracting and/or Credentialing.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy GG.1609Δ: Credentialing and Recredentialing
F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Department Health Care Services (DHCS) contract with CalOptima
H. Medicaid Program Integrity Manual, Revised 2011
I. Medicare Managed Care Manual, Chapters 9 and 21
J. Medicare Program Integrity Manual, Revised 2014
K. Sections 1128 and 156 of the Social Security Act
L. Title 42, Code of Federal Regulations (C.F.R.), §1001.1901
M. Title 42, United States Code (U.S.C.), §1320a-7(a)(1)(D), (a)(4)(c), 1320a-7(b)(8)
N. Updated: OIG's Provider Self-Disclosure Protocol, Issued April 17, 2013Updated: Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs, Issued May 8, 2013

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2012	HH.2021	Vendor Exclusion Monitoring and Audits	Medi-Cal
Revised	08/01/2013	HH.2021Δ	Vendor Exclusion Monitoring and Audits	Medi-Cal OneCare
Effective	05/01/2014	MA.9121	Exclusion Monitoring	OneCare
Revised	09/01/2015	HH.2021	Vendor Exclusion Monitoring and Audits	Medi-Cal
Revised	09/01/2015	MA.9121	Exclusion Monitoring	OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9121	Exclusion Monitoring	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2021	Vendor Exclusion Monitoring and Audits	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
Excluded	Suspension, exclusion, or debarment from participation in Federal and/or state health care programs.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Governing Body	The Board of Directors of CalOptima.
Member	A beneficiary who is enrolled in a CalOptima Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

Policy #:	HH.2022Δ.A
Title:	**Record Retention and Access**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	Michael Schrader
Effective Date:	06/01/13
Last Review Date:	0912/01/165
Last Revised Date:	1209/01/156
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy establishes the requirements for CalOptima and its First Tier, Downstream and Related Entities (FDRs) to retain and make available contracts, books, documents, records and financial statements, in accordance with federal and state regulations for the purpose of any audit or investigation of a CalOptima program.

II. DEFINITIONS

Term	Definition
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal Program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Department of Managed Health Care (DMHC)	The State Agency that responsible for licensing and regulating health care services plans/health maintenance organizations in accordance with the Knox Keene Health Care Service Plan Act of 1975 and as subsequently amended.
Downstream Entity	Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
First Tier, Downstream, and Related Entities (FDR)	FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement with CalOptima to provide administrative services or health care services to a Medicare or Medicaid eligible individual under the CalOptima program.
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of

~~Term~~	~~Definition~~
	~~Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.~~
~~National Committee for Quality Assurance (NCQA)~~	~~An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.~~
~~Quality Improvement Organization (QIO)~~	~~An organization comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. A QIO reviews Complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care plans, and ambulatory surgical centers. A QIO also reviews continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in Skilled Nursing Facilities, Home Health Agencies, and Comprehensive Outpatient Rehabilitation Facilities.~~
~~Related Entity~~	~~Any entity that is related to CalOptima by common ownership or control and:~~ ~~1. Performs some of the management functions under contract or delegation;~~ ~~2. Furnishes services to Medicare or Medicaid enrollees under an oral or written agreement; or~~ ~~3. Leases real property or sells materials to CalOptima at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.~~

~~III.~~II. POLICY

A. CalOptima and its FDRs shall retain and make available contracts, books, documents, records and financial records, in accordance with the provisions of this policy. These documents include, but are not limited to the following:

1. Data relating to Medicare utilization and costs;

~~1.~~2. Reinsurance costs;

~~2.~~3. Low-income subsidy payments;

~~3.~~4. Risk corridor costs;

~~4.~~5. Bid calculations;

~~5.~~6. Rebate information;

~~6.~~7. Medical Records;

~~7.~~8. Medical charts and prescription files; and

~~8.~~9. Other documentation pertaining to medical and non-medical services rendered to Members.

B. CalOptima and its FDRs shall maintain and make available contracts, books, documents, records and financial statements regarding the Medi-Cal program for a minimum of five (5) years from the end of the current fiscal year, in which, the date of service occurred, or, in the event of notification of an audit or investigation, until such time as the matter under audit or investigation has been resolved, whichever is later.

1. For Medi-Cal, if there is a termination, dispute or allegation of fraud or similar fault, document retention requirements for CalOptima and its FDRs may be extended to at least six (6) years from the date of any resulting final resolution of the termination, dispute or allegation of fraud or similar fault.

2. In the event a FDR's contract providers for a longer retention and access time period, that time period shall apply.

~~B.~~ CalOptima's and its FDRs shall maintain and make available contracts, books, documents, records and financial statements regarding the CalOptima Medicare programs for a minimum of ten (10) years, and such records shall be maintained for an additional ten (10) years from the final date of the contract period or from completion of any audit or investigation, whichever is later.

C.

~~C. If there is a termination, dispute or allegation of fraud or similar fault, document retention requirements for CalOptima and its FDRs may be extended to six (6) years from the date of any resulting final resolution of the termination, dispute or allegation of fraud or similar fault.~~

1. For Medicare, if there is a termination, dispute or allegation of fraud or similar fault, document retention requirements for CalOptima and its FDRs may be extended to ten (10) years from the date of any resulting final resolution of the termination, dispute or allegation of fraud, or similar fault.

D. CalOptima and its FDRs shall retain and make available contracts, books, documents, records and financial statements to any authorized state and federal agencies or contractors for inspections, evaluations and auditing including, but are not limited to:

1. Centers for Medicare & Medicaid Services (CMS);

2. Department of Managed Health Care (DMHC);

3. Department of Health Care Services (DHCS);

4. The U.S. Department of Health and Human Services (HHS);

5. The U.S. Government Accountability Office (GAO); and

6. Any Quality Improvement Organization (QIO) or accrediting organizations, including NCQA, their designees and other representatives of regulatory or accrediting organizations.

~~IV.~~III. PROCEDURE

A. CalOptima and its FDRs shall provide an authorized entity with the requested and required contracts, books, documents, records and financial statements at any time during normal business hours for audit and other investigative activities.

~~V.~~IV. ATTACHMENTS

Not Applicable

~~VI.~~V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~A.~~D. CalOptima ~~Contract with the Department of Health Care Services (DHCS) for PACE~~PACE Program Agreement
~~B. CalOptima Compliance Program~~
E. CalOptima Policy AA.1000: Glossary of Terms
F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~C.~~G. Title 42, Code of Federal Regulations (C.F.R.), §422.504(d)(2)

~~VII.~~VI. REGULATORY AGENCY ~~APPORVALS~~APPROVALS

A. 0~~Not Applicable~~7/12/13: Department of Health Care Services ~~DHCS MMCD Approval~~

~~VIII.~~VII. BOARD ACTIONS

~~7/12/13: DHCS MMCD Approva~~None to Date~~l~~

~~IX.~~VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2007	MA.9106	Record Retention and Access	OneCare
Revised	06/01/2013	MA.9106	Record Retention and Access	OneCare
Effective	06/01/2013	HH.2022Δ	Record Retention and Access	Medi-Cal OneCare
Revised	09/01/2014	MA.9106	Record Retention and Access	OneCare
Revised	09/01/2015	HH.2022	Record Retention and Access	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	09/01/2015	MA.9106	Record Retention and Access	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2022Δ	Record Retention and Access	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9106	Record Retention and Access	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Department of Managed Health Care (DMHC)	The California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code, Sections 1340 *et seq.*
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Member	A beneficiary who is enrolled in a CalOptima Program.
National Committee for Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
Quality Improvement Organization (QIO)	An organization comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. A QIO reviews Complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care plans, and ambulatory surgical centers. A QIO also reviews continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in Skilled Nursing Facilities, Home Health Agencies, and Comprehensive Outpatient Rehabilitation Facilities.

Term	Definition
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

Policy #:	HH.2022Δ
Title:	**Record Retention and Access**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	Michael Schrader _____
Effective Date:	06/01/13
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy establishes the requirements for CalOptima and its First Tier, Downstream and Related Entities (FDRs) to retain and make available contracts, books, documents, records and financial statements, in accordance with federal and state regulations for the purpose of any audit or investigation of a CalOptima program.

II. POLICY

A. CalOptima and its FDRs shall retain and make available contracts, books, documents, records and financial records, in accordance with the provisions of this policy. These documents include, but are not limited to the following:

1. Data relating to Medicare utilization and costs;
2. Reinsurance costs;
3. Low-income subsidy payments;
4. Risk corridor costs;
5. Bid calculations;
6. Rebate information;
7. Medical Records;
8. Medical charts and prescription files; and
9. Other documentation pertaining to medical and non-medical services rendered to Members.

B. CalOptima and its FDRs shall maintain and make available contracts, books, documents, records and financial statements regarding the Medi-Cal program for a minimum of five (5) years from the end of the current fiscal year, in which, the date of service occurred, or, in the event of notification of an audit or investigation, until such time as the matter under audit or investigation has been resolved, whichever is later.

1. For Medi-Cal, if there is a termination, dispute or allegation of fraud or similar fault, document retention requirements for CalOptima and its FDRs may be extended to at least six (6) years from the date of any resulting final resolution of the termination, dispute or allegation of fraud or similar fault.

2. In the event a FDR's contract providers for a longer retention and access time period, that time period shall apply.

C. CalOptima's and its FDRs shall maintain and make available contracts, books, documents, records and financial statements regarding the CalOptima Medicare programs for a minimum of ten (10) years, and such records shall be maintained for an additional ten (10) years from the final date of the contract period or from completion of any audit or investigation, whichever is later.

1. For Medicare, if there is a termination, dispute or allegation of fraud or similar fault, document retention requirements for CalOptima and its FDRs may be extended to ten (10) years from the date of any resulting final resolution of the termination, dispute or allegation of fraud, or similar fault.

D. CalOptima and its FDRs shall retain and make available contracts, books, documents, records and financial statements to any authorized state and federal agencies or contractors for inspections, evaluations and auditing including, but are not limited to:

1. Centers for Medicare & Medicaid Services (CMS);

2. Department of Managed Health Care (DMHC);

3. Department of Health Care Services (DHCS);

4. The U.S. Department of Health and Human Services (HHS);

5. The U.S. Government Accountability Office (GAO); and

6. Any Quality Improvement Organization (QIO) or accrediting organizations, including NCQA, their designees and other representatives of regulatory or accrediting organizations.

III. PROCEDURE

A. CalOptima and its FDRs shall provide an authorized entity with the requested and required contracts, books, documents, records and financial statements at any time during normal business hours for audit and other investigative activities.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage

C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy AA.1000: Glossary of Terms
F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Title 42, Code of Federal Regulations (C.F.R.), §422.504(d)(2)

VI. REGULATORY AGENCY APPROVALS

A. 07/12/13: Department of Health Care Services

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2007	MA.9106	Record Retention and Access	OneCare
Revised	06/01/2013	MA.9106	Record Retention and Access	OneCare
Effective	06/01/2013	HH.2022Δ	Record Retention and Access	Medi-Cal OneCare
Revised	09/01/2014	MA.9106	Record Retention and Access	OneCare
Revised	09/01/2015	HH.2022	Record Retention and Access	Medi-Cal
Revised	09/01/2015	MA.9106	Record Retention and Access	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2022Δ	Record Retention and Access	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9106	Record Retention and Access	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Department of Managed Health Care (DMHC)	The California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code, Sections 1340 *et seq*.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Member	A beneficiary who is enrolled in a CalOptima Program.
National Committee for Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
Quality Improvement Organization (QIO)	An organization comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. A QIO reviews Complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care plans, and ambulatory surgical centers. A QIO also reviews continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in Skilled Nursing Facilities, Home Health Agencies, and Comprehensive Outpatient Rehabilitation Facilities.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

Policy #:	HH.2023Δ
Title:	**Compliance Training**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	Michael Schrader
Effective Date:	09/01/15
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy~~o~~ describes ~~the process~~ CalOptima's Compliance and Fraud, Waste, and Abuse (FWA) education and training requirements for ~~is taking to educate all~~ Eemployees, members of the Governing Body, and First Tier, Downstream, and Related Eentities (FDRs)~~.~~ ~~on Compliance training expectations (i.e., Compliance; Fraud, Waste, and Abuse (FWA); Code of Conduct, and Health Insurance Portability and Accountability Act (HIPAA)).~~

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~
~~Abuse~~	~~A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima and the CalOptima programs, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima and the CalOptima programs.~~
~~Downstream Entity~~	~~Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.~~
~~Employee~~	~~For the purposes of this policy, the term employee shall refer to any full time, intern, temporary, volunteer and any as needed employee.~~
~~First Tier, Downstream, and Related Entities (FDR)~~	~~FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.~~
~~First Tier Entity~~	~~Any party that enters into a written arrangement with CalOptima to provide administrative services or health care services to a Medicare or Medicaid eligible individual under the CalOptima program.~~
~~Fraud~~	~~An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations~~

	~~section 455.2, Welfare and Institutions Code section 14043.1(i).~~
~~Governing Body~~	~~For the purpose of this policy, the term governing body shall refer to the Board of Directors.~~
~~Health Insurance Portability and Accountability Act (HIPAA)~~	~~The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information as amended.~~
~~Provider~~	~~A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Physician Medical Group, or other person or institution who furnishes Covered Services.~~
~~Related Entity~~	~~Any entity that is related to CalOptima by common ownership or control and:~~ ~~1. Performs some of the management functions under contract or delegation;~~ ~~2. Furnishes services to Medicare or Medicaid enrollees under an oral or written agreement; or~~ ~~3. Leases real property or sells materials to CalOptima at a cost of more than two-thousand five-hundred dollars ($2,500) during a contract period.~~
~~Waste~~	~~Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the CalOptima Programs. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.~~

~~III.~~II. POLICY

A. All CalOptima ~~employees~~Employees, members of the Governing Body, and FDRs must successfully complete the required Compliance training within ninety (90) calendar days of hire or contracting and annually thereafter.

B. All CalOptima ~~employees~~Employees and members of the Governing ~~Bodies~~ Body shall complete the knowledge verification for the applicable Compliance Training module with a score of eighty percent (80%) or greater.

C. When reviewing and establishing the content of Compliance and FWA training, the Compliance Officer may consider applicable statutes, regulations, regulator contractual requirements, and regulatory guidance. ~~When reviewing the Compliance and FWA training, the Executive Compliance Director~~Compliance Officer ~~shall consider laws and regulations.~~ The following are examples of topics the general Compliance Training Program shall communicate:

1. A description of the compliance program, including a review of compliance policies and procedures, the ~~Standards~~ Code of Conduct, and CalOptima's ~~the sponsor's~~ commitment to business ethics and compliance with all CalOptima program requirements;

2. An overview of how to ask compliance questions, request compliance clarification, or report suspected or detected ~~noncompliance~~non-compliance. Training should emphasize ~~confidentiality~~Confidentiality, anonymity, and non-~~retaliation~~Retaliation for reporting

compliance related questions, or reports of suspected or detected ~~noncompliance~~non-compliance or potential FWA;

3. The requirement to report to CalOptima actual or suspected program ~~noncompliance~~non-compliance or potential FWA;

4. Scenarios of reportable ~~noncompliance~~non-compliance that an Eemployee might observe;

5. A review of the disciplinary guidelines for non-compliant or fraudulent behavior. The guidelines will communicate how such behavior can result in mandatory retraining and may result in disciplinary action, including possible termination when such behavior is serious or repeated or when knowledge of a possible violation is not reported;

6. Discussion of attendance and participation in compliance and FWA training programs as a condition of continued employment and a criterion to be included in employee evaluations;

7. A review of policies related to contracting with the government, such as the laws addressing gifts and gratuities for g~~G~~overnment employees;

8. A review of potential conflicts of interest and CalOptima's system for disclosure of conflicts of interest;

9. An overview of HIPAA/Health Information ~~-~~Technology for Economic and Clinical Health Act (HITECH), the CMS Data Use Agreement (if applicable), and the importance of maintaining the ~~confidentiality~~Confidentiality of ~~Personal~~ Protected Health Information;

10. An overview of the M~~m~~onitoring and A~~a~~uditing process; and

11. A review of the laws that govern employee conduct in the CalOptima programs.

D. CalOptima Eemployees, members of the Governing Body, as well as FDR~~s~~[2] ~~e~~employees who have involvement in the administration or delivery of Parts C and D benefits must, at a minimum, receive FWA training within ninety (90) calendar days of initial hiring (or contracting in the case of FDRs), and annually thereafter. Additional, specialized or refresher training may be provided on issues posing FWA risks based on the individual's job function (e.g., pharmacist, statistician, customer service, etc.). Training may be provided:

1. Upon appointment to a new job function;

2. When requirements change;

3. When ~~employees~~Employees are found to be ~~noncompliant~~non-compliant;

4. As a corrective action to address a ~~noncompliance~~non-compliance issue; and

5. When an employee works in an area implicated in past FWA.

E. Topics that may be addressed in FWA training include, but are not limited to the following:

1. Laws and regulations related to Medicare Part C~~A~~ and Part D FWA (i.e., False Claims Act, Anti-Kickback statute, HIPAA/HITECH, etc.);

2. Obligations of FDRs to have appropriate policies and procedures to address FWA;

3. Processes for CalOptima ~~employees~~Employees, members of the Governing Body, FDRs, and FDR employees to report suspected FWA to CalOptima (or, as to FDR employees, either to CalOptima directly or to their employers who then must report it to CalOptima);

4. Protections for CalOptima and FDR employees who report suspected FWA; and

5. Types of FWA that can occur in the settings in which CalOptima and FDR employees work. All CalOptima FDRs shall receive ~~CMS' model~~CalOptima Compliance and FWA training and CalOptima's Code of Conduct training upon contracting. Additionally, training modules are provided through the CalOptima v~~V~~endor and p~~P~~rovider website with updates provided to FDRs and annually thereafter.

F. FDRs who have met the FWA (as per Chapter 21, Section 50.3 of the Medicare Managed Care Manual) training and education certification requirements through enrollment into Parts A or B of the Medicare program, or through accreditation as a supplier of Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS), are NOT exempt from the general compliance training requirement. ~~deemed to have met the compliance training and education requirements for FWA. No additional documentation beyond the documentation necessary for proper credentialing is required to establish that an FDR, or FDR employee, is deemed to have met the compliance training and education requirements.~~

G. Documentation of Compliance with Training

1. CalOptima Employees, members of the Governing Body, FDRs, and FDR employees, who are performing services on behalf of CalOptima shall successfully complete all required Compliance training modules.

2. Failure to successfully complete all required Compliance training may lead to disciplinary action (up to and including termination), Corrective Action Plan requirements, and/or Sanctions, in accordance with CalOptima Policies HH.2002Δ: Sanctions and HH.2005Δ: Corrective Action Plan. CalOptima Employees, members of the Governing Body, and FDRs are expected to inform CalOptima immediately in the event of any failure to comply with training requirements. For CalOptima Employees and members of the Governing Body, the Human Resources (HR) Training Unit has a systematic indicator that identifies those who fail to comply within the mandated timeframes; non-compliance will result in revoking CalOptima system access.

3. The Office of Compliance is responsible for Monitoring and Auditing the compliance of Employees, members of the Governing Body, and FDRs with the Compliance and FWA training and education requirements.

4. FDRs shall provide annual attestations confirming completion of all Compliance training as stated in this policy. Failure to provide timely attestation will lead to further corrective actions.

~~F.~~H. Training Document Retention.

1. CalOptima and FDRs shall maintain all evidence of Compliance-related training completion for at least ten (10) years. Such materials include, but are not limited to:

   a. Attendance;

   b. Topic;

   c. Certificates of Completion;

   ~~c.~~d. FDR Attestations;

   ~~d.~~e. Test scores; and

   ~~e.~~f. Tests administered to ~~employees~~Employees.

~~G. All CalOptima Eemployees, members of the Governing Bodies~~Body, ~~FDRs, and FDR employees, who are performing services on behalf of CalOptima shall:~~

~~1. Successfully complete all required Compliance training modules.~~

~~2. Failure to successfully complete all required Compliance training may lead to disciplinary action (up to and including termination), Corrective Action Plan requirements, and/or Sanctions, in accordance with CalOptima Policies HH.2002Δ: Sanctions and HH.2005Δ: Corrective Action Plan. Employees, members of the Governing Bodies~~Body, ~~and FDRs are expected to inform CalOptima immediately in the event of any failure to comply with tTraining requirements. For employees~~Employees ~~and members of the Governing Bodies~~Body, ~~the Human Resources (HR) Training Uunit has a systematic indicator that identifies those who fail to comply within the mandated timeframes; non-compliance will result in revoking CalOptima system access.~~

~~3. The Office of Compliance is responsible for Mmonitoring and Aauditing the compliance of employees~~Employees, ~~members of the Governing Bodies~~Body, ~~and FDRs with the Compliance and FWA training and education requirements.~~

~~4. FDRs shall provide annual attestations confirming completion of all Compliance training as stated in this policy. Failure to provide timely attestation will lead to further corrective actions.~~

~~IV.~~III. PROCEDURE

A. Distributing Training for Existing Employees and Members of the Governing Body

1. On an annual basis, the HR Training Unit shall communicate to all E~~e~~mployees and members of the Governing Body~~ies~~ an updated Compliance training is available and must be successfully completed within thirty (30) calendar days.

2. Upon completion, ~~employees~~Employees and members of the Governing ~~Bodies~~Body shall receive an e-certificate confirming successful completion. The e-certificate will include the training title and completion date. ~~Human Resources (~~HR~~)~~, via the HR Training U~~u~~nit, is responsible for retaining evidence of an E~~e~~mployee's and members of the Governing ~~Bodies~~Body's ~~-~~successful completion of all Compliance training modules.

B. Distributing Training for New Employees and Members of the Governing Body

1. Upon hire, the HR Training Unit shall provide each new E~~e~~employee and members of the Governing Body with instructions to complete the Compliance Training.

2. The HR Training Unit shall cre~~gener~~ate a system generated report that identifies those who fail to comply within the mandated timeframes. Non-compliance will result in revoking system access.~~.~~

C. Distributing Training to FDRs

1. The Office of Compliance shall ensure the training is uploaded and available on the CalOptima v~~V~~endor and p~~P~~rovider website.

2. Upon contracting, the Office of Compliance shall distribute an FDR Compliance Package composed of compliance documents, including CalOptima~~-~~ Compliance and FWA Training, CalOptima's Code of Conduct & FWA Plan, and an FDR Attestation that confirms the required Compliance training is completed by FDRs and their employees within ninety (90) calendar days of hire and at least annually thereafter.~~.~~

3. Annually, the Office of Compliance shall distribute and M~~m~~onitor receipt of ~~an~~ updated attestation to all FDRs for execution.

4. When there are update~~(s)~~ to c~~C~~ompliance training materials and/or related policies and proceduress ~~documents~~ ~~documents~~, the Office of Compliance shall communicate updates to all FDRs with instructions to access the CalOptima v~~V~~endor and p~~P~~rovider w~~W~~ebsite to retrieve them.

~~V.~~IV. ATTACHMENTS

A. FDR Compliance Attestation

~~VI.~~V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima ~~Contract with the Department of Health Care Services (DHCS) for PACE~~ PACE Program Agreement
~~B.~~
~~C. contract with the Department of Health Care Services ()~~CalOptima Policy GA.8022: Progressive ~~Discipline Policy~~
E. CalOptima Policy HH.2002Δ: Sanctions
~~D.~~F. CalOptima Policy HH.2005Δ: Corrective Action Plan
~~E. CalOptima Policy HH.2002: Sanctions~~
~~F.~~G. CalOptima Policy HH.2028Δ: Code of Conduct
H. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services and the Department of Health Care Services (DHCS) for Cal MediConnect

I. Medicare Managed Care Manual, Chapters 9 and 21
J. ~~CalOptima Compliance Plan,~~ ,Title 42, Code of Federal Regulations (C.F.R.), §§422.503(b)(4)(vi)(A) and (D)
K. Title 42, Code of Federal Regulations (C.F.R.), §§423.504(b)(4)(vi)(A) and (D)
L. Title 42, Code of Federal Regulations (C.F.R.), §438.608
M. Title 42, Code of Federal Regulations (C.F.R.), §455.2
N. "Update—Reducing the Burden of the Compliance Program Training Requirements," Health Plan Management System (HPMS) Memorandum, Issued 7/17/2015
O. "Additional Guidance -- Compliance Program Training Requirements and Audit Process Update," Health Management System (HPMS) Memorandum, Issued 2/10/2016.
P. Welfare and Institutions Code, §14043.1(a)
~~G.~~

~~VII.~~VI. REGULATORY AGENCY APPROVALS

~~Not Applicable~~None to Date

~~VIII.~~VII. BOARD ACTIONS

None to D~~d~~ate

~~IX.~~VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2014	MA.9119	Compliance Training	OneCare
Revised	11/01/2014	MA.9119	Compliance Training	OneCare
Effective	09/01/2015	HH.2023	Compliance Training	Medi-Cal
Revised	09/01/2015	MA.9119	Compliance Training	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2023Δ	Compliance Training	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9119	Compliance Training	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Code of Conduct	The statement setting forth the principles and standards governing CalOptima's activities to which CalOptima's Board of Directors, employees, contractors, and agents are required to adhere.
Corrective Action Plan	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Covered Services	Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract and DHCS Contract.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.

Term	Definition
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C Section 1347).
Governing Body	The Board of Directors of CalOptima.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information as amended.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Protected Health Information	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Physician Medical Group, or other person or institution who furnishes Covered Services.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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Policy #:	HH.2023Δ
Title:	**Compliance Training**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	Michael Schrader
Effective Date:	09/01/15
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy describes CalOptima's Compliance and Fraud, Waste, and Abuse (FWA) education and training requirements for Employees, members of the Governing Body, and First Tier, Downstream, and Related Entities (FDRs).

II. POLICY

A. All CalOptima Employees, members of the Governing Body, and FDRs must successfully complete the required Compliance training within ninety (90) calendar days of hire or contracting and annually thereafter.

B. All CalOptima Employees and members of the Governing Body shall complete the knowledge verification for the applicable Compliance Training module with a score of eighty percent (80%) or greater.

C. When reviewing and establishing the content of Compliance and FWA training, the Compliance Officer may consider applicable statutes, regulations, regulator contractual requirements, and regulatory guidance. The following are examples of topics the general Compliance Training Program shall communicate:

1. A description of the compliance program, including a review of compliance policies and procedures, the Code of Conduct, and CalOptima's commitment to business ethics and compliance with all CalOptima program requirements;

2. An overview of how to ask compliance questions, request compliance clarification, or report suspected or detected non-compliance. Training should emphasize Confidentiality, anonymity, and non-Retaliation for reporting compliance related questions, or reports of suspected or detected non-compliance or potential FWA;

3. The requirement to report to CalOptima actual or suspected program non-compliance or potential FWA;

4. Scenarios of reportable non-compliance that an Employee might observe;

5. A review of the disciplinary guidelines for non-compliant or fraudulent behavior. The guidelines will communicate how such behavior can result in mandatory retraining and may result in disciplinary action, including possible termination when such behavior is serious or repeated or when knowledge of a possible violation is not reported;

6. Discussion of attendance and participation in compliance and FWA training programs as a condition of continued employment and a criterion to be included in employee evaluations;

7. A review of policies related to contracting with the government, such as the laws addressing gifts and gratuities for government employees;

8. A review of potential conflicts of interest and CalOptima's system for disclosure of conflicts of interest;

9. An overview of HIPAA/Health Information Technology for Economic and Clinical Health Act (HITECH), the CMS Data Use Agreement (if applicable), and the importance of maintaining the Confidentiality of Protected Health Information;

10. An overview of the Monitoring and Auditing process; and

11. A review of the laws that govern employee conduct in the CalOptima programs.

D. CalOptima Employees, members of the Governing Body, as well as FDR employees who have involvement in the administration or delivery of Parts C and D benefits must, at a minimum, receive FWA training within ninety (90) calendar days of initial hiring (or contracting in the case of FDRs), and annually thereafter. Additional, specialized or refresher training may be provided on issues posing FWA risks based on the individual's job function (e.g., pharmacist, statistician, customer service, etc.). Training may be provided:

1. Upon appointment to a new job function;

2. When requirements change;

3. When Employees are found to be non-compliant;

4. As a corrective action to address a non-compliance issue; and

5. When an employee works in an area implicated in past FWA.

E. Topics that may be addressed in FWA training include, but are not limited to the following:

1. Laws and regulations related to Medicare Part C and Part D FWA (i.e., False Claims Act, Anti-Kickback statute, HIPAA/HITECH, etc.);

2. Obligations of FDRs to have appropriate policies and procedures to address FWA;

3. Processes for CalOptima Employees, members of the Governing Body, FDRs, and FDR employees to report suspected FWA to CalOptima (or, as to FDR employees, either to CalOptima directly or to their employers who then must report it to CalOptima);

4. Protections for CalOptima and FDR employees who report suspected FWA; and

5. Types of FWA that can occur in the settings in which CalOptima and FDR employees work. All CalOptima FDRs shall receive CalOptima Compliance and FWA training and CalOptima's Code of Conduct training upon contracting. Additionally, training modules are provided through the CalOptima vendor and provider website with updates provided to FDRs and annually thereafter.

F. FDRs who have met the FWA (as per Chapter 21, Section 50.3 of the Medicare Managed Care Manual) training and education certification requirements through enrollment into Parts A or B of the Medicare program, or through accreditation as a supplier of Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS), are NOT exempt from the general compliance training requirement.

G. Documentation of Compliance with Training

1. CalOptima Employees, members of the Governing Body, FDRs, and FDR employees, who are performing services on behalf of CalOptima shall successfully complete all required Compliance training modules.

2. Failure to successfully complete all required Compliance training may lead to disciplinary action (up to and including termination), Corrective Action Plan requirements, and/or Sanctions, in accordance with CalOptima Policies HH.2002Δ: Sanctions and HH.2005Δ: Corrective Action Plan. CalOptima Employees, members of the Governing Body, and FDRs are expected to inform CalOptima immediately in the event of any failure to comply with training requirements. For CalOptima Employees and members of the Governing Body, the Human Resources (HR) Training Unit has a systematic indicator that identifies those who fail to comply within the mandated timeframes; non-compliance will result in revoking CalOptima system access.

3. The Office of Compliance is responsible for Monitoring and Auditing the compliance of Employees, members of the Governing Body, and FDRs with the Compliance and FWA training and education requirements.

4. FDRs shall provide annual attestations confirming completion of all Compliance training as stated in this policy. Failure to provide timely attestation will lead to further corrective actions.

H. Training Document Retention.

1. CalOptima and FDRs shall maintain all evidence of Compliance-related training completion for at least ten (10) years. Such materials include, but are not limited to:

a. Attendance;

b. Topic;

c. Certificates of Completion;

d. FDR Attestations;

e. Test scores; and

f. Tests administered to Employees.

III. PROCEDURE

A. Distributing Training for Existing Employees and Members of the Governing Body

1. On an annual basis, the HR Training Unit shall communicate to all Employees and members of the Governing Body an updated Compliance training is available and must be successfully completed within thirty (30) calendar days.

2. Upon completion, Employees and members of the Governing Body shall receive an e-certificate confirming successful completion. The e-certificate will include the training title and completion date. HR, via the HR Training Unit, is responsible for retaining evidence of an Employee's and members of the Governing Body's successful completion of all Compliance training modules.

B. Distributing Training for New Employees and Members of the Governing Body

1. Upon hire, the HR Training Unit shall provide each new Employee and members of the Governing Body with instructions to complete the Compliance Training.

2. The HR Training Unit shall create a system generated report that identifies those who fail to comply within the mandated timeframes. Non-compliance will result in revoking system access.

C. Distributing Training to FDRs

1. The Office of Compliance shall ensure the training is uploaded and available on the CalOptima vendor and provider website.

2. Upon contracting, the Office of Compliance shall distribute an FDR Compliance Package composed of compliance documents, including CalOptima Compliance and FWA Training, CalOptima's Code of Conduct & FWA Plan, and an FDR Attestation that confirms the required Compliance training is completed by FDRs and their employees within ninety (90) calendar days of hire and at least annually thereafter.

3. Annually, the Office of Compliance shall distribute and Monitor receipt of updated attestation to all FDRs for execution.

4. When there are updates to compliance training materials and/or related policies and procedures , the Office of Compliance shall communicate updates to all FDRs with instructions to access the CalOptima vendor and provider website to retrieve them.

IV. ATTACHMENTS

A. FDR Compliance Attestation

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage

C. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy HH.2002Δ: Sanctions
F. CalOptima Policy HH.2005Δ: Corrective Action Plan
G. CalOptima Policy HH.2028Δ: Code of Conduct
H. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services and the Department of Health Care Services (DHCS) for Cal MediConnect
I. Medicare Managed Care Manual, Chapters 9 and 21
J. Title 42, Code of Federal Regulations (C.F.R.), §§422.503(b)(4)(vi)(A) and (D)
K. Title 42, Code of Federal Regulations (C.F.R.), §§423.504(b)(4)(vi)(A) and (D)
L. Title 42, Code of Federal Regulations (C.F.R.), §438.608
M. Title 42, Code of Federal Regulations (C.F.R.), §455.2
N. "Update—Reducing the Burden of the Compliance Program Training Requirements," Health Plan Management System (HPMS) Memorandum, Issued 7/17/2015
O. "Additional Guidance -- Compliance Program Training Requirements and Audit Process Update," Health Management System (HPMS) Memorandum, Issued 2/10/2016.
P. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2014	MA.9119	Compliance Training	OneCare
Revised	11/01/2014	MA.9119	Compliance Training	OneCare
Effective	09/01/2015	HH.2023	Compliance Training	Medi-Cal
Revised	09/01/2015	MA.9119	Compliance Training	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2023Δ	Compliance Training	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9119	Compliance Training	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Code of Conduct	The statement setting forth the principles and standards governing CalOptima's activities to which CalOptima's Board of Directors, employees, contractors, and agents are required to adhere.
Corrective Action Plan	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Covered Services	Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract and DHCS Contract.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.

Term	Definition
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C Section 1347).
Governing Body	The Board of Directors of CalOptima.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information as amended.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Protected Health Information	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Physician Medical Group, or other person or institution who furnishes Covered Services.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1

FDR COMPLIANCE ATTESTATION

Please complete and execute this attestation and return it to CalOptima's Office of Compliance via fax (714) 481-6457, email Compliance@caloptima.org , or mail: Cal Optima, Office of Compliance, Attn: Annie Phillips 505 City Parkway West, Orange, CA 92868, within thirty (30) calendar days for (existing FDRs) or sixty (60) calendar days for (new FDRs) of this notice.

Check which CalOptima program(s) this form pertains to:

- ☐ OneCare Connect
- ☐ OneCare HMO SNP
- ☐ Medi-Cal
- ☐ PACE

I hereby attest that [_____(the "Organization")], and all its downstream entities, if any, that are involved in the provision of health or administrative services for any of the CalOptima programs identified above:

I. Provide effective Fraud, Waste and Abuse Training and compliance training to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers, within ninety (90) calendar days of appointment, hire or contracting, as applicable, and at least annually thereafter as a condition of appointment, employment or contracting. The Organization and its downstream entities currently use (Select all that apply):

- ☐ CMS's Fraud, Waste, and Abuse Training and compliance training module. (The Organization shall maintain records per CMS retention requirement)
- ☐ An internal training program that meets CMS's Fraud, Waste, and Abuse and compliance training module requirements. (The Organization shall maintain records per CMS retention requirement)

II. Administer specialized compliance training to Organization and downstream entity board members, employees, temporary employees, and volunteers: (i) based on their job function within the first ninety (90) days of hire and at least annually thereafter as a condition of appointment, employment or contracting, (ii) when requirements change; (iii) when such persons work in an area previously found to be non-compliant with program requirements or implicated in past misconduct.

III. Have established and publicized compliance policies and procedures, standards of conduct, and compliance reference material that meet the requirements outlined in 42 CFR § 422.503(b)(4)(vi)(A) and 42 CFR § 423.504(b)(4)(vi)(A) which information, and any updates thereto, are distributed to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers within ninety (90) days of appointment, hire or contracting, as applicable, and at least annually thereafter. Evidence of receipt of such compliance by such persons is obtained and retained by the Organization.

IV. Review all Organization and downstream entity board members, officers, potential and actual employees, temporary employees, and volunteers against the (Suspended and Ineligible Provider List) S & I Medi-Cal, (Health and Human Services) HHS, (Office of Inspector General) OIG List of Excluded Individuals & Entities list, (System for Award Management) SAM/(General Services Administration) GSA Debarment list (here after "Lists") upon appointment, hire or contracting, as applicable, and monthly thereafter. Further, in the event that the Organization or downstream entity becomes aware that any of the foregoing persons or entities are included on these Lists, the Organization will notify CalOptima within five (5) calendar days, the relationship with the listed person/entity will be terminated as it relates to CalOptima, and appropriate corrective action will be taken.

V. Screen the Organization and its subcontractors' governing bodies for conflicts of interest as defined in state and federal law and CalOptima policies and procedures upon hire or contracting and annually thereafter.

VI. Will report suspected fraud, waste, and abuse, as well as all other forms of non-compliance, as it relates to CalOptima.

VII. Understand that any violation of any laws, regulations, or CalOptima policies and procedures are grounds for disciplinary action, up to and including termination of Organization's contractual status.

VIII Are aware that persons reporting suspected fraud, waste, and abuse, and other non-compliance are protected from retaliation under the False Claims Act and other applicable laws prohibiting retaliation.

IX. Retain documented evidence of compliance with the above, including training and exclusion screening (i.e. sign-in sheets, certificates, attestations, OIG and GSA search results, etc.) for at least ten (10) years, and provide such documentation to CalOptima upon request.

The individual signing below is knowledgeable about and authorized to attest to the foregoing matters on behalf of the Organization.

_____	_____
Signature	Date
_____	_____
Name	Organization

Policy #:	HH.2028Δ
Title:	**Code of Conduct**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	Michael Schrader
Effective Date:	09/01/15
Last Review Date:	12/01/16
Last Revision Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

~~To~~ This policy describes the process CalOptima utilizes to review, approve, and communicate its expectation that all Employees, members of its Governing Body, and First Tier, Downstream, and Related Entities (FDRs) conduct themselves in an ethical and legal manner and in compliance with the Code of Conduct.~~This policy describes the process for CalOptima utilizes to communicate its expectation that of all Eemployees, (permanent, temporary, volunteer and as-needed employees), members of its Governing Body, and First Tier, Downstream, and Related Entities (FDRs) to conduct themselves in an ethical and and legal manner, and in compliance with the Code of Conduct.~~

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~
~~Abuse~~	~~A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima and the CalOptima programs, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima and the CalOptima programs.~~
~~Code of Conduct~~	~~The statement setting forth the principles and standards governing CalOptima activities to which CalOptima's Board of Directors, employees, FDRs, and agents are required to adhere.~~
~~Downstream Entity~~	~~Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.~~
~~First Tier, Downstream, and Related Entities (FDR):~~	~~FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.~~
~~First Tier Entity~~	~~Any party that enters into a written arrangement with CalOptima to provide administrative services or health care services to a Medicare or Medicaid eligible individual under the CalOptima program.~~
~~Fraud~~	~~An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to~~

~~Term~~	~~Definition~~
	~~himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).~~
~~Governing Body~~	~~For the purpose of this policy, the term governing body shall refer to the Board of Directors.~~
~~Related Entity~~	~~Any entity that is related to CalOptima by common ownership or control and:~~ ~~1. Performs some of the management functions under contract or delegation;~~ ~~2. Furnishes services to Medicare or Medicaid enrollees under an oral or written agreement; or~~ ~~3. Leases real property or sells materials to CalOptima at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.~~
~~Waste~~	~~Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to CalOptima Programs. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.~~

~~III.~~II. POLICY

~~A. All CalOptima employees and members of its Governing Body shall receive CalOptima's Code of Conduct within ninety (90) calendar days of appointment, hire or contracting, and at least annually thereafter, as well as when the Code of Conduct is modified.~~

~~B. Upon hire and annually thereafter, the Code of Conduct shall be communicated to all employees through CalOptima's web-based learning management system, or other means of distribution. In accordance with CalOptima Policy: HH.2023: Compliance Training.~~

~~C.~~ CalOptima requires that all members of the Governing Body, Employees, ~~Volunteers (including unpaid interns),~~ and FDRs to conduct themselves in an ethical and legal manner and in compliance with the Code of Conduct.

~~D.~~A. ~~When reviewing the Code of Conduct, the Executive Director of Compliance~~Compliance Officer ~~shall consider the state and federal laws, regulations, health care program requirements, and other guidance.~~

~~E. All CalOptima FDRs shall receive CalOptima's Code of within ninety (90) calendar days of appointment, hire or contracting, and at least annually thereafter, as well as when the Code of Conduct is modified. Additionally, the Code of Conduct is provided through the CalOptima vendor and Provider website with notification of updates provided via email. Upon contracting and annually thereafter, FDRs shall confirm receipt and understanding of CalOptima's Code of Conduct via the initial and annual FDR attestation.~~

~~F. CalOptima requires that all members of the Governing Body, Employees, Volunteers (including unpaid interns), and FDRs conduct themselves in an ethical and legal manner and in compliance with the Code of Conduct.~~

~~G.~~B. Failure to comply with the Code of Conduct or the guidelines for behavior that the Code of Conduct represents may lead to disciplinary action up to and including termination. Employees and FDRs are expected to inform CalOptima's Office of Compliance immediately in the event of any violations to the Code of Conduct in accordance with CalOptima Policy HH.2019Δ: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Policies~~Reporting Suspected Misconduct or Violation.~~.

~~H.~~C. Employees, Members of the Governing Body, and FDRs shall provide attestations upon appointment, hire, or the commencement of the contract and annually thereafter. Completion and attestation of such review of the Code of Conduct is a condition of continued appointment, employment, or contract services.~~FDRs and CalOptima Eemployees shall provide annual attestations confirming receipt and understanding of CalOptima's Code of Conduct. Failure to provide timely attestation will lead to further corrective actions.~~

~~IV.~~III. PROCEDURE

A. Reviewing and Approving the Code of Conduct

1. The Office of Compliance is responsible for ensuring a review of the current Code of Conduct at least annually, or as needed. The following sources should be considered to determine if changes to the Code of Conduct are required:

   a. Changes in state and federal laws or regulations;

   b. Changes in health care program requirements; and

   c. Other guidance, as applicable.

2. Once approved by the Board of Directors, the Office of Compliance is responsible for ensuring the Code of Conduct is made available by uploading on the CalOptima's InfoNet, vendor, and provider websites.

B. Distributing and Monitoring for Employees

1. All CalOptima Employees shall receive CalOptima's Code of Conduct within ninety (90) calendar days of appointment, hire, or contracting, and at least annually thereafter, as well as when the Code of Conduct is modified.

2. If mid-year or annual revisions are made to the Code of Conduct, the Office of Compliance will inform the Human Resources Department, who will communicate to all Employees that an updated Code of Conduct is available and must be reviewed.

a. If the Code of Conduct is revised and distributed as part of the annual review, then the Human Resources Department shall distribute via web-based training, in accordance with CalOptima Policy HH.2023Δ: Compliance Training.

——If there are revisions to the to the Code of Conduct that occur mid-year, the Human Resources Department shall compose and distribute an email to all Employees announcing an updated Code of Conduct is available on CalOptima's InfoNet and to electronically confirm receipt, review, and understanding of the updated Code of Conduct.

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~~A.~~b. ~~2. All CalOptima Eemployees , volunteers (including unpaid interns) and members of its Governing Body shall receive CalOptima's Code of Conduct within ninety (90) calendar days of appointment, hire or contracting, and at least annually thereafter, as well as when the Code of Conduct is modified.~~

3. ~~Upon hire and annually thereafter, t~~The Code of Conduct shall be communicated to all ~~employees~~Employees~~, volunteers (including unpaid interns)~~ through CalOptima's web-based learning management system, or other means of distribution.~~, i~~In accordance with CalOptima Policy: HH.2023Δ: Compliance Training.

~~B.~~

C. Distributing and Monitoring for Members of the Governing Body

1. All members of CalOptima's Governing Body shall receive CalOptima's Code of Conduct within ninety (90) calendar days of appointment, and at least annually thereafter, as well as when the Code of Conduct is modified.

~~1.~~2. If mid-year or annual revisions are made to the Code of Conduct, the Office of Compliance will inform the Clerk of the Board, who will communicate to all members of the Governing Body that an updated Code of Conduct is available and must be reviewed.

~~a.~~ If the Code of Conduct is revised and distributed as part of the annual review, then the Human Resources Department shall distribute via web-based training, in accordance with CalOptima Policy HH.2023Δ: Compliance Training.

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~~i.~~a. The Clerk of the Board shall also provide a copy of the current Code of Conduct to all members of the Governing Body through a written memorandum and request an updated attestation to be executed from all members of the Governing Body.

b. If there are revisions to the to the Code of Conduct that occur mid-year, the Clerk of the Board shall compose and distribute a written memorandum to all members of the Governing Body announcing an updated Code of Conduct is available and to electronically confirm receipt, review, and understanding of the updated Code of Conduct.

~~All CalOptima FDRs shall receive CalOptima's Code of Conduct within ninety (90) calendar days of appointment, hire or contracting, and at least annually thereafter, as well as when the Code of Conduct is modified. Additionally, the Code of Conduct is provided through the CalOptima vendor and provider website with notification of updates provided via email.~~

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~~Upon contracting and annually thereafter, FDRs shall confirm receipt and understanding of CalOptima's Code of Conduct via the initial and annual FDR attestation.~~

~~D. Reviewing and Aapproving the Code of Conduct~~

~~1. The Office of Compliance is responsible for ensuring a review of the current Code of Conduct as needed, but at least annually or as needed. The following sources should be considered to determine if changes to the Code of Conduct are required:~~

~~a. Changes in state and federal laws or regulations;~~

~~b. Changes in health care program requirements; and~~

~~c. Other guidance, as appropriateapplicable.~~

~~2. Once approved by the Board of Directors, the Office of Compliance is responsible for ensuring the Code of Conduct is made available by uploading on the CalOptima's InfoNet, and CalOptima's vendor, and pProvider websites.~~

~~E. Distributing and Monitoring Code of Conduct tofor Employees~~

~~1. If mid-year or annual revisions are made to the Code of Conduct, the Office of Compliance will inform the Human Resources Ddepartment, who will communicate to all employeesEmployees that an updated Code of Conduct is available and must be reviewed.~~

~~a. If the Code of Conduct is revised and distributed as part of the annual review, then the Human Resources Ddepartment shall distribute via web-based training, i. In accordance with CalOptima Policy HH.2023: Compliance Training.~~

~~b. If there are revisions to the to the Code of Conduct that occur mid-year, then the Human Resources Ddepartment shall compose and distribute an email to all employeesEmployees announcing an updated Code of Conduct is available on CalOptima's InfoNet and to electronically confirm receipt, review, and understanding of the updated Code of Conduct.~~

~~F.~~D. Distributing and Monitoring for ~~to~~ FDRs

1. The Office of Compliance shall ensure the updated Code of Conduct is uploaded on to the CalOptima vendor and p~~P~~rovider website~~.~~.

2. Upon contracting, the Office of Compliance distributes a FDR compliance attestation package composed of compliance documents, including CalOptima's Code of Conduct, and an FDR attestation, that confirms receipt of the CalOptima Code of Conduct.

3. All CalOptima FDRs shall receive CalOptima's Code of Conduct within ninety (90) calendar days of appointment, hire or contracting, and at least annually thereafter, as well as when the Code of Conduct is modified. Additionally, the Code of Conduct is provided through the CalOptima vendor and provider website with notification of updates provided via email.

a. Upon contracting and annually thereafter, FDRs shall confirm receipt and understanding of CalOptima's Code of Conduct via the initial and annual FDR attestation.

~~2.~~4. FDRs are required to disseminate copies of the Code of Conduct and Policies and Procedures to their employees, agents, and/or Downstream Entities.

~~3.~~5. Annually, the Office of Compliance shall request an updated attestation to be executed from all FDRs. Failure, to submit the requested documents may result in a notice of non-compliance, in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

~~-~~The Office of Compliance shall communicate to all FDRs any update(s) to compliance documents with instructions to access the CalOptima vendor and p~~P~~rovider website.

~~Distributing and Monitoring for Members of the Governing Body~~

~~If mid-year or annual revisions are made to the Code of Conduct, the Office of Compliance will inform the Clerk of the Board, who will communicate to all members of the Governing Body that an updated Code of Conduct is available and must be reviewed.~~

~~If the Code of Conduct is revised and distributed as part of the annual review, then the Human Resources Department shall distribute via web-based training, in accordance with CalOptima Policy HH.2023Δ: Compliance Training.~~

~~The Clerk of the Board shall also provide a copy of the current Code of Conduct to all members of the Governing Body through a written memorandum and request an updated attestation to be executed from all members of the Governing Body.~~

~~If there are revisions to the to the Code of Conduct that occur mid-year, the Clerk of the Board shall compose and distribute a written memorandum to all members of the Governing Body announcing an updated Code of Conduct is available and to electronically confirm receipt, review, and understanding of the updated Code of Conduct.~~

6.

~~V.~~IV. ATTACHMENTS

A. FDR Compliance Attestation

~~VI.~~V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Policy HH.2005-Δ: Corrective Action Plan
~~B.~~C. CalOptima Policy HH.2019Δ: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Policies
~~C.~~D. CalOptima Policy HH.2023-Δ: Compliance Training
E. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
F. CalOptima Contract with the Department of Health Care Services (~~/~~DHCS) for Medi-Cal

G. CalOptima ~~Contract with the Department of Health Care Services (DHCS) for PACE~~PACE Program Agreement
H. ~~Medi-Cal Program Contract, Exhibit E, Attachment 2, Section 27.B.~~CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
I. Medicare Managed Care Manual, Chapters 9 and 21
~~D.~~
~~E.~~ Title 42, Code of Federal Regulations~~,~~ (C.F.R.), ~~Section~~ §455.2
~~F.~~J. ~~Welfare and Institutions Code, Section 14043.1(i)~~
K. Title 42, Code of Federal Regulations (C.F.R.), §422.503(b)(4)(vi)(A)
L. Title 42, Code of Federal Regulations (C.F.R.), §423.504(b)(4)(vi)(A)
~~G.~~M. Title 42, Code of Federal Regulations (C.F.R.), ~~Section~~ §438.608
~~H.~~N. Welfare and Institutions Code, ~~Section~~ §14043.1(a~~i~~)

~~VII.~~VI. REGULATORY AGENCY APPROVALS

None to Date

~~VIII.~~VII. BOARD ACTIONS

None to Date

~~IX.~~VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2014	MA.9120	Code of Conduct	OneCare
Revised	11/01/2014	MA.9120	Code of Conduct	OneCare
Effective	09/01/2015	HH.2028	Code of Conduct	Medi-Cal
Revised	09/01/2015	MA.9120	Code of Conduct	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2028	Code of Conduct	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9120	Code of Conduct	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Code of Conduct	The statement setting forth the principles and standards governing CalOptima's activities to which Board Members, Employees, FDRs, and agents of CalOptima are expected to adhere.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.~~Includes permanent, temporary and contracted staff of CalOptima.~~
First Tier, Downstream, and Related Entities (FDR):	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Governing Body	The Board of Directors of CalOptima.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

Policy #:	HH.2028Δ
Title:	**Code of Conduct**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	Michael Schrader _____
Effective Date:	09/01/15
Last Review Date:	12/01/16
Last Revision Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy describes the process CalOptima utilizes to review, approve, and communicate its expectation that all Employees, members of its Governing Body, and First Tier, Downstream, and Related Entities (FDRs) conduct themselves in an ethical and legal manner and in compliance with the Code of Conduct.

II. POLICY

A. CalOptima requires that all members of the Governing Body, Employees, and FDRs to conduct themselves in an ethical and legal manner and in compliance with the Code of Conduct.

B. Failure to comply with the Code of Conduct or the guidelines for behavior that the Code of Conduct represents may lead to disciplinary action up to and including termination. Employees and FDRs are expected to inform CalOptima's Office of Compliance immediately in the event of any violations to the Code of Conduct in accordance with CalOptima Policy HH.2019Δ: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Policies.

C. Employees, Members of the Governing Body, and FDRs shall provide attestations upon appointment, hire, or the commencement of the contract and annually thereafter. Completion and attestation of such review of the Code of Conduct is a condition of continued appointment, employment, or contract services.

III. PROCEDURE

A. Reviewing and Approving the Code of Conduct

1. The Office of Compliance is responsible for ensuring a review of the current Code of Conduct at least annually, or as needed. The following sources should be considered to determine if changes to the Code of Conduct are required:

   a. Changes in state and federal laws or regulations;

   b. Changes in health care program requirements; and

c. Other guidance, as applicable.

2. Once approved by the Board of Directors, the Office of Compliance is responsible for ensuring the Code of Conduct is made available by uploading on the CalOptima's InfoNet, vendor, and provider websites.

B. Distributing and Monitoring for Employees

1. All CalOptima Employees shall receive CalOptima's Code of Conduct within ninety (90) calendar days of appointment, hire, or contracting, and at least annually thereafter, as well as when the Code of Conduct is modified.

2. If mid-year or annual revisions are made to the Code of Conduct, the Office of Compliance will inform the Human Resources Department, who will communicate to all Employees that an updated Code of Conduct is available and must be reviewed.

a. If the Code of Conduct is revised and distributed as part of the annual review, then the Human Resources Department shall distribute via web-based training, in accordance with CalOptima Policy HH.2023Δ: Compliance Training.

b. If there are revisions to the to the Code of Conduct that occur mid-year, the Human Resources Department shall compose and distribute an email to all Employees announcing an updated Code of Conduct is available on CalOptima's InfoNet and to electronically confirm receipt, review, and understanding of the updated Code of Conduct.

3. The Code of Conduct shall be communicated to all Employees through CalOptima's web-based learning management system, or other means of distribution, in accordance with CalOptima Policy: HH.2023Δ: Compliance Training.

C. Distributing and Monitoring for Members of the Governing Body

1. All members of CalOptima's Governing Body shall receive CalOptima's Code of Conduct within ninety (90) calendar days of appointment, and at least annually thereafter, as well as when the Code of Conduct is modified.

2. If mid-year or annual revisions are made to the Code of Conduct, the Office of Compliance will inform the Clerk of the Board, who will communicate to all members of the Governing Body that an updated Code of Conduct is available and must be reviewed.

a. If the Code of Conduct is revised and distributed as part of the annual review, then the Human Resources Department shall distribute via web-based training, in accordance with CalOptima Policy HH.2023Δ: Compliance Training. The Clerk of the Board shall also provide a copy of the current Code of Conduct to all members of the Governing Body through a written memorandum and request an updated attestation to be executed from all members of the Governing Body.

b. If there are revisions to the to the Code of Conduct that occur mid-year, the Clerk of the Board shall compose and distribute a written memorandum to all members of the Governing Body announcing an updated Code of Conduct is available and to electronically confirm receipt, review, and understanding of the updated Code of Conduct.

D. Distributing and Monitoring for FDRs

1. The Office of Compliance shall ensure the updated Code of Conduct is uploaded on to the CalOptima vendor and provider website.

2. Upon contracting, the Office of Compliance distributes a FDR compliance attestation package composed of compliance documents, including CalOptima's Code of Conduct, and an FDR attestation, that confirms receipt of the CalOptima Code of Conduct.

3. All CalOptima FDRs shall receive CalOptima's Code of Conduct within ninety (90) calendar days of appointment, hire or contracting, and at least annually thereafter, as well as when the Code of Conduct is modified. Additionally, the Code of Conduct is provided through the CalOptima vendor and provider website with notification of updates provided via email.

   a. Upon contracting and annually thereafter, FDRs shall confirm receipt and understanding of CalOptima's Code of Conduct via the initial and annual FDR attestation.

4. FDRs are required to disseminate copies of the Code of Conduct and Policies and Procedures to their employees, agents, and/or Downstream Entities.

5. Annually, the Office of Compliance shall request an updated attestation to be executed from all FDRs. Failure, to submit the requested documents may result in a notice of non-compliance, in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

6. The Office of Compliance shall communicate to all FDRs any update(s) to compliance documents with instructions to access the CalOptima vendor and provider website.

IV. ATTACHMENTS

A. FDR Compliance Attestation

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Policy HH.2005Δ: Corrective Action Plan
C. CalOptima Policy HH.2019Δ: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Policies
D. CalOptima Policy HH.2023Δ: Compliance Training
E. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
F. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
G. CalOptima PACE Program Agreement
H. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
I. Medicare Managed Care Manual, Chapters 9 and 21
J. Title 42, Code of Federal Regulations (C.F.R.), §455.2Title 42, Code of Federal Regulations (C.F.R.), §422.503(b)(4)(vi)(A)
K. Title 42, Code of Federal Regulations (C.F.R.), §423.504(b)(4)(vi)(A)
L. Title 42, Code of Federal Regulations (C.F.R.), §438.608
M. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2014	MA.9120	Code of Conduct	OneCare
Revised	11/01/2014	MA.9120	Code of Conduct	OneCare
Effective	09/01/2015	HH.2028	Code of Conduct	Medi-Cal
Revised	09/01/2015	MA.9120	Code of Conduct	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2028	Code of Conduct	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9120	Code of Conduct	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Code of Conduct	The statement setting forth the principles and standards governing CalOptima's activities to which Board Members, Employees, FDRs, and agents of CalOptima are expected to adhere.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDR):	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Governing Body	The Board of Directors of CalOptima.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

FDR COMPLIANCE ATTESTATION

Please complete and execute this attestation and return it to CalOptima's Office of Compliance via fax (714) 481-6457, email Compliance@caloptima.org , or mail: Cal Optima, Office of Compliance, Attn: Annie Phillips 505 City Parkway West, Orange, CA 92868, within thirty (30) calendar days for (existing FDRs) or sixty (60) calendar days for (new FDRs) of this notice.

Check which CalOptima program(s) this form pertains to:

- ☐ OneCare Connect
- ☐ OneCare HMO SNP
- ☐ Medi-Cal
- ☐ PACE

I hereby attest that [_____(the "Organization")], and all its downstream entities, if any, that are involved in the provision of health or administrative services for any of the CalOptima programs identified above:

I. Provide effective Fraud, Waste and Abuse Training and compliance training to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers, within ninety (90) calendar days of appointment, hire or contracting, as applicable, and at least annually thereafter as a condition of appointment, employment or contracting. The Organization and its downstream entities currently use (Select all that apply):

- ☐ CMS's Fraud, Waste, and Abuse Training and compliance training module. (The Organization shall maintain records per CMS retention requirement)
- ☐ An internal training program that meets CMS's Fraud, Waste, and Abuse and compliance training module requirements. (The Organization shall maintain records per CMS retention requirement)

II. Administer specialized compliance training to Organization and downstream entity board members, employees, temporary employees, and volunteers: (i) based on their job function within the first ninety (90) days of hire and at least annually thereafter as a condition of appointment, employment or contracting, (ii) when requirements change; (iii) when such persons work in an area previously found to be non-compliant with program requirements or implicated in past misconduct.

III. Have established and publicized compliance policies and procedures, standards of conduct, and compliance reference material that meet the requirements outlined in 42 CFR § 422.503(b)(4)(vi)(A) and 42 CFR § 423.504(b)(4)(vi)(A) which information, and any updates thereto, are distributed to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers within ninety (90) days of appointment, hire or contracting, as applicable, and at least annually thereafter. Evidence of receipt of such compliance by such persons is obtained and retained by the Organization.

IV. Review all Organization and downstream entity board members, officers, potential and actual employees, temporary employees, and volunteers against the (Suspended and Ineligible Provider List) S & I Medi-Cal, (Health and Human Services) HHS, (Office of Inspector General) OIG List of Excluded Individuals & Entities list, (System for Award Management) SAM/(General Services Administration) GSA Debarment list (here after "Lists") upon appointment, hire or contracting, as applicable, and monthly thereafter. Further, in the event that the Organization or downstream entity becomes aware that any of the foregoing persons or entities are included on these Lists, the Organization will notify CalOptima within five (5) calendar days, the relationship with the listed person/entity will be terminated as it relates to CalOptima, and appropriate corrective action will be taken.

V. Screen the Organization and its subcontractors' governing bodies for conflicts of interest as defined in state and federal law and CalOptima policies and procedures upon hire or contracting and annually thereafter.

VI. Will report suspected fraud, waste, and abuse, as well as all other forms of non-compliance, as it relates to CalOptima.

VII. Understand that any violation of any laws, regulations, or CalOptima policies and procedures are grounds for disciplinary action, up to and including termination of Organization's contractual status.

VIII Are aware that persons reporting suspected fraud, waste, and abuse, and other non-compliance are protected from retaliation under the False Claims Act and other applicable laws prohibiting retaliation.

IX. Retain documented evidence of compliance with the above, including training and exclusion screening (i.e. sign-in sheets, certificates, attestations, OIG and GSA search results, etc.) for at least ten (10) years, and provide such documentation to CalOptima upon request.

The individual signing below is knowledgeable about and authorized to attest to the foregoing matters on behalf of the Organization.

_____	_____
Signature	Date
_____	_____
Name	Organization

~~Policy #: MA.9116HH.2029Δ~~
~~Title: **Annual Compliance Program Effectiveness Audit**~~
~~Department: Office of Compliance~~
~~Section: Regulatory Affairs & Compliance~~

~~CEO Approval: Michael Schrader~~

~~Effective Date: 05/01/14~~
~~Last Review Date: 9/1/1512/01/16~~
~~Last Revised Date: 9/1/1512/01/16~~

~~This policy shall apply to the following CalOptima line of business (LOB):~~
- ~~OneCare~~
- ~~OneCare Connect~~
- ~~PACE~~

Policy #: HH.2029Δ
Title: **Annual Compliance Program Effectiveness Audit**
Department: Office of Compliance
Section: Regulatory Affairs & Compliance

CEO Approval: Michael Schrader

Effective Date: ~~12/01/16~~05/01/14
Last Review Date: ~~Not Applicable~~12/01/16
Last Revised Date: ~~Not Applicable~~12/01/16

Applicable to:
☒ Medi-Cal
☒ OneCare
☒ OneCare Connect
☒ PACE

I. PURPOSE

This policy~~o~~ describes the process through which CalOptima's Office of Compliance ~~is taking to~~ determines the overall effectiveness of the Compliance Program.

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~
~~Compliance Program~~	~~A comprehensive program that incorporates the fundamental elements identified by the state and federal governments and CalOptima as necessary~~

	to prevent and detect violations of ethical standards, contractual obligations, and applicable laws and the involvement of CalOptima's governing body and executive staff. Elements of the Compliance Program include standards, oversight, training, reporting, monitoring, enforcement, and remediation. The Compliance Program applies to CalOptima's Board of Directors, employees, and contractors including delegated entities, providers, and suppliers.
Downstream Entity	Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
First Tier, Downstream, and Related Entities (FDR)	FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement with CalOptima to provide administrative services or health care services to a Medicare or Medicaid eligible individual under the CalOptima program.
Related Entity	Any entity that is related to CalOptima by common ownership or control and: 1. Performs some of the management functions under contract or delegation; 2. Furnishes services to Medicare or Medicaid enrollees under an oral or written agreement; or 3. Leases real property or sells materials to CalOptima at a cost of more than two-thousand five-hundred dollars ($2,500) during a contract period.

III.II. POLICY

A. CalOptima will assess the overall effectiveness of its Compliance Program on an annual basis, including both internal and external methods of evaluation.

A. CalOptima shall use multiple methods to perform a comprehensive Compliance Effectiveness Assessment to assist in measuring the overall effectiveness of its Compliance Program.

B. The Office of Compliance shall complete a self assessment at least bi-annually.

C. The Office of Compliance shall utilize an independent third party to conduct an evaluation of the effectiveness of the Compliance Program on an annual basis.

D. CalOptima shall routinely monitor overall compliance effectiveness through at least quarterly dashboard reports, and audit and monitoring results.

The Office of Compliance shall perform a compliance self assessment based on the seven (7) elements of an effective Compliance Program.

~~E. The compliance self-assessment is conducted during the independent third party's evaluation of the effectiveness of the Compliance Program.~~

~~IV.~~III. PROCEDURE

A. The Office of Compliance shall conduct a self assessment based on the seven (7) elements of an effective Compliance Program utilizing the Compliance Program Effectiveness Self Assessment Questionnaire. The compliance self-~~-~~assessment is conducted during the independent third party's evaluation of the effectiveness of the Compliance Program.

B. The Office of Compliance shall utilize an independent third party to conduct an evaluation of the effectiveness of the Compliance Program on an annual basis.

~~C. The Office of Compliance shall utilize an independent third party to conduct a review of the Compliance Program monitoring.~~

C. CalOptima shall routinely monitor overall compliance effectiveness through at least quarterly dashboard reports, and A~~a~~udit and M~~m~~onitoring results.

D. The Office of Compliance shall present the Compliance Effectiveness results to the Compliance Committee and Board of Directors at least annually.

E. The Office of Compliance shall review the Compliance Effectiveness results and include in the annual Compliance work plan, as needed.

~~V.~~IV. ATTACHMENTS

A. Compliance Program Effectiveness Self Assessment Questionnaire

~~VI.~~V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima ~~Contract with the Department of Health Care Services for PACE~~PACE Program Agreement
D. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
E. Medicare Managed Care Manual, Chapters 9 ~~Chapter~~ and 21
F. Title 42, Code of Federal Regulations (C.F.R.), §§422.503(b)(4)(vi)
G. Title 42, Code of Federal Regulations (C.F.R.), §§422.504(b)(4)(vi)

~~B. of the Medicare Managed Care Manual~~
~~C. Chapter 9 of the Prescription Drug Benefit Manual~~

~~VII.~~VI. REGULATORY AGENCY APPROVALS

None to Date

~~VIII.~~VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2014	MA.9116	Annual Compliance Program Effectiveness Audit	OneCare
Revised	11/01/2014	MA.9116	Annual Compliance Program Effectiveness Audit	OneCare
Revised	09/01/2015	MA.9116	Annual Compliance Program Effectiveness Audit	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2029Δ	Annual Compliance Program Effectiveness Audit	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9116	Annual Compliance Program Effectiveness Audit	OneCare OneCare Connect PACE

~~IX.~~

~~Version~~	~~Date~~	~~Policy Number~~	~~Policy Title~~	~~Line(s) of Business~~
~~Effective~~	~~12/01/2016~~	~~HH.2029Δ~~	~~Annual Compliance Program Effectiveness Audit~~	~~Medi-Cal~~ ~~OneCare~~ ~~OneCare Connect~~ ~~PACE~~
~~Revised~~				
~~Revised~~				
~~Revised~~				
~~Revised~~				

~~Version~~	~~Version Date~~	~~Policy Number~~	~~Policy Title~~	
~~Original Date~~	~~5/1/14~~	~~MA.9116~~	~~Annual Compliance Program Effectiveness Audit~~	~~OneCare~~
~~Revision Date 1~~	~~11/1/14~~	~~MA.9116~~	~~Annual Compliance Program Effectiveness Audit~~	~~OneCare~~

~~Revision Date 2~~	~~9/1/15~~	~~MA.9116~~	~~Annual Compliance Program Effectiveness Audit~~

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IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Compliance Program	The program (including, without limitation, this Compliance Plan, Code of Conduct and Policies and Procedures and Procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Member, Employees and FDRs comply with applicable law and ethical standards.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

Policy #:	HH.2029Δ
Title:	**Annual Compliance Program Effectiveness Audit**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	Michael Schrader _____
Effective Date:	05/01/14
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy describes the process through which CalOptima's Office of Compliance determines the overall effectiveness of the Compliance Program.

II. POLICY

A. CalOptima will assess the overall effectiveness of its Compliance Program on an annual basis, including both internal and external methods of evaluation.

III. PROCEDURE

A. The Office of Compliance shall conduct a self assessment based on the seven (7) elements of an effective Compliance Program utilizing the Compliance Program Effectiveness Self Assessment Questionnaire. The compliance self-assessment is conducted during the independent third party's evaluation of the effectiveness of the Compliance Program.

B. The Office of Compliance shall utilize an independent third party to conduct an evaluation of the effectiveness of the Compliance Program on an annual basis.

C. CalOptima shall routinely monitor overall compliance effectiveness through at least quarterly dashboard reports, and Audit and Monitoring results.

D. The Office of Compliance shall present the Compliance Effectiveness results to the Compliance Committee and Board of Directors at least annually.

E. The Office of Compliance shall review the Compliance Effectiveness results and include in the annual Compliance work plan, as needed.

IV. ATTACHMENTS

A. Compliance Program Effectiveness Self Assessment Questionnaire

V. REFERENCES

A. CalOptima Compliance Plan

B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima PACE Program Agreement
D. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
E. Medicare Managed Care Manual, Chapters 9 and 21
F. Title 42, Code of Federal Regulations (C.F.R.), §§422.503(b)(4)(vi)
G. Title 42, Code of Federal Regulations (C.F.R.), §§422.504(b)(4)(vi)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2014	MA.9116	Annual Compliance Program Effectiveness Audit	OneCare
Revised	11/01/2014	MA.9116	Annual Compliance Program Effectiveness Audit	OneCare
Revised	09/01/2015	MA.9116	Annual Compliance Program Effectiveness Audit	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2029Δ	Annual Compliance Program Effectiveness Audit	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9116	Annual Compliance Program Effectiveness Audit	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Compliance Program	The program (including, without limitation, this Compliance Plan, Code of Conduct and Policies and Procedures and Procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Member, Employees and FDRs comply with applicable law and ethical standards.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

ATTACHMENT I-A
MEDICARE ADVANTAGE AND PRESCRIPTION DRUG COMPLIANCE PROGRAM EFFECTIVENESS SELF-ASSESSMENT QUESTIONNAIRE

(Rev. 4. 2-2015)

Name of Sponsoring Organization:

MA-PD/PDP Contract Numbers:

Name/Title of Person Completing Assessment:

Date of Assessment:

Note: Sponsoring Organizations should not interpret every question as a mandatory CMS requirement, but rather as a guide in evaluating the effectiveness of their Compliance Program.

Directions for completing the self-assessment questionnaire:

This document will help your organization evaluate the effectiveness of your Medicare Compliance Program. Please respond to each question according to the current status of your Compliance Program. If the answer is "YES" to any question below, check the "YES" box and provide a BRIEF description of what documents support that response in the "Documentation" column. The Documentation description should also provide a cross reference (when applicable) to where this documentation can be located. For example, if your response is "YES" to the third question below *("Do your written Ps & Ps and/or Standards of Conduct articulate the organization's commitment to comply with all applicable Federal and State standards including but not limited to statutes, regulations and sub regulatory guidance"),* please indicate the section/page of the Standards of Conduct or policies and procedures where these compliance provisions are found.

If the answer is "NO" to a question, check the "NO" box and document the rationale for the response in the "Documentation" column.

Please specifically note the following when completing the questionnaire:

- "You" refer to your organization, not necessarily a specific person.
- "Employees" refers to employees, including senior management, who support your Medicare business.
- "Compliance Officer" refers to the compliance officer who oversees the Medicare business.

ATTACHMENT I-A
MEDICARE ADVANTAGE AND PRESCRIPTION DRUG COMPLIANCE PROGRAM EFFECTIVENESS SELF-ASSESSMENT QUESTIONNAIRE

- "CEO" refers to Chief Operating Officer of the organization or the most senior officer, usually the President.
- "Compliance Program" refers to your Medicare compliance program.
- If the Medicare contract holder is a wholly owned subsidiary of a parent company, references to the board of directors, CEO and highest level of the organization's management are to the board, CEO and management of the company (parent or subsidiary/contract holder) that the organization has chosen to oversee its Medicare compliance program. .
- Unless specific reference is made in the question to the "full board", the term "board of directors" means either the full board or a committee of the board delegated to conduct oversight of the day-to-day operation of the Medicare compliance program on behalf of the full board.

Element I: Written Policies and Procedures and Standards of Conduct

42 CFR §422.503(b)(4)(vi)(A) and 42 CFR §423.504(b)(4)(vi)(A)

	Description	Yes	No	Documentation (include specific page number, paragraph, and/or section)	Responsible Party or Department
1.	Do you have written policies and procedures (Ps & Ps) and/or Standards of Conduct that:				
A.	Articulate the organization's commitment to comply with all applicable Federal and State standards?				
B.	Describe compliance expectations as embodied in the standards of conduct?				
C.	Implement the operation of the compliance program?				

ATTACHMENT I-A
MEDICARE ADVANTAGE AND PRESCRIPTION DRUG COMPLIANCE PROGRAM EFFECTIVENESS SELF-ASSESSMENT QUESTIONNAIRE

Element I: Written Policies and Procedures and Standards of Conduct

42 CFR §422.503(b)(4)(vi)(A) and 42 CFR §423.504(b)(4)(vi)(A)

	Description	Yes	No	Documentation	Responsible Party or Department
D.	Provide guidance to employees and others on dealing with potential compliance issues?				
E.	Identify how to communicate compliance issues to appropriate compliance personnel?				
F.	Describe how potential compliance issues are investigated and resolved by the organization?				
G.	Include a policy of non-intimidation and no-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials?				
2.	Are your Ps & Ps detailed and specific in their description of the operation of the compliance program?				

ATTACHMENT I-A
MEDICARE ADVANTAGE AND PRESCRIPTION DRUG COMPLIANCE PROGRAM EFFECTIVENESS SELF-ASSESSMENT QUESTIONNAIRE

Element I: Written Policies and Procedures and Standards of Conduct *42 CFR §422.503(b)(4)(vi)(A) and 42 CFR §423.504(b)(4)(vi)(A)*					
	Description	**Yes**	**No**	**Documentation**	**Responsible Party or Department**
3.	Do you distribute your Standards of Conduct and Ps & Ps to your employees within 90 days of hire, when there are updates and annually thereafter?				
4.	Do you update your Ps & Ps to incorporate changes in applicable laws, regulations and other program requirements?				

Element II: Compliance Officer, Compliance Committee, Governing Body *42 CFR §422.503(b)(4)(vi)(B) and 42 CFR §423.504(b)(4)(vi)(B)*					
	Description	**Yes**	**No**	**Documentation**	**Responsible Party or Department**
5.	Does your CEO receive your compliance officer's reports on the status and activities of the compliance program?				

ATTACHMENT I-A
MEDICARE ADVANTAGE AND PRESCRIPTION DRUG COMPLIANCE PROGRAM EFFECTIVENESS SELF-ASSESSMENT QUESTIONNAIRE

Element II: Compliance Officer, Compliance Committee, Governing Body

42 CFR §422.503(b)(4)(vi)(B) and 42 CFR §423.504(b)(4)(vi)(B)

	Description	Yes	No	Documentation	Responsible Party or Department
6.	If your compliance officer does not report directly, in-person to your CEO, are his/her reports routed through the President of the division that houses the Medicare and/or through the President of the organization rather than through operational management?				
7.	Does your compliance officer have express authority (oral or written, preferably written) to make in-person reports to your CEO and Board of Directors in the compliance officer's sole discretion?				
8.	Is your compliance officer employed by your organization, parent organization, or corporate affiliate?				
9.	If employed by your parent or corporate affiliate, does your compliance officer have detailed involvement in and familiarity with your Medicare operational and compliance activities?				

ATTACHMENT I-A
MEDICARE ADVANTAGE AND PRESCRIPTION DRUG COMPLIANCE PROGRAM EFFECTIVENESS SELF-ASSESSMENT QUESTIONNAIRE

Element II: Compliance Officer, Compliance Committee, Governing Body

42 CFR §422.503(b)(4)(vi)(B) and 42 CFR §423.504(b)(4)(vi)(B)

	Description	Yes	No	Documentation	Responsible Party or Department
10.	Does your Board of Directors periodically receive compliance reports on Medicare program noncompliance and Medicare fraud, waste and abuse ("FWA") which include issues identified, investigated, and resolved?				
11.	If your compliance officer does not report in-person to your Board of Directors, are his/her reports routed through the compliance infrastructure?				
12.	Is your compliance officer a full-time employee?				
13.	Does your compliance officer have both compliance and operational responsibilities?				
14.	Do you have a compliance committee whose responsibilities include oversight of the compliance program?				

Element II: Compliance Officer, Compliance Committee, Governing Body

42 CFR §422.503(b)(4)(vi)(B) and 42 CFR §423.504(b)(4)(vi)(B)

	Description	Yes	No	Documentation	Responsible Party or Department
15.	Does your compliance officer and compliance committee provide the Board of Directors with regularly scheduled updates on the status and activities of the compliance program, including compliance program outcomes, the results of internal and external audits and about all government compliance enforcement activity?				

Element III: Effective Training and Education

42 CFR §422.503(b)(4)(vi)(C) and 42 CFR §423.504(b)(4)(vi)(C)

	Description	Yes	No	Documentation	Responsible Party or Department
16.	Do you establish, implement and provide effective training and education, addressing compliance and FWA for your employees, including temporary employees, volunteers and Board of Directors?				

Element III: Effective Training and Education

42 CFR §422.503(b)(4)(vi)(C) and 42 CFR §423.504(b)(4)(vi)(C)

	Description	Yes	No	Documentation	Responsible Party or Department
17.	Is your training for employees and board members provided within 90 days of hire/appointment and annually thereafter?				
18.	Do you maintain attendance, topic, certificates of completion and/or test scores for 10 years?				
19.	Do you ensure that your employees are aware of Medicare requirements related to their job functions?				
20.	Does your general compliance education include the reporting requirements and available methods for reporting noncompliance and potential FWA?				
21.	Do you provide training on FWA risks based on the individual's job function?				

Element IV: Effective Lines of Communication

42 CFR §422.503(b)(4)(vi)(D) and 42 CFR §423.504(b)(4)(vi)(D)

ATTACHMENT I-A
MEDICARE ADVANTAGE AND PRESCRIPTION DRUG COMPLIANCE PROGRAM EFFECTIVENESS SELF-ASSESSMENT QUESTIONNAIRE

	Description	Yes	No	Documentation	Responsible Party or Department
22.	Do you have an effective method(s) to communicate information from your compliance officer to others, within a reasonable time frame, including changes in laws, regulations and sub-regulatory guidance as well as changes to your Standards of Conduct and Ps & Ps?				
23.	Do your Standards of Conduct and/or Ps & Ps require your employees and members of the Board of Directors to report compliance concerns and potential FWA?				
24.	Do you have a system to receive, record, respond to and track compliance questions or concerns and reports of potential FWA from your employees, members of your Board of Directors, FDRs and their employees and enrollees?				
25.	Does your system allow anonymous reporting and maintain confidentiality to the extent possible?				

ATTACHMENT I-A
MEDICARE ADVANTAGE AND PRESCRIPTION DRUG COMPLIANCE PROGRAM EFFECTIVENESS SELF-ASSESSMENT QUESTIONNAIRE

Element IV: Effective Lines of Communication

42 CFR §422.503(b)(4)(vi)(D) and 42 CFR §423.504(b)(4)(vi)(D)

	Description	Yes	No	Documentation	Responsible Party or Department
26.	Does your system emphasize your policy of non-retaliation and that of your FDRs'?				
27.	Is your system well-publicized throughout your facilities and those of your FDRs?				
28.	Are your reporting mechanisms user-friendly, easy to access and navigate and available 24 hours a day for employees, members of your Board of Directors and FDRs?				
29.	Have you adopted, widely publicized and enforced a no-tolerance policy for retaliation or retribution against any employee, FDR, or FDR employee who reports potential FWA?				
30.	Do you educate your enrollees about the identification and reporting of FWA?				

ATTACHMENT I-A
MEDICARE ADVANTAGE AND PRESCRIPTION DRUG COMPLIANCE PROGRAM EFFECTIVENESS SELF-ASSESSMENT QUESTIONNAIRE

Element VI: Effective System for Routine Monitoring, Auditing, and Identification of Compliance Risks *42 CFR §422.503(b)(4)(vi)(F) and 42 CFR §423.504(b)(4)(vi)(F)*					
	Description	**Yes**	**No**	**Documentation**	**Responsible Party or Department**
31.	Do you have a system of ongoing monitoring and auditing to test and confirm compliance with Medicare regulations, sub-regulatory guidance, contractual agreements and all applicable federal and state laws?				
32.	Are adequate resources devoted to your audit function considering the scope of your Parts C and D programs, compliance history, current compliance risks and resources available?				
33.	Do you have a monitoring and auditing work plan that addresses risks associated with Medicare Parts C and D?				
34.	Does your compliance officer receive regular reports from those who are conducting the auditing or the audit department on the results of auditing and monitoring and on the status and effectiveness of corrective actions taken?				

ATTACHMENT I-A
MEDICARE ADVANTAGE AND PRESCRIPTION DRUG COMPLIANCE PROGRAM EFFECTIVENESS SELF-ASSESSMENT QUESTIONNAIRE

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

42 CFR §422.503(b)(4)(vi)(F) and 42 CFR §423.504(b)(4)(vi)(F)

	Description	Yes	No	Documentation	Responsible Party or Department
35.	Does your compliance officer or his/her designee provide updates on the results of monitoring and auditing to your compliance committee, CEO, senior leadership and Board of Directors?				
36.	Have you established and implemented Ps & Ps to conduct a formal baseline risk assessment of the major compliance and risk areas in all Medicare operational areas?				
37.	Does your monitoring and auditing strategy prioritize (a) risks identified through CMS audits and oversight and through your own monitoring; and (b) those risks that have the greatest impact?				
38.	Do you periodically re-evaluate the accuracy of your baseline risk assessment?				
39.	Do you have an auditing and monitoring work plan that includes:				

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

42 CFR §422.503(b)(4)(vi)(F) and 42 CFR §423.504(b)(4)(vi)(F)

	Description	Yes	No	Documentation	Responsible Party or Department
A.	A process for responding to all monitoring and auditing results?				
B.	A process for conducting follow-up reviews of areas found to be noncompliant to determine if corrective actions have fully address the underlying problems?				
C.	A schedule that lists all auditing and monitoring activities for the calendar year?				
40.	Do you use appropriate methods to:				
A.	Select operational areas for audit?				
B.	Select first tier entities for audit?				
C.	Determine sample size?				
D.	Extrapolate audit findings to the full universe, using statistically valid methods that comply with generally accepted auditing standards?				

ATTACHMENT I-A
MEDICARE ADVANTAGE AND PRESCRIPTION DRUG COMPLIANCE PROGRAM EFFECTIVENESS SELF-ASSESSMENT QUESTIONNAIRE

Element VI: Effective System for Routine Monitoring, Auditing, and Identification of Compliance Risks *42 CFR §422.503(b)(4)(vi)(F) and 42 CFR §423.504(b)(4)(vi)(F)*					
	Description	**Yes**	**No**	**Documentation**	**Responsible Party or Department**
E.	Apply specialized targeted techniques or stratified sampling methods driven by data mining, complaint monitoring and aberrant behavior?				
F.	Assess compliance with internal processes and procedures?				
41.	Do you have staff dedicated to the audit function?				
A.	Are your auditors Knowledgeable about CMS operational requirements for areas under review, independent and not engaged in self-policing?				
42.	Does your audit staff have access to relevant personnel, information, records and areas of operation under review, including operational areas at plan and FDR level?				
43.	Do you audit the effectiveness of your compliance program at least annually?				

ATTACHMENT I-A
MEDICARE ADVANTAGE AND PRESCRIPTION DRUG COMPLIANCE PROGRAM EFFECTIVENESS SELF-ASSESSMENT QUESTIONNAIRE

Element VI: Effective System for Routine Monitoring, Auditing, and Identification of Compliance Risks *42 CFR §422.503(b)(4)(vi)(F) and 42 CFR §423.504(b)(4)(vi)(F)*					
	Description	**Yes**	**No**	**Documentation**	**Responsible Party or Department**
44.	Is the audit conducted by persons other than your compliance officer and/or compliance department staff?				
45.	Do you share the results of the audits of the effectiveness of the compliance program with your Board of Directors?				
46.	Do you review the OIG and GSA exclusion lists for your employees (including temporary employees), volunteers, consultants and the members of your board of directors prior to hiring/contracting/appointment and monthly thereafter?				
47.	Do you utilize data analysis for monitoring for FWA?				
48.	Do you either have a Special Investigations Unit ("SIU") or ensure that the responsibilities generally conducted by an SIU are conducted by your compliance department?				

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

42 CFR §422.503(b)(4)(vi)(F) and 42 CFR §423.504(b)(4)(vi)(F)

	Description	Yes	No	Documentation	Responsible Party or Department
49.	If you have an SIU, is it accessible through multiple channels, e.g. phone, mail, Internet message?				
50.	Do your SIU and compliance departments communicate and coordinate closely?				

Element VII: Procedures and Systems for Promptly Responding to Compliance Issues

42 CFR §422.503(b)(4)(vi)(G) and 42 CFR §423.504(b)(4)(vi)(G)

	Description	Yes	No	Documentation	Responsible Party or Department
51.	Do you make a reasonable inquiry into all compliance incidents/issues and potential FWA?				
52.	Do you require and ensure that your inquiries are well-documented?				

Element VII: Procedures and Systems for Promptly Responding to Compliance Issues

42 CFR §422.503(b)(4)(vi)(G) and 42 CFR §423.504(b)(4)(vi)(G)

	Description	Yes	No	Documentation	Responsible Party or Department
53.	Do you require and ensure that inquiries are initiated as quickly as possible and not later than two weeks after the date the potential noncompliance or FWA is identified?				
54.	Do you undertake appropriate corrective actions that:				
A.	Are designed to correct and prevent future noncompliance, including conducting a root cause analysis?				
B.	Are tailored to address the particular FWA, problem or deficiency identified?				
C.	Include time frames for specific achievements?				
55.	Do you continue to monitor corrective actions after their implementation to ensure that they are effective?				

ATTACHMENT I-A
MEDICARE ADVANTAGE AND PRESCRIPTION DRUG COMPLIANCE PROGRAM EFFECTIVENESS SELF-ASSESSMENT QUESTIONNAIRE

Element VII: Procedures and Systems for Promptly Responding to Compliance Issues

42 CFR §422.503(b)(4)(vi)(G) and 42 CFR §423.504(b)(4)(vi)(G)

	Description	Yes	No	Documentation	Responsible Party or Department
A.	Do you ensure that noncompliance or FWA committed by your employees is documented and includes ramifications should the employee fail to satisfactorily implement the corrective action?				
56.	Do you maintain thorough documentation of all compliance deficiencies identified and the corrective actions taken?				
57.	Do you have procedures to refer potential FWA issues to the NBI MEDIC and serious issues of program noncompliance to CMS?				
58.	Do you conclude your investigations of FWA within a reasonable time after the activity is discovered?				
59.	Do you review past paid claims from entities identified in fraud alerts and remove them from their event data submissions e.g. PDEs?				

FDR Oversight

Sponsor Accountability for and Oversight of FDRs

42 CFR §422.503(b)(4)(vi) and 42 CFR §423.504(b)(4)(vi)

	Description	Yes	No	Documentation	Responsible Party or Department
60.	Do you have a process for determining which delegated entities are properly identified as FDRs subject to Medicare compliance requirements?				
61.	Do you have a system to monitor FDRs' compliance with Medicare program requirements?				

FDR Oversight

Element I: Written Policies and Procedures and Standards of Conduct

42 CFR §422.503(b)(4)(vi)(A) and 42 CFR §423.504(b)(4)(vi)(A)

	Description	Yes	No	Documentation	Responsible Party or Department
62.	Do you ensure that either your Standards of Conduct and Ps & Ps or comparable Standards of Conduct and Ps & Ps are distributed to FDR's employees within 90 days of hire / contracting and annually thereafter?				

FDR Oversight

Element III: Effective Training and Education

42 CFR §422.503(b)(4)(vi)(C) and 42 CFR §423.504(b)(4)(vi)(C)

	Description	Yes	No	Documentation	Responsible Party or Department
63.	Do you ensure that general compliance information is communicated to your FDRs?				

64.	Do you ensure that your non-deemed FDRs' employees receive FWA training within 90 days of hiring/contracting and annually thereafter?				
65.	Do you provide training directly to your FDRs, provide them with FWA training materials or use CMS Learning Network module for FWA training for your FDRs?				

FDR Oversight

Element III: Effective Training and Education

42 CFR §422.503(b)(4)(vi)(C) and 42 CFR §423.504(b)(4)(vi)(C)

	Description	Yes	No	Documentation	Responsible Party or Department
66.	Do you require your FDRs to maintain records of the FWA training of their employees for ten years, as required?				

FDR Oversight

Element VI: Monitoring and Auditing of FDRs

42 CFR §422.503(b)(4)(vi)(F) and 42 CFR §423.504(b)(4)(vi)(F)

	Description	Yes	No	Documentation	Responsible Party or Department
67.	Do you have a strategy to monitor and audit your first tier entities?				
68.	Does your strategy for monitoring and auditing your first tier entities include:				
A.	Ensuring that they are in compliance with Medicare Parts C and D requirements?				
B.	Ensuring that they are monitoring their downstream entities?				

FDR Oversight

Element VI: Monitoring and Auditing of FDRs

42 CFR §422.503(b)(4)(vi)(F) and 42 CFR §423.504(b)(4)(vi)(F)

	Description	Yes	No	Documentation	Responsible Party or Department
69.	Do you monitor and audit your related entities?				
70.	Does your monitoring and auditing work plan include the number of first tier entities that will be audited and how the entities will be identified for auditing?				
71.	If you do not monitor and audit all of your first tier entities, do you perform a risk assessment to identify the high risk first tier entities and then select a reasonable number to audit from the highest risk groups?				
72.	Do you have procedures to ensure that your FDRs are not excluded from participation in Federal health care programs? (42 CFR § 1001.1901)				

FDR Oversight

Element VI: Monitoring and Auditing of FDRs

42 CFR §422.503(b)(4)(vi)(F) and 42 CFR §423.504(b)(4)(vi)(F)

	Description	Yes	No	Documentation	Responsible Party or Department
73.	Does your system include review of the OIG and GSA exclusion lists prior to hiring or contracting and monthly thereafter for FDRs and their employees either by you, your first entities, or the downstream entities themselves?				

FDR Oversight

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

42 CFR §422.503(b)(4)(vi)(G) and 42 CFR §423.504(b)(4)(vi)(G)

	Description	Yes	No	Documentation	Responsible Party or Department
74.	Do you ensure that needed corrective actions are taken by first tier entities?				
75.	Do you continue to monitor FDR corrective actions after their implementation to ensure that they are effective?				

FDR Oversight

Element VI: Monitoring and Auditing of FDRs

42 CFR §422.503(b)(4)(vi)(F) and 42 CFR §423.504(b)(4)(vi)(F)

	Description	Yes	No	Documentation	Responsible Party or Department
A.	Do you ensure that noncompliance or FWA committed by FDRs is well-documented and includes ramifications should the FDR fail to satisfactorily implement the corrective action?				
76.	Do you maintain thorough documentation of all deficiencies identified and the corrective actions taken?				

Compliance Program Effectiveness Self-Assessment Questionnaire Submitted By:

[Name]
[Title]
[Company]
[Address]
[Phone Number]
[Email Address]

(Signature) **(Date)**

Policy #:	HH.3012Δ
Title:	**Non-Retaliation for Reporting Violations**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	Michael Schrader
Effective Date:	04/01/03
Last Review Date:	12/01/169/1/15
Last Revised Date:	12/01/169/1/15
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

To This policy reinforces CalOptima's commitment to compliance with applicable laws, regulations, and policies and its policy against intimidation, harassment, discrimination or any other retaliatory action against individuals who report or seek guidance related to suspected or actual non-compliance with such laws, regulations, or related to unethical conduct.

II. DEFINITIONS

Term	Definition
Abuse:	A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima and the CalOptima programs, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima and the CalOptima programs
Disclosure:	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Downstream Entity:	Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Employee	For the purposes of this policy the term employee shall refer to any full time, intern, temporary, volunteer and any as needed employee.
First Tier, Downstream, and Related Entities (FDR):	FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity:	Any party that enters into a written arrangement with CalOptima to provide administrative services or health care services to a Medicare or Medicaid eligible individual under the CalOptima program.

Fraud:	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, and Welfare and Institutions Code section 14043.l(i).
Member:	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Protected Health Information (PHI):	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Related Entity:	Any entity that is related to CalOptima by common ownership or control and: 1. Performs some of the management functions under contract or delegation; 2. Furnishes services to Medicare or Medicaid enrollees under an oral or written agreement; or 3. Leases real property or sells materials to CalOptima at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.
Retaliation	Includes, but is not limited to, coercion, threats, harassment, intimidation, discrimination, and other forms of retaliatory action against individuals.
Waste:	Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to CalOptima Programs. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

III.II. POLICY

A. CalOptima, its Governing Body members, ~~employee~~Employees, and First Tier, Downstream, and Related Entities (FDRs) shall not threaten, intimidate, coerce, harass, discriminate, or otherwise ~~retaliate~~Retaliate against individuals who report or file ~~complaints c~~Complaints related to suspected or actual non-compliance with applicable laws, regulations or policies (including, without limitation, HIPAA, the False Claims Act, and other laws) and/or related to unethical conduct.

B. CalOptima, its Governing Body members, ~~employee~~Employees, and FDRs shall not be subject to retaliatory action or discrimination by CalOptima for reporting in good faith suspected or actual non-compliance or unethical conduct or for participating in any investigation.

C. CalOptima, its Governing Body members, ~~employee~~Employees, and FDRs shall not ~~retaliate~~Retaliate for:

1. The exercise of any right under, or participating in, any process established by federal, state, or local law, regulations, or policy, including, but not limited to, filing a C~~c~~omplaint with CalOptima and/or the United States Department of Health and Human Services relating to privacy;

2. Testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing; or

3. Opposing any act or practice made unlawful by law, provided that the person has a good faith belief that the practice is unlawful, and the manner of the opposition is reasonable and does not involve a Disclosure of Protected Health Information (PHI) in violation of law and policies.

D. CalOptima, its Governing Body members, ~~employee~~Employees, and FDRs shall immediately report any action believed to be ~~retaliation~~Retaliation or discrimination against any individual for reporting suspected or actual non-compliance with laws, unethical conduct, or wrongdoing, or for participating in any investigation.

E. CalOptima shall provide guidance, in accordance with CalOptima Policy HH.2018Δ: Compliance and Ethics Hotline, on how an ~~employee~~Employee, member of the Governing Body ~~member~~, FDR, or Member may anonymously report potential non-compliance and Fraud, Waste and Abuse (FWA) issues to the extent permitted by applicable law and circumstances.

F. CalOptima does not tolerate intimidation, coercion, harassment, discrimination, or other forms of ~~retaliation~~Retaliation towards individuals who report suspected or actual non-compliance. Individuals or entities determined to have violated CalOptima's non-~~retaliation~~Retaliation policy will be subject to disciplinary or other corrective action, up to and including termination.

~~IV.~~III. PROCEDURE

A. ~~–~~CalOptima shall protect against any ~~retaliation~~Retaliation toward an ~~employee~~Employee, Governing Body, FDR, or Member by ensuring all verbal or written reports, made in good faith, remain C~~c~~onfidential to the extent allowable by law.

B. CalOptima shall maintain Confidential methods for Employees, members of the Governing Body, FDRs, or Members to report suspected violations of policy, rules, and regulations by:

1. Calling the Compliance and Ethics Hotline, toll-free, twenty-four (24) hours a day, seven (7) days a week; or

2. Reporting directly to the CalOptima Compliance Officer;

3. Sending an email to: compliance@caloptima.org; or

4. Completing a Request for Compliance Action Form.

~~B.~~C. CalOptima and the Office of Compliance shall ensure ~~employee~~Employees, Governing Body, FDRs, or Members are informed of CalOptima's non-~~retaliation~~Retaliation policy by posting information on the CalOptima InfoNet and w~~W~~ebsite, as well as sending periodic Member notifications.

~~C. CalOptima shall maintain Cconfidential methods for employee~~Employees, ~~members of the Governing Body, FDRs or Members to report suspected violations of policy, rules, and regulations by:~~

~~1. Calling the Compliance and Ethics Hotline, toll-free, twenty-four (24) hours a day, seven (7) days a week; or~~

~~Reporting directly to the CalOptima Compliance Officer; or~~

~~Sending an email to: compliance@caloptima.org; or~~

~~2.~~

~~3. Completing a Request for Compliance Action Form.~~

D. It is the responsibility of all CalOptima ~~employee~~Employees, Governing Body, and FDRs ~~and Members~~ to report, in good faith, perceived or known misconduct, in accordance with CalOptima Policy HH.2019Δ: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Policies~~Reporting Suspected Misconduct or Violation~~.

E. Knowledge of a violation or potential violation of this policy shall be reported directly to the Compliance Officer, or to the Compliance and Ethics Hotline.

F. Failure of a CalOptima ~~employee~~Employee to report any such violation or possible violation may be grounds for disciplinary action.

~~V.~~IV. ATTACHMENTS

Not Applicable

~~VI.~~V. REFERENCES

~~A. Title 45, Code of Federal Regulations, Section164.530(g) Administrative Requirements Standard: Refraining From Intimidating or Retaliatory Acts~~

~~B.~~A. CalOptima Compliance Plan

B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services for Medi-Cal
D. CalOptima Contract with the Department of Health Care Services for PACE
~~C. CalOptima Policy AA.10100: Glossary of Terms~~
~~D.~~E. CalOptima Policy HH.2018Δ: Compliance and Ethics Hotline
F. CalOptima Policy HH.2019Δ: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Policies~~Reporting Suspected Misconduct or Violation~~
G. CalOptima Policy MA.1001: Glossary of Terms
~~E.~~H. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
I. False Claims Act (31 U.S.C. ~~Section~~ §3730(h))
J. Medicare Managed Care Manual, Chapters 9 and 21
~~F.~~
K. Title 42, Code of Federal Regulations (C.F.R.), §455.2
~~G.~~ Title 45, Code of Federal Regulations (C.F.R.), ~~Section~~§§164.530(g) and 160.316 ~~Administrative Requirements Standard: Refraining From Intimidating or Retaliatory Acts~~
L.
~~H.~~M. Welfare and Institutions Code, §14043.1(a)~~False Claims Act (31 U.S.C. Section 3730(h))~~

~~VII.~~VI. REGULATORY AGENCY APPROVALS

A. 07/02/13: Department of Health Care Services
B. 03/19/12: Department of Managed Health Care
~~None to Date~~

~~VIII.~~VII. BOARD ACTIONS

None to Date
~~A. 7/2/13: DHCS Approval~~
~~B. 3/19/12: DMHC Approval~~

~~IX.~~VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	10/01/2002	MA.9223	Reporting Non-Intimidation and Non-Retaliation	OneCare
Effective	04/01/2003	HH.3012	Prohibition on Retaliation on Reporting Violations to Privacy Policies and Procedures	Medi-Cal
Revised	11/01/2004	MA.9223	Reporting Non-Intimidation and Non-Retaliation	OneCare

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	04/01/2007	HH.3012	Prohibition on Retaliation on Reporting Violations to Privacy Policies and Procedures	Medi-Cal
Revised	07/01/2007	MA.9223	Reporting Non-Intimidation and Non-Retaliation	OneCare
Revised	01/01/2010	MA.9223	Reporting Non-Intimidation and Non-Retaliation	OneCare
Revised	02/01/2012	HH.3012	Non-Retaliation for Reporting Violation	Medi-Cal
Revised	02/01/2013	HH.3012Δ	Non-Retaliation for Reporting Violation	Medi-Cal OneCare
Revised	09/01/2014	MA.9223	Reporting Non-Intimidation and Non-Retaliation	OneCare
Revised	09/01/2015	HH.3012	Non-Retaliation for Reporting Violation	Medi-Cal
Revised	09/01/2015	MA.9223	Non-Retaliation for Reporting Violation	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3012Δ	Non-Retaliation for Reporting Violation	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9223	Non-Retaliation for Reporting Violation	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Confidential	Entrusted with private or personal information that is confined to a person or group as opposed to the public.
Disclosure	Has the meaning in in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.~~Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.~~
~~Downstream Entity~~	~~Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.~~
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
~~First Tier Entity~~	~~Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.~~
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C Section 1347).
Governing Body	The Board of Directors of CalOptima.
Member	A beneficiary who is enrolled in a CalOptima Program.

Term	Definition
Protected Health Information (PHI)	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. ~~Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.~~ This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Retaliation (or Retaliate)	Includes, but is not limited to, coercion, threats, harassment, intimidation, discrimination, and other forms of retaliatory action against individuals.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1

Policy #:	HH.3012Δ
Title:	**Non-Retaliation for Reporting Violations**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	Michael Schrader
Effective Date:	04/01/03
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy reinforces CalOptima's commitment to compliance with applicable laws, regulations, and policies and its policy against intimidation, harassment, discrimination or any other retaliatory action against individuals who report or seek guidance related to suspected or actual non-compliance with such laws, regulations, or related to unethical conduct.

II. POLICY

A. CalOptima, its Governing Body members, Employees, and First Tier, Downstream, and Related Entities (FDRs) shall not threaten, intimidate, coerce, harass, discriminate, or otherwise Retaliate against individuals who report or file complaints related to suspected or actual non-compliance with applicable laws, regulations or policies (including, without limitation, HIPAA, the False Claims Act, and other laws) and/or related to unethical conduct.

B. CalOptima, its Governing Body members, Employees, and FDRs shall not be subject to retaliatory action or discrimination by CalOptima for reporting in good faith suspected or actual non-compliance or unethical conduct or for participating in any investigation.

C. CalOptima, its Governing Body members, Employees, and FDRs shall not Retaliate for:

1. The exercise of any right under, or participating in, any process established by federal, state, or local law, regulations, or policy, including, but not limited to, filing a Complaint with CalOptima and/or the United States Department of Health and Human Services relating to privacy;

2. Testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing; or

3. Opposing any act or practice made unlawful by law, provided that the person has a good faith belief that the practice is unlawful, and the manner of the opposition is reasonable and does not involve a Disclosure of Protected Health Information (PHI) in violation of law and policies.

D. CalOptima, its Governing Body members, Employees, and FDRs shall immediately report any action believed to be Retaliation or discrimination against any individual for reporting suspected or

actual non-compliance with laws, unethical conduct, or wrongdoing, or for participating in any investigation.

E. CalOptima shall provide guidance, in accordance with CalOptima Policy HH.2018Δ: Compliance and Ethics Hotline, on how an Employee, member of the Governing Body, FDR, or Member may anonymously report potential non-compliance and Fraud, Waste and Abuse (FWA) issues to the extent permitted by applicable law and circumstances.

F. CalOptima does not tolerate intimidation, coercion, harassment, discrimination, or other forms of Retaliation towards individuals who report suspected or actual non-compliance. Individuals or entities determined to have violated CalOptima's non-Retaliation policy will be subject to disciplinary or other corrective action, up to and including termination.

III. PROCEDURE

A. CalOptima shall protect against any Retaliation toward an Employee, Governing Body, FDR, or Member by ensuring all verbal or written reports, made in good faith, remain Confidential to the extent allowable by law.

B. CalOptima shall maintain Confidential methods for Employees, members of the Governing Body, FDRs, or Members to report suspected violations of policy, rules, and regulations by:

1. Calling the Compliance and Ethics Hotline, toll-free, twenty-four (24) hours a day, seven (7) days a week; or

2. Reporting directly to the CalOptima Compliance Officer;

3. Sending an email to: compliance@caloptima.org; or

4. Completing a Request for Compliance Action Form.

C. CalOptima and the Office of Compliance shall ensure Employees, Governing Body, FDRs, or Members are informed of CalOptima's non-Retaliation policy by posting information on the CalOptima InfoNet and website, as well as sending periodic Member notifications.

D. It is the responsibility of all CalOptima Employees, Governing Body, and FDRs to report, in good faith, perceived or known misconduct, in accordance with CalOptima Policy HH.2019Δ: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Policies.

E. Knowledge of a violation or potential violation of this policy shall be reported directly to the Compliance Officer, or to the Compliance and Ethics Hotline.

F. Failure of a CalOptima Employee to report any such violation or possible violation may be grounds for disciplinary action.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Compliance Plan

B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services for Medi-Cal
D. CalOptima Contract with the Department of Health Care Services for PACE
E. CalOptima Policy HH.2018Δ: Compliance and Ethics Hotline
F. CalOptima Policy HH.2019Δ: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Policies
G. CalOptima Policy MA.1001: Glossary of Terms
H. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
I. False Claims Act (31 U.S.C. §3730(h))
J. Medicare Managed Care Manual, Chapters 9 and 21
K. Title 42, Code of Federal Regulations (C.F.R.), §455.2
L. Title 45, Code of Federal Regulations (C.F.R.), §§164.530(g) and 160.316

Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVALS

A. 07/02/13: Department of Health Care Services
B. 03/19/12: Department of Managed Health Care

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	10/01/2002	MA.9223	Reporting Non-Intimidation and Non-Retaliation	OneCare
Effective	04/01/2003	HH.3012	Prohibition on Retaliation on Reporting Violations to Privacy Policies and Procedures	Medi-Cal
Revised	11/01/2004	MA.9223	Reporting Non-Intimidation and Non-Retaliation	OneCare
Revised	04/01/2007	HH.3012	Prohibition on Retaliation on Reporting Violations to Privacy Policies and Procedures	Medi-Cal
Revised	07/01/2007	MA.9223	Reporting Non-Intimidation and Non-Retaliation	OneCare
Revised	01/01/2010	MA.9223	Reporting Non-Intimidation and Non-Retaliation	OneCare
Revised	02/01/2012	HH.3012	Non-Retaliation for Reporting Violation	Medi-Cal
Revised	02/01/2013	HH.3012Δ	Non-Retaliation for Reporting Violation	Medi-Cal OneCare

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	09/01/2014	MA.9223	Reporting Non-Intimidation and Non-Retaliation	OneCare
Revised	09/01/2015	HH.3012	Non-Retaliation for Reporting Violation	Medi-Cal
Revised	09/01/2015	MA.9223	Non-Retaliation for Reporting Violation	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3012Δ	Non-Retaliation for Reporting Violation	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9223	Non-Retaliation for Reporting Violation	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Confidential	Entrusted with private or personal information that is confined to a person or group as opposed to the public.
Disclosure	Has the meaning in in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C Section 1347).
Governing Body	The Board of Directors of CalOptima.
Member	A beneficiary who is enrolled in a CalOptima Program.
Protected Health Information (PHI)	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

Term	Definition
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Retaliation (or Retaliate)	Includes, but is not limited to, coercion, threats, harassment, intimidation, discrimination, and other forms of retaliatory action against individuals.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1

Policy #: MA.9124
Title: **CMS Self-Disclosure**
Department: Office of Compliance
Section: Regulatory Affairs & Compliance

CEO Approval: Michael Schrader

Effective Date: 08/01/14
Last Review Date: 12/01/16
Last Revised Date: 12/01/16

Applicable to:
☒ OneCare
☒ OneCare Connect
☒ PACE

~~Policy #: MA.9124~~
~~Title: **CMS Self-Disclosure**~~
~~Department: Office of Compliance~~
~~Section: Compliance~~

~~CEO Approval: Michael Schrader~~

~~Effective Date: 08/01/14~~
~~Last Review Date: 912/01/165~~
~~Last Revised Date: 912/01/165~~

~~This policy shall apply to the following CalOptima line of business (LOB):~~
- ~~OneCare~~
- ~~OneCare Connect~~
- ~~PACE~~

I. PURPOSE

This policy~~e~~ establishes a process for self-disclosing incidences of -significant Medicare program non-compliance to CalOptima's Centers for Medicare & Medicaid Services (CMS) Regional Account Manager and/or the Department of Health Care Services (DHCS) Contract Manager. ~~for record and future non-compliance credit purposes.~~ This self-disclosing process ensures that corrective actions are taken timely when non-compliance incidents are identified.

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~
~~Centers for Medicare & Medicaid Services (CMS):~~	~~The Federal Agency within the Department of Health and Human Services that is responsible for the administration of the Medicare programs as well as overseeing other federal health care programs such as the Children's Health Insurance Program (CHIP).~~
~~Compliance Program~~	~~The program including, without limitation, the Compliance Plan, Code of Conduct, and CalOptima policies, developed and adopted by CalOptima to promote, monitor, and ensure that~~

Term	Definition
	CalOptima's operations and practices and the practices of its Board members, employees, contractors, and providers comply with applicable law and ethical standards.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, regulating bodies, or designated representatives. Delegates may be required to complete CAPs to ensure they are in compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements identified by CalOptima and its regulators.
Self Disclosure	The act of voluntarily notifying the compliance governing body of a non-compliance incident.

III.II. POLICY

A. CalOptima follows the guidelines and regulations set forth by the Centers for Medicare & Medicaid Services (CMS), regarding compliance to the Medicare Program and monitoring process for Part C and Part D programs.

B. The Office of Compliance oversees and implements an effective Compliance Program to prevent, detect and correct Part C and Part D programs' non-compliance.

C. This policy encourages internal and external business units to voluntarily identify, disclose, and correct non-compliance incidents to meet the Medicare program guidelines and regulations set forth by CMS.

D. Self–reported non-compliance incidents reported to the Office of Compliance are investigated and Corrective Action Plans (CAPs) issued and responded to as promptly as the severity level assigned to the non-compliance incident allows, as described in CalOptima policy MA.9104HH.2005Δ: Corrective Action Plan.

IV.III. PROCEDURE

A. Submitting a Self Disclosure:

1. The department Director, Manager, or delegate liaison have twenty-—four hours (24) hours (once an incident is identified) to Self-Disclose a non-compliance incident to the Office of Compliance. In severe non-compliance incidents impacting and threatening a beneficiary's Member's state of health, Self Disclosure must be completed as soon as it is identified.

2. The department Director, Manager or delegate liaison must document the non-compliance incident identified using the Self Disclosure Form (SDF) and submit the completed SDF to the Office of Compliance.

3. The disclosure must be submitted electronically.

4. Depending on the severity of the incident being reported, the Office of Compliance will review the submission and respond back within three to five (3-5) business days to the submitting party either accepting or rejecting the disclosure.

B. Required Information Related to the Self Disclosing Incident:

1. To Self Disclose a non-compliance incident to the Office of Compliance, the submitting party must provide the following contact information in the SDF: submitter contact name, phone, email, and address (for external submitters), area of non-compliance (For example: Enrollment, Pharmacy, Customer Service, Sales, etc.) and include the following information in the SDF:

   a. A brief description/summary of the identified non-compliance incident, including specific timeframes the internal or external party might have been out of compliance. Any applicable supporting documentation should be included.

   b. A brief description of why the internal or external party believes they are out of compliance with the identified area.

   c. Circumstances under which the non-compliance was discovered (For example: grievance, complaint, Aaudits, or through a business data analysis), and actions taken, if any, to correct the non-compliance upon discovery of the incident.

   d. Include a root cause analysis and the impact on, risks to health, safety or quality of care posed by the incident disclosed with sufficient information to allow compliance to assess the severity of the non-compliance incident, risk and steps that should be taken to meet compliance.

   e. If applicable, the dates or range of dates whereby the non-compliance was cured and if any claims or services where or have been impacted.

   f. Remediation of measures taken to prevent future non- compliance of that nature from reoccurring, M~~m~~onitoring steps and implementation timeframes, including proof of remediation. (For example: employee training, enhancing internal control procedures, increased internal A~~a~~uditing efforts, increased oversight by management, etc.).

   g. A description of appropriate Member/provider notices, if applicable, provided with disclosure of the non compliance incident.

C. Office of Compliance Investigation & Corrective Action Plan:

1. Upon receipt of a self-disclosure submission, the Office of Compliance will begin its investigation of the disclosed information. The extent of the investigation will depend upon the severity of the incident and evidence or documentation provided with the SDF.

2. If additional, non-compliance incidents are discovered during the investigation process, that incident will be treated as a new non-compliance incident and the self-disclosing party will be required to complete a new SDF for that incident.

3. To facilitate the investigation process, the Office of Compliance will review and request additional information and conduct interviews if necessary with the applicable parties/departments. If additional information is requested based on the severity of the incident, the self-disclosing applicable parties/departments ~~have three (3) business days to~~ shall submit the requested information to Regulatory Affairs & Compliance, ~~as described in CalOptima Medicare policy of Disciplinary Action~~in accordance with HH.2005Δ: Corrective Action Plan.

4. ~~In accordance with CalOptima Policy MA.9104: Corrective Action Plan, T~~the Office of Compliance ~~will have fourteen (14) calendar days to~~shall complete its initial investigation, upon which the self-disclosing department will be provided with initial findings and a request for CAP which must be completed and responded to by the self-disclosing business unit, in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan ~~within fourteen (14) calendar days~~.

5. If the non-compliance is a result of a Grievance filing, the Office of Compliance will provide the Grievance & Appeals Director with the final resolution for insertion into the M~~m~~ember grievance file.

D. Findings Report:

1. Upon completion of the investigation, the Office of Compliance will submit the f~~F~~inal Self-Disclosure Form to the Compliance Officer for review and sign off.

2. Once the above step has been completed, and an accepted CAP (if applicable) has been submitted, the Compliance Officer or ~~the Medicare Compliance Director~~his or her D~~d~~esignee will submit the non-Compliance incident to CalOptima's CMS Regional Account Manager and/or the Department of Health Care Services (DHCS) Contract Manager including any steps taken to correct the non-compliance.

3. ~~In accordance with title 42 Code of Federal Regulations sections 422.503(b)(4)(vi)(G) and 423.504(b)(4)(vi)(G),~~ CalOptima shall report the incident to CMS as soon as possible after its discovery.

4. The Compliance Officer or ~~the Medicare Compliance Director~~his or her D~~d~~esignee will also submit the final, signed Self-Disclosure form outlining the course of actions that included the accepted CAP, and continued M~~m~~onitoring efforts to the Director of the business unit and applicable Committees.

~~V.~~IV. ATTACHMENTS

A. Self Disclosure Form

~~VI.~~V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima ~~Contract with the Department of Health Care Services for PACE~~PACE Program Agreement
~~CalOptima Policy CMC.1001: Glossary of Terms~~

D. CalOptima Policy HH.2005Δ: Corrective Action Plan
~~CalOptima Policy MA.1001: Glossary of Terms~~
E. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~B.~~F. ~~CMS HPMS Memo.~~ "CMS C~~c~~onsideration of S~~s~~elf-D~~d~~isclosure by P~~p~~lan S~~s~~ponsors of N~~n~~on-C~~c~~ompliance C~~c~~onduct in the D~~d~~etermination of C~~c~~ompliance A~~a~~ctions" Health Plan Management System, Issued 02/~~February~~ 27/~~,~~ 2013.
~~C.~~G. Medicare Managed Care Manual, Chapters 9 and 21~~: Compliance Program Guidelines~~
~~D.~~ Title ~~Medicare Prescription Drug Benefits Manual, Chapter 9: Compliance Program Guidelines~~
~~E. CalOptima Policy MA.9104: Corrective Action Plan~~
~~F.~~H. 42 Code of Federal Regulations (C.F.R.), §§ 422.503(b)(4)(vi)(G)
~~G.~~I. Title 42 Code of Federal Regulations (C.F.R.), §§ 423.504(b)(4)(vi)(G)

~~VII.~~VI. REGULATORY AGENCY APPROVALS

None to Date

~~VIII.~~VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY
~~IX.~~

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	08/01/2014	MA.9124	CMS Self Disclosure	OneCare
Revised	12/01/2014	MA.9124	CMS Self Disclosure	OneCare
Revised	09/01/2015	MA.9124	CMS Self Disclosure	OneCare OneCare Connect PACE
Revised	12/01/2016	MA.9124	CMS Self Disclosure	OneCare OneCare Connect PACE

~~Version~~	~~Version Date~~	~~Policy Number~~	~~Policy Title~~	~~Line(s) of Business~~
~~Original DateEffective~~	~~08/01/2014~~	~~MA.9124~~	~~CMS Self Disclosure~~	~~OneCare~~
~~Revision Date 1Revised~~	~~12/01/2014~~	~~MA.9124~~	~~CMS Self Disclosure~~	~~OneCare~~
~~Revision Date 2Revised~~	~~09/01/2015~~	~~MA.9124~~	~~CMS Self Disclosure~~	~~OneCare OneCare Connect PACE~~
~~Revised~~	~~12/01/2016~~	~~MA.9124~~	~~CMS Self Disclosure~~	~~OneCare OneCare Connect PACE~~

IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers that Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Program	The program (including, without limitation, this Compliance Plan, Code of Conduct and Policies and Procedures and Procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Member, Employees and FDRs comply with applicable law and ethical standards.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services, or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Department of Health Care Services	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Grievance	Any Complaint, other than one involving an Organization Determination, expressing dissatisfaction with any aspect of CalOptima's, a Physician Medical Group's, or a Provider's operations, activities, or behavior, regardless of any request for remedial action.
Member	A beneficiary who is enrolled in a CalOptima Program.
Self Disclosure	The act of voluntarily notifying the compliance governing body of a non-compliance incident.

Policy #:	MA.9124
Title:	**CMS Self-Disclosure**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	Michael Schrader _____
Effective Date:	08/01/14
Last Review Date:	12/01/16
Last Revised Date:	12/01/16
Applicable to:	☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy establishes a process for self-disclosing incidences of significant Medicare program non-compliance to CalOptima's Centers for Medicare & Medicaid Services (CMS) Regional Account Manager and/or the Department of Health Care Services (DHCS) Contract Manager. This self-disclosing process ensures that corrective actions are taken timely when non-compliance incidents are identified.

II. POLICY

A. CalOptima follows the guidelines and regulations set forth by the Centers for Medicare & Medicaid Services (CMS), regarding compliance to the Medicare Program and monitoring process for Part C and Part D programs.

B. The Office of Compliance oversees and implements an effective Compliance Program to prevent, detect and correct Part C and Part D programs' non-compliance.

C. This policy encourages internal and external business units to voluntarily identify, disclose, and correct non-compliance incidents to meet the Medicare program guidelines and regulations set forth by CMS.

D. Self–reported non-compliance incidents reported to the Office of Compliance are investigated and Corrective Action Plans (CAPs) issued and responded to as promptly as the severity level assigned to the non-compliance incident allows, as described in CalOptima policy HH.2005Δ: Corrective Action Plan.

III. PROCEDURE

A. Submitting a Self Disclosure:

1. The department Director, Manager, or delegate liaison have twenty-four hours (24) hours (once an incident is identified) to Self-Disclose a non-compliance incident to the Office of Compliance. In severe non-compliance incidents impacting and threatening a Member's state of health, Self Disclosure must be completed as soon as it is identified.

2. The department Director, Manager or delegate liaison must document the non-compliance incident identified using the Self Disclosure Form (SDF) and submit the completed SDF to the Office of Compliance.

3. The disclosure must be submitted electronically.

4. Depending on the severity of the incident being reported, the Office of Compliance will review the submission and respond back within three to five (3-5) business days to the submitting party either accepting or rejecting the disclosure.

B. Required Information Related to the Self Disclosing Incident:

1. To Self Disclose a non-compliance incident to the Office of Compliance, the submitting party must provide the following contact information in the SDF: submitter contact name, phone, email, and address (for external submitters), area of non-compliance (For example: Enrollment, Pharmacy, Customer Service, Sales, etc.) and include the following information in the SDF:

   a. A brief description/summary of the identified non-compliance incident, including specific timeframes the internal or external party might have been out of compliance. Any applicable supporting documentation should be included.

   b. A brief description of why the internal or external party believes they are out of compliance with the identified area.

   c. Circumstances under which the non-compliance was discovered (For example: grievance, complaint, Audits, or through a business data analysis), and actions taken, if any, to correct the non-compliance upon discovery of the incident.

   d. Include a root cause analysis and the impact on, risks to health, safety or quality of care posed by the incident disclosed with sufficient information to allow compliance to assess the severity of the non-compliance incident, risk and steps that should be taken to meet compliance.

   e. If applicable, the dates or range of dates whereby the non-compliance was cured and if any claims or services where or have been impacted.

   f. Remediation of measures taken to prevent future non- compliance of that nature from reoccurring, Monitoring steps and implementation timeframes, including proof of remediation. (For example: employee training, enhancing internal control procedures, increased internal Auditing efforts, increased oversight by management, etc.).

   g. A description of appropriate Member/provider notices, if applicable, provided with disclosure of the non compliance incident.

C. Office of Compliance Investigation & Corrective Action Plan:

1. Upon receipt of a self-disclosure submission, the Office of Compliance will begin its investigation of the disclosed information. The extent of the investigation will depend upon the severity of the incident and evidence or documentation provided with the SDF.

2. If additional, non-compliance incidents are discovered during the investigation process, that incident will be treated as a new non-compliance incident and the self-disclosing party will be required to complete a new SDF for that incident.

3. To facilitate the investigation process, the Office of Compliance will review and request additional information and conduct interviews if necessary with the applicable parties/departments. If additional information is requested based on the severity of the incident, the self-disclosing applicable parties/departments shall submit the requested information to Regulatory Affairs & Compliance, in accordance with HH.2005Δ: Corrective Action Plan.

4. The Office of Compliance shall complete its initial investigation, upon which the self-disclosing department will be provided with initial findings and a request for CAP which must be completed and responded to by the self-disclosing business unit, in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

5. If the non-compliance is a result of a Grievance filing, the Office of Compliance will provide the Grievance & Appeals Director with the final resolution for insertion into the Member grievance file.

D. Findings Report:

1. Upon completion of the investigation, the Office of Compliance will submit the final Self-Disclosure Form to the Compliance Officer for review and sign off.

2. Once the above step has been completed, and an accepted CAP (if applicable) has been submitted, the Compliance Officer or his or her Designee will submit the non-Compliance incident to CalOptima's CMS Regional Account Manager and/or the Department of Health Care Services (DHCS) Contract Manager including any steps taken to correct the non-compliance.

3. CalOptima shall report the incident to CMS as soon as possible after its discovery.

4. The Compliance Officer or his or her Designee will also submit the final, signed Self-Disclosure form outlining the course of actions that included the accepted CAP, and continued Monitoring efforts to the Director of the business unit and applicable Committees.

IV. ATTACHMENTS

A. Self Disclosure Form

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima PACE Program Agreement
D. CalOptima Policy HH.2005Δ: Corrective Action Plan
E. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect

F. "CMS Consideration of Self-Disclosure by Plan Sponsors of Non-Compliance Conduct in the Determination of Compliance Actions" Health Plan Management System, Issued 02/27/2013.
G. Medicare Managed Care Manual, Chapters 9 and 21
H. Title 42, Code of Federal Regulations **(**C.F.R.), §§ 422.503(b)(4)(vi)(G)
I. Title 42, Code of Federal Regulations (C.F.R.), §§ 423.504(b)(4)(vi)(G)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	08/01/2014	MA.9124	CMS Self Disclosure	OneCare
Revised	12/01/2014	MA.9124	CMS Self Disclosure	OneCare
Revised	09/01/2015	MA.9124	CMS Self Disclosure	OneCare OneCare Connect PACE
Revised	12/01/2016	MA.9124	CMS Self Disclosure	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers that Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Program	The program (including, without limitation, this Compliance Plan, Code of Conduct and Policies and Procedures and Procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Member, Employees and FDRs comply with applicable law and ethical standards.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services, or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Department of Health Care Services	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Grievance	Any Complaint, other than one involving an Organization Determination, expressing dissatisfaction with any aspect of CalOptima's, a Physician Medical Group's, or a Provider's operations, activities, or behavior, regardless of any request for remedial action.
Member	A beneficiary who is enrolled in a CalOptima Program.
Self Disclosure	The act of voluntarily notifying the compliance governing body of a non-compliance incident.

Non- Compliance Self Disclosure Form

Person Submitting Form

Department Name or Organization (Vendor):	**Department (Vendor) Contact Name and Phone Number (Vendor address if applicable):**
Date Non-Compliance Allegation Received	**Date of Non- Compliance:**
Summary of Issue:	
Root Cause:	
Member Impact (if applicable, how many member's, which member's?)	

Non- Compliance Information

Who Caused the issue?	**Who was affected by the problem?**
Remediation Taken: (Step by Step of Who , What, When and Where)	
Proof of Remediation:	
How will Dept./ Vendor prevent this from happening again?	

For Compliance Only

☐ **Corrective Action Plan**	☐ **Retrain**	☐ **No action Required**	☐ **Other**

CAP			
Compliance Findings:			

Compliance Officer Signature	**Date:**

Policy #: HH.4002Δ
Title: **CalOptima Internal Oversight**
Department: Office of Compliance
Section: Audit & Oversight (Internal)

CEO Approval: Michael Schrader _____

Effective Date: 12/01/16
Last Review Date: Not Applicable
Last Revised Date: Not Applicable

I. PURPOSE

This policy defines the process for internal Monitoring and oversight of CalOptima to ensure compliance with statutory, regulatory, contractual, and CalOptima policy requirements.

II. POLICY

A. The Audit and Oversight Department shall establish protocols to ensure compliance risks are identified and conduct effective Auditing and Monitoring of internal department processes, and outcomes within CalOptima to ensure continuous improvement of Member care, administrative processes, and management.

B. The Audit and Oversight Department shall perform an annual risk assessment as outlined in CalOptima Policy HH.4003: Annual Risk Assessment and develop an annual Internal Audit and Monitoring Work Plan.

1. The risk assessment and Internal Audit and Monitoring Work Plan will incorporate, at minimum, current Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) contractual requirements, Department of Managed Health Care (DMHC) Technical Assistance Guides, CMS program audit process and protocols, National Committee of Quality Assurance (NCQA) standards, and any identified high-risk areas related to the CalOptima Medi-Cal, OneCare, OneCare Connect, and PACE programs.

C. Every CalOptima department identified on the Internal Audit and Monitoring Work Plan (hereinafter, the Work Plan) will be subject to Audit and/or routine Monitoring, and Focused Reviews.

D. The Work Plan shall identify the functional area subject to Audit and describe the schedule of Audits to be conducted by the Audit and Oversight Department in the coming year. The Work Plan shall also identify specific functional areas that require continuous Monitoring.

E. The Audit and Oversight Department shall identify through internal Audits and Monitoring activities, risk assessments, or regulatory Audits, functional areas requiring improvement, and shall Monitor performance to ensure performance meets applicable regulatory and industry standards. In the event Monitoring results reveal deficiencies, the internal department(s) will be subject to a Focused Review.

F. CalOptima shall continually assess a functional area's ability to perform functions through initial reviews, on-going Monitoring, performance reviews, analysis of data and reports, against industry, regulatory or quality benchmarks, when available.

G. Audits of CalOptima's internal functional areas will be conducted, at minimum, annually by desktop review.

H. CalOptima's Audit and Oversight Department shall maintain documentation of Internal Oversight activities described herein.

I. The Auditing and Monitoring results shall be reported to the Audit and Oversight Committee (AOC), and the Compliance Committee for review and recommendations. When appropriate, CalOptima's Regulatory Affairs & Compliance Department shall inform CMS, DHCS, DMHC, National Benefit Integrity Medicare Drug Contractor (NBI MEDIC), or law enforcement of aberrant findings that may cause harm, or impact the delivery of care to CalOptima Members.

III. PROCEDURE

A. CalOptima shall conduct activities in accordance with the terms and conditions of CalOptima contracts with the CMS and/or the DHCS, DMHC Full Service Technical Assistance Guides, the CalOptima Contract with DHCS, the three-way contract between CalOptima, CMS, and DHCS, and NCQA certification requirements.

B. CalOptima shall provide Internal Oversight using, without limit, the following components:

1. Desktop reviews;

2. Focused and ad hoc reviews and audits and monitoring;

3. Periodic reviews and audits; and

4. On-going monitoring.

C. Functional areas shall include, without limit:

1. Credentialing, recredentialing and facility site review;

2. Utilization management, including but not limited to the following activities, decision making timeliness, clinical decisions, Member and Provider notifications, provision of Emergency Services, structure;

3. Claims processing/adjudication and payment timeliness;

4. Provider disputes and claim appeals;

5. Member rights;

6. Customer service;

7. Grievance and appeals;

8. Provider network adequacy;

9. Pharmacy;

10. Communication services, including but not limited to, cultural & linguistic services, and alternative formats;

11. Access and availability, including compliance with the Americans with Disabilities Act (ADA);

12. Systems utilized to carry out business functions; and

13. Reporting and Monitoring.

D. The Audit and Oversight Department shall develop comprehensive audit tools for Internal Oversight of the focus areas as described in Section III.C. of this policy, in consultation with subject matter experts including CalOptima operational departments, Regulatory Affairs & Compliance, and Legal, as necessary. The Audit and Oversight Department shall review and update audit tools in collaboration with the respective subject matter experts annually, or more often, based upon regulatory, contractual, and accreditation changes.

E. Annual Audit Oversight Process

1. At least annually, the Audit and Oversight Department shall identify and schedule an Audit as a result of the annual risk assessment, focused Audit findings, deficient Monitoring results, Fraud, Waste, and Abuse (FWA), or program Audit findings. Internal Oversight Audits are required annually and shall be conducted as desktop Audits.

2. The Audit will evaluate, at a minimum, performance with applicable statutes, regulations, and compliance with CalOptima policies and procedures.

3. Two (2) weeks prior to the scheduled Audit, the Audit and Oversight Department will send, via email, the CalOptima department management staff a notice confirming the date and scope of the Audit. The notice will include a description of any universes required, the Audit period, the due date, method of delivery, and Audit format. The Audit and Oversight Department shall utilize industry standard Audit protocols and appropriate methods for Auditing with respect to tools, sample size, data mining, etc.

4. Upon receipt of the requested universe(s), the assigned Audit and Oversight auditor shall select a sample size as determined by Audit and Oversight that is appropriate for the type of Audit being conducted:

   a. Processes considered to be high-risk and/or have potential Member harm;

   b. Compliance with CMS, DHCS, DMHC, and NCQA-mandated elements or contractual obligations; and

   c. Areas identified as deficient in previous Audits.

5. If the minimum number of cases is not available in the universe the auditor may elect to expand the Audit period or request additional information, or documentation.

6. The Audit and Oversight auditor will notify the CalOptima department of samples selected and documentation required seven (7) calendar days prior to the Audit when provided in electronic format or when sample files are supplied in alternate formats.

a. The Audit and Oversight auditor shall review sample cases shall review and functional areas shall submit samples and documentation electronically whenever possible.

b. The Audit and Oversight auditor may, at his or her discretion, request additional materials during the review.

7. The audit will include validation of documentation, including but not limited to CalOptima policies and procedures, training, reports, systems, and file review(s).

8. The Audit and Oversight auditor shall discuss findings from the annual audit with the respective CalOptima department and document such findings in an audit findings report. If any CalOptima department receives a score of less than the established passing score for an individual audit element, the department will be required to develop a Corrective Action Plan in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

a. The Audit and Oversight auditor shall have ultimate responsibility remediation, monitoring, and reporting of the CAP to the AOC. The Audit and Oversight auditor shall report the findings of the audit, CAPs, if any, and the timeline for CAP remediation to the AOC.

9. Audit findings will be presented to the AOC by the Audit and Oversight auditor for the respective functional area reviewed. The Audit and Oversight Department shall determine any follow up activities, process improvement, and/or additional review based on the recommendations of the Audit and Oversight auditor.

10. A department must resolve the elements of the CAP in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

11. In the event the elements of the CAP are not successfully completed within ninety (90) calendar days, the Director of Audit and Oversight shall report status to the AOC following the CAP period. The AOC will review the outstanding CAP items to determine, at its discretion, whether the CAP deadline should be extended.

a. The Audit and Oversight auditor must demonstrate to the AOC the appropriateness for an extension and provide a detailed action plan to ensure that the items for correction are being addressed in a timely manner.

12. The Audit and Oversight Department shall determine whether ad hoc audits, reviews, and or other remediation or actions are necessary to resolve identified issues. Issues escalated will be reviewed by the Audit and Oversight Department, AOC, and the Compliance Committee, as applicable.

F. Ongoing Internal Oversight Process

1. The Audit and Oversight Department will conduct on-going Internal Oversight of the business areas outlined in Section III.C. of this policy based on the level of risk determined as part of the annual risk assessment, and as outlined on the Internal Audit and Monitoring Work Plan.

2. Internal Dashboard Reporting: On a monthly basis, data shall be used to Monitor areas of processing timeliness and accuracy of business activities.

a. The AOC shall Monitor dashboard results and may make recommendations for corrective action if performance falls below the standard defined by the AOC.

b. If there is a consistent pattern of noncompliance, the Audit and Oversight Department shall conduct a Focused Review.

i. If the results of the Focused Review are unfavorable, the auditor will escalate for further action. This includes, but is not limited to, reporting the issue up to Compliance Committee for disciplinary action and/or development of remediation plan.

G. Corrective Action Plan

1. If any area of deficiency or non-compliance is identified, including but not limited to, Member or Provider Complaints, readiness assessment reviews, regular reports, oversight reviews, and ongoing Monitoring, the Audit and Oversight Department will be required to issue a CAP request, in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy AA.1000: Glossary of Terms
F. CalOptima Policy CMC.1001: Glossary of Terms
G. CalOptima Policy HH.2005Δ: Corrective Action Plan
H. CalOptima Policy HH.4003 Annual Risk Assessment
I. CalOptima Policy MA.1001: Glossary of Terms
J. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services(DHCS) for Cal MediConnect
K. Title 42, Code of Federal Regulations (C.F.R.), §455.2
L. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	12/01/16	HH.4002Δ	CalOptima Internal Oversight	Administrative

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Business Owner	CalOptima management and staff vested in the compliance of their respective CalOptima functional area in accordance with statutory, regulatory, contractual, and CalOptima policy requirements.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Department of Managed Health Care (DMHC)	The California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code, Sections 1340 *et seq*.
Focused Review	An audit that specifically targets areas of potential deficiency.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. Section 1347.)

Term	Definition
Internal Audit and Monitoring Work Plan	An outline of goals and objectives to define the audit scope for internal functional areas to ensure health plan compliance, as well as conduct on-going performance measurements to determine opportunities for improvement and/or the effectiveness of interventions.
Internal Oversight	The process by which CalOptima's Audit and Oversight Department conducts audits to monitor internal functional areas in accordance with regulatory, statutory, contractual, and CalOptima policy requirements to ensure health plan compliance.
Member	A beneficiary who is enrolled in a CalOptima Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
National Committee for Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

2

Policy #:	HH.4003Δ
Title:	**Annual Risk Assessment (Internal)**
Department:	Office of Compliance
Section:	Audit & Oversight (Internal)
CEO Approval:	Michael Schrader _____
Effective Date:	12/01/16
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the internal annual risk assessment process conducted by the CalOptima Audit and Oversight Department to identify specific areas vulnerable to potential Compliance risk. Such areas are documented in CalOptima's Risk Assessment, which will influence the development of CalOptima's Internal Audit and Monitoring Work Plan.

II. POLICY

A. The Audit and Oversight Department is responsible for completing a risk assessment, at least annually, to develop its Internal Audit and Monitoring Plan that provides a comprehensive assessment of CalOptima. In assessing risk, the Audit and Oversight Department shall consider the following:

1. Statutory, regulatory, and contractual standards;
2. CalOptima policies and procedures;
3. Business impact on Member care; and
4. Past compliance issues (e.g., CAPs, Regulator Notices); and.
5. Compliance dashboard results.

B. The Audit and Oversight Department shall stay current with all regulatory communication and guidance from the regulatory agencies.

C. The Audit and Oversight Department shall present annual risk assessment results and the proposed Internal Audit and Monitoring Work Plan to the Compliance Committee for review and approval by the end of the fiscal year to be effective for the following year.

III. PROCEDURE

A. The Audit and Oversight Department shall schedule meetings with all operational department leads in order to complete the assessment.

1. Discovery and Analysis. The Audit and Oversight Department shall undertake a discovery process to determine which regulatory, statutory, regulatory, contractual, and CalOptima policy requirements are completely implemented, their operational effectiveness, and how the practices and the documentation support compliance. The discovery process shall consist of document

review, an interview process, and review of other relevant information. The analysis component of risk assessment is based on the evaluation of the data from the business area.

1. In order to determine whether there are accurate and compliant processes and systems in place, the Audit and Oversight Department shall conduct the following activities:

   i. A review of CalOptima policies and procedures and other supporting documents, such as regulatory communications. For each internal area reviewed in the risk assessment process, the Audit and Oversight Department shall request from the applicable department the policies and procedures and supporting documentation that describe processes used to meet regulatory requirements. The Audit and Oversight Department shall evaluate the documents for compliance and provide a risk score that is entered into the Annual Risk Assessment Tool.

   ii. Schedule interviews with internal functional area department management and relevant support staff to discuss the following:

      a) Processes that are supported by policies and procedures and other relevant documentation;

      b) Changes in laws or regulations in the previous year that impact their area;

      c) Changes in management and staffing; and

      d) The degree to which the activities conducted by their area impact CalOptima Members; and

      e) Material changes in processes that are expected to impact the functional areas.

B. The Audit and Oversight Department shall review the following information for internal areas, and the appropriate operational department shall review the following information as part of the risk assessment process:

1. Regulatory agencies identify a particular area as problematic through enforcement actions, CalOptima audit findings, notices of non-compliance, etc.;

2. Whether there is a Corrective Action Plan (CAP) in effect, and if so, its relative risk for the non-compliant area; and

3. CalOptima's Star Ratings scores for specific requirements, to be populated as applicable.

C. Analysis. To validate compliance of the staff interviews, and review of other relevant information, the Audit Oversight Department shall rely on data gathered using the Annual Risk Assessment Tool, and conduct baseline risk assessment audits evaluating file reviews, data collected from annual Audit results, and number of CAPs issued during the review period.

1. As data-driven analysis is significant to determine functional area risk to Members, the Audit and Oversight Department shall compile the data, using the scoring methodology for the risk assessment tool and then ranks the risks based on the greatest impact.

D. The Audit and Oversight Department shall prioritize those with greatest risk when developing the annual Audit and Monitoring plan.

E. The Audit and Oversight Department shall present the internal risk assessment results and proposed Audit and Monitoring plan following approval by the Compliance Committee.

F. The Audit and Oversight Department shall re-evaluate the risk plan based on internal changes (e.g., staffing and organizational structure changes, internal audit results, monitoring results, etc.) and external changes (e.g., regulatory changes, marketplace changes, regulatory agency audits results).

G. Upon completion, results of the internal risk assessment are presented to the Audit Oversight Committee (AOC) and the Compliance Committee.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Compliance Plan

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	12/01/2016	HH.4003Δ	Annual Risk Assessment (Internal)	Administrative

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Annual Risk Assessment Tool	A tool utilized to stratify level of risk (high, medium, low) based upon audit results and corrective actions issued to identify specific CalOptima functional areas vulnerable to potential Compliance risk.
Centers for Medicare & Medicaid Services	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of the Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.
Corrective Action Plan	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Department of Health Care Services	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. Section 1347.)

Term	Definition
Internal Audit and Monitoring Work Plan	An outline of goals and objectives to define the audit scope for internal functional areas to ensure health plan compliance, as well as conduct on-going performance measurements to determine opportunities for improvement and/or the effectiveness of interventions.
Member	A beneficiary who is enrolled in a CalOptima Program.
Monitor	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Regulatory Agencies	For the purposes of this policy, regulatory agencies include Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Office of Inspector General (OIG), and Office of Civil Rights.
Waste	Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1

Policy #:	HH.5000Δ
Title:	**Provider Overpayment Investigation and Determination**
Department:	Office of Compliance
Section:	Fraud, Waste, and Abuse – Special Investigations Unit
CEO Approval:	Michael Schrader _____
Effective Date:	12/01/16
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy establishes an effective system for the review of suspect claims to detect and prevent Fraud, Waste, and Abuse (FWA) within a CalOptima program, in accordance with federal and state regulations, and to identify resulting Overpayments for recoupment.

II. POLICY

A. The CalOptima Special Investigations Unit (SIU) shall be responsible for identifying Overpayments and recoupment opportunities that may emerge in the course of a FWA investigation.

B. During the course of an investigation, the SIU team shall review claims and/or billing activity to either verify if services were rendered, or if services were appropriately billed, as applicable.

C. CalOptima may receive complaints of suspected FWA from any of the following sources, including but not limited to:

1. Compliance and Ethics Hotline;
2. Internal audits;
3. Internal operational reviews;
4. External audits, including audits conducted by consultants and regulatory agencies;
5. FWA software runs;
6. Pharmacy Benefits Manager (PBM);
7. Compliance Committee;
8. Audit and Oversight Committee;
9. Internal department referrals;
10. Claims auditors who review provider claims through the claims review software system;

11. Internal and external claims and compliance audits; and

12. Any other source that identifies potential FWA.

III. PROCEDURE

A. Identification of Overpayments

1. CalOptima's SIU team shall investigate any identified Overpayments that are suspected to be the result of inappropriate and/or inaccurate billing activity.

2. Upon referral to CalOptima's SIU team, the SIU team shall utilize investigation software/tools to identify suspicious billing patterns, or industry-identified FWA trends to determine whether CalOptima disbursed an Overpayment to a Provider.

   a. Suspicious billing patterns or trends may include, but are not limited to, Providers who:

      i. Bill an unusually large percentage of their claims with modifiers;

      ii. Bill a large proportion of Evaluation and Management (E/M) Codes; or

      iii. Prescribe an unusual amount of Schedule II Medications in relation to their peers.

3. During the course of an investigation, the SIU team shall review claims and/or billing activity to either verify if services were rendered, or if services were appropriately billed, as applicable.

B. Investigation Protocol of Overpayments

1. During the course of an investigation, CalOptima's SIU team may identify actual or potential Overpayments that are suspected to be the result of inappropriate and/or inaccurate activity.

2. FWA investigations may identify inappropriate and inaccurate activity pursuant to various activities, including but not limited to, inbound complaints, proactive data analysis, collaboration meetings with internal and external departments, and Centers for Medicaid & Medicare Services (CMS) Health Plan Management System (HPMS) memorandums.

3. CalOptima's SIU investigation may include the following elements:

   a. Interviews with Members, Providers, and witnesses;

   b. Data analysis, including but not limited to, analysis of claims billing, payment trends, and procedure code combinations, etc.;

   c. Review of Medical Records by the SIU investigator, or, for complex reviews, a clinician, such as, a Registered Nurse (RN), Licensed Vocational Nurse (LVN), Medical Doctor (MD), and Doctor of Pharmacy (Pharm. D); and

   d. All relevant and pertinent data/information, as appropriate, that will aid in completing the investigation to closure.

4. If CalOptima's SIU investigation yields findings, and if an Overpayment is determined to be an appropriate administrative action that is based on potential FWA, inappropriate and/or inaccurate billing, SIU shall proceed with Overpayment recoupment activities. SIU shall provide guidance to CalOptima Claims Department, including drafting the content of overpayment letters and instructions for referring calls from Providers regarding FWA Overpayments to SIU.

C. Documentation

1. If SIU identifies an Overpayment as a result of an investigation, an "Overpayment Spreadsheet" shall be provided by CalOptima SIU team in detail with each determination to the Claims Department.

2. The "Overpayment Spreadsheet" shall include the minimum necessary information to adequately review, investigate, and determine if claims were overpaid. The "Overpayment Spreadsheet" may include the following details, as applicable:

   a. Member name;

   b. Unique Member identification (ID) number;

   c. Claim number;

   d. HCPCS/CPT Code;

   e. ICD-9 and/or ICD-10 codes;

   f. Revenue codes;

   g. Date(s) of service;

   h. Number of services billed;

   i. Number of units allowed;

   j. Billed amount;

   k. Allowed amount;

   l. Paid amount;

   m. Overpayment amount; and

   n. Denial reason.

D. Resolution

1. Once CalOptima's SIU investigation has identified an Overpayment, the Overpayment shall be referred to CalOptima Claims Department for Overpayment set up, collection, and recoupment.

2. CalOptima's SIU Team shall review and educate Providers about billing protocols to minimize future occurrences of Overpayments.

3. CalOptima's SIU shall notify the Department of Health Care Services (DHCS) and/or the Centers for Medicare & Medicaid Services (CMS) of Overpayment determinations, as required by law and state and federal regulations, in accordance with CalOptima Policy HH.1107Δ: Fraud, Waste, and Abuse Investigation and Reporting and as required by law and state and federal regulations, but no later than sixty (60) calendar days after the date CalOptima identified the overpayment.

4. When the Overpayment is the result of inappropriate and/or inaccurate billing, and contains a component of FWA, SIU shall refer such Overpayment determinations to the CalOptima Claims Department for recoupment.

    a. FWA overpayment determinations may be the result of FWA findings, including but not limited to:

        i. Providers failing to provide appropriate documentation in the Medical Record;

        ii. Improbable medical circumstances, including but not limited to, billing for services in excess of twenty-four (24) hours a day, billing for services rendered to a deceased Member, billing for three (3) hip replacements, or prescribing Acquired Immunodeficiency Syndrome (AIDS) or Hepatitis C medication to a Member with no diagnosis of such disease;

        iii. Services not rendered, but billed for, or

        iv. Services provided after the Provider has been suspended by a licensing board or government entity.

5. If, the claim(s) review, determines that the billing was improperly paid and if the payment was determined to be based on inappropriate and/or inaccurate billing activity, and contains a component of FWA, CalOptima's SIU shall:

    a. Document the rationale for assessing the Overpayment;

    b. Initiate recoupment process of the Overpayment through appropriate channels, including coordination with the CalOptima Claims Department;

    c. Send the Provider the required demand letter, signed by SIU staff;

    d. Continue collection activity, as necessary; and assist respective department(s) as needed with investigation in coordination with the CalOptima Claims Department.

    e. Notify the Department of Health Care Services (DHCS) and/or the Centers for Medicare & Medicaid Services (CMS) of Overpayment determinations, in accordance with CalOptima Policy HH.1107Δ: Fraud, Waste, and Abuse Investigation and Reporting and as required by law and state and federal regulations, but no later than sixty (60) calendar days after the date CalOptima identified the overpayment.

6. If DHCS issues a credible allegation of fraud as described in CalOptima Policy HH.1107Δ: Fraud, Waste, and Abuse Investigation and Reporting. CalOptima shall initiate recoupment of overpayments in according to Section III. D. of this policy.

7. If, the claim(s) review, determines that the billing was improperly paid and if the payment was determined to be based on inappropriate and/or inaccurate billing activity, and does not contains a component of FWA, CalOptima's Claims Administration Department shall follow up with standard recoupment process.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. California Health and Safety Code §1371
B. CalOptima Policy HH.1107Δ: Fraud, Waste, and Abuse Investigation and Reporting
C. CMS Guidance for Reporting Medicare Advantage Organization and/or Sponsor Identified Overpayments for CMS
D. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-026: Actions Required following Notice of a Credible Allegation of Fraud
E. Social Security Act, §1128J(d)
F. Title 22, California Code of Regulations, §§51045, 51047, 51458.1
G. Title 28, California Code of Regulations, §1300.71
H. Title 42, Code of Federal Regulations, §§405.980, 405.982, 405.984, 405.986, 405.978, 405.990, 422.326 and 423.360
I. Title 42, Code of Federal Regulations, §§411.404, 411.406, 411.408
J. Title 45, Code of Federal Regulations, §79
K. Welfare and Institutions Codes, 14172, 14172.5, 14173, 14176, 14177

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	12/01/2016	HH.5000 Δ	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347.)
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history.
Overpayment	For purposes of this policy, a payment disbursed in excess amounts properly payable under Medicare and Medi-Cal statutes and regulations.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, , Physician Medical Group, or other person or institution who furnishes Covered Services.
Schedule II Medication	Narcotic substances with a high potential for abuse which may lead to severe psychological or physical dependence.
Waste	Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Policy #:	MA.5004
Title:	**Health Network Sub-delegation and Sub-contracting**
Department:	Office of Compliance
Section:	Audit & Oversight
CEO Approval:	Michael Schrader _____
Effective Date:	8/1/05
Last Review Date:	9/1/15
Last Revised Date:	9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect

I. PURPOSE

To detail requirements and processes required for Health Network Sub-delegation and sub-contracting.

II. DEFINITIONS

Term	Definition
Center for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), or designated representatives. Delegates may be required to complete CAPs to ensure they are in compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements identified by CalOptima and its regulators.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California). DHCS is generally referred to as the state in this document.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network. For the purposes of this policy, the term Health Network shall include Health Network(s) (PMGs).

Term	Definition
Management Services Organization (MSO)	A healthcare entity providing management and administrative support service on behalf of the delegated medical group.
Physician Medical Group (PMG)	A group practice, independent practice association, or other formal business arrangement comprised of individuals, each of whom holds an unrestricted license to practice medicine or osteopathy in the state in which they practice, and which participates with a Hospital in a PHC or holds a shared risk contract with CalOptima.
Sub-delegation	The process by which a Health Network expressly grants, by a formal agreement, to a sub-delegated entity the authority to carry out a function that would otherwise be required to be performed by the Health Network in order to meet its obligations under the Health Network Service Agreement.
Sub-contracting	A written agreement entered into by the Contractor with any of the following: a. A provider of health care services who agrees to furnish Covered Services to Members. b. Any other organization or person(s) who agree(s) to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor's obligations to CMS.

III. POLICY

A. Sub-delegation

1. Except as otherwise limited by the CalOptima Service Agreement or CalOptima policies, a Health Network may delegate required administrative functions to a Management Services Organization (MSO), medical group, or Independent Practice Association (IPA).

2. Sub-delegation shall not absolve a Health Network of oversight responsibilities or ultimate obligation and responsibilities set forth in the CalOptima Service Agreement.

   a. The Health Network may provide a sub-delegated entity the authority to act on behalf of the Health Network, but the Health Network retains oversight and accountability for the delegated function.

   b. The Health Network shall not abdicate responsibility for the function performed by a sub-delegated entity according to the requirements of the CalOptima Service Agreement and those established by CalOptima policies.

3. A Health Network shall obtain CalOptima's written approval for Sub-delegation, in accordance with the terms and conditions of this policy.

4. A Health Network shall provide CalOptima with written evidence of Sub-delegation including:

a. A copy of the written agreement that meets all requirements of the CalOptima Service Agreement and CalOptima policies and includes the following:

   i. The sub-delegated entity shall comply with all applicable Medicare laws, regulations, Centers for Medicare & Medicaid Services (CMS) instructions, and Department of Health Care Services (DHCS).

   ii. The sub-delegated entity shall comply with all state and federal confidentiality requirements;

   iii. The sub-delegated entity shall grant the Department of Health and Human Services (DHHS), the Comptroller General, or their designees the right to inspect all pertinent information related to the contract during the contract term and for ten (10) years from the final date of the contract period, and in certain instances described in the regulation, periods in excess of ten (10) years;

   iv. The Health Network shall have the right to revoke the delegation if the sub-delegated entity fails to perform in a satisfactory manner; and

   v. The sub-delegated entity shall meet all applicable credentialing requirements.

b. A description of the relationship between the Health Network and the sub-delegated entity including the following information:

   i. The delegated functions;

   ii. The responsibilities of the Health Network and the sub-delegated entity;

   iii. The frequency of reporting and reviewing the sub-delegated entity's performanceof the delegated functions;

   iv. The process by which the Health Network evaluates the sub-delegated entity's performance; and

   v. The Health Network's remedies if the sub-delegated entity fails to fulfill its obligations including revocation of the delegation.

c. A description of the Health Network's process by which it evaluates and selects the sub-delegated entity to perform the delegated functions, including the sub-delegated entity's score on a selection tool, if any; and

d. A record of the Health Network's ongoing oversight process, as requested by CalOptima including:

   i. The Health Network's annual evaluation of whether the sub-delegated entity is performing the delegated functions in accordance with the CalOptima Service Agreement and the Centers for Medicare & Medicaid Services (CMS) instructions, and Department of Health Care Services (DHCS);

ii. The Health Network's review of the sub-delegated entity's regular reports; and

iii. Reports and data required to be submitted to CalOptima.

5. A Health Network shall terminate, as soon as practical, to meet the health care needs of Members upon receiving written notification from CalOptima, any delegation that fails to meet standards established by CalOptima or any requirement in the CalOptima Service Agreement or CalOptima policy MA.7014: Delegation Oversight.

6. A Health Network shall report to CalOptima in accordance with all requirements established in the CalOptima Service Agreement and CalOptima policies, data and information that includes and encompasses all of the Health Network's membership, including those receiving services from a sub-delegated entity.

7. A Health Network shall audit a sub-delegated entity no less than once in any twelve (12) month period.

8. A Health Network shall establish standards and performance requirements for the delegated function(s) and requirements for a sub-delegated entity to meet, or exceed, all requirements of the Health Network in the CalOptima Service Agreement and CalOptima policy MA.7014: Delegation Oversight.

9. If a sub-delegated entity fails to meet performance requirements, the Health Network shall place the sub-delegated entity on a Corrective Action Plan (CAP). The CAP shall meet the requirements of CalOptima policy MA.9104: Corrective Action Plan and detail:

   a. The sub-delegated entity's deficiencies;

   b. Specific steps, tasks, and activities to bring the sub-delegated entity into compliance; and

   c. A timeline for completion of corrective action and to achieve compliance with performance requirements.

10. A Health Network shall notify CalOptima of any sub-delegated entity providing services to Members that is on a CAP. The Health Network shall provide CalOptima with a copy of the CAP upon request.

B. Sub-contracting

1. A Health Network may subcontract certain functions required by the CalOptima Service Agreement, in accordance with CalOptima policies.

2. A Health Network shall ensure that a subcontract is in writing and includes all provisions required by the CalOptima Service Agreement.

3. A Health Network shall inform CalOptima of a subcontractor's name and business address.

4. A Health Network shall include the following in a subcontract that relates to the provision of Covered Services:

   a. The subcontractor shall make all books and records relative to the provision of and reimbursement for items and services furnished by the subcontractor to the Health Network available at all reasonable times for inspection, examination, or copying by CalOptima or duly authorized representatives of the state or federal government;

   b. The subcontractor shall maintain such books and records:

      i. In accordance with the general standards applicable to such books and records and any record requirements in the CalOptima Service Agreement and CalOptima policy MA.9106: Record Retention and Access; and

      ii. At the subcontractor's place of business or at such other mutually agreeable location in California.

   c. The subcontractor shall establish and maintain access to Medical and Administrative Records as set forth in the CalOptima Service Agreement and CalOptima policy MA.9106: Record Retention and Access;

   d. The subcontractor shall ensure access to premises as set forth in the CalOptima Service Agreement and CalOptima policy MA.9106: Record Retention and Access;

   e. The subcontractor shall provide Covered Services to Members in the same manner that it provides such services to other patients;

   f. The subcontractor shall notify the Health Network of any investigation of a sub-contractor's professional conduct or any suspension of, or comment on, a subcontractor's professional licensure, whether temporary or permanent;

   g. The subcontractor shall comply with the CalOptima Compliance Program as described in CalOptima policy MA.9101: Compliance Program;

   h. The subcontractor shall comply with the CalOptima Approved Drug List, as set forth in the CalOptima Service Agreement and in CalOptima policies;

   i. The subcontractor shall comply with all applicable Medicare laws, regulations, and CMS and DHCS instructions;

   j. The subcontractor shall comply with all state and federal confidentiality requirements;

   k. The subcontractor shall meet all applicable credentialing requirements;

   l. The subcontractor shall grant DHHS, the Comptroller General, or their designees the right to inspect all pertinent information related to the contract during the contract term and for ten (10) years from the final date of the contract period, and in certain instances described in the regulation, periods in excess of ten (10) years;

m. The Health Network shall have the right to revoke the subcontract if the subcontractor fails to perform in a satisfactory manner.

IV. PROCEDURE

A. A Health Network shall notify the CalOptima Audit and Oversight Department of any sub-delegation or sub-contracted relationships in writing.

B. The Audit and Oversight, Compliance, and Regulatory Affairs Department staff shall review requests for approval of delegation submitted by a Health Network.

C. CalOptima's review may include:

1. Site visits with the prospective sub-delegated entity;

2. Audits;

3. Interviews of the prospective sub-delegated entity staff;

4. Assessment of the prospective sub-delegated entity obtained from other clients or patients of the prospective sub-delegated entity;

5. Demonstration of capabilities by the prospective sub-delegated entity;

6. Review of the prospective sub-delegated entity's financial reports, statements, and audits; and

7. Background investigations of the prospective sub-delegated entity and key staff of the prospective sub-delegated entity.

D. Upon completion of the initial review, CalOptima may approve Sub-delegation, deny Sub-delegation, or approve Sub-delegation with corrective action requirements.

1. CalOptima shall notify the Delegate of its determination in writing within thirty (30) days of the initial review.

2. If CalOptima approves Sub-delegation with corrective action requirements, CalOptima shall detail corrective action requirements in a Corrective Action Plan (CAP) provided to the Health Network and the sub-delegated entity.

a. The Health Network and the sub-delegated entity shall comply with the corrective action requirements within the time frames specified in the CAP.

b. The Health Network and the sub-delegated entity shall document meeting all requirements of any CAP to CalOptima.

c. CalOptima may further review the sub-delegated entity to confirm that the sub-delegated entity met requirements of the CAP.

d. CalOptima may require further corrective action or may approve or deny Sub-delegation upon review of actions taken by the sub-delegated entity to meet requirements of any CAP.

V. ATTACHMENTS

Not Applicable

VI. REFERENCES

A. CalOptima Policy MA.7014: Delegation Oversight
B. CalOptima Policy MA.9101: Compliance Program
C. CalOptima Policy MA.9104: Corrective Action Plan
D. CalOptima Policy MA.9106: Record Retention and Access
E. County Organized Health Systems Boilerplate Contract - CalOptima County Organized Health Systems Boilerplate Contract - dba CalOptima 08-85214 A15
F. United States Department of Health and Human Services Centers for Medicare & Medicaid Services In Partnership with California Department of Health Care Services and Orange County Organized Health System - dba CalOptima

VII. REGULATORY APPROVALS

Not Applicable

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	08/01/2005	MA.5004	Health Network Sub-delegation and Sub-contracting
Revision Date 1	09/01/2015	MA.5004	Health Network Sub-delegation and Sub-contracting

Policy #: MA.9112
Title: **Claims Delegation and Oversight**
Department: Office of Compliance
Section: Audit &Oversight
CEO Approval: Michael Schrader

Effective Date: 8/1/05
Last Review Date: 9/1/15
Last Revision Date: 9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To ensure a delegated Health Network or Physician Medical Group (PMG) is in compliance with statutory, regulatory, contractual, CalOptima policy, and other claims processing requirements.

II. DEFINITIONS

Term	Definition
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), or designated representatives. Delegates
Health Network	For purposes of this policy, a Physician Hospital Consortium (PHC), Physician Medical Group (PMG), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.

III. POLICY

A. CalOptima may delegate the processing and adjudication of claims to a Health Network or PMG for services rendered to Members, in accordance with the CalOptima Division of Financial Responsibility (DOFR), as set forth in the CalOptima Health Network Service Agreement.

B. CalOptima shall maintain ultimate responsibility for all delegated claims activities.

C. CalOptima shall conduct ongoing monitoring of a delegated Health Network, or PMG, including an annual performance review, to ensure that the delegated Health Network, or PMG, adheres to claims

processing standards, as set forth in CalOptima Policy MA.9129: Health Network Claims Processing.

D. The Audit and Oversight Department shall conduct a pre-delegation assessment of an HN or PMG to determine the Health Network's or PMG's ability to implement delegated claims activities, prior to delegating such activities.

E. CalOptima may impose Sanctions against a delegated Health Network or PMG based on such Health Network's or PMG's or its agent's failure to comply with any statutory, regulatory, contractual, CalOptima policy and other requirements related to CalOptima , in accordance with CalOptima Policy MA.9105: Sanctions.

IV. PROCEDURE

A. Pre-delegation Assessment

1. The pre-delegation assessment shall consist of a comprehensive on-site assessment, utilizing the Readiness Assessment Tool, and shall evaluate the Health Network's capacity to successfully administer all delegated functions, including, but not limited to, the Health Network's ability to:

   a. Process claims and all claims related functions in a timely manner; and

   b. Make claims determinations in accordance with applicable statutory, regulatory and contractual requirements.

2. The Auditor shall report the pre-delegation assessment results to the Delegation Oversight Committee.

3. The Delegation Oversight Committee shall determine if the Health Network or PMG meets CalOptima's criteria for delegation of claims activities, based on the Health Network's s pre-delegation assessment.

B. Monitoring

1. Audit and Oversight shall monitor a delegated Health Network's claims activities through routine audits, reports and continuous improvements activities.

2. A delegated Health Network or PMG shall submit reports to CalOptima on a periodic basis, as specified by CalOptima, including, but not limited to, those reports specified in the CalOptima Health Network Service Agreement and CalOptima policies.

3. A delegated Health Network shall forward copies of selected Claims notice of denial of payment letters to CalOptima for review. CalOptima's Audit and Oversight Department shall review the notice of denial of payment letters for appropriate denial language.

C. Performance Reviews

1. CalOptima shall conduct annual performance reviews of a delegated Health Network, or PMG, in accordance with CalOptima Policy MA.9103: Health Network Performance Review.

2. The delegated Health Network shall:

   a. Cooperate in furnishing information in response to performance reviews, the Corrective Action Plan (CAP) process, and validation reviews; and

   b. Make staff available during the performance review to answer questions and provide information necessary to complete the review.

3. The Audit and Oversight Department shall provide a delegated Health Network with the performance review report report after completing a performance review.

4. CalOptima may take the following actions, based on a performance review:

   a. Require a delegated Health Network to submit a CAP addressing all areas of deficiency, as determined by CalOptima, in accordance with Section IV.D of this policy;

   b. Audit a delegated Health Network's implementation and completion of an approved CAP, and any performance area that CalOptima required the Health Network or PMG to address in the CAP;

   c. Impose Sanctions against a delegated Health Network , in accordance with CalOptima Policy MA.9105: Sanctions; and

   d. Initiate the de-delegation process, in accordance with Section IV.E of this policy.

5. The Audit and Oversight Department shall report its findings from performance reviews and CAPs to theDelegation Oversight Committee , with recommendations for follow-up activities.

D. Corrective Action Plan

1. CalOptima may require a delegated Health Network to develop and submit a CAP for any area of deficiency or non-compliance related to delegated claims activities, in accordance with CalOptima Policy MA.9104: Corrective Action Plan.

E. De-delegation

1. The Audit and Oversight Department shall report all CAP activities to the Delegation Oversight Committee.

2. The Delegation Oversight Committee.shall review a delegated Health Network's delegation status based on the CAP timeline and level of achievement and recommendations from the Audit and Oversight Department.

3. If a delegated Health Network or PMG fails to achieve compliance within the timeframes set forth in the CAP, the Delegation Oversight Committee may recommend de-delegation of claims activities to the Compliance Committee.

4. The Compliance Committee may approve complete or partial de-delegation of claims activities from a delegated Health Network.

5. If the Compliance Committee approves de-delegation of claims activities from a delegated Health Network, CalOptima shall:

   a. Provide the Health Network with thirty (30) calendar day written notice of CalOptima's intent to de-delegate.

   b. Inform Members and Providers of the de-delegation and instructions for continued services;

   c. Adjust the Health Network's payments as appropriate to the de-delegated claims activities; and

   d. Prepare appropriate CalOptima departments to provide the de-delegated claims activities.

6. The Health Network shall cooperate with CalOptima to ensure smooth transition and continuous care for Members during the transition period.

7. CalOptima shall re-evaluate a Health Network's ability to perform delegated claims activities not less than twelve (12) months after de-delegation.

   a. CalOptima shall utilize the pre-delegation assessment process, as described in Section IV.A of this policy.

   b. CalOptima shall delegate claims activities to the Health Network based on the pre-delegation assessment results.

   c. If the Compliance Committee approves delegation of claims activities to the Health Network, CalOptima shall re-delegate such activities, and adjust the Health Network's or PMG's payment accordingly.

   d. If the Compliance Committee denies re-delegation of claims activities to the Health Network , it may recommend additional Sanctions on the Health Network or PMG, up to and including termination of the CalOptima Provider Service Agreement.

F. A delegated Health Network shall establish and maintain a Provider Appeal and dispute process.

G. A Health Network may file a Grievance with CalOptima, in accordance with CalOptimaPolicy MA.9006: Provider Compliant Process.

V. ATTACHMENTS

Not Applicable

VI. REFERENCES

A. OneCare Physician Medical Group Service Agreement
B. CalOptima Policy MA.1001: Glossary of Terms
C. CalOptima Policy MA.3101: Claims Processing
D. CalOptima Policy MA.9006: Provider Complaint Process
E. CalOptima Policy MA.9103: Physician Medical Group Performance Review

F. CalOptima Policy MA.9104: Corrective Action Plan
G. CalOptima Policy MA.9105: Contracted Provider Sanctions

VI. REGULATORY APPROVALS

None to Date

VII. BOARD ACTION

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	08/01/2005	MA.3102	Claims Delegation and Oversight
Revision Date 1	07/01/2007	MA.3102	Claims Delegation and Oversight
Revision Date 2	10/01/2012	MA.9112	Claims Delegation and Oversight
Revision Date 3	09/01/2015	MA.9112	Claims Delegation and Oversight

Policy #:	MA. 9117
Title:	**Annual Risk Assessment**
Department:	Office of Compliance
Section:	Compliance
CEO Approval:	Michael Schrader _____
Effective Date:	5/1/14
Last Review Date:	9/1/15
Last Revised Date:	9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To describe the Annual Risk Assessment Plan process CalOptima is taking to identify specific areas vulnerable to Fraud, Waste, or Abuse and potential Compliance risk. Such areas are documented in CalOptima's Risk Plan, which will influence the development of CalOptima's Internal Audit and Monitoring Plan.

II. DEFINITIONS

Term	Definition
Abuse	A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima programs, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima programs.
Centers for Medicare and Medicaid Services	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Compliance Committee	The CalOptima committee that consists of executive officers, leadership of key operating divisions, and legal counsel that implements and oversees CalOptima's Compliance Program.
Department of Health Care Services	The single State Department responsible for administration of the Medi-Cal Program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Downstream Entity	Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
First Tier, Downstream, and Related Entities (FDR)	FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.

Term	Definition
First Tier Entity	Any party that enters into a written arrangement with CalOptima to provide administrative services or health care services to a Medicare or Medicaid eligible individual under the CalOptima program.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i)
Member	An enrollee-beneficiary of a CalOptima program.
Regulatory Agencies	For the purposes of this policy, regulatory agencies include Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Office of Inspector General (OIG), and Office of Civil Rights.
Related Entity	Any entity that is related to CalOptima by common ownership or control and: 1. Performs some of the management functions under contract or delegation; 2. Furnishes services to Medicare or Medicaid enrollees under an oral or written agreement; or 3. Leases real property or sells materials to CalOptima at a cost of more than two-thousand five-hundred dollars ($2,500) during a contract period.
Waste	Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to CalOptima Programs. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

III. POLICY

A. The Office of Compliance is responsible for completing a Program Risk Assessment, at least annually, to develop its Internal Audit and Monitoring Plan that provides a comprehensive assessment of CalOptima operational areas including First Tier, Downstream, Related Entities (FDR) oversight, as well as delegated FDR obligations. In assessing risk, CalOptima must consider the following:

1. Size of the department;
2. Complexity of work;
3. Amount of training that has taken place;
4. Past Compliance issues; and
5. Budget.

B. In assessing additional risk, CalOptima shall stay current with all regulatory communication and guidance from the regulatory agencies.

C. CalOptima's Risk Assessment results and the proposed Internal Audit and Monitoring Plan shall be

presented to the Compliance Committee by the Office of Compliance for review and approval by the end of the Fiscal Year to be effective for the following year.

IV. PROCEDURE

A. The Office of Compliance shall schedule meetings with all operational department leads in order to complete the assessment.

1. The two key steps in the risk assessment process are discovery and analysis. Discovery is the process of determining which requirements are completely implemented, their operational effectiveness, and how the practices and the documentation support compliance. The discovery process shall consist of document review, an interview process, and review of other relevant information. The analysis component of risk assessment is based on the evaluation of the data from the actual practices.

B. Discovery Process. In order to determine whether there are accurate and compliant processes and systems in place, the Office of Compliance shall conduct the following activities:

1. Review of policies and procedures and other supporting documents, such as regulatory communications. For each internal area reviewed in the risk assessment process, the Compliance audit team shall request from the applicable department the policies and procedures and supporting documentation that describe processes used to meet regulatory requirements. The Office of Compliance shall evaluate the documents for compliance and provide a risk score that is entered into the Annual Risk Assessment Tool.

2. Staff interviews. The Office of Compliance may schedule interviews with internal functional area department supervisors and relevant support staff to discuss the following:

a. Processes that are supported by policies and procedures and other relevant documentation;

b. Changes in laws or regulations in the previous year that impact their area;

c. Changes in management and staffing; and

d. The degree to which the activities conducted by their area impact CalOptima Members.

3. FDR interviews. The operational departments responsible for oversight of FDRs may schedule interviews with their contact at the FDR to discuss the same four items listed in section IV. B.2. of this policy.

C. The Office of Compliance shall interview the Special Investigations Unit to determine the activities that have confirmed or potential fraud identification.

D. Review of other risk factors. The Office of Compliance shall review the following information for internal areas, and the appropriate operational department shall review the following information as it applies to activities delegated to FDRs, as part of the risk assessment process:

1. Regulatory agencies identify a particular area as problematic through enforcement actions, CalOptima audit findings, notices of non-compliance, etc.;

2. Corrective Action Plan (CAP): whether there is a CAP in effect, and if so, its relative risk for the non-compliant area;

3. CalOptima's Star Ratings scores for specific requirements, to be populated as applicable.

E. Analysis. To validate compliance of the staff interviews, and review of other relevant information, the Office of Compliance relies on data gathered through the internal monitoring process, and conducts baseline risk assessment audits because regulatory agencies expect significant use of data in determining risks to Members, results from internal monitoring and from the risk assessment audits of requirements are weighted heavily in the risk scoring on the Annual Risk Assessment Tool.

F. The Office of Compliance shall compile the data, using the scoring methodology for the risk assessment tool and then ranks the risks based on the greatest impact.

G. The Office of Compliance shall prioritize those with greatest risk when developing the annual audit and monitoring plan.

H. The Office of Compliance shall present the risk assessment results and proposed audit and monitoring plan for approval by the Compliance Committee.

I. The Office of Compliance re-evaluates the risk plan based on internal changes (staffing and organizational structure changes, internal audit results, monitoring results, etc.) and external changes (regulatory changes, marketplace changes, regulatory agency audits results).

J. Results of the FDR risk assessment are presented to the Delegation Oversight Committee (DOC) to be used in the evaluation process as established by the DOC.

V. ATTACHMENTS

A. Internal Auditing and Monitoring Work Plan
B. FDR Risk Assessment Tool

VI. REFERENCES

A. CalOptima Compliance Plan

VII. REGULATORY APPROVALS

None to Date

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	5/1/14	MA.9117	Annual Risk Assessment

Revision Date 1	11/1/14	MA.9117	Annual Risk Assessment
Revision Date 2	9/1/15	MA.9117	Annual Risk Assessment

Policy #: MA. 9118
Title: **Internal Auditing and Monitoring**
Department: Office of Compliance
Section: Compliance

CEO Approval: Michael Schrader _____
Effective Date: 5/1/14
Review Date: 11/1/14
Revised Date: 11/1/14

This policy shall apply to the following CalOptima line of business (LOB):

- Cal MediConnect
- OneCare
- PACE

I. PURPOSE

To describe the process CalOptima will use to conduct audits and monitoring of internal departments to assure compliance with required elements of the Medicare program(s).

II. DEFINITIONS

Term	Definition
Abuse	A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima.
Compliance Committee	The CalOptima committee that consists of executive officers, managers of key operating divisions, and legal counsel that oversees implementation of CalOptima's Compliance Program.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring actives by CalOptima, the Centers of Medicare & Medicaid Services (CMS), or, designated representatives. Delegates may be required to complete CAPs to ensure they are in Compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements identified by CalOptima and its regulators.
Downstream Entity	Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit or Part D benefit, below the level of the arrangement between CalOptima or applicant or a Part D plan sponsor or applicant and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
First Tier Entity	Any party that enters into a written arrangement with a MAO or contract applicant to provide administrative services or health care services for a Medicare eligible individual.
Immediate Corrective Action Plan (ICAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to immediately correct program deficiencies or problems identified by formal audits or monitoring actives by CalOptima, the Centers of Medicare & Medicaid Services (CMS), or, designated representatives. This occurs when the condition causes significant beneficiary harm. Sponsors have three (3) days from the issuance of the Immediate Corrective Action Required (ICAR) notice to remediate the condition and provide an ICAP to ensure they are in Compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements identified by CalOptima and its regulators.
Health Plan Management System (HPMS)	A web-enabled information system that serves a critical role in supporting the implementation and ongoing operations of CalOptima. HPMS and its software modules are used to collect and receive data.
Related Entity	Any entity that is related to the MAO by common ownership or control and: 1. Performs some of the MAO's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or 3. Leases real property or sells materials to the MAO at a cost of more than twenty-five-thousand dollars ($2,500) during a contract period.
Waste:	Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources

III. POLICY

A. The Office of Compliance shall establish protocols to ensure compliance risks are identified and shall conduct effective auditing and monitoring of internal departments.

B. The Office of Compliance shall perform an annual risk assessment and develop an annual audit and monitoring work plan, which takes into account current CMS Program Audit Process and Protocols and identified high-risk areas related to CalOptima's Medicare business.

C. Every CalOptima department identified on the Internal Audit and Monitoring Work Plan (see attachment A) will be subject to audit and/or routine monitoring.

D. The work plan shall identify the area to be audited and describe the schedule of audits to be conducted in the coming year. The work plan shall identify specific areas that require continued

monitoring. In the event monitoring results reveal deficiencies, the department(s) will be subject to an audit.

E. The auditing and monitoring results are reported to the Compliance Committee for review and recommendations. When appropriate, CalOptima shall inform CMS, National Benefit Integrity Medicare Drug Integrity Contractor (MEDIC), or law enforcement of aberrant findings.

IV. PROCEDURE

A. Monitoring

1. Office of Compliance monitoring will be established, when identified by the Office of Compliance as a result of "risk assessment, focused audit findings, CMS program audit findings, or other regulatory findings.

2. Office of Compliance shall routinely monitor the CalOptima departments and functions to determine if auditing and/or corrective action is required.

3. The monitoring results and any corresponding corrective actions shall be forwarded to the Compliance Committee for review at the next regularly scheduled meeting.

B. Audits

1. Audits of internal departments will be identified and scheduled by the Office of Compliance as a result of the annual risk assessment, focused audit findings, deficient monitoring results, Fraud, Waste, and Abuse (FWA), or CMS Program Audit findings.

2. Auditor from the Office of Compliance will be assigned to complete internal audits.

3. CalOptima departments are audited through different methods including, but not limited to:

   a. On-site audits – Involves a scheduled or unscheduled review of predetermined areas within the CalOptima departments. Management is notified of the specific items to be reviewed.

   b. Off-site audits – Involves the review of a specific CalOptima department with no site visit and no mandate to notify the respective department in advance. Such audits utilize reports as well as internal and external data to monitor performance.

   c. Data Analysis – Involves the use of data analytical techniques to identify patterns of overutilization and potentially abusive utilization.

   d. Testing – Verifies an individual's job-related compliance knowledge and skill. May be performed via written examination, interview, or demonstrated performance.

   e. Attestation – Involves a validation audit based on a sample of attestations received by CalOptima departments or First Tier, Downstream, and Related Entities (FDR). An

attestation must be signed by an authorized representative certifying that the information attested to such as required training, workshops, manuals, and policies and procedures are compliant.

f. Independent Review – Involves the use of an outside reviewer with knowledge, skills, and abilities to assist in the review of a specific department or delegated entity.

4. On-site Audits
   a. A month prior to the scheduled audit the assigned Compliance auditor will email the CalOptima department a notice confirming the date and scope of the audit. The notice will include a description of any universes required including the audit period, the due date, method of delivery, format, etc. CalOptima uses industry standard audit protocols and utilizes appropriate methods for auditing (i.e. sample size, data mining, etc.).

   b. Upon receipt of the requested universe(s), the assigned Compliance auditor shall select the sample size according to CMS audit protocol criteria where applicable and sample size of thirty (30) for non-audit protocol areas and based on:

      i. Processes considered to be high risk and/or have potential Member harm;

      ii. Compliance with CMS mandated elements such as effectuation timeliness, required Member and provider notifications, etc.;

      iii. Areas identified as deficient in previous audits.

   c. If the minimum number of cases is not available in the universe the reviewer may expand the audit period or request additional information. For example, if Grievances and Appeals reported no grievances for the audit period the reviewer might a) expand the timeframe for the audit period by several months, and or; 2) request Customer Service Call Logs for the audit period and review for potential grievances that were not categorized as such.

   d. Compliance auditor will notify the CalOptima department of samples selected and documentation required for audit no later than forty eight (48) hours before the audit occurs when provided in electronic form and seven (7) calendar days when sample files are supplied in alternate formats. Sample cases should be reviewed electronically whenever possible. The reviewer may, at his/her discretion, request additional materials during the site visit.

   e. Compliance auditor reviews cases against the applicable regulatory requirements described in the Code of Federal Regulations, Medicare Managed Care Manual, Claims Manual, Prescription Drug Benefit Manual or HPMS memos announcing updates or clarification to current guidance.

f. Findings from the audit are discussed with the CalOptima department and documented by the Compliance auditor in an audit findings report. The report details the number of cases reviewed, any issues of non-compliance and the level of corrective action required. The level of corrective actions are defined as the following:

i. Immediate Corrective Action Plan (ICAP) - Requires the department to correct the detected condition within three (3) calendar days. This occurs when the condition caused significant beneficiary harm, which is defined as policies, procedures, systems, and/or operations that may result in numerous beneficiaries not receiving medical services or prescription drugs. The department has three (3) calendar days from the issuance of the ICAP notice to remediate the condition and provide a Corrective Action Plan to the Compliance auditor.

ii. Corrective Action Plan (CAP) – A request that the department correct the detected condition. This occurs when a department "fails" the audit element or the condition caused beneficiary harm. The department is given fourteen (14) calendar days from the date of the issuance of the final report to remediate the condition and provide a corrective action plan to the Compliance auditor.

g. The audit findings report must be reviewed and approved by the Compliance Director before distributing to the CalOptima Manager.

h. The department's plan to resolve both ICAPs and CAPs must be documented on a CalOptima Corrective Action Form and emailed to the Compliance auditor within the requested time period. The Compliance auditor will review the document to ensure it addresses the identified issue accurately and thoroughly, requesting additional information or clarification whenever necessary. The final ICAPs and CAPS must be reviewed and approved by the Compliance Director prior to implementation.

i. The audit findings report and any corresponding Corrective Action Forms will be forwarded to the Compliance Committee for review at the next regularly scheduled meeting. Corrective Action Plans will be monitored and re-audited to ensure corrective actions have been implemented and successfully corrected the condition.

C. Unscheduled On-Site Procedures

1. The Compliance auditor will communicate the purpose and scope of the planned audit to the Compliance Committee and receive prior approval before proceeding. Examples of reasons for an unplanned on-site review are:

a. A visit to ensure compliance with HIPAA privacy rules

b. Observation of a sales presentation to ensure compliance with Marketing Guidelines.

c. Any compliance issues that may have been reported to the Office of Compliance related to FWA or that impact a Member's ability to obtain services or prescription drugs.

2. The Compliance auditor visits the location and informs the staff of the purpose of the review and the circumstances that prompted the review.

3. The Compliance auditor conducts the audit using the applicable regulatory requirements described in the Code of Federal Regulations, Medicare Managed Care Manual, Claims Manual, Prescription Drug Benefit Manual or HPMS memos announcing updates or clarification to current guidance.

4. The Compliance auditor shall follow steps as mentioned in section IV.B.4.f-i of this policy. Compliance auditor

D. Testing Procedures

1. Upon identifying the department to be tested the Compliance auditor will send an email to the CalOptima department informing him/her of the pending testing. The email will indicate:

a. Date of testing;

b. Subject and purpose of the test; and

c. Minimum test score requirements.

2. The Compliance auditor will conduct the test utilizing a test and answer sheet that was pre-approved by the Compliance Director.

3. After scoring the tests, if the CalOptima department is found to have not met the minimum test score requirements, the Compliance auditor will issue an audit findings report and a request for a Corrective Action Plan.

E. Attestation Procedures

1. Upon identifying the department and function, the Compliance auditor shall provide the department with the attestation that includes at minimum:

a. Applicable attestation period;

b. Subject and purpose of the attestation; and

c. Required signature.

2. The CalOptima department or FDR must validate/audit its data to ensure the attestation is accurate and complete.

3. The Compliance auditor shall perform a follow-up to validate the attestation as mentioned in section IV.B.3.e of this policy.

4. The Compliance auditor shall follow steps as mentioned in section IV.B.4.f-i of this policy.

F. Follow-Up

1. The Compliance auditor shall evaluate the CalOptima department's progress on corrective actions and request for updates based on due dates.

2. CalOptima department shall forward any newly create or revised documentation related to the corrective actions to the Compliance auditor for review and approval prior to implementation.

3. The Compliance auditor shall re-audit deficient areas (validation audit) using the methodologies described above to confirm the conditions requiring corrective actions have been resolved. The timing and scope of the audits will depend on the severity of the condition(s) but generally should occur three (3) months after the corrective actions have been implemented.

4. Findings shall be documented on the audit findings report and shared with the manager of the department and the Compliance Director. Areas of continued non-compliance may require further corrective actions.

5. The re-audit findings and any corrective actions shall be forwarded to the Compliance Committee for review and recommendations. The Compliance Committee is responsible for determining when a corrective action is considered "closed".

V. ATTACHMENTS

A. Attachment A
B. Auditing Findings Report
C. Corrective Action Forms

VI. REFERENCES

A. CalOptima Compliance Program
B. Chapter 21 of the Medicare Managed Care Manual
C. Chapter 9 of the Prescription Drug Benefit Manual
D. CMS Program Audits and Protocols
E. Policy MA. 9117: Annual Risk Assessment
F. Policy MA.9122: Internal Corrective Action Plan

VII. REGULATORY APPROVALS

Not Applicable

VIII. BOARD ACTION

None to date

IX. REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	5/1/14	MA.9118	Internal Auditing and Monitoring
Revised Date 1	11/1/14	MA.9118	Internal Auditing and Monitoring

Policy #: MA.9127
Title: **Delegation Oversight Committee**
Department: Office of Compliance
Section: Audit & Oversight
CEO Approval: Michael Schrader _____

Effective Date: 9/1/15
Last Review Date: N/A
Last Revised Date: N/A

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To establish a committee comprised of CalOptima executives that shall provide assistance to the CalOptima Board of Directors (BOD) in fulfilling its oversight and monitoring responsibilities with respect to federal, state, and accreditation compliance of its delegated entities.

II. DEFINITIONS

Term	Definition
Abuse	A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima and its programs, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima and its programs. Or the intentional or careless act that causes harm or serious risk of harm to an older person or vulnerable adult, including: physical abuse, emotional abuse, sexual abuse, and exploitation, neglect, abandonment or self-neglect.
Compliance Committee	The CalOptima committee that consists of executive officers, managers of key operating divisions, and legal counsel that oversees implementation of CalOptima's Compliance Program.
Compliance Program	A comprehensive program that incorporates the fundamental elements identified by the state and federal governments and CalOptima as necessary to prevent and detect violations of ethical standards, contractual obligations, and applicable laws and the involvement of CalOptima's governing body and executive staff. Elements of the Compliance Program include standards, oversight, training, reporting, monitoring, enforcement, and remediation. The Compliance Program applies to CalOptima's Board of Directors, employees, and contractors including delegated entities, providers, and suppliers.
Designee	A person selected or deginated to carry out a duty or role. The assigned

Term	Definition
	designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Downstream Entity	Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
First Tier Entity	Any party that enters into a written arrangement with CalOptima or contract applicant to provide administrative services or health care services for a Medicare or Medicaid eligible individual under the CalOptima program.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42, Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14013.1(i).
Physician Medical Group (PMG)	A California professional medical corporation that employs or has entered into contracts with physicians who are licensed to practice medicine in the State of California that has entered into a contract with CalOptima to arrange for the provision of Covered Service to Member assigned to that Provider Group.
Related Entity	Any entity that is related to CalOptima by common ownership or control and: Performs some management functions under contract or delegation; Furnishes services to Medicare or Medicaid enrollees under an oral or written agreement; or Leases real property or sells materials to CalOptima at a cost of more than two-thousand five hundred ($2,500) during a contract period.
Waste	Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the CalOptima programs. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

III. POLICY

A. Delegation oversight is critical to CalOptima as this process is mandated by federal, state, regulatory contracts, regulations, and accreditation standards and is necessary to ensure sound fiscal practices, prevent fraud, waste, and abuse, and provide quality care to CalOptima Members.

B. CalOptima's Delegation Oversight Committee (DOC) shall primarily conduct the following activities:

1. Oversee the monitoring, auditing, and reporting processes for identified First Tier, Downstream and Related Entities (FDRs) including, but not limited to delegated Health Networks;

2. Provide oversight of FDRs who perform applicable core administrative functions and/or health care services for any of CalOptima's programs by evaluating performance measures and audit findings;

3. Impose and recommend sanctions up to and including the revocation and/or termination of delegation if the delegated entity's performance is inadequate in accordance with CalOptima Policy MA.9105: Sanctions

4. Assist CalOptima in ensuring delegate compliance with accreditation, contractual, and regulatory requirements for administering all CalOptima programs including Medi-Cal, OneCare, OneCare Connect, Program of All-Inclusive Care for the Elderly (PACE), and any future programs in which CalOptima participates.

5. Establish clearly defined processes and criteria for the evaluation and categorization of CalOptima's vendors and delegated health care providers, as qualifying or not qualifying, as FDRs and conduct such determinations on an ongoing basis.

6. Develop and/or revise policies and procedures for FDR oversight and reporting including, but not limited to, identifying the scope, frequency and nature of oversight monitoring and auditing, and recommendations related to corrective action plan(s) (CAPs) and present such policies and procedures to the Compliance Committee for review and approval prior to presentation to the Policy Review Committee (PRC) and Board of Directors.

IV. PROCEDURE

A. DOC members shall include the following:

1. Chief Operating Officer;

2. Chief Network Officer;

3. Chief Financial Officer;

4. Chief Medical Officer;

5. Medical Directors;

6. Executive Director, Clinical Operations;

7. Executive Director, Compliance;

8. Director, Audit and Oversight;

9. Director, Regulatory Affairs;

10. Director, Pharmacy Management;

11. Director, Network Management; and

12. Executive Director, Quality

B. Voting members may appoint a Designee, as appropriate. The Designee shall serve as a subject matter expert at the Compliance Committee.

C. All activities of the DOC shall be privileged and not subject to disclosure.

D. DOC Responsibilities:

1. Oversight and Reporting

a. Oversee the pre-delegation/contract readiness assessment processes conducted by Compliance Department in conjunction with relevant operational departments;

b. Provide Quarterly report findings and recommendations related to delegation oversight to the Compliance Committee for corrective/remedial action;

c. Conduct follow-up oversight reviews deemed necessary by the DOC to ensure that any deficiencies reported during the oversight of the delegates FDRs have been fully addressed;

d. Report and make recommendations to the Compliance Committee on a regular but no less than quarterly basis. All DOC recommendations that potentially impact Members' access to covered services or quality of care that require prompt action shall be referred immediately to CalOptima's Compliance Committee and/or Quality Improvement Committee, as appropriate under the circumstances for review and action.

2. Delegation Oversight Work Plan

a. Prepare an annual Delegation Oversight Work Plan based on a risk assessment to identify highest risk First Tier Entities.

b. Include activities identified in other Department Work Plans (e.g., Quality Improvement Delegation Work Plan) in the Delegation Oversight Work Plan.

c. Submit the annual Delegation Oversight Work Plan for review to the Compliance Committee.

3. Annual Report

a. Prepare an Annual Report of agency-wide FDR oversight activities resulting from the Delegation Oversight Work Plan and other relevant ad hoc oversight activities including those related to risk assessments and/or arising from auditing activities (both internal and external).

b. Include in the Annual Report recommendations related to changes to and/or addition of oversight activities.

c. Deliver Annual Report to the Compliance Committee for further action.

4. DOC Meetings

a. The DOC shall meet at least monthly and may meet more frequently, as appropriate. The Chair or any three (3) members of the DOC may call a meeting of the DOC. Annually, DOC members shall receive a calendar of meetings for the following calendar year.

b. A committee binder shall be distributed to all meeting attendees prior to the DOC meeting. Committee binder shall include, but is not limited to:

i. Current meeting agenda;

ii. Previous meeting final draft minutes for approval; and

iii. Listing of open action items.

c. Minutes of the DOC meeting shall be confidential.

d. Ad-hoc DOC meetings may be held at the discretion of the chairperson, as deemed appropriate.

5. Establishment of Quorum

a. Quorum for the Subcommittee is based on a simple majority. The support of a majority of the quorum present is required for the DOC to take action on any agenized item.

b. In the absence of quorum, the meeting may proceed, however, any issues requiring a vote shall be deferred until the next regular meeting.

V. ATTACHMENTS

Not Applicable

VI. REFERENCES

Not Applicable

VII. REGULATORY APPROVALS

None to Date

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	9/1/15	MA.9127	Delegation Oversight Committee

Policy #: MA.9107
Title: **Fraud, Waste, and Abuse Detection**
Department: Office of Compliance
Section: Fraud, Waste, and Abuse – Special Investigations Unit
CEO Approval: Michael Schrader_____

Effective Date: 01/01/07
Last Review Date: 06/01/16
Last Revised Date: 06/01/16

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To establish a process to prevent and detect suspected Fraud, Waste, or Abuse (FWA) in a CalOptima program by a CalOptima employee, a Member, First Tier, Downstream, and Related Entities (FDRs), in accordance with federal and state regulations.

II. DEFINITIONS

Term	Definition
Abuse:	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Authorized Representative:	Any individual authorized by a Member, or under state law, to act on his or her behalf in obtaining an Organization Determination or in dealing with any level of the Appeal process. An Authorized Representative is subject to the rules described in Title 20 of the Code of Federal Regulations, Part 404, Subpart R, unless otherwise stated in the Medicare Managed Care Manual (Use form CMS-1696 for Claims Adjudication or Claims Appeals process).

Term	Definition
Complaint:	Any expression of dissatisfaction of CalOptima, a Provider, or the Quality Improvement Organization (QIO) by a Member made orally or in writing. A Complaint may include concerns about operations of Providers or CalOptima such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, respect paid to Members, and claims regarding the right of a Member to receive services or receive payment for services previously rendered. A Compliant may also involve Cal Optima's refusal to provide services which a Member believes he or she is entitled. A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.
Covered Service:	Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Center of Medicare & Medicaid Services (CMS) Contract.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Downstream Entity:	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Encounter:	Any unit of Covered Service provided to a Member by a Health Network regardless of Health Network reimbursement methodology. These services include any Covered Services provided to a Member, regardless of the service location or Provider, including out-network- Covered Services and sub-capitated and delegated Covered Services. Encounter data submitted to CalOptima should not include denied, adjusted, or duplicate claims.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortiums, and Health Maintenance Organizations.
First Tier Entity:	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.

Term	Definition
Fraud:	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C Section 1347).
Health Insurance Portability and Accountability Act (HIPAA):	The Health Insurance Portability Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information as amended.
Health Network:	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medically Necessary:	Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness or injury.
Medical Record:	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term "Medical Record" is used both for the physical folder for each individual patient and for the body Information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member:	An enrollee-beneficiary of a CalOptima program.
Pharmacy:	An area, place or premises licensed by the State Board of Pharmacy in which the profession of pharmacy is practiced and where Prescriptions are compounded and dispensed, and for the purpose of this policy, the licensed dispensing area of a community clinic.
Pharmacy Benefit Manager (PBM):	An entity that provides pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.

Term	Definition
Practitioner:	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech and Language Therapist furnishing Covered Services.
Provider:	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Physician Medical Group, or other person or institution who furnishes Covered Services.
Related Entity:	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Waste:	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

III. POLICY

A. CalOptima maintains a zero tolerance policy toward FWA by any CalOptima employee or FDR.

B. CalOptima and its FDRs shall comply with applicable statutory, regulatory, other requirements, sub-regulatory guidance, and contractual commitments related to the delivery of covered Medi-Cal services, which include, but are not limited to, federal and state False Claims Acts, Anti-Kickback statutes, prohibitions on inducements to beneficiaries, Health Insurance Portability and Accountability Act (HIPAA), and other applicable statutes.

C. CalOptima employees and its FDRs are expected and required to promptly report suspected violations of any statute, regulations, or guidelines applicable to any CalOptima program. CalOptima maintains a strict policy of non-retaliation and non-retribution toward employees and its FDRs who make such reports in good faith. CalOptima employees and its FDRs are protected from retaliation under Title 31, United State Code, Section 3730(h), for False Claims Act Complaints, as well as any other anti-retaliation protections.

D. This policy is reviewed annually to ensure relevancy and accuracy, ensuring that CalOptima's FWA program are in alignment with industry best practices.

IV. PROCEDURE

A. Prevention:

1. CalOptima's Office of Compliance shall provide regular training to employees and FDRs regarding the process for detecting suspected FWA, the specific provisions regarding FWA under the False Claims Act, and the protections afforded to those who report such concerns in good faith.

2. CalOptima has developed system controls, including claims edits, claims review processes, internal controls for protection of CalOptima assets, education programs for CalOptima employees, contractors and members, and metrics for monitoring potential FWA.

3. CalOptima shall provide regular FWA training and information sessions to:

   a. New Employees;

   b. Annually to CalOptima Employees;

   c. Health Networks

4. CalOptima shall provide Members with information related to FWA through:

   a. The Member Handbook;

   b. Periodic communications;

   c. The CalOptima website.

B. Detection:

1. CalOptima may receive Complaints of suspected FWA from any of the following sources, but is not limited to only these sources:

   a. Hotline;

   b. Internal audits;

   c. Internal operational reviews;

   d. External audits, including consultants and regulatory agencies;

   e. FWA software runs;

   f. PBM;

   g. The Compliance Committee;

   h. The Audit and Oversight Committee;

i. Internal departmental referrals; and

2. CalOptima shall provide oversight to the Health Networks' Compliance Programs by the Office of Compliance, to ensure that the programs are in place, and are comprehensive and in compliance with CalOptima contractual requirements.

3. CalOptima shall utilize "claims edits" in accordance with Federal and State regulations, the DHCS Contract, and industry best practices, including but not limited to the National Correct Coding Initiative.

4. CalOptima shall conduct data validation reviews by claims auditors within the Office of Compliance. These reviews are intended to detect any anomalies between items billed, items rendered, and all affiliated documentation related to the claims and Encounters.

5. CalOptima shall utilize data analytics including software to identify potential FWA cases. This data compares CalOptima claims and Encounters against national data to identify any suspected instances of FWA. These cases are forwarded to the Special Investigations Unit (SIU) for investigation.

6. CalOptima shall perform reviews on data samples to test the following, but not limited to:

   a. Ensure that Prior Authorizations are on file for services/drugs requiring Prior Authorization;

   b. Review Low-Dollar/High-Volume utilization by doctor, specialty and geographic comparison;

   c. CalOptima shall conduct monthly reviews of claims to review for adjustment codes and denials, reviewing for inappropriate denials and improper down coding, with a focus on CPTs 99284 and 99285. CalOptima's Claims Auditors review Emergency Room claims to ensure that down coding does not occur when claims are submitted without accompanying Medical Records. Emergency Room claims are reviewed during regular claims audits, and documentation is requested from the Health Network, at the time of the audit. Results of the audit are reviewed by the Audit and Oversight Committee (AOC). The AOC will be responsible for issuing corrective actions for Health Networks who are found to be down coding inappropriately;

   d. CalOptima reviews provider claims that have been identified as potential FWA. Claims may be identified by the claims review software system, by the Claims Auditors, by internal and external claims and compliance audits, or any other source that identifies potential FWA. As part of the review process, CalOptima will document the investigation of the claims or provider in the FWA Tracking Database. Once the investigation is complete (in accordance with the investigation process outlined elsewhere in this policy), the case information will be documented in the FWA database, and a referral may be made to the State, if appropriate. The referral shall be submitted on a Medi-Cal Complaint Report (MC 609) that can be sent to DHCS via secure e-mail (Iron Port), secure facsimile, Federal Express with Tracking number or certified mail, in accordance with the instructions provided in Exhibit E of

CalOptima's contract with the Department of Health Care Services for Medi-Cal.

e. In accordance with the Pharmacist Referral to SIU Team Desktop, CalOptima's Pharmacy Department refers cases to the SIU Team for members exhibiting drug seeking behavior or suspected of FWA issues related to Pharmacy services.

7. CalOptima shall implement a Service Verification Survey process to survey a sampling of Members monthly to ensure that:

   a. Services that were billed were received;

   b. Face to face services were provided for services/equipment/medications requiring recent or regular face to face appointments;

   c. Durable Medical Equipment (DME) that were billed were received;

   d. Medications that were billed were received.

   e. The focus of these surveys will vary as decided by the SIU and/or the Office of Compliance designated staff. The focus may be on a specific code, Provider, Member category, geographic area, and DME description, reports by other agencies of potential FWA, and industry findings and best practices.

8. CalOptima shall utilize the forum of the Compliance Committee to detect any suspected FWA throughout the organization and the FDRs and determine appropriate investigative and reporting steps.

9. CalOptima shall treat the detection of suspected FWA in a confidential manner, and shall not retaliate or make retribution against any CalOptima employee, FDR, or Member for such detection in accordance with CalOptima policy MA.9223: Non-Retaliation for Reporting Violations.

10. CalOptima may detect FWA by a Member in circumstances that include, but are not limited to, the following:

    a. Using another individual's identity, Benefits Identification Card (BIC), CalOptima or Health Network identification card, Medi-Cal number, or other documentation of Medi-Cal or CalOptima program eligibility to obtain Covered Services, unless such person is an Authorized Representative who is presenting such document or information on behalf of a Member to obtain Covered Services for that Member;

    b. Selling, loaning, or giving a Member's identity, Benefits Identification Card (BIC), Health Network identification card, Medi-Cal number, or other documentation of Medi-Cal or CalOptima program eligibility to obtain Covered Services, unless such person is an Authorized Representative who is obtaining services on behalf of a Member;

    c. Making an unsubstantiated declaration of Medi-Cal eligibility;

d. Using a Covered Service for purposes other than the purposes for which it was prescribed or provided, including use of such Covered Service by an individual other than the Member for whom the Covered Service was prescribed or provided;

e. Failing to report other health coverage; and

f. Soliciting or receiving a kickback, bribe, rebate, or other financial incentive as an inducement to receive or not receive Covered Services.

11. CalOptima may detect FWA by an FDR in circumstances that include, but are not limited to, the following:

a. Unsubstantiated declaration of eligibility to participate in the Medi-Cal program as a Provider, Practitioner, Billing Intermediary, or HN;

b. Submission of a claim or a request for payment for:

i. Covered Services that are substantially and demonstrably in excess of an individual's usual charges for such Covered Services;

ii. Covered Services that were not provided to the Member for whom such Covered Services were claimed;

iii. Covered Services substantially in excess of the quantity that is Medically Necessary for the Member;

iv. Covered Services using a billing code that will result in greater payment than the billing code that reflects the Covered Services actually provided;

v. Covered Services that were already included in the capitation rate; and

vi. Covered Services billed to both CalOptima and another third party payer without making full disclosure of material facts or notification of other insurance payments.

c. Charging a Member in excess of allowable co-payments or deductibles for Covered Services;

d. Billing a Member for Covered Services without obtaining written consent to bill for such Covered Services;

e. Soliciting, offering, receiving, or paying a kickback, bribe or rebate as an inducement to refer or fail to refer a Member;

f. Failing to disclose any significant beneficial interest in any other Provider to which the Provider or Practitioner may refer a Member for the provision of Covered Services;

g. Billing Intermediary failure to register with the California Department of Health Care Services (DHCS), as appropriate;

h. False certification of Medical Necessity;

i. Attributing a diagnosis code to a Member that does not accurately reflect the Member's Medical Condition for the purposes of obtaining higher reimbursement;

j. Providing false or inaccurate Credentialing information;

k. Providing false or inaccurate information during the CalOptima Provider registration process.

l. Submitting data files or Reports that contain:

i. Unsubstantiated data;

ii. Data that is inconsistent with underlying clinical, Encounter, or payment records; or;

iii. Data that has been altered in a manner, or for a purpose, that is inconsistent with CalOptima policies, Contract, or applicable regulations and statutes.

V. ATTACHMENTS

A. Suspected Fraud or Abuse Referral Form (English)
B. Suspected Fraud or Abuse Referral Form (Spanish)
C. Suspected Fraud or Abuse Referral Form (Vietnamese)
D. Suspected Fraud or Abuse Referral Form (Korean)
E. Suspected Fraud or Abuse Referral Form (Chinese)
F. Suspected Fraud or Abuse Referral Form (Farsi)
G. Suspected Fraud or Abuse Referral Form (Arabic)

VI. REFERENCES

A. California Business and Professions Code, §4040
B. California Welfare and Institutions Code, §§14026 and 14107.2
C. CalOptima Contract with Department of Health Care Services (DHS) #99-86099
D. CalOptima Policy AA.1000: Glossary of Terms
E. CalOptima Policy CMC.1001: Glossary of Terms
F. CalOptima Policy MA.9108: Fraud, Waste and Abuse Investigation and Reporting
G. CalOptima Policy MA.9223: Non-Retaliation for Reporting Violations
H. Title 42, Code of Federal Regulations, §455.2
I. United States Code, Title 31, §3730 (h).

VII. REGULATORY AGENCY APPROVALS

None to Date

VIII. BOARD ACTIONS

None to Date

IX. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title
Effective	01/01/2007	MA.9107	Fraud, Waste, and Abuse Detection
Revised	02/01/2013	HH.1105Δ	Fraud, Waste, and Abuse Detection
Revised	04/01/2014	MA.9107	Fraud, Waste, and Abuse Detection
Revised	12/01/2014	MA.9107	Fraud, Waste, and Abuse Detection
Revised	09/01/2015	MA.9107	Fraud, Waste, and Abuse Detection
Revised	06/01/2016	MA.9107	Fraud, Waste, and Abuse Detection

Policy #: MA.9108
Title: **Fraud, Waste, and Abuse Investigation and Reporting**
Department: Office of Compliance
Section: Fraud, Waste, and Abuse – Special Investigations Unit
CEO Approval: Michael Schrader_____

Effective Date: 01/01/07
Last Review Date: 06/01/16
Last Revised Date: 06/01/16

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To establish a process to investigate and report suspected Fraud, Waste, or Abuse (FWA) in a CalOptima program by a CalOptima employee, a Member, or a First Tier, Downstream or Related Entity (FDR), in accordance with federal and state regulations.

II. DEFINITIONS

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Executive Director of Compliance; and Executive Director of Human Resources.
Compliance Program	The program (including, without limitation, this Compliance Plan, Code of Conduct and Policies and Procedures and Procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Member, Employees and FDRs comply with applicable law and ethical standards.

Term	Definition
Covered Service	Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortiums, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C Section 1347).
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Member	An enrollee-beneficiary of a CalOptima program.
Pharmacy Benefit Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, Pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or

Term	Definition
	written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

III. POLICY

A. CalOptima maintains a zero tolerance policy toward FWA by any CalOptima employee or FDR.

B. CalOptima and its FDRs shall comply with applicable statutory, regulatory, other requirements, sub-regulatory guidance, and contractual commitments related to the delivery of covered CMS services, which include, but are not limited to, federal and state False Claims Acts, Anti-Kickback statutes, prohibitions on inducements to beneficiaries, Health Insurance Portability and Accountability Act (HIPAA), and other applicable statutes.

C. CalOptima employees and its FDRs are expected and required to promptly report suspected violations of any statute, regulations, or guidelines applicable to any CalOptima program. CalOptima maintains a strict policy of non-retaliation and non-retribution toward employees and its FDRs who make such reports in good faith. CalOptima Employees and its FDRs are protected from retaliation under Title 31, United State Code, Section 3730(h), for False Claims Act complaints, as well as any other anti-retaliation protections.

D. This policy is reviewed annually to ensure relevancy and accuracy, ensuring that CalOptima's FWA program are in alignment with industry best practices.

E. CalOptima shall establish a process for timely and reasonable investigation and reporting of suspected FWA in accordance with this policy.

F. CalOptima's Office of Compliance shall coordinate all activities associated with the investigation and reporting of suspected FWA.

G. CalOptima's Office of Compliance shall maintain a system for the review of suspect claims to detect and prevent FWA, in accordance with federal and state regulations, and to identify resulting overpayments for recoupment in accordance with CalOptima policy.

H. CalOptima shall cooperate with the Centers for Medicare and Medicaid (CMS) and law enforcement agencies related to any Fraud and Abuse investigations or audits.

I. CalOptima shall conduct a preliminary investigation of any allegation of suspected FWA and shall report suspected FWA to the appropriate agency, in accordance with its Contracts with CMS and this policy.

J. Upon determination of validity of the allegation, CalOptima shall report suspected FWA to CMS for further investigation, as appropriate.

K. CalOptima's Office of Compliance shall maintain a database and a uniform filing system to maintain suspected FWA referrals, including reports, investigations, and correspondence, in accordance with CalOptima's Compliance Program.

L. CalOptima's Office of Compliance shall develop data and other supporting evidence for a FWA investigation, consult with Legal Counsel, and function as the liaison between CalOptima and CMS, appropriate state Medical Boards, the State Board of Pharmacy, other licensing entities, law enforcement, prosecuting agencies as appropriate, and other relevant entities.

M. CalOptima's Office of Compliance shall ensure appropriate confidentiality of case files or other documentation relating to any investigation of a suspected FWA case.

N. CalOptima's Office of Compliance shall report the status and results of all suspected FWA investigations to CalOptima's Compliance Committee.

O. CalOptima shall fully coordinate and cooperate with CMS and other law enforcement agencies related to any FWA investigations or audits to support health oversight matters.

IV. PROCEDURE

A. Investigation:

1. Upon detection of suspected FWA, the Office of Compliance shall review the suspected activity using data from reports, including, but not limited to, the following:

a. Claims data;

b. Encounter data;

c. Medical Records;

d. Member and Provider Complaints, Appeals, and Grievance reviews;

e. Utilization Management reports;

f. Pharmacy data;

g. Audits;

h. Provider utilization profiles;

i. Member utilization profiles;

j. Geographic and demographic studies;

k. Evaluation of a Provider's Member capacity; and

l. Interviews.

2. CalOptima shall complete the preliminary investigation, including the review of listed and other documents. CalOptima shall conduct, complete and report to CMS contractor, NBI MEDIC (National Benefit Integrity Medicare Drug Integrity Contractor), the results of a preliminary investigation of the suspected fraud and/or abuse within thirty (30) business days of the date CalOptima first became aware of, or is in notice of such activity.

3. When included on the FWA Referral Form, or when the FWA Investigator is able to determine the probable root cause of the suspected FWA, the information will be documented in the Fraud Tracking Database. Additionally, the FWA Investigator will track and trend on the root causes as part of the FWA Trend Analysis on a quarterly basis to the Compliance Committee, when there are root causes that have been identified and able to be trended.

4. In accordance with CalOptima Policies MA.9104: Corrective Actions Plans, MA.9105: Sanctions, GA.8021: Employee Conduct and GA.8022: Progressive Discipline, CalOptima shall issue corrective actions to employees, and its FDRs related to validated instances of FWA. Corrective actions will be monitored by the Compliance Committee, or the Department of Human Resources, as appropriate. Corrective actions may include financial sanctions, regulatory reporting, performance improvement plans, or termination. Should such corrective action need to be issued, CalOptima Office of Compliance will initiate review and discussion at the first Compliance Committee following the date of identification of the suspected FWA, the date of report to CMS, or the date of FWA substantiation by CMS subsequent to the report.

5. The following is a list of potential FWA classifications for Member and Provider Fraud and Abuse Program, along with some examples of potential detection criteria that may be used to detect these types of suspected FWA:

MEMBER FRAUD OR PROGRAM ABUSE		**DETECTION CRITERIA Including but not limited to:**
M01	Using another individual's identity or documentation of Medi-Cal eligibility to obtain Covered Services.	Members with multiple areas of service; members who attempt more than one PCP; reports of members who are hiding assets or income
M02	Selling, loaning, or giving a member's identity or documentation of Medi-Cal eligibility to obtain services.	Members with multiple areas of service; members who attempt more than one PCP; reports of members who are hiding assets or income
M03	Making an unsubstantiated declaration of eligibility.	Members with multiple areas of service; members who attempt more than one PCP; reports of members who are hiding assets or income
M04	Using a Covered Service for purposes other than the purpose for which it was described including use of such Covered Service.	Selling a covered wheelchair; selling medications; abusing prescription medications
M05	Failing to report other health coverage.	Payments by OHI
M06	Soliciting or receiving a kickback, bribe, or rebate as an inducement to	Hotline reports; internal reports; reports by Health Networks

	receive or not receive Covered Services.	
M07	Other (please specify).	Any source
M08	Member Pharmacy Utilization.	PBM reports; data analytics; claims data; encounter data; FWA software
M09	Doctor Shopping.	PBM reports; data analytics; claims data; encounter data; FWA software
M10	Altered Prescription.	Provider report; DEA report; pharmacy report; PBM reports; data analytics; claims data; encounter data; FWA software

PROVIDER FRAUD OR PROGRAM ABUSE		**DETECTION CRITERIA Including but not limited to:**
P01	Unsubstantiated declaration of eligibility to participate in the CalOptima program.	Provider information not able to be verified during credentialing or contracting process; providers on the excluded provider list
P02	Submission of claims for Covered Services that are substantially and demonstrably in excess of any individual's usual charges for such Covered Services.	PBM reports; data analytics; claims data; encounter data; FWA software
P03	Submission of claims for Covered Services that are not actually provided to the member for which the claim is submitted.	PBM reports; data analytics; claims data; encounter data; FWA software; verification survey; hotline
P04	Submission of claims for Covered Services that are in excess of the quantity that is Medically Necessary.	PBM reports; data analytics; claims data; encounter data; FWA software
P05	Submission of claims for Covered Services that are that are billed using a code that would result in great payment than the code that reflects the covered services.	PBM reports; data analytics; claims data; encounter data; FWA software
P06	Submission of claims for Covered Services that are already included in the capitation rate.	PBM reports; data analytics; claims data; encounter data; FWA software
P07	Submission of claims for Covered Services that are submitted for payment to both CalOptima and another third party payer without full disclosure.	PBM reports; data analytics; claims data; encounter data; FWA software; payment by OHI
P08	Charging a member in excess of allowable co-payments and deductibles for Covered Services.	Member report; hotline report; oversight audits
P09	Billing a member for Covered Services without obtaining written consent to	Member report; hotline report; oversight audits

	bill for such services.	
P10	Failure to disclose conflict of interest.	Hotline; credentialing or contracting process
P11	Receiving, soliciting, or offering a kickback, bribe or rebate to refer or fail to refer a member.	Hotline report; oversight report
P12	Failure to register billing intermediary with the Department of Health Services.	Oversight audit; report by regulatory body; hotline
P13	False certification of Medical Necessity.	Medical record review; claims data; encounter data; FWA software
P14	Attributing a diagnosis code to a member that does not reflect the member's medical condition for the purpose of obtaining higher reimbursement.	Medical record review; claims data; encounter data; FWA software
P15	False or inaccurate Minimum Standards or credentialing information.	Hotline; credentialing or contracting process
P16	Submitting reports that contain unsubstantiated data, data that is inconsistent with records, or has been altered in a manner that is inconsistent with policies, contracts, statues or regulations.	Medical record review; claims data; encounter data; FWA software
P17	Other (please specify).	Any source
P18	Provider Pharmacy Utilization.	PBM reports; data analytics; claims data; encounter data; FWA software
P19	Billing Medi-Cal Member for Services.	Member report; hotline report; oversight audits
P20	Durable Medical Equipment- Covered Services that are not actually provided to beneficiary.	Member report; hotline report; oversight audits; verification survey

6. All documentation related to any suspected FWA case must be entered into the Fraud Tracking Database System Section, in a timely manner. Documentation of the final disposition is to be documented in a timely manner once the case has been determined to be closed.

7. Compliance Action/Outcomes may include but are not limited to:

C01	Contract amendment
C02	Corrective action plan
C03	Education
C04	Focused Audit
C05	Investigation
C06	Monitoring
C07	New Policy
C08	Policy Revision
C09	Prepayment Review

C10	Process Review
C100	Referred to CalOptima Legal
C101	No Fraud Folder Created
C102	Criminal Filing- Pending
C11	Criminal Filing- Conviction
C111	Criminal Filing- Exonerated
C12	Non-Criminal Action Taken
C13	Does not meet prosecutorial guidelines
C14	Technical issues- resolved
C15	Insufficient evidence of fraud
C16	Allegations/Violation confirmed: Warning Letter Issued
C18	Allegations/Violation confirmed: Administrative Action
C19	Allegations/Violation confirmed: Warning Letter & Administrative Action
C20	Administrative Error
C21	Administrative Action
C22	Unable to establish violation of the Medi-Cal Program
C23	Medi-Cal Usage Minimal
C24	DHS Referred to Other Agency
C26	Criminal Filing
C98	No Action Taken
C99	Other: (Explain)

B. Reporting:

1. CalOptima shall provide a method for CalOptima employees, FDRs, and Members to anonymously report suspected FWA to the Office of Compliance. CalOptima employees and its FDRs may call the Compliance and Ethics Hotline at (877) 837-4417 to anonymously report concerns regarding Fraud and Abuse.

2. CalOptima employee who detects suspected FWA shall complete a Suspected Fraud or Abuse Referral Form and transmit it to the Office of Compliance.

3. An FDR with a contractual obligation to report suspected FWA shall notify CalOptima of suspected FWA, in accordance with the terms and conditions of its Contract and this policy.

4. CalOptima's Office of Compliance shall investigate and report suspected FWA, in accordance with this policy.

5. CalOptima shall report to CMS via the National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by CalOptima employees, FDRs, or Members. CalOptima shall conduct, complete and report to CMS, the results of a preliminary investigation of the suspected fraud and/or abuse within thirty (30) business days of the date CalOptima first became aware of, or is in notice of such activity.

   Referrals to NBI MEDIC, where SIU detection activities results in a reason to believe that suspected fraud or abuse has occurred and requires further investigation by NBI MEDIC shall be sent on the Part D/MEDIC Complaint Form. The Part D/MEDIC Complaint Form and attachments submitted to the NBI MEDIC must at a minimum include:

a. Number of complaints of fraud and abuse submitted that warranted preliminary investigation;

b. For each complaint which warranted a preliminary investigation:

i. Name and/or SSN or CIN;

ii. Source of Complaint;

iii. Type of provider;

iv. Nature of complaint;

v. Approximate dollars involved if known;

vi. Legal and administrative disposition of the case.

c. The referral shall be submitted on a Part D/MEDIC Complaint form that can be sent to CMS contractor, NBI MEDIC, via secure e-mail (Iron Port), secure facsimile, Federal Express with Tracking Number, or certified mail;

d. CalOptima shall submit applicable police reports, investigation documentation (background, interviews, etc), member information, Provider enrollment data, confirmation of services, list items or services furnished by Provider, pharmaceutical data, and any other pertinent information.

V. ATTACHMENTS

A. Suspected Fraud or Abuse Referral Form (English)
B. Suspected Fraud or Abuse Referral Form (Spanish)
C. Suspected Fraud or Abuse Referral Form (Vietnamese)
D. Suspected Fraud or Abuse Referral Form (Korean)
E. Suspected Fraud or Abuse Referral Form (Chinese)
F. Suspected Fraud or Abuse Referral Form (Farsi)
G. Suspected Fraud or Abuse Referral Form (Arabic)
H. CalOptima Referral to MEDIC

VI. REFERENCES

A. CalOptima Compliance Program
B. CalOptima Policy MA.9107: Fraud, Waste and Abuse Detection
C. CalOptima Policy MA.9105: Sanctions
D. CalOptima Policy MA.9104: Corrective Action Plan
E. CMS Medicare Prescription Drug Benefit Manual, Chapter 9 – Part D Program to Control Fraud and Abuse
F. Contract for Centers for Medicare and Medicaid
G. Title 42, Code of Federal Regulations, § 423.504(b)(4)(vi)(G)(1)
H. Title 42, Code of Federal Regulations, § 455.2Title 31, United State Code, § 3730(h), for False Claims Act complaints

VII. REGULATORY AGENCY APPROVALS

None to Date

VIII. BOARD ACTIONS

None to Date

IX. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title
Effective	01/01/2007	MA.9108	Fraud, Waste and Abuse Investigation and Reporting
Revised	09/01/2008	MA.9108	Fraud, Waste and Abuse Investigation and Reporting
Revised	12/01/2010	MA.9108	Fraud, Waste and Abuse Investigation and Reporting
Revised	02/01/2013	MA.9108	Fraud, Waste and Abuse Investigation and Reporting
Revised	12/01/2014	MA.9108	Fraud, Waste and Abuse Investigation and Reporting
Revised	09/01/2015	MA.9108	Fraud, Waste and Abuse Investigation and Reporting
Revised	06/01/2016	MA.9108	Fraud, Waste and Abuse Investigation and Reporting

Policy #:	HH.3013
Title:	**Mitigation**
Department:	Office of Compliance
Section:	Health Insurance Portability and Accountability Act (HIPAA)
CEO Approval:	Michael Schrader _____
Effective Date:	4/1/03
Last Review Date:	9/1/15
Last Revised Date:	9/1/15

I. PURPOSE

To state CalOptima's policy on mitigation of violations of Health Insurance Portability and Accountability Act (HIPAA) related privacy policies and procedures.

II. DEFINITIONS

Term	Definition
Corrective Action Plan (CAP)	A plan delineating specific and identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the State, or designated representatives. Health Networks and Providers may be required to complete CAPs to ensure that they are in compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements identified by CalOptima and its regulators.
Disclosure	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261through264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Protected Health Information (PHI)	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form of medium. This information indentifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and related to: 1. The past, present, or future physical or mental health or condition of a Member;

	2. The provision of health care to a Member, or 3. Past, present, or future Payment for the provision of health care to a Member.
Sanctions	Action taken by CalOptima including, without limitations, restrictions, monetary fines, termination or a combination thereof, based on a Health Network's or its delegate's, subcontractor's, or any Health Network partner's failure to comply with statutory, regulatory, contractual, CalOptima policy, or other requirements related to the CalOptima Medi-Cal program.
Use of PHI	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. The sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

III. POLICY

A. CalOptima shall mitigate, to the extent practicable, any harmful effect that is known to CalOptima of a Use or Disclosure of Protected Health Information (PHI) in violation of CalOptima's policies and procedures by a CalOptima employee, or by a Business Associate.

IV. PROCEDURE

A. When it comes to the attention of the Office of Compliance that violations or potential violations of CalOptima policies and procedures related to PHI may have occurred, the Office of Compliance shall:

1. Initiate a review of the incident;

2. Formulate a reasonable Corrective Action Plan (CAP), as appropriate. The CAP may include, but not be limited to, the following acts:

   a. Communication with Members impacted by the violation and correction of any errors of Uses or Disclosures to the extent possible based on the type of violation;

   b. Facilitation of education and training, or counseling, or imposition of Sanctions of involved CalOptima staff or FDR; and

   c. Implementation of any necessary revisions to CalOptima policy and procedures to reduce the risk of, or prevent future violations or potential violations.

3. Report the violation or potential violation to the appropriate governmental agency(ies) and affected Members, in accordance with CalOptima Policy HH.3020: Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information, as appropriate.

V. ATTACHMENTS

Not Applicable

VI. REFERENCES

A. Title 45, Code of Federal Regulations, Section 164.530(f) Standard: Mitigation
B. CalOptima Privacy Program, 2003
C. Office of Civil Rights, HIPAA Privacy Guidance, Business Associates, pp. 39-53
D. CalOptima Policy AA.1000: Glossary of Terms
E. CalOptima Policy HH.3020: Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information
K. CalOptima Policy HF.1000: Glossary of Terms
L. CalOptima Policy HF.9020: Reporting an Unauthorized Use or Disclosure of Protected Health Information, Breach of Data Security, or Intrusion
M. NCQA Standard RR5 Privacy and Confidentiality - 2014

VII. REGULATORY APPROVALS

None to Date

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Name
Original Date	04/01/2003	HH.3013	Mitigation
Revision Date 1	04/01/2007	HH.3013	Mitigation
Revision Date 2	11/01/2011	HH.3013	Mitigation
Revision Date 3	12/01/2012	HH.3013	Mitigation
Revision Date 4	12/01/2013	HH.3013	Mitigation
Revision Date 5	11/01/2014	HH.3013	Mitigation
Revision Date 6	09/01/2015	HH.3013	Mitigation

Policy #:	HH.3017
Title:	**Use or Disclosure of Protected Health Information for Research**
Department:	Office of Compliance
Section:	Health Insurance Portability and Accountability Act (HIPAA)
CEO Approval:	Michael Schrader
Effective Date:	4/03
Last Review Date:	9/1/15
Last Revised Date:	9/1/15

I. PURPOSE

To describe the conditions under which CalOptima may Use or Disclose Protected Health Information (PHI) for Research.

II. DEFINITIONS

Term	Definition
Authorized Representative	Has the meaning given such term in section 164.502(g) 45 CFR of Title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of un-emancipated minors.
Disclosure	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the Cal Optima program.
Minimum Necessary	The principle that a covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment or Health Care Operations.
Protected Health Information (PHI)	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic

	media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Research	Systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalize knowledge.
Treatment	Activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use of PHI	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. The sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

III. POLICY

A. CalOptima shall release Member's PHI for Research purposes only with written Authorization from the Member.

B. CalOptima may release Minimum Necessary health information, without Authorization by the Member, by removing all identifiers with respect to the individual Member, his or her relatives, employers, and household Members from the Protected Health Information (PHI), in accordance with CalOptima Policy HH.3019: De-Identification of Protected Health Information.

IV. PROCEDURE

A. Uses and Disclosures for Research Purposes: Member Authorization

1. Authorization for release of PHI for Research purposes must include the following elements:

a. A description of the information to be Used or Disclosed that identifies the information in a specific and meaningful manner;

b. The name or other specific identification of the person(s), or class of persons, authorized to make the requested Use or Disclosure;

c. The name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested Use or Disclosure;

d. A description of each purpose of the requested Use or Disclosure;

e. A statement that the Authorization does not expire or state that the Authorization continues until the "end of the Research study";

f. Signature of the Member and the date, or if signed by Member's Authorized Representative, a description of the Personal Representative's relationship to the Member;

g. Statement that further Disclosure of the PHI is prohibited unless another Authorization is obtained from the Member (California Civil Code 56.10(c)); and

h. Additional elements that apply if Authorization is requested by CalOptima:

i. A statement that CalOptima will not condition Treatment or Payment on the Member signing the Authorization request;

ii. A statement that the Member can refuse to sign the Authorization;

iii. A statement that the Member is entitled to a copy of the signed Authorization; and

iv. As applicable, a statement if a Disclosure will result in either direct or indirect Payment to CalOptima from the receiver of the PHI.

B. Use and Disclosure for Research: De-identification of PHI

1. The following processes may be used to determine that PHI has been de-identified to protect the confidentiality of the Member, in accordance to CalOptima Policy HH.3019: De-identification of Protected Health Information.

a. Qualified Reviewer

i. A person with appropriate knowledge of, and experience with, generally accepted statistical and scientific principles and methods for rendering information not individually identifiable determines that the risk is very small that the information could be used, alone or in combination with other reasonably

available information, by an anticipated recipient to identify an individual who is a subject of the information.

ii. There is documentation on the methods used by the person, and results of the analysis that justifies the determination that the information has been de-identified appropriately.

b. Removal of Specific Identifiers

i. The De-identification of PHI will include the removal of the following identifiers:

1) Name(s);

2) Social Security number;

3) Geographic subdivisions smaller than a state including:

a) Address;

b) City;

c) County;

d) Precinct;

e) Zip code or equivalent geocode;

4) Telephone number(s);

5) Facsimile number(s);

6) E-mail address;

7) Medical Record number;

8) Health plan beneficiary number;

9) All elements of dates (except year) for dates related to an individual:

a) Birth date;

b) Admission date;

c) Discharge date;

d) Date of death;

e) All ages over eighty-nine (89) years;

f) All elements of dates (including year) indicative of age, except an aggregated single category of ninety (90) or older is permissible;

10) Account number;

11) Certificate or license number;

12) Vehicle identifiers, serial numbers, and license plate number;

13) Device identifiers and serial numbers;

14) Web Universal Resource Locators (URLs);

15) Internet Protocol (IP) address numbers;

16) Biometric identifiers, voice, and fingerprints;

17) Full face photographs and comparable images; and

18) Any other unique identifying number, characteristic, or code.

ii. There is no actual knowledge that the information could be used alone, or in combination with other information, to identify an individual who is a subject of the information.

C. Re-identification of information

1. A code or other means of record identification may be assigned, provided:

a. The code is not derived from or related to information about the individual that would allow the individual to be identified, i.e., the last four digits of a social security number; and

b. The code is only used by CalOptima to re-identify the data, and the code is not released for Use by another person or entity.

V. ATTACHMENTS

A. Authorization for Use or Disclosure of Protected Health Information (PHI)

VI. REFERENCES

A. California Welfare and Institution Code, Section 14100.2 Confidentiality of Medi-Cal records
B. CalOptima Policy AA.1000: Glossary of Terms
C. CalOptima Policy HH.3015: Authorization for Release of Protected Health Information
D. CalOptima Policy HH.3019: De-Identification of Protected Health Information

E. HIPAA Patient Privacy Compliance Guide, Atlantic Information Services, Inc, 2002, Patient Health Information and Research, pages 2000-39-41
F. Title 45 Code of Federal Regulations, Section 160.103 and 164.501 Definitions Required by Law
G. Title 45 Code of Federal Regulations, Section164.514 Standard: De-Identification of Protected Health Information
H. Title 45, Code of Federal Regulations, Sections 164.501, 164.508, 164.512(i), 164.514(e), 164.528, and 164.532

VII. REGULATORY APPROVALS

None to Date

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	4/1/03	HH.3017	Use or Disclosure of Protected Health Information for Research
Revision Date 1	4/1/07	HH.3017	Use or Disclosure of Protected Health Information for Research
Revision Date 2	1/1/08	HH.3017	Use or Disclosure of Protected Health Information for Research
Revision Date 3	12/01/12	HH.3017	Use or Disclosure of Protected Health Information for Research
Revision Date 4	04/01/14	HH.3017	Use or Disclosure of Protected Health Information for Research
Revision Date 5	09/01/2015	HH.3017	Use or Disclosure of Protected Health Information for Research

Policy #:	HH.3021
Title:	**Disclosure of Information to Family Members or Friends Involved in Member Care**
Department:	Office of Compliance
Section:	Health Insurance Portability and Accountability Act (HIPAA)
CEO Approval:	Michael Schrader
Effective Date:	9/1/09
Last Review Date:	9/1/15
Last Revised Date:	9/1/15

I. PURPOSE

Identify the situations and conditions under which Protected Health Information (PHI) may be Disclosed to a Member's family members or friends involved in the Member's care or for notification.

II. DEFINITIONS

Term	Definition
Authorized Representative	Has the meaning given such term in section 164.502(g) 45 CFR of title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Disclosure	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Payment	Activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.

Term	Definition
Protected Health Information	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Treatment	Activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.

III. POLICY

A. CalOptima may Use or Disclose PHI to a Member's family member or close personal friend, or other person identified by the Member, if the Member is present and either gives permission or is given the opportunity to object and fails to object to the Disclosure.

B. CalOptima may Use or Disclose PHI to a Member's family member or friend, or other person identified by the Member, pursuant to a written authorization executed by the Member.

C. For all other Uses or Disclosures of PHI for purposes other than Treatment, Payment, or Health Care Operations, CalOptima shall obtain written authorization from the Member prior to the Use or Disclosure, in accordance with CalOptima Policy HH.3015: Authorization for Release of Protected Health Information.

IV. PROCEDURE

A. CalOptima may Use or Disclose PHI to a Member's family member or close personal friend, or other person identified by the Member, when the Use or Disclosure is relevant to that family Member's involvement in the Member's care if the Member is present for, or otherwise available prior to, the Use or disclosure, and has the capacity to make health care decisions, and:

1. CalOptima obtains the Member's agreement;

2. CalOptima provides the Member with the opportunity to object to the Disclosure, and the Member does not express an objection; or

3. CalOptima, based on the exercise of professional judgment, reasonably infers from the circumstances that the individual does not object to the Disclosure.

B. Unless otherwise authorized in writing, CalOptima may only Use or Disclose PHI to a Member's family member or close personal friend, or other person identified by the Member, when the Member is not present for the Use or Disclosure, or the opportunity to agree or object to the Use or Disclosure cannot practicably be provided due to the Member's incapacity or an emergency circumstance, if, in the exercise of professional judgment, CalOptima determines that the Use or Disclosure is in the best interest of the Member, and the Use or Disclosure is limited to only that PHI that is directly relevant to family member's or friend's involvement in the Member's health care.

C. CalOptima may Use or Disclose PHI to a Member's family member or close personal friend, or other person identified by the Member, when the Use or Disclosure is relevant to that family Member's involvement in the Member's care pursuant to a written authorization. A valid authorization shall contain the following core elements:

1. A description of the information to be Used or Disclosed;

2. The name of the person or organization that will Use or Disclose the PHI;

3. The name of the person or organization that will receive the PHI;

4. A description of the purpose for which the PHI will be used (except for requests by the Member, which can indicate "at Member's request" without further explanation);

5. The expiration date or event;

6. Statement that further Use or Disclosure of the PHI is prohibited unless another authorization is obtained from the Member or such Use or Disclosure is specifically required or permitted by law.

7. A statement that the Member has the right to revoke the authorization in writing and any exceptions to this right;

8. Member's signature and the date (if the Member's Personal Representative, state the relationship); and

9. Additional elements that apply if authorization is requested by CalOptima;

   a. A statement that CalOptima will not condition Treatment or Payment on the Member signing the authorization request;

   b. A statement that the Member can refuse to sign the authorization;

c. A statement that the Member is entitled to a copy of the signed authorization. A copy of the signed authorization shall be given to the Member; or

d. A statement when any Disclosure will result in either direct or indirect Payment to CalOptima from the receiver of the PHI.

V. ATTACHMENTS

CalOptima Authorization for Use or Disclosure of Protected Health Information to Family Member or Friend Involved in Member Care

VI. REFERENCES

A. Title 45, Code of Federal Regulations, Section 164.508, Uses and Disclosures for which an Authorization is Required
B. Title 45, Code of Federal Regulations, Section 164.510, Uses and Disclosures Requiring an Opportunity for the Individual to Agree or to Object
C. California Civil Code, Sections 56.10(c) and 56.1007
D. CalOptima Policy AA.1000: Glossary of Terms
E. CalOptima Policy HH.3006: Tracking and Reporting Disclosures of Protected Health Information
F. CalOptima Policy HH.3003: Verification of Identity for Disclosures of Protected Health Information
G. CalOptima Policy HH.3015: Authorization for Release of Protected Health Information
H. Guide to Medical Privacy and HIPAA, Thompson Publishing Group, Inc., Appendix III – Glossary
I. HIPAA Patient Privacy Compliance Guide, Atlantic Information Services, Inc., pp.1500-105 through 1500-112
J. Multipurpose Senior Services Program Standards, California Department of Aging
K. Privacy & Security Policies and Procedures: A Resource Document, WEDI, 2002, pp.19-23
L. The California Patient Privacy Manual, California Healthcare Association, 2002, pp. 73-78
M. Centers for Medicare & Medicaid (CMS): Medicare General Information, Eligibility, and Entitlement Chapter 6

VII. REGULATORY APPROVALS

Not Applicable

VIII. BOARD ACTION

Not Applicable

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	09/01/2009	HH.2021	Disclosure of Information to Family Members or Friends Involved in

Version	Version Date	Policy Number	Policy Title
			Member Care
Revision Date 1	08/01/2013	HH.2021	Disclosure of Information to Family Members or Friends Involved in Member Care
Revision Date 2	09/01/2015	HH.2021	Disclosure of Information to Family Members or Friends Involved in Member Care

Policy #: MA.9202
Title: **Notice of Privacy Practices**
Department: Office of Compliance
Section: Health Insurance Portability and Accountability Act (HIPAA)
CEO Approval: Michael Schrader _____

Effective Date: 6/1/05
Last Review Date: 9/1/15
Last Revised Date: 9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To define the process by which CalOptima shall provide Members with a copy of the Notice of Privacy Practice (NPP).

III. DEFINITIONS

Term	Definition
Disclosure:	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Health Care Operations:	Activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Maintenance Organization:	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Member:	An enrollee-beneficiary of a CalOptima program.
Notice of Privacy Practices (NPP):	Notice provided to a Member that describes Cal Optima's practices in the Use and Disclosure of Protected Health Information, Member Rights, and CalOptima legal duties with respect to Protected Health Information.
Payment:	Activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or

	justification of charges; and, 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Protected Health Information (PHI):	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Required by Law:	Mandated in law and compelling a covered entity (provider, health plan, or clearinghouse) to make a use or Disclosure of PHI and that is enforceable in a court of competent jurisdiction.
Threshold Languages:	As specified in annual guidance to Contractors on specific translation requirements for their service areas.
Treatment:	Activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use of PHI:	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. The sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

II. POLICY

A. CalOptima shall provide a Member with a copy of the NPP upon enrollment.

B. CalOptima shall revise and distribute the NPP to Members within sixty (60) calendar days after a material change in:

1. The Use or Disclosure of Protected Health Information (PHI) by CalOptima;

2. A Member's rights regarding PHI; or

3. The legal requirements for handling PHI.

IV. PROCEDURE

A. The NPP shall be made available to anyone, upon request, by calling or writing to the CalOptima Customer Service Department. CalOptima's Customer Service Department shall make the NPP available, in Threshold languages, to anyone by mail, in person, or through the CalOptima website.

B. The content of the NPP shall be written in plain language, and contain the following elements:

1. Mandated header;

2. Description and one (1) example each, of the types of Use and Disclosure that CalOptima is permitted under state and federal regulations for the purposes of Treatment, Payment, and Health Care Operations, or as otherwise Required by Law;

3. Statement that other Use and Disclosure shall be made only with a Member's written authorization, and that the Member may revoke this authorization;

4. Statement to address, as applicable:

   a. Appointment reminders and information on Treatment alternatives or other health-related benefits and services; or

   b. Disclose the Member's PHI to a group health plan, insurance issuer, or Health Maintenance Organization (HMO).

5. Statement to describe the Member's rights concerning his or her PHI, how to exercise these rights, and restrictions on such right, that shall include information on:

   a. Restrictions concerning certain Use and Disclosure of PHI, and provision that CalOptima is not required to agree to those restrictions, in accordance with CalOptima Policy MA.9206: Member Right to Request Restrictions on Use and Disclosure of Protected Health Information;

   b. Right to receive confidential communications of PHI, in accordance with CalOptima Policy MA.9211: Member Right to Request Confidential Communications;

   c. Right to inspect and copy PHI , in accordance with CalOptima Policy MA.9203: Member Access to Designated Record Set;

   d. Right to request amendment to PHI, in accordance with CalOptima Policy MA.9207: Member Request to Amend Record;

   e. Right to receive accounting of Disclosures, with certain exceptions, in accordance with CalOptima Policy MA.9209: Member Request for Accounting of Disclosures; and

   f. Right to receive a paper copy of the NPP, in accordance with this policy.

6. Statement specifically describing CalOptima's duties and rights under the privacy rule, including:

   a. The responsibility to maintain the privacy of the Member's PHI, in accordance with CalOptima policies, which shall include processes to ensure internal protection of;

      i. Verbal (i.e. when talking to individuals on the telephone or in person about a Member), and written information, in accordance with CalOptima policies MA.9205: Verification

of Identity for Disclosures of Protection Health Information, MA.9212: Access by Member's Authorized Representatives, MA.9220: Guidelines for Handling Private Health Information Offsite, and MA.9221: De-Identification of Protected Health Information.

ii. Electronic Information, in accordance with CalOptima policies, MA.9218: Use of Electronic Mail with Protected Health Information, GA.5005a: Use of Technology Resources, GA.5005b: Email and Internet Use, and GA.5005c: Laptop Loaner Policy;

b. The responsibility to abide by the terms of the NPP currently in effect;

c. The right to change the terms of the NPP and to make new notice provisions effective for PHI that CalOptima maintains; and

d. A description of how CalOptima provides Members with a revised NPP.

7. Statement that the Member may complain to CalOptima, California Department of Health Care Services (DHCS), and the United States Department of Health and Human Services if the Member believes his or her privacy rights have been violated, and include contact title and telephone number for filing the complaint with CalOptima or to get further information concerning the notice. The contact information should include:

a. Privacy Officer
c/o: Office of HIPAA Compliance
Department of Health Care Services
P.O. Box 997413, MS 4722
Sacramento, CA 95899-7413
Email: privacyofficer@dhcs.ca.gov
Telephone: (916) 445-4646
Fax: (916) 440-7680;

b. Information Security Officer
DHCS Information Security Office
P.O. Box 997413, MS 6400
Sacramento, CA 95899-7413
Email: iso@dhcs.ca.gov
Fax: (916) 440-5537
Telephone: ITSD Service Desk
(916) 440-7000 or (800) 579-0874; and

c. Michael Leoz, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Voice Phone (800) 368-1019
FAX (415) 437-8329
TDD (800) 537-7697
Email: OCRComplaint@hhs.gov

7. Effective date of the notice.

C. CalOptima shall distribute the NPP by:

1. Ensuring initial distribution by mail to all Members;

2. Including copies in all new enrollment packets;

3. Posting a copy in the Customer Service Department lobby in Threshold languages;

4. Posting the NPP on the CalOptima website; and

5. Notifying all Members at least once every three (3) years that a copy of the NPP is available upon request, or may be obtained on the CalOptima website at www.caloptima.org.

D. Documentation and Retention:

1. CalOptima shall document compliance with this policy, and retain copies of the notices issued for a period of ten (10) years from the effective date of the notice.

V. ATTACHMENTS

A. Notice of Privacy Practices

VI. REFERENCE

A. CalOptima Policy AA.1000: Glossary of Terms
B. CalOptima Policy CMC.1001: Glossary of Terms
C. CalOptima Policy MA.1001 Glossary of Terms
D. CalOptima Policy MA.9203: Member Access to Designated Record Set
E. CalOptima Policy MA.9205 Verification of Identity for Disclosures of Protection Health Information
F. CalOptima Policy MA.9206: Member Right to Request Restrictions on Use and Disclosure of Protected Health Information
G. CalOptima Policy MA.9207: Member Request to Amend Record
H. CalOptima Policy MA.9209: Member Request for Accounting of Disclosures
I. CalOptima Policy MA.9211: Member Right to Request Confidential Communications
J. CalOptima Policy MA.9218 Use of Electronic Mail with Protected Health Information
K. CalOptima Policy MA.9212 Access by Member's Authorized Representatives
L. CalOptima Policy MA.9220 Guidelines for Handling Private Health Information Offsite
M. CalOptima Policy MA.9221 De-Identification of Protected Health Information
N. CalOptima Policy GA.5005a: Use of Technology Resources
O. CalOptima Policy GA.5005b: Email and Internet Use
P. CalOptima Policy GA.5005c: Laptop Loaner Policy
Q. Office of Civil Rights, HIPAA Guidance, December 2002
R. Guide to Medical Privacy and HIPAA, 2002, p. 127-131
S. CalOptima Compliance Plan
T. Title 45, Code of Federal Regulations, Section 164.520, Notice of Privacy Practices for Protected Health Information
U. Title 45, Code of Federal Regulations, Section 164.530(g), Administrative Requirements

VII. REGULATORY APPROVALS

Not Applicable

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	6/1/05	MA.9202	Notice of Privacy Practices
Revision Date 1	2/1/08	MA.9202	Notice of Privacy Practices
Revision Date 2	1/1/13	HH.3000Δ	Notice of Privacy Practices
Revision Date 3	5/1/14	MA.9202	Notice of Privacy Practices
Revision Date 4	11/1/14	MA.9202	Notice of Privacy Practices
Revision Date 5	9/1/15	MA.9202	Notice of Privacy Practices

Policy #: MA.9203
Title: **Member Access to Designated Record Set**
Department: Office of Compliance
Section: Health Insurance Portability and Accountability Act (HIPAA)
CEO Approval: Michael Schrader _____

Effective Date: 8/1/05
Last Review Date: 9/1/15
Last Revised Date: 9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To define the Designated Record Set (DRS) that contains Protected Health Information (PHI) for a Member, maintained by CalOptima and the conditions under which the Member may access, inspect, or obtain a copy of his or her PHI in the DRS.

II. DEFINITIONS

Term	Definition
Authorized Representative	Any individual authorized by a Member, or under state law, to act on his or her behalf in obtaining an Organization Determination or in dealing with any level of the Appeal process. An Authorized Representative is subject to the rules described in Title 20 of the Code of Federal Regulations, Part 404, Subpart R, unless otherwise stated in the Medicare Managed Care Manual (Use form CMS-1696 for Claims Adjudication or Claim Appeals process)..
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of a covered entity or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs, or assists in the performance of: a. A function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or b. Any other function or activity regulated by this subchapter; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or

Term	Definition
	financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the services involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.
Designated Record Set	A group of records maintained by or for CalOptima that includes enrollment, Payment, claims adjudication, and case or medical management record system(s) used by or maintained for the agency, or used, in whole or in part, by or for CalOptima to make decisions about the Member. The DRS excludes patient-identifiable data used for administrative, regulatory, Health Care Operations and Payment/financial purpose; employment records held by CalOptima in its role as employer.
Disclosure	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner or information outside of the entity holding the information.
FACETS™	Licensed software product that supports administrative, claims processing and adjudication, membership data, and other information needs of managed care organizations.
Health Care Operations	Activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Network (HN)	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member (Global)	An enrollee-beneficiary of a CalOptima program.
Payment	Activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.

Term	Definition
Protected Health Information (PHI)	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. Past, present, or future Payment for the provision of health care to a Member. 2. The provision of health care to a Member; or 3. The past, present, or future physical or mental health or condition of a Member.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Research	Systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.
Treatment	Activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use of PHI	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. The sharing, employment, application, utilization, examination, or analysis of the Plll within an entity that maintains such information.

III. POLICY

A. Members shall have the right to access, inspect, or obtain a copy of his or her PHI in the DRS for as long as CalOptima maintains the PHI record.

B. CalOptima shall grant a Member's Authorized Representative access to a Member's PHI, in accordance with CalOptima policies, MA.9212: Access by Member's Authorized Representative and MA.9219: Authorization for Release of Protected Health Information.

C. Any person with knowledge of a violation or potential violation of this policy shall report such information to the Privacy Officer directly or through the CalOptima Compliance Ethics Hotline at 1-877-837-4417.

IV. PROCEDURE

A. Request for access to inspect or copy a DRS:

1. A Member shall submit a written request for access to inspect or copy the DRS by submitting the Individual Request for Access to Personal Health Information form, to the Office of Compliance.

2. The DRS does not include copies of records created and/or maintained by other Providers.

3. CalOptima shall process a request to inspect or obtain copies of the DRS within thirty (30) calendar days after receipt of the written request. If necessary, a thirty (30) calendar day extension may be used to retrieve data located off-site.

4. The Office of Compliance shall notify the Member in writing of the determination on the request. The notice will contain the information set forth in Section IV.E of this policy.

5. Verification of Member identification requesting access to inspect or copy the DRS:

   a. If the Member makes such request in person to the Customer Service Department, the Customer Service staff shall:

      i. Request identification (e.g., Member ID card or letter from CalOptima) or ask to verify Member's date of birth or address based on CalOptima Claims System data; and

      ii. Provide the Member with a copy of the Individual Request for Access to Personal Health Information form for the Member to complete.

      iii. If the Member request is received by mail, the Office of Compliance staff shall accept the completed form as being from the Member unless there is an error in the information included on the request form that requires additional verification from the requestor.

6. The Office of Compliance shall accept the request from the Member as valid, provided all information on the request is complete and accurate. All requests shall include, as applicable:

   a. An Authorization for Use or Disclosure of Protected Health Information form;

   b. An Individual Request for Access to Personal Health Information form;

   c. A written request that provides sufficient information as necessary to identify the specific PHI sought;

   Documentation that verifies the identity of the Member, in accordance with CalOptima Policy MA.9205: Verification of Identity for Disclosure of Protected Health Information.

7. The Office of Compliance shall review the request, determine if Member access is appropriate, and which parts of the DRS the Member cannot access.

8. The Office of Compliance shall deny Member access to the following:

   a. PHI compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;

b. PHI obtained from someone other than a Provider under a promise of confidentiality, and the access requested would be reasonably likely to reveal the source of the information; or

c. PHI covered under the Clinical Laboratory Improvements Act (CLIA).

9. CalOptima may deny access without the right of the Member to request review by a CalOptima designated licensed health care professional under the following conditions:

   a. PHI as set forth in Section IV.A.8 of this policy; or

   b. When the PHI is used for Research and Treatment, CalOptima may temporarily suspend access, provided:

      i. The Member agreed to the denial of access when consenting to participate in the Research and Treatment; and

      ii. The Provider informed the Member that the right to access shall be reinstated upon completion of the Research.

10. CalOptima may deny access, with the right of the Member to request review by a CalOptima designated licensed health care professional, under the following conditions:

    a. A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the Member or another person;

    b. The PHI makes reference to another person other than the Member, unless that person is a Provider, and a licensed health care professional determines, in his or her professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or

    c. The Authorized Representative requests for access, and a licensed healthcare professional has determined, in his or her professional judgment, that the provision of access to such Authorized Representative is reasonably likely to cause substantial harm to the individual or another person.

11. The Office of Compliance shall route the request to the department(s) or Business Associate responsible for creating or maintaining the requested record(s).

12. The responsible department or Business Associate shall send a copy of the requested PHI to the Office of Compliance within fourteen (14) calendar days of receiving the request.

B. The following departments within CalOptima shall have responsibility for the DRS, as follows:

1. Customer Service Department;

2. Finance Department;

3. Information Systems (IS);

4. Claims Administration;

5. Case Management:

   a. Prior Authorization records only; or

   b. Case or Medical Management records only.

6. Pharmacy:

   a. Prior Authorization records only.

7. Multipurpose Senior Services Program (MSSP):

   a. Prior Authorization records only.

8. Long Term Care (LTC):

   a. Case or Medical Management Records.

C. Department staff shall consult with the Privacy Officer if there is any doubt about the appropriateness of releasing the PHI to the Member.

D. If CalOptima does not maintain the PHI that is the subject of the Member's request for access, and CalOptima knows where the requested information is maintained, CalOptima shall inform the Member of the entity to whom the Member may direct such request.

E. Notification to Member:

1. The Office of Compliance shall notify the Member regarding the record request:

   a. Approved: If CalOptima approves the Member's request, CalOptima shall provide the Member with the records requested, in accordance with the format and method designated on the Individual Request for Access to Personal Health Information Form.

   b. Denied: If CalOptima denies the Member's request, CalOptima shall send a letter to the Member within the required timeframes informing the Member of the decision, the reason for denial, and instructions on Member's appeal rights to have the materials reviewed, if applicable.

F. Documentation:

1. The Office of Compliance shall retain a record of the request and related letters, including a copy of the information released to the Member for ten (10) years from the date of the release.

G. The following table summarizes the content of CalOptima's DRS:

Designated Record Set Content	**Source**	**Media Type For Member**

Designated Record Set Content	Source	Media Type For Member
Enrollment Records Enrollment Form from Member	Customer Service	Paper Form
Auto-Assignment & Physician Medical Group changes	IS	Print out/report from CalOptima Claims System
Payment Records (1) Eligibility Records	IS	Print out/report from CalOptima Claims System
(2) Claims Records	Claims	Paper copy from microfiche Print out/report from CalOptima Claims System
(3) Prior, current and retrospective Authorization Records (ARF/PA request and attachments*, notice of action (NOA) letters)	Care Coordination	Print out/report from CalOptima Claims System, clinical systems. Paper copy from ARF/PA File, shared drive, or CD-rom.
	Pharmacy	Paper copy Summary- Pharmacy Benefit Manager (PBM) data files
	MSSP	Paper copy Print out/report MSSP data base
*Note: Excludes medical records created and maintained by Providers	LTC	Paper copy, Print out/report from LTC database
Case or Medical Management Record Entries in Care Management Data Systems including contacts with Member or other coordination activities used in making decisions about the Member.	Care Coordination	Paper copy Summary reports from clinical systems and database files.
Excluded Patient-identifiable data used for administrative, regulatory, Health Care Operations and Payment/financial purpose; employment records held by CalOptima in its role as employer.		Examples include protocols, practice guidelines, accreditation reports, best practice guidelines, public health records, statistical reports, MDS Report, and patient identifiable data reviewed for quality assurance.

V. ATTACHMENTS

A. Authorization for Use or Disclosure of Protected Health Information
B. Individual Request for Access to Personal Health Information
C. Letter: Denial of Access-Subject to review
D. Letter: Denial of Access-Not Subject to review

VI. REFERENCES

A. California Health and Safety Code, Section 123110
B. CalOptima Notice of Privacy Practices
C. CalOptima Privacy Program
D. CalOptima Policy AA.1000: Glossary of Terms
E. CalOptima Policy CMC.1001: Glossary of Terms
F. CalOptima Policy MA.1001: Glossary of Terms
G. CalOptima Policy MA.9205: Verification of Identity for Disclosure of Protected Health Information
H. CalOptima Policy MA.9212: Access by Member's Authorized Representative
I. CalOptima Policy MA.9219: Authorization for Release of Protected Health Information
J. CalOptima Compliance Plan
K. Title 45, Code of Federal Regulations, Section 164.524 Access of Individuals to Protected Health Information
L. Title 45, Code of Federal Regulations, Section 164.524, Administrative Requirements, (j)(2) Implementation specification: Retention period

VII. REGULATORY APPROVALS

Not Applicable

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	08/01/2005	MA.9203	Member Access to Designated Record Set
Revision Date 1	09/01/2008	MA.9203	Member Access to Designated Record Set
Revision Date 2	07/01/2011	MA.9203	Member Access to Designated Record Set
Revision Date 3	06/01/2014	MA.9203	Member Access to Designated Record Set
Revision Date 4	11/01/2014	MA.9203	Member Access to Designated Record Set
Revision Date 5	09/01/2015	MA.9203	Member Access to Designated Record Set

Policy #: MA.9204
Title: **Minimum Necessary Uses and Disclosures of Protected Health Information and Document Controls**
Department: Office of Compliance
Section: Health Insurance Portability and Accountability Act (HIPAA)
CEO Approval: Michael Schrader _____

Effective Date: 6/1/05
Last Review Date: 9/1/15
Last Revised Date: 9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To describe the conditions under which CalOptima shall control access to, request, Use, or Disclose Protected Health Information (PHI) to ensure that the data used is the Minimum Necessary to fulfill the request or carry out the required function.

II. DEFINITIONS

Term	Definition
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of a covered entity or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs, or assists in the performance of: a. A function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or b. Any other function or activity regulated by this subchapter; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the services involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.
Capitation Payments	The monthly amount paid to a Health Network by CalOptima for the delivery of Covered Services to Members.

Term	Definition
Covered Entity	A health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by Title 45, Code of Federal Regulations, Part 160.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disclosure	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Encounter	Any unit of Covered Service provided to a Member by a Health Network regardless of Health Network reimbursement methodology. These services include any Covered Services provided to a Member, regardless of the service location or Provider, including out-of-network Covered Services and sub-capitated and delegated Covered Services. Encounter data submitted to CalOptima should not include duplicate claims.
FACETS:	Licensed software product that supports administrative, claims processing and adjudication, membership data, and other information needs of managed care organizations.
Health Care Operations	Activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	An enrollee-beneficiary of a CalOptima program.
Minimum Necessary	The principle that a covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment or Health Care Operations.
Payment	Activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.

Term	Definition
Protected Health Information (PHI	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Treatment	Activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use of PHI	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. The sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

III. POLICY

A. CalOptima employees shall make every reasonable effort to control unauthorized access to, and to only request, Disclose, or Use the Minimum Necessary data to complete Health Care Operations or to carry out any request for Member health-related information related to those activities which are for purposes directly connected with the administration of the CalOptima programs.

B. CalOptima employees shall not divulge the Medi-Cal status of a Member without prior approval of the Department of Health Care Services (DHCS), except for Treatment, Payment and Health Care Operations, or as Required by Law.

C. Minimum Necessary shall apply to all PHI that CalOptima receives or creates.

D. Minimum Necessary policy shall not apply to:

1. Disclosures to, or Use by, a health care Provider for Treatment;

2. Disclosures made to the Member who is the subject of the information;

3. Disclosures made pursuant to authorization by the Member;

4. Disclosures to the Department of Health and Human Services (HHS) when Disclosure of information is a requirement under the Privacy Rule for enforcement purposes; and

5. Other Uses or Disclosures that are required by Law.

IV. PROCEDURE

A. Minimum Necessary Use of PHI

1. CalOptima shall limit staff access to a Member's PHI to those employees who need to Use the data to carry out their specific job-related duties, including those related to Treatment, Payment, and Health Care Operations.

2. The respective department director or manager shall determine access to electronic and paper data files. The department director shall assign an employee access level for computer systems. The CalOptima Information Systems Applications Management Department shall manage password control.

3. Within CalOptima, the following departments shall require and maintain the indicated levels of access to PHI on a routine basis to appropriately accomplish their duties and responsibilities:

Department	CalOptima Claims System Member Eligibility	CalOptima Claims System Customer Service	CalOptima Claims System Claims	CalOptima Claims System Finance/Cap	CalOptima Claims System Accounts Payable	CalOptima Claims System G&A	CalOptima Claims System UM/CM	Department Level Hard Copy Databases	Clinical Support Systems
Care Management, MSSP, and Medical Management	P	C	P		P	C	C	Selective	C
Claims Administration	P	C	C	P			P	All	
Customer Service	C	C	P			P	P-Sel	Selective	
Fiscal Services	P		P	C	C		P-Sel	Selective	
Provider/Encounter	P		P	P			P	Selective	
Grievance & Appeals Resolution Services (GARS)	P	C	P			C	C	All	
Office of Compliance	P	P	P				P	Selective	
Government Affairs-Regulatory	P	P	P				P	Selective	
Legal Affairs	P	P	P		P	P	P	All	
Executive Office	P	P	P	P	P	P	P		
KEY:	*C= View & Access* *P= View Only*								

	Selective= Restricted to certain department staff *P-Sel= UM Inquiry View only*

4. The respective department director or manager may grant access to other job categories on a specific "need to know" basis, and shall restrict access to Minimum Necessary data to complete the work activity.

B. Minimum Disclosure of PHI

1. All routine Disclosures for Payment and Health Care Operations shall contain only the PHI data necessary to complete the Health Care Operations or Payment process.

2. CalOptima shall control unauthorized access to PHI in paper form as follows:

   a. A CalOptima employee shall not leave PHI in paper form unattended at any time, unless it is locked in a file cabinet, file room, desk, or office. Unattended means that the information is not under observation by an employee authorized to access such information.

   b. An authorized CalOptima employee shall escort a visitor through an area where PHI is contained and shall keep PHI out of sight while a visitor is in the area, unless the visitor is authorized to view the PHI.

   c. A CalOptima employee shall dispose of PHI through confidential means, including, but not limited to, shredding or pulverizing.

   d. A CalOptima employee shall not remove PHI from the CalOptima premises, except for routine business purposes or with the express written permission of DHCS or CMS.

   e. Facsimile containing PHI

      i. A CalOptima employee shall not leave an incoming or outgoing facsimile containing PHI unattended.

      ii. CalOptima shall house facsimile machines in a secure area.

      iii. An outgoing facsimile shall contain a confidentiality statement notifying an individual receiving a facsimile in error to destroy the facsimile.

      iv. A CalOptima employee shall verify a facsimile number prior to sending the facsimile.

   f. Mail containing PHI

      i. CalOptima shall send mail that contains PHI only by a secure method.

      ii. CalOptima shall send a mailing that contains PHI of two-thousand-five-hundred (2,500) Members or more by a secure, bonded courier with signature required on the receipt.

      iii. CalOptima shall encrypt electronic media sent by mail.

3. CalOptima shall control unauthorized access to PHI in oral form as follows:

   a. A CalOptima employee shall not discuss PHI in public areas.

   b. A CalOptima employee shall not discuss PHI with unauthorized person(s).

4. Routine recurring Disclosures, or requests for PHI, include:

   a. Membership, Capitation Payments, and Encounter reporting with contracted Physician Medical Groups.

   b. Payment of claims for services provided to Members.

   c. Coordination of care between CalOptima and the Health Care Agency (HCA), Regional Center of Orange County (RCOC), Health Networks, and Providers.

   d. Complying with regulatory reporting requirements and oversight activities.

   e. Requests for PHI to carry out peer review or other Quality Improvement (QI) activities.

C. Review of Non-routine Disclosures or Requests for PHI

1. All requests for non-routine Disclosures of PHI shall be routed to the Privacy Officer, or his or her designee, for review.

2. The Privacy Officer, or his or her Designee, shall review all non-routine Disclosures or requests on an individual basis to determine that the PHI requested is limited to the information reasonably necessary to accomplish the stated purpose for which the request is made.

D. Criteria for Reviewing Non-routine Requests for PHI Disclosures

1. The requestor(s) clearly states the purpose for which the PHI is requested.

2. All requested information is reasonably necessary to meet the need stated on the request.

3. When applicable, the requestor(s) submits valid authorization with the request for the PHI, in accordance with CalOptima Policy MA.9219: Authorization for Release of Protected Health Information.

4. The Disclosure is consistent with CalOptima policy, MA.9202: Notice of Privacy Practice.

5. Requests may be accepted as the Minimum Necessary for the stated purpose when requested under the following conditions:

   a. A professional or Business Associate requests the information in order to provide a professional service to CalOptima, and the requestor represents that the request is the Minimum Necessary information for the stated purpose; or

   b. Another Covered Entity requests the information.

E. The Privacy Officer, or his or her Designee, shall make a determination on the request, and authorize or deny the request for the release of the PHI, in whole or part, based on the above criteria and relevant California law including, but not limited to, those related to:

1. Elder abuse;

2. Persons with Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS);

3. Family planning;

4. Immunization status; and

5. Child Health and Disability Prevention Program (CHDP) screening, including blood, lead, substance abuse, mental health, and developmental disabilities.

F. Knowledge of a violation or potential violation of this policy shall be reported directly to the Office of Compliance or the Compliance Ethics Hotline 1-877-837-4417.

G. Documentation:

1. CalOptima shall record all Disclosures pursuant to the standard Disclosure tracking procedure, in accordance with CalOptima Policy MA.9210: Tracking Disclosures of Protected Health Information (PHI).

V. ATTACHMENTS

Not Applicable

VI. REFERENCE

A. CalOptima Policy AA.1000: Glossary of Terms
B. CalOptima Policy CMC.1001: Glossary of Terms
C. CalOptima Policy MA.9202: Notice of Privacy Practice
D. CalOptima Policy MA.9210: Tracking Disclosures of Protected Health Information
E. CalOptima Policy MA.9219: Authorization for Release of Protected Health Information
F. CalOptima Privacy Program
G. Workgroup for Electronic Data Interchange (WEDI) – Strategic National Implementation Process (SNIP) Security and Privacy Workgroup Privacy Policies and Procedures White Paper, http://www.wedi.org/cmsUploads/pdfUpload/WhitePaper/pub/ACFA092.pdf
H. CalOptima Compliance Plan
I. Title 42, Code of Federal Regulations, Section 431.00 et seq.
J. Title 45, Code of Federal Regulations, Section 164.502, Uses and Disclosures of PHI
K. Title 45, Code of Federal Regulations, Section 164.514, Other Requirements Related to Uses and Disclosures of PHI

VII. REGULATORY APPROVALS

None to Date

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	06/01/2005	MA.9204	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls
Revision Date 1	02/01/2008	MA.9204	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls
Revision Date 2	07/01/2011	MA.9204	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls
Revision Date 3	06/01/2014	MA.9204	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls
Revision Date 4	11/01/2014	MA.9204	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls
Revision Date 5	09/01/2015	MA.9204	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls

Policy #:	MA.9205
Title:	**Verification of Identity for Disclosure of Protected Health Information**
Department:	Office of Compliance
Section:	Health Insurance Portability and Accountability Act (HIPAA)
CEO Approval:	Michael Schrader
Effective Date:	6/1/05
Last Review Date:	9/1/15
Last Revised Date:	9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To define the steps necessary for verification of identity of a person requesting Protected Health Information (PHI) prior to Disclosure.

II. DEFINITIONS

Term	Definition
Authorized Representative:	Any individual authorized by a Member, or under state law, to act on his or her behalf in obtaining an Organization Determination or in dealing with any level of the Appeal process. An Authorized Representative is subject to the rules described in Title 20 of the Code of Federal Regulations, Part 404, Subpart R, unless otherwise stated in the Medicare Managed Care Manual (Use form CMS-1696 for Claims Adjudication or Claim Appeals process).
Disclosure	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
FACETS:	Licensed software product that supports administrative, claims processing and adjudication, membership data, and other information needs of managed care organizations.
Protected Health Information (PHI):	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The

Term	Definition
	information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Member (Global):	An enrollee-beneficiary of a CalOptima Program.

III. POLICY

A. CalOptima, and its programs, shall take necessary reasonable steps to verify the identity and legal authority of a person requesting Disclosure of PHI.

IV. PROCEDURE

A. Verification of a Member:

1. Telephone: A person representing him or herself to be a Member can be verified using the following method:

   a. Demographic information that is confirmed in FACETS™ (Member number, address, or date of birth);

   b. The use of confirming data in the system such as prior entries regarding services; or

   c. The Member is known to CalOptima staff from prior contact.

2. In person: A person representing him or herself to be a Member can be verified by:

   a. Presentation of identification such as a driver's license, Membership card, or other materials such as letters from public agencies or CalOptima, addressed to the Member;

   b. Verbal statements of address, date of birth, other data confirmed in FACETS™; or

   c. The Member is known to OneCare staff from prior contact.

B. Verification of a Member's Authorized Representative:

1. Telephone and in person: An Authorized Representative shall provide information to identify his or her relationship to the minor, dependent adult, or deceased Member. Accepted documents include:

   a. Legal documents: Executed power of attorney, proof of guardianship, medical power of attorney, certified letter of conservatorship, executor of will, letters testamentary, or letters of administration, or if the Member is deceased and the Authorized

Representative is the next of kin or other family member, accepted documentation may be the Authorized Representative's birth certificate and drivers license; or

b. A valid written authorization signed by the Member or the court.

2. Documentation of the Authorized Representative's known relationship shall be documented in FACETS™ and the documentation provided by the Authorized Representative shall be saved in the Customer Service Department shared files.

3. OneCare shall grant a Member's Authorized Representative access to a Member's PHI in accordance with the following policies, MA.9203: Member Access to Designated Record Set, MA.9212: Access by Member's Authorized Representative, and MA.9219: Authorization for Release of Protected Health Information.

C. Verification of a Disclosure requested by a family member, relative, close friend of the Member, or any other person identified by the Member:

1. Member is available: If the Member is available on the telephone or in person, CalOptima staff shall obtain the Member's consent before disclosing the PHI or based on the circumstances if it is inferred that the Member was given the opportunity to object and did not object to the Disclosure. Documentation of the Disclosure is required as follows:

a. CalOptima staff shall document that the Member was present and verbally agreed to the Disclosure; or

b. The circumstances that led the CalOptima staff to believe that the Member agreed to or did not object to the disclosure of PHI to the family member, relative, close friend of the Member, or any other person identified by the Member.

2. Member is not available: If there in an emergency or if the Member is incapacitated, CalOptima staff may use their professional judgment to determine whether the Disclosure of PHI is in the best interest of the Member. Staff may only disclose the PHI that is relevant to the person's involvement in the Member's care and shall document the emergency that supported the Disclosure of PHI to the family member, relative, close friend of the Member, or any other person identified by the Member.

D. Written Requests for PHI:

1. A written request for copies of PHI may be accepted as valid, provided all information on the request is complete and accurate based on CalOptima data.

2. A request from a Member's Authorized Representative shall include written authorization from the Member to release the PHI, unless otherwise permitted in accordance with the following CalOptima policies, MA.9213: Protected Health Information Disclosures Required by Law, and MA.9214: Use and Disclosure for Treatment, Payment and Health Care Operations.

3. Deceased Member: The PHI of a deceased Member is subject to the federal HIPAA privacy provisions for as long as OneCare maintains the PHI. An Authorized Representative with legal authority to act on behalf of a deceased Member or their estate may request the Member's PHI.

4. CalOptima shall verify the legal authority of a public official or person acting on behalf of a public official through a review of:

   a. Documentation, statements, or presentations that, upon initial review, meet the applicable requirements for a Disclosure of PHI;

   b. Presentation of an agency identification badge, other official credentials, or other proof of government authority;

   c. Other evidence or documentation from an agency which establishes that the person is acting on behalf of the public official, such as a contract for services, memorandum of understanding, or purchase order;

   d. A written statement of legal authority under which the information is requested;

   e. If a written statement is impracticable, an oral statement of such legal authority; or

   f. A request that is made pursuant to a warrant, subpoena, order, or other legal process issued by a grand jury or a judicial or administrative tribunal that is presumed to constitute legal authority.

E. CalOptima staff may rely on the exercise of professional judgment in making a Disclosure to avert a serious threat to the health and safety of a Member or others.

V. ATTACHMENTS

A. Authorization for Use or Disclosure of Protected Health Information

VI. REFERENCES

A. Title 45, Code of Federal Regulations, Section 164.514(h)
B. Title 45, Code of Federal Regulations §164.510(b)
C. CalOptima Policy CMC.1001: Glossary of Terms
D. CalOptima Policy MA. 9202: Notice of Privacy Practices
E. CalOptima Policy MA.9203: Member Access to Designated Record Set
F. CalOptima Policy MA.9212: Access by Member's Authorized Representative
G. CalOptima Policy MA.9213: Protected Health Information Disclosures Required by Law
H. CalOptima Policy MA.9214: Use and Disclosure for Treatment, Payment, and Health Care Operations
I. CalOptima Policy MA.9219: Authorization for Release of Protected Health Information

VII. REGULATORY APPROVALS

Not Applicable

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	06/01/2005	MA.9205	Verification of Identity for Disclosure of Protected Health Information
Revision Date 1	01/01/2009	MA.9205	Verification of Identity for Disclosure of Protected Health Information
Revision Date 2	05/01/2014	MA.9205	Verification of Identity for Disclosure of Protected Health Information
Revision Date 3	09/01/2015	MA.9205	Verification of Identity for Disclosure of Protected Health Information

Policy #:	MA.9206
Title:	**Member Right to Request Restrictions on Use and Disclosure of Protected Health Information**
Department:	Office of Compliance
Section:	Health Insurance Portability and Accountability Act (HIPAA)
CEO Approval:	Michael Schrader _____
Effective Date:	6/1/05
Last Review Date:	9/1/15
Last Revised Date:	9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To describe the process by which a Member may request CalOptima to restrict the Use and Disclosure of his or her Protected Health Information (PHI), and the process by which CalOptima shall process such requests in accordance with applicable statutory, regulatory and contractual requirements.

II. DEFINITIONS

Term	Definition
Authorized Representative:	Any individual authorized by a Member, or under state law, to act on his or her behalf in obtaining an Organization Determination or in dealing with any level of the Appeal process. An Authorized Representative is subject to the rules described in Title 20 of the Code of Federal Regulations, Part 404, Subpart R, unless otherwise stated in the Medicare Managed Care Manual.
Business Associate:	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of a covered entity or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs or assists in the performance of: a. A function or activity involving the use of disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing benefit management, practice management, and repricing; or b. Any other function or activity regulated by this subchapter; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the services involves the

	disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.
Disclosure:	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Emergency Services:	Those covered inpatient and outpatient services required that are (1) furnished by a physician qualified to furnish emergency services; and (2) needed to evaluate or stabilize an Emergency Medical Condition.
Member (Global):	An enrollee-beneficiary of a CalOptima Program
Protected Health Information:	All individually identifiable health information that is transmitted electronically, maintained in any electric medium, or transmitted or maintained in other form of medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider:	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Physician Group, or other person or institution who furnishes Covered Services.
Required by Law:	Mandated in law and compelling a covered entity (provider, health plan, or clearinghouse) to make a use or disclosure of Protected Health Information (Pill) and that is enforceable in a court of competent jurisdiction.
Use of PHI:	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. The sharing, employment application, utilization, examination, or analysis of PHI within an entity that maintains such information.

III. POLICY

A. A Member may request to CalOptima, in writing, to restrict the Use and Disclosure of his or her PHI.

B. CalOptima retains the right to approve or deny such request.

C. If CalOptima approves a Member's request to restrict the Use and Disclosure of the Member's PHI, CalOptima shall not be subject to such restrictions if:

1. Disclosure is Required by Law; or

2. The restricted PHI is needed:

   a. By a treating Provider;

   b. For public health activities;

   c. To report abuse, neglect, domestic violence, and activities related to criminal acts; or

   d. By a coroner.

3. The Member requires Emergency Services; or

4. The Disclosure is among those defined in Title 45, Code of Federal Regulations, Sections 164.512 and 164.522.

IV. PROCEDURE

A. Requests for restrictions on Use and Disclosure:

1. A Member or a Member's Authorized Representative shall submit a written request to restrict either the Use or Disclosure of the Member's PHI to the CalOptima Office of Compliance. The request must include:

   a. Request to Restrict Information on Use and Disclosure of Protected Health Information form;

   b. The PHI that is to be restricted;

   c. Whether the Member wants to restrict the Use, Disclosure, or both; and

   d. To whom the limitations apply (e.g., Disclosure to a spouse).

2. CalOptima shall discuss the request with a Member or a Member's Authorized Representative to ensure that such restrictions are in the Member's best interest.

3. CalOptima shall remind a Member that CalOptima:

   a. Retains the right to approve or deny such request;

   b. May release the restricted PHI in emergency situations;

   c. May release the restricted PHI, if Required by Law; and

   d. May terminate the agreement to restrict PHI.

4. CalOptima shall review a Member's request to restrict Use and Disclosure of PHI in coordination with Business Associates, as appropriate.

5. CalOptima shall document the restriction, if any.

6. CalOptima shall notify a Member of the decision to approve or deny the Member's request within thirty (30) calendar days upon receipt of the request, using the Response to Request for Restriction on Use and Disclosure of PHI form.

B. Terminating a Restriction

1. CalOptima may terminate its agreement to a restriction of Use and Disclosure under the following circumstances:

   a. A Member agrees to, or requests, the termination in writing to CalOptima;

   b. Member agrees verbally to the termination, and the verbal agreement is documented by CalOptima; or

   c. CalOptima notifies the Member that it shall terminate its agreement to the restriction(s); except that such termination is only effective with respect to PHI created or received after the individual has been notified of the termination.

C. The Office of Compliance shall retain copies of all requests and related notices on file for ten (10) years from the date the request is received by CalOptima.

V. ATTACHMENTS

A. Request for Restriction on Use and Disclosure of Protected Health Information
B. Response to Request for Restriction on Use and Disclosure of Protected Health Information
C. Termination of Restriction

VI. REFERENCES

A. CalOptima Policy AA.1001: Glossary of Terms
B. CalOptima Policy CMC.1001: Glossary of Terms
C. CalOptima MA.9202: Notice of Privacy Practices
D. CalOptima Privacy Program
E. WEDI – Strategic National Implementation Process (SNIP) Security and Privacy Workgroup Privacy Policies and Procedures White Paper, http://www.montaguerm.com/ftp/mn_2002_11_01.pdf
F. Title 45, Code of Federal Regulations, Section 160.103
G. Title 45 Code of Federal Regulations, Section 164.512 Uses and Disclosures for which an Authorization or Opportunity to Agree or Object is not Required
H. Title 45 Code of Federal Regulations, Section 164.522 Rights to Request Privacy Protection for Protected Health Information

VII. REGULATORY APPROVALS

Not Applicable

VIII. BOARD ACTION

None to date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	06/01/2005	MA.9206	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information
Revision Date 1	01/01/2009	MA.9206	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information
Revision Date 2	07/01/2011	MA.9206	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information
Revision Date 3	01/01/2013	HH.3007Δ	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information
Revision Date 4	05/01/2014	MA.9206	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information
Revision Date 5	11/01/2014	MA.9206	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information
Revision Date 6	09/01/2015	MA.9206	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information

Policy #:	MA.9207
Title:	**Member Request to Amend Records**
Department:	Office of Compliance
Section:	Health Insurance Portability and Accountability Act (HIPAA)
CEO Approval:	Michael Schrader _____

Effective Date:	6/1/05
Last Review Date:	9/1/15
Last Revised Date:	9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To define the process by which Members may request amendments to their Protected Health Information (PHI) maintained in the Designated Record Set (DRS) by CalOptima or by its Business Associate(s).

II. DEFINITIONS

Term	Definition
Business Associate	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of a covered entity or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs or assists in the performance of: a. A function or activity involving the use of disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing benefit management, practice management, and repricing; or b. Any other function or activity regulated by this subchapter; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the services involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.
Complaint	Any expression of dissatisfaction to CalOptima, a Provider, or the Quality Improvement Organization (QIO) by a Member made orally or in writing. A Complaint may include concerns about the operations of Providers or Cal Optima such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, respect paid to Members, and claims regarding the

	right of a Member to receive services or receive payment for services previously rendered. A Complaint may also involve CalOptima's refusal to provide services to which a Member believes he or she is entitled. A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.
Designated Record Set	A group of records maintained by or for Cal Optima that includes enrollment, Payment, claims adjudication, and case or medical management record system(s) used by or maintained for the agency, or used, in whole or in part, by or for CalOptima to make decisions about the Member. The DRS excludes patient-identifiable data used for administrative, regulatory, Health Care Operations and Payment/financial purpose; employment records held by CalOptima in its role as employer.
Disclosure	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Health Network (HN)	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term "Medical Record" is used both for the physical folder for each individual patient and for the body. Information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member (Global)	An enrollee-beneficiary of a CalOptima program.
Protected Health Information (PHI)	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form of medium. This information indentifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and related to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member, or 3. Past, present, or future Payment for the provision of health care to a Member.

III. POLICY

A. CalOptima shall honor a Member's right to request an amendment or correction to his or her PHI, if the Member feels that the information is incomplete or inaccurate. The Member has

the right to request an amendment of his or her PHI for as long as CalOptima or a Business Associate maintains such PHI in the DRS.

B. CalOptima shall retain the right to approve or deny a Member's request for an amendment or correction to his or her PHI.

IV. PROCEDURE

A. The Office of Compliance shall be responsible for receiving, processing, and responding to requests for amendments to PHI.

B. All Members requests for amendments to PHI or other health information shall be in writing and directed to the Office of Compliance.

C. Members shall document the reason(s) to support the amendment request.

D. CalOptima shall review a request from a Member who is enrolled in a Health Network (HN) in coordination with the Member's HN or Business Associate, as appropriate.

E. The Office of Compliance shall refer the request to a designated health care professional or the department responsible for maintaining the DRS in question on a case-by-case basis.

F. CalOptima may deny a Member's request to amend PHI that:

1. Is not created by CalOptima, unless the originator is no longer available to act on the request;

2. Is not part of the Member's DRS (Note: CalOptima does not create or maintain clinical Medical Records for Members);

3. Is not accessible to the Member due to federal or state laws that do not permit; or

4. Is accurate and complete.

G. The Office of Compliance shall inform the Member no later than sixty (60) calendar days after receipt of the request if the amendment is approved.

H. CalOptima shall not extend the allotted period for action by no more than thirty (30) calendar days.

I. If CalOptima extends the time period for action, the Office of Compliance shall within thirty (30) calendar days after receipt of the request, provide the Member with a written statement of the reasons for the delay, and the date by which CalOptima shall complete the action on the request.

J. If CalOptima approves the request for amendment, the Office of Compliance shall:

1. Make the appropriate amendment, or arrange to have the appropriate department make the amendment;

2. Inform the Member in a timely manner that the amendment has been approved, and obtain the Member's identification and agreement to have CalOptima notify the relevant person(s) with which the amendment needs to be shared; and

3. Within a reasonable time frame, make reasonable efforts to provide the amendment to:

   a. Persons identified by the Member as having received PHI about the Member and needing the amendment; and

   b. A person, including a Business Associate that CalOptima knows to have the PHI that is the subject of the amendment, and may have relied on, or may rely on the information to the detriment of the Member, using the Notification of Amendment to Protected Health Information form.

K. Amendment Request is Denied

1. If CalOptima denies the request for amendment, the Office of Compliance shall provide the Member with a timely written denial letter that contains:

   a. The basis for the denial;

   b. Information on a Member's right to submit a written statement of disagreement with the denial, and how the Member may file such a statement;

   c. A description of how the Member may file a Complaint with CalOptima, in accordance with CalOptima Policies MA.9001: Complaint Process and MA.9002: Member Grievance Process;

   d. A description of how the Member may file a Complaint with the Secretary of Health and Human Services; and

   e. The following statement: "If the Member does not submit a statement of disagreement, the Member may request CalOptima to provide the Member's request for amendment and the denial with any future Disclosure of the PHI that is the subject of the amendment request."

2. If a Member provides a statement of disagreement, CalOptima may prepare a written rebuttal to the Member's statement of disagreement.

3. CalOptima shall provide the Member with a copy of the rebuttal.

4. CalOptima shall append or otherwise link the following to the DRS or the PHI that is the subject of the disputed amendment:

   a. The Member's request for amendment;

   b. The denial of the request;

   c. The Member's statement of disagreement, if any; and

d. CalOptima's rebuttal, if any.

5. Any subsequent Disclosures of the PHI to which a Member's written disagreement relates shall include the following:

   a. The appended material as described in Section IV.K.4; or

   b. An accurate summary of any such information.

6. CalOptima may transmit subsequent Disclosures separately from a standard transaction if the standard transaction does not allow transmission of the amendment information.

7. If the Member has not submitted a written statement of disagreement, CalOptima shall include the Member's request for amendment and CalOptima's denial, or an accurate summary of such information, with any subsequent Disclosure of the PHI only if the individual has requested such action.

L. CalOptima shall retain a copy of a Member's request and the outcome of the review for ten (10) years from the receipt of the request.

V. ATTACHMENTS

A. Member Request to Amend Protected Health Information
B. Notification of Amendment to Protected Health Information
C. Response to Request to Amend Protected Health Information
D. Statement of Disagreement/Request to Include Amendment Request and Denial with Future Disclosures

VI. REFERENCES

A. CalOptima Notice of Privacy Practices
B. CalOptima Policy CMC.1001: Glossary of Terms
C. CalOptima Policy MA.1001: Glossary of Terms
D. CalOptima Policy MA.9001: Complaint Process
E. CalOptima Policy MA.9002: Member Grievance Process
F. CalOptima Policy MA.9202: Notice of Privacy Practices
G. CalOptima Privacy Program
H. HIPAA Patient Privacy Compliance Guide, 1340: The Right of Individuals to Amend PHI
I. The California Patient Privacy Manual, California Health Care Association, 2002, Chapter 3, Patient Rights
J. Title 45, Code of Federal Regulations, Section 164.524 Access of Individuals to Protected Health Information
K. Title 45, Code of Federal Regulations, Section164.526 Amendment of Personal Health Information
L. Title 45, Code of Federal Regulations, Section 164.501 Definitions Required by Law
M. Workgroup for Electronic Data Interchange (WEDI) – Strategic National Implementation Process (SNIP) Security and Privacy Workgroup Privacy Policies and Procedures-2002

VII. REGULATORY APPROVALS

Not Applicable

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	06/01/2005	MA.9207	Member Request to Amend Record
Revision Date 1	02/01/2008	MA.9207	Member Request to Amend Record
Revision Date 2	07/01/2011	MA.9207	Member Request to Amend Record
Revision Date 3	11/01/2014	MA.9207	Member Request to Amend Record
Revision Date 4	09/01/2015	MA.9207	Member Request to Amend Record

Policy #:	MA.9209
Title:	**Member Request for Accounting of Disclosures**
Department:	Office of Compliance
Section:	Health Insurance Portability and Accountability Act (HIPAA)
CEO Approval:	Michael Schrader _____

Effective Date:	6/1/05
Last Review Date:	9/1/15
Last Revised Date:	9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To define the scope of a Member's right to request an accounting of all Disclosures made by CalOptima of the Member's Protected Health Information (PHI) created or maintained in a Designated Record Set (DRS) by CalOptima or its Business Associate.

II. DEFINITIONS

Term	Definition
Business Associate	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of a covered entity or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs or assists in the performance of: a. A function or activity involving the use of disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing benefit management, practice management, and repricing; or b. Any other function or activity regulated by this subchapter; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the services

	involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.
Designated Record Set (DRS)	A group of records maintained by or for CalOptima that includes enrollment, Payment, claims adjudication, and case or medical management record system(s) used by or maintained for the agency, or used, in whole or in part, by or for CalOptima to make decisions about the Member. The DRS excludes patient-identifiable data used for administrative, regulatory, Health Care Operations and Payment/financial purpose; employment records held by CalOptima in its role as employer.
Disclosure	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Health Care Operations	Activities including quality assessment and improvement activities, care management, professional review, compliance audits, health insurance underwriting, premium rating and other activities related to a contact and health benefits, management and administration activities customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Limited Data Set	Protected Health Information (PHI) that uses the indirect identifiers (State, town or city, zip codes, dates of service, birth, and death) and excludes direct identifiers of the Member or the Member's relatives, employers, or household members.
Member (Global)	An enrollee-beneficiary ofa CalOptima program.
Payment	Activities carried out by CalOptima including: 1. Determination eligibility, risk adjustments based on the Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification or charges; and 3. Utilization review activities including pre-certification, pre-authorization, concurrent, or retrospective review of services.
Protected Health Information (PHI)	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form of medium. This information indentifies the individual or there is a reasonable basis to believe the information can be used to identify the

	individual. The information was created or received by CalOptima or Business Associates and related to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member, or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Physician Medical Group, or other person or institution who furnishes Covered Services.
Use of PHI	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. The sharing, employment, application, utilization, examination, or analysis of the fill within an entity that maintains such information.

III. POLICY

A. Upon a Member's request, CalOptima shall provide an accounting of PHI Disclosures released for a time period not to exceed six (6) years and not prior to April 14, 2003.

1. Disclosures

a. CalOptima is not required to provide an accounting of Disclosures if the information was:

i. Used to provide Member care, Payment for services, or Health Care Operations, including but not limited to, disclosures to Providers, clearinghouses, and Business Associates;

ii. Provided to the Member;

iii. Provided to national security or intelligence;

iv. Provided to correctional facilities or law enforcement officials;

v. Made pursuant to a Member's Authorization to Disclose;

vi. Part of a Limited Data Set; or

vii. Incidental to another permissible Use or Disclosure.

B. The Office of Compliance shall track all other Disclosures of PHI not mentioned in Section III.A, in accordance with CalOptima Policy MA.9210: Tracking and Reporting Disclosures of Protected Health Information.

C. Disclosure of PHI is not limited to hard-copy information and may include any information disclosed by other means, such as verbally, electronic data release, or by facsimile.

D. CalOptima shall temporarily suspend a Member's right to receive an accounting of Disclosures to a health oversight agency or law enforcement official if:

1. CalOptima receives a written statement from such agency or official that an accounting to the Member would be reasonably likely to impede the agency's activities, and specifying the time for which such a suspension is required; or

2. A health oversight agency or law enforcement official provides an verbal statement to CalOptima, in which case CalOptima shall:

   a. Document the statement, including the identity of the agency or official making the statement;

   b. Temporarily suspend the Member's right to an accounting of Disclosures subject to the statement; and

   c. Limit the temporary suspension to no longer than thirty (30) calendar days from the date of the oral statement, unless CalOptima receives a written request for suspension.

IV. PROCEDURE

A. A Member may request an accounting of Disclosures of his or her PHI that CalOptima released, for a period of time less than six (6) years from the date of the request, by submitting a Request for an Accounting of Disclosures Form to the Customer Service Department.

B. The Customer Service Department shall:

   1. Provide the Member with a Request for an Accounting of Disclosures Form by U.S. mail or in person at the CalOptima office; and

   2. Assist the Member in completing the form, if necessary.

C. CalOptima's Customer Service Department shall forward all requests to the Office of Compliance who shall process the request.

D. CalOptima shall review a Member's request for an accounting of Disclosure from Members enrolled in a Health Network in coordination with the Health Network or other Business Associate, as appropriate.

E. A written account of the Disclosures shall include:

   1. Disclosures of PHI that occurred during the six (6) years, or shorter time period as designated on the Member's request, prior to the date of the request for an accounting;

      a. The date of the Disclosure;

      b. The name and address of the person or entity who received the PHI;

      c. A brief description of the PHI released;

      d. A brief statement of the purpose for the information, or, instead of a statement, a copy of the written request for the information; and

e. If multiple requests were made by the same individual or entity, the list will include the frequency, periodicity, number of times the information was released and the date of the last release during the period requested by the Member.

F. The Office of Compliance shall act on the Member's request, and:

1. Provide the Member with the PHI accounting within sixty (60) calendar days after the date of request; or

2. If the PHI accounting will not be prepared within the sixty (60) calendar days, communicate to the Member:

a. The reasons why the PHI accounting will not be prepared within sixty (60) calendar days;

b. The date in which the PHI accounting will be prepared; and

c. Complete the request within an additional thirty (30) calendar days after the expiration of the initial sixty (60) calendar days.

G. Documentation

1. The Office of Compliance shall document the request in the Office of Compliance tracking database that shall include, but not be limited to:

a. Date of request;

b. Name of person who processed the request; and

c. Date the accounting was released to Member.

2. The Office of Compliance shall maintain a copy of the PHI accounting provided to the Member for ten (10) years from the date the request is received.

H. CalOptima shall provide the Member with the first request for an accounting in any twelve (12) month period at no charge. CalOptima may charge the Member a reasonable, cost-based fee for each future request within the twelve (12) month period, provided that CalOptima informs the Member in advance of the fee, and offers the Member a chance to withdraw or modify the request to avoid or reduce the fee.

I. Any person with knowledge of a violation or potential violation of this policy shall report such information directly to the Office of Compliance or through the CalOptima Compliance and Ethics Hotline at 1-877-837-4417.

V. ATTACHMENTS

A. Request for an Accounting of Disclosures Form
B. Response to Request for Accounting of Disclosures

VI. REFERENCES

A. CalOptima Policy AA.1000: Glossary of Terms
B. CalOptima Policy CMC.1001: Glossary of Terms
C. CalOptima Policy MA.1001: Glossary of Terms
D. CalOptima Policy MA.9210: Tracking Disclosures of Protected Health Information
E. CalOptima Privacy Program
F. Guide to Medical Privacy and HIPAA, Thompson Publishing Group, 2002, Section 400-Medical Records Privacy Requirements
G. The California Patient Privacy Manual, California Health care Association, 2002, Chapter 3- Patient Rights
H. Title 45 Code of Federal Regulations, Section 164.528, Accounting of Disclosures of Protected Health Information.

VII. REGULATORY APPROVALS

Not Applicable

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	06/01/2005	MA.9209	Member Request for Accounting of Disclosures
Revision Date 1	02/01/2008	MA.9209	Member Request for Accounting of Disclosures
Revision Date 2	07/01/2011	MA.9209	Member Request for Accounting of Disclosures
Revision Date 3	06/01/2014	MA.9209	Member Request for Accounting of Disclosures
Revision Date 4	11/01/2014	MA.9209	Member Request for Accounting of Disclosures
Revision Date 5	09/01/2015	MA.9209	Member Request for Accounting of Disclosures

Policy #:	MA.9210
Title:	**Tracking and Reporting Disclosures of Protected Health Information**
Department:	Office of Compliance
Section:	Health Insurance Portability and Accountability Act (HIPAA)
CEO Approval:	Michael Schrader _____
Effective Date:	4/1/03
Last Review Date:	9/1/15
Last Revised Date	9/1/15

This policy shall apply to the following CalOptima lines of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To define the process by which CalOptima shall track and report Disclosures of a Member's Protected Health Information (PHI).

II. DEFINITIONS

Term	Definition
Authorized Representative:	Any individual authorized by a Member, or under state law, to act on his or her behalf in obtaining an Organization Determination or in dealing with any level of the Appeal process. An Authorized Representative is subject to the rules described in Title 20 of the Code of Federal Regulations, Part 404, Subpart R, unless otherwise stated in the Medicare Managed Care Manual (Use form CMS-1696 for Claims Adjudication or Claim Appeals process).
Designated Record Set (DRS):	A group of records maintained by or for CalOptima that includes enrollment, Payment, claims adjudication, and case or medical management record system(s) used by or maintained for the agency, or used, in whole or in part, by or for CalOptima to make decisions about the Member. The DRS excludes patient-identifiable data used for administrative, regulatory, Health Care Operations and Payment/financial purpose; employment records held by CalOptima in its role as employer.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disclosure:	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Health Care Operations:	Activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities

	related to a contract and health benefits, management and administration activities customer services, resolution of internal grievances, business planning, and development activities related to compliance with the privacy rule.
Medical Record:	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term "Medical Record" is used both for the physical folder for each individual patient and for the body of information which compromises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member (Global):	An enrollee-beneficiary of a CalOptima program.
Payment:	Activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Protected Health Information (PHI):	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form of medium. This information identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Treatment:	Activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.

III. POLICY

A. CalOptima shall maintain a tracking process for all oral, written, facsimile, electronic, or other form of Disclosures of PHI that is not related to Treatment, Payment, or Health Care Operations, to the Member or when the Member authorized Disclosure, or other functions specified in this policy.

B. CalOptima shall maintain a tracking process for all requests for a Member's PHI, other than a request for Medical Records, and shall report this information, as applicable.

C. CalOptima shall maintain a tracking process for the entities, other than those within CalOptima's treatment network, to which CalOptima discloses Member names and addresses, and shall report this information.

IV. PROCEDURE

A. The following categories of Disclosures are not required to be included on the report when a Member requests an accounting of the Disclosure made of his or her PHI as defined in the Designated Record Set (DRS):

1. Used to carry out activities related to Treatment, Payment, or Health Care Operations;

2. Disclosed to the Member, or Member's Authorized Representative, or authorized by the Member;

3. Incidental Disclosures;

4. Disclosures made prior to April 14, 2003;

5. For national security or intelligence purposes; and

6. Disclosure of PHI directly relevant to an individual's involvement in a Member's care, (e.g., family member, other relative, or a close personal friend of the Member, or any other person identified by the Member).

B. Any other Disclosure shall be recorded and reported to the Privacy Officer, his or her Designee, or the Office of Compliance. The following list is the most common types of routine Disclosures that shall be tracked:

1. Required by law;

2. For health oversight activities;

3. Required for public health activities;

4. About victims of abuse, neglect, or domestic violence;

5. To coroners or medical examiners;

6. To funeral directors;

7. For organ, eye or tissue donation; and

8. To avert a serious threat to health or safety.

C. Tracking Routine Recurring Disclosures

1. Departments that Disclose PHI on a regular basis to the same agency or entity shall maintain a current log with the following elements included in hard copy or in an electronic spreadsheet:

   a. Date of initial Disclosure;

   b. Name of person or organization receiving the PHI;

   c. Address, if known;

   d. Brief description of information Disclosed; and

   e. Brief statement of purpose and the frequency of Disclosure.

2. Disclosure reports for recurring Disclosures shall be summarized to include the above stated information with the number of times the information was Disclosed and the date of the last Disclosure.

D. Tracking Non-Recurring Disclosures

1. The Office of Compliance shall enter any Disclosure made that is not included in the routine recurring Disclosures reported into the Office of Compliance PHI Tracking Database for tracking and reporting purposes.

2. The following information shall be reported:

   a. Member name and Identification number;

   b. Date of the Disclosure;

   c. Name of organization or person who received information, and their address, if known;

   d. Brief description of information Disclosed;

   e. Brief statement of the purpose for the Disclosure;

   f. Name of the person making the Disclosure; and

   g. Department of the person making the report.

3. The report for non-recurring routine type of Disclosures may be submitted on a Reporting Non-Routine Disclosures of Protected Health Information (PHI) Form or e-mailed with the above

information to the Office of Compliance within three (3) business days of making the routine Disclosure.

E. Documentation: The Office of Compliance shall:

1. Enter in the Office of Compliance Tracking Database the Disclosure reports from other departments and those Disclosures reviewed by the Privacy Officer, or his or her Designee.

2. Maintain a log of all requests from Members for accounting of Disclosures, including the following information:

   a. Date request received;

   b. Name of Member or Member's Authorized Representative requesting the accounting;

   c. Member Identification number;

   d. Date range requested;

   e. Name of staff person handling the request; and

   f. Date the report was provided to the Member.

3. Retain the request and a copy of the report given to the Member for six (6) years from the date CalOptima received the request.

F. Tracking and Reporting Requests for PHI other than a request for Medical Records

1. The Office of Compliance shall track all requests for a Member's PHI, other than a request for Medical Records.

2. The Regulatory Affairs Department shall report this information, as applicable.

G. Tracking and Reporting of Entities Outside of the treatment network to which CalOptima Discloses Member names and addresses

1. Each Department shall track the entities outside the CalOptima treatment network to which CalOptima discloses Member names and addresses, and report this information to the Office of Compliance annually. An entity outside the CalOptima treatment network shall include any person, organization, or agency that CalOptima contracts with for non-medical services.

2. The Regulatory Affairs Department shall report this information as applicable.

V. ATTACHMENTS

A. Reporting Non-Routine Disclosures of Protected Health Information (PHI)

VI. REFERENCES

A. CalOptima Policy AA.1000: Glossary of Terms
B. CalOptima Policy CMC.1001: Glossary of Terms
C. CalOptima Policy MA.1001: Glossary of Terms
D. CalOptima Privacy Program
E. CalOptima Compliance Program
F. Guide to Medical Privacy and HIPAA, Section 400: Medical Records Privacy Requirements, Thompson Publishing Group, 2002
G. Title 45, Code of Federal Regulations, Section 164.528, Accounting of Disclosures of Protected Health Information
H. Volume 65, Federal Register, Number 250

VII. REGULATORY APPROVALS

Not Applicable

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	02/02/2008	MA.9210	Tracking and Reporting Disclosures of Protected Health Information (PHI)
Revision Date 1	01/01/2010	MA.9210	Tracking and Reporting Disclosures of Protected Health Information (PHI)
Revision Date 2	02/01/2014	MA.9210	Tracking and Reporting Disclosures of Protected Health Information (PHI)
Revision Date 3	09/01/2014	MA.9210	Tracking and Reporting Disclosures of Protected Health Information (PHI)
Revision Date 4	09/01/2015	MA.9210	Tracking and Reporting Disclosures of Protected Health Information (PHI)

Policy #: MA.9211
Title: **Member Right to Request Confidential Communications**
Department: Office of Compliance
Section: Health Insurance Portability and Accountability Act (HIPAA)
CEO Approval: Michael Schrader

Effective Date: 6/1/05
Last Review Date: 9/1/15
Last Revised Date: 9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To describe the process by which a Member may request to receive Confidential Communications from CalOptima regarding Protected Health Information (PHI).

II. DEFINITIONS

Term	Definitions
Authorized Representative:	Any individual authorized by a Member, or under state law, to act on his or her behalf in obtaining an Organization Determination or in dealing with any level of the Appeal process. An Authorized Representative is subject to the rules described in Title 20 of the Code of Federal Regulations, Part 404 Subpart R, unless otherwise stated in the Medicare Managed Care Manual (Use form CMS-1696 for Claims Adjudication or Claim Appeal process).
Business Associates:	Has the meaning given such term in section 160.103 of title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of a covered entity or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs, or assists in the performance of: a) A function or activity involving the use of disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or b) Any other function or activity regulated by this subchapter; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data

Term	Definitions
	aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the services involves the disclosure of individually identifiable health information from such covered entity arrangement, or from another business associate of such covered entity or arrangement, to the person.
Confidential Communications:	The provision of communications of Protected Health Information (PHI) by alternative means or at alternative locations based upon a Member's reasonable request.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
FACETS:	Licensed software product that supports administrative, claims processing and adjudication, membership data, and other information needs of managed care organizations.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member (Global):	An enrollee-beneficiary of a CalOptima program.
Protected Health Information (PHI):	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form of medium. This information identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

III. POLICY

A. CalOptima shall accommodate a reasonable written request to receive communications of PHI by alternative means or at alternative locations when there is a risk of personal danger to the Member, if PHI is communicated by telephone or mail to the Member's home by CalOptima.

IV. PROCEDURE

A. A Member shall complete and submit a Request for Restriction on Manner/Method of Confidential Communications Form to CalOptima's Customer Service Department in person or by mail to:

Attention: Customer Service Department
CalOptima
505 City Parkway West
Orange, CA 92868

B. CalOptima's Customer Service Department may assist the Member, or the Member's Authorized Representative, in completing the Request for Restriction on Manner/Method of Confidential Communications Form.

C. CalOptima shall only grant a request for Confidential Communications in cases in which the Member:

a. Clearly states that the disclosure of all or part of that information could endanger the Member by receiving CalOptima information at home; and

b. Provides an alternate address or method of contact for communications.

D. The Privacy Officer, or his or her Designee, shall review all written requests for Confidential Communications and shall be responsible for coordinating the review, logistics of implementing the request, and the response to the Member.

E. The Privacy Officer, or his or her Designee, shall coordinate requests from Members who are enrolled in a Physician Group with the Physicians Medical Group, or other Business Associate, as appropriate.

F. The Privacy Officer, or his or her Designee, shall notify the Member of the decision regarding the request for Confidential Communications within thirty (30) calendar days of the receipt of the request.

G. If the Privacy Officer, or his or her Designee, approves the request, he or she shall notify the following departments of the Member's Confidential Communications status:

Department	**Potential Communication Materials Subject to Confidential Treatment**
Customer Service	Newsletters, notices regarding preventive health visits, enrollment, Physician Medical Group options, or other mass or individual Member mailings, including surveys.
Grievance and Appeals Resolutions	Communication regarding follow-ups or investigation of a Member, Health Network, or Provider complaints.
Care Coordination or Long Term Care (LTC)	Any care management, disease interventions, notices of actions, or other communications involving contact with the Member.
Pharmacy	Any notice of actions (NOAs), clinical pharmacy issues, or other direct contact with the Member.

H. If the Privacy Officer, or his or her Designee, approves the request, he or she shall notify the Information Services (IS) Department, whereby IS shall flag the Member's record on FACETS™ to indicate a Confidential Communication status.

V. ATTACHMENTS

A. Request for Restriction on Manner/Method of Confidential Communications Form

VI. REFERENCES

A. CalOptima Policy MA.1001: Glossary of Terms
B. CalOptima Policy MA.9202: Notice of Privacy Practices
C. CalOptima Privacy Program
D. Title 45, Code of Federal Regulations, Sections 164.502(h) and 164.522(b)(1)(2)California Patient Privacy Manual, California Health Care Association, Chapter 3: Patient Rights, 2002
E. WEDI – SNIP Security and Privacy Workgroup Privacy Policies and Procedures, Individual Rights-Request Confidential Communications, 2002
F. Workgroup for Electronic Data Interchange (WEDI) – Strategic National Implementation Process (SNIP) Security and Privacy Workgroup Privacy Policies and Procedures White Paper, http://www.wedi.org/cmsUploads/pdfUpload/WhitePaper/pub/ACFA092.pdf

VII. REGULATORY APPROVALS

Not Applicable

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	06/01/2005	MA.9211	Member Right to Request Confidential Communications
Revision Date 1	04/01/2007	MA.9211	Member Right to Request Confidential Communications
Revision Date 2	02/01/2012	MA.9211	Member Right to Request Confidential Communications
Revision Date 3	02/01/2014	MA.9211	Member Right to Request Confidential Communications
Revision Date 4	06/01/2014	MA.9211	Member Right to Request Confidential Communications
Revision Date 5	09/01/2014	MA.9211	Member Right to Request Confidential Communications
Revision Date 6	09/01/2015	MA.9211	Member Right to Request Confidential Communications

Policy #:	MA. 9212
Title:	**Access by Member's Authorized Representative**
Department:	Office of Compliance
Section:	Health Insurance Portability and Accountability Act (HIPAA)
CEO Approval:	Michael Schrader

Effective Date:	4/1/03
Last Review Date:	9/1/15
Last Revised Date:	9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To define the parameters for recognizing a Member's Authorized Representative as having the right to access the Member's Protected Health Information (PHI).

II. DEFINITIONS

Term	Definitions
Authorized Representative:	Any individual authorized by a Member, or under state law, to act on his or her behalf in obtaining an Organization Determination or in dealing with any level of the Appeal process. An Authorized Representative is subject to the rules described in Title 20 of the Code of Federal Regulations, Part 404, Subpart R, unless otherwise stated in the Medicare Managed Care Manual (Use form CMS-1696 for Claims Adjudication or Claim Appeal process).
Member (Global):	An enrollee-beneficiary of a CalOptima program.
Protected Health Information (PHI):	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form of medium. This information identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or

	3. Past, present, or future Payment for the provision of health care to a Member.
Treatment	Activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.

III. POLICY

A. CalOptima shall recognize a Member's Authorized Representative as the Member with respect to the Member's PHI.

IV. PROCEDURE

A. CalOptima recognizes that a parent, guardian, or other person acting *in loco parentis* has the authority to act on behalf of the Member who is an unemancipated minor with regard to PHI, subject to the limitations set forth in Section IV.B of this policy.

B. If a minor, age twelve (12) years and older, consents on his or her own behalf for the following services, without parental consent, PHI related to these services cannot be released to the parent or the Member's Authorized Representative without specific authorization from the minor Member under California law:

1. Pregnancy test, prenatal care, or birth control;
2. Testing or treatment for sexual disease, including the Human Immunodeficiency Virus (HIV);
3. Mental health treatment or counseling;
4. Rape or sexual assault; and
5. Alcohol or substance abuse treatment.

C. CalOptima may exercise professional judgment and refuse to accept an individual as an Authorized Representative, if CalOptima believes:

1. A Member has been, or may be subjected to, domestic violence, abuse, or neglect; or
2. A Member's life may be endangered by the individual identified as the Authorized Representative.

D. Individuals who must be recognized as the Member's Authorized Representative:

If the Member is:	The Member's Authorized Representative is:
An adult or an emancipated minor	A person with legal authority to make health care decisions on behalf of the Member.

If the Member is:	The Member's Authorized Representative is:
	Examples: ▪ Health care power of attorney ▪ Court appointed legal guardian ▪ General power of attorney
An unemancipated minor	A parent, guardian, or other person acting *in loco parentis* with legal authority to make health care decision on behalf of the minor child. Exceptions: ▪ For special sensitive services, that California law allows minors age twelve (12) or older to give consent for Treatment. ▪ Court has appointed someone other than the parent ▪ Parent agrees to the confidential relationship between the minor and a physician. ▪ Suspected abuse by parent or guardian
A decedent	A person with legal authority to act on behalf of the decedent or the estate, not restricted to health care decisions. Examples: ▪ Executor or Administrator of the estate ▪ Durable power of attorney for health care

E. CalOptima shall grant a Member's Authorized Representative access to a Member's PHI, in accordance with CalOptima Policy MA.9205: Verification of Identity for Disclosures of Protected Health Information.

V. ATTACHMENTS

Not Applicable

VI. REFERENCES

A. California Family Code, Sections 6920-6929
B. California Patient Privacy Manual, California Health care Association, 2002
C. CalOptima Policy MA.1001: Glossary of Terms
D. CalOptima Policy MA. 9202: Notices of Privacy Practices
E. CalOptima Policy MA.9205: Verification of Identity for Disclosures of Protected Health Information
F. CalOptima Privacy Program
G. Office of Civil Rights, Standards for Privacy of Individually Identifiable Health Information, Personal Representatives, 2002
H. Title 45, Code of Federal Regulations, Section 164.502(g), Standard: Authorized Representative

VII. REGULATORY APPROVALS

Not Applicable

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	06/01/2005	MA.9212	Access by Member's Authorized Representative
Revision Date 1	04/01/2007	MA.9212	Access by Member's Authorized Representative
Revision Date 2	02/01/2008	MA.9212	Access by Member's Authorized Representative
Revision Date 3	02/01/2012	MA.9212	Access by Member's Authorized Representative
Revision Date 4	02/01/2013	MA.9212	Access by Member's Authorized Representative
Revision Date 5	02/01/2014	MA.9212	Access by Member's Authorized Representative
Revision Date 6	09/01/2014	MA.9212	Access by Member's Authorized Representative
Revision Date 7	09/01/2015	MA.9212	Access by Member's Authorized Representative

Policy #: MA.9213
Title: **Protected Health Information Disclosures Required by Law**
Dept.: Office of Compliance
Section: Health Insurance Portability and Accountability Act (HIPAA)
CEO Approval: Michael Schrader _____

Effective Date: 6/1/05
Last Review Date: 9/1/15
Last Revised Date: 9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To describe the manner in which CalOptima processes Use and Disclosures of Protected Health Information (PHI) mandated by Health Insurance Portability and Accountability Act (HIPAA) and permitted as required by law.

II. DEFINITIONS

Term	Definition
Authorized Representative:	Any individual authorized by a Member, or under state law, to act on his or her behalf in obtaining an Organization Determination or in dealing with any level of the Appeal process. An Authorized Representative is subject to the rules described in Title 20 of the Code of Federal Regulations, Part 404, Subpart R, unless otherwise stated in the Medicare Managed Care Manual (Use form CMS-1696 for Claims Adjudication or Claim Appeals process).
Disclosure:	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner or information outside of the entity holding the information.
Health Insurance Portability and Accountability Act (HIPAA):	The Health Insurance Portability Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information as amended.
Member:	An enrollee-beneficiary of a CalOptima program.
Minimum Necessary:	The principle that a covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclose, or request for Treatment, Payment, or Health Care Operations.
Protected Health Information (PHI):	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or

	transmitted or maintained in any other form of medium. This information indentifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and related to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member, or 3. Past, present, or future Payment for the provision of health care to a Member.
Use of PHI:	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. The sharing, employment, application, utilization, examination, or analysis of the fill within an entity that maintains such information.

III. POLICY

A. CalOptima may not Use or Disclose PHI except as permitted or required by HIPAA.

B. CalOptima shall disclose PHI:

1. To the Member when requested under, and as required by, the Member's access and accounting rights set forth in 45 CFR Sections 164.524 and 164.528); or

2. When required by the Secretary of the Department of Health and Human Services (HHS) to investigate or determine CalOptima's Compliance with HIPAA.

C. CalOptima may use or Disclose PHI to the extent that such Use or Disclosure is required by law and the Use or Disclosure is limited to the relevant requirements of such law and complies with HIPAA requirements specifically related to such Uses or Disclosures as provided in 45 CFR Section 164.512(a)(2).

D. CalOptima shall comply with the Welfare and Institutions Code Section 14100.2 and Title 22 CCR Section 51009 in making permitted Uses or Disclosures required by law under 45 CFR Section 164.512(a). Compliance with these laws extends beyond Member PHI and includes all confidential member information (e.g. the fact that the Member is a Medi-Cal/Medicare recipient). In the event that CalOptima makes a Use or Disclosure required by law, it must first determine that the Use or Disclosure is for the purpose directly connected with the administration of the Medi-Cal/Medicare program.

E. Except for Uses and Disclosures described under Section III.B above, Uses and Disclosures of Member PHI sought, demanded or otherwise requested by any non-Member party by any means including through subpoenas, document requests, court orders, informal inquiries, etc. that fall within this policy shall be immediately referred to CalOptima's legal counsel for review and handling.

IV. PROCEDURE

A. HIPAA required Uses and Disclosures

1. Member requests involving the Use or Disclosure of PHI under the Member's HIPAA access and accounting rights shall be governed by CalOptima Policies MA.9203: Member Access to Designated Record Set and MA.9209: Member Request for an Accounting of Disclosures.

2. If CalOptima receives a request from Department of Health and Human Services (DHHS) for Member PHI to investigate or determine CalOptima's compliance with HIPAA, such requests or demands shall be immediately referred to CalOptima's Privacy Officer. CalOptima's Privacy Officer shall notify CalOptima's legal counsel of such requests and seek guidance in order to comply with such requests.

B. Permitted Uses and Disclosures required by Law:

1. CalOptima shall comply with requirements to maintain the confidentiality of all types of information concerning a Member which information shall not be open for examination except as directly connected with the administration of the CalOptima program.

2. Purposes directly connected to the administration of the CalOptima program encompasses those administrative activities and responsibilities in which the Centers for Medicare and Medicaid Services (CMS) and CalOptima are required to engage in order to ensure effective program operations including, without limitation:

   a. Establishing eligibility and methods of reimbursement;

   b. Determining the amount of medical assistance;

   c. Providing services; conducting or assisting in investigations, prosecution or civil or criminal proceedings related to the administration of the CalOptima program; and

   d. Conducting or assisting a legislative investigation or audit related to the administration of the CalOptima program.

3. CalOptima may Disclose Member confidential information including PHI and other identifying information, without the Member's Authorization, only if and to the extent that CalOptima first determines that the Disclosure is directly related to the administration of the CalOptima program and is otherwise permitted under Welfare& Institutions Code Section 14100.2 and Title 22 CCR 51009 and meets the following requirements, as applicable to the Use or Disclosure:

   a. In the course of any judicial proceeding, in response to a court order, provided that the PHI disclosed is limited to that specifically authorized by the court order.

   b. In the course of any administrative proceeding, in response to an order of an administrative tribunal, provided that the PHI disclosed is limited to that specifically authorized by the administrative tribunal order.

c. In response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal if:

i. In connection with a state civil action or proceeding and certain administrative proceedings, the party seeking the PHI by civil subpoena duces tecum has complied with the service and notice requirements of California Code of Civil Procedure Section 1985.3, which requires actual notice to the individual. In such cases, CalOptima shall examine the subpoena for compliance with Section 1987.3; or

ii. In cases where Section 1985.3 is not applicable, CalOptima has received satisfactory assurance as defined by HIPAA from the party seeking the PHI that it has notified the Member that is the subject of the PHI, with enough information about the litigation or proceeding so that the Member can raise an objection to the court or administrative tribunal; and the time for the Member to raise an objection with the court or tribunal has expired, and that there were no objections or all objections were resolved by the court of administrative tribunal, and the PHI requested is consistent with that resolution. In such cases, CalOptima review the written statement and accompanying documentation submitted by the party seeking the PHI to determine compliance with these requirements; or

iii. CalOptima receives satisfactory assurance from the party seeking the PHI that the parties to the dispute or proceeding have agreed to a qualified protective order, within the meaning of 45 CFR 164.512(e), and have presented it to the court or administrative tribunal, or the party seeking the PHI provides proof that a qualified protective order, within the meaning of 45 CFR 164.512(e), has been issued by the court or administrative tribunal. In such cases, CalOptima shall review the written statement and accompanying documentation submitted by the party seeking the PHI to determine compliance with these requirements.

d. In compliance with and as limited by the relevant requirements of an administrative request, including an administrative subpoena or summons, a civil or an authorized investigative demand, or similar process authorized under law, provided that:

i. The information sought is relevant and material to a legitimate law enforcement inquiry;

ii. The request is specific, and limited in scope to the extent reasonable practicable in light of the purpose for which the information is sought; and

iii. De-identified information could not reasonably be used.

e. In compliance with, and as limited by, the relevant requirements of a court-ordered search warrant or a grand jury subpoena;

f. For other law enforcement purposes such as

i. Limited information for identification and location purposes;

ii. A law enforcement official's request for information related to victims of a crime;

iii. About a person who has died to alert law enforcement of the death if the death is suspected to have resulted from criminal conduct; and

iv. To report crimes in emergencies.

v. Disclosures under this Section shall comply with the applicable provisions of 42 CFR Section 164.512(f)(2) and any relevant State laws that are more protective of the individual.

g. Disclosures about victims of abuse, neglect or domestic violence are addressed in CalOptima policies GG.1320: Elder or Dependent Adult Abuse Reporting and GG.1706: Child Abuse Report.

h. Other circumstances when specifically required by law provided that such Uses and Disclosures are in compliance with such law and limited to the relevant requirements of such law.

4. State and Federal laws governing Uses and Disclosures required by law including those related to Disclosure of PHI to law enforcement are complex and may implicate multiple laws relevant to the particular circumstances. In responding to any requests, demands, orders or requests under Section IV.B.3, CalOptima shall also comply with State and Federal laws governing special protected categories of PHI including mental health and developmental disability information, HIV test results, substance abuse records and psychotherapy notes.

5. CalOptima shall also comply with other State requirements relevant to the release of PHI in the context of civil and criminal State and Federal proceedings or to law enforcement.

6. All Uses and Disclosures of Member PHI and/or other confidential information sought, demanded or otherwise requested by any non-Member party shall be immediately referred to CalOptima's legal counsel for review and handling.

7. All Uses and Disclosures made under this Policy shall be referred to the Privacy Officer and shall be recorded in accordance with CalOptima Policy MA.9210: Tracking Disclosures of Protected Health Information.

V. ATTACHMENTS

Not Applicable

VI. REFERENCES

A. California Code of Civil Procedure Section 1985.3 & Section 1987.3
B. CalOptima Compliance Plan
C. CalOptima Policy GG.1320: Elder or Dependent Adult Abuse Reporting
D. CalOptima Policy AA.1000: Glossary of Terms
E. CalOptima Policy CMC.1001: Glossary of Terms
F. CalOptima Policy GG.1706: Child Abuse Report
G. CalOptima Policy MA.1001: Glossary of Terms
H. CalOptima Policy MA.9203: Member Access to Designated Record Set
I. CalOptima Policy MA.9205: Member Request for an Accounting of Disclosures
J. CalOptima Policy MA.9210: Tracking Disclosures of Protected Health Information

K. Civil Code Section 56.30(b)
L. Title 22, CCR Section 51009
M. Title 45, Code of Federal Regulations, Sections 164.501; 164.502(a), (b); Section 164.512(a), (c), (e) and (f); 1654.524 and 164.528(i) or (ii)
N. Welfare & Institutions Code Section 14100.2

VII. REGULATORY APPROVALS

Not Applicable

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	06/01/2005	MA.9213	Protected Health Information Disclosures Required by Law
Revision Date 1	07/01/2007	MA.9213	Protected Health Information Disclosures Required by Law
Revision Date 2	01/01/2008	MA.9213	Protected Health Information Disclosures Required by Law
Revision Date 3	11/01/2012	MA.9213	Protected Health Information Disclosures Required by Law
Revision Date 4	09/01/2014	MA.9213	Protected Health Information Disclosures Required by Law
Revision Date 5	09/01/2015	MA.9213	Protected Health Information Disclosures Required by Law

Policy #:	MA. 9214
Title:	**Use and Disclosure for Treatment, Payment, and Health Care Operations**
Department:	Office of Compliance
Section:	Health Insurance Portability and Accountability Act (HIPAA)
CEO Approval:	Michael Schrader
Effective Date:	6/1/05
Last Review Date:	9/1/15
Last Revised Date:	9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To define the general guidelines for the Use or Disclosure of Protected Health Information (PHI) for Treatment, Payment, or Health Care Operations.

II. DEFINITIONS

Term	Definition
Care Coordination:	Case management provided to Members who are at moderate risk, but still have an acute or chronic medical condition that requires assessment and coordination of resources in order to maintain the Members in the least restrictive setting.
Case Management:	A collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet a Member's health needs through communication and available resources to promote quality cost-effective outcomes.
Covered Service:	Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.
Credentialing:	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Disclosure:	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Durable Medical Equipment (DME):	Walkers, wheelchairs, canes, crutches, helmets and other equipment that could be used by one (1) person and used again by another person (i.e., not single use equipment.

Term	Definition
Grievance:	Any Complaint, other than one involving an Organization Determination, expressing dissatisfaction with any aspect of CalOptima's, a Health Network's, or a Provider's operations, activities, or behavior, regardless of any request for remedial action.
Health Care Operations:	Activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities customer services, resolution of internal grievances, business planning, and development activities related to compliance with the privacy rule.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Limited Data Set:	Protected Health Information (PHI) that uses the indirect identifiers (State, town or city, zip codes, dates of service, birth, and death) and excludes direct identifiers of the Member or the Member's relatives, employers, or household members.
Long Term Care (LTC):	A variety of services that help Members with health or personal needs and activities of daily living over a period of time. Long Term Care (LTC) may be provided at home, in the community or in various types of facilities, including nursing homes and assisted living facilities.
Medically Necessary:	Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Member (Global):	An enrollee-beneficiary of a CalOptima program.
Minimum Necessary:	The principle that covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment or Health Care Operations.

Term	Definition
Payment:	Activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Protected Health Information (PHI):	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form of medium. This information identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider:	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Physician Medical Group, or other person or institution who furnishes Covered Services.
Treatment:	Activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use of PHI:	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. The sharing, employment, application, utilization, examination, or analysis of the Pill within an entity that maintains such information.

III. POLICY

A. CalOptima shall maintain the privacy of PHI in compliance with all federal and state laws when Using or Disclosing PHI for Treatment, Payment, and Health Care Operations, including applying the Minimum Necessary standard, when applicable.

B. Except as otherwise required by law, CalOptima may Use or Disclose PHI pertaining to a Member to perform functions, activities, or services for the purposes directly related to the administration of the CalOptima program.

IV. PROCEDURE

A. CalOptima may Use or Disclose PHI without permission from a Member under the following circumstances:

1. Treatment

a. Activities undertaken by designated staff on behalf of a Member that includes:

i. Direct and indirect provision of health care;

ii. Coordination and management of health care and related services;

iii. Referral to and consultation between health care Providers; and

iv. Coordination with third parties for services related to the management of the Member's health care benefits.

b. Examples of Treatment activities include, but are not limited to:

i. Disclosing a Member's PHI to facilitate Long Term Care (LTC) placement;

ii. Referral for home health care, physical therapy, obtaining Durable Medical Equipment (DME) or medical supplies; and

iii. Providing medical information when referring the Member for consultations with other Providers.

B. Health Care Operations

1. Activities related to functions necessary to administer the CalOptima program and to support the core function of Treatment and Payment include, but are not limited to:

a. Establishing eligibility and methods of reimbursement;

b. Determining the amount of medical assistance;

c. Providing services for a Member;

d. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the CalOptima program;

e. Conducting or assisting a legislative investigation or audit related to the administration of the CalOptima program;

f. The submission of aggregated Member data to the Department of Health Care Services (DHCS);

g. Conducting quality assessment and improvement activities, including outcomes evaluation, and development of clinical guidelines and related functions that do not include Treatment;

h. Population-based activities relating to improving health or reducing health care costs;

i. Contacts with health care Providers and Members with information about Treatment alternatives;

j. Case Management and Care Coordination;

k. Reviewing the competence or qualifications of health care professionals, evaluating Provider and Health Network performance;

l. Training health care and non-health care professionals;

m. Accreditation, certification, licensing, or Credentialing activities;

n. Professional review, compliance and audits, health insurance underwriting, premium rating;

o. Underwriting and other activities relating to:

   i. The creation, renewal, or replacement of a contract of health insurance or health benefits; and

   ii. Ceding, securing, or placing a contract for reinsurance or risk relating to health care claims, including stop-loss and excess of loss insurance.

p. Conducting or arranging for medical review, legal and auditing services, including fraud and abuse detection and compliance programs;

q. Business planning and development, such as:

   i. Conducting cost-management and planning analyses related to managing and operating the agency, including formulary development and administration; and

   ii. Development or improvement of methods of Payment or coverage policies.

r. Business management and general administrative activities, including those related to implementing and complying with the privacy rule and other administrative simplification rules, customer services resolution of internal Grievances, sale or transfer of assets, creating de-identified health information or a Limited Data Set, and fundraising for the benefit for the agency.

C. Payment

1. Activities necessary for CalOptima to ensure a Member has access to and that a Provider receives payment for Medically Necessary Covered Services, including:

a. Determination of eligibility and to fulfill responsibility for coverage and provision of health benefits under agency programs;

b. Reimbursement for provision of health care services and coordination of benefits with other health coverage;

c. Risk adjustments based on Member health status and demographics, billing, claims management, and collection activities;

d. Review of health care services regarding Medical Necessity, coverage under a health plan and appropriateness of care or justification of charges;

e. Utilization review activities including precertification, preauthorization, and concurrent and retrospective review of services;

f. Disclosure to consumer reporting agencies of any of the following PHI relating to collection of premiums or reimbursement:

i. Name and address;

ii. Date of birth;

iii. Social Security Number;

iv. Payment History;

v. Account number; or

vi. Name and address of CalOptima.

V. ATTACHMENTS

Not Applicable

VI. REFERENCES

A. California Welfare and Institutions Code, section 14100.2 (a)

B. CalOptima Compliance Plan
C. CalOptima Policy CMC.1001: Glossary of Terms
D. CalOptima Policy MA.1001: Glossary of Terms
E. CalOptima Privacy Program
F. HIPAA Patient Privacy Compliance Guide, Atlantic Information Services, Inc. 2003
G. Office of Civil Rights, Standards for Privacy of Individually Identifiable Health Information Guidelines
H. Title 42 Code of Federal Regulations, section 431.00 et seq.
I. Title 45, Code of Federal Regulations, Section 164.506, Uses and Disclosures to Carry out Treatment, Payment, or Health Care Operations

VII. REGULATORY APPROVALS

Not Applicable

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	06/01/2005	MA.9214	Use and Disclosure for Treatment, Payment, and Health Care Operations
Revision Date 1	02/01/2008	MA.9214	Use and Disclosure for Treatment, Payment, and Health Care Operations
Revision Date 2	04/01/2013	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations
Revision Date 3	09/01/2014	MA.9214	Use and Disclosure for Treatment, Payment, and Health Care Operations
Revision Date 4	09/01/2015	MA.9214	Use and Disclosure for Treatment, Payment, and Health Care Operations

Policy #:	MA.9215
Title:	**Use or Disclosure of Protected Health Information for Research**
Department:	Office of Compliance
Section:	Health Insurance Portability and Accountability Act (HIPAA)
CEO Approval:	Michael Schrader
Effective Date:	4/03
Last Review Date:	9/1/15
Last Revised Date:	9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To describe the conditions under which CalOptima may Use or Disclose Protected Health Information (PHI) for Research.

II. DEFINITIONS

Term	Definitions
Authorized Representative:	Any individual authorized by a Member, or under state law, to act on his or her behalf in obtaining an Organization Determination or in dealing with any level of the Appeal process. An Authorized Representative is subject to the rules described in Title 20 of the Code of Federal Regulations, Part 404 Subpart R, unless otherwise stated in the Medicare Managed Care Manual (Use form CMS-1696 for Claims Adjudication or Claim Appeal process).
Disclosure:	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Medical Record:	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member (Global):	An enrollee-beneficiary of a CalOptima program.
Minimum Necessary:	The principle that a covered entity must make reasonable

	efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment or Health Care Operations.
Payment:	Activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Protected Health Information (PHI):	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Research:	Systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalize knowledge.
Treatment:	Activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use of PHI:	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. The sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

III. POLICY

A. CalOptima shall release Member's PHI for Research purposes only with written authorization from the Member.

B. CalOptima may release Minimum Necessary health information, without authorization by the Member, by removing all identifiers with respect to the individual Member, his or her relatives, employers, and household Members from the Protected Health Information (PHI), in accordance with CalOptima Policy MA.9221: De-identification of Protected Health Information.

IV. PROCEDURE

A. Uses and Disclosures for Research Purposes: Member Authorization

1. Authorization for release of PHI for Research purposes must include the following elements:

a. A description of the information to be Used or Disclosed that identifies the information in a specific and meaningful manner;

b. The name or other specific identification of the person(s), or class of persons, authorized to make the requested Use or Disclosure;

c. The name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested Use or Disclosure;

d. A description of each purpose of the requested Use or Disclosure;

e. A statement that the authorization does not expire or state that the authorization continues until the "end of the Research study";

f. Signature of the Member and the date, or if signed by Member's Authorized Representative, a description of the Authorized Representative's relationship to the Member;

g. Statement that further Disclosure of the PHI is prohibited unless another authorization is obtained from the Member (California Civil Code 56.10(c)); and

h. Additional elements that apply if authorization is requested by CalOptima:

i. A statement that CalOptima will not condition Treatment or Payment on the Member signing the authorization request;

ii. A statement that the Member can refuse to sign the authorization;

iii. A statement that the Member is entitled to a copy of the signed authorization; and

iv. As applicable, a statement if a Disclosure will result in either direct or indirect Payment to CalOptima from the receiver of the PHI.

B. Use and Disclosure for Research: De-identification of PHI

1. The following processes may be used to determine that PHI has been de-identified to protect the confidentiality of the Member, in accordance with CalOptima Policy MA.9221: De-identification of Protected Health Information.

a. Qualified Reviewer

i. A person with appropriate knowledge of, and experience with, generally accepted statistical and scientific principles and methods for rendering information not individually identifiable determines that the risk is very small that the information could be used, alone or in combination with other reasonably available information, by an anticipated recipient to identify an individual who is a subject of the information.

ii. There is documentation on the methods used by the person, and results of the analysis that justifies the determination that the information has been de-identified appropriately.

b. Removal of Specific Identifiers

i. The De-identification of PHI will include the removal of the following identifiers:

1) Name(s);

2) Social Security number;

3) Geographic subdivisions smaller than a state including:

a) Address;

b) City;

c) County;

d) Precinct;

e) Zip code or equivalent geocode;

4) Telephone number(s);

5) Facsimile number(s);

6) E-mail address;

7) Medical Record number;

8) Health plan beneficiary number;

9) All elements of dates (except year) for dates related to an individual:

a) Birth date;

b) Admission date;

c) Discharge date;

d) Date of death;

e) All ages over eighty-nine (89) years;

f) All elements of dates (including year) indicative of age, except an aggregated single category of ninety (90) or older is permissible;

10) Account number;

11) Certificate or license number;

12) Vehicle identifiers, serial numbers, and license plate number;

13) Device identifiers and serial numbers;

14) Web Universal Resource Locators (URLs);

15) Internet Protocol (IP) address numbers;

16) Biometric identifiers, voice, and fingerprints;

17) Full face photographs and comparable images; and

18) Any other unique identifying number, characteristic, or code.

ii. There is no actual knowledge that the information could be used alone, or in combination with other information, to identify an individual who is a subject of the information.

C. Re-identification of information

1. A code or other means of record identification may be assigned, provided:

a. The code is not derived from or related to information about the individual that would allow the individual to be identified, i.e., the last four digits of a social security number; and

b. The code is only used by CalOptima to re-identify the data, and the code is not released for Use by another person or entity.

V. ATTACHMENTS

A. Authorization for Use or Disclosure of Protected Health Information (PHI)

VI. REFERENCES

A. CalOptima Compliance Plan
B. HIPAA Patient Privacy Compliance Guide, Atlantic Information Services, Inc, 2002, Patient Health Information and Research, pages 2000-39-41
C. CalOptima Policy MA.1001: Glossary of Terms
D. CalOptima Policy MA.9221: De-identification of Protected Health Information
E. Title 45 Code of Federal Regulations, Section 160.103
F. Title 45, Code of Federal Regulations, Sections 164.501, 164.508, 164.512(i), 164.514(e), 164.528, and 164.532

VII. REGULATORY APPROVALS

Not Applicable

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	06/01/2005	MA.9215	Use or Disclosure of Protected Health Information for Research
Revision Date 1	02/01/2008	MA.9215	Use or Disclosure of Protected Health Information for Research
Revision Date 2	09/01/2014	MA.9215	Use or Disclosure of Protected Health Information for Research
Revision Date 3	09/01/2015	MA.9215	Use or Disclosure of Protected Health Information for Research

Policy #:	MA.9217
Title:	**Mitigation**
Department:	Office of Compliance
Section:	Health Insurance Portability and Accountability Act (HIPAA)
CEO Approval:	Michael Schrader

Effective Date:	6/1/05
Last Review Date:	9/1/15
Last Revision Date:	9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To state CalOptima's policy on mitigation of violations of Health Insurance Portability and Accountability Act (HIPAA) related privacy policies and procedures.

II. DEFINITIONS

Term	Definition
Business Associate	1. Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: On behalf of a covered entity or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs, or assists in the performance of: a. A function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or b. Any other function or activity regulated by this subchapter; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the services involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.
Corrective Action	A plan delineating specific identifiable activities or undertakings that

Plan (CAP)	address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by Cal Optima, the Centers of Medicare & Medicaid Services (CMS), or designated representatives. Delegates may be required to complete CAPs to ensure they are in compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements identified by CalOptima and its regulators.
Disclosure	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Member	An enrollee-beneficiary of a Cal Optima program.
Protected Health Information (PHI)	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form of medium. This information indentifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and related to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member, or 3. Past, present, or future Payment for the provision of health care to a Member.
Sanctions	Action taken by CalOptima including, without limitations, restrictions, monetary fines, termination or a combination thereof, based on a Health Network's or its delegate's, subcontractor's, or any Health Network partner's failure to comply with statutory, regulatory, contractual, CalOptima policy, or other requirements related to the CalOptima program.
Use of PHI	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. The sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

III. POLICY

CalOptima shall mitigate, to the extent practicable, any harmful effect that is known to CalOptima of a Use or Disclosure of Protected Health Information (PHI) in violation of CalOptima's policies and procedures by a CalOptima employee, or by a Business Associate.

IV. PROCEDURE

A. When it comes to the attention of the Office of Compliance that violations or potential violations of CalOptima policies and procedures related to PHI may have occurred, the Office of Compliance shall:

1. Initiate a review of the incident;

2. Formulate a reasonable Corrective Action Plan (CAP), as appropriate. The CAP may include, but not be limited to, the following acts:

   a. Communication with Members impacted by the violation and correction of any errors of Uses or Disclosures to the extent possible based on the type of violation;

   b. Facilitation of education and training, or counseling, or imposition of Sanctions of involved CalOptima staff or Business Associates; and

   c. Implementation of any necessary revisions to CalOptima policy and procedures to reduce the risk of, or prevent future violations or potential violations.

3. Report the violation or potential violation to the appropriate governmental agency(ies) and affected Members, in accordance with CalOptima Policy MA.9222: Reporting an Unauthorized Disclosure of Protected Health Information or Breach of Data, Security, or Intrusion, as appropriate

V. ATTACHMENTS

Not Applicable

VI. REFERENCES

A. CalOptima Privacy Program
B. CalOptima Policy MA.1001: Glossary of Terms
C. CalOptima Policy MA.9222: Reporting an Unauthorized Disclosure of Protected Health Information or Breach of Data, Security, or Intrusion
D. Office of Civil Rights, HIPAA Privacy Guidance, Business Associates, pp. 39-53
E. Title 45, Code of Federal Regulations, Section 164.530(f) Standard: Mitigation
F. Title 45, Code of Federal Regulations, Section 164.530(f)

VII. REGULATORY APPROVALS

Not Applicable

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Name

Original Date	06/01/2005	MA.9217	Mitigation
Revised Date	02/01/2008	MA.9217	Mitigation
Revised Date	12/01/2012	MA.9217	Mitigation
Revised Date	01/01/2014	MA.9217	Mitigation
Revised Date	09/01/2015	MA.9217	Mitigation

Policy #:	MA.9218
Title:	**Use of Electronic Mail with Protected Health Information**
Department:	Office of Compliance
Section:	Health Insurance Portability and Accountability Act (HIPAA)
CEO Approval:	Michael Schrader
Effective Date:	6/1/05
Last Review Date:	9/1/15
Last Revised Date:	9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To define CalOptima's procedures for the use of electronic mail (e-mail) containing Protected Health Information (PHI) between CalOptima and its Business Associates.

II. DEFINITIONS

Term	Definition
Business Associate:	1. Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: On behalf of a covered entity or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs, or assists in the performance of: a. A function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or b. Any other function or activity regulated by this subchapter; or **2.** Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where

	the provision of the services involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.
Disclosure:	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Encryption:	The use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without use of a confidential process or key or a method of converting an original message of regular text into encoded or unreadable text that is eventually decrypted into plan comprehensible text.
Minimum Necessary:	The principle that a covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment or Health Care Operations.
Protected Health Information (PHl):	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member
Use of PHI:	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. The sharing, employment, application, utilization, examination, or analysis of the Pill within an entity that maintains such information.

III. POLICY

A. CalOptima and its FDRs shall send email containing PHI as follows:

1. Internal e-mail

a. E-mail sent within CalOptima's mail system may contain PHI that is limited to the Use and Disclosure of the Minimum Necessary data to complete the required message, in accordance with CalOptima Policy MA.9204: Minimum Necessary Use and Disclosure of Protected Health Information.

b. PHI (e.g., Member name, Social Security number, Client Index Number [CIN]) shall not be included in the subject line of the e-mail.

2. External e-mail sent on the Internet

a. E-mail that CalOptima, or a Business Associate sends to an external entity via the open Internet shall not contain PHI unless the e-mail or attachment has been encrypted to prevent anyone, other than the intended receiver, from reading the contents.

b. E-mail that CalOptima or a Business Associate sends to an outside entity may contain PHI that is limited to the Use and Disclosure of the Minimum Necessary data to complete the required message, in accordance with CalOptima Policy MA.9204: Minimum Necessary Use and Disclosure of Protected Health Information.

c. PHI (e.g., Member name, Social Security number, Client Index Number [CIN]) shall not be included in the subject line of the e-mail.

B. CalOptima staff shall follow instructions for use of e-mail as set forth in CalOptima Policy GA.5005b: Email and Internet Use.

IV. PROCEDURE

A. Communications via e-mail sent through the open Internet requires Encryption to prevent unauthorized access to the PHI.

B. CalOptima employees and Business Associates shall immediately report any suspected or known Breach of data security, Intrusion, or unauthorized Use or Disclosure of PHI to the CalOptima Privacy Officer, or Designee, in accordance with CalOptima policy MA.9222: Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information.

V. ATTACHMENTS

Not Applicable

VI. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Policy MA.1001: Glossary of Terms
C. CalOptima Policy GA.5005b: Email and Internet Use

D. CalOptima Policy MA.9204: Minimum Necessary Use and Disclosure of Protected Health Information
E. CalOptima Policy MA.9222: Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information

VII. REGULATORY APPROVALS

Not Applicable

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	06/01/2005	MA.9218	Use of Electronic Mail with Protected Health Information
Revision Date 1	02/01/2008	MA.9218	Use of Electronic Mail with Protected Health Information
Revision Date 2	06/01/2010	MA.9218	Use of Electronic Mail with Protected Health Information
Revision Date 3	01/01/2011	MA.9218	Use of Electronic Mail with Protected Health Information
Revision Date 4	04/01/2013	HH.3014	Use of Electronic Mail with Protected Health Information
Revision Date 5	02/01/2014	MA.9218	Use of Electronic Mail with Protected Health Information
Revision Date 6	09/01/2014	MA.9218	Use of Electronic Mail with Protected Health Information
Revision Date 7	09/01/2015	MA.9218	Use of Electronic Mail with Protected Health Information

Policy #:	MA.9219
Title:	**Authorization for Release of Protected Health Information**
Department:	Office of Compliance
Section:	Health Insurance Portability and Accountability Act (HIPAA)

CEO Approval:	Michael Schrader _____
Effective Date:	6/1/05
Last Review Date:	9/1/15
Last Revised Date:	9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To identify the scope and content of Authorizations as they relate to Use and Disclosure of Protected Health Information (PHI).

II. DEFINITIONS

Term	Definition
Disclosure	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Health Care Operations	Activities including quality assessment and improvement activities, care management, professional review, compliance audits, health insurance underwriting, premium rating and other activities related to a contact and health benefits, management and administration activities customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Minimum Necessary	The principle that a covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment, or Health Care Operations.
Payment	Activities carried out by CalOptima including: 1. Determination eligibility, risk adjustments based on the Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification or charges; and 3. Utilization review activities including pre-certification, pre-authorization, concurrent, or retrospective review of services.
Protected Health Information (PHI)	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by

	electronic media, maintained in electronic media, or transmitted or maintained in any other form of medium. This information indentifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and related to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member, or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Physician Medical Group, or other person or institution who furnishes Covered Services.
Member	An enrollee-beneficiary of a CalOptima program.
Treatment	Activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use of PHI	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. The sharing, employment, application, utilization, examination, or analysis of the fill within an entity that maintains such information.

III. POLICY

A. CalOptima shall obtain written authorization from a Member prior to Use or Disclosure of PHI for purposes other than Treatment, Payment, or Health Care Operations, unless otherwise permitted or required under the privacy standards.

B. CalOptima shall obtain written authorization from the Member for the Use or Disclosure of PHI to a close personal friend, family member, or other individual involved in the Member's care, in accordance with CalOptima Policy, Disclosure of Information to Family or Friends Involved in Member Care.

IV. PROCEDURE

A. Authorization requests initiated by CalOptima shall be limited to the Minimum Necessary to accomplish the purpose for which the Use or Disclosure is described on the authorization form.

B. All valid authorizations shall contain the following core elements:

1. A description of the information to be Used or Disclosed;

2. The name of the person or organization that will Use or Disclose the PHI;

3. The name of the person or organization that will receive the PHI;

4. A description of the purpose for which the PHI will be used (except for requests by Member, which can indicate "at Member's request" without further explanation);

5. The expiration date or event;

6. Statement that further Use or Disclosure of the PHI is prohibited unless another authorization is obtained from the Member or such Use or Disclosure is specifically required or permitted by law.

7. A statement that the Member has the right to revoke the authorization in writing and any exceptions to this right;

8. Member's signature and the date (if signed by Member Personal Representative, state relationship); and

9. Additional elements that apply if authorization is requested by CalOptima;

   a. A statement that CalOptima will not condition Treatment or Payment on the Member signing the authorization request;

   b. A statement that the Member can refuse to sign the authorization;

   c. A statement that the Member is entitled to a copy of the signed authorization. A copy of the signed authorization must be given to the Member; or

   d. A statement when any Disclosure will result in either direct or indirect Payment to CalOptima from the receiver of the PHI.

C. CalOptima shall obtain authorization from the Member for any use or Disclosure of psychotherapy notes except in the following situations:

1. Use by the originator of the psychotherapy notes for Treatment;

2. Use or Disclosure by a covered entity's own training program for students, trainees, or practitioners in mental health, under supervision, to improve skills;

3. Use by a Provider for purposes of diagnosis or Treatment of the Member;

4. Use or Disclosure by a covered entity to defend itself in a legal action or other proceeding brought by the Member; or

5. Evaluation or oversight of the practitioner creating the psychotherapy notes.

D. Authorization shall be obtained from the Member for any Use or Disclosure of PHI for Marketing, except when:

1. Face-to-face communication is made by CalOptima to the Member; or

2. A promotional gift of nominal value is provided by CalOptima.

E. An authorization shall be considered invalid if the document submitted contains any of the following defects:

1. The expiration date has passed or the expiration date is known by CalOptima to have passed;

2. The authorization does not contain all the required elements;

3. The authorization is known by CalOptima to have been revoked;

4. The authorization is combined with any other document in a manner that is not permitted under the privacy standard; or

5. The authorization contains material information known by CalOptima to be false.

F. CalOptima staff shall verify the identity of the Authorized Representative in accordance with CalOptima Policy MA.9205: Verification of Identity for Disclosures of Protected Health Information.

G. Circumstance under which services may be dependent upon the Member's signing Authorization for Use or Disclosure of PHI includes research-related treatment.

H. Revocation of Authorization

1. A Member may revoke an authorization at any time by writing to CalOptima and requesting that the authorization be revoked.

2. The revocation will not apply to those Uses or Disclosures made with reliance on the authorization prior to the receiving the request to revoke the authorization.

I. Authorizations for Multipurpose Senior Services Program (MSSP):

1. The MSSP unit shall follow the standards for obtaining authorizations for all Disclosures as required by contract with the Department of Aging, including the use of the MSSP authorization from provided by the Department of Aging.

2. Documentation for MSSP:

a. Copies of all signed authorizations are maintained in the MSSP record for the Member.

b. Disclosures that are not specifically authorized by the Member and are not part of Payment or Health Care Operations will be reported to the Office of Compliance for tracking purposes per CalOptima Policy MA.9210: Tracking and Reporting Disclosures of Protected Health Information.

J. All signed authorization and revocation notices are retained on file for ten (10) years from the date the documents are received by CalOptima.

K. Upon receipt of a signed authorization form or a revocation notice, CalOptima shall forward a copy of the authorization form or revocation notice to the Member for his or her records.

V. ATTACHMENTS

A. Authorization for Use and Disclosure of Protected Health Information

VI. REFERENCES

A. California Civil Code 56.10(c)
B. California Civil Code 56.104
C. CalOptima Policy MA.9210: Tracking Disclosures of PHI
C. CalOptima Policy Disclosure of Information to Family or Friends Involved in Member Care.
D. CalOptima Policy MA.1001: Glossary of Terms
E. CalOptima Policy MA.9205: Verification of Identity for Disclosures of Protected Health Information
F. Multipurpose Senior Services Program Standards, California Department of Aging
G. NCQA Standard RR5 Privacy and Confidentiality – 2014
H. Title 45 Code of Federal Regulations, Section 164.508 Uses and Disclosures for which an Authorization is Required

VII. REGULATORYAPPROVALS

Not Applicable

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	06/01/2005	MA.9219	Authorization for Release of Protected Health Information (PHI)
Revision Date 1	02/01/2008	MA.9219	Authorization for Release of Protected Health Information (PHI)
Revision Date 2	05/01/2013	MA.9219	Authorization for Release of Protected Health Information (PHI)
Revision Date 3	06/01/2014	MA.9219	Authorization for Release of Protected Health Information (PHI)
Revision Date 4	11/01/2014	MA.9219	Authorization for Release of Protected Health Information (PHI)
Revision Date 5	09/01/2015	MA.9219	Authorization for Release of Protected Health Information (PHI)

Policy #:	MA.9220
Title:	**Guidelines for Handling Protected Health Information Offsite**
Department:	Office of Compliance
Section:	Health Insurance Portability and Accountability Act (HIPAA)
CEO Approval:	Michael Schrader
Effective Date:	6/1/05
Last Review Date:	9/1/15
Last Revised Date:	9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To describe the process for handling Protected Health Information (PHI) created, accessed, or taken offsite from CalOptima offices.

II. DEFINITIONS

Term	Definition
Access Controls:	Controls that identify and authenticate a user to allow access to confidential information and Protected Health Information (PHI) based on a business need to know. Access Controls protect the computer systems from unauthorized access as well as determine the type of access a user is entitled to have.
Business Associate:	1. Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: On behalf of a covered entity or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs, or assists in the performance of: a. A function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or b. Any other function or activity regulated by this subchapter; or 2. Provides, other than in the capacity of a member of the

	workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the services involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.
Breach:	An unauthorized disclosure of Protected Health Information (PHI) that violates either federal or state laws (HIPAA Privacy Rule and State Information Practices Act of 1977) or PHI that has been reasonably believed to have been acquired by an unauthorized person. A breach may be paper or electronic.
Designee:	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disclosure:	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Long Term Care (LTC):	A variety of services that help Members with health or personal needs and activities of daily living over a period of time. Long Term Care (LTC) may be provided at home, in the community or in various types of facilities, including nursing homes and assisted living facilities.
Medical Record:	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member:	An enrollee-beneficiary of a CalOptima program.
Minimum Necessary:	The principle that covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment or Health Care Operations.
Prior Authorization:	A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures.
Protected Health Information (PHI):	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form of medium.

	This information identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Use of PHI:	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. The sharing, employment, application, utilization, examination, or analysis of the Pill within an entity that maintains such information.

III. POLICY

A. CalOptima employees shall exercise reasonable precautions in handling PHI created, accessed, or taken off site from the main office.

IV. PROCEDURE

A. General guidelines

1. Staff shall exercise professional judgment in viewing and recording the Minimum Necessary data when reviewing Medical Records in facilities for purposes of certification or re-certification of Member's need for admission or continuing stays as inpatients for acute or Long-Term Care (LTC) services.

2. Staff shall collect all data relative to a Member, whether by interview, observation, or review of documents, in a setting that provides reasonable privacy and protects the information from unauthorized Disclosure.

3. Staff shall protect all physical documents that contain Member PHI from the view or access by an unauthorized person during transport from and to the office through use of:

   a. Binders;

   b. Folders or other protective cover; or

   c. Locked in trunk of the vehicle.

4. Staff shall not leave documents including assessment forms, Prior Authorization, or other data collection forms unattended in areas accessible by an unauthorized person.

5. Staff shall not store confidential, personal, or sensitive information unattended in vehicles at any time.

6. Staff shall not store confidential, personal, or sensitive information unattended in baggage, at any time, during travel.

7. Staff shall not save or store data files in an electronic format that contain PHI on public or private computers, including data files that are accessed through the Internet via electronic mail or webmail.

8. Staff shall maintain physical control of laptops, cell phones, tablets, USB drives, and all mobile devices at all times.

9. Staff shall encrypt all portable storage devices or files (i.e., USB drives, writeable CDs/DVDs, etc.) that contain PHI, in accordance with CalOptima Policy GA.5005a: Use of Technology Resources.

10. Staff shall shred PHI documents or files prior to disposal. If necessary, staff shall return documents or files to the main office for disposal.

B. Use of Personal Computer (PC) from remote locations

1. Employees granted access to CalOptima IS are required to adhere to the following procedures:

   a. Maintain the confidentiality of his or her user sign-on identification code and password;

   b. Keep the PC secure at all times and do not leave it unattended when in public places, including, but not limited to, hospitals, LTC facilities, or other Member or agency locations;

   c. Log off the network when the PC will be left inactive or unattended; and

   d. Ensure that passwords or operating instructions for accessing the CalOptima systems are not stored with the computer.

C. CalOptima employees and its First Tier, Downstream and Related Entities (FDRs) shall report any unauthorized Use or Disclosure of PHI, any Breach of data security, or Intrusion immediately after discovery during a work week to the CalOptima Privacy Officer, or his or her Designee, in accordance with CalOptima Policy MA.9222: Reporting of a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information.

V. ATTACHMENTS

Not Applicable

VI. REFERENCES

A. CalOptima Compliance Plan

B. CalOptima Policy GA.5005a: Use of Technology Resources
C. CMS Missive, Privacy, and Security of Beneficiary Information, dated June 9, 2006
D. Health Administrative Manual, Section 6-1050.3
E. CalOptima Policy MA.1001: Glossary of Terms
F. CalOptima Policy MA.9222: Reporting of a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information
G. Title 45, Code of Federal Regulations, 164.502(b) Standard: Minimum Necessary
H. Title 45, Code of Federal Regulations, 164.530(c)(1) Standard: Safeguards
I. Title 45, Code of Federal Regulations, Section 164.103 Definitions

VII. REGULATORY APPROVALS

Not Applicable

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	06/01/2005	MA.9220	Guidelines for Handling Protected Health Information (PHI) Offsite
Revision Date 1	04/01/2007	MA.9220	Guidelines for Handling Protected Health Information (PHI) Offsite
Revision Date 2	01/01/2009	MA.9220	Guidelines for Handling Protected Health Information (PHI) Offsite
Revision Date 3	09/01/2014	MA.9220	Guidelines for Handling Protected Health Information (PHI) Offsite
Revision Date 4	09/01/2015	MA.9220	Guidelines for Handling Protected Health Information (PHI) Offsite

Policy #:	MA.9221
Title:	**De-identification of Protected Health Information**
Department:	Office of Compliance
Section:	Health Insurance Portability and Accountability Act (HIPAA)

CEO Approval: Michael Schrader

Effective Date:	6/1/05
Last Review Date:	9/1/15
Last Revised Date:	9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To describe the identifiers that shall be removed prior to the release of Protected Health Information (PHI) containing individual identifying health data for Research or other purposes.

II. DEFINITIONS

Term	Definition
De-identified Information	Health information that does not identify a Member and does not provide a reasonable basis to believe that the information can be used to identify a Member.
Disclosure:	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Member:	An enrollee-beneficiary of a CalOptima program.
Medical Record:	A medical records, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term "Medical Record" is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Minimum Necessary:	The principle that covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment or Health Care Operations.
Protected Health Information (PHI):	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information

Term	Definition
	transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form of medium. This information identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Research:	Systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.

III. POLICY

A. CalOptima may Disclose Minimum Necessary health information without authorization by the Member by removing all identifiers with respect to the individual Member, his or her relatives, employers, and household members from the PHI.

IV. PROCEDURE

A. The Office of Compliance may use any of the following processes to determine if PHI has been De-identified to protect the confidentiality of the Member.

1. Qualified Reviewer

   a. A person with appropriate knowledge of, and experience with, generally accepted statistical and scientific principles and methods for rendering information not individually identifiable.

   b. The Qualified Reviewer shall:

      i. Determine if the risk is minimal, meaning the information can be used, alone or in combination with other reasonable available information, by an anticipated recipient to identify an individual who is a subject of the information; and

      ii. Document the methods used and results of the analysis, which justify the determination that the information has been De-identified appropriately.

2. Removal of Specific Identifiers

   a. The De-identification of PHI includes the removal of the following identifiers:

i. Name;

ii. Social Security number;

iii. Geographic subdivisions smaller than a state including:

a) Address;

b) City;

c) County;

d) Precinct; and

e) Zip code or equivalent geocode;

iv. Telephone numbers;

v. Facsimile numbers;

vi. E-mail address;

vii. Medical Record number;

viii. Health plan beneficiary number;

ix. All elements of dates (except year) for dates related to an individual:

a) Birth date;

b) Admission date;

c) Discharge date;

d) Date of death;

e) All ages over eighty-nine (89) years; and

f) All elements of dates (including year) indicative of age, except an aggregated single category of "ninety (90) years or older" is permissible.

x. Account number;

xi. Certificate or license number;

xii. Vehicle identifiers, serial numbers, and license plate number;

xiii. Device identifiers and serial numbers;

xiv. Web Universal Resource Locators (URLs);

xv. Internet Protocol (IP) address numbers;

xvi. Biometric identifiers, voice, and finger prints;

xvii. Full face photographs and comparable images; and

xviii. Any other unique identifying number, characteristic, or code.

b. There is no actual knowledge that the information could be used alone or in combination with other information to identify an individual who is a subject of the information.

3. Re-identification of information

a. A code or other means of record identification may be assigned if:

i. The code is not derived from or related to information about the individual that would allow the individual to be identified (i.e., the first four digits of a social security number).

ii. The code is only used by CalOptima to re-identify the data and the code is not released for use by another person or entity.

V. ATTACHMENTS

Not Applicable

VI. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Policy MA.1001: Glossary of Terms
C. HIPAA Patient Privacy Compliance Guide, Atlantic Information Services, Inc, 2002, Patient Health Information and Research, pp. 2000-39-41
D. Title 45, Code of Federal Regulations, Section 164.501 Definitions Required by Law
E. Title 45, Code of Federal Regulations, Section 164.514 Standard: De-Identification of Protected Health Information

VII. REGULATORY APPROVALS

Not Applicable

VIII. BOARD ACTION

None to date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	06/01/2005	MA.9221	De-identification of Protected Health Information
Revision Date 1	02/01/2008	MA.9221	De-identification of Protected Health Information
Revision Date 2	09/01/2014	MA.9221	De-identification of Protected Health Information
Revision Date 3	09/01/2015	MA.9221	De-identification of Protected Health Information

Policy #:	MA.9222
Title:	**Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information**
Department:	Office of Compliance
Section:	Health Insurance Portability and Accountability Act (HIPAA)

CEO Approval:	Michael Schrader _____
Effective Date:	8/1/07
Last Review Date:	9/1/15
Last Revised Date:	9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To describe the process for notifying the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), the Department of Health and Human Services (HHS), and Affected Members of any Breach of data security, Intrusion, or unauthorized Use or Disclosure of Protected Health Information (PHI).

II. DEFINITIONS

Term	Definition
Breach	An unauthorized disclosure of protected health information (PHI) that violates either federal or state laws (HIPAA Privacy Rule and State Information Practices Act of 1977) or PHI that has been reasonably believed to have been acquired by an unauthorized person. A breach may be paper or electronic.
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of a covered entity or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs, or assists in the performance of: a. A function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or b. Any other function or activity regulated by this subchapter; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health

Term	Definition
	care arrangement in which the covered entity participates, where the provision of the services involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.
Corrective Action Plan	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), or designated representatives. Delegates may be required to complete CAPs to ensure they are in compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements identified by CalOptima and its regulators.
Covered Entity	A health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by Title 45, Code of Federal Regulations, Part 160.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disclosure	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 19696. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information as amended.
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Intrusion	The act of wrongfully (without authorization) entering upon, seizing, or taking possession of computerized data that compromises the security, confidentiality, or integrity of personal information maintained by CalOptima or its Business Associates.
Member (Global)	An enrollee-beneficiary of a CalOptima program
Protected Health Information (PHI)	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member;

Term	Definition
	2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Use of PHI	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. The sharing, employment, application, utilization, examination, or analysis of the Pill within an entity that maintains such information.

III. POLICY

A. As a Covered Entity, CalOptima and Business Associates shall have Administrative, Physical, and Technical Safeguards in place that reasonably protect the Confidentiality, Integrity, and Availability of PHI, both electronic (EPHI) and non-electronic, in accordance with applicable state and federal regulations, Health Insurance Portability and Accountability Act (HIPAA), and CalOptima privacy and security policies.

B. CalOptima employees and Business Associates shall immediately report any suspected or known Breach of data security, Intrusion, or unauthorized Use or Disclosure of PHI to the CalOptima Privacy Officer, or Designee, in accordance with this policy.

C. Examples of Breaches include, but are not limited to:

1. Lost or Stolen electronic devices that contain PHI;
2. A Covered Entity that wrongfully Uses or Discloses PHI;
3. PHI from CalOptima that is posted on a public website by a disgruntled employee;
4. Electronic mail containing PHI that is sent unencrypted and is intercepted by an unintended third party;
5. Lost or Stolen prior authorization forms that are left in an employee's automobile;
6. PHI that is wrongfully sent by facsimile to an unintended recipient; and
7. Records containing PHI sent by courier service that are lost or stolen.

D. CalOptima shall notify CMS and DHCS of the discovery of a suspected or known Breach of data security, Intrusion, or unauthorized Use or Disclosure of PHI, in accordance with this policy.

E. Business Associates shall notify CalOptima of discovery of any known or suspected Breach of data security, Intrusion, or unauthorized Use or Disclosure of PHI, who shall notify CMS and DHCS within the timeframe specified in the CMS and DHCS contract and Section IV. B. 1 of this policy. Business Associates shall submit a written report to CalOptima of a suspected or known Breach, Intrusion, or unauthorized Use or Disclosure of PHI, in accordance with this policy.

F. CalOptima shall investigate such a Breach, Intrusion, or unauthorized Use or Disclosure of PHI and provide a written report of the investigation to CMS and DHCS, in accordance with this policy.

G. CalOptima shall provide a written report of the investigation to the CMS and DHCS of a suspected or known Breach, Intrusion, or unauthorized Use or Disclosure of PHI affecting CalOptima Members.

H. CalOptima shall notify individual Members whose unsecured PHI has been or believed to have been accessed, acquired, Used, or Disclosed as a result of a Breach by a Covered Entity, which compromises the security or privacy of the PHI. Such notice shall be made without unreasonable delay and no later than sixty (60) calendar days from the date of discovery of the Breach, in accordance with Section III. D of this policy.

I. CalOptima shall notify the HHS of Breaches of PHI involving five-hundred (500) or more Members concurrently with notification to affected Members. For breaches of PHI involving less than five-hundred (500) Members, CalOptima shall submit a log to the HHS no later than sixty (60) calendar days after the end of each calendar year.

J. A Covered Entity shall take prompt corrective action to mitigate any risks or damages caused by a Breach, to the extent possible, in accordance with CalOptima Policy MA.9217: Mitigation.

K. CalOptima and Business Associates shall follow the notification requirements for affected Members of the CalOptima Program, in accordance with CalOptima Policy MA.9222: Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Heath Information.

IV. PROCEDURE

A. Discovery

1. CalOptima employees and Business Associates shall report any Breach of data security, Intrusion, or unauthorized Use or Disclosure of PHI immediately after discovery during the business day to the CalOptima Privacy Officer, or Designee.

2. If the initial discovery occurs during non-business hours, CalOptima employees and Business Associates shall report the initial discovery to CalOptima's Customer Service Department.

3. If the Business Associate has a direct contract with Medical, the Business Associate shall directly report to DHCS the discovery of any suspected or known Breach of data security, Intrusion, or unauthorized Use or Disclosure of PHI involving a CalOptima Member. The Business Associate shall send a copy of the report to CalOptima's Office of Compliance immediately after notification to DHCS, in accordance with Section IV. B. 2 of this policy.

B. The CalOptima Privacy Officer shall notify and report the discovery of any known or suspected Breach of data security, Intrusion, or unauthorized Use or Disclosure of PHI to CMS and DHCS, in accordance with the following guidelines:

1. Notification to CMS

a. The CalOptima Privacy Officer or Designee shall follow the notification requirements of Department of Health and Human Services (HHS) Office of Civil Rights (OCR) posted at http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule.

b. All reports submitted to OCR shall be concurrently submitted to CMS Account Manager, with the same information that was submitted to OCR.

c. If an incident has the potential for significant harm to CalOptima member (i.e. a high likelihood that the information was used inappropriately), or the situation may have heightened public or media scrutiny (i.e. a higher number of members affected or particularly egregious breaches), CalOptima Privacy Officer or Designee shall immediately notify CMS Account Manager of the incident, and no later than two (2) business days.

2. Notification to DHCS

a. EPHI: The CalOptima Privacy Officer shall notify DHCS immediately after the discovery,.

b. PHI in non-electronic form: The CalOptima Privacy Officer shall notify DHCS within twenty-four (24) hours after the initial discovery, in accordance with Section IV. B. 1. c of this policy.

c. The CalOptima Privacy Officer shall notify the DHCS Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer by electronic mail or facsimile, and by telephone, as required.

d. If the incident is discovered during non-business hours and involves EPHI, the CalOptima Privacy Officer shall notify DHCS immediately by calling the DHCS ITSD Help Desk at 1-916-440-7000.

3. Business Associates shall notify CalOptima of discovery of any known or suspected Breach of data security, Intrusion, or unauthorized Use or Disclosure of PHI, who shall contact DHCS immediately, as specified in the DHCS contract and Section IV. B of this policy. Business Associates shall submit a written report directly to the CalOptima Privacy Officer within three (3) business days after the initial discovery. The written report shall contain the elements specified in Section III.B.4.b of this policy. CalOptima shall investigate the incident and report directly to DHCS, in accordance with Section III. B of this policy.

4. If the Business Associate is an HMO that has a direct contract with Medi-Cal, the HMO shall report its discovery of a Breach directly to DHCS if it involves a CalOptima Member. The HMO shall simultaneously copy the report to the CalOptima Privacy Officer by electronic mail to HNReporting@caloptima.org. The HMO Privacy Officer shall report the Breach as it pertains to CalOptima Members to DHCS using the guidelines in Section III. B of this policy.

5. Investigation and written report to DHCS:

a. The CalOptima Privacy Officer or Designee shall investigate the Breach, Intrusion, or unauthorized Use or Disclosure of PHI, and provide an interim written report of the

investigation to the DHCS Privacy Officer, the DHCS Contract Manager, and the DHCS Information Security Officer within seventy-two (72) hours after the initial discovery.

b. Within ten (10) working days of the initial discovery, CalOptima Privacy Officer or Designee shall submit a complete investigation report to the DHCS Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer.

c. CalOptima shall use the DHCS Privacy Incident Report Form, which include but not limited to the following:

i. The date of the incident, when the incident was discovered, and when DHCS was notified of the incident;

ii. A complete description of the incident, including:

1) The data elements involved and the extent of the data involved in the Breach;

2) The primary job function of the person known or reasonably believed to have improperly Used or Disclosed PHI;

3) A description of where the PHI is believed to have been improperly transmitted, sent, or utilized;

4) The cause or probable cause of the incident;

5) The impact of the incident including, but not limited to, potential misuse of data or identity theft;

6) If California Civil Code sections 1798.39 and 1798.82, Title 13 of the American Recovery and Reinvestment Act of 2009, or any other federal or state laws requiring individual notifications of Breaches are triggered;

7) The steps taken to reduce the harmful effects (mitigation); and

8) A Corrective Action Plan (CAP) that describes how CalOptima will prevent reoccurrence of this incident in the future.

C. CalOptima shall notify Members whose unsecured PHI has been or is believed to have been accessed, acquired, Used, or Disclosed as a result of a Breach which compromises the security or privacy of the PHI. All notifications shall be provided without unreasonable delay and no later than sixty (60) calendar days after the date of discovery, which is the first day the breach is known by a Covered Entity, or would have been known by exercising reasonable diligence. CalOptima shall provide notification as specified below.

1. CalOptima shall write the notification in plain language and include, to the extent possible:

a. A brief description of what occurred, including the date of the Breach and the date of the discovery of the Breach, if known;

b. A description of the types of unsecured PHI that were involved in the Breach (e.g., full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information involved);

c. Any steps Members should take to protect themselves from potential harm resulting from the Breach;

d. A brief description of what the Covered Entity is doing to investigate the Breach, to mitigate harm to Members, and to protect against any further Breaches; and

e. Contact procedures for members to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, website, or postal address.

2. CalOptima shall provide notification in the following form:

a. CalOptima shall send written notification by first-class mail to the Member at the last known address or by electronic mail if the Member has agreed to receive notice by electronic mail. CalOptima may provide notification in one (1) or more mailings as information is available.

i. If the Member is deceased, CalOptima shall provide written notification by first-class mail to either the next of kin or personal representative of the member, if contact information is known.

ii. If current contact information is unavailable for fewer than ten (10) Members, CalOptima may provide a substitute notice by an alternative form of written notice, telephone, or other means.

iii. If current contact information is unavailable for ten (10) or more Members, CalOptima shall provide a substitute notice by a readily visible posting on the homepage of CalOptima's Website for ninety (90) calendar days or by a readily visible notice in a major print or broadcast media. The notice shall include a toll-free telephone number that remains active for at least ninety (90) calendar days for Members to obtain information regarding the Breach.

b. If CalOptima deems a Breach incident to require urgency because of a possible imminent misuse of unsecured PHI, CalOptima may provide Breach notification to Members by telephone or other means, in addition to written notice.

c. For a Breach of unsecured PHI affecting more than five hundred (500) Members, CalOptima shall notify and ensure publication of the Breach by prominent media outlets serving Orange County, in addition to providing individual written notices.

D. The CalOptima Privacy Officer shall notify the Secretary of HHS following the discovery of a Breach of unsecured PHI as follows:

1. For Breaches of unsecured PHI involving five hundred (500) or more Members, the CalOptima Privacy Officer shall provide notification to the Secretary of HHS concurrently with notifications provided to Affected Members.

2. For Breaches of unsecured PHI involving less than five hundred (500) Members, the CalOptima Privacy Officer shall submit a log of such Breaches for the preceding calendar year, no later than sixty (60) calendar days after the end of each calendar year.

V. ATTACHMENTS

A. DHCS Privacy Incident Report Form

VI. REFERENCES

A. California Civil Code Sections 1798.39 and 1798.82
B. CalOptima Compliance Plan
C. CalOptima Privacy Program
D. CMS, September 28, 2010 Update on Security and Privacy Breach Reporting Procedures
E. CalOptima Policy MA.1001: Glossary of Terms
F. CalOptima Policy MA.9217: Mitigation
G. Title 13, American Recovery and Reinvestment Act of 2009
H. Title 45, Code of Federal Regulations 164.502 Uses and Disclosures of PHI
I. Title 45, Code of Federal Regulations 164.514 Other Requirements Related to Uses and Disclosures of PHI

VII. REGULATORY APPROVALS

Not Applicable

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	08/01/2007	MA.9222	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information
Revision Date 1	01/01/2010	MA.9222	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information
Revision Date 2	09/01/2011	MA.9222	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information
Revision Date 3	06/01/2014	MA.9222	Reporting a Breach of Data Security, Intrusion,

Version	Version Date	Policy Number	Policy Title
			or Unauthorized Use or Disclosure of Protected Health Information
Revision Date 4	11/01/2014	MA.9222	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information
Revision Date 5	09/01/2015	MA.9222	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information

Policy #:	MA.9224
Title:	**Disclosure of Information to Family Members or Friends Involved in Member Care**
Department:	Office of Compliance
Section:	Health Insurance Portability and Accountability Act (HIPAA)
CEO Approval:	Michael Schrader
Effective Date:	9/1/09
Last Review Date:	9/1/15
Last Revised Date:	9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

Identify the situations and conditions under which Protected Health Information (PHI) may be Disclosed to a Member's family member or friends involved in the Member's care or for notification.

II. DEFINITIONS

Authorized Representative:	Any individual authorized by a Member, or under state law, to act on his or her behalf in obtaining an Organization Determination or in dealing with any level of the Appeal process. An Authorized Representative is subject to the rules described in Title 20 of the Code of Federal Regulations, Part 404, Subpart R, unless otherwise stated in the Medicare Managed Care Manual (Use form CMS-1696 for Claims Adjudication or Claim Appeal process).
Disclosure:	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Health Care Operations:	Activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities customer services, resolution of internal grievances, business planning, and development activities related to compliance with the privacy rule.
Member (Global):	An enrollee-beneficiary of a CalOptima program.
Payment:	Activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member

	health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Protected Health Information (PHI):	Has the meaning given such term in section160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form of medium. This information identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Treatment:	Activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use of PHI:	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. The sharing, employment, application, utilization, examination, or analysis of the Pill within an entity that maintains such information.

III. POLICY

A. CalOptima may Use or Disclose PHI to a Member's family member or close personal friend, or other person identified by the Member, if the Member is present and either gives permission or is given the opportunity to object and fails to object to the Disclosure.

B. CalOptima may Use or Disclose PHI to a Member's family member or friend, or other person identified by the Member, pursuant to a written authorization executed by the Member.

C. For all other Uses or Disclosures of PHI for purposes other than Treatment, Payment, or Health Care Operations, CalOptima shall obtain written authorization from the Member prior

to the Use or Disclosure, in accordance with CalOptima Policy MA.9219: Authorization for Release of Protected Health Information.

IV. PROCEDURE

A. CalOptima may Use or Disclose PHI to a Member's family member or close personal friend, or other person identified by the Member, when the Use or Disclosure is relevant to that family Member's involvement in the Member's care if the Member is present for, or otherwise available prior to, the Use or disclosure, and has the capacity to make health care decisions, and:

1. CalOptima obtains the Member's agreement;

2. CalOptima provides the Member with the opportunity to object to the Disclosure, and the Member does not express an objection; or

3. CalOptima, based on the exercise of professional judgment, reasonably infers from the circumstances that the individual does not object to the Disclosure.

B. Unless otherwise authorized in writing, CalOptima may only Use or Disclose PHI to a Member's family member or close personal friend, or other person identified by the Member, when the Member is not present for the Use or Disclosure, or the opportunity to agree or object to the Use or Disclosure cannot practicably be provided due to the Member's incapacity or an emergency circumstance, if, in the exercise of professional judgment, CalOptima determines that the Use or Disclosure is in the best interest of the Member, and the Use or Disclosure is limited to only that PHI that is directly relevant to family member's or friend's involvement in the Member's health care.

C. CalOptima may Use or Disclose PHI to a Member's family member or close personal friend, or other person identified by the Member, when the Use or Disclosure is relevant to that family Member's involvement in the Member's care pursuant to a written authorization. A valid authorization shall contain the following core elements:

1. A description of the information to be Used or Disclosed;

2. The name of the person or organization that will Use or Disclose the PHI;

3. The name of the person or organization that will receive the PHI;

4. A description of the purpose for which the PHI will be used (except for requests by the Member, which can indicate "at Member's request" without further explanation);

5. The expiration date or event;

6. Statement that further Use or Disclosure of the PHI is prohibited unless another authorization is obtained from the Member or such Use or Disclosure is specifically required or permitted by law.

7. A statement that the Member has the right to revoke the authorization in writing and any exceptions to this right;

8. Member's signature and the date (if the Member's Authorized Representative, state the relationship); and

9. Additional elements that apply if authorization is requested by CalOptima;

   a. A statement that CalOptima will not condition Treatment or Payment on the Member signing the authorization request;

   b. A statement that the Member can refuse to sign the authorization;

   c. A statement that the Member is entitled to a copy of the signed authorization. A copy of the signed authorization shall be given to the Member; or

   d. A statement when any Disclosure will result in either direct or indirect Payment to CalOptima from the receiver of the PHI.

V. ATTACHMENTS

A. Authorization for Use or Disclosure of Protected Health Information to Family Member or Friend Involved in Member Care

VI. REFERENCES

A. Title 45, Code of Federal Regulations, Section 164.508, Uses and Disclosures for which an Authorization is Required
B. Title 45, Code of Federal Regulations, Section 164.510, Uses and Disclosures Requiring an Opportunity for the Individual to Agree or to Object
C. California Civil Code, Sections 56.10(c) and 56.1007
D. CalOptima Policy CMC.1001: Glossary of Terms
E. CalOptima Policy MA.1001: Glossary of Terms
F. CalOptima Policy MA.9210: Tracking and Reporting Disclosures of Protected Health Information (PHI)
G. CalOptima Policy MA.9205: Verification of Identity for Disclosures of Protected Health Information
H. CalOptima Policy MA.9219: Authorization for Release of Protected Health Information
I. Guide to Medical Privacy and HIPAA, Thompson Publishing Group, Inc., Appendix III - Glossary
J. HIPAA Patient Privacy Compliance Guide, Atlantic Information Services, Inc., pp.1500-105 through 1500-112
K. Multipurpose Senior Services Program Standards, California Department of Aging
L. Privacy & Security Policies and Procedures: A Resource Document, WEDI, 2002, pp.19-23
M. The California Patient Privacy Manual, California Healthcare Association, 2002, pp. 73-78
N. Centers for Medicare & Medicaid (CMS): Medicare General Information, Eligibility, and Entitlement Chapter 6

VII. REGULATORY APPROVALS

Not Applicable

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Name
Original Date	9/1/09	MA.9224	Disclosure of Information to Family Members or Friends Involved in Member Care
Revised Date 1	5/1/13	MA.9224	Disclosure of Information to Family Members or Friends Involved in Member Care
Revised Date 2	9/1/14	MA.9224	Disclosure of Information to Family Members or Friends Involved in Member Care
Revised Date 3	9/1/15	MA.9224	Disclosure of Information to Family Members or Friends Involved in Member Care

Policy #:	MA.9101
Title:	**Compliance Program**
Department:	Office of Compliance
Section:	Compliance

CEO Approval:	Michael Schrader
Effective Date:	6/1/05
Last Review Date:	9/1/15
Last Revised Date:	9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To establish a Compliance Program to ensure and enforce compliance with ethical standards, contractual requirements, applicable federal and state statutes and regulations, and CalOptima policies.

II. DEFINITIONS

Term	Definition
Compliance Committee	The CalOptima committee that consists of executive officers, managers of key operating divisions, and legal counsel that oversees implementation of CalOptima's Compliance Program.
Compliance Program	A comprehensive program that incorporates the fundamental elements indentified by the state and federal governments and CalOptima as necessary to prevent and detect violations of ethical standards, contractual obligations, and applicable laws and the involvement of CalOptima's governing body and executive staff. Elements of the Compliance Program include standards, oversight, training, reporting, monitoring, enforcement, and remediation. The Compliance Program applies to CalOptima's Board of Directors, employees, and contractors including delegated entities, providers, and suppliers.
Downstream Entity	Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
First Tier Entity	Any party that enters into a written arrangement with CalOptima to provide administrative services or health care services to a Medicare or Medicaid eligible individual under the CalOptima program.

First Tier, Downstream, and Related Entities (FDR)	FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
Member	An enrollee-beneficiary of CalOptima program.
Providers	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Physician Medical Group, or other person or institution who furnishes Covered Services.
Related Entity	Any entity that is related to CalOptima by common ownership or control and: 1. Performs some of the management functions under contract or delegation; 2. Furnishes services to Medicare or Medicaid enrollees under an oral or written agreement; or 3. Leases real property or sells materials to CalOptima at a cost of more than two-thousand five-hundred dollars ($2,500) during a contract period.

III. POLICY

A. CalOptima shall establish a written Compliance Program, in accordance with this policy.

B. CalOptima's First Tier, Downstream and Related Entities (FDR) shall at a minimum develop a written Compliance Program, in accordance with the policy.

C. CalOptima shall revise and update the Compliance Program, including the Compliance Plan and all applicable CalOptima policies, as changes occur in CalOptima's needs, regulatory requirements, and applicable laws.

D. The CalOptima Board of Directors shall review and approve the Compliance Program, in accordance with this policy.

E. The Compliance Committee shall provide oversight, analysis and continuous monitoring of compliance activities and shall provide a summary of such activities to the Board of Directors on a periodic basis.

F. The Board of Directors, employees, and FDRs shall comply with the Compliance Program.

IV. PROCEDURE

A. The Office of Compliance shall modify the Compliance Plan, as necessary, to maintain compliance with contractual requirements, applicable state and federal statutes and regulations, and CalOptima policies, or as otherwise indicated to meet the needs of Members.

B. The Executive Director of Compliance shall submit recommended revisions to the Compliance Plan to the Compliance Committee for review and approval.

C. Upon the Compliance Committee's approval, the Executive Director of Compliance shall present the revised Compliance Plan to the Board of Directors for approval and adoption into the Compliance Program.

V. ATTACHMENTS

A. CalOptima Compliance Plan

VI. REFERENCES

A. CalOptima Compliance Plan
B. Medicare Managed Care Manual, Chapter 21: Compliance Program Guidelines
C. Medicare Prescription Drug Benefits Manual, Chapter 9: Compliance Program Guidelines
D. Office of Inspector General Guidelines for Operating an Effective Compliance Program
E. OneCare Policy MA.1001: Glossary of Terms
F. OneCare Connect Policy CMC.1001: Glossary of Terms

VII. REGULATORY APPROVALS

None to Date

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	6/1/05	MA.9101	Compliance Program
Revision Date 1	6/1/13	MA.9101	Compliance Program
Revision Date 2	6/1/14	MA.9101	Compliance Program
Revision Date 3	9/1/15	MA.9101	Compliance Program

Policy #: MA.9104
Title: **Corrective Action Plan**
Department: Office of Compliance
Section: Compliance

CEO Approval: Michael Schrader_____

Effective Date: 8/1/05
Last Review Date: 9/1/15
Last Revised Date: 9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To define the requirements for CalOptima and its First Tier, Downstream and Related Entities (FDRs) for development and submission of an Immediate Corrective Action Plan (ICAP) or Corrective Action Plan (CAP) for areas of non-compliant performance, as identified by CalOptima's Office of Compliance.

II. DEFINITIONS

Term	Definition
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, regulating bodies, or designated representatives. Delegates may be required to complete CAPs to ensure they are in compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements identified by CalOptima and its regulators.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Downstream Entity	Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
First Tier, Downstream, and Related Entities (FDRs)	FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement with CalOptima to provide administrative services or health care services to a Medicare or Medicaid eligible individual under the CalOptima program.
Immediate Corrective Action Plan (ICAP)	An ICAP is the result of non-compliance with specific requirements that has the potential to cause significant member harm. Significant

	member harm exists if the non-compliance resulted in the failure to provide medical items, services or prescription drugs, causing financial distress, or posing a threat to member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Related Entity	Any entity that is related to CalOptima by common ownership or control and: 1. Performs some of the management functions under contract or delegation; 2. Furnishes services to Medicare or Medicaid enrollees under an oral or written agreement; or 3. Leases real property or sells materials to CalOptima at a cost of more than two-thousand five-hundred dollars ($2,500) during a contract period.
Sanction	Action taken by CalOptima including, without limitations, restrictions, monetary fines, termination or a combination thereof, based on a FDR failure to comply with statutory, regulatory, contractual, CalOptima policy, or other requirements related to CalOptima programs.

III. POLICY

A. CalOptima's Office of Compliance shall conduct auditing, operational monitoring, and investigations of internal CalOptima departments and its FDRs to ensure compliance with statutory, regulatory, contractual, CalOptima policy and other requirements related to CalOptima programs.

B. CalOptima's Office of Compliance may require that an internal department or FDR develop an ICAP or CAP based on the identified area(s) of non-compliance.

C. CalOptima's Office of Compliance shall require that internal departments and CalOptima's FDRs bring its operations into full compliance with statutory, regulatory, contractual, CalOptima policy and other requirements, which CalOptima or its regulators have identified as non-compliant within timeframes established by CalOptima's Office of Compliance.

D. An internal department or FDR shall develop, submit, and take corrective action under an approved ICAP or CAP in the time and manner required by CalOptima's Office of Compliance.

1. Failure by the internal department to respond accurately, timely and in compliance with statutory, regulatory, contractual, CalOptima policy or other requirements to CalOptima's Office of Compliance's ICAP or CAP shall lead to further action, in accordance with CalOptima policy GA.8022: Progressive Discipline.

2. Failure by an FDR to respond accurately, timely and in compliance with statutory, regulatory, contractual, CalOptima policy or other requirements to the Office of Compliance's ICAP or CAP shall lead to further action, in accordance with CalOptima Policy MA.9105: Sanctions. CalOptima may impose Sanctions for the underlying non-

compliant performance that gave rise to the ICAP or CAP, or failure to develop, submit, and meet the requirements of the ICAP or CAP.

IV. PROCEDURE

A. Basis for ICAP or CAP

1. CalOptima's Office of Compliance shall routinely monitor performance metrics, conduct routine or focused audits, and conduct ongoing monitoring and investigations of reported non-compliance, for internal department or FDRs, through a variety of mechanisms, including but not limited to performance and quality related metrics. In the event that the Office of Compliance determines an internal department or a FDR has failed to comply with statutory, regulatory, contractual, CalOptima policy or other requirements, the Office of Compliance may request an ICAP or CAP to address the issue.

B. ICAP and CAP Issuance and Requirements

1. CalOptima's Office of Compliance shall utilize a standardized ICAP or CAP template.

2. Non-compliance with specific requirements that have the potential to cause significant Member harm or place CalOptima's accreditation, participation and/or contractual status with regulatory agencies in jeopardy will require an ICAP response.

   a. If the finding requires an ICAP, as determined by CalOptima's Office of Compliance, the internal department or FDR is required to cease non-compliant activities within two (2) business days of receiving the ICAP.

   b. The internal department or FDR shall provide a written response, within three (3) business days, detailing how it will mitigate and prevent further non-compliance. Following the acceptance of the ICAP, the internal department or FDR, is required to resolve the issue in a manner and timeframe as deemed appropriate by CalOptima's Office of Compliance.

3. A CAP is the result of a material non-compliance with specific requirements that does not rise to the level of an ICAP.

   a. The internal department or FDR is required to respond to the CAP request within fourteen (14) business days. Following the acceptance of the CAP, the internal department or FDR, is required to resolve the issue in a manner and timeframe as deemed appropriate by CalOptima's Office of Compliance.

4. An ICAP or CAP response shall include the following elements:

   a. A root cause analysis of the deficiency which may include a description of the policies and procedures, staffing, training and systems that failed;

   b. Steps taken to resolve the deficiency;

   c. Steps taken to avoid reoccurrence;

d. Method for implementation and completion of ICAP or CAP;

e. Individual responsible for implementation of the ICAP or CAP;

f. An attestation by the internal department or FDR conveying a plan to remedy its identified deficiencies; and

g. ICAP or CAP completion date, as applicable.

C. Inadequate Resolution to an ICAP or CAP

1. If the internal department's or FDR's resolution to the deficiency is inadequate or the internal department or FDR fails to respond, CalOptima's Office of Compliance shall issue a letter to the internal department's Chief or the FDR's Chief Executive Officer (CEO), or his or her Designee, which shall include:

a. A summary of previous outreach and required action;

b. How it was determined that the resolution was not adequate or a response was not received;

c. A revised resolution timeline of two (2) business days;

d. Reiteration of consequences – specific to the nature of the issue and degree of completeness, in accordance with CalOptima policies GA.8022: Progressive Discipline or MA.9105: Sanctions; and

e. Referral to Delegation Oversight and/or Compliance Committee.

D. Adequate Resolution with ICAP or CAP Requirements

1. If the internal department's, or FDR's, resolution to the deficiency is deemed adequate by the Executive Director of Compliance, or his or her Designee, CalOptima's Office of Compliance may issue an acceptance letter, which shall include:

a. An acknowledgement of acceptance;

b. A description of follow up actions, which includes, but is not limited to:

i. Submission of finalized documentation, or

ii. Focused audit, as described in section IV.E of this policy, or

iii. Monitoring, as deemed appropriate by CalOptima's Office of Compliance and as described in section IV.F of this policy.

2. If the internal department or FDR's resolution to the deficiency is accepted and deemed sufficient, by the Executive Director of Compliance, or his or her Designee, CalOptima's Office of Compliance shall issue a closure letter which shall include:

   a. An acknowledgement of closure;

   b. An effective date of closure; and

   c. Consequences of repeat deficiencies.

E. Focused Audits

1. CalOptima's Office of Compliance may conduct a focused audit of an internal department or FDR to confirm implementation of the accepted ICAP or CAP remediation.

2. CalOptima's Office of Compliance shall notify the internal department or FDR of the scope, audit period, and audit deliverables that shall be required to complete the audit.

3. CalOptima's Office of Compliance may continue to monitor or audit an internal department's, or FDR's, performance of critical functions.

F. Monitoring Period

1. CalOptima's Office of Compliance may conduct monitoring of the internal department's or FDR's resolution to determine if it is adequate.

2. CalOptima's Office of Compliance shall monitor the internal department's or FDR's resolution for a predetermined timeframe as established by CalOptima's Office of Compliance.

3. CalOptima's Office of Compliance shall notify the internal department or FDR of the scope, monitoring period and deliverables that shall be required to complete the monitoring.

4. CalOptima's Office of Compliance may continue to monitor or audit an internal department's or FDR's performance of critical functions.

G. Failure to Maintain Adequate Resolution

1. If during the monitoring period or the focused audit, the internal department or FDR fails to maintain the remedies in place, CalOptima's Office of Compliance shall issue the internal department, or FDR, an ICAP. The internal department, or FDR, shall be required to resolve the issue within three (3) business days from the re-issuance of the finding.

2. The ICAP shall require the information as described in section IV.B.4 of this policy.

H. CAP Tracking and Reporting

1. CalOptima's Office of Compliance shall track all CAPs issued utilizing a CAP tracker.

2. All CAPs shall be reported to the Delegation Oversight and/or Compliance Committee.

3. If CalOptima's internal department, or FDR, has repeat deficiencies, the issue(s) shall be reported to the Delegation Oversight and/or Compliance Committee by the Office of Compliance for further action.

V. ATTACHMENTS

A. ICAP/CAP template

VI. REFERENCES

A. CalOptima Compliance Plan
B. Contract for Health Care Services
C. CalOptima Policy MA.1001: Glossary of Terms
D. CalOptima Policy MA.9105: Sanctions
E. CalOptima Policy GA.8022: Progressive Discipline

VII. REGULATORY APPROVALS

None to Date

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	08/01/2005	MA.9104	Corrective Action Plan
Revision Date 1	08/01/2008	MA.9104	Corrective Action Plan
Revision Date 2	04/01/2014	MA.9104	Corrective Action Plan
Revision Date 3	12/01/2014	MA.9104	Corrective Action Plan
Revision Date 4	09/01/2015	MA.9104	Corrective Action Plan

Policy #: MA.9105
Title: **Sanctions**
Department: Office of Compliance
Section: Compliance

CEO Approval: Michael Schrader

Effective Date: 10/1/98
Last Review Date: 9/1/15
Last Revision Date: 9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To promote First Tier, Downstream and Related Entity (FDR) compliance with statutory, regulatory, contractual, CalOptima policy and other requirements related to CalOptima programs and to describe the process in which CalOptima shall issue and apply Sanctions and penalties.

II. DEFINITONS

Term	Definition
Abuse	A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima and the CalOptima programs, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima and the CalOptima programs.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Compliance Committee	The CalOptima committee that consists of executive officers, leadership of key operating divisions, and legal counsel that oversees implementation of CalOptima's Compliance Program.
Compliance Program	The program including, without limitation, the Compliance Plan, Code of Conduct, and CalOptima policies, developed and adopted by CalOptima to promote, monitor, and ensure that CalOptima's operations and practices and the practices of its Board members, employees, contractors, and providers comply with applicable law and ethical standards.
Corrective Action Plan	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), or designated representatives. Delegates may

Term	Definition
	be required to complete CAPs to ensure they are in compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements identified by CalOptima and its regulators.
Covered Service	Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the CMS Contract.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California). DHCS is generally referred to as the state in this document.
Department of Managed Health Care (DMHC)	The state department charged with overseeing health care service plans licensed under the Knox-Keene Health Care Services Act of 1975.
Downstream Entity	Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Encounter	Any unit of Covered Service provided to a Member by a Health Network regardless of Health Network reimbursement methodology. These services include any Covered Services provided to a Member, regardless of the service location or Provider, including out-of-network Covered Services and sub-capitated and delegated Covered Services. Encounter data submitted to CalOptima should not include denied, adjusted, or duplicate claims.
First Tier Entity	Any party that enters into a written arrangement with CalOptima to provide administrative services or health care services to a Medicare or Medicaid eligible individual under the CalOptima program.
First Tier, Downstream, and Related Entities (FDR)	FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, and Welfare and Institutions Code section 14043.1(i).
Member	An enrollee-beneficiary of a CalOptima Program.
Related Entity	Any entity that is related to CalOptima by common ownership or control and: 1. Performs some of the management functions under contract or delegation; 2. Furnishes services to Medicare or Medicaid enrollees under an oral or written agreement; or 3. Leases real property or sells materials to CalOptima at a cost of more than two-thousand five-hundred dollars ($2,500) during a contract

Term	Definition
	period.
Sanction	Action taken by CalOptima including, without limitations, restrictions, monetary fines, termination or a combination thereof, based on a FDR failure to comply with statutory, regulatory, contractual, CalOptima policy, or other requirements related to CalOptima programs.
Waste	Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to CalOptima Programs. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

III. POLICY

A. CalOptima, through the Compliance Committee, may impose Sanctions against an FDR if it fails to comply with statutory, regulatory, contractual, CalOptima policy and other requirements related to CalOptima programs. The Compliance Committee shall approve and oversee Sanctions.

B. CalOptima may impose Sanctions against an FDR immediately following the FDR's failure to comply with statutory, regulatory, contractual, CalOptima policy or other requirements related to CalOptima programs, with or without a Corrective Action Plan (CAP) requirement.

C. If required by CalOptima, an FDR must submit a CAP to CalOptima in accordance with CalOptima policy MA.9104: Corrective Action Plan. CalOptima may also impose Sanctions if an FDR fails to submit, remediate or implement a CAP, or take corrective action under any approved CAP in the time or manner required by CalOptima.

D. The extent of the Sanction shall be commensurate with the severity of the deficiency identified as it relates to the risk posed to the CalOptima Member as well as other financial or accreditation exposure to CalOptima.

E. Sanctions include, but are not limited to, financial penalties, suspension of membership enrollment, de-delegation and/or termination of contract. CalOptima retains the right to take termination action in addition to, and notwithstanding, the imposition of other sanctions under this policy.

F. In the event an FDR fails to remediate its non-compliance in the time or manner required by CalOptima, CalOptima may impose additional and/or more severe sanctions.

IV. PROCEDURE

A. Basis for Sanctions

1. CalOptima may impose Sanctions or take any other action against an FDR based on the identification of deficient performance or non-compliance of an FDR. Non-compliance includes, but is not limited to:

a. Findings from performance reviews, in accordance with CalOptima Policy MA.9103 Health Network Performance Reviews;

b. Findings from delegation oversight activities, in accordance with CalOptima Policy MA.7014: Delegation Oversight;

c. Regulatory reviews; including but not limited to Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC) audits and Centers for Medicare & Medicaid (CMS) audits;

d. Provider and Member complaints and surveys;

e. Failing to function in the best interest of a Member including, but not limited to, inappropriately withholding Covered Services from a Member or failing to maintain Member access to Covered Services;

f. Failing to meet performance and quality requirements;

g. Failing to furnish Covered Services in the scope or manner required by the CalOptima contract or agreement;

h. Engaging in acts of prohibited discrimination;

i. Engaging in fraud, waste, or abuse as specified in CalOptima Policy MA.9107: Fraud, Waste and Abuse Detection;

j. Failing to report data or other information in the time or manner required by CalOptima including, but not limited to, Encounter data;

k. Engaging in any prohibited Marketing Activities, as specified in CalOptima policy MA.2001: Marketing Materials Standards;

l. Failing to have the required amounts and types of financial reserves or to meet financial solvency requirements;

m. Failing to comply with the CalOptima Compliance Program and investigations including, but not limited to, CalOptima's Code of Conduct and policies, or cooperate with investigations;

n. Breaching any covenant, condition, or term of the contract or agreement including, but not limited to, failing to perform contracted duties and responsibilities in the time or manner required by CalOptima;

o. Failing to submit, remediate or implement a CAP, or take corrective action under any approved CAP in the time or manner required by CalOptima; and

p. Failing to comply with any other review of statutory, regulatory, contractual, CalOptima policy and other requirements related to a CalOptima policy.

B. Determining Sanction

1. CalOptima's Compliance Committee shall review findings of an FDR's deficient performance or non-compliance as provided by CalOptima's Delegation Oversight committee or in accordance with CalOptima policies, MA.7014: Delegation Oversight and MA.9103: Health Network Performance Reviews.

2. The CalOptima Compliance Committee has the authority to authorize and implement all Sanctions, and shall oversee and monitor all Sanctions imposed.

3. The Compliance Committee shall determine the severity of the Sanction based upon findings of deficient performance or non-compliance. Sanctions will vary in severity based on the extent and type of finding. Actions that are determined to endanger a Member or prevent access to Covered Services will be reviewed and acted upon immediately, by the Office of Compliance. Sanctions imposed may include, but not be limited to, termination of the contract between the FDR and CalOptima.

C. Types of Sanctions

1. Sanctions may include any of the following:

   a. Financial penalties defined in the contract;

   b. Enrollment freeze - Auto Assignment; Member selection, or both;

   c. De-delegation of delegated function;

   d. Financial responsibility to pay a consultant or contractor, as determined by CalOptima, to work with the non-compliant organization to bring it into compliance;

   e. Termination of the contract or agreement with the non-compliant organization;

   f. Forfeiture of FDR Financial Security;

   g. Capitation deduction; or

   h. Any other action CalOptima deems appropriate and reasonable.

2. Monetary Sanctions are imposed independently, and are in addition to any other sums owed to CalOptima, such as refunding of overpayments. Parties with pending monetary Sanctions are responsible for paying monetary sanctions in the time and manner required by CalOptima.

D. Notification

1. CalOptima shall notify an FDR in writing. Such notice shall:

   a. Detail the findings of non-compliance;

b. Reference the applicable statutory, regulatory, contractual, CalOptima policy or other requirements that are the basis of the findings;

c. Provide detailed information describing the Sanction;

d. Identify timeframes by which the FDR shall be required to achieve compliance, as applicable;

e. Inform the FDR that CalOptima may impose additional Sanctions if compliance is not achieved; and

f. Provide notice of the FDR's right to file a complaint, in accordance with CalOptima policy.

E. The Compliance Committee shall oversee and monitor the FDR response to the Sanctions letter.

V. ATTACHMENTS

Not Applicable

VI. REFERENCES

A. CalOptima Contract with the Centers for Medicare and Medicaid Services
B. Contract for Health Care Services
C. Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i)
D. Title 22, California Code of Regulations, Section 51301 et. seq.
E. CalOptima Policy MA.2001: Marketing Materials Standards
F. CalOptima Policy MA.7014: Delegation Oversight
G. CalOptima Policy MA.9107: Fraud and Abuse Detection
H. CalOptima Policy MA.9103: Health Network Performance Reviews
I. CalOptima Policy MA.1001: Glossary of Terms
J. CalOptima Policy CMC.1001: Glossary of Terms
~~K. CalOptima Policy MA.9128: Process for a Request for Reconsideration of Finding~~
~~L.~~K. CalOptima Compliance Plan
~~M.~~L. CalOptima Code of Conduct

VII. REGULATORY APPROVALS

None to Date

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	10/01/1998	MA.9105	Contracted Provider Sanctions
Revision Date 1	08/01/2005	MA.9105	Contracted Provider Sanctions
Revision Date 2	08/01/2008	MA.9105	Contracted Provider Sanctions
Revision Date 3	04/01/2013	HH.2002Δ	Health Network Sanction
Revision Date 4	04/01/2014	MA.9105	Sanctions
Revision Date 5	09/01/2015	MA.9105	Sanctions

Policy #: MA.9106
Title: **Record Retention and Access**
Department: Office of Compliance
Section: Compliance
CEO Approval: Michael Schrader _____

Effective Date: 1/1/07
Last Review Date: 9/1/15
Last Revised Date: 9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To establish the requirements for CalOptima and its First Tier, Downstream, and Related Entities (FDRs) to retain and make available contracts, books, documents, records and financial statements, in accordance with federal and state regulations for the purpose of any audit or investigation of a CalOptima program.

II. DEFINITONS

Term	Definition
Downstream Entity	Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
First Tier, Downstream, and Related Entities (FDR)	FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement with CalOptima to provide administrative services or health care services to a Medicare or Medicaid eligible individual under the CalOptima program.
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term "Medical Record" is used both for the physical folder for each individual patient and for the body of information which compromises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	An enrollee-beneficiary of a CalOptima program.
National Committee for Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials, verification organizations, disease management programs and other health-related programs.

Quality Improvement Organization (QIO)	An organization comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. A QIO reviews Complaints raised by enrollees about the quality of care provided by physicians, impatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care plans, and ambulatory surgical centers. A QIO also reviews continued stay denials for enrollees receiving care in acute inpatient hospitals facilities as well as coverage terminations in Skilled Nursing Facilities, Home Health Agencies, and Comprehensive Outpatient Rehabilitation Facilities.
Related Entity	Any entity that is related to CalOptima by common ownership or control and: 1. Performs some of the management functions under contract or delegation; 2. Furnishes services to Medicare or Medicaid enrollees under an oral or written agreement; or 3. Leases real property or sells materials to CalOptima at a cost of more than two-thousand five-hundred dollars ($2,500) during a contract period.

III. POLICY

A. CalOptima and its FDRs shall retain and make available contracts, books, documents, records and financial records, in accordance with the provisions of this policy. These documents include, but are not limited to the following:

1. Data relating to Medicare utilization and costs;
2. Reinsurance costs;
3. Low-income subsidy payments;
4. Risk corridor costs;
5. Bid calculations;
6. Rebate information;
7. Medical Records;
8. Medical charts and prescription files; and
9. Other documentation pertaining to medical and non-medical services rendered to Members.

B. CalOptima's and its FDRs shall maintain and make available contracts, books, documents, records and financial statements regarding the CalOptima Medicare programs for a minimum of ten (10) years, and such records shall be maintained for an additional ten (10) years from the final date of the contract period or from completion of any audit or investigation, whichever is later.

C. If there is a termination, dispute or allegation of fraud or similar fault, document retention requirements for CalOptima and its FDRs may be extended to ten (10) years from the date of any resulting final resolution of the termination, dispute or allegation of fraud, or similar fault.

D. CalOptima and its FDRs shall retain and make available contracts, books, documents, records and financial statements to any authorized state and federal agencies or contractors for inspections, evaluations and auditing including, but are not limited to:

1. Centers for Medicare & Medicaid Services (CMS);
2. Department of Managed Health Care (DMHC);
3. Department of Health Care Services (DHCS);
4. The U.S. Department of Health and Human Services (HHS);
5. The U.S. Government Accountability Office (GAO); and
6. Any Quality Improvement Organization (QIO) or accrediting organizations, including NCQA, their designees and other representatives of regulatory or accrediting organizations.

IV. PROCEDURE

A. CalOptima and its FDRs shall provide an authorized entity with the requested and required contracts, books, documents, records and financial statements at any time during normal business hours for audit and other investigative activities.

V. ATTACHMENTS

Not Applicable

VI. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services
C. CalOptima Policy MA.1001: Glossary of Terms
D. CalOptima Policy CMC.1001: Glossary of Terms
E. Medicare Managed Care Manual, Chapter 21: Compliance Program Guidelines
F. Medicare Prescription Drug Benefits Manual, Chapter 9: Compliance Program Guidelines
G. Title 42, Code of Federal Regulations, Section 422.504(d)
H. Title 42, Code of Federal Regulations, Section 422.505(d)

I. Title 42, Code of Federal Regulations, Section 422.505(e)(4)(ii)
J. Title 42, Code of Federal Regulations, Section 423.504(d)
K. Title 42, Code of Federal Regulations, Section 423.505(d)Title 42, Code of Federal Regulations, Section 423.505(e)(4)(ii)

VII. REGULATORY APPROVALS

None to Date

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	1/1/07	MA.9106	Record Retention and Access
Revision Date 1	6/1/13	HH.2022Δ	Record Retention and Access
Revision Date 2	9/1/14	MA.9106	Record Retention and Access
Revision Date 3	9/1/15	MA.9106	Record Retention and Access

Policy #: MA.9113
Title: **Compliance and Ethics Hotline**
Department: Office of Compliance
Section: Compliance

CEO Approval: Michael Schrader

Effective Date: 4/1/12
Last Review Date: 9/1/15
Last Revision Date: 9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To establish procedures whereby CalOptima shall receive, document, and manage calls made to CalOptima's compliance and ethics hotline.

II. DEFINITIONS

Term	Definition
Caller	Anyone who calls CalOptima's compliance and ethics hotline.
Complaint	Any expression of dissatisfaction to CalOptima, a Provider, or the Quality Improvement Organization (QIO) by a Member made orally or in writing. A Complaint may include concerns about the operations of Providers or CalOptima such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, respect paid to Members, and claims regarding the right of a Member to receive services or receive payment for services previously rendered. A Complaint may also involve CalOptima's refusal to provide services to which a Member believes he or she is entitled. A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, regulating bodies, or designated representatives. Delegates may be required to complete CAPs to ensure they are in compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements identified by CalOptima and its regulators.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the

	appropriate qualifications or certifications related to the duty or role.
Downstream Entity	Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
First Tier, Downstream, and Related Entities (FDR)	FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement with CalOptima to provide administrative services or health care services to a Medicare or Medicaid eligible individual under the CalOptima program.
Immediate Corrective Action Plan (ICAP)	An ICAP is the result of non-compliance with specific requirements that has the potential to cause significant member harm. Significant member harm exists if the non-compliance resulted in the failure to provide medical items, services or prescription drugs, causing financial distress, or posing a threat to member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Member	An enrollee-beneficiary of the CalOptima program.
Provider	A physician, pharmacist, nurse, nurse midwife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Physician Medical Group, or other person or institution who furnishes Covered Services.
Related Entity	Any entity that is related to CalOptima by common ownership or control and: 1. Performs some of the management functions under contract or delegation; 2. Furnishes services to Medicare or Medicaid enrollees under an oral or written agreement; or 3. Leases real property or sells materials to CalOptima at a cost of more than two-thousand five-hundred dollars ($2,500) during a contract period.

III. POLICY

A. CalOptima's First Tier, Downstream and Related Entities (FDRs) shall develop a process for receiving, documenting, and managing calls made to the FDR's hotline, in accordance with this policy.

B. A third party vendor contracted by CalOptima shall:

1. Take and document all incoming calls to the compliance and ethics hotline;

2. Secure all information provided by the Caller and log the information on an intake form; and

3. Send the intake information to the Office of Compliance within one (1) business day of the call.

C. All calls made to CalOptima's compliance and ethics hotline shall be handled in a manner that protects the privacy of the Caller, either named or anonymous. All Callers shall be asked if he or she would like to remain anonymous.

D. The Office of Compliance shall investigate all calls made to CalOptima's compliance and ethics hotline within three (3) business days of receipt.

E. Access to CalOptima's compliance and ethics hotline is available to callers twenty-four (24) hours per day, seven (7) days per week, by calling 1-877-837-4417.

F. Availability of CalOptima's compliance and ethics hotline shall be publicized in Member, Provider, employee, and community communications.

G. CalOptima maintains a strict policy of non-retaliation and non-retribution towards an employee who makes such reports in good faith, in accordance with CalOptima Policies MA.9223: Non-Retaliation for Reporting Violations, MA.9114: Reporting Suspected Misconduct or Violation.

IV. PROCEDURE

A. Receipt and Documentation of Call

1. The third party vendor shall intake phone calls received on the compliance and ethics hotline and shall document all pertinent information, including the name, phone number, and location of the Caller, if the Caller is willing to provide that information.

2. The third party vendor will:

a. Document the nature of the concern and attempt to secure all identifiable information, such as name, location, specifics of the allegation, and any unique identifiers, such as the Client Index Number (CIN) or National Provider Number (NPI).

b. Ascertain whether the Caller wants a call back after the investigation closes. If so, the third party vendor shall obtain a phone number for the call back.

c. Forward the call intake information to CalOptima's Office of Compliance for investigation within one (1) business day of the call.

3. The Office of Compliance shall assign a case number, create electronic and paper files, and refer the case to the Director of Compliance, or his or her Designee, for review within two (2) business days of receipt from the third party vendor.

B. Call Investigation

1. If the call concerns a general inquiry or a general Complaint about a CalOptima Provider or procedure, the Executive Director of Compliance, or his or her Designee, shall route the call to the appropriate CalOptima department for follow-up.

2. If the call concerns allegations of wrongdoing on the part of a CalOptima Member, board member, Provider, or employee, the Executive Director of Compliance, or his or her Designee, shall initiate an investigation into the allegations.

3. The Executive Director of Compliance, or his or her Designee, shall review the case and determine if additional information is necessary to develop an investigative plan. If additional information is required, the Caller, if identified, shall be contacted by the Executive Director of Compliance, or his or her Designee, to obtain the additional information. If the Caller is anonymous, the Executive Director of Compliance, or his or her Designee, shall evaluate the information provided, and determine if the investigation can proceed with the information at hand. If the investigation cannot proceed without additional information, the Executive Director of Compliance, or his or her Designee, shall close the case and document the rationale for closure in the case file.

4. If the investigation proceeds, the Executive Director of Compliance, or his or her Designee, shall review and investigate the case in accordance with CalOptima Policy MA.9125: Conducting Compliance Investigations and MA.9108: Fraud, Waste, and Abuse Investigation and Reporting.

5. The Executive Director of Compliance, or his or her Designee, shall report any CalOptima employee matters that appear to involve criminal liability or substantial civil liability to the appropriate department.

6. The Office of Compliance may consult with CalOptima Legal Counsel, as necessary.

7. Once the preliminary investigation has been completed, and has been sufficiently documented with all relevant questions answered, the Director of Compliance, or his or her designee, shall determine whether the allegations should be referred to the appropriate regulatory enforcement branch for further investigation.

8. If preliminary investigation finds that there is no basis for the allegation, the Executive Director of Compliance, or his or her Designee, shall close the case and document the rationale for such closure in the case file.

9. If the preliminary investigation finds that there is validity to the allegations made, the Office of Compliance shall forward the case file to the appropriate regulatory agency, in accordance with CalOptima Policy MA.9108: Fraud, Waste, and Abuse Investigation and Reporting.

10. For cases that are not appropriate for referral to the State and/or Federal regulators, but involve behaviors that must be corrected, an Immediate Corrective Action Plan (ICAP), Corrective Action Plan (CAP) or some other disciplinary measure consistent with CalOptima policies and procedures shall be required to be implemented by the parties involved. The Executive Director of Compliance, or his or her Designee, shall be responsible for monitoring successful completion of any CAP or other disciplinary measures imposed on the parties involved, while maintaining the privacy and confidentiality of such parties.

V. ATTACHMENTS

Not Applicable

VI. REFERENCES

A. CalOptima Compliance Plan
B. 31 United States Code, Section 3730(h) — Civil Actions for False Claims
C. Title 45, Code of Federal Regulations, Section 164.530 – Administrative Requirements
D. CalOptima Policy MA.9114: Reporting Suspected Misconduct or Violation
E. CalOptima Policy MA.1001: Glossary of Terms
F. CalOptima Policy MA.9108: Fraud, Waste, and Abuse Investigation and Reporting
G. CalOptima Policy MA.9125: Conducting Compliance Investigations
H. CalOptima Policy MA.9223: Non Retaliation for Reporting Violations

VII. REGULATORY APPROVALS

None to Date

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	04/01/2012	HH. 2018Δ	Compliance and Ethics Hotline
Revision Date 1	03/01/2013	HH. 2018Δ	Compliance and Ethics Hotline
Revision Date 2	05/01/2014	MA.9113	Compliance and Ethics Hotline
Revision Date 3	09/01/2015	MA.9113	Compliance and Ethics Hotline

Policy #:	MA.9114
Title:	**Reporting Suspected Misconduct or Violation**
Department:	Office of Compliance
Section:	Compliance

CEO Approval: Michael Schrader _____

Effective Date: 4/1/12
Last Review Date: 9/1/15
Last Revision Date: 9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To establish a structure whereby CalOptima Governing Body, employees, and First tier, Downstream and Related Entities (FDRs) are able to report suspected misconduct or violations, in good faith, without fear of retaliation or retribution.

II. DEFINTIONS:

Term	Definition
Code of Conduct:	The statement setting forth the principles and standards governing CalOptima's activities to which CalOptima's Board of Directors, employees, FDRs and agents are required to adhere.
Compliance Committee:	The CalOptima committee that consists of executive officers, leadership of key operating divisions, and legal counsel that implements and oversees CalOptima's Compliance Program.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Downstream Entity	Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Employee	For the purpose of this policy the term Employee shall refer to any full time, intern, temporary, volunteer and any as-needed employee.
First Tier, Downstream, and Related Entities (FDR):	FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement with CalOptima to provide administrative services or health care services to a Medicare or Medicaid eligible individual under the CalOptima program.
Governing Body	For purposes of this policy, the term governing body shall refer to the

	Board of Directors.
Member	An enrollee-beneficiary of a CalOptima program.
Related Entity	Any entity that is related to CalOptima by common ownership or control and: 1. Performs some of the management functions under contract or delegation; 2. Furnishes services to Medicare or Medicaid enrollees under an oral or written agreement; or 3. Leases real property or sells materials to CalOptima at a cost of more than two-thousand five-hundred dollars ($2,500) during a contract period.

III. POLICY

A. CalOptima is committed to establishing a culture that promotes prevention, detection and resolution of instances of conduct that do not conform to its organizational policies, its Code of Conduct, State and Federal laws or regulations, or program requirements of Federal and State health care programs.

B. All CalOptima Members, members of the Governing Body, Employees, and FDRs have the responsibility to promptly report suspected violations, in good faith, of any statute, regulation or guideline, applicable to Federal and /or State health care programs, or of CalOptima's policies and procedures.

1. A member of the CalOptima Governing Body, Employee, or FDR may file a report, without fear of retaliation or retribution, by doing one (1) of the following:

a. Notifying his or her immediate supervisor;

b. Notifying the Executive Director of Compliance, or his or her Designee, or a member of management;

c. Completing a Request for Compliance Action (RCA) Form;

d. Calling CalOptima's compliance and ethics hotline; or

e. Reports can be made directly to CalOptima's Office of Compliance department via mail, facsimile or email for confidential reporting.

C. CalOptima is committed to a policy that encourages timely reporting of compliance concerns, and prohibits any action directed against a member of the Governing Body, Employee or FDR for making such a report in good faith.

D. CalOptima policy strictly prohibits retaliation for reporting, in good faith, perceived or suspected violations of any statute, regulation or guideline applicable to Federal and /or State health care programs, or of CalOptima's policies and procedures, or for participation in an investigation of an

alleged violation, in accordance with CalOptima Policy MA.9223: Non-Retaliation for Reporting Violations.

E. Individuals cannot exempt themselves from the consequences of their own misconduct by self-reporting, although self-reporting may be taken into account when determining the appropriate course of action.

F. Any person who intentionally provides false information may be subject to disciplinary action.

IV. PROCEDURE

A. The Office of Compliance, in collaboration with the CalOptima management team, shall ensure awareness of the following compliance measures:

1. Employee-manager or supervisor open communication about any questions regarding compliance. Managers and supervisors shall respond to any inquiry and/or refer the question to appropriate personnel.

2. Management's "open door policy," all management personnel shall have an open door policy that allows an employee to present any suspected violation.

3. All CalOptima Members, member of the Governing Body, Employees, and FDRs are responsible for promptly reporting suspected violations, in good faith, of any statute, regulation, or guideline applicable to Federal and /or State health care programs, or of CalOptima's policies and procedures, or other instances of misconduct.

B. The Office of Compliance, in collaboration with the CalOptima management team, shall implement and publicize, in writing, compliance measures to, include, but not limited to:

1. CalOptima Employee Handbook;

2. CalOptima Code of Conduct; and

3. Compliance training.

C. Mechanisms for reporting suspected violations

1. A member of the CalOptima Governing Body, Employee, or FDR may:

a. Report to a manager or supervisor: Concerns about business conduct in any department; and

b. Managers or supervisors who receive such reports from employees shall immediately report the information to the Executive Director of Compliance, or his or her Designee.

2. Call CalOptima's Compliance and Ethics Hotline:

a. CalOptima's compliance and ethics hotline shall be accessible by calling 1-877-837-4417.

b. CalOptima's compliance and ethics hotline shall be accessible twenty-four (24) hours a day, seven (7) days a week.

c. The caller may choose to remain anonymous.

d. The Office of Compliance shall receive, document, and manage calls, in accordance with CalOptima Policy MA.9113: Compliance and Ethics Hotline.

3. Request for a Compliance Action Form

a. This form is available on the CalOptima Intranet (InfoNet) and CalOptima Website at www.caloptima.org; and

b. Information received on the Compliance Action Form shall be handled in the same manner as calls received on CalOptima's compliance and ethics hotline, in accordance with CalOptima Policy MA.9113: Compliance and Ethics Hotline.

4. Report to the Executive Director of Compliance, or his or her Designee:

a. The Executive Director of Compliance, can be reached at 1-657-235-6997, 7:30 a.m.-5 p.m. Pacific Standard Time (PST), Monday through Friday.

b. Reports can be made directly to the Executive Director of Compliance in lieu of other reporting options.

c. Any information received by the Executive Director of Compliance, or his or her Designee, shall be handled in the same manner as calls received on CalOptima's compliance and ethics Hotline, in accordance with CalOptima Policy MA.9113: Compliance and Ethics Hotline.

5. Reports can be made directly to CalOptima's Office of Compliance department via mail, facsimile or email for confidential reporting.

a. Emails can be sent to HNreporting@caloptima.org. Faxes can be sent to 1-714-481-6457.

D. The Executive Director of Compliance, or his or her Designee, is responsible for reviewing all reports of suspected violations. The Executive Director of Compliance, or his or her Designee, shall maintain, as great a degree as practical, the confidentiality of the identity of any employee who submits a report of suspected violation, as allowed by law.

E. The Executive Director of Compliance, or his or her Designee, shall conduct an investigation, in accordance with CalOptima Policy MA.9125: Conducting Internal Investigations, and shall report findings to the Compliance Committee, the Board of Directors, regulatory and/or law enforcement agency, as appropriate.

V. ATTACHMENTS

A. Request for Compliance Action Form

VI. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Employee Handbook
C. CalOptima Policy MA.9113: Compliance and Ethics Hotline
G. CalOptima Policy MA.9223: Non-Retaliation for Reporting Violations
D. CalOptima Policy MA.9125: Conducting Internal Investigations
E. CalOptima Policy MA.1001: Glossary of Terms
F. Title 45, Code of Federal Regulations, Section 164.530 – Administrative Requirements

VII. REGULATORY APPROVALS

None to Date

VIII. BOARD ACTIONS

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	4/1/12	HH.2019	Reporting Suspected Misconduct or Violations
Revision Date 1	3/1/13	HH.2019	Reporting Suspected Misconduct or Violations
Revision Date 2	6/1/14	MA.9114	Reporting Suspected Misconduct or Violations
Revision Date 3	9/1/15	MA.9114	Reporting Suspected Misconduct or Violations

Policy #:	MA.9116
Title:	**Annual Compliance Program Effectiveness Audit**
Department:	Office of Compliance
Section:	Compliance
CEO Approval:	Michael Schrader _____
Effective Date:	5/1/14
Last Review Date:	9/1/15
Last Revised Date:	9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To describe the process CalOptima's Office of Compliance is taking to determine the overall effectiveness of the Compliance Program.

II. DEFINITIONS

Term	Definition
Compliance Program	A comprehensive program that incorporates the fundamental elements identified by the state and federal governments and CalOptima as necessary to prevent and detect violations of ethical standards, contractual obligations, and applicable laws and the involvement of CalOptima's governing body and executive staff. Elements of the Compliance Program include standards, oversight, training, reporting, monitoring, enforcement, and remediation. The Compliance Program applies to CalOptima's Board of Directors, employees, and contractors including delegated entities, providers, and suppliers.
Downstream Entity	Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
First Tier, Downstream, and Related Entities (FDR)	FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement with CalOptima to provide administrative services or health care services to a Medicare or Medicaid eligible individual under the CalOptima program.
Related Entity	Any entity that is related to CalOptima by common ownership or control and: 1. Performs some of the management functions under contract or delegation;

	2. Furnishes services to Medicare or Medicaid enrollees under an oral or written agreement; or 3. Leases real property or sells materials to CalOptima at a cost of more than two-thousand five-hundred dollars ($2,500) during a contract period.

III. POLICY

A. CalOptima shall use multiple methods to perform a comprehensive Compliance Effectiveness Assessment to assist in measuring the overall effectiveness of its Compliance Program.

B. The Office of Compliance shall complete a self assessment at least bi-annually.

C. The Office of Compliance shall utilize an independent third party to conduct an evaluation of the effectiveness of the Compliance Program on an annual basis.

D. CalOptima shall routinely monitor overall compliance effectiveness through at least quarterly dashboard reports, and audit and monitoring results.

E. The Office of Compliance shall perform a compliance self assessment based on the seven (7) elements of an effective Compliance Program.

IV. PROCEDURE

A. The Office of Compliance shall conduct a self assessment utilizing the Compliance Program Effectiveness Self Assessment Questionnaire.

B. The Office of Compliance shall utilize an independent third party to conduct a review of the Compliance Program monitoring.

C. The Office of Compliance shall present the Compliance Effectiveness results to the Compliance Committee and Board of Directors at least annually.

The Office of Compliance shall review the Compliance Effectiveness results and include in the annual Compliance work plan, as needed.

V. ATTACHMENTS

A. Compliance Program Effectiveness Self Assessment Questionnaire

VI. REFERENCES

A. CalOptima Compliance Plan
B. Chapter 21 of the Medicare Managed Care Manual
C. Chapter 9 of the Prescription Drug Benefit Manual

VII. REGULATORY APPROVALS

None to Date

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	5/1/14	MA.9116	Annual Compliance Program Effectiveness Audit
Revision Date 1	11/1/14	MA.9116	Annual Compliance Program Effectiveness Audit
Revision Date 2	9/1/15	MA.9116	Annual Compliance Program Effectiveness Audit

Policy #:	MA.9119
Title:	**Compliance Training**
Department:	Office of Compliance
Section:	Compliance
CEO Approval:	Michael Schrader
Effective Date:	5/1/14
Last Review Date:	9/1/15
Last Revised Date:	9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To describe the process CalOptima is taking to educate all employees, Governing Body, and First Tier, Downstream, and Related entities (FDRs) on Compliance training expectations (i.e., Compliance; Fraud, Waste, and Abuse (FWA); Code of Conduct, and Health Insurance Portability and Accountability Act (HIPAA)).

II. DEFINITIONS

Term	Definition
Abuse	A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima and the CalOptima programs, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima and the CalOptima programs.
Downstream Entity	Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Employee	For purposes of this policy, the term Employee shall refer to any full time, intern, temporary, volunteer and any as needed employee.
First Tier, Downstream, and Related Entities (FDR)	FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement with CalOptima to provide administrative services or health care services to a Medicare or Medicaid eligible individual under the CalOptima program.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).

Term	Definition
Governing Body	For the purpose of this policy, the term governing body shall refer to the Board of Directors.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information as amended.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Physician Medical Group, or other person or institution who furnishes Covered Services.
Related Entity	Any entity that is related to CalOptima by common ownership or control and: 1. Performs some of the management functions under contract or delegation; 2. Furnishes services to Medicare or Medicaid enrollees under an oral or written agreement; or 3. Leases real property or sells materials to CalOptima at a cost of more than two-thousand five-hundred dollars ($2,500) during a contract period.
Waste	Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the CalOptima Programs. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

III. POLICY

A. All CalOptima employees, member of the Governing Bodies and FDRs must successfully complete the required Compliance training within ninety (90) days of hire or contracting and annually thereafter.

B. All CalOptima employees and members of the Governing Body shall complete the knowledge verification for the applicable Compliance Training module with a score of 80% or greater.

C. When reviewing the Compliance and FWA training, the Executive Compliance Director shall consider the Laws and Regulations referenced in Chapter 9 of the Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care Manual, Appendix B: Laws and Regulations to Consider in Standards of Conduct. The following are examples of topics the general Compliance Training Program shall communicate:

1. A description of the compliance program, including a review of compliance policies and procedures, the Standards of Conduct, and the sponsor's commitment to business ethics and compliance with all Medicare and Medi-Cal program requirements;

2. An overview of how to ask compliance questions, request compliance clarification or report suspected or detected noncompliance. Training should emphasize confidentiality, anonymity, and non-retaliation for reporting compliance related questions or reports of suspected or detected noncompliance or potential FWA;

3. The requirement to report to CalOptima actual or suspected Medicare and Medi-Cal program noncompliance or potential FWA;

4. Scenarios of reportable noncompliance that an employee might observe;

5. A review of the disciplinary guidelines for non-compliant or fraudulent behavior. The guidelines will communicate how such behavior can result in mandatory retraining and may result in disciplinary action, including possible termination when such behavior is serious or repeated or when knowledge of a possible violation is not reported;

6. Discussion of attendance and participation in compliance and FWA training programs as a condition of continued employment and a criterion to be included in employee evaluations;

7. A review of policies related to contracting with the government, such as the laws addressing gifts and gratuities for Government employees;

8. A review of potential conflicts of interest and CalOptima's system for disclosure of conflicts of interest;

9. An overview of HIPAA/Health Information Technology for Economic and Clinical Health Act (HITECH), the CMS Data Use Agreement (if applicable), and the importance of maintaining the confidentiality of Personal Health Information;

10. An overview of the monitoring and auditing process; and

11. A review of the laws that govern employee conduct in the Medicare and Medi-Cal programs.

D. CalOptima Employees, members of the Governing Body, as well as FDRs' employees who have involvement in the administration or delivery of Parts C and D benefits must, at a minimum, receive FWA training within ninety (90) calendar days of initial hiring (or contracting in the case of FDRs), and annually thereafter. Additional, specialized or refresher training may be provided on issues posing FWA risks based on the individual's job function (e.g., pharmacist, statistician, customer service, etc.). Training may be provided:

1. Upon appointment to a new job function;

2. When requirements change;

3. When employees are found to be non-compliant;

4. As a corrective action to address a noncompliance issue; and

5. When an employee works in an area implicated in past FWA.

E. Topics that may be addressed in FWA training include, but are not limited to the following:

1. Laws and regulations related to Medicare Part C and Part D FWA (i.e., False Claims Act, Anti-Kickback statute, HIPAA/HITECH, etc.);

2. Obligations of FDRs to have appropriate policies and procedures to address FWA;

3. Processes for CalOptima employees, FDRs, and FDR employees to report suspected FWA to CalOptima (or, as to FDR employees, either to CalOptima directly or to their employers who then must report it to CalOptima);

4. Protections for CalOptima and FDR employees who report suspected FWA; and

5. Types of FWA that can occur in the settings in which CalOptima and FDR employees work. All CalOptima FDRs shall receive CMS' model Compliance and FWA training and CalOptima's Code of Conduct training upon contracting. Additionally, training modules are provided through the CalOptima Vendor and Provider website with updates provided to FDRs and annually thereafter.

F. FDRs who have met the FWA (as per Chapter 21, Section 50.3) training certification requirements through enrollment into Parts A or B of the Medicare program, or through accreditation as a supplier of Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS), are deemed to have met the compliance training and education requirements for FWA. No additional documentation beyond the documentation necessary for proper credentialing is required to establish that an employee, Governing Bodies, FDR, or employee of an FDR is deemed to have met the compliance training and education requirements.

G. Training Document Retention.

1. CalOptima and FDRs shall maintain all evidence of Compliance-related training completion for at least ten (10) years. Such materials include, but are not limited to:

a. Attendance;

b. Topic;

c. Certificates of Completion;

d. Test scores; and

e. Tests administered to employees.

H. All CalOptima Employees, members of the Governing Body FDRs, and FDR employees who are performing services on behalf of CalOptima shall:

1. Successfully complete all required Compliance training modules.

2. Failure to successfully complete all required Compliance training may lead to disciplinary action up to and including termination. Employees, Governing Bodies and FDRs are expected to inform CalOptima immediately in the event of any failure to comply with Training requirements. For employees and Governing Bodies the HR Training unit has a systematic indicator that identifies those who fail to comply within the mandated timeframes; noncompliance will result in revoking CalOptima system access.

3. The Office of Compliance is responsible for monitoring and auditing the compliance of employees, Governing Bodies, and FDRs.

4. FDRs shall provide annual attestations confirming completion of all Compliance training as stated in this policy. Failure to provide timely attestation will lead to further corrective actions.

IV. PROCEDURE

A. Distributing Training for Existing Employees and Members of the Governing Body

1. On an annual basis, the HR Training Unit shall communicate to all Employees and member of the Governing Body an updated Compliance training is available and must be successfully completed within thirty (30) calendar days.

2. Upon completion, Employees and members of the Governing Body shall receive an e-certificate confirming successful completion. The e-certificate will include the training title and completion date. Human Resources (HR), via the HR Training unit is responsible for retaining evidence of employee's and Governing Bodies successful completion of all Compliance training modules.

B. Distributing Training for New Employees and Members of the Governing Body

1. Upon hire, the HR Training Unit shall provide each new Employee and member of the Governing Body with instructions to complete the Compliance Training.

2. The HR Training Unit shall generate a system generated report that identifies those who fail to comply within the mandated timeframes. Noncompliance will result in revoking system access.

C. Distributing Training to FDRs

1. The Office of Compliance shall ensure the training is uploaded and available on the CalOptima Vendor and Provider website.

2. Upon contracting, the Office of Compliance shall distribute an FDR Compliance Package composed of compliance documents, including CMS' model Compliance and FWA Training, CalOptima's Code of Conduct & FWA Plan, and an FDR Attestation that confirms the required Compliance training is completed by FDRs and their employees within ninety (90) days of hire and at least annually thereafter, unless the FDR is deemed by Medicare.

3. Annually, the Office of Compliance shall distribute an updated attestation to all FDRs for execution.

4. When there are update(s) to Compliance documents, the Office of Compliance shall communicate updates to all FDRs with instructions to access the CalOptima Vendor and Provider Website to retrieve them.

V. ATTACHMENTS

A. FDR Compliance Attestation

VI. REFERENCES

A. CalOptima Contract with the Centers of Medicare and Medicaid Services
B. Chapter 9 of the Prescription Drug Benefit Manual
C. Chapter 21 of the Medicare Managed Care Manual
D. CalOptima Policy: GA.8022: Progressive Discipline Policy
E. CalOptima Policy MA. 9104: Corrective Action Plan
F. CalOptima Policy MA. 9105: Sanctions
G. CalOptima Policy MA. 9120: Code of Conduct
H. CalOptima Compliance Plan

VII. REGULATORY APPROVALS

None to Date

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	5/1/14	MA.9119	Compliance Training
Revision Date 1	11/1/14	MA.9119	Compliance Training
Revision Date 2	9/1/15	MA.9119	Compliance Training

Policy #: MA.9120
Title: **Code of Conduct**
Department: Office of Compliance
Section: Compliance

CEO Approval: Michael Schrader _____

Effective Date: 05/01/14
Last Review Date: 09/01/15
Last Revision Date: 09/01/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To describe the process for CalOptima to communicate its expectation that all employees (permanent, temporary, volunteer and as-needed employees), members of its Governing Body and First Tier, Downstream, and Related Entities (FDRs) conduct themselves in an ethical and legal manner in compliance with the Code of Conduct.

II. DEFINITIONS

Term	Definition
Abuse	A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima and the CalOptima programs, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima and the CalOptima programs.
Code of Conduct	The statement setting forth the principles and standards governing CalOptima activities to which CalOptima's Board of Directors, employees, FDRs, and agents are required to adhere.
Downstream Entity	Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
First Tier, Downstream, and Related Entities (FDR):	FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement with CalOptima to provide administrative services or health care services to a Medicare or Medicaid eligible individual under the CalOptima program.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal

	Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Governing Body	For the purpose of this policy, the term governing body shall refer to the Board of Directors.
Related Entity	Any entity that is related to CalOptima by common ownership or control and: 1. Performs some of the management functions under contract or delegation; 2. Furnishes services to Medicare or Medicaid enrollees under an oral or written agreement; or 3. Leases real property or sells materials to CalOptima at a cost of more than two-thousand five-hundred dollars ($2,500) during a contract period.
Waste	Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to CalOptima Programs. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

III. POLICY

A. All CalOptima employees and members of its Governing Body shall receive CalOptima's Code of Conduct within ninety (90) calendar days of appointment, hire, or contracting, and at least annually thereafter, as well as whenever the Code of Conduct is modified..

B. Upon hire and annually thereafter, the Code of Conduct shall be communicated to all employees through CalOptima's web-based learning management system, or other means of distribution. In accordance with CalOptima Policy, MA.9119 Compliance Training.

C. When reviewing the Code of Conduct, the Executive Compliance Director shall consider the state and federal laws, regulations, health care program requirements, and other guidance.

D. All CalOptima FDRs shall receive CalOptima's Code of Conduct within ninety (90) calendar days of appointment, hire, or contracting, and at least annually thereafter, as well as whenever the Code of Conduct is modified. Additionally, the Code of Conduct is provided through the CalOptima vendor and Provider website with notification of updates provided via email. Upon contracting and annually thereafter, FDRs shall confirm receipt and understanding of CalOptima's Code of Conduct via the initial and annual FDR attestation.

E. CalOptima requires that all members of the Governing Body, Employees, Volunteers (including unpaid interns), and FDRs conduct themselves in an ethical and legal manner and in compliance with the Code of Conduct.

F. Failure to comply with the Code of Conduct or the guidelines for behavior that the Code of Conduct represents may lead to disciplinary action up to and including termination. Employees and FDRs are expected to inform CalOptima's Office of Compliance immediately in the event of any violations to the Code of Conduct.

G. FDRs shall provide annual attestations confirming receipt and understanding of CalOptima's Code of Conduct. Failure to provide timely attestation will lead to further corrective actions.

IV. PROCEDURE

A. Reviewing and approving the Code of Conduct

1. The Office of Compliance is responsible for ensuring a review of the current Code of Conduct as needed, but at least annually. The following sources should be considered to determine if changes are required:

   a. Changes in state and federal laws or regulations;

   b. Changes in health care program requirements; and

   c. Other guidance.

2. Once approved by the Board of Directors, the Office of Compliance is responsible for ensuring the Code of Conduct is made available by uploading on the CalOptima's InfoNet and CalOptima's vendor and Provider website.

B. Distributing and Monitoring Code of Conduct to Employees

1. If mid-year or annual revisions are made to the Code of Conduct, the Office of Compliance will inform the Human Resources department, who will communicate to all employees that an updated Code of Conduct is available and must be reviewed.

   a. If the Code of Conduct is revised and distributed as part of the annual review, then the Human Resources department shall distribute via web-based training. In accordance with CalOptima policy MA.9119: Compliance Training.

   b. If there are revisions to the to the Code of Conduct that occur mid-year, the Human Resources department shall compose and distribute an email to all employees announcing an updated Code of Conduct is available on CalOptima's InfoNet and to electronically confirm receipt, review, and understanding of the updated Code of Conduct.

C. Distributing to FDRs

1. The Office of Compliance ensures the updated Code of Conduct is uploaded on to the CalOptima vendor and Provider website

2. Upon contracting, the Office of Compliance distributes a FDR compliance attestation package composed of compliance documents, including CalOptima's Code of Conduct and an FDR attestation that confirms receipt of the CalOptima Code of Conduct.

3. Annually, the Office of Compliance shall request an updated attestation to be executed from all FDRs. Failure, to submit the requested documents may result in a notice of non-compliance, in accordance with CalOptima policy MA.9104: Corrective Action Plan.

4. The Office of Compliance shall communicate to all FDRs any update(s) to compliance documents with instructions to access the CalOptima vendor and Provider website.

V. ATTACHMENTS

A. FDR Compliance Attestation

VI. REFERENCES

A. CalOptima Compliance Plan
B. Chapter 21 of the Medicare Managed Care Manual
C. Chapter 9 of the Prescription Drug Benefit Manual
D. CalOptima Policy: MA.9104 Corrective Action Plan
E. CalOptima Policy: MA.9119 Compliance Training
F. CalOptima Policy: GA.1001 Website Content Management
G. Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i)
H. Title 42, Code of Federal Regulations, Section 422.503(b)(4)(vi)(A)
I. Title 42, Code of Federal Regulations, Section 423.504(b)(4)(vi)(A)

VII. REGULATORY APPROVALS

None to Date

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	05/01/2014	MA.9120	Code of Conduct
Revision Date 1	11/01/2014	MA.9120	Code of Conduct
Revision Date 2	09/01/2015	MA.9120	Code of Conduct

Policy #: MA.9121
Title: **Exclusion Monitoring**
Department: Office of Compliance
Section: Compliance

CEO Approval: Michael Schrader_____

Effective Date: 5/1/12
Last Review Date: 9/1/15
Last Revised Date: 9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To establish a process for verifying and monitoring the eligibility of an employee (permanent, temporary, volunteer and as-needed employees), member of the Governing Body, First Tier, Downstream, and Related entities (FDRs), and vendors to participate in CalOptima's federally-funded health care programs through state and federal exclusions and ineligible lists.

II. DEFINITIONS

Term	Definition
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Downstream Entity	Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
First Tier, Downstream, and Related Entities (FDR)	FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement with CalOptima to provide administrative services or health care services to a Medicare or Medicaid eligible individual under the CalOptima program.
Governing Body	For purposes of this policy, the term governing body shall refer to the Board of Directors.
Member	An enrollee-beneficiary of a CalOptima program.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Physician Medical Group, or other person or institution who furnishes Covered Services.
Related Entity	Any entity that is related to CalOptima by common ownership or control

Term	Definition
	and: 1. Performs some of the management functions under contract or delegation; 2. Furnishes services to Medicare or Medicaid enrollees under an oral or written agreement; or 3. Leases real property or sells materials to CalOptima at a cost of more than two-thousand five-hundred dollars ($2,500) during a contract period.

III. POLICY

A. CalOptima shall ensure all employees, members of the Governing Body, FDRs, and vendors are eligible to participate in CalOptima's federally-funded health care programs, and shall be responsible for:

1. Ensuring the employee, member of the Governing Body, FDR, or vendor has no knowledge of an impending exclusion, of the employee, member of the Governing Body, or FDR;

2. Conducting the initial eligibility verification of an employee, member of the Governing Body, FDR, and vendor prior to hiring, renewing or entering in any new agreement with CalOptima, or issuing payment thereto;

3. Performing eligibility verification of an employee, member of the Governing Body, FDR, and vendor monthly thereafter; and

4. Maintaining a record of all initial and monthly verification.

B. CalOptima shall utilize state and federal exclusion and ineligible list sources referenced in this policy to verify the eligibility of an employee, member of the Governing Body, FDR, or vendor and shall maintain a record of completion indicating, at minimum:

1. The date of verification;

2. The exclusion and ineligible list source(s);

3. Verification results; and

4. The name of the person who conducted the verification.

C. In the event an employee, member of the Governing Body, FDR or vendor is identified on an exclusion list, CalOptima will immediately terminate and/or block for future payment. CalOptima shall deny payment and participation to an individual or entity, from any and all CalOptima programs.

Group	Prior to contracting/hire, CalOptima will verify through …	Monthly thereafter, CalOptima will verify through …
Employees (excluding Board & Committee members)	Human Resources	Human Resources
Members of the Governing Body	Compliance	Compliance
FDRs (excluding Providers and PMGs)	Purchasing	Compliance
Providers	Credentialing	Credentialing
PMGs	Audit & Oversight	Compliance

D. All CalOptima FDRs and vendors shall verify the eligibility of all its employees and/or downstream entities (as defined above) and its FDRs and vendors prior to hiring/contracting and monthly thereafter. The FDR and vendor shall maintain a record of completion indicating, at minimum:

1. Date of verification;
2. The exclusion and ineligible list source(s);
3. Verification results; and
4. The name of the person who conducted the verification.

E. In the event an employee, FDR or vendor has been identified in an exclusion list, the FDR or vendor must immediate terminate the employee, FDR or vendor and immediately notify CalOptima of the identified ineligible person/entity.

F. The Office of Compliance may audit CalOptima departments responsible for exclusion activities, as necessary.

IV. PROCEDURE

A. Monitoring Sources

1. CalOptima shall use monitoring sources to retrieve verification and eligibility data, including, but not limited to:
   a. The General Services Administration's (GSA) System for Award Management (SAM) website;
   b. Medicare Exclusion Database (MED);
   c. Medi-Cal's Suspended and Ineligible (S&I) list;
   d. OIG Exclusions Database (OIG LEIE Database); and
   e. Other monitoring sources as identified in CalOptima Policy GG.1609Δ: Credentialing and Recredentialing.

2. Prior to hiring or contracting, the applicable responsible department, as detailed in section III.C of this policy shall verify against one (1) or more of the monitoring sources listed in this policy.

B. On a monthly basis, prior to publishing the next verification list update, the responsible department shall monitor exclusion and ineligible lists using one (1) or more of the monitoring sources listed in this policy, as applicable.

C. The responsible department shall deem an employee, member of the Governing Body, FDR, or vendor excluded or ineligible if identified on one (1) or more monitoring sources. If applicable, the Office of Compliance shall complete a CalOptima Provider Alert to notify all appropriate CalOptima departments of the excluded or ineligible individual or entity.

D. In accordance with Title 42, Code of Federal Regulations, Section 1001.1901(b) (1), CalOptima shall immediately suspend and halt payment for services for an ineligible or excluded employee, member of the Governing Body, FDR or vendor. The payment prohibition applies in the excluded or ineligible employee, member of the Governing Body, FDR or vendor regardless of who submits the claim.

E. CalOptima may recoup monies paid to the employee, member of the Governing Body, FDR or vendor while excluded.

F. If CalOptima declines to include an FDR or vendor from participating in any CalOptima program, it shall notify the FDR or vendor, in writing, noting the reason for denial. The FDR or vendor may contest the denial if they feel there is an error or inappropriate exclusion. If CalOptima determines that there is an inappropriate exclusion, correction shall be made as stated in the Centers for Medicare & Medicaid Services Center for Program Integrity Center for Medicare Letter dated June 29, 2011.

G. If the FDR or vendor has been re-instated by an excluding source listed on this policy, and is now in good standing and able to participate in CalOptima's federally-funded health care programs, the FDR or vendor may express interest in participating with CalOptima. CalOptima will require evidence to verify re-instated participation in CalOptima's federally-funded health care programs. In addition, the FDR or vendor will require re-processing through contracting and/or credentialing.

V. ATTACHMENTS

Not Applicable

VI. REFERENCES

A. Chapter 21 of the Medicare Managed Care Manual
B. Chapter 9, Prescription Drug Benefit Manual
C. Department of Health Care Services (DHCS) contract with CalOptima
D. Title 42, Code of Federal Regulations, Section 1001.1901
E. Title 42 U.S. Code section 1320a-7(a) (4) (c), 1320a-7(b) (8)

F. Section 1128 and 156 of the Social Security Act
G. Health insurance Portability and Accountability Act of 1996
H. Balanced Budget Act of 1997
I. CMS: Center for Program Integrity Center for Medicare Letter, June 29, 2011
J. Updated: Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs, Issued May 8, 2013
K. Updated: OIG's Provider Self-Disclosure Protocol, Issued April 17, 2013
L. CalOptima Policy GG 1609Δ: Credentialing and Recredentialing
M. CalOptima Policy MA.1001: Glossary of Terms
N. CalOptima Compliance Plan

VII. REGULATORY APPROVALS

None to Date

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	05/01/2012	HH.2021Δ	Vendor Exclusion Monitoring and Audits
Revised Date 1	08/01/2013	HH.2021Δ	Vendor Exclusion Monitoring and Audits
Revised Date 2	09/01/2015	HH.2021	Vendor Exclusion Monitoring and Audits

Policy #: MA.9123
Title: **Compliance Committee**
Department: Office of Compliance
Section: Compliance

CEO Approval: Michael Schrader_____

Effective Date: 8/1/14
Last Review Date: 9/1/15
Last Revised Date: 9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To establish a process in which the Compliance Officer shall report results at least quarterly to the Compliance Committee and Board of Directors. Reporting shall ensure and enforce the compliance of ethical standards, contractual requirements, applicable federal and state statutes, regulations, the Compliance Program including Fraud, Waste, and Abuse (FWA) Plan, and Code of Conduct (COC) and CalOptima policies.

II. DEFINITIONS

Term	Definition
Abuse	A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima and the CalOptima programs, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima and the CalOptima programs.
Auditing	Auditing is a formal, systematic and disciplined approach designed to evaluate and improve the effectiveness of processes and related controls. Auditing is governed by professional standards, completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Code of Conduct (COC)	The statement setting forth the principles and standards governing CalOptima's activities to which CalOptima's Board of Directors, employees, contractors, and agents are required to adhere.
Compliance Committee	The CalOptima committee that consists of executive officers, leadership of key operating divisions, and legal counsel that implements and oversees CalOptima's Compliance Program.
Compliance Program	The program including, without limitation, the Compliance Plan, Code of Conduct, and CalOptima policies, developed and adopted by CalOptima to promote, monitor, and ensure that CalOptima's operations and practices and

Term	Definition
	the practices of its Board members, employees, contractors, and providers comply with applicable law and ethical standards.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Downstream Entity	Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
First Tier, Downstream, and Related Entities (FDR)	FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement with CalOptima to provide administrative services or health care services to a Medicare or Medicaid eligible individual under the CalOptima program.
Fraud	An international deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1 (i).
Monitoring	Monitoring is an on-going process usually directed by management to ensure processes are working as intended. Monitoring is an effective detective control within a process and is typically completed by department staff and communicated to department management.
Related Entity	Any entity that is related to CalOptima by common ownership or control and: 1. Performs some of the management functions under contract or delegation; 2. Furnishes services to Medicare or Medicaid enrollees under an oral or written agreement; or 3. Leases real property or sells materials to CalOptima at a cost of more than two-thousand five-hundred dollars ($2,500) during a contract period.
Waste	Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to CalOptima Programs. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

III. POLICY

A. The Compliance Committee shall oversee compliance efforts in accordance with the Compliance Program including the Fraud, Waste, and Abuse (FWA) Plan, Code of Conduct

(COC), all applicable state and federal regulations, policies and procedures, and federal and state contracts.

B. The Compliance Committee, Executive Department, and Board of Directors shall recommend corrective action as appropriate and shall evaluate the effectiveness of the Corrective Action Plan (CAP).

C. The Compliance Committee shall recommend and monitor, in collaboration with the Executive Department, Board of Directors, and the Audit and Oversight Department, the development of internal processes and procedures that support Code of Conduct, FWA Plan, and adherence to relevant statutory, regulatory and contractual obligations.

IV. PROCEDURE

A. Compliance Committee Organization

1. The Executive Director of Compliance shall serve as Chairperson of the Compliance Committee.

2. The Directors of Medicare Compliance and Medi-Cal Compliance shall serve as Co-Vice Chairpersons and are considered the Chairperson Designees.

3. The Compliance Committee consists of executive officers, leadership staff of key operating divisions, and legal counsel that implements and oversees CalOptima's Compliance Program.

4. Voting members may appoint a Designee, when deemed appropriate. The Designee shall serve as a subject matter expert at the Compliance Committee; however, the Designee would not have voting rights unless approved in advance by the Executive Director of Compliance.

5. CalOptima employees may attend a Compliance Committee meeting, on an ad-hoc basis, at the request of the Chairperson. Attendance may be warranted to support discussion items at the Compliance Committee meeting to promote clarification for the voting members.

6. All activities of the Compliance Committee shall be considered privileged and not subject to disclosure.

B. Compliance Committee Meetings

1. The Compliance Committee and Board of Directors shall meet at least on a quarterly basis or more frequently as significant non-compliant and/or FWA issues are identified outside of the quarterly time period. Annually, Compliance Committee members shall receive a calendar of meetings for the calendar year as well as a reporting matrix which includes all planned reports to be presented during scheduled Compliance Committees.

2. A Committee binder is distributed to all meeting attendees prior to the Compliance Committee meeting. The Committee binder shall include but are not limited to:

a. Current meeting agenda;

b. Previous meeting final draft meeting minutes for Compliance Committee approval;

c. Listing of open action items;

d. Submitted Compliance Committee reports;

e. Scheduled audit reports;

f. CAP Monitoring;

g. Notices of Non-Compliance; and

h. Special reports, which may include, but not be limited to, any reports not regularly presented to the Compliance Committee that may be of interest or concern, or is intermittent in nature.

3. Minutes of Compliance Committee meetings shall be maintained in a confidential electronic and hard-copy file in the Office of Compliance department.

4. Ad-hoc Compliance Committee meetings may be held at the discretion of the Chairperson as deemed appropriate.

5. For purposes of voting, a quorum shall consist of fifty-one percent (51%) of the Compliance Committee members. In the absence of a quorum, the meeting may proceed, however any issues requiring a vote shall be deferred until the next regular meeting. If an action by the Compliance Committee is critical, a vote may be taken by the Chairperson, or his, or her Designee outside of the meeting by phone, electronic mail or via documented votes. Action will be documented and made part of the minutes.

C. Compliance Committee Responsibilities

1. The Compliance Committee shall oversee the following, but not limited to, program compliance efforts:

a. Meets at least on a quarterly basis, or more frequently as appropriate to enable reasonable oversight of the Compliance Program;

b. Develop strategies to promote compliance and to prevent, detect, and correct Part C and Part D and State programs' non compliance;

c. Review and approve training related to Compliance and FWA. Ensures that training and education are effective and appropriately completed;

d. Assist with the creation and implementation of the Office of Compliance Annual Risk Assessment;

e. In cooperation with the Delegation Oversight Committee, the Office of Compliance shall create, enforce, and implement:

   i. Monitoring and Auditing process, work plan(s), and implement appropriate corrective and preventive action(s);

f. Enforce effective corrective actions and review overall effectiveness of the of internal controls designed to ensure compliance with applicable regulations in daily operations;

g. Consult with advisors as necessary;

h. Analyze Medicare and State programs including contractual, legal, regulatory requirements, areas of risks, and coordinate with the Executive Director of Compliance to ensure the adequacy of the Compliance Program;

i. Receive quarterly reports from the Executive Director of Compliance concerning the Compliance Program;

j. Determine compliance strategies to promote and identify issues of non-compliance;

k. Review the Office of Compliance's process for soliciting, evaluating, and responding to reports and disclosures within the Compliance Program;

l. Recommendations of appropriate actions to ensure CalOptima is complying with the applicable law and regulations and ethical standards;

m. Ensure legal counsel is consulted as appropriate and all applicable rights are preserved, including the attorney-client privilege;

n. Ensure CalOptima has a Compliance hotline and Office of Compliance email address for employees, including FDRs, to outreach for compliance questions and report potential issues regarding any CalOptima Program. Inquiries may include, but are not limited to, non-compliance and potential FWA. Information presented shall be handled confidentially and may be submitted anonymously, if desired by the informant, without fear of retaliation in accordance with, CalOptima policy, MA.9223:Non-Retaliation for Reporting Violations;

o. Ensure CalOptima has appropriate and current compliance policies and procedures;

p. Review and address reports of Monitoring and Auditing of areas in which a CalOptima Program is at risk of non-compliance or potential FWA, and ensure CAPs are implemented and monitored for effectiveness; and

q. Provides regular and ad-hoc status reports of compliance with recommendations to the CalOptima Board of Directors.

2. In accordance with CalOptima Policy, MA.9104: Corrective Action Plan, the Compliance Committee in cooperation with Delegation Oversight Committee (DOC) shall determine Sanctions, in accordance with CalOptima Policy, MA.9105: Sanctions or other remedial actions as appropriate to ensure compliance.

3. The Compliance Committee, in collaboration with the DOC, shall evaluate the effectiveness of such corrective actions in collaboration with the appropriate CalOptima departments and shall make recommendations regarding ongoing monitoring activities to ensure continuing compliance.

D. The Compliance Committee Chairperson shall report to the Board of Directors, Finance, and Audit Committee on a quarterly basis. The report shall include a summary of compliance issues taken before the Compliance Committee, remedial action taken, and outcomes of such actions.

V. ATTACHMENTS

Not Applicable

VI. REFERENCES

A. CalOptima Compliance Plan
B. Medicare Managed Care Manual, Chapter 21
C. Medicare Managed Care Prescription Drug Benefit Manual, Chapter 9
D. CalOptima Policy MA.9104: Corrective Action Plan
E. CalOptima Policy MA.9105: Sanctions
F. CalOptima Policy MA.1001: Glossary of Terms

VII. REGULATORY APPROVALS

None to Date

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	8/1/14	MA.9123	Compliance Committee
Revision Date 1	12/1/14	MA.9123	Compliance Committee
Revision Date 2	9/1/15	MA.9123	Compliance Committee

Policy #: MA.9125
Title: **Conducting Compliance Investigations**
Department: Office of Compliance
Section: Compliance
CEO Approval: Michael Schrader _____

Effective Date: 12/01/12
Last Review Date: 09/01/15
Last Revised Date: 09/01/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To outline policies and procedures for conducting and overseeing compliance investigations or inquiries into allegations of violations of any statute, regulation, or guideline applicable to federal and/or state health care programs, or of CalOptima's policies and procedures.

II. DEFINITIONS

Term	Definition
Compliance Committee:	The CalOptima committee that consists of executive officers, managers of key operating divisions, and legal counsel that oversees implementation of CalOptima's Compliance Program.
Compliance Program:	The program including, without limitation, the Compliance Plan, Code of Conduct, and CalOptima policies, developed and adopted by CalOptima to promote, monitor, and ensure that CalOptima's operations and practices and the practices of its Board members, employees, contractors, and providers comply with applicable law and ethical standards.
Designee:	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Downstream Entity:	Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Employee	For the purposes of this policy, the term employee shall refer to any full time, intern, temporary, volunteer and any as needed employee.
First Tier, Downstream, and Related Entities (FDR):	FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity:	Any party that enters into a written arrangement with CalOptima to provide administrative services or health care services to a Medicare or Medicaid eligible individual under the CalOptima program.

Governing Body:	For the purpose of this policy, the term governing body shall refer to the Board of Directors.
Health Insurance Portability and Accountability Act (HIPAA):	The program including, without limitation, the Compliance Plan, Code of Conduct, and CalOptima policies, developed and adopted by CalOptima to promote, monitor, and ensure that CalOptima's operations and practices and the practices of its Board members, employees, contractors, and providers comply with applicable law and ethical standards.
Protected Health Information (PHI):	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Related Entity:	Any entity that is related to CalOptima by common ownership or control and: 1. Performs some of the management functions under contract or delegation; 2. Furnishes services to Medicare or Medicaid enrollees under an oral or written agreement; or 3. Leases real property or sells materials to CalOptima at a cost of more than two-thousand five-hundred dollars ($2,500) during a contract period.
Sanction	Action taken by CalOptima including, without limitations, restrictions, monetary fines, termination or a combination thereof, based on a FDR failure to comply with statutory, regulatory, contractual, CalOptima policy, or other requirements related to CalOptima programs.

III. POLICY

A. CalOptima employees, Governing Body and First Tier and Downstream and Related Entities (FDRs), have affirmative obligations under CalOptima's Compliance Program to report all violations and suspected violations of law, regulations and/or policies, and/or other compliance issues. CalOptima maintains various disclosure and reporting mechanisms (i.e., hotline) which allow such individuals to fulfill these obligations. CalOptima has a non-retaliation policy regarding the reporting and investigating of incidents of noncompliance

with applicable laws, regulations and/or policies, or other compliance issues, as stated in CalOptima Policy MA.9223: Non-Retaliation on Reporting Violations.

B. The Executive Director of Compliance, or his or her Designee, is responsible for investigating potential noncompliance with applicable laws, regulations, and/or policies, or other compliance issues involving CalOptima, including its officers and employees, and refers matters to the Compliance Committee, as appropriate. Potential noncompliance with applicable laws, regulations, and/or policies, or other compliance issues, may be discovered through, for example, reports to CalOptima's hotline, complaints, routine monitoring, or regulatory audits.

C. The Executive Director of Compliance, or his or her Designee, shall promptly conduct a preliminary review of potential incidents of noncompliance with applicable laws, regulations, and/or policies, or other compliance issues, to determine whether there is sufficient credible information and basis to warrant to a full compliance investigation of the matter. In conducting such preliminary review, the Executive Director of Compliance, or his or her Designee, may refer the matter to another appropriate CalOptima department, including referrals to the Director of Human Resources, who is responsible for investigations related to employee harassment and discrimination and related matters.

D. The Privacy Officer, or his or her Designee, in collaboration with the Security Officer, shall be responsible for investigations of potential violations of Protected Health Information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended, and Health Information Technology for Economic and Clinical Health (HITECH) Act, and /or applicable state privacy and confidentiality laws.

E. Whenever there is credible evidence that suggests violation of criminal, civil, or administrative laws, the Executive Director of Compliance, or his or her Designee, shall discuss with CalOptima's Legal Affairs, for further guidance regarding reports to law enforcement agencies or state or federal regulators, or other appropriate actions.

F. Whenever there is credible evidence that suggests Fraud, Waste, or Abuse, the Executive Director of Compliance, or his or her Designee, shall evaluate, investigate, and report the matter as appropriate, in accordance with CalOptima Policies MA.9107: Fraud, Waste, and Abuse Detection and MA.9108: Fraud, Waste, and Abuse Investigation and Reporting.

G. In conducting internal investigations, CalOptima, including the Office of Compliance personnel, shall respect the rights of all persons involved in the investigation, including those persons accused of non-compliance, in accordance with CalOptima Policy MA.9223: Non-Retaliation on Reporting Violations. CalOptima strictly prohibits retaliation against employees for reporting compliance concerns, and/or participating in internal investigations.

IV. PROCEDURE

A. Preliminary Investigation

1. The Executive Director of Compliance, or his or her Designee, shall:

a. Evaluate all incidents of potential noncompliance with applicable laws, regulations, and/or policies, or other compliance issues regardless of source;

b. Determine whether there is sufficient information and basis to proceed with a full investigation of the incident/matter, or whether additional information is necessary;

c. Determine whether the incident/matter is an inquiry, or is otherwise appropriate for referral to another CalOptima Department, or whether it is a non-issue that warrants closure of the compliance matter; and

d. Determine whether the incident, if verified to be true, would necessitate a referral or report to one or more of CalOptima's regulatory agencies (or such agency's designated contractor e.g., DHCS Audits and Investigations, CMS MEDIC) in accordance with CalOptima Policy MA.9124 CMS Self Disclosure.

2. If the Executive Director of Compliance, or his or her Designee, determines that a full investigation of the incident is appropriate, then he or she shall review whether CalOptima needs to take any preventative or corrective actions prior to the Executive Director of Compliance's, or his or her Designee's, completion of the full investigation, including, without limitation, preliminary reports to regulatory agencies, placement of employees on administrative leave, etc. The Executive Director of Compliance, or his or her Designee, may recommend the temporary or permanent cessation of internal activities that may be the cause of, or contribute to, the alleged non-compliance, as appropriate. The Executive Director of Compliance, or his or her Designee, may consult with CalOptima's Legal Affairs Department on such actions as needed.

3. The Executive Director of Compliance, or his or her Designee, shall determine if an investigation is warranted. The Executive Director of Compliance, or his or her Designee, shall establish the scope of the investigation, based on the following factors, to include, but not be limited to:

   a. The availability of individuals who may be involved;

   b. The time frame of the alleged violations;

   c. Whether the alleged violations appear to be an isolated incident or pattern of improper conduct;

   d. Whether the alleged violations indicate a systemic or procedural deficiency in a department's operation; and

   e. The time requirements for conducting the investigation, including, any regulatory obligations for commencement and completion of the investigation.

4. Prior to initiating the investigation, the Executive Director of Compliance, or his or her Designee, shall fully explore and understand all the allegations and related issues raised in a complaint.

5. Based on the scope of the investigation, the Executive Director of Compliance, or his or her Designee, shall develop an investigative plan. The Executive Director of Compliance may delegate investigative activities, but retains ultimate supervision and responsibility for compliance investigations.

6. The Executive Director of Compliance shall assume responsibility for carrying out the investigation, or shall assign a qualified person to carry out the investigation, who is organizationally removed from any of the parties directly involved in the investigation.

B. Investigation

1. The Executive Director of Compliance, or his or her Designee, shall initiate the investigation (including gathering all documents, conducting interviews and obtaining other relevant evidence) promptly and generally no later than two (2) weeks after the potential noncompliance was identified (and earlier if the regulatory requirement dictate such and/or if the matter requires more immediate resolution).

2. All communications, evidence, and reports shall be saved, logged, and sequentially numbered upon receipt by the Executive Director of Compliance, or his or her Designee, and maintained in the investigation case file.

3. All information gathered by the Executive Director of Compliance, or his or her Designee, during the investigation shall be held in confidence, in accordance with applicable state and federal law, except as specifically authorized by CalOptima policies, procedures, and applicable law.

4. The Executive Director of Compliance, or his or her Designee, shall:

   a. Conduct interviews, in person and in private, with one (1) interviewee at a time;

   b. Follow professional interview principles and techniques; and

   c. Ensure circumstance and content of the interview are supported by a witness for sensitive interviews.

5. The Executive Director of Compliance, or his or her Designee, shall have a full understanding of the relevant laws, regulations, and government guidance pertinent to the investigation before conducting the investigation, and may consult with CalOptima's Legal Affairs Department for legal guidance on the subject matter at issue.

6. Investigations shall be completed within a reasonable time period, and as expeditiously as possible, based on the circumstances, including, but not limited to, consideration of relevant regulatory timing requirements, the potential that the matter involves fraud or abuse, and/or the potential for ongoing financial or other harm to CalOptima, any federal or state health care program, and/or any individual while the investigation is conducted.

7. The Executive Director of Compliance, or his or her Designee, shall review whether there are sufficient internal resources, or whether external resources are needed to conduct the

investigation. If external resources are necessary, the Executive Director of Compliance, or his or her Designee, may consult with CalOptima's Legal Affairs Department to determine the best course of action.

C. Involvement of Legal Representation

1. Any member of a CalOptima Governing Body, permanent or temporary employee, or FDR who is the subject of an investigation should be reminded that he or she is free to retain independent counsel. If a member of a CalOptima Governing Body, employee, or contractor is already represented by counsel, the Executive Director of Compliance, or his or her Designee, shall discuss ramifications with CalOptima's Legal Affairs Department before proceeding.

2. If a member of a CalOptima Governing Body, permanent or temporary employee, or FDR is being interviewed, and requests the presence of an attorney, the interview shall be stopped, and the Executive Director of Compliance, or his or her Designee, shall notify CalOptima's Legal Affairs Department.

3. If the interview is with a member of a CalOptima Governing Body, employee, or FDR who is suspected of serious misconduct, CalOptima's Legal Affairs Department shall advise the member of a CalOptima Governing Body, employee, or FDR of the seriousness of the matter and CalOptima's policy to disclose the result of its investigation to other government agencies, including appropriate state and/or federal law enforcement agencies.

D. Documenting and reporting findings of the investigation

1. For every interview, the Executive Director of Compliance, or his or her Designee, shall prepare a written interview report covering all the key points derived from that contact.

2. The Executive Director of Compliance, or his or her Designee, shall:

   a. Write the investigation report;

   b. File with the original written communication; and

   c. Include a summary of the individual's complaint, a chronology of events, the investigator's findings/conclusions, and, as appropriate, recommended actions with specific responsibilities assigned to managers to ensure implementation.

3. The Executive Director of Compliance, or his or her Designee, shall develop root cause analyses, corrective action plans, remediation plans, and future monitoring/auditing plans, as appropriate, to address verified incidents of noncompliance or deficiencies to ensure they do not recur in the future. The Executive Director of Compliance, or his or her Designee, may consult with the Compliance Committee, CalOptima Legal Affairs, Human Resources, or other parties, as necessary and appropriate, to develop these plans.

4. The Executive Director of Compliance, or his or her Designee, shall report the findings to the Compliance Committee, as appropriate, along with recommendations for final

corrective action, in order to confirm completion of the investigative tasks. The Compliance Committee can determine if additional steps are necessary to complete the investigation.

5. The Executive Director of Compliance, or his or her Designee, shall distribute and report complete investigations to the Compliance Committee. No copies shall be provided to other parties, unless requested to do so and approved by the Executive Director of Compliance, or his or her Designee.

6. If potential legal issues exist, the report shall be provided to CalOptima's Legal Affairs Department for appropriate action.

7. If the investigation and report have been requested or directed by CalOptima's Legal Affairs Department, the report should be marked "Attorney-Client Privilege" or "Attorney Work Product," as requested by CalOptima's Legal Affairs Department, and furnished only to CalOptima's Legal Affairs Department. Under those circumstances, it shall be the responsibility of CalOptima's Legal Affairs Department to report and advise management about the facts, circumstances, and alternative courses of action.

8. Once the report has been reviewed by the Compliance Committee, the Executive Director of Compliance, or his or her Designee, shall act upon the findings and recommendations for corrective action measures and determine whether adverse actions should be taken against any parties, and if so, determine the Sanction itself. The Executive Director of Compliance, or his or her Designee, as appropriate, may consult with CalOptima's Legal Affairs Department in making the necessary decisions.

9. Before taking action on the results of an investigation, the Executive Director of Compliance, or his or her Designee, shall ensure that the complainant (if known) has received general feedback on the results of the investigation, but not the details of the investigation, or any specific action or decisions relating to any individual.

10. The Executive Director of Compliance, or his or her Designee, shall report the results of an investigation to the CalOptima Board of Directors and the Chief Executive Officer, as appropriate.

V. ATTACHMENTS

Not Applicable

VI. REFERENCES

A. Health Insurance Portability and Accountability Act (HIPAA) of 1996
B. Health Information Technology for Economic and Clinical Health (HITECH) Act
C. CalOptima Policy MA.1001: Glossary of Terms
D. CalOptima Policy MA.9107: Fraud, Waste, and Abuse Detection
E. CalOptima Policy MA.9108: Fraud, Waste, and Abuse Investigation and Reporting
F. CalOptima Policy MA.9223: Non-Retaliation of Reporting Violations

VII. REGULATORY APPROVALS

None to Date

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	12/1/12	HH.2020Δ	Conducting Internal Investigations
Revision Date 1	11/1/14	MA.9125	Conducting Internal Investigations
Revision Date 2	9/1/15	MA.9125	Conducting Compliance Investigations

Policy #:	MA. 9223
Title:	**Non-Retaliation for Reporting Violations**
Department:	Office of Compliance
Section:	Compliance
CEO Approval:	Michael Schrader _____
Effective Date:	10/1/02
Last Review Date:	9/1/15
Last Revised Date:	9/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To reinforce CalOptima's commitment to compliance with applicable laws, regulations, and policies and its policy against intimidation, harassment, discrimination or any other retaliatory action against individuals who report or seek guidance related to suspected or actual non-compliance with such laws, regulations, or related to unethical conduct.

II. DEFINITIONS

Term	Definitions
Abuse	A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima and the CalOptima programs, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima and the CalOptima programs
Disclosure	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Downstream Entity	Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Employee	For the purposes of this policy the term employee shall refer to any full time, intern, temporary, volunteer and any as needed employee.
First Tier, Downstream, and Related Entities (FDR)	FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement with CalOptima to provide administrative services or health care services to a Medicare or Medicaid eligible individual under the CalOptima program.
Fraud	An intentional deception or misrepresentation made by a person with the

	knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, and Welfare and Institutions Code section 14043.l(i).
Governing Body	For the purpose of this policy, the term governing body shall refer to the Board of Directors and all advisory committees.
Member	An enrollee-beneficiary of a CalOptima program.
Protected Health Information (PHI)	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Related Entity	Any entity that is related to CalOptima by common ownership or control and: 1. Performs some of the management functions under contract or delegation; 2. Furnishes services to Medicare or Medicaid enrollees under an oral or written agreement; or 3. Leases real property or sells materials to CalOptima at a cost of more than two-thousand five-hundred dollars ($2,500) during a contract period.
Waste	Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to CalOptima Programs. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

III. POLICY

A. CalOptima, its Governing Body members, employees, and FDRs shall not threaten, intimidate, coerce, harass, discriminate, or otherwise retaliate against individuals who report or file complaints related to suspected or actual non-compliance with applicable laws, regulations or policies (including, without limitation, HIPAA, the False Claims Act, and other laws) and/or related to unethical conduct.

B. CalOptima, its Governing Body members, employees, and FDRs shall not be subject to retaliatory action or discrimination by CalOptima for reporting in good faith suspected or actual non-compliance or unethical conduct or for participating in any investigation.

C. CalOptima, its Governing Body members, employees, and FDRs shall not retaliate for:

1. The exercise of any right under, or participating in, any process established by federal, state, or local law, regulations, or policy, including, but not limited to, filing a complaint with CalOptima and/or the United States Department of Health and Human Services relating to privacy;

2. Testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing; or

3. Opposing any act or practice made unlawful by law, provided that the person has a good faith belief that the practice is unlawful, and the manner of the opposition is reasonable and does not involve a Disclosure of Protected Health Information (PHI) in violation of law and policies.

D. CalOptima, its Governing Body members, employees, and FDRs shall immediately report any action believed to be retaliation or discrimination against any individual for reporting suspected or actual non-compliance with laws, unethical conduct, or wrongdoing, or for participating in any investigation.

E. CalOptima shall provide guidance, in accordance with CalOptima Policy MA.9113: Compliance and Ethics Hotline, on how an employee, Governing Body, FDR, or Member may anonymously report potential non-compliance and FWA issues to the extent permitted by applicable law and circumstances.

F. CalOptima does not tolerate intimidation, coercion, harassment, discrimination, or other forms of retaliation towards individuals who report suspected or actual non-compliance. Individuals or entities determined to have violated CalOptima's non-retaliation policy will be subject to disciplinary or other corrective action, up to and including termination.

IV. PROCEDURE

A. CalOptima shall protect against any retaliation toward an employee, Governing Body, FDR, or Member by ensuring all verbal or written reports, made in good faith, remain confidential to the extent allowable by law.

B. CalOptima and the Office of Compliance shall ensure employees, Governing Body, FDRs, or Members are informed of CalOptima's non-retaliation policy by posting information on the CalOptima InfoNet and Website, as well as sending periodic Member notifications.

C. CalOptima shall maintain confidential methods for employees, Governing Body, FDRs or Members to report suspected violations of policy, rules, and regulations by:

1. Calling the Compliance and Ethics Hotline, toll-free, twenty-four (24) hours a day, seven (7) days a week; or

2. Reporting directly to the CalOptima Compliance Officer; or

3. Completing a Request for Compliance Action Form.

D. It is the responsibility of all CalOptima employees, Governing Body, FDRs and Members to report, in good faith, perceived or known misconduct, in accordance with CalOptima Policy MA.9114: Reporting Suspected Misconduct or Violation.

E. Knowledge of a violation or potential violation of this policy shall be reported directly to the Compliance Officer or to the Compliance and Ethics Hotline.

F. Failure of a CalOptima employee to report any such violation or possible violation may be grounds for disciplinary action.

V. ATTACHMENTS

Not Applicable

VI. REFERENCES

A. Title 45, Code of Federal Regulations, Section164.530(g) Administrative Requirements Standard: Refraining From Intimidating or Retaliatory Acts
B. CalOptima Compliance PlanMedicare Managed Care Manual, Chapter 21: Compliance Program Guidelines
C. Medicare Prescription Drug Benefits Manual, Chapter 9: Compliance Program Guidelines
D. CalOptima Policy MA.1001: Glossary of Terms
E. CalOptima Policy MA.9113: Compliance and Ethics Hotline
F. CalOptima Policy MA.9114: Reporting Suspected Misconduct or Violation

VII. REGULATORY APPROVALS

None to Date

VIII. BOARD ACTIONS

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	10/1/02	MA.9223	Reporting Non-Intimidation and Non-Retaliation
Revision Date 1	11/1/04	MA.9223	Reporting Non-Intimidation and Non-Retaliation
Revision Date 2	7/1/07	MA.9223	Reporting Non-Intimidation and Non-Retaliation
Revision Date 3	1/1/10	MA.9223	Reporting Non-Intimidation and Non-Retaliation
Revision Date 4	9/1/14	MA.9223	Reporting Non-Intimidation and Non-Retaliation

Version	Version Date	Policy Number	Policy Title
Revision Date 5	9/1/15	MA.9223	Non-Retaliation on Reporting Violations