



Policy and Procedure No: CO 4.8	Revision No: 8
Division: Care Management	
Department: Compliance	
Title: PHC-CA Compliance Training and Education	
Effective Date: 1/1/2006	
Supersedes Policy No: 97004, CO 4.0, CO 4.1, CO 4.2, CO 4.3, CO 4.4, CO 4.5, CO 4.6, CO 4.7	
Reviewed/Revised by: Sandra Holzner	Review/Revision Date: 12/13/2025
Approving Committee: Compliance Committee	Date: 12/15/2025
Executive Oversight Committee Date: 12/16/2025	

Purpose:

The purpose of this policy is to establish and maintain a comprehensive Compliance Training and Education Program for PHC California (the Health Plan). This program ensures adherence to all applicable federal and state laws, regulations, and Department of Health Care Services (DHCS) contractual requirements, including Exhibit A, Attachment III, Subsection 1.3.7.A. The Health Plan is committed to promoting a culture of compliance, integrity, and accountability by providing timely and effective training to all employees, board members, subcontractors, downstream subcontractors, and network providers

Policy:

1. The Health Plan must provide to all its employees, Subcontractors, Downstream Subcontractors, and Network Providers written policies containing detailed information about the False Claims Act and other federal and State laws described in 42 USC section 1396a(a)(68), including information about rights of employees to be protected as whistleblowers. (See also 42 CFR § 438.608(a)(6).) Upon request by DHCS, the Health Plan must demonstrate compliance with DHCS Contract, Exhibit A, Attachment III, Subsection 1.3.7.A (Employee Education about False Claims Recovery), which may include providing DHCS with copies of the Health Plan’s applicable written policies and procedures and any relevant employee handbook excerpts.
2. The Health Plan must have system for training and educating the compliance officer, senior management, and employees on federal and State standards and requirements of the DHCS Contract. Training must address the Health Plan’s standards of conduct, compliance plan, and compliance policies and procedures compliance training completion must be verified such as through a certification or attestation upon training completion and review of the standard of conduct, compliance program, and compliance policies and procedures. The Health Plan must ensure that training for the compliance officer, senior management, and employees on the compliance program is completed within (90) ninety days of employment and annually thereafter. The Health Plan’s training and education program shall:
 - a. Ensure that all board members, senior managers, officers, directors, managers, employees, and contractors know and understand the Health Plan’s Compliance and Fraud, Waste and Abuse (FWA) policies and procedures;
 - b. Teach how to prevent and detect potential or suspected FWA;
 - c. Teach how to report suspected FWA when detected;

- d. Describe the specific controls that the Health Plan has in place for preventing and detecting potential or suspected FWA; and,
- e. Instruct on how to make confidential reports of FWA, the Health Plan's non-retaliation policy, and whistleblower actions.
- f. Training on the Health Plan's Code of Conduct
- g. Training on the Health Plan's policies and procedures, generally and relevant to specific job functions;
- h. Network Providers completion of required initial and ongoing Network Provider training within the established timeframes in accordance with Exhibit A, Attachment III, Subsection 3.2.5 (Network Provider Training), Members' rights as required under Exhibit A, Attachment III, Section 3.2 (Provider Relations), and Advanced Directives in accordance with 42 CFR sections 422.128 and 438.3(j) set forth in Exhibit A, Attachment III, Subsection 5.1.1 (Members Rights and Responsibilities);
- i. Member Services staff completion of required training as set forth in Exhibit A, Attachment III, Subsection 5.1.2 (Member Services Staff) and include diversity, equity and inclusion training in accordance with Exhibit A, Attachment III, Subsection 5.2.11.C. (Cultural and Linguistic Programs and Committees); and
- j. For staff carrying out obligations under MOUs, the training required under Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*)

Procedure:

1. All Health Plan Directors and managers are responsible for ensuring their staff is trained on how to perform their jobs lawfully and ethically.
2. The Care Management Compliance Officer shall participate in relevant outside training seminars, conference calls, and events to ensure knowledge of pertinent laws and regulations related to the Health Plan. The Compliance Officer monitors changes in laws and instructions from the Center for Medicare & Medicaid Services (CMS), Medicaid, DHCS, and Department of Managed Health Care (DMHC) and revise or add training programs as needed to keep the Health Plan's directors, officers, staff and contractors compliant with current requirements.
3. All Health Plan employees will receive formal fraud and abuse training within ninety (90) days of initial hiring, and annually thereafter as a condition of employment. The Compliance Officer oversees the development of the formal training materials, which are administered through AHF University (AHFU). The web-based program is administered by the Human Resources Department (HR). Status of course completion, delinquent/past due training are monitored through a system-generated report. These reports are reviewed by the Compliance Department, and the appropriate supervisors are then notified if delinquencies exist in their area.



4. HR documents and retain evidence of the at-hire training and any formal, annual training program (e.g., web-based program) in the employee personnel file. HR staff and the Compliance Officer will be available to staff taking any computerized course to answer technical questions. The training will instruct participants on how to contact the Compliance Officer with any substantive questions.
5. At a minimum, the Health Plan's Compliance training will address pertinent laws related to FWA (e.g., Anti-Kickback Statute, False Claims Act, Stark Law etc.) and describe the Health Plan's compliance program; how to report compliance issues; and protections for those who make good-faith reports.
6. Employee training will include information on how to report risks to the employee's supervisor (unless the employee believes doing so would be risky for the employee or unlikely to resolve the issue). In such case, employees will be instructed to seek the counsel of the Compliance Officer. Employees and downstream contractors will also be given the Compliance hotline number (1-800-AIDSHIV) and information about how to report to various government agencies:
 - Call the Medi-Cal Fraud Hotline at 1-800-822-6222, or
 - They may make confidential reports of any perceived violations to DHCS by filing an on-line complaint through a Confidential Medi-Cal Complaint Report (MC -609) and forwarding it by fax to 916-440-5281 or email PIUCases@DHCS.ca.gov
 - Or call the California Office of Attorney General toll free at 1-800-952-5225
7. Beyond the annual formal education programs, the Compliance Officer or his/her designee will provide ongoing compliance training and education by periodically making short presentations at staff and departmental meetings, distributing compliance-related policies and procedures and memos, emailing periodic reminders, etc. The Compliance Department maintains records of these trainings (i.e., minutes, sign-in sheets), including materials used for the training.
8. The Compliance Officer or his/her designee will periodically audit training records to ensure that all managed care staff, directors, and officers have participated in the required trainings. Failure to complete required compliance training within established timeframes will result in corrective action, which may include disciplinary measures up to and including termination of employment or contract. Persistent non-compliance will be escalated to the Compliance Officer and Executive Leadership and may be reported to DHCS as required under contractual obligations. Non-compliance by subcontractors or downstream entities may result in sanctions, financial penalties, or termination of delegation agreements.
9. The Compliance Officer will report on Health Plan compliance with training to the Care Management Compliance Committee, which shall report the same to the EOC.
10. Specific topics that may be addressed in the Health Plan compliance trainings include:
 - a. A description of the compliance program, including a review of compliance policies and procedures, the code of conduct, and the Health Plan's commitment to business ethics and compliance with all statutory and regulatory requirements.
 - b. Overview of system or process to ask compliance questions, request compliance clarification or report potential non-compliance or potential fraud, waste, or abuse. Training

should emphasize confidentiality, anonymity, and non-retaliation for compliance related questions, or reports of potential non-compliance.

- c. Review of the disciplinary guidelines for non-compliant or fraudulent behavior, including possible termination when such behavior is serious or repeated or when knowledge of a possible violation is not reported.
 - d. Attendance and participation in formal training programs as a condition of continued employment, and a criterion to be included in employee evaluations.
 - e. Review of policies related to contracting with the government, such as the laws addressing fraud and abuse or gifts and gratuities for government employees.
 - f. Review of potential conflicts of interest and the Health Plan's disclosure/attestation system.
 - g. Overview of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other confidentiality laws/rules and the importance of maintaining the confidentiality of personal health information.
 - h. Review of lawful marketing practices and training on approved Health Plan marketing practices for Medi-Cal.
11. Employees whose job responsibilities implicate specific risk areas will be required to attend specialized sessions specific to the individual risk area. Examples of areas where employees may require specialized training:
- a. Marketing
 - b. Pharmacy
 - c. Claims processing
 - d. Coverage determination and appeals
 - e. Contracting
 - e. Payment reconciliation
 - f. Data reporting to DHCS
 - h. Information security
12. The Health Plan requires all network providers to complete compliance training and Fraud, Waste, and Abuse (FWA) training in strict accordance with the Medi-Cal Managed Care Contract requirements, including Exhibit A, Attachment III, Subsection 1.3.7.A (Employee Education about False Claims Recovery), related provisions under 42 CFR §438.608(a)(6), and 42 USC §1396a(a)(68). Compliance training shall address DHCS contractual obligations, Health Plan policies and procedures, the Code of Conduct, HIPAA and confidentiality standards, marketing practices, and processes for reporting compliance concerns. FWA training shall include identification, prevention, and reporting of suspected fraud, waste, and abuse, as well as cooperation with investigations. These training courses are mandatory upon contracting and

annually thereafter. The Provider Relations Department is responsible for ensuring that all network providers receive and complete the required training, collecting and maintaining evidence of completion, and making such documentation available for DHCS review upon request. Failure to comply with these training requirements may result in corrective action, sanctions, termination of the provider agreement, and reporting to DHCS as required under Exhibit E of the Medi-Cal Managed Care Contract.

Monitoring:

This policy is updated, as necessary, and reviewed and approved annually by the Care Management Compliance Committee.

Definitions:

1. Abuse: means practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program.
2. AHF: AIDS Healthcare Foundation and its affiliates/subsidiaries who offer managed care health plans or programs.
3. Fraud: means an intentional deception or misrepresentation made by persons with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person and includes any act that constitutes Fraud under applicable federal or State law, including 42 CFR section 455.2 and W&I section 14043.1(i).
4. Network Provider: means any Provider or entity that has a Network Provider Agreement with Health Plan, Health Plan's Subcontractor, or Health Plan's Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under this Contract. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement.
5. Provider: means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
6. Subcontractor: means an individual or entity that has a Subcontractor Agreement with Contractor that relates directly or indirectly to the performance of Contractor's obligations under this Contract. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.
7. Waste: means the overutilization or inappropriate utilization of services and misuse of resources.

Reference(s):

1. 42 C.F.R. § 423.504(b)(4)(vi)(C)
2. 42 USC section 1396a(a)(68)
3. 42 CFR § 438.608(a)(6)

4. DHCS Contract, Exhibit A, Attachment III, Subsection 1.3.1 (Compliance Program)
5. DHCS Contract, Exhibit A, Attachment III, Subsection 1.3.7.A (Employee Education about False Claims Recovery)

