



Policy and Procedure No: CO 1.7	Revision No: 7
Division: Care Management	
Department: Compliance	
Title: PHC-CA Compliance and Anti-Fraud Plan	
Effective Date: 12/30/2005	
Supersedes Policy No: 97001, CO 1.1, CO 1.2, CO 1.3, CO 1.4, CO 1.5, CO 1.6	
Reviewed/Revised by: Sandra Holzner	Review/Revision Date: 12/12/2025
Approving Committee: Compliance Committee	Date: 12/15/2025
Executive Oversight Committee Date: 12/16/2025	

Purpose:

To describe the elements of PHC California’s (the Health Plan) Compliance and Anti-Fraud Plan and its measures to detect, correct, and prevent fraud, waste, and abuse.

Policy:

The Health Plan is committed to complying with all applicable Federal and State laws and to operating ethically and in the best interests of the health and well-being of its members and patients at all times. This commitment is reflected in a current, comprehensive, written Compliance and Antifraud Plan ("Compliance Plan").

Program Integrity and Compliance Program

The Health Plan must establish administrative and management policies and procedures which are designed to prevent and detect Fraud, Waste, and Abuse. In furtherance of this goal, AHF must establish a Compliance program, a Fraud, Waste, and Abuse prevention program, and other program integrity processes. In establishing these policies, procedures, and programs, Contractor must meet the requirements of 42 CFR section 438.608.

While the Health Plan may contract with entities to support Contractor on compliance activities (such as training and auditing), Health Plan may not delegate program integrity and compliance program functions to Subcontractors or Downstream Subcontractors.

The Health Plan must ensure that all Subcontractors and Downstream Subcontractors also have a robust program integrity and compliance program in place. This requirement may be fulfilled by the Health Plan maintaining all program integrity and compliance program functions on behalf of Subcontractor or Downstream Subcontractor.

Compliance Program

The Health Plan must have a compliance program that includes, at a minimum, the following elements:

1. A compliance plan which:
 - a. Outlines the key elements of the compliance program;
 - b. Includes reference to the standards of conduct;

- c. Allows the compliance program to act independently of operational and program areas without fear of repercussions for uncovering deficiencies or noncompliance;
 - d. Details how it will implement and maintain elements of the compliance program;
 - e. Includes the compliance reporting structure and positions of key personnel involved in ensuring compliance, including the compliance officer;
 - f. References the delegation reporting and compliance plan
 - g. References policies and procedures operationalizing the compliance program;
 - h. Is reviewed and approved by the board of director's compliance and oversight committee routinely, but not less than biennially; and
 - i. Is publicly posted on the Health Plan's website
2. A delegation reporting and compliance plan as described in the DHCS Contract Exhibit A, Attachment III, Subsection 3.1.3 (Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan) and Exhibit J, (Delegation Reporting and Compliance Plan);

Procedure:

1. The Compliance Officer is responsible for developing a written Compliance and Anti-Fraud Plan with the following elements:
 - a. Written policies, procedures, and standards of conduct that articulate the Health Plan's commitment to comply with all applicable federal and state standards.
 - b. The designation of a Compliance Officer and a Care Management Compliance Committee that are accountable to Senior Management.
 - c. Identify adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist AHF in preventing and detecting potential Fraud and Abuse activities.
 - b. Effective training and education between the Care Management Compliance Officer and AHF's Care Management employees, managers and directors, and the Health Plan's first tier, downstream, and related entities.
 - c. Effective lines of communication between the Compliance Officer, members of the Care Management Compliance Committee, employees, managers and directors, first tier, downstream, and related entities.
 - d. Enforcement of standards through well-publicized statutory and contractual requirements and disciplinary guidelines.
 - e. Procedures for internal monitoring and auditing.



- g. Procedures for ensuring prompt response to detected offenses and development of corrective action initiatives relating to the Health Plan's contracts with the respective government agency (i.e., CMS, DHCS, or DMHC). Specifically, procedures for:
 1. In the event the Health Plan discovers evidence of misconduct related to payment or delivery of items or services under one of its government contracts, conducting a timely, reasonable inquiry into that conduct.
 2. Taking appropriate corrective actions (for example, repayment of overpayments, disciplinary actions against responsible employees) in response to the potential violation.
 3. Voluntarily self-reporting potential fraud or misconduct related to AHF to the appropriate government agency (i.e., CMS, DHCS, or DMHC).
2. When a suspended provider is removed from the Medi-Cal network, the Compliance Officer or their designee will notify the Medi-Cal Care Management Program/Program Integrity Unit with ten (10) working days of removing the suspended provider.
3. The Compliance Plan is prepared by the Compliance Officer and Care Management Compliance Committee. The Compliance Plan is also submitted to the Executive Oversight Committee (EOC) for its review and approval.
4. The Compliance Officer and the Care Management Compliance Committee, periodically reviews the Compliance Plan and update it to conform to current regulatory and contractual requirements. If the Compliance Plan is revised, the revised Compliance Plan will be submitted to the EOC for approval.
5. The Annual Compliance and Antifraud Plan must be submitted to the Department of Managed Health Care (DMHC) anytime substantive changes are made to the Plan for review and approval. Formatting changes to the Annual Compliance and Antifraud Plan do not need to be submitted for review.
 - i. The Annual Compliance and Antifraud Plan must be submitted with redlined changes from the last prior approved Plan.
 - ii. It must be submitted via the DMHC portal and include an E-1 Summary of E-filing and J-8 Antifraud Plan.
6. Upon approval by DMHC, the Annual Compliance and Antifraud Plan is publicly posted on the Health Plan's website.

Monitoring:

This policy is updated, as necessary, reviewed and approved annually by the Compliance Officer or his/her designee and reviewed and Approved 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 that offer Health Plans.
3. Corrective Actions: means specific identifiable activities or undertakings of Contractor which address Contract deficiencies or noncompliance.
4. Department of Health Care Services (DHCS) or Department: means the single State department responsible for the administration of the Medi-Cal Program, California Children’s Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health-related programs, as provided by statute and/or regulation.
5. 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).
6. Waste: means the overutilization or inappropriate utilization of services and misuse of resources.

References:

1. 42 C.F.R. § 438.608
2. 42 C.F.R. § 455 [Program Integrity]
3. DHCS Managed Care Contract

Regulatory Agency Approval(s):

Date	Version	Regulatory Agency	Purpose	Response
8/22/2023		Department of Health Care Services (DHCS)	2024 Operational Readiness (OR) R.0243.2	Approved
12/7/2023	1.5	DHCS	2024 OR R.0022	AIR1
Not avail.	1.5	DHCS	2024 OR R.0024	Approved
Not avail.	1.6	DHCS	2024 OR R.0022 AIR1	Approved

