Catholic Health

Corporate Compliance Plan

CHS-CCP-100

Corporate Compliance Plan
TABLE OF CONTENTS

Supplemental to this document are eight Corporate Compliance Plans entitled:

- **Home Health Agency (Home Care) and Infusion Pharmacy (CHIP) AKA Community Based Care**
- **Nursing Facilities**
- **Hospital**
- **Clinical Laboratory**
- **Physician Enterprise**
- **CH-LIFE**

Dear Catholic Health Associates:

Catholic Health is proud to have a system wide Corporate Compliance Program that has been created to help us to understand the ethical, professional and legal obligations we have as health care providers. Every associate in our Catholic Health organization plays an individual role in meeting these important obligations.

The Corporate Compliance Program is an ongoing effort and was incorporated under the direction of the Board of Directors and the CHS Leadership Team. We ask that you become an active participant in our compliance efforts as CHS is dedicated to conducting business honestly and ethically. This can only occur through your active participation, setting the standard of conduct to be followed by all CHS personnel.

The Catholic Health associate education program examines the principles and expectations of corporate compliance, while providing the tools and resources for a successful program that defines system responsibility, standards for individual and organizational conduct as well as a process to report, monitor and correct situations that hinder our compliance efforts. Through the educational process, you will learn about the legal aspects of health care and the specific laws and regulations that shape our industry.

The Chief Compliance Officer for Catholic Health is located at the Administrative & Regional Training Center, Corporate Compliance, 144 Genesee Street, eh Floor, Buffalo, NY 14203 and can be reached at (716) 821-4471. This program is designed to be a positive experience that will set new standards for organizational excellence, ensure maximum use of available resources and reaffirm the principles of honesty and integrity in all that we do. I look forward to sharing this journey with you and ask that you look at this as an opportunity to strengthen our organization and the values that are the hallmark of Catholic healthcare in Western New York.

Thank you for your commitment to Corporate Compliance.

Sincerely,

Joyce Markiewicz
President & Chief Executive Officer
Catholic Health

Dear Catholic Health System Associates and Constituents,

As CHS Chief Compliance Officer, my role is to educate, facilitate, monitor and investigate compliance related activities within CHS and to provide guidance to our associates at all levels of employment.

Catholic Health is committed and obligated to comply with all applicable federal and state standards. Catholic Health continues to identify governing laws, and regulations applicable to the risk areas identified within the Compliance Program. Corporate Compliance is an ongoing effort and is the responsibility of all associates, providers and vendors. As representatives of CHS, it is important that we as individuals conduct ourselves in a manner that is consistent with honest, ethical behavior and commit ourselves to the responsible management of our resources. This means that we have a duty to familiarize ourselves with policies and procedures that are in place and a duty to ensure that we are in compliance with governmental rules, regulations and laws and a duty to report any actual or potential noncompliance activity.

Please take the time to read the applicable Compliance Guidebooks, including the Corporate Compliance Program, as well as the Associate, Vendor and Physician Guidebooks. I am sure you will find them comprehensive, invaluable resource covering various aspects of the Compliance Program.

I look forward to your support of our Compliance Program and to working together to further strengthen Catholic Health's core values of Reverence, Compassion, Integrity, Innovation, Community, and Excellence.

Should you have questions or concerns, please do not hesitate to

contact me. Sincerely,

Kimberly E. Whistler, Esq., CHC
Chief Compliance Officer
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Corporate Compliance Plan Overview

PURPOSE: The Catholic Health System is committed to maintaining an organizational and accountability structure which assures compliance with governmental laws, rules and regulations, and supports the Organization's ethical standards, code of conduct and zero tolerance for fraud, abuse and waste.

APPLIES TO: All Catholic Health System entities and their constituents, to include but not limited to: Associates, Physicians, Vendors, Contractors, Volunteers and Students (collectively, "constituents").

GENERAL STATEMENT OF POLICY AND GOALS: The Catholic Health System has developed a program for system-wide Corporate Compliance to give constituents throughout our organization an opportunity to further the mission, vision and values that define our healing ministry. Our Corporate Compliance Program helps us better understand the ethical, professional, and legal obligations we have as health care providers and the individual role we each play in meeting these important obligations.

We have designed educational programs that examine the principles and expectations of Corporate Compliance and provides us with the tools and resources to implement a successful program of organizational responsibility. As components of this program, CHS has developed standards for individual and organizational conduct and processes to report, monitor and correct situations that can hinder our compliance efforts. Through the educational process, associates will also learn about the legal aspects of health care and the specific laws and regulations that shape our industry.

The Board of Directors and the CHS Leadership Teams have directed that this program be implemented. It is mandatory that each constituent become an active participant in our compliance efforts. CHS is dedicated to conducting business honestly and ethically. Through each constituent's participation in the Corporate Compliance Program, they will help set the standards of conduct to be followed by all CHS personnel and unify our compliance initiatives throughout the System.

PROCEDURE:

Based on the guidance put forth by the Office of Inspector General (OIG) of the Department of Health and Human Services, and the New York State Office of Medicaid Inspector General (OMIG), the Catholic Health System (CHS) has developed a voluntary compliance program. Corporate Compliance Plans have been developed based on industry segments and/or departments within the Catholic Health System. Effective July 1, 2009, New York State DOH-OMIG requires Medicaid providers with $1,000,000 or more in annual Medicaid billings to have and effective compliance program. The CHS plans include:

- CHS Corporate Compliance Plan
- Home Health Agency and Infusion Pharmacy Corporate Compliance Plan
- Nursing Facilities Corporate Compliance Plan
- Clinical Laboratory Corporate Compliance Plan
- Physician Enterprise Corporate Compliance Plan
- Hospital Corporate Compliance Plan
- CH-LIFE Corporate Compliance Plan

The relationship of the CHS organizations to the above listed Corporate Compliance Plan documents as listed:

1. CHS Home Health Agencies:
   - CHS Corporate Compliance Plan
   - Home Health Agency (HHA) and Infusion Pharmacy Corporate Compliance Plan
2. CHS Nursing/Adult Care Facilities:
   - CHS Corporate Compliance Plan
   - Nursing Facilities Corporate Compliance Plan
3. Clinical Laboratory
   - CHS Corporate Compliance Plan
   - Clinical Laboratory Corporate Compliance Plan
4. Physician Enterprise
   - CHS Corporate Compliance Plan
   - Physician Enterprise Corporate Compliance Plan
5. CHS Hospitals:
   - CHS Corporate Compliance Plan
   - Hospital Corporate Compliance Plan
   - Clinical Laboratory Corporate Compliance Plan
   - Physician Enterprise Corporate Compliance Plan
   - Home Health Agency and Infusion Pharmacy Corporate Compliance Plan (as appropriate)
   - Nursing Facilities Corporate Compliance Plan (as appropriate)
6. CHS- Life Program (PACE):
   - CHS Corporate Compliance Plan
   - CH-LIFE Corporate Compliance Plan
   - Fraud, Waste, & Abuse Part D

These documents present guidelines designed to promote prevention, detection and resolution of instances of conduct that do not conform to federal and state law, and federal, state and private payor health care requirements as well as sound business policies.

The compliance program assists management in providing leadership concerning ethical business practices within the organization, and ensures that adequate systems are in place to facilitate ethical and legal conduct.

I. Standards of Conduct

PURPOSE: Catholic Health System (CHS) pledges to meet our mission in an atmosphere that recognizes its responsibility to conduct its business affairs with integrity based on sound ethical and moral standards. CHS recognizes our responsibility to treat the people we serve with the same standards of care, regardless of payor source and in accordance with applicable rules, regulations and laws. CHS is intolerant of fraud, waste and abuse throughout the organization and strives to always deliver medically necessary services in the most efficient and prudent manner. CHS also holds those with whom we conduct business to these same standards.

We intend to meet our mission through on-going, appropriate and timely education of all our constituents. We promote self-monitoring of our activities by providing oversight of our directors, officers, managers, associates, medical staff, house staff, contractors, vendors volunteers, students ("constituents") and others to assure compliance with these standards. We seek to provide an atmosphere that is safe, encourages open discussions on these matters with no fear of retribution, and promptly identifies and resolves issues.

This Corporate Compliance Statement is consistent with and supports the Mission Statement of the Catholic Health System:

"We are called to reveal the healing love of Jesus to all."

APPLIES TO: All Catholic Health System entities and constituents, to include but not limited to: constituents, including: Associates, Physicians, Vendors, Contractors, Volunteers and Students.

POLICY:

A. Code of Conduct Statement

In keeping with the mission and goals of Catholic Health, directors, officers, managers, associates, medical staff, house staff, contractors, vendors, volunteers, students and other agents are expected to comply with the following guidelines. This Code of Conduct does not replace sound ethical and professional judgment.

Expectations of all work force members in Catholic Health are to:

1. **Uphold Legal and Regulatory Compliance**
   - Adhere to both the spirit and letter of applicable federal, state and local laws and regulations.
   - Refuse offers, solicitations and payments to induce referrals of the people we serve for an item or service reimbursable by a third party payor.
   - Protect and retain records and documents as required by professional standards, governmental regulations and organizational policies.
2. **Promote Ethical Business Conduct**
   - Deal openly and honestly with fellow associates, customers, contractors, government entities and others.
   - Maintain high standards of business and ethical conduct in accordance with the Catholic Health System Mission, directives of the Catholic Church and applicable federal, state and local laws and regulations
   - Document work related activities completely and accurately.
   - Conduct business dealings with the best interests of the Catholic Health System in view.
   - Ensure compliance requirements regarding billing are monitored and enforced.
   - Exercise discretion in the billing of services, incorporating payor guidance.
3. **Disclose Potential Conflict of Interest**
   - Disclose financial interests and/or affiliations or secondary employment with outside entities as required by the Conflict of Interest Statement Policy.
   - As requested, complete timely submission of the Conflict of Interest Disclosure Statement
4. **Appropriately Use Resources**
   - Use supplies and services in a manner that supports financial stability and positive environmental impact.
5. **Preserve Confidentiality**
   - Preserve patient confidentiality within the requirements of the law.
   - Maintain confidentiality of proprietary information

6. **Exhibit Catholic Health Behavioral Conduct**
    - Act with integrity by exhibiting CH value based behaviors in work related activities.
    - If applicable, follow ethical standards of respective professional organizations.
    - Hold vendors to this same Code of Conduct as part of their dealings with the Catholic Health System.
    - Uphold the Non-Retaliation Policy for those who report concerns in good faith.
7. **Act Responsibly & Be Accountable**
    - Accept mission aligned challenges as opportunities for improvement.
    - Notify the appropriate person of instances of non-compliance and in a timely manner.
    - Ensure appropriate corrective action is taken in a timely manner.

All constituents and others affiliated with the Catholic Health System are informed of this Code of Conduct as much as practicable, and sign an Affirmation Statement indicating their adherence to the Code of Conduct.

B. <u>Code of Ethics Statement</u>

The Catholic Health System, through its constituents conducts patient care and other business operations in an ethical and non-discriminatory manner consistent with the mission, vision, values, strategic plan and Administrative policies.

The Catholic Health System has adopted a Code of Ethics as an expression of its identity as a Catholic Healthcare Organization and on behalf of the people it serves. A general framework for this code can be found in the Ethical and Religious Directives for Catholic Health Care Services, the codes of ethics of the various professional groups working within the Catholic Health System, applicable state and federal laws, as well as other documents. Specific guidelines for the code, which are summarized below, can be found in the above mentioned documents as well as in the following documents: quality of care, patient and associate rights policies, billing policies; marketing policies; admission, transfer, and discharge policies; conflict of interest and other policies. Also addressed in this code are procedures that should be followed in the event ethical conflicts or uncertainties arise.

1. **Quality of Care**
   Policies support the commitment of the Catholic Health System to provide quality of care and services necessary to attain or maintain highest practicable physical, mental and psychosocial wellbeing. Appropriate and sufficient treatment and services will be provided to address the needs of the people served. Patients may only receive care that has been ordered by a Physician or qualified practitioner with established clinical privileges. The Catholic Health System establishes and implements policies and protocols related to the quality of care and perform ongoing evaluations of compliance to these policies and protocols.

2. **Patient Rights and Responsibilities Policies**
    - Policies support the rights of the people we serve to ask and be informed about the existence and nature of the business relationships between the health system, organizations, educational institutions, other healthcare providers, payors, or networks that may influence treatment and service.
    - To advance protections for all those we serve, Catholic Health prohibits discrimination of any kind, including but not limited to discrimination based on an individual's race, color, national origin, religion, sex, gender identity and expression, sexual orientation, age or disability, pregnancy, childbirth and related medical conditions. In addition, women are to be treated equally with men with respect to the healthcare they receive and individuals are to be treated consistent with their gender identity, including having access to facilities, and may not categorically be excluded or limited to healthcare services due to gender transition. Hard

copies of Catholic Health's Non-Discrimination Statement will be posted in public spaces at Catholic Health facilities or offices. Conspicuously posting the notice on the Catholic Health System Website is also required.

- Every effort is made to help the people we serve and their families understand and exercise their rights and responsibilities. The people we serve are the primary decision makers in their own healthcare decisions and, to the extent possible, information regarding diagnosis, treatment, research options, and prognosis is to be provided in the patient's preferred language. Language Service taglines with at minimum, the top 15 languages spoken outside of English in New York State, shall be posted at all Catholic Health locations where patients are seen. See policy CHS-CCP-121A Communication Assistance.
- Should a patient believe that Catholic Health in any way has failed to provide services or discriminated in another way, a patient may file a grievance with:

Kimberly E. Whistler, Esq., CHC
Chief Compliance Officer
144 Genesee Street, 6th Floor-West, Buffalo, NY 14203
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The Chief Compliance Officer will have the right to delegate the grievance to a site representative.

- Outpatient, rehabilitative and ancillary services for the people we serve also safeguard the patient's respect, dignity, autonomy, positive self-esteem, and civil rights, and assure their involvement in all aspects of care. This safeguarding of the involvement of the people we serve includes taking account of their perceptions of their strengths, weaknesses, resources, and relevant demands of their environment(s) both within and without the healthcare setting.

3. **Developing New Services or Acquiring New Technologies, and for Newly Constructed or Altered Facilities**
   The Catholic Health System provides those services that are compatible with its mission and values. New services and technologies are evaluated on the basis of criteria related to this mission and these values. The following criteria are also used to evaluate new services and technologies: safety, efficacy, efficiency, cost, experience, availability from other sources, number of individuals who benefit, and the effect on the Catholic Health System's ability to provide other needed services as well as the competence and qualifications of the staff required to provide those services or technologies in question.
   For individuals with disabilities, Catholic Health System will make all programs and activities provided through electronic information technology accessible; ensure the physical accessibility of newly constructed or altered facilities; and provide auxiliary aids and services to individuals with disabilities.

4. **All Associates and Constituents Rights Policies**
   It is the policy of the Catholic Health System to value associates, their wellbeing and their satisfaction; to respect the differences and diversity of its associates; and not to discriminate on the basis of race, color, religion, sex, pregnancy, gender identity and expression, national origin, age, veteran status or disability. The Catholic Health System fosters an organizational culture that encourages open communication, without fear of retaliation. All associates and constituents the right to work in an environment free of harassment and disruptive behavior.

5. **Billing Policies**
   The Catholic Health System ensures that the people we serve and third party payors are billed only for medically necessary services actually provided and duly documented. Policies are established and mechanisms are implemented to help ensure that the people we serve are billed only for those services and care provided. It is also policy that the Catholic Health System will bill all payors in compliance with all federal and state rules and regulations.

6. **Marketing and Public Relations Policies**
   The Catholic Health System fairly and accurately represents itself, its services, and its capabilities to the public. Marketing practices recognize the dignity of the person, freedom of speech and assembly, and the importance of freedom of the press. Marketing materials accurately reflect those services available, the level of licensure and accreditation in place, and comply with applicable laws and regulations governing truth in advertising and non-discrimination under the Public Health Service Act and the Rehabilitation Act of 1973, and other applicable state and federal laws and regulations. Marketing associates use their best efforts to adhere to the Code of Professional Standards as adopted by the Governing Assembly of the Public Relations Society of America. Marketing practices or benefits designs that discriminate on the basis of disability or other prohibited bases are not allowed.

7. **Admission, Transfer, and Discharge Policies**
   Admission, transfer, and discharges are conducted in an ethical manner and in accordance with applicable local, state and federal regulations. Admission, transfer, and discharge policies are based on the need of the individual person and the ability of the Catholic Health System to meet that need. See Policy RSK-006 Patient Transfers (EMTALA/Cobra).

8. **Procedures when Ethical Conflicts of Interest or other Issues Arise**
   It is recognized that ethical conflicts may arise when people who are trying to do right or realize good, either disagree or are uncertain about what constitutes the appropriate, right or good. The Catholic Health System's Ethics Committee has processes to resolve such conflicts. Also see policy HR-050–Managing Associate Ethical Conflicts for additional guidance.

II. Corporate Compliance Structure

A. The Board of Directors' Responsibilities and Duties

The Catholic Health System is committed to maintaining an organizational and accountability structure which assures compliance with governmental laws, rules and regulations, and supports the Organization's ethical standards, code of conduct and zero tolerance for fraud, abuse and waste.

The overall accountability for the Catholic Health System's Corporate Compliance Program rests with the Board of Directors and the Audit Committee of the Board. The duties of the Board of Directors relative to compliance efforts are as follows:

- To set the standard for the Catholic Health System for corporate compliance through its explicit and implicit adherence to its ethical standards, code of conduct and zero tolerance of fraud, abuse and waste in business and personnel dealings.
- To be knowledgeable about the content and operations of the compliance program and to exercise reasonable oversight over it:
- To appoint a multi-disciplinary Corporate Compliance Committee composed of representatives that may include members of Senior Management, Medical Staff, Finance, Billing, Legal Counsel, Clinical Departments and Human Resources to implement the Corporate Compliance Plan approved by the Board of Directors.

- To appoint a Chief Compliance Officer who is responsible for the day-to-day oversight of the Corporate Compliance Program.
- To take action on the Corporate Compliance Program and any revisions recommended by the Corporate Compliance Committee to the Board of Directors.
- To receive sufficient reports as outlined in the Corporate Compliance Program from the Corporate Compliance Committee and Chief Compliance Officer to effectively conduct its compliance oversight.
- To take timely and appropriate actions as warranted and outlined in the Corporate Compliance Program on issues which may arise from daily operations, monitoring activities or external factors.

B. The Corporate Compliance Committee's Responsibilities and Duties

The duties of the Corporate Compliance Committee include, but are not limited to the following:

- To review and, if necessary, revise and then recommend to the Board of Directors for approval the Corporate Compliance Program which addresses the seven critical elements of the U.S. Federal Sentencing Guidelines; and eight elements of the NYS Compliance program;
- To review and, if necessary, revise the procedures, work programs and protocols developed by the Chief Compliance Officer which operationalize the Corporate Compliance Program;
- To ensure due care is exercised in assigning and carrying out of responsibilities;
- To work with the Chief Compliance Officer and other organization members, as necessary, to develop effective on-going training methods and materials for all affected associates;
- To develop on-going analyses of the Catholic Health System's business, industry and legal risks and assure appropriate steps are undertaken to address these risks in a timely manner;
- To assure that methodologies developed to monitor compliance are appropriate to maximize compliance and assure confidential treatment of materials and oversee such activities on an on-going basis;
- To develop a system of communication within the Catholic Health System and a response to allegations of improper or illegal activities;
- To establish and maintain a reporting system to address compliance issues, and report to the Board of Directors on a regular basis;
- To create procedures for reporting to the Catholic Health System's Audit Committee which is the oversight body on a regular basis;
- To oversee and approve disciplinary compliance policies and procedures;
- To review the results of monitoring and auditing activities, including hotlines; and
- To recommend changes or updates to the Corporate Compliance Program, policies and procedures

C. The Chief Compliance Officer's Responsibilities and Duties

The Chief Compliance Officer shall serve as the focal point for compliance activities and shall be a "high level individual" within the Catholic Health System. The Chief Compliance Officer shall have direct access to the Board of Directors and will report to a senior officer of the Catholic Health System. The Chief Compliance Officer shall report on a regular and periodic basis to the Compliance Committee, the Audit Committee of the Board and the Board of Directors. The CHS Chief Compliance Officer also functions as the Chief Compliance Officer of each Catholic Health System organization. The primary duties of the Chief Compliance Officer shall include but not be limited to the following:

- To develop and monitor the implementation of the Corporate Compliance Program;
- To develop annual work plan and protocols which address key initiatives to be undertaken based on the Catholic Health System's policies, perceived areas of risk and governmental focus on compliance issues;

- To periodically review and recommend revising the Corporate Compliance Program as necessary, to meet the changing needs of the Catholic Health System in its business and regulatory environment;
- To oversee the coordination of billing, personnel, contracting and all other specific compliance issues and plans with appropriate management personnel to assure compliance with the Corporate Compliance Program and compliance issues;
- To oversee training and monitoring of new and existing associates such that they receive timely and accurate information related to Compliance and Compliance issues and that the associates sign affirmation statements in a timely manner;
- To assure that internal auditing and monitoring standards meet the needs of the Corporate Compliance Program;
- To assure that outside contractors and vendors comply with the Catholic Health System's Code of Conduct;
- To assure compliance with the Catholic Health System's contracting policies;
- To develop methodologies to address any issues which arise from audits and other oversight measures on a timely basis;
- To assure that monitoring activities are conducted in a non-threatening way and,
- To assure a confidential communication process for the solicitation, evaluation and response to complaints and problems.

The Chief Compliance Officer shall have the authority to access all Catholic Health System records in order to carry out responsibilities of the Corporate Compliance Office.

D. All Associates' and other Constituents' Responsibilities and Duties

While the Board of Directors and its Audit Committee, Corporate Compliance Committee, and Chief Compliance Officer hold significant roles in assuring the Catholic Health System's compliance activities, adherence to the Organization's Corporate Compliance Program is the responsibility of all officers, managers, associates, medical staff members, contractors, vendors, volunteers, students and others.

Members of Senior Management have specific duties related to compliance including:

- To support and maintain on a daily basis the Organization's culture as one of compliance to laws and regulations, open communication and zero tolerance of fraud, abuse and waste;
- To work closely with and support the efforts of those with specific responsibility for oversight and encourage departments to attend appropriate Compliance education sessions;
- To fairly evaluate managers relative to their dealings with associates on Corporate Compliance efforts and to only promote those managers who have demonstrated their support in this area; and,
- To participate openly and on a timely basis with requests for information or investigations

Because of the nature of the Corporate Compliance efforts, members of the Board of Directors, Audit Committee, Corporate Compliance Committee and designated management personnel, along with the Chief Compliance Officer sign a confidentiality statement to help assure confidentiality in dealings related to the Corporate Compliance Program and issues.

Other associates within the Organization, whether or not in a supervisory position, are expected to act on a daily basis in a manner which indicates recognition and full support of the Catholic Health System's Corporate Compliance efforts including adherence to the Code of Conduct, Corporate Compliance policies and specific departmental or issue-related policies.

All other constituents involved with the Catholic Health System are held to the same high standard of compliance to the Code of Conduct and overall Corporate Compliance policies as the Board of Directors and all associates. Failure to abide by the CHS Compliance Program could result in termination of the contract.

III. Conflict of Interest

PURPOSE: The Catholic Health System (CHS) will demonstrate the value of integrity by setting forth a policy prohibiting conflict of interest and providing a mechanism for reporting potential conflict of interest situations.

The purpose of this Conflicts of Interest Policy is to protect the interests of CHS when there is contemplation of entering into a transaction or arrangement that might benefit the private interest of an officer, board member, associate, or physician of CHS or other "Interested Person" as defined below. The primary benefit of the Policy is that decisions can be made in an objective manner without undue influence. This Policy can help to assure that CHS fulfills its charitable purposes, and properly oversees the activities of its officers, directors, and other constituents. CHS encourages individuals to avoid conflicts of interest in appearance and in fact. This Policy is intended to supplement but not replace any applicable state laws governing conflicts of interest applicable to nonprofit and charitable corporations.

For additional information see the following policies/forms:

CHS-CCP-103: Conflict of Interest
CHS-CCP-103-F02: Conflicts of Interest Disclosure Statement and Confidentiality Agreement

IV. Training and Education

PURPOSE: The Catholic Health System (CHS) has adopted a Corporate Compliance Initiative, Code of Ethics and Code of Conduct consistent with its mission. Corporate Compliance is an integral part of Catholic Health System as a whole and is designed to respond to ever-changing laws and regulations.

Affirmation Statements: An integral part of the execution of the compliance program is assuring that constituents understand and are knowledgeable about compliance standards. The Catholic Health System's personnel are held responsible and accountable for adhering to compliance standards as delineated in the Corporate Compliance Plan.

For additional information see the following policies:
CHS-CCP-104: Training, Education and Affirmation Statements
HR-011-PC: Conduct Principles and Corrective Action

V. Human Resources

PURPOSE: The success and effectiveness of the Corporate Compliance Plan depends upon the extent to which associates understand and internalize its philosophy, objectives, and processes.

APPLIES TO: All Catholic Health System (CHS) associates.

POLICY: Human Resources' Policies shall address Corporate Compliance issues at the following times/intervals (1) the initial and continued employment/engagement of associates; (2) associate performance evaluations; (3) associate disciplinary actions; and, (4) employment termination.

All CHS personnel files will contain CHS Compliance Program requirements related to background checks, job responsibilities, and education

PROCEDURE:

1. Existing Human Resources' Policies and Procedures will be reviewed and new policies and procedures developed, where necessary, to accomplish the following:
    A. The Organization's employment application will specifically require the applicant to disclose any criminal conviction or any action to exclude, sanction or limit the individual with regard to any Medicare, Medicaid or other federally funded healthcare program.

    Associates will be entrusted to notify Human Resources and the Compliance Office should they become excluded, sanctioned or limited in participation in any federally funded healthcare program once hired by the Catholic Health System.

    Standard employment reference checks will be performed. Also, prior to employment being offered to any associate, the Organization will include a check of the Office of Inspector General's List of Excluded Individuals/Entities, the System for Award Management (SAM), and NYS OMIG list of excluded individuals.

    Additionally, as required by organization specific regulations, the New York State Nurse Aide Registry of Sanctioned Findings or Convictions, the New York State Education Department Office of Professional Licensing Verification and other licensing/certification bodies will be contacted to verify credentials of the applicant.

    B. The sanction lists identified in 1A. above will be checked on a regular monthly basis for existing associates.

    C. Employment of an individual who has been recently convicted of a criminal offense related to health care or who is listed as debarred, excluded, sanctioned, or otherwise ineligible for participation in federal health care programs and/or NYS Medicare Program will be prohibited.

    Pending the resolution of any criminal charges related to health care against an associate or proposed debarment or exclusion from participation in federally funded health care programs and/or NYS Medicare Program, the associate, will be removed from direct responsibility for or involvement in any federally funded health care and/or NYS Medicare Program.

    D. Attendance and participation by associates, in Corporate Compliance related education and training sessions is a condition of continued employment. At a minimum, this includes initial orientation to the organization, and mandatory annual policy review.

2. Promotion of and adherence to Corporate Compliance policies and other requirements is incorporated into each job description and is a factor in the performance evaluations of all associates including supervisors and managers.

    In addition, all managers and supervisors will:
    - Discuss with all supervised associates and relevant contractors the compliance policies and legal requirements applicable to their function;

- Inform all supervised personnel that strict compliance with these policies and requirements is a condition of employment; and
- Disclose to all supervised personnel that the organization will take disciplinary action up to and including termination for violation of these policy requirements.

3. The range of disciplinary actions that may be imposed upon associates for failing to comply with the Catholic Health System's Standards of Conduct, the Corporate Compliance Plan, policies and procedures related to compliance issues, and applicable laws and regulations will be specified in writing. The disciplinary policy will be publicized on M-files, through the Human Resources Department and other appropriate means, and will include the following:

    A. Significant disciplinary action for reckless or intentional noncompliance.

    B. Disciplinary action for supervisors or managers who fail to adequately instruct subordinates on Corporate compliance obligations; fail to detect violations and/or noncompliance with applicable policies and legal requirements which, with reasonable diligence, would have led to discovery of any problem or violation or fail to take corrective action upon discovery of a violation. (see policy CHS HR-011-PC Conduct and Corrective Action)

4. Upon hire and annually thereafter, associates are required to attest indicating that they understand and agree with the compliance requirements and recognize their responsibility to remain knowledgeable about compliance standards.

5. Upon termination of employment, voluntary or otherwise, a Human Resources Administrator or designee will endeavor to schedule an exit interview which will include questions to assess whether or not the exiting associate has any knowledge of lack of compliance within the Catholic Health System.

VI. Compliance Reporting

PURPOSE: The Catholic Health System's constituents and others have an ethical duty to report any violations or possible violations of the Organization's Code of Ethics, Code of Conduct, policies and procedures or Federal and State laws and regulations.

Non-Retaliation for Reporting Concerns: Catholic Health System (CHS) protects its associates from adverse action when they do the right thing and report a genuine concern. Therefore, no one at any level of the organization is permitted to engage in retaliation or any form of harassment against an associate, physician, trustee, or volunteer contractor or agent reporting such a concern.

CHS is firmly committed and encourages timely disclosure of such concerns. Action directed against an associate, physician, trustee or volunteer for making a good faith report of their concerns are prohibited.

For additional information see the following policies:
CHS-CCP-106: Compliance Reporting
CHS-CCP-106A: Non-Retaliation & Non-Intimidation
HR-011-PC: Conduct Principles and Corrective Action

VII. Prevention and Enforcement

PURPOSE: A proactive approach of prevention is a key component of the CHS Compliance Program. Compliance educational materials are updated as new information becomes available and presented to associates at orientation, during annual compliance training, and on a timelier basis if determined by the situation. When preventative measures have not been adequate and alleged compliance concerns are raised then a reactive approach is taken.

Upon receipt of a complaint or other information (including audit results) which suggests the existence of conduct that may be in violation of compliance policies and applicable laws or regulations, an investigation shall be commenced as detailed in the Procedures for Prompt Investigation. (Policy CHS- CCP-108)

APPLIES TO: All Catholic Health System entities

POLICY: Internal investigations shall be promptly undertaken for the following reasons:

- To identify those situations in which the laws, rules and standards may not have been followed;
- To identify individuals who may have knowingly or inadvertently caused claims to be submitted or processed in a manner which violated laws, rules, or standards;
- To implement those procedures necessary to insure future compliance;
- To protect the Organization in the event of civil or criminal enforcement actions; and,
- To preserve and protect the Catholic Health System's assets.

The Corporate Compliance Committee will review investigations on an ongoing basis to assure that actions are appropriate and to determine if any revisions to the Corporate Compliance plan are necessary.

The Chief Compliance Officer reports the results of the investigation as deemed appropriate to the President and CEO of the Catholic Health System, to the Catholic Health System Board, the Audit Committee, the Compliance Committee or other appropriate committees. Appropriate feedback is also provided to any party reporting violations, in good faith, whenever possible, as determined by the Chief Compliance Officer.

PROCEDURE: All reports received, whether by managerial associates of the Catholic Health System's business unit or directly through the Compliance Line, counsel or internal audit shall be forwarded to the Chief Compliance Officer who prepares a Compliance Report Form. Through the assistance of counsel, as deemed necessary, the Chief Compliance Officer will be responsible for directing the investigation of the alleged problem or incident. In undertaking this investigation, the Chief Compliance Officer may solicit the support of internal and external resources with knowledge, of the applicable laws and regulations and required policies, procedures or standards that relate to the specific problem in question.

1. **The Investigative Process:** Shall be commenced as detailed. When appropriate, Senior Management will be notified of the nature of the complaint. If necessary, counsel will be engaged prior to the start of the investigation. The investigation shall be commenced as soon as reasonably possible but in no event more than 14 days following the receipt of the complaint. (Refer also to Procedures for Prompt Investigation Policy CHS-CCP-108).
2. **Organizational Response to Potential Criminal Activity:** In the event the investigation reveals billing or other revelations of the law which constitute criminal activity and are the result of intentional or willfully indifferent conduct on the part of any associate or business unit, the Organization will immediately stop all billing related to the problem in the unit(s) where the problem exists until such time as the offending practices are corrected.

The Organization shall initiate appropriate disciplinary action against the person or persons whose conduct appears to have been intentional, willfully indifferent or with reckless disregard for Medicare, Medicaid and other applicable state and federal laws. Appropriate disciplinary action includes, at a minimum, the removal of the person from any position with oversight for or impact upon the claims submissions or billing process and may include, in addition, suspension, demotion, and discharge.

When only Medicaid is involved, the appropriate state agency and/or the state Attorney General is notified and the overpayment will be reported and returned, with explanation, to the Office of Medicaid Inspector General consistent with §363-d of the Social Services Law. In the event that Medicare and Medicaid Claims are involved, the Catholic Health System notifies the programs through the local United States Attorney's Office or the local office of the United States Department of Health and Human Services' Office of the Inspector General Division, as the Catholic Health System compliance counsel deems appropriate. The Organization, through its counsel, shall attempt to negotiate the terms of voluntary disclosure prior to the disclosure.

3. **Other Non-Compliance:** In the event the investigation reveals billing or other problems which do not appear to be the result of conduct which is intentional, willfully indifferent, or with reckless disregard for Medicare and Medicaid laws, the Catholic Health System nevertheless will undertake the steps as outlined in the Procedure for Prompt Investigation (CHS-CCP-108). This procedure includes actions to be undertaken in the event the problem results in duplicate payments by Medicare or Medicaid, or payments for services not rendered or provided other than as claimed.

4. **Discipline:** Associates shall be subject to discipline for failing to participate in organizational compliance efforts, including but not limited to:
   a. The failure of an associate to perform any obligation required of the associate related to the Compliance Program or applicable laws or regulations;
   b. The failure to report suspected violations of Compliance Program requirements and other laws or regulations to an appropriate person; and
   c. The failure on the part of a supervisory or managerial associate to implement and maintain policies and procedures reasonably necessary to ensure compliance with the terms of the program or applicable laws and regulations;

Disciplinary actions shall be appropriately structured to reinforce compliance principles, be corrective in nature while recognizing the need to protect the organization. Disciplinary action shall follow the Catholic Health System's existing associate policies and procedures. (Refer to policy CHS-HR-011 PC "Conduct Principles and Corrective Action").

VIII. Procedures For Prompt Investigation

PURPOSE: To establish a process to address potential or actual violations and to report to the appropriate governmental agencies violations of laws or regulations requiring the return of prior payments to the government.

The NYS mandated Compliance Programs requires a system for responding to compliance issues as they arise to include identifying, reporting compliance issues to DOH and OMIG and refunding overpayments. PPACA requires the mandatory reporting, repayment and explanation of overpayments. Also, retention of overpayments by more than 60 days can trigger a potential false claim.

The Catholic Health System (CHS) will immediately investigate all reports that a Catholic Health System practice has not been, is not, or may not be in compliance with a statute or regulation (a "potential non- compliance issue").

For additional information see the following policies:

CHS-CCP-108: Compliance Program Procedures for Prompt Investigation
CHS-CCP-108A: Critical Events Required Communications (Non-Clinical)
CHS-CCP-108-F01 Guidelines for Response to Reported Compliance Event/Issue

IX. Corrective Action Response Related to Identified Non-Compliance Matters

PURPOSE: In order for the Corporate Compliance Plan to effectively serve its purpose, reasonable steps will be taken to respond appropriately to any compliance offense or problem detected or reported and to prevent future similar offenses or problems.

For additional information see the following policies:

CHS-CCP-109: Corrective Action Response Related to Identified Non-Compliance
Matters HR-011-PC: Conduct Principles and Corrective Action

X. Auditing and Monitoring Compliance

PURPOSE: An integral part of the Compliance Program is monitoring the implementation and execution of the program. These audits and reviews examine the organization's compliance with specific rules and policies that have been the focus of particular attention on the part of the Medicare fiscal intermediaries or carriers, and law enforcement, as evidenced by OIG Special Fraud Alerts, OIG audits and evaluations and law enforcement's initiatives. Also, any areas of specific concern identified within the organization and those that were identified from outside of the organization will receive focused attention.

For additional information see policy:
CHS-CCP-110: Auditing and Monitoring Compliance

XI. Governmental Investigations

PURPOSE: To determine the correct course of action for a CHS associate to follow when contacted by a governmental agency to participate in a CHS work related governmental investigation.

For additional information see policy:
CHS-CCP-111: Governmental Investigations

XII. Confidentiality and Information Security

HIPAA Consent and Notice of Privacy Practice: Per the HIPAA Privacy Rule, a "covered entity" may generally disclose "protected health information" (PHI) to another covered entity for treatment, payment or health care operations (TPO) without consent (164.506(a), 164.506(c)). A covered entity may use or disclose PHI without an authorization or opportunity to agree or object to the extent that such use or disclosure is "required by law" (164.512(a), 164.501(Required by law)).

The NYS Public Health Law §17 is more stringent, pre-empting the Federal regulations and requires a written consent for treatment, payment or health operation (TPO) disclosures. Therefore upon entry into CHS for services, patients will be required to sign a consent for disclosure related to TPO and is part of the Consent and Financial Agreement.

Notice of Privacy Practice: The HIPAA Privacy Rule requires health plans and covered health care providers to develop and distribute a notice that provides a clear, user friendly explanation of individual's rights with respect to their personal health information and the privacy practices of health plans and health care providers. Per Privacy 01 policy-The System shall make accessible a copy of our Privacy Notice (Form #CHS-PRIV-01-F01) to each patient with a direct treatment relationship with the System and shall display, maintain and revise the Privacy Notice in accordance with State and Federal law.

PURPOSE: All persons authorized to have access to confidential (organizational, patient, associate) information are responsible for its security.

For additional information see the following policies:

CHS-CCP-112: Confidentiality and Information Security
CHS-PRIV-26: Storing and Safeguarding Medical Information
HR-011-PC: Conduct Principles and Corrective Action

XIII. Gifts, Gratuities and Discounts

PURPOSE: The purpose of this policy is to ensure compliance with all applicable federal and state laws and regulations affecting relationships with vendors, contractors and other third parties in order to promote sound business judgments.

For additional information see the following policies:

CHS-CCP-113: Gifts, Gratuities and Discounts
CHS-CCP-113A: Non-Monetary Compensation to Physicians and Immediate Family Members and Medical Staff Incidental Benefits

XIV. Fundraising and Contributions

PURPOSE: The Catholic Health System (CHS) preserves and protects its reputation for sound business practices and avoids the appearance of impropriety in all fundraising activities and acceptance of contributions. CHS, its constituents, and others are prohibited from undertaking fundraising activities, giving or accepting contributions or other things of value, directly or indirectly, that in any way may influence decision-making, or actions affecting services, or of influencing the judgment or decision- making process of any purchases, supplier, customer, governmental official, or other person.

For additional information see policy:
CHS-CCP-114: Fundraising and Contributions

XV. Tax-Exempt Status

PURPOSE: Catholic Health System (CHS) not for Profit entities have adopted policies and procedures to maintain tax exempt status

For additional information see policy:
CHS-CCP-115: Tax Exempt Status

XVI. Antitrust

PURPOSE: The Catholic Health System has adopted and distributed to its constituents, antitrust policies in order to help its constituents and others comply with the law.

For additional information see policy:
CHS-CCP-116: Antitrust

XVII. Records Management

PURPOSE: The purpose of this policy is to define the requirements for managing business records of Catholic Health. The goals of the records management process are to retain documents for only as long as they benefit the company and to comply with the requirements by law. This policy defines the requirement to establish and maintain a Record Retention Schedule. This policy further defines Catholic Health's records management process, including record media types, and use responsibilities.

For additional information see policy:
CHS-LS-005: Records Management

XIII. Contracting

PURPOSE: When entering into contractual agreements, the Catholic Health System will observe principles that will maintain the Organization's integrity in keeping with laws, rules and regulations of Medicare, Medicaid and other federally funded health care programs.

For additional information see policy:
CHS-CCP-119: Contracting

XIX. Medical Staff

PURPOSE: The success and effectiveness of the Corporate Compliance Plan in part depends upon the extent to which the medical staff understands and internalizes the Catholic Health System philosophy, objectives, and processes related to compliance. Compliance policies related to the medical staff shall address the following issues:

1. Sanctions under federally funded health care programs,
2. Mandated Office of Inspector General educational requirements, and
3. Rules and regulations related to physician arrangements and contracting.

For additional information see the following policies:

CHS-CCP-120: Medical Staff
CHS-CCP-119: Contracting
CHS-CCP-113A: Non-Monetary Compensation to Physicians and Immediate Family Members and Medical Staff Incidental Benefits

XX. Clinical

PURPOSE: The Catholic Health System is dedicated to providing appropriate, high quality care, and enhancing the patient experience to those we serve in the proper setting. Skilled and compassionate care throughout the term of treatment, recovery and/or maintenance is essential to ensure the best outcome for the people served.

For additional information see policy:
CHS-CCP-121: Clinical

XXI. Coding and Billing Principles

I. Introduction

CHS Coding and Billing principles apply to all coding and billing departments within all CHS Organizations. CHS Coding and Billing departments are responsible for ensuring that all clinically functional areas within each CHS organization are submitting claims in accordance with applicable statutes and regulations.

This section presents a set of guidelines designed to promote prevention, detection and resolution of instances of conduct that do not conform to federal and state law, and federal, state and private payor health care requirements as well as sound business policies.

CHS Coding and Billing departments will develop and distribute, as appropriate, written policies, standards and practices that identify specific coding and billing risks for all areas within the organization for which they are providing services.

II. Standards of Conduct

A. General

The organization's billing and coding policies set forth specific procedures for personnel to follow when submitting initial and follow-up claims to federal and NY State health care programs. The policies are designed to address issues that include but are not limited to:

- the education and training requirements for billing and coding personnel;
- the risk areas for fraud, waste and abuse;
- the methodology for resolving ambiguities in the organization's documentation

B. Policy and Procedure Development

In addition to the general policy addressed in this section, there are more specific policies and procedures adopted at the individual organization, department levels and by coding and billing departments.

Policies clearly delineate standards of conduct for all associates with regard to fraud, waste and abuse and the adherence to all statutes, regulations and other program requirements. (See CHS Corporate Compliance Plan, Section I, Standards of Conduct)

The coding and billing departments will consider prior history of noncompliance with applicable statutes, regulations and federal health care program requirements when developing standards and procedures to prevent avoidable recurrence.

Written policies and procedures concerning proper coding will reflect the current reimbursement principles set forth in applicable statutes, regulations and federal, state or private payor health care program requirements and are developed in tandem with organizational standards. Furthermore, written policies and procedures will ensure that coding and billing are based on medical record documentation. Particular attention is paid to issues of appropriate diagnosis codes, DRG, HHRG or RUG-III coding, individual Medicare Part A or B claims and the use of patient discharge codes. Rejected claims pertaining to diagnosis and procedure codes will be reviewed to facilitate a reduction in similar errors.

Written policies and procedures will address the following risk areas:

- internal coding practices;
- "assumption" coding (coding a diagnosis or procedure without the supporting clinical documentation);
- alteration of documentation;
- coding without proper documentation of all physician and other professional services;
- billing for services provided by unqualified or unlicensed clinical personnel;
- availability of all necessary documentation at the time of coding; and
- employment of sanctioned individuals.

The policies will create a mechanism for the billing or reimbursement staff to communicate effectively and accurately with the patient care and other support departments within CHS organizations.

The organization's billing and coding policies set forth specific procedures for personnel to follow when submitting initial and follow-up claims to federal health care programs. The policies are designed to address issues that include but are not limited to:

- the education and training requirements for billing and coding personnel;
- the risk areas for fraud, waste and abuse;
- the integrity of the organization's information system;
- the methodology for resolving ambiguities in the organization's paperwork;
- the procedure for identifying and reporting credit balances; and
- the procedure to ensure duplicate bills are not submitted in an attempt to gain duplicate payment.

The organization's policies and procedures describe the steps that are required in reviewing a billing document. Specific attention is placed on the proper steps a coder should take if unable to locate a code for a documented diagnosis or procedure or if the medical record documentation does not sufficiently identify a diagnosis or procedure.

Written policies and procedures will also address risk areas.

III. Specific Coding and Billing Risk Areas

A. Among the coding and billing risk areas identified by the OIG and OMIG as particularly problematic are:

- billing for items or services not rendered, not provided as claimed or not adequately documented;
- submitting claims for equipment, medical supplies and services that are not reasonable and medically necessary
- unbundling (the practice of using separate billing codes for services that have an aggregate billing code);
- billing for non-covered services as if covered;
- upcoding the level of services provided, including DRG/HHRG/RUG creep (using billing codes that provide higher reimbursement rates than the billing codes that actually reflect the service furnished to the patient);
- inappropriate balance billing;
- inadequate resolution of overpayments- credit balances;
- lack of integrity in computer systems;
- computer software programs that encourage billing personnel to enter data in fields indicating services were rendered though not actually performed or documented;
- failure to maintain the confidentiality of information/records;
- knowing misuse of provider identification numbers, which results in improper billing;
- improper claims for "pass through" drugs, outlier payments, provider based services and "same day" readmissions;
- billing for outpatient services rendered in connection with inpatient stays;
- duplicate billing in an attempt to gain duplicate payment;
- failure to properly use coding modifiers;
- clustering (coding/charging) one or two middle level service codes exclusively under the philosophy that some will be higher, some lower, and the charges will average out over an extended period;

- billing/coding incentives that violate the anti-kickback statute or other similar federal or state statute or regulation;
- routine waiver of co-payments and billing third-party insurance only;
- improper discounts and professional courtesy;
- ordered services;
- medical necessity;
- quality of care;
- governance;
- mandatory reporting;
- credentialing;
- contractor, subcontractor, agent or independent contract oversight; and,
- other risk areas that are or should reasonably be identified by the provider through its organizational experience.

B. Claim Development and Submission Process

The coding and billing policies and procedures to help support the objectives are as follows:

- ensure that proper and timely documentation of all physician and other professional services are obtained prior to billing to ensure that only accurate, medically necessary, and properly documented services are billed;
- emphasize that claims will be submitted only when appropriate documentation supports the claims and only when such documentation is maintained, appropriately organized in legible form and available for audit and review;
- the diagnosis and procedures reported on the reimbursement claim will be based on the medical record and other documentation, and that the documentation necessary for accurate code assignment should be available to coding staff at the time of coding. Codes used by the coding staff will accurately describe the service rendered that was ordered by the physician;
- compensation for coding and billing personnel does not provide any financial incentive to improperly upcode claims;
- ongoing monitoring for pre- and post-submission review of claims to ensure claims submitted for reimbursement accurately represent services provided, are supported by sufficient documentation and are in conformity with any applicable coverage criteria for reimbursement;
- clarification is obtained from the originating service/department/provider when documentation is confusing or lacking adequate justification; and
- mechanisms are established to provide feedback to the appropriate departments or service areas of rejected claims for the purpose of facilitating performance improvement opportunities.
- Established procedures provide access to medical experts when necessary to assist coding staff with clinical issues.

C. Credit Balances

Credit balances occur when payments, allowances or charge reversals posted to an account exceed the charges to the account. Policies and procedures will assign responsibility and address timely and appropriate identification and resolution of these overpayments. A complete audit trail of all credit balances will be maintained. Responsibility for the tracking, recording and reporting of credit balances has been specifically delegated.

D. Data System Integrity

Procedures have been developed for maintaining the integrity of the data collection systems. This includes procedures for regularly backing-up data to ensure the accuracy of all data collected in connection with submission of claims and reporting of credit balances.

At all times, a complete and accurate audit trail is maintained. Electronic data are protected against unauthorized access, contamination or disclosure. New computer and software systems that impact coding, billing or the generation or transmission of information related to federal health care programs or their beneficiaries will undergo thorough assessment.

E. Training and Education

In addition, to general compliance education upon hire and annually thereafter, CHS coding and billing personnel, and providers will receive specific training in the identified risk areas of the organization. This training will include but will not be limited to, such topics as:

- specific Government and private payor reimbursement principles;
- general prohibitions on paying or receiving remuneration to induce referrals;
- proper selection and sequencing of diagnoses;
- improper alterations to documentation;
- submitting a claim for physician services when rendered by a non-physician practitioner (NPP) *(i.e.*, the "incident to" rule and the physician physical presence requirement);
- proper documentation of services rendered, including the correct application of official coding rules and guidelines;
- signing a form for a physician without the physician's authorization; and
- duty to report misconduct.

Coding personnel will receive ongoing training on the updated codes for the current year. The coding and billing departments will emphasize the importance of safeguarding the confidentiality of medical, financial and other personal information. Compliance issues will remain at the forefront of the organization's educational and training priorities.

F. Auditing and Monitoring

A process of evaluation to assess the compliance risks of coding and billing functions within the organization has been developed and implemented to include ongoing auditing and monitoring of compliance matters. At a minimum, these audits address compliance with laws governing kickback arrangements, coding practices, claims submissions and reimbursement.

In addition, these audits and reviews examine the organization's compliance with specific rules and policies that have been the focus of particular attention on the part of the Medicare fiscal intermediaries or carriers, and law enforcement, as evidenced by OIG Special Fraud Alerts, OIG audits and evaluations and law enforcement's initiatives. Also, any areas of specific concern identified within the organization and those that were identified from outside of the organization will receive focused attention.

If non-compliance is identified, prompt steps will be taken to correct the problem. For further details see Section X, Monitoring.

IV. Compliance with the False Claims Act

PURPOSE: It is the responsibility of the Catholic Health System (CHS) to ensure that mechanisms are implemented to prevent abusive and fraudulent billing practices. These practices have an adverse financial impact on the organization, third party payors, and the people served.

A. Compliance with the False Claims Act

PURPOSE: The Federal False Claims Act and the NYS False Claims Act make it a crime for any person organization to knowingly make a false record, file, or submit a false claim with the government for payment. "Knowing" means that the person or organization:

- Knows the record or claim is false, or
- Seeks payment while ignoring whether or not the record or claim is false, or
- Seeks payment recklessly without caring whether or not the record or claim is false.

Under certain circumstances, an inaccurate Medicare, Medicaid, VA, Federal Employee Health Plan or Worker's Compensation claim could become a False Claim. Examples of possible False Claims include someone knowingly billing Medicare or Medicaid for services that were not provided, or for services that were not ordered by a physician, or for services that were provided at sub-standard quality where the government would not pay. Penalties are severe for violating the False Claims Act.

The 2009 Fraud Enforcement and Recovery Act (FERA) imposed penalties on any person who knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government.

The Patient Protection and Affordable Care Act (PPACA) signed into law March 23, 2010 expanded the false claims rules. In PPACA violations of the Anti-Kickback Statute (AKS) may trigger "False" claims and states overpayments are to be returned within 60 days of discovery. A person who knows a false claim was filed for payment can file a lawsuit (Qui Tam action) on behalf of the government. PPACA impacts Qui tam relators in that it narrows the scope of what is considered public disclosure, and expands the definition of what can be considered an original source of incriminating information.

For additional information see the following policies:

CHS-CCP-122: Coding & Billing Principles
CHS-CCP-122A: Compliance with the False Claims Act

XXII. Discounts: Health Care Services

PURPOSE: Fraud and abuse laws prohibit hospitals and other health care providers from influencing referrals with financial incentives. This policy will provide a framework wherein the Catholic Health System may provide discounts, which will be in compliance with such regulations.

For additional information see the following policies:

CHS-CCP-123: Discount Program for CHS Medical Staff (Non-Employed) and Board Members (Inpatient and Outpatient Services)
CHS-CCP-123 F01: Medical Staff (Non-Employed) and Board Members Discount Form)

XXIII. Copyrights and Licensing

PURPOSE: The Catholic Health System through its Code of Conduct and Organization policies are compliant with copyright laws.

For additional information see policy:
CHS-CCP-124: Copyrights & Licensing

XXIV. Environment

PURPOSE: It is the expectation that Catholic Health System constituents be familiar with the environment, utilize resources appropriately and efficiently, and recycle where possible or otherwise dispose of waste in accordance with applicable laws and regulations.

APPLIES TO: All Catholic Health System constituents.

POLICY: It is the policy of the Catholic Health System to conduct operations in compliance with environmental laws and regulations. The Catholic Health System member organizations have established procedures to implement environmental policies. These procedures include but are not limited to handling and disposal of liquid, solid, hazardous, radioactive and infectious waste.

PROCEDURE: For further detail on Health, Safety and Environmental concerns see the Hazard Communication Program policy on M-files.

Catholic Health

Thank you for your attention to the Corporate Compliance Plan policies of the Catholic Health System.

If you have questions about the CHS Standards of Conduct or Compliance policies contact:

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144 Genesee Street, Buffalo, NY 14203
Phone: (716) 821-4471 | Fax: (716) 821-4460
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--OR--

Call the Compliance Line toll free 24 hours a day, 7 days a week at:

1-888-200-5380

--OR--

Visit online at
https://www.mycompliancereport.com
Access ID: CTH

All reporting is confidential and the person may remain anonymous, if desired.

More information on Catholic Health programs and services is available by calling (716) 447-6205 or visiting chsbuffalo.org

Published April 1999 * Revised November 2000 * Revised November 2001 * Revised November 2004 Revised 2009, 2011, 2013, November 2014, November 2016, November 2017, May 2018, August 2018, August 2019, August 2020, August 2021, August 2022. Revised March 2023, August 2023, November 2023, October 2025.

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