Corporate Compliance Program

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Samaritan is committed and obligated to comply with all applicable federal and state standards.

The purpose of our Compliance Program is For **EVERYONE TO WORK TOGETHER** to help Samaritan abide by federal and state laws, rules, regulations, and standards of ethical organizational conduct.

Having a proactive, effective program helps us avoid fraud, waste, abuse, and discrimination that could put the organization at risk.

Corporate Compliance Program

Applicability:

The Program applies to employees, medical staff, volunteers, executives, students, interns, vendors, agents, independent contractors and members of the Board of Trustees throughout Samaritan, which includes:

- Samaritan Medical Center
- Samaritan Clinics
- Samaritan Keep Home
- Samaritan Medical Practice
- Samaritan Summit Village
- Samaritan Home Health

All persons affected by Samaritan's risk areas, including employees, the chief executive officer and other senior administrators, managers, and contractors, agents, subcontractors, independent contractors (collectively "Contractors") , and governing body and corporate officers of Samaritan are considered Affected Individuals.

Regulators:

Federal and NYS Laws and Regulations make it mandatory for **ALL** health care facilities that provide care to any patients paying in full or in part with federal or state healthcare dollars to have an active and effective compliance program.

Compliance Code of Conduct

***S*afeguard resources**

- Protect the assets of the organization

***A*ppropriately** retain, authenticate, & destroy documents/records

***M*aintain confidentiality** Keep all patient info confidential

***A*void conflicts of interest**

***R*eport possible violations**

- SEE SOMETHING SAY SOMETHING.

***I*ntegrity of billing and payer relationships**

- All patient records, financial records, timesheets, and other business records must be accurate and truthful. You must not alter/falsify information on any record.

***T*rain and educate**

- Training is required initially and annually

***A*void inappropriate acceptance of gifts**

***N*on-compliant acts may result in progressive discipline or other corrective action**

- Never participate in unethical or illegal conduct. Act in an ethical and honest manner.

All Affected Individuals are expected to act consistent with our code of conduct, policies & procedures.

Elements of an Effective Corporate Compliance (CC) Program

Required by Office Inspector General **('OIG')** and Office of Medicaid Inspector General **('OMIG'):**

Policies & Procedures	Compliance Officer & Compliance Comittee	Effective Communication	Internal Auditing & Monitoring	Responding to Issues/ Investigations	Corrective Actions/ Discipline	Non-intimidation and Non-retaliation

Element 1
Establish Written Policies/Procedures

Our policies and procedures provide guidance and are based on regulations + Samaritan's requirements.

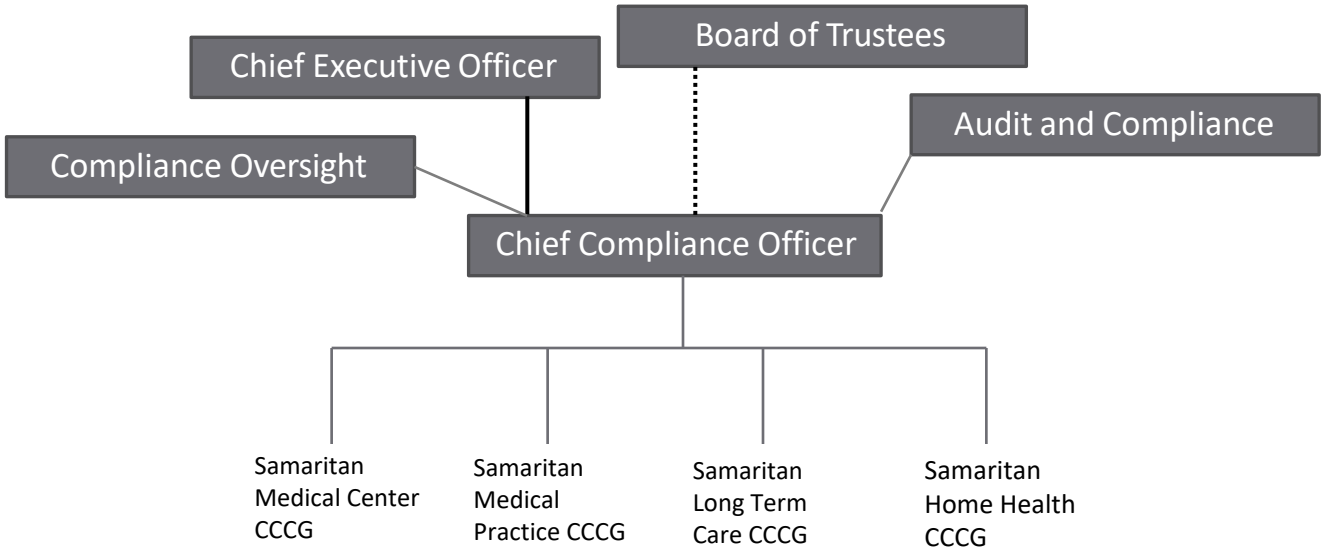
Policies and Procedures are on Samaritan's Intranet (Heartbeat) page. You're responsible to review and follow them. Compliance Policies are also accessible on Samaritan's website: https://samaritanhealth.com/corporate-compliance/

Element 2
Chief Compliance Officer (CCO) & Oversight

The CCO is responsible for day-to-day operations and oversight of the Compliance Program, and reports to the Chief Executive Officer with a dotted-line report to the Board.

Each facility has a Corporate Compliance Core Group (CCCG)-they submit reports related to their Work Plan quarterly.

Compliance Officer Reporting Tier



The Audit and Compliance Committee assists the Board with oversight, by monitoring the accounting and financial policies, controls, and processes of the organization. It also assists the Board in assuring the integrity of financial accounts of the organization in a manner consistent with its charitable mission & purposes.

Element 3
Effective Lines of Communication

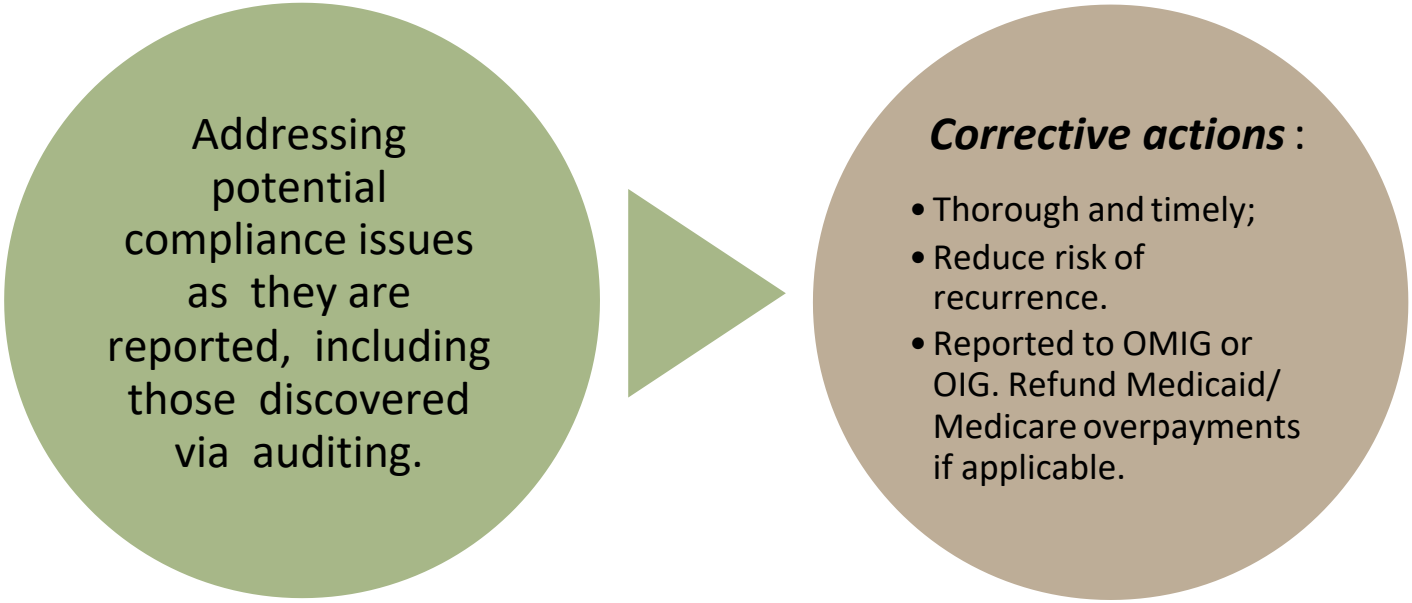
Reports are confidential to as reasonably possible or permissible by law.
Ways to report:

- Compliance Hotline (anonymous option)
- Online submission form, linked here
- Safety Zone
- Email
- Phone
- Face to Face

Element 4
Training & Education

- Required Initially and annually.
- Targeted training provided if/when needed
- Compliance & Ethics Week *(November)*
- Daily briefing

Element 5
Auditing and Monitoring



Auditing and Monitoring

Audits & Monitoring to identify risk areas

Compliance program MUST apply to risk areas. These are areas of operation affected by the Compliance Program and apply to at least: Billings, payments, ordered services, medical necessity, quality of care, governance, mandatory reporting, credentialing, contractor/ subcontractor/agent or independent contract oversight; and other risk areas reasonably identified by Samaritan through its organizational experience.

Monitoring Examples

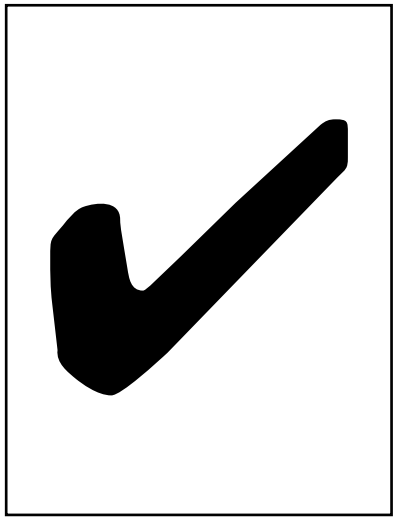
Walkthrough audits

Review of medical record audit trails

Auditing Examples

Review of OIG and OMIG work plan

items Facility wide Risk Assessment



Results of risk assessments help determine what will be monitored the upcoming year on the work plan. The Work Plan is flexible.

#6 Investigation & response

The Chief Compliance Officer (CCO) or his/her designee will promptly respond and investigate compliance issues that are raised.

CCO may work with the appropriate leader/dept. to investigate a concern.

Investigations conducted by Compliance are documented via a standard report format. Investigations include a review of all relevant evidence (Ex. data, interviews, etc)

Corrective actions :

- Thorough, timely;
- Reduce risk of recurrence.
- Reported to OMIG or OIG. Refund overpayments if applicable.
- Corrective Action Plans: Implemented by Leadership to avoid recurrence of an issue. These involve a review of the cause of the issue, making initial corrections, developing a plan to prevent recurrence taking into consideration of the source of the problem, identifying person(s) responsible, and the date for completion.

#8 - Disciplinary Policies

Failure to comply with policies, procedures, code of conduct, or laws/regulations will result in disciplinary action. Our Corrective Action Policy/Procedure outlines the process.

Discipline is escalated based on circumstances of the violation.

Intentional/reckless behavior is subject to more significant discipline.

For contracted personnel, see contract terms. Non-compliance may result in Samaritan discontinuing its relationship with the violator and terminating the Agreement with the Vendor.

- Applicable federal & state regulations;
- Applicable Samaritan policies and procedures;
- Report suspected fraud/ abuse
- Participate in investigations;
- Engage in compliant & ethical behavior;
- Attend required trainings; and
- Assist in resolution of issues

Violations of blatant disregard, reckless behavior, or with malicious intent:

- could be terminated immediately

Element 7 - Policy of Non-Retaliation

'Good Faith' means you are reporting the incident as you believe it occurred and not knowingly misrepresenting information.

- If you suspect or have knowledge of misconduct, including any activity, policy or practice that you reasonably believe does or may cause fraud, waste and abuse, or violate any Laws or Samaritan's policies and procedures, including the Compliance Plan or the Code of Conduct, you have an obligation to promptly report, in good faith, such activities with full confidence that they will not be subject to any form of retaliation or retribution from Samaritan or it's representatives. Intimidation or retaliation is a violation of Samaritan policy and its Compliance Program and will not be tolerated.

- You will not be subject to intimidation or retaliation by any person affiliated with Samaritan based on reports that you reasonably believe to be true, submitted in good faith.

- Refer to the Non-Retaliation Policy, found here: **https://samaritanhealth.com/corporate-compliance/**

- False Claims Act (FCA) Whistleblower or "Qui Tam" Provision: In order to encourage individuals to come forward and report misconduct involving false claims, the FCA also permits private persons to bring suit on behalf of the United States and entitles the private persons bringing suit to receive a percentage of monies obtained through settlements, penalties and/or fines collected in such action. Actions brought by private persons, or "relators" for violations of the FCA are known as "qui tam" actions. If a qui tam action brought by a relator is frivolous or commenced in order to harass the defendant, the relator may be liable to pay defendant's associated fees & costs.

- Relief may include reinstatement with the same seniority status the employee would have enjoyed but for the discrimination; two times the amount of back pay; interest on back pay; and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorney's fees

References: NYS Labor Law Sections 740 and 741; Federal and NYS False Claims Act

Follow our 'Acceptance and or Solicitation of Gifts and Benefits' Policy

X **MEALS PROVIDED BY VENDORS** with no educational/legitimate business component **ARE PROHIBITED.**

X **NEVER** accept gifts **IN EXCHANGE FOR** prescribing/providing products, services/drugs, or intended to generate business. **NO GIFTS** accepted **IF THERE'S STRINGS ATTACHED**

X **NO GIFTS TO GOVERNMENT EMPLOYEES**/officials.

X Business courtesies that could influence conducting your duties must be declined. Providers have additional guidelines they need to follow in the policy.

X You're **NOT** to **GIVE GIFTS TO PATIENTS**. This implicates Civil Monetary Penalties Law, Anti-Kickback, and ACO requirements.

X You're **NOT** to **ACCEPT GIFTS FROM A PATIENT**/resident/family EXCEPT:

- ✓ Those that are perishable items of nominal value given occasionally & shared amongst staff

✓ **OK to** accept gifts from a **VENDOR, if it:**

1. has no intent to induce/reward referrals or purchase of health care items/services; and,
2. Has a bona fide educational purpose; and
3. Is not in the form of cash/cash equivalent; and
4. Does not exceed $100 per-person per-day and cannot exceed $300 total in a year.

Full policy linked here

Fraud, Waste, and Abuse

FRAUD means an intentional deception or misrepresentation made with the knowledge that the deception could result in an unauthorized benefit to the provider or another person

Examples of Fraud:

- Billing ins. for appointments the patient failed to keep;
- Knowingly billing for services at a complexity level higher than provided **or** documented (**upcoding**);
- Knowingly billing for services/supplies not furnished, including falsifying records to show delivery
- Paying for referrals ("**kickbacks**").

Fraud, Waste, and Abuse

Waste is overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to health care programs, such as Medicare and Medicaid.

Examples:

Ordering excessive lab tests when only 1 test is needed.	A prescription for a brand name drug when a generic drug equally effective is available.

Fraud, Waste, and Abuse

Abuse:

Abuse means practices that are inconsistent with sound fiscal, business, medical or professional practices and which result in unnecessary costs to the medical assistance program, payments for services which were not medically necessary, or payments for services which fail to meet recognized standards for health care.

Examples of Abuse:

- Billing for unnecessary medical services
- Charging excessively for services/supplies
- Misusing codes on a claim. Ex. upcoding or unbundling

False Claims Act (FCA)

To deter fraud, waste, and abuse.

Care must be **MEDICALLY NECESSARY**, appropriate, safe and **SUPPORTED BY ACCURATE DOCUMENTATION**.

Those involved in the service, must have proper credentials, registration, skills & competency. If your credentials are in jeopardy, immediately notify Samaritan's Chief Compliance Officer.

Examples of False Claims include billing for services:

- Not provided
- Provided by an unqualified person (Ex. outside of scope, unlicensed, etc.)
- Billed in a manner other than actually provided

Stark Law

Stark Law prohibits a physician from referring Medicare/Medicaid patients for "designated health services" to an entity with which the physician (or an immediate family member) has a financial relationship, unless an exception applies.

A financial relationship means a direct or indirect ownership or investment interest or a compensation arrangement between an entity and a physician/ immediate family member. The Stark Law also prohibits the entity furnishing the designated health services (for example, SMC) from submitting claims to Medicare/Medicaid for those services resulting from a prohibited referral.

Stark is a civil law.

The government does not need to show that a party intended to violate the law for sanctions to be imposed. Potential sanctions include repayment, civil penalties, fines, and program exclusion.

Anti-Kickback Statute (AKS)

AKS makes it a crime to knowingly offer, pay, be involved in, or receive anything of value directly or indirectly to induce or reward referrals of items or services reimbursable by a Federal health care programs (including Medicare and Medicaid).

Examples of prohibited kickbacks:

- receiving and being a part of extravagant trips or dinners associated with drug and/or supply companies you do business with,
- receiving financial incentives for referrals,
- free or very low rent for office space,
- excessive compensation for medical directorships,
- waving copayments, either routinely or on a selective case-by-case basis.

Possible penalties for violating AKS: fines of up to $25,000, jail time, and exclusion from Medicare & Medicaid care program business.

Program Exclusion

Office of Inspector General oversees federal healthcare regulations, and

Office of Medicaid Inspector General oversees state healthcare regulations.

Exclusion lists include individuals/entities not allowed to care for directly/indirectly any patients paying in full/part with federal or state healthcare program $. E.g. Medicare, Medicaid, Tricare, etc.

On list for at least 5yrs; reinstatement is not automatic.

Program Exclusion Authority

Reasons for exclusions:

- Fraud or other health-care related misconduct
- Patient abuse/neglect
- Convictions for unlawful distribution, prescription, dispensing of controlled substances
- Suspension, revocation, or surrender of a license related to professional competence/ performance, or financial integrity
- Providing unnecessary or substandard services
- Engaging in unlawful kickback arrangements
- Defaulting on health education loans

You may not provide services paid for by government health care programs such as Medicare/Medicaid if disqualified or excluded.

You must immediately report any exclusion to the Compliance Officer.

In the news…

- **CEO & 4 Physicians Charged in Connection with $200 Million Health Care Fraud Scheme Involving UNNECESSARY PRESCRIPTIONS OF CONTROLLED SUBSTANCES and Harmful Injections**

- **NY doctor sentenced to 4 years in prison FOR TAKING BRIBES In test-referral Scheme With NJ Clinical Lab**

- **$114 Million Judgement against 3 Individuals for PAYING KICKBACKS for Lab referrals and medically unnecessary Tests**

Accountable Care Organization (ACO) & Medicare Shared Savings Program (MSSP)

ACOs are groups of doctors, hospitals, and other health providers, who come together to give coordinated high quality care to Medicare Fee for service patients.

The goal is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services.

MSSP –Rewards ACOs that lower their growth in health care costs &meet performance standards. Can share a portion of the savings. Samaritan Medical Center and Samaritan Medical Practice participate in an ACO.

RETENTION - We must maintain ACO records for at least 10 years from the ACO agreement/or an audit (whichever is later) unless a longer period applies

- We can't avoid 'at risk' beneficiaries.

ACO

We're prohibited from:

(1) PROVIDING INDUCEMENTS TO BENEFICIARIES

- Can not provide gifts or other remuneration to induce patients to remain in the MSSP ACO or to continue receiving items or services from the ACO. Remuneration may include anything of value, whether cash or in-kind, and may be provided directly or indirectly.

•**(2**) **CONDITIONING PARTICIPATION** on referrals of Federal health care program business that the ACO, its ACO participants, ACO providers/suppliers or others performing functions related to the ACO know or should know is being/would be provided to beneficiaries who are not assigned to ACO and

•**(3) REQUIRING THAT PATIENTS BE REFERRED ONLY TO ACO** participants or ACO providers/suppliers within the ACO or others, except for referrals made by employees/contractors operating within scope of employment or contractual arrangements, provided employees and contractors remain free to make referrals without restriction or limitation if the beneficiary expresses a preference for a different provider, practitioner, or supplier; the beneficiary's insurer determines the provider, practitioner, or supplier; or the referral is not in patient's best medical interests.

ACO-specific Compliance violations: Report to ACO Compliance Officer LeeAnn Hastings 916-542-4686 lhastings@signifyhealth.com. Anonymous option: 844-232-8709 location "ACO" or www.signifyhealth.ethicspoint.com

Government investigations

If approached by an investigator government agent, refer to our “Response to Government Investigations Policy.”

Brandi Husenitza,
Compliance Officer
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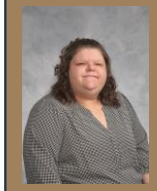

Ruth Strickland,
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(315) 779-6695

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www.SamaritanHealth.com/Corporate-Compliance

confidential or anonymous

Hotline: 315-779-5170
or 877-740-7070

Do the right thing.

REPORT SUSPICIONS OR CONCERNS.

CONTACT COMPLIANCE WITH YOUR QUESTIONS OR CONCERNS.