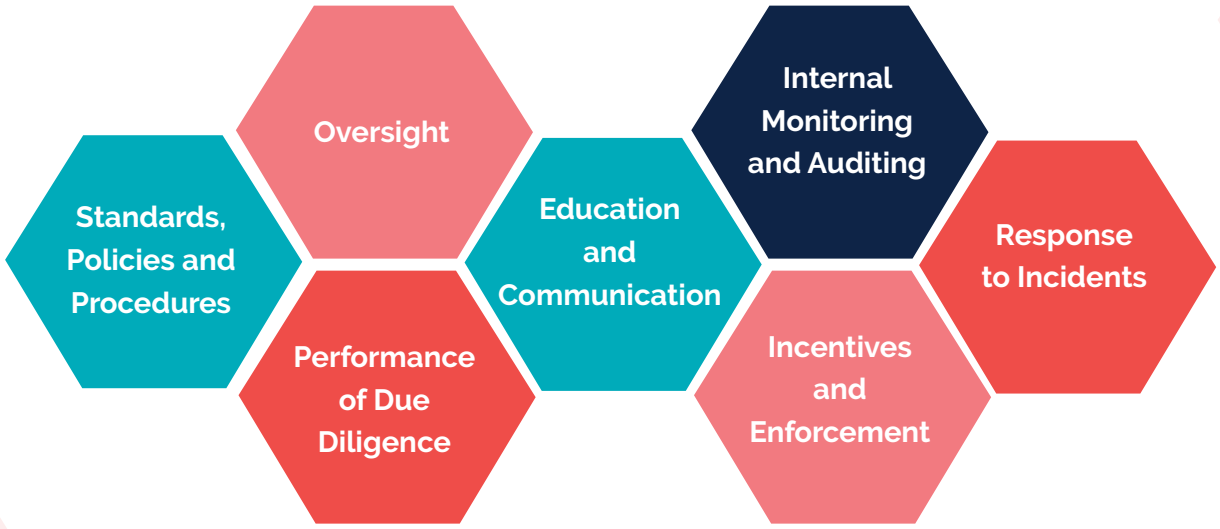
EHS
Episcopal Health Services

2024 - 2025

Episcopal Health Services Inc.

COMPLIANCE PLAN



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Episcopal Health Services

Episcopal Health Services Inc. Compliance Program

OVERVIEW

Episcopal Health Services, Inc. ("EHS") is committed to fostering a culture of compliant and ethical conduct that includes the prevention, detection, and remediation of actions or behaviors that fail to comply with applicable law, ethical standards, and/or policies and procedures.

EHS is subject to federal and New York State ("NYS") laws, regulations, and guidelines that require it to implement an effective compliance program as a condition of payment for care, services, items, or supplies, including eligibility to submit claims. These obligations include, but are not limited to: NYS' Public Health Law, Mental Hygiene Law, Social Services Law § 363-d with compliance program regulations codified at 18 NYCRR, Part 521, and state guidance from the NYS Office of the Medicaid Inspector General ("OMIG"), as well as federal guidance from the U.S. Sentencing Commission Guidelines ("USSG") Manual, the U.S. Department of Health and Human Services Office of Inspector General ("OIG"), and the Centers for Medicare and Medicaid Services ("CMS"). Annually, EHS certifies to NYS that it maintains an effective Compliance Program.

EHS' Compliance Program focuses on:

- Preventing, detecting, and deterring healthcare fraud, waste, and abuse, and illegal conduct;
- Promoting an environment that encourages ethical conduct, as well as compliance with laws and regulations;
- Developing and maintaining practices that promote the privacy of health and business information; and
- Creating and enforcing policies and procedures that describe the implementation of the Compliance Program and processes for addressing potential non-compliance.

The scope of the Compliance Program includes all EHS employees, medical staff, volunteers, students, trainees, and agency staff (collectively "Personnel"), as well as members of the EHS Board of Trustees, businesses, contractors, subcontractors, independent contractors, affiliates, entities, vendors, agents, and all other individuals associated with EHS regardless of employment, contractual, or affiliation relationship with EHS (collectively "Covered Persons").

The Compliance Program works in collaboration with all lines of business at EHS, as well as with outside regulatory entities, such as OMIG, NYS Department of Health, NYS Office of Mental Health, NYS Attorney General's Office ("AG") and its Medicaid Fraud Control Unit ("MFCU"), OIG, CMS, U.S. Department of Health and Human Services Office for Civil Rights ("OCR"), and Federal Department of Justice ("DOJ").

Compliance Plan

The Compliance Plan is a fundamental component of EHS' Compliance Program. Its purpose is to provide a guide for the development, implementation, and administration of policies, procedures, and operations that assist EHS in fulfilling its legal and regulatory obligations.

The Compliance Plan is designed to achieve the following objectives:

- Establish an administrative framework for conducting an effective and diligent compliance effort, including addressing plans to meet the required federal and state elements of an effective Compliance Program;
- Create effective communication channels to deliver EHS' commitment to ethical business practices and receive feedback regarding adherence to these practices;
- Outline a commitment to educate Covered Persons regarding compliance requirements and how to conduct their job activities in compliance with federal and state laws and according to the policies and procedures of the Compliance Plan;
- Provide an overview of monitoring and auditing functions to measure the effectiveness of the Compliance Plan and to address problems in an efficient and timely manner;
- Outline enforcement and disciplinary components that encourage all Covered Persons take their compliance responsibilities seriously; and
- Identify EHS' plan to minimize organizational compliance risks.

The Compliance Plan will be reviewed at least annually. The review process occurs in order to evaluate the effectiveness of the Compliance Program. It reflects on current practices and changes to demonstrate that services are monitored, delivered, and evaluated in accordance with the Compliance Program.

Compliance Program Administration & Oversight

RESPONSIBILITY OF THE COMPLIANCE OFFICER

EHS engages a Compliance Officer whose primary responsibility is the oversight of EHS compliance and privacy functions that include the following duties:

- Supervising and implementing the Compliance Program and coordination of all compliance efforts;
- Developing, implementing, revising and enforcing compliance and privacy policies and procedures

and reviewing such on an annual basis and as otherwise needed to conform to regulatory and operational changes;

- Providing Covered Persons with EHS' Code of Conduct, Compliance Plan, and access to any other written compliance and privacy policies and guidelines that are relevant to performing their functions;
- Establishing and maintaining a Compliance Committee, educating Compliance Committee members about their responsibilities, and generally overseeing the activities of the Compliance Committee;
- Developing, approving, and disseminating compliance and privacy training and education materials, as well as developing and annually reviewing a Compliance Training Plan designed to outline the topics, timing, applicability, and tracking of related compliance and privacy training activities;
- Working with EHS departments and key individuals in the oversight of appropriate provider credentialing and the quality and efficiency of services provided;
- Coordinating with departments, units, and programs to demonstrate that compliance is an integral part of performance assessment and assessments performed on contractors, subcontractors, independent contractors, vendors, or other third parties;
- Developing a system for federal and state exclusionary and sanction monitoring;
- Developing and disseminating communications that encourage active participation in the Compliance Program;
- Implementing anonymous and confidential mechanisms for reporting potential non-compliance and the oversight of compliance and privacy investigations;
- Identifying and assessing operational areas that present compliance risks, including susceptibility to fraud, waste, abuse, and overpayments, as well as prioritizing resources to mitigate and reduce those risks;
- Collaborating with various departments, units, and programs to coordinate and respond timely to governmental audits or inquiries; and
- Conducting an annual Compliance Program assessment, as required by applicable laws and regulations.

The Compliance Officer reports regularly and directly to the Chief Executive Officer and no less than quarterly to the EHS Board of Trustees.

Compliance Committee

EEHS has an operational Compliance Committee. The Compliance Committee meets quarterly or more frequently as required by specific circumstances. It is responsible for the following activities:

- Supporting the Compliance and Privacy Department in developing, monitoring, and assessing the Compliance Program;
- Providing mechanisms of communication among leadership and management, persons responsible for compliance functions, and the Board of Trustees;
- Periodically analyzing EHS' risk environment by identifying specific risk areas and developing a Compliance Work Plan to review and mitigate vulnerabilities;
- Assessing and revising compliance, privacy, and security policies and procedures to coordinate, advise, and demonstrate compliance with applicable laws, regulations, and contracts;
- Assisting key individuals in designing and coordinating internal and external compliance reviews and monitoring activities;
- Ensuring EHS' Compliance Officer is allocated sufficient funding and resources to be able to fully and effectively execute designated responsibilities;
- Developing and reviewing EHS' compliance training and education initiatives, including the annual training plan;
- Reviewing the effectiveness of internal controls, including the Compliance Committee Charter and Compliance Program, designed to demonstrate compliance with Medicare and Medicaid regulations in daily operations; and
- Analyzing reports and corrective actions resulting from internal and external audits or compliance investigations.

Compliance Committee member composition is an array of individuals from departments and functions that are considered instrumental to developing, implementing, and maintaining the compliance goals of EHS. Membership includes:

1. Executive administration:
   A. Chief Executive Officer;
   B. Chief Operating Officer
   C. Chief Financial Officer;
   D. Chief Nursing Officer;
   E. Chief Medical Officer;
   F. Chief Quality Officer; and
   G. Chief Information Officer; and

2. Administration and senior management level personnel from the following:
   A. Compliance and Privacy;
   B. Legal – General Counsel;
   C. Risk Management

D. Licensure & Accreditation;
E. Performance Improvement;
F. Information Technology and Services;
G. Health Information Management;
H. Patient Access;
I. Finance and Revenue Cycle Management;
J. People Operations;
K. Behavioral Health;
L. Ambulatory Services;
M. Oncology and Cardiology;
N. Pharmacy;
O. Managed Care; and
P. Subsidiary corporation or entity administration (ad hoc).

Board Oversight

As part of its governance oversight responsibilities, the EHS Board of Trustees is responsible for having knowledge of Compliance Program operations and resources. The Compliance and Privacy Department is appointed the day-to-day authority for the management of the Compliance Program and execution of the Compliance Plan. There is a direct reporting relationship between those responsible for the day-to-day operations of the Compliance Program and the Board of Trustees. The Board of Trustee by-laws recognize the importance of supporting an effective Compliance Program, as demonstrated by the adoption of certain policies and procedures, including the establishment of an EHS Compliance Committee.

Code of Conduct

EHS maintains a Code of Conduct that provides a summary of the expected standards and behaviors for all Covered Persons. The Code of Conduct articulates EHS' commitment to compliance by outlining the broad ethical and legal principles under which EHS operates. The Code of Conduct is a foundational document of the Compliance Program. It is provided to individuals upon initial employment or affiliation with EHS. The Code of Conduct is available to Personnel on the EHS intranet, as well as to Covered Persons and the public at large by visiting ***www.ehs.org*** and selecting "Compliance and Privacy".

Policies & Procedures

EHS maintains compliance and privacy policies that are designed to support Compliance Program operations, as well as compliance with applicable regulatory requirements. EHS complies with the Deficit Reduction Act of 2005 ("DRA"). This federal law requires that EHS provide its employees, agents, and contractors information about federal and state false claims laws and related statutes, the penalties for violating these laws, and the protections for whistleblowers that report potential fraud, waste, and abuse, including false claims and other types of non-compliance.

Covered Persons are encouraged to seek clarification of any compliance or privacy related policy or procedure by contacting the Compliance and Privacy Department. Questions and responses are evaluated and guidance provided to requestors. When appropriate, answers are shared with other Covered Persons so that policies are better understood and can be improved to reflect necessary regulatory or operational changes or clarifications. EHS policies are available to Personnel by accessing the EHS intranet.

Training & Education

General compliance training is provided to all new Personnel during their orientation or onboarding phase. Personnel receive information on the Compliance Program that covers the following topics and risk areas:

- Compliance Reporting mechanisms;
- Privacy and confidentiality, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as well as other applicable federal and state privacy laws;
- Code of Conduct;
- False claims and fraud, waste, and abuse;
- Organizational risk areas
- Enforcement and disciplinary standards for failure to comply; and
- Whistleblower and non-retaliation or intimidation protections.

Ongoing training on these topics is provided on an annual basis. General compliance and privacy training is also provided to contractors, vendors, and members of the Board of Trustees, and ICARE Foundation Advisory Committee through various means and mechanisms.

Supplemental, remedial, or targeted training and educations is performed on topics or issues that may present a heightened risk of non-compliance, particularly to those directly affected by the statutes, regulations, policies, procedures, and program guidelines for federal and state healthcare programs. Details related to compliance training and education are outlined in the Compliance Training Plan that is developed and revised annually.

Reporting Potential Non-Compliance

Covered Persons have an obligation to report or participate in the investigation of any known or suspected non-compliance. Non-compliance includes the following activities:

- Known or suspected misconduct, compliance, or non-compliance issues;
- Known or suspected violations of patient privacy or confidentiality;
- Known or suspected violations of any applicable law or regulation;
- Known or suspected violations of EHS' policies and procedures, the Code of Conduct, or the Compliance Program;
- Performing or participation in internal or external investigations, reviews, and audits;
- Cooperating with the implementing of remedial actions in response to noted compliance issues, deficiencies, or failures;
- Known or suspected fraud, waste, or abuse, including actions related to false claims or services that are medically unnecessary or constitute potential overpayments;
- Situations covered under Labor Law §§ 740 and 741, including violations that create and/or present a substantial and specific danger to public health or safety, or which constitute healthcare fraud, or when Personnel reasonably believe that situations constitute improper quality of patient care; and/or
- Situations covered under Labor Law § 218-b, including: workplace safety; reporting In Good Faith potential violations of this Labor Law or seeking intervention related to this Labor Law; or refusing to work in environments where Personnel reasonably believe that such work presents an unreasonable risk of exposure to disease due to the failure to maintain compliance with applicable laws or guidelines covering work conditions and disease prevention.

Covered Persons or other individuals or entities may report any suspected non-compliance or other issue outlined in this Compliance Plan, as follows:

- By phone at (718) 869-5711;
- By email at compliance@ehs.org;
- Via the 24/7 Confidential and Anonymous Compliance Hotline by calling 1-844-973-0162 or visiting www.ehs.ethicspoint.com; or
- By mail at Episcopal Health Services Inc., 327 Beach 19th Street, Far Rockaway, NY 11691. Attn: Compliance and Privacy.

Note: If you suspect Medicare fraud or that which involves a health plan, you can also contact the health plan sponsor directly or contact the OIG at 1-800-HHS-TIPS.

IThe Compliance Hotline ("Hotline") is owned and operated by an independent third-party company. Hotline representatives are not employed or otherwise affiliated with EHS. The Hotline uses both telephonic and online, web-based mechanisms for communication and reporting. Both mechanisms are accessible 24 hours a day, 7 days a week, 365 days a year.

All reports to the Compliance Hotline are confidential to the extent permissible under federal, New York State ("NYS"), or local law. A reporter's identity is confidential. It may be released or revealed only on a need-to-know basis or as required by law, including if the matter is subject to disciplinary proceedings or under investigation by the NYS AG, MFCU, OMIG, federal OIG, OCR, CMS, or other regulatory, law enforcement, or judicial authority.

Non-Retaliation or Intimidation

EHS strictly prohibits intimidation, harassment, or retaliation, in any form, against any individual or entity that "In Good Faith" participates in the EHS Compliance Program by reporting or participating in the investigation of any known or suspected violation of law, privacy, EHS policies and procedures, potential fraud, waste, abuse, or other non-compliance The Compliance and Privacy Department is responsible for the oversight of any investigation into allegations of retaliation. Any attempt to intimidate or retaliate against an individual or entity that participates in the EHS Compliance Program will result in action up to and including termination of employment, contractual, or other affiliation relationship with EHS.

Responding to Reports of Non-Compliance

The Compliance and Privacy Department has the discretion and authority to investigate queries, reports, problems, concerns, matters, complaints, and requests for guidance (collectively "Reports") of known or suspected Non-Compliance. Patient care related matters or those that involve an imminent threat to Personnel, patients, visitors, or the public will take priority. Reports of non-compliance that are received, referred, discovered, or otherwise obtained by the Compliance and Privacy Department will be assigned a case identification number and entered into the compliance reporting tracking system.

Compliance and Privacy Department representatives and others assisting with compliance or privacy investigations or reviews have an obligation to protect the integrity of the investigatory process. This includes:

- Maintaining a confidential process;
- Taking appropriate measures to limit the likelihood of retaliation or intimidation of Personnel or other individuals or entities that are cooperating with an investigation;
- Informing those participating in the investigation of EHS' policy on non-retaliation or intimidation; and
- Proceeding with discretion to protect the identities of those being investigated to the extent reasonably possible and appropriate under the circumstances.

Throughout the investigation or review of known or suspected non-compliance, the Compliance and Privacy Department reserves the independent authority to engage the services of legal counsel when appropriate, as well as engage the assistance or services of other EHS departments or Personnel. The Compliance and Privacy Department will notify any external regulatory or enforcement agency or entity, as may be required by federal or state law, of any pending or ongoing investigation or the outcome of such investigation.

Typically, unless an imminent threat or situation is identified, investigations or reviews will commence within a reasonable period of time after the receipt of a Report of known or suspected non-compliance. The Compliance and Privacy Department will take the necessary time to review or investigate thoroughly any Report of known or suspected non-compliance. Investigations and reviews will take into account the applicability of the facts. They will also comply with applicable legal requirements regarding any external reporting or notice.

Covered Persons have an affirmative obligation to participate in a review or investigation conducted by the Compliance and Privacy Department. Therefore, the Compliance Program maintains a method of confidential and anonymous communication that is available to all Personnel and other individuals and entities 24 hours a day, 7 days a weeks, 365 days a year for reporting known or suspected non-compliance. Unless otherwise required by applicable federal or state law, all investigations and reviews will be conducted in a confidential manner to determine whether there is credible evidence of non-compliance.

If an investigation or review identifies actual or potential non-compliance, the Compliance and Privacy Department will respond appropriately and in conformance with applicable laws, regulations, guidelines, and/or policies and procedures, including:

- Prompt identification, resolution, and return of any overpayments via processes specified by law, including Self-Disclosure Protocols;
- Notification to the appropriate government agency or law enforcement entity;
- Revision of current policies, procedures, process, or system modification(s);
- Training or education; or
- Referral of disciplinary action up to an including termination of employment, contractual, or other affiliation relationship with EHS.

Enforcement Actions & Discipline

Covered Persons who violate applicable laws regulations, or Compliance Program requirements are subject to enforcement actions and discipline. These actions will be consistent with EHS' progressive discipline policies and collective bargaining obligations. Enforcement of the Compliance Program is applied equitably, ethically, legally, and consistently regardless of title, rank, role, or position within EHS. Actions may include, re-training, counseling, warning, suspension, or termination of employment, contractual, or other affiliation relationship with EHS. Covered Persons that engage in reckless disregard and purposefully egregious conduct are subject to immediate and significant action. These significant actions are considered and applied on a case-by-case basis.

Auditing & Monitoring

EHS uses auditing and monitoring processes to assess the effectiveness of its Compliance Program. Audits and monitoring reviews are conducted internally or externally, by using outside resources such as legal counsel, auditors, or other individuals or entities. Audits and monitoring reviews are selected from applicable OIG and OMIG Work Plans risk areas, EHS identified risk areas, or as otherwise determined by the Compliance and Privacy Department or Compliance Committee on an annual or as needed basis.

The results of audit and monitoring reviews are presented to the Compliance Committee, which assesses the findings and recommends any necessary corrective measures. Additionally, the reporting of audit and review findings, dependent on the nature or scope, are reported to the Board of Trustees.

In compliance with applicable laws and regulation, an annual Compliance Program review is conducted to assess effectiveness. The results of the review are presented to the Compliance Committee, senior leadership, and the Board of Trustees.

Exclusions & Sanctions Monitoring

EHS maintains a system for the performance of an initial and monthly screening of Personnel and applicable Covered Persons, as required by law, regulation, guidance, or industry best practice. Initial screening will be performed prior to establishing employment, affiliation, or contractual relationship with Personnel or applicable Covered Persons. Screening will continue at a minimum on a monthly basis for the duration of the relationship with EHS. EHS prohibits the employment, contractual, or other affiliation relationship with individuals or entities that are excluded from participation in any federal or state healthcare program.

Privacy & Security

EHS is subject to laws and regulations that govern the use and disclosure of an individual's Protected Health Information ("PHI"), Personal Identifiable Information ("PI"), and standards for an individual's privacy rights. Privacy & Security are components of EHS' Compliance Program. In addition, the Compliance Officer is the designated Privacy Officer. The Chief Information Officer is the designated Information Security Officer. The Privacy Officer is responsible for the development, implementation, and enforcement of EHS' privacy requirements

The Compliance Program performs the following activities in order to prevent, identify, and address Privacy & Security risks:.

- Maintains responsibility for EHS' compliance with HIPAA rules and regulations;
- Implements processes to maintain compliance with federal and state laws related to the privacy, security, and confidentiality of PHI and PI;
- Evaluates and monitors operations and systems development for Privacy & Security requirements;

- Promotes collaboration between the Compliance and Privacy Department and Information Technology and Services;
- Involvement and oversight of periodic Privacy & Security risk assessments;
- Works with all EHS owned, operated, or affiliated facilities, entities, and programs to measure, evaluate, audit, and/or review the implementation, effectiveness, and quality of EHS' Privacy & Security policies and procedures and related expectations; and
- Investigates, documents, addresses and mitigates unauthorized uses and disclosures of PHI, as well as unauthorized access, acquisition, or other potential breach of PHI, PI, and/or other confidentiality or privacy complaints.

Information Security is everyone's responsibility at EHS. Covered Persons are responsible for protecting patient, employee, and other confidential business information. EHS maintains and monitors security systems, data backup systems, and storage capabilities so that information is maintained safely, effectively, and securely. The Compliance and Privacy Department collaborates with the Information Security Officer to ensure that policies, procedures, processes, and practices are in place to protect the confidentiality of information.

Conflicts of Interest

EHS maintains policies and procedures to prevent, identify, and address potential conflicts of interest. A conflict of interest is a situation when a person may have multiple interests, one or more of which could possibly affect the person's motivations or actions in a way that is contrary to EHS' mission, vision, or values.

Covered Persons must refrain from situations that create a conflict of interest. Furthermore, Covered Persons are strictly prohibited from knowingly and willfully soliciting, receiving, offering, or paying remuneration, including kickbacks, rebates, or bribes, for referrals for services that are paid, in whole or in part, by a federal or state healthcare programs.

Key Personnel and Covered Persons must disclose potential and actual conflicts when they arise, as well as on an annual basis through a process that is developed, implemented, and managed by the Compliance and Privacy Department. This process assists the Compliance Program identify potential conflicts or violations of applicable law, including the Physician Sunshine Act, Anti-kickback Statute, Stark Law, and Civil Monetary Penalties Law. Each conflict of interest disclosure is reviewed and monitored by the Compliance and Privacy Department and steps are taken to remediate potential conflicts.

Quality of Care

The OIG and OMIG have the respective authority to exclude a hospital from participating in the Medicare or Medicaid programs when a hospital provides items or services that fail to meet professionally recognized standards of healthcare. EHS continually measures its performance against comprehensive standards in order to achieve quality related goals and obligations.

EHS has developed quality of care protocols and has implemented mechanisms for evaluating compliance with those protocols. The Compliance Program assists EHS in establishing methods to improve the efficiency and quality of services provided to those it serves.

Furthermore, EHS plays an active part in monitoring the quality of care and medical services provided at each location, facility, or program by appropriately overseeing the credentialing and peer review processes of the medical staff and other credentialed providers.

Access to Emergent Care

EHS complies with the requirements of federal, state, and local laws pertaining to the treatment of emergent care patients, including the Emergency Medical Treatment and Labor Act ("EMTALA"). Every person that comes to the Emergency Department or other designated and applicable area of EHS and seeks medical treatment or examination for a condition, as well as those in active labor, will be provided with a medical screening exam by a qualified medical professional.

The medical screening exam is designed to determine if an emergency medical condition exists. Emergency medical and stabilizing treatment is provided to all patients regardless of insurance status or ability to pay. When transferring a patient to an appropriate facility is warranted by circumstances, a transfer will be conducted according to applicable laws and regulations. The Compliance Program monitors adherence to these legal and regulatory requirements, as well as to the Emergency Medical Treatment and Labor Act ("EMTALA") policy.

Records Management

EHS maintains a Records Management Program designed to accomplish the following:

- Establishes an accurate, efficient, secure, and cost effective program for the retention, preservation, and destruction or disposal of records;
- Maintains a written Records Management Schedule that maximizes the availability of records for patient care, administrative, research, quality improvement, and medico-legal purposes;
- Applies effective and cost efficient management techniques to maintain and preserve complete, accurate, quality records;
- Ensures that patient health information is available to meet the needs of EHS, its patients, regulatory, and other operational requirements;
- Protects the disposal, destruction, maintenance, and preservation of records that are sought in connection with any legal proceeding (pending or anticipated), under contractual obligation, or as otherwise required by federal, state, or local law.

The integrity and accuracy of EHS documents and records is extremely important. All EHS records must be maintained in accordance with applicable federal, state, or local law, accreditation standards, contracts, and/or CMS requirements, as well as EHS' Records Management Program. EHS must make available any such records to regulatory or enforcement entities (e.g., OIG, MFCU, OMIG, CMS) upon request. EHS' Compliance Officer is the designated Records Management Officer.