

**CORPORATE INTEGRITY AGREEMENT
BETWEEN THE
OFFICE OF INSPECTOR GENERAL
OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
AHS HILLCREST MEDICAL CENTER, LLC**

I. PREAMBLE

AHS Hillcrest Medical Center, LLC (HMC) hereby enters into this Corporate Integrity Agreement (CIA) with the Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS) to promote compliance with the statutes, regulations, and written directives of Medicare, Medicaid, and all other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)) (Federal health care program requirements). Contemporaneously with this CIA, AHS Tulsa Regional Medical Center, L.L.C., Ardent Health Services, L.L.C., Ardent Medical Services, Inc., and AHS Hillcrest Medical Center, L.L.C. are entering into a Settlement Agreement with the United States.

II. TERM AND SCOPE OF THE CIA

A. The period of the compliance obligations assumed by HMC under this CIA shall be five years from the effective date of this CIA. The “Effective Date” shall be the date on which the final signatory of this CIA executes this CIA, unless otherwise specified. Each one-year period, beginning with the one-year period following the Effective Date, shall be referred to as a “Reporting Period.”

B. As expressly limited to the “Unit,” obligations in this CIA apply to HMC in its activities related to the ownership and operation of the Children and Adolescent Behavioral Health Services Unit presently located at Oklahoma State University Medical Center (OSUMC) (“the Unit”). The term “HMC” is not limited to the Unit, unless expressly limited.

C. Sections VII, X, and XI shall expire no later than 120 days after OIG’s receipt of: (1) HMC’s final annual report; or (2) any additional materials submitted by HMC pursuant to OIG’s request, whichever is later.

D. The scope of this CIA shall be governed by the following definitions:

1. "Covered Persons" includes:

- a. all natural persons who are owners of HMC;
- b. all officers, directors, and employees of HMC; and
- c. all contractors, subcontractors, agents, and other persons who, on behalf of HMC, and in connection with items or services provided to patients in the Unit: (1) are involved directly or indirectly in the delivery of patient care; (2) make assessments of patients that affect treatment decisions or reimbursement; (3) perform billing, coding, audit, or review functions; (4) make decisions or provide oversight about staffing, patient care, reimbursement, policies and procedures, or this CIA; or (5) perform any function that relates to or is covered by this CIA, including individuals who are responsible for quality assurance, setting policies or procedures, or making staffing decisions.

2. "Relevant Covered Persons" includes all Covered Persons who, on behalf of HMC, and in connection with items or services provided to patients in the Unit: (1) are involved directly or indirectly in the delivery of patient care; (2) make assessments of patients that affect treatment decisions or reimbursement; (3) perform billing, coding, audit, or review functions; (4) make decisions or provide oversight about staffing, patient care, reimbursement, policies and procedures, or this CIA; or (5) perform any function that relates to or is covered by this CIA, including individuals who are responsible for quality assurance, setting policies or procedures, or making staffing decisions.

III. CORPORATE INTEGRITY OBLIGATIONS

HMC shall establish and maintain a Compliance Program that includes the following elements:

A. Compliance Responsibilities of Compliance Officer, Compliance Committee, and Board of Directors

1. *Compliance Officer.* HMC has a Compliance Officer and shall maintain a Compliance Officer for the term of the CIA. The Compliance Officer shall be responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements set forth in this CIA, Federal health care program requirements, and professionally recognized standards of care. The Compliance Officer shall also be responsible for monitoring the day-to-day compliance activities engaged in by HMC and any reporting obligations created under this CIA. The Compliance Officer shall ensure that HMC is appropriately identifying and correcting issues relating to provision of services to patients of the Unit. The Compliance Officer must have sufficient compliance experience to effectively oversee the implementation of the requirements of this CIA. The Compliance Officer shall be a member of senior management of HMC, shall report directly to the Chief Executive Officer of HMC, shall make periodic (at least quarterly) reports regarding compliance matters directly to the Board of Directors of HMC, and shall be authorized to report on such matters to the Board of Directors of HMC at any time. The Compliance Officer shall not be or be subordinate to the General Counsel or Chief Financial Officer of any entity, including, but not limited to HMC. Any noncompliance job responsibilities of the Compliance Officer shall be limited and must not interfere with the Compliance Officer's ability to perform the duties outlined in this CIA.

HMC shall report to OIG, in writing, any changes in the identity of the Compliance Officer, or any actions or changes that would affect the Compliance Officer's ability to perform the duties necessary to meet the obligations in this CIA, within five business days after such a change.

2. *Compliance Committee.* HMC has and shall continue to maintain a Compliance Committee. The Compliance Committee includes, and shall continue to include, at a minimum, the Compliance Officer and other members of senior management necessary to meet the requirements of this CIA (e.g., senior executives of relevant departments, such as billing, clinical, human resources, audit, and operations). The Compliance Officer chairs and shall continue to chair the Compliance Committee, and the Committee supports and shall continue to support the Compliance Officer in fulfilling his/her responsibilities (e.g., assists and shall continue to assist in the analysis of HMC's risk areas; and oversees and shall continue to oversee monitoring of internal and external audits and investigations). The Compliance Committee meets and shall continue to meet at least quarterly.

HMC shall report to OIG, in writing, any changes in the composition of the Compliance Committee, or any actions or changes that would affect the Compliance Committee's ability to perform the duties necessary to meet the obligations in this CIA, within 15 days after such a change.

3. *Board of Directors Compliance Obligations.* The Board of Directors (Board) of HMC shall be responsible for the review and oversight of matters related to compliance with Federal health care program requirements and the obligations of this CIA.

The Board shall, at a minimum, be responsible for the following:

- a. meeting at least quarterly to review and oversee the Compliance Program required by this CIA, including but not limited to the performance of the Compliance Officer and Compliance Committee;
- b. ensuring that HMC adopts and implements policies, procedures, and practices designed to ensure compliance with the requirements set forth in this CIA and Federal health care program requirements; and
- c. for each Reporting Period of the CIA, adopting a resolution, signed by each member of the Board summarizing its review and oversight of HMC's compliance with Federal health care program requirements in connection with items or services provided to patients in the Unit and the obligations of this CIA.

At minimum, the resolution shall include the following language:

“The Board of Directors has made a reasonable inquiry into the operations of the Compliance Program required by the Corporate Integrity Agreement by and between the Office of Inspector General of the United States Department of Health and Human Services and HMC including the performance of the Compliance Officer and the Compliance Committee. Based on its inquiry and review, the Board has concluded that, to the best of its knowledge, HMC has implemented an effective Compliance Program designed to meet Federal health care program requirements in connection with items or services provided to patients in the Children and Adolescent Behavioral Health Services Unit and the obligations of

the CIA.”

If the Board is unable to provide such a conclusion in the resolution, the Board shall include in the resolution a written explanation of the reasons why it is unable to provide the conclusion and the steps it is taking to implement an effective Compliance Program to meet Federal health care program requirements and the obligations of the CIA.

HMC shall report to OIG, in writing, any changes in the composition of the Board, or any actions or changes that would affect the Board’s ability to perform the duties necessary to meet the obligations in this CIA, within 15 days after such a change.

B. Written Standards

1. *Code of Conduct.* HMC has developed, implemented, and distributed a written Code of Conduct to all Covered Persons. The promotion of, and adherence to, the Code of Conduct is an element in evaluating the performance of all employees. The Code of Conduct sets forth, and shall, at a minimum, continue to set forth:

- a. HMC’s commitment to full compliance with all Federal health care program requirements, including its commitment to prepare and submit accurate claims consistent with such requirements;
- b. HMC’s requirement that all of its Covered Persons are expected to comply with all Federal health care program requirements and with HMC’s own Policies and Procedures;
- c. the requirement that all Covered Persons are expected to report to the Compliance Officer, or other appropriate individual designated by HMC, suspected violations of any Federal health care program requirements or of HMC’s own Policies and Procedures; and
- d. the right of all individuals to use the Disclosure Program described in Section III.E, and HMC’s commitment to nonretaliation and to maintain, as

appropriate, confidentiality and anonymity with respect to such disclosures.

Each Covered Person certifies in writing, and shall continue to certify in writing, at least annually, that he or she has received, read, understood, and shall abide by HMC's Code of Conduct. New Covered Persons shall receive the Code of Conduct and shall complete the required certification within 30 days after becoming a Covered Person or within 90 days after the Effective Date, whichever is later.

HMC shall periodically review the Code of Conduct to determine if revisions are appropriate and shall make any necessary revisions based on such review. Any revised Code of Conduct shall be distributed within 30 days after any revisions are finalized. Each Covered Person shall certify, in writing, that he or she has received, read, understood, and shall abide by the revised Code of Conduct within 30 days after the distribution of the revised Code of Conduct.

2. *Policies and Procedures.* Within 90 days after the Effective Date, HMC shall implement written Policies and Procedures regarding the operation of the compliance program required by this CIA, including the compliance program requirements outlined in this CIA and HMC's compliance with Federal health care program requirements. At a minimum, the Policies and Procedures shall address:

- a. the compliance program requirements outlined in this CIA; and
- b. management and oversight of inpatient psychiatric services provided to patients of the Unit, including but not limited to: (1) ensuring proper staffing and management of the Unit in accordance with all applicable laws, rules, and regulations; (2) ensuring delivery of all care required by applicable laws to be delivered to inpatient psychiatric patients of the Unit, including but not limited to the therapy that must be provided pursuant to the Oklahoma Administrative Code; (3) ensuring appropriate recordkeeping and documentation of therapy and other care provided to inpatient psychiatric patients of the Unit; and (4) implementing measures to ensure compliance with all laws, rules, and regulations applicable to providing

inpatient psychiatric services to patients of the Unit, including but not limited to the requirements presently set forth at Title 317 of the Oklahoma Administrative Code.

Within 90 days after the Effective Date, the Policies and Procedures shall be distributed to all individuals whose job functions relate to the Unit. Appropriate and knowledgeable staff shall be available to explain the Policies and Procedures. The Policies and Procedures shall be available to OIG upon request.

At least annually (and more frequently, if appropriate), HMC shall assess and update, as necessary, the Policies and Procedures. Within 30 days after the effective date of any revisions, any such revised Policies and Procedures shall be distributed to all individuals whose job functions relate to those Policies and Procedures.

C. Training and Education

1. *General Training.* Within 90 days after the Effective Date, HMC shall provide at least two hours of General Training to each Covered Person. This training, at a minimum, shall explain HMC's:

- a. CIA requirements; and
- b. Compliance Program (including the Code of Conduct and the Policies and Procedures as they pertain to general compliance issues).

New Covered Persons shall receive the General Training described above within 30 days after becoming a Covered Person or within 90 days after the Effective Date, whichever is later. After receiving the initial General Training described above, each Covered Person shall receive at least one hour of General Training in each subsequent Reporting Period.

2. *Specific Training.* Within 90 days after the Effective Date, HMC shall initiate the provision of Specific Training to each Relevant Covered Person. Within the first Reporting Period, each Relevant Covered Person shall receive at least five hours of Specific Training pertinent to their responsibilities in addition to the General Training required above. This Specific Training shall include a discussion of:

- a. the Federal health care program requirements regarding the accurate coding and submission of claims;
- b. policies, procedures, and other requirements applicable to the documentation of medical records;
- c. the policies implemented pursuant to Section III.B.2 of this CIA, as appropriate for the job category of each Relevant Covered Person;
- d. the personal obligation of each individual involved in patient care to ensure that care is appropriate and meets professionally recognized standards of care;
- e. applicable reimbursement statutes, regulations, and program requirements and directives;
- f. examples of proper and improper care; and
- g. legal sanctions for violations of the Federal health care program requirements.

New Relevant Covered Persons shall begin receiving this training within 30 days after the start of their employment or contract (or becoming Relevant Covered Persons) or within 90 days after the Effective Date, whichever is later.

After receiving the initial Specific Training described in this section, each Relevant Covered Person shall receive at least five hours of Specific Training in each subsequent Reporting Period.

3. *Competency-Based Training.* All Specific and Periodic Training required in this section shall be competency-based. Specifically, the training must be developed and provided in such a way as to focus on Relevant Covered Persons achieving learning outcomes to a specified competency and to place emphasis on what a Relevant Covered Person has learned as a result of the training.

4. *Board Member Training.* Within 90 days after the Effective Date, HMC shall provide at least two hours of training to each member of the Board, in addition to the General Training. This training shall address the

responsibilities of board members and corporate governance.

New members of the Board shall receive the Board Member Training described above within 30 days after becoming a member or within 90 days after the Effective Date, whichever is later.

5. *Certification.* Each individual who is required to attend training shall certify, in writing, or in electronic form, if applicable, that he or she has received the required training. The certification shall specify the type of training received and the date received. The Compliance Officer (or designee) shall retain the certifications, along with all course materials and documentation evidencing that the individual attained competency in the required training areas. These shall be made available to OIG, upon request.

6. *Qualifications of Trainer.* Persons providing the training shall be knowledgeable about the subject area.

7. *Update of Training.* HMC shall review the training annually, and, where appropriate, update the training to reflect changes in Federal health care program requirements, any issues discovered during internal audits or by the Independent Review Organization, described below in Section III.D., and any other relevant information.

8. *Computer-based Training.* HMC may provide the training required under this CIA through appropriate computer-based training approaches. If HMC chooses to provide computer-based training, it shall make available appropriately qualified and knowledgeable staff or trainers to answer questions or provide additional information to the individuals receiving such training.

D. Review Procedures

1. General Description.

- a. *Engagement of Independent Review Organization.* Within 60 days after the Effective Date, HMC shall retain an appropriately qualified Independent Review Organization (IRO), to perform the reviews listed in this Section III.D. The IRO may retain additional personnel, including, but not limited to, independent consultants, if needed to help meet the IRO's obligations under this CIA. The applicable requirements relating to the IRO are outlined in

Appendix A to this CIA, which is incorporated by reference.

- b. *Retention of Records.* The IRO and HMC shall retain and make available to OIG, upon request, all work papers, supporting documentation, correspondence, and draft reports (those exchanged between the IRO and HMC) related to the reviews.

2. *Systems Assessment.* The IRO shall be responsible for assessing the effectiveness, reliability, and thoroughness of the following:

- a. HMC's internal quality control systems applicable to inpatient psychiatric services provided to patients of the Unit, including, but not limited to:
 - i. whether the systems in place to ensure that all care required by applicable laws is available to patients of the Unit and to ensure appropriate recordkeeping and documentation of therapy and other care provided to patients of the Unit;
 - ii. whether the systems in place to promote and respond to issues concerning quality of health care items and services are operating in a timely and effective manner;
 - iii. whether the communication system is effective, allowing for accurate information, decisions, and results of decisions to be transmitted to the proper individuals in a timely fashion; and
 - iv. whether the training programs are effective, thorough, and competency-based.
- b. HMC's response to the following issues applicable to inpatient psychiatric services provided to patients of the Unit, which shall include an assessment of:
 - i. HMC's ability to identify the problem;

- ii. HMC's ability to determine the scope of the problem, including, but not limited to, whether the problem is isolated or systemic;
 - iii. HMC's ability to conduct a root cause analysis;
 - iv. HMC's ability to create an action plan to respond to the problem;
 - v. HMC's ability to execute the action plan; and
 - vi. HMC's ability to monitor and evaluate whether the assessment, action plan, and execution of that plan was effective, reliable, and thorough.
 - c. HMC's proactive steps to ensure that each patient in the Unit receives care in accordance with:
 - i. professionally recognized standards of health care;
 - ii. Federal, state, and local statutes, regulations, and other directives or guidelines;
 - iii. the Policies and Procedures adopted by HMC, including those implemented under Section III.B of this CIA; and
 - d. HMC's compliance with applicable requirements governing staffing of the Unit.
- 3. On an annual basis, the IRO shall:
 - a. assess the effectiveness, reliability, and thoroughness of the systems described above in Section III.D.2;
 - b. assess HMC's response to recommendations made in prior IRO Systems Assessment Reports, as defined below in Section III.D.3.d;
 - c. in conducting the Systems Assessments, visit the Unit,

and, at a minimum, observe quality assurance meetings, observe corporate compliance meetings, observe care planning meetings, interview key employees, review relevant documents, and observe patient care. HMC shall take all steps necessary to give the IRO access to the Unit, documents, and individuals sufficient to enable the IRO to perform the activities set forth in this Section III.D.3.c. in a legally and clinically appropriate manner; and

- d. submit a written report to HMC and OIG (hereinafter an “IRO Systems Assessment Report”) that sets forth, at a minimum:
 - i. a summary of the IRO’s activities in conducting the Systems Assessments;
 - ii. the IRO’s findings regarding the effectiveness, reliability, scope, and thoroughness of each of the systems described in Section III.D.2;
 - iii. the IRO’s recommendations to HMC as to how to improve the effectiveness, reliability, scope, and thoroughness of the systems described in Section III.D.2; and
 - iv. the IRO’s assessment of HMC’s response to the IRO’s recommendations in prior IRO Systems Assessment Reports.

Each Systems Assessment shall be based on the most recent Reporting Period and the IRO shall submit the IRO Systems Assessment Report to HMC and OIG no later than 30 days after the end of the Reporting Period.

4. *HMC Systems Assessment Report Response.* HMC shall:
 - a. within 30 days after receipt of each IRO Systems Assessment Report, submit to OIG and the IRO a written response to each recommendation contained in these Reports stating what action HMC took in response to each recommendation or why HMC has

elected not to take action based on the recommendation; and

- b. provide to its Compliance Committee and Board of Directors copies of all documents and reports provided to the IRO;

5. *Claims Review.* In addition to the Systems Assessment, described above in Section III.D.2, the IRO shall review HMC's coding, billing, and claims submission to Federal health care programs for services provided to patients of the Unit and reimbursement received for services provided to patients of the Unit (Claims Review) and shall prepare a Claims Review Report, as outlined in Appendix B to this CIA, which is incorporated by reference.

6. *Unallowable Cost Review.* For the first Reporting Period, the IRO shall conduct a review of HMC's compliance with the unallowable cost provisions of the Settlement Agreement. The IRO shall determine whether HMC has complied with its obligations not to charge to, or otherwise seek payment from, federal or state payors for unallowable costs (as defined in the Settlement Agreement) and its obligation to identify to applicable federal or state payors any unallowable costs included in payments previously sought from the United States, or any state Medicaid program. This unallowable costs analysis shall include, but not be limited to, payments sought in any cost reports, cost statements, information reports, or payment requests already submitted by HMC or any affiliates. To the extent that such cost reports, cost statements, information reports, or payment requests, even if already settled, have been adjusted to account for the effect of the inclusion of the unallowable costs, the IRO shall determine if such adjustments were proper. In making this determination, the IRO may need to review cost reports and/or financial statements from the year in which the Settlement Agreement was executed, as well as from previous years.

7. *Unallowable Cost Review Report.* The IRO shall prepare a report based upon the Unallowable Cost Review performed (Unallowable Cost Review Report). The Unallowable Cost Review Report shall include the IRO's findings and supporting rationale regarding the Unallowable Cost Review and whether HMC has complied with its obligation not to charge to, or otherwise seek payment from, federal or state payors for unallowable costs (as defined in the Settlement Agreement) and its obligation to identify to applicable federal or state payors any unallowable costs included in payments previously sought from such payor.

8. *Validation Review.* In the event OIG has reason to believe that: (a) HMC's Claims Review or Unallowable Cost Review fails to conform to the requirements of this CIA; or (b) the IRO's findings or Claims Review or Unallowable Cost Review results are inaccurate, OIG may, at its sole discretion, conduct its own review to determine whether the Claims Review or Unallowable Cost Review complied with the requirements of the CIA and/or the findings or Claims Review or Unallowable Cost Review results are inaccurate (Validation Review). HMC shall pay for the reasonable cost of any such review performed by OIG or any of its designated agents. Any Validation Review of Reports submitted as part of HMC's final Annual Report shall be initiated no later than one year after HMC's final submission (as described in Section II) is received by OIG.

Prior to initiating a Validation Review, OIG shall notify HMC of its intent to do so and provide a written explanation of why OIG believes such a review is necessary. To resolve any concerns raised by OIG, HMC may request a meeting with OIG to: (a) discuss the results of any Claims Review or Unallowable Cost Review submissions or findings; (b) present any additional information to clarify the results of the Claims Review or Unallowable Cost Review or to correct the inaccuracy of the Claims Review or Unallowable Cost Review; and/or (c) propose alternatives to the proposed Validation Review. HMC agrees to provide any additional information as may be requested by OIG under this Section III.D.8 in an expedited manner. OIG will attempt in good faith to resolve any Claims Review or Unallowable Cost Review issues with HMC prior to conducting a Validation Review. However, the final determination as to whether or not to proceed with a Validation Review shall be made at the sole discretion of OIG.

9. *Independence and Objectivity Certification.* The IRO shall include in its report(s) to HMC a certification or sworn affidavit that it has evaluated its professional independence and objectivity and has concluded that it is, in fact, independent and objective.

E. Disclosure Program

HMC has established and shall maintain a Disclosure Program that includes a mechanism (e.g., a toll-free compliance telephone line) to enable individuals to disclose, to the Compliance Officer or some other person who is not in the disclosing individual's chain of command, any identified issues or questions associated with HMC's policies, conduct, practices, or procedures with respect to a Federal health care program believed by the individual to be a potential violation of criminal, civil, or administrative law. HMC has appropriately publicized and shall continue to appropriately publicize the existence of the disclosure mechanism

(e.g., via periodic e-mails to employees or by posting the information in prominent common areas).

The Disclosure Program shall continue to emphasize a nonretribution, nonretaliation policy, and shall include a reporting mechanism for anonymous communications for which appropriate confidentiality shall be maintained. Upon receipt of a disclosure, the Compliance Officer (or designee) shall gather all relevant information from the disclosing individual. The Compliance Officer (or designee) shall make a preliminary, good faith inquiry into the allegations set forth in every disclosure to ensure that he or she has obtained all of the information necessary to determine whether a further review should be conducted. For any disclosure that is sufficiently specific so that it reasonably: (1) permits a determination of the appropriateness of the alleged improper practice; and (2) provides an opportunity for taking corrective action, HMC shall conduct an internal review of the allegations set forth in the disclosure and ensure that proper follow-up is conducted.

The Compliance Officer (or designee) shall maintain a disclosure log, which shall include a record and summary of each disclosure received (whether anonymous or not), the status of the respective internal reviews, and any corrective action taken in response to the internal reviews.

F. Ineligible Persons

1. *Definitions.* For purposes of this CIA:
 - a. an “Ineligible Person” shall include an individual or entity who:
 - i. is currently excluded, debarred, suspended, or otherwise ineligible to participate in the Federal health care programs or in Federal procurement or nonprocurement programs; or
 - ii. has been convicted of a criminal offense that falls within the scope of 42 U.S.C. § 1320a-7(a), but has not yet been excluded, debarred, suspended, or otherwise declared ineligible.
 - b. “Exclusion Lists” include:

- i. the HHS/OIG List of Excluded Individuals/Entities (available through the Internet at <http://www.oig.hhs.gov>); and
- ii. the General Services Administration's List of Parties Excluded from Federal Programs (available through the Internet at <http://www.epls.gov>).

2. *Screening Requirements.* HMC shall ensure that all prospective and current Covered Persons are not Ineligible Persons, by implementing the following screening requirements:

- a. HMC shall screen all prospective Covered Persons against the Exclusion Lists prior to engaging their services and, as part of the hiring or contracting process, shall require such Covered Persons to disclose whether they are Ineligible Persons.
- b. HMC shall screen all Covered Persons against the Exclusion Lists within 90 days after the Effective Date and on an annual basis thereafter.
- c. HMC shall implement a policy requiring all Covered Persons to disclose immediately any debarment, exclusion, suspension, or other event that makes that person an Ineligible Person.

Nothing in Section III.F affects HMC's responsibility to refrain from (or its liability for) billing Federal health care programs for items or services furnished, ordered, or prescribed by excluded persons. HMC understands that items or services furnished by excluded persons are not payable by Federal health care programs and that HMC may be liable for overpayments and/or criminal, civil, and administrative sanctions for employing or contracting with an excluded person regardless of whether HMC meets the requirements of Section III.F.

3. *Removal Requirement.* If HMC has actual notice that a Covered Person has become an Ineligible Person, HMC shall remove such Covered Person from responsibility for, or involvement with, HMC's business operations related to the Federal health care programs and shall remove such Covered Person from any position for which the Covered Person's compensation

or the items or services furnished, ordered, or prescribed by the Covered Person are paid in whole or part, directly or indirectly, by Federal health care programs or otherwise with Federal funds at least until such time as the Covered Person is reinstated into participation in the Federal health care programs.

4. *Pending Charges and Proposed Exclusions.* If HMC has actual notice that a Covered Person is charged with a criminal offense that falls within the scope of 42 U.S.C. §§ 1320a-7(a), 1320a-7(b)(1)-(3), or is proposed for exclusion during the Covered Person's employment or contract term or during the term of a physician's or other practitioner's medical staff privileges, HMC shall take all appropriate actions to ensure that the responsibilities of that Covered Person have not and shall not adversely affect the quality of care rendered to any beneficiary, patient, resident, or any claims submitted to any Federal health care program.

G. Notification of Government Investigation or Legal Proceedings

Within 30 days after discovery, HMC shall notify OIG, in writing, of any ongoing investigation or legal proceeding known to HMC conducted or brought by a governmental entity or its agents involving an allegation that HMC or any entity, facility, or unit of a facility in which HMC has an ownership or control interest, as defined in 42 U.S.C. 1320a-3(a)(3), or any entity, facility, or unit of a facility operated or managed by HMC (any "HMC Entity") has committed a crime or has engaged in fraudulent activities. This notification shall include a description of the allegation, the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding. HMC shall also provide written notice to OIG within 30 days after the resolution of the matter, and shall provide OIG with a description of the findings and/or results of the investigation or proceedings, if any.

In addition, within 15 days after notification, HMC shall notify OIG, in writing, of any adverse final determination made by a federal, state, or local government agency or accrediting or certifying agency (e.g., JCAHO) relating to inpatient psychiatric care issues at any HMC Entity.

H. Repayment of Overpayments

1. *Definition of Overpayments.* For purposes of this CIA, an "Overpayment" shall mean the amount of money HMC has received in excess of the amount due and payable under any Federal health care program requirements for services or items provided to patients in the Unit.

2. *Repayment of Overpayments.*

- a. If, at any time, HMC identifies or learns of any Overpayment, HMC shall repay the Overpayment to the appropriate payor (e.g., Oklahoma Medicaid, or a Medicare fiscal intermediary or carrier) within 30 days after identification of the Overpayment and take remedial steps within 60 days after identification (or such additional time as may be agreed to by the payor) to correct the problem, including preventing the underlying problem and the Overpayment from recurring. If not yet quantified, within 30 days after identification, HMC shall notify the payor of its efforts to quantify the Overpayment amount along with a schedule of when such work is expected to be completed. Notification and repayment to the payor shall be done in accordance with the payor's policies.
- b. Notwithstanding the above, notification and repayment of any Overpayment amount that routinely is reconciled or adjusted pursuant to policies and procedures established by the payor should be handled in accordance with such policies and procedures.

I. Reportable Events

1. *Definition of Reportable Event.* For purposes of this CIA, a "Reportable Event" means anything that involves:

- a. a substantial Overpayment;
- b. a matter that a reasonable person would consider a probable violation of criminal, civil, or administrative laws applicable to any Federal health care program for which penalties or exclusion may be authorized;
- c. the employment of or contracting with a Covered Person who is an Ineligible Person as defined by Section III.F.1.a; or

- d. the filing of a bankruptcy petition by HMC.

A Reportable Event may be the result of an isolated event or a series of occurrences.

2. *Reporting of Reportable Events.* If HMC determines (after a reasonable opportunity to conduct an appropriate review or investigation of the allegations) through any means that there is a Reportable Event, HMC shall notify OIG, in writing, within 30 days after making the determination that the Reportable Event exists.

3. *Reportable Events under Section III.I.1.a.* For Reportable Events under Section III.I.1.a, the report to OIG shall be made at the same time as repayment to the payor required in Section III.H, and shall include:

- a. a copy of the notification and repayment to the payor required in Section III.H.2;
- b. a description of the steps taken by HMC to identify and quantify the Overpayment;
- c. a complete description of the Reportable Event, including the relevant facts, persons involved, and legal and Federal health care program authorities implicated;
- d. a description of HMC's actions taken to correct the Reportable Event; and
- e. any further steps HMC plans to take to address the Reportable Event and prevent it from recurring.

4. *Reportable Events under Section III.I.1.b and c.* For Reportable Events under Section III.I.1.b and c, the report to OIG shall include:

- a. a complete description of the Reportable Event, including the relevant facts, persons involved, and legal and Federal health care program authorities implicated;

- b. a description of HMC's actions taken to correct the Reportable Event;
- c. any further steps HMC plans to take to address the Reportable Event and prevent it from recurring; and
- d. if the Reportable Event has resulted in an Overpayment, a description of the steps taken by HMC to identify and quantify the Overpayment.

5. *Reportable Events under Section III.I.1.d.* For Reportable Events under Section III.I.1.d, the report to OIG shall include documentation of the bankruptcy filing and a description of any Federal health care program authorities implicated.

6. *Reportable Events Involving the Stark Law.* Notwithstanding the reporting requirements outlined above, any Reportable Event that involves only a probable violation of section 1877 of the Social Security Act, 42 U.S.C. §1395nn (the Stark Law) should be submitted by HMC to the Centers for Medicare & Medicaid Services (CMS) through the self-referral disclosure protocol (SRDP), with a copy to the OIG. The requirements of Section III.H.2 that require repayment to the payor of any identified Overpayment within 30 days shall not apply to any Overpayment that may result from a probable violation of only the Stark Law that is disclosed to CMS pursuant to the SRDP.

IV. CHANGES TO BUSINESS UNITS OR LOCATIONS

A. Change or Closure of Unit or Location. In the event that, after the Effective Date, HMC changes the location of or closes the Unit, HMC shall notify OIG of this fact as soon as possible, but no later than within 30 days after the date of change of location or closure of the Unit.

B. Purchase or Establishment of New Unit or Location. In the event that, after the Effective Date, HMC purchases or establishes a new business unit or location related to the furnishing of inpatient psychiatric services that may be reimbursed by Federal health care programs, HMC shall notify OIG at least 30 days prior to such purchase or the operation of the new business unit or location. This notification shall include the address of the new business unit or location, phone number, fax number, the location's Medicare and state Medicaid program provider number and/or supplier number(s), and the name and address of each Medicare and state Medicaid program contractor to which HMC currently submits

claims. Each new business unit or location and all Covered Persons at each new business unit or location shall be subject to the applicable requirements of this CIA.

C. Sale of Unit or Location. In the event that, after the Effective Date, HMC proposes to sell the Unit, HMC shall notify OIG of the proposed sale at least 30 days prior to the sale of the Unit. This notification shall include a brief description of the terms of the sale, and the name and contact information of the prospective purchaser. This CIA shall be binding on the purchaser of the Unit, unless otherwise determined and agreed to in writing by OIG.

V. IMPLEMENTATION AND ANNUAL REPORTS

A. Implementation Report. Within 120 days after the Effective Date, HMC shall submit a written report to OIG summarizing the status of its implementation of the requirements of this CIA (Implementation Report). The Implementation Report shall, at a minimum, include:

1. the name, address, phone number, and position description of the Compliance Officer required by Section III.A, and a summary of other noncompliance job responsibilities the Compliance Officer may have;
2. the names of the members of the Compliance Committee required by Section III.A;
3. the names and positions of the members of the Board of Directors;
4. a copy of HMC's Code of Conduct required by Section III.B.1;
5. the number of individuals required to complete the Code of Conduct certification required by Section III.B.1, the percentage of individuals who have completed such certification, and an explanation of any exceptions (the documentation supporting this information shall be available to OIG, upon request);
6. a summary of all Policies and Procedures required by Section III.B.2 (a copy of such Policies and Procedures shall be made available to OIG upon request);

7. the following information regarding each type of training required by Section III.C:

- a. a description of such training, including a summary of the topics covered, the length of sessions, and a schedule of training sessions; and
- b. the number of individuals required to be trained, percentage of individuals actually trained, and an explanation of any exceptions.

A copy of all training materials and the documentation supporting this information shall be made available to OIG, upon request.

8. the following information regarding the IRO(s): (a) identity, address, and phone number; (b) a copy of the engagement letter; (c) information to demonstrate that the IRO has the qualifications outlined in Appendix A to this CIA; (d) a summary and description of any and all current and prior engagements and agreements between HMC and the IRO; and (e) a certification from the IRO regarding its professional independence and objectivity with respect to HMC;

9. a description of the Disclosure Program required by Section III.E;

10. a description of the process by which HMC fulfills the requirements of Section III.F regarding Ineligible Persons;

11. a list of all of HMC's locations (including locations and mailing addresses); the corresponding name under which each location is doing business; the corresponding phone numbers and fax numbers; each location's Medicare and state Medicaid program provider number(s) and/or supplier number(s); and the name and address of each Medicare and state Medicaid program contractor to which HMC currently submits claims;

12. a description of HMC's corporate structure, including identification of any individual owners and investors, parent and sister companies, subsidiaries, and their respective lines of business; and

13. the certifications required by Section V.C.

B. Annual Reports. HMC shall submit to OIG annually a report with respect to the status of, and findings regarding, HMC's compliance activities for each of the five Reporting Periods (Annual Report).

Each Annual Report shall include, at a minimum:

1. any change in the identity, position description, or other noncompliance job responsibilities of the Compliance Officer and any change in the membership of the Compliance Committee described in Section III.A;
2. the Board of Directors Resolution required by Section III.A.3;
3. a summary of any changes or amendments to HMC's Code of Conduct required by Section III.B.1 and the reason for such changes, along with a copy of the revised Code of Conduct;
4. the number of individuals required to complete the Code of Conduct certification required by Section III.B.1, the percentage of individuals who have completed such certification, and an explanation of any exceptions (the documentation supporting this information shall be made available to OIG, upon request);
5. a summary of any significant changes or amendments to the Policies and Procedures required by Section III.B and the reasons for such changes (e.g., change in contractor policy);
6. the following information regarding each type of training required by Section III.C:
 - a. a description of the initial and annual training, including a summary of the topics covered, the length of sessions, and a schedule of training sessions; and
 - b. the number of individuals required to complete the initial and annual training, the percentage of individuals who actually completed the initial and annual training, and an explanation of any exceptions.

A copy of all training materials and the documentation to support this information shall be made available to OIG, upon request.

7. a complete copy of all reports prepared pursuant to Section III.D, along with a copy of the IRO's engagement letter;
8. HMC's response and action plan(s) related to any written recommendations of the IRO pursuant to any report prepared pursuant to Section III.D;
9. a summary and description of any and all current and prior engagements and agreements between HMC and the IRO (if different from what was submitted as part of the Implementation Report);
10. a certification from the IRO regarding its professional independence and objectivity with respect to HMC;
11. a copy of the disclosure log required under Section III.E (excluding any calls that relate solely to human resources issues);
12. a summary of Reportable Events (as defined in Section III.I) identified during the Reporting Period and the status of any corrective and preventative action relating to all such Reportable Events;
13. any changes to the process by which HMC fulfills the requirements of Section III.F regarding Ineligible Persons;
14. a report of the aggregate Overpayments that have been returned to Federal health care programs. Overpayment amounts shall be broken down into the following categories: inpatient Medicare, outpatient Medicare, Medicaid (report each applicable state separately, if applicable), and other Federal health care programs. Overpayment amounts that are routinely reconciled or adjusted pursuant to policies and procedures established by the payor do not need to be included in this aggregate Overpayment report;
15. a summary describing any ongoing investigation or legal proceeding required to have been reported pursuant to Section III.G. The summary shall include a description of the allegation, the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding;
16. a description of all changes to the most recently provided list of HMC's locations (including addresses) as required by Section V.A.11; the corresponding name under which each location is doing business; the

corresponding phone numbers and fax numbers; each location's Medicare and state Medicaid program provider number(s) and/or supplier number(s); and the name and address of each Medicare and state Medicaid program contractor to which HMC currently submits claims; and

17. the certifications required by Section V.C.

The first Annual Report shall be received by OIG no later than 60 days after the end of the first Reporting Period. Subsequent Annual Reports shall be received by OIG no later than the anniversary date of the due date of the first Annual Report.

C. Certifications

The Implementation Report and Annual Reports shall include certifications by the Compliance Officer that:

- a. to the best of his or her knowledge, except as otherwise described in the applicable report, HMC is in compliance with all of the requirements of this CIA;
- b. he or she has reviewed the Report and has made reasonable inquiry regarding its content and believes that the information in the Report is accurate and truthful; and
- c. to the best of his or her knowledge, HMC has complied with its obligations under the Settlement Agreement: (a) not to resubmit to any Federal health care program payors any previously denied claims related to the Covered Conduct addressed in the Settlement Agreement, and not to appeal any such denials of claims; (b) not to charge to or otherwise seek payment from federal or state payors for unallowable costs (as defined in the Settlement Agreement); and (c) to identify and adjust any past charges or claims for unallowable costs.

D. Designation of Information. HMC shall clearly identify any portions of its submissions that it believes are trade secrets, or information that is commercial or financial and privileged or confidential, and therefore potentially

exempt from disclosure under the Freedom of Information Act (FOIA), 5 U.S.C. § 552. HMC shall refrain from identifying any information as exempt from disclosure if that information does not meet the criteria for exemption from disclosure under FOIA.

VI. NOTIFICATIONS AND SUBMISSION OF REPORTS

Unless otherwise stated in writing after the Effective Date, all notifications and reports required under this CIA shall be submitted to the following entities:

OIG:

Administrative and Civil Remedies
Branch
Office of Counsel to the Inspector General
Office of Inspector General
U.S. Department of Health and Human Services
Cohen Building, Room 5527
330 Independence Avenue, S.W.
Washington, DC 20201
Telephone: 202.619.2078
Facsimile: 202.205.0604

HMC:

Bonnie Peterson, Compliance Officer
1120 South Utica Avenue
Tulsa, Oklahoma 74104
Telephone: 918.584.1351
Facsimile: 918.579.3369

Unless otherwise specified, all notifications and reports required by this CIA may be made by certified mail, overnight mail, hand delivery, or other means, provided that there is proof that such notification was received. For purposes of this requirement, internal facsimile confirmation sheets do not constitute proof of receipt. Upon request by OIG, HMC may be required to provide OIG with an electronic copy of each notification or report required by this CIA in searchable portable document format (pdf), in addition to, a paper copy.

VII. OIG INSPECTION, AUDIT, AND REVIEW RIGHTS

In addition to any other rights OIG may have by statute, regulation, or contract, OIG or its duly authorized representative(s) may examine or request

copies of HMC's books, records, and other documents and supporting materials and/or conduct on-site reviews of any of HMC's locations for the purpose of verifying and evaluating: (a) HMC's compliance with the terms of this CIA; and (b) HMC's compliance with the requirements of the Federal health care programs in which it participates. The documentation described above shall be made available by HMC to OIG or its duly authorized representative(s) at all reasonable times for inspection, audit, or reproduction. Furthermore, for purposes of this provision, OIG or its duly authorized representative(s) may interview any of HMC's employees, contractors, or agents who consent to be interviewed at the individual's place of business during normal business hours or at such other place and time as may be mutually agreed upon between the individual and OIG. HMC shall assist OIG or its duly authorized representative(s) in contacting and arranging interviews with such individuals upon OIG's request. HMC's employees may elect to be interviewed with or without a representative of HMC present.

VIII. DOCUMENT AND RECORD RETENTION

HMC shall maintain for inspection all documents and records relating to reimbursement from the Federal health care programs, or to compliance with this CIA, for six years (or longer if otherwise required by law) from the Effective Date.

IX. DISCLOSURES

Consistent with HHS's FOIA procedures, set forth in 45 C.F.R. Part 5, OIG shall make a reasonable effort to notify HMC prior to any release by OIG of information submitted by HMC pursuant to its obligations under this CIA and identified upon submission by HMC as trade secrets, or information that is commercial or financial and privileged or confidential, under the FOIA rules. With respect to such releases, HMC shall have the rights set forth at 45 C.F.R. § 5.65(d).

X. BREACH AND DEFAULT PROVISIONS

HMC is expected to fully and timely comply with all of its CIA obligations.

A. Stipulated Penalties for Failure to Comply with Certain Obligations.

As a contractual remedy, HMC and OIG hereby agree that failure to comply with certain obligations as set forth in this CIA may lead to the imposition of the following monetary penalties (hereinafter referred to as “Stipulated Penalties”) in accordance with the following provisions.

1. A Stipulated Penalty of \$2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day HMC fails to establish and effectively implement any of the following obligations as described in Section III:

- a. a Compliance Officer;
- b. a Compliance Committee;
- c. a written Code of Conduct;
- d. written Policies and Procedures;
- e. the training of Covered Persons, Relevant Covered Persons, and Board Members in the manner required by Section III.C;
- f. a Disclosure Program;
- g. Ineligible Persons screening and removal requirements;
- h. notification of Government investigations or legal proceedings; and
- i. reporting of Reportable Events.

2. A Stipulated Penalty of \$2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day HMC fails to engage and use an IRO, as required in Section III.D, Appendix A, and Appendix B.

3. A Stipulated Penalty of \$2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day HMC fails to

submit the Implementation Report or any Annual Reports to OIG in accordance with the requirements of Section V by the deadlines for submission.

4. A Stipulated Penalty of \$2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day HMC fails to submit any: (a) IRO Systems Assessment Report in accordance with the requirements of Section III.D; or (b) Claims Review Report or Unallowable Cost Review Report in accordance with the requirements of Section III.D and Appendix B.

5. A Stipulated Penalty of \$1,500 for each day HMC fails to grant access as required in Section VII. (This Stipulated Penalty shall begin to accrue on the date HMC fails to grant access.)

6. A Stipulated Penalty of \$5,000 for each false certification submitted by or on behalf of HMC as part of its Implementation Report, Annual Report, additional documentation to a report (as requested by OIG), or otherwise required by this CIA.

7. A Stipulated Penalty of \$1,000 for each day HMC fails to comply fully and adequately with any obligation of this CIA. OIG shall provide notice to HMC stating the specific grounds for its determination that HMC has failed to comply fully and adequately with the CIA obligation(s) at issue and steps HMC shall take to comply with the CIA. (This Stipulated Penalty shall begin to accrue 10 days after HMC receives this notice from OIG of the failure to comply.) A Stipulated Penalty as described in this Subsection shall not be demanded for any violation for which OIG has sought a Stipulated Penalty under Subsections 1-6 of this Section.

B. Timely Written Requests for Extensions. HMC may, in advance of the due date, submit a timely written request for an extension of time to perform any act or file any notification or report required by this CIA. Notwithstanding any other provision in this Section, if OIG grants the timely written request with respect to an act, notification, or report, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until one day after HMC fails to meet the revised deadline set by OIG. Notwithstanding any other provision in this Section, if OIG denies such a timely written request, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until three business days after HMC receives OIG's written denial of such request or the original due date, whichever is later. A "timely written request" is defined as a request in writing received by OIG at least five business

days prior to the date by which any act is due to be performed or any notification or report is due to be filed.

C. Payment of Stipulated Penalties

1. *Demand Letter.* Upon a finding that HMC has failed to comply with any of the obligations described in Section X.A and after determining that Stipulated Penalties are appropriate, OIG shall notify HMC of: (a) HMC's failure to comply; and (b) OIG's exercise of its contractual right to demand payment of the Stipulated Penalties. (This notification shall be referred to as the "Demand Letter.")

2. *Response to Demand Letter.* Within 10 days after the receipt of the Demand Letter, HMC shall either: (a) cure the breach to OIG's satisfaction and pay the applicable Stipulated Penalties; or (b) request a hearing before an HHS ALJ to dispute OIG's determination of noncompliance, pursuant to the agreed upon provisions set forth below in Section X.E. In the event HMC elects to request an ALJ hearing, the Stipulated Penalties shall continue to accrue until HMC cures, to OIG's satisfaction, the alleged breach in dispute. Failure to respond to the Demand Letter in one of these two manners within the allowed time period shall be considered a material breach of this CIA and shall be grounds for exclusion under Section X.D.

3. *Form of Payment.* Payment of the Stipulated Penalties shall be made by electronic funds transfer to an account specified by OIG in the Demand Letter.

4. *Independence from Material Breach Determination.* Except as set forth in Section X.D.1.d, these provisions for payment of Stipulated Penalties shall not affect or otherwise set a standard for OIG's decision that HMC has materially breached this CIA, which decision shall be made at OIG's discretion and shall be governed by the provisions in Section X.D, below.

D. Exclusion for Material Breach of this CIA

1. *Definition of Material Breach.* A material breach of this CIA means:

- a. a repeated or flagrant violation of the obligations under this CIA, including, but not limited to, the obligations addressed in Section X.A;

- b. a failure by HMC to report a Reportable Event, take corrective action, and make the appropriate refunds, as required in Section III.I;
- c. a failure to respond to a Demand Letter concerning the payment of Stipulated Penalties in accordance with Section X.C; or
- d. a failure to engage and use an IRO in accordance with Section III.D, Appendix A, and Appendix B.

2. *Notice of Material Breach and Intent to Exclude.* The parties agree that a material breach of this CIA by HMC constitutes an independent basis for HMC's exclusion from participation in the Federal health care programs. Upon a determination by OIG that HMC has materially breached this CIA and that exclusion is the appropriate remedy, OIG shall notify HMC of: (a) HMC's material breach; and (b) OIG's intent to exercise its contractual right to impose exclusion. (This notification shall be referred to as the "Notice of Material Breach and Intent to Exclude.")

3. *Opportunity to Cure.* HMC shall have 30 days from the date of receipt of the Notice of Material Breach and Intent to Exclude to demonstrate to OIG's satisfaction that:

- a. HMC is in compliance with the obligations of the CIA cited by OIG as being the basis for the material breach;
- b. the alleged material breach has been cured; or
- c. the alleged material breach cannot be cured within the 30-day period, but that: (i) HMC has begun to take action to cure the material breach; (ii) HMC is pursuing such action with due diligence; and (iii) HMC has provided to OIG a reasonable timetable for curing the material breach.

4. *Exclusion Letter.* If, at the conclusion of the 30-day period, HMC fails to satisfy the requirements of Section X.D.3, OIG may exclude HMC from participation in the Federal health care programs. OIG shall notify HMC in writing of its determination to exclude HMC. (This letter shall be referred to as

the “Exclusion Letter.”) Subject to the Dispute Resolution provisions in Section X.E, below, the exclusion shall go into effect 30 days after the date of HMC’s receipt of the Exclusion Letter. The exclusion shall have national effect and shall also apply to all other Federal procurement and nonprocurement programs. Reinstatement to program participation is not automatic. After the end of the period of exclusion, HMC may apply for reinstatement by submitting a written request for reinstatement in accordance with the provisions at 42 C.F.R. §§ 1001.3001-.3004.

E. Dispute Resolution

1. *Review Rights.* Upon OIG’s delivery to HMC of its Demand Letter or Exclusion Letter, and as an agreed-upon contractual remedy for the resolution of disputes arising under this CIA, HMC shall be afforded certain review rights comparable to the ones that are provided in 42 U.S.C. § 1320a-7(f) and 42 C.F.R. Part 1005 as if they applied to the Stipulated Penalties, or exclusion sought pursuant to this CIA. Specifically, OIG’s determination to demand payment of Stipulated Penalties, or seek exclusion shall be subject to review by an HHS ALJ and, in the event of an appeal, the HHS Departmental Appeals Board (DAB), in a manner consistent with the provisions in 42 C.F.R. § 1005.2-1005.21. Notwithstanding the language in 42 C.F.R. § 1005.2(c), the request for a hearing involving Stipulated Penalties shall be made within 10 days after receipt of the Demand Letter and the request for a hearing involving exclusion shall be made within 25 days after receipt of the Exclusion Letter.

2. *Stipulated Penalties Review.* Notwithstanding any provision of Title 42 of the United States Code or Title 42 of the Code of Federal Regulations, the only issues in a proceeding for Stipulated Penalties under this CIA shall be: (a) whether HMC was in full and timely compliance with the obligations of this CIA for which OIG demands payment; and (b) the period of noncompliance. HMC shall have the burden of proving its full and timely compliance and the steps taken to cure the noncompliance, if any. OIG shall not have the right to appeal to the DAB an adverse ALJ decision related to Stipulated Penalties. If the ALJ agrees with OIG with regard to a finding of a breach of this CIA and orders HMC to pay Stipulated Penalties, such Stipulated Penalties shall become due and payable 20 days after the ALJ issues such a decision unless HMC requests review of the ALJ decision by the DAB. If the ALJ decision is properly appealed to the DAB and the DAB upholds the determination of OIG, the Stipulated Penalties shall become due and payable 20 days after the DAB issues its decision.

3. *Exclusion Review.* Notwithstanding any provision of Title 42 of the United States Code or Title 42 of the Code of Federal Regulations, the only issues in a proceeding for exclusion based on a material breach of this CIA shall be:

- a. whether HMC was in material breach of this CIA;
- b. whether such breach was continuing on the date of the Exclusion Letter; and
- c. whether the alleged material breach could not have been cured within the 30-day period, but that: (i) HMC had begun to take action to cure the material breach within that period; (ii) HMC has pursued and is pursuing such action with due diligence; and (iii) HMC provided to OIG within that period a reasonable timetable for curing the material breach and HMC has followed the timetable.

For purposes of the exclusion herein, exclusion shall take effect only after an ALJ decision favorable to OIG, or, if the ALJ rules for HMC, only after a DAB decision in favor of OIG. HMC's election of its contractual right to appeal to the DAB shall not abrogate OIG's authority to exclude HMC upon the issuance of an ALJ's decision in favor of OIG. If the ALJ sustains the determination of OIG and determines that exclusion is authorized, such exclusion shall take effect 20 days after the ALJ issues such a decision, notwithstanding that HMC may request review of the ALJ decision by the DAB. If the DAB finds in favor of OIG after an ALJ decision adverse to OIG, the exclusion shall take effect 20 days after the DAB decision. HMC shall waive its right to any notice of such an exclusion if a decision upholding the exclusion is rendered by the ALJ or DAB. If the DAB finds in favor of HMC, HMC shall be reinstated effective on the date of the original exclusion.

5. *Finality of Decision.* The review by an ALJ or DAB provided for above shall not be considered to be an appeal right arising under any statutes or regulations. Consequently, the parties to this CIA agree that the DAB's decision (or the ALJ's decision if not appealed) shall be considered final for all purposes under this CIA.

XI. EFFECTIVE AND BINDING AGREEMENT

HMC and OIG agree as follows:

A. This CIA shall be binding on the successors, assigns, and transferees of HMC.

B. This CIA shall become final and binding on the date the final signature is obtained on the CIA.

C. This CIA constitutes the complete agreement between the parties and may not be amended except by written consent of the parties to this CIA.

D. OIG may agree to a suspension of HMC's obligations under this CIA based on a certification by HMC that it is no longer providing inpatient behavioral health services to children or adolescents that will be billed to any Federal health care program and that it does not have any ownership or control interest, as defined in 42 U.S.C. § 1320a-3, in any entity that provides inpatient behavioral health services to children or adolescents that will be billed to any Federal health care program. If HMC is relieved of its CIA obligations, HMC will be required to notify OIG in writing at least thirty (30) days in advance if HMC plans to resume providing inpatient behavioral health services to children or adolescents that are billed to any Federal health care program or to obtain an ownership or control interest in any entity that provides inpatient behavioral health services to children or adolescents that will be billed to any Federal health care program. At such time, OIG shall evaluate whether the CIA will be reactivated or modified.

E. The undersigned HMC signatories represent and warrant that they are authorized to execute this CIA. The undersigned OIG signatory represents that he is signing this CIA in his official capacity and that he is authorized to execute this CIA.

F. This CIA may be executed in counterparts, each of which constitutes an original and all of which constitute one and the same CIA. Facsimiles of signatures shall constitute acceptable, binding signatures for purposes of this CIA.

ON BEHALF OF AHS HILLCREST MEDICAL CENTER, LLC

/Steve Petrovich/

4/22/11

Steve Petrovich
Senior Vice President
AHS Hillcrest Medical Center, LLC

DATE

/Paul Kalb/

4/22/11

Paul Kalb
Sidley Austin LLP
Counsel for AHS Hillcrest Medical Center, LLC

DATE

ON BEHALF OF THE OFFICE OF INSPECTOR GENERAL
OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

/Gregory E. Demske/

GREGORY E. DEMSKE
Assistant Inspector General for Legal Affairs
Office of Inspector General
U. S. Department of Health and Human Services

4/22/11
DATE

/Keshia B. Thompson/

KESHIA B. THOMPSON ✓
Senior Counsel
Office of Counsel to the Inspector General
U. S. Department of Health and Human Services

4/22/11
DATE

APPENDIX A

INDEPENDENT REVIEW ORGANIZATION

This Appendix contains the requirements relating to the Independent Review Organization (IRO) required by Section III.D of the CIA.

A. IRO Engagement

1. HMC shall engage an IRO that possesses the qualifications set forth in Paragraph B, below, to perform the responsibilities in Paragraph C, below. The IRO shall conduct the review in a professionally independent and objective fashion, as set forth in Paragraph D. Within 30 days after OIG receives the information identified in Section V.A.8 of the CIA or any additional information submitted by HMC in response to a request by OIG, whichever is later, OIG will notify HMC if the IRO is unacceptable. Absent notification from OIG that the IRO is unacceptable, HMC may continue to engage the IRO.

2. If HMC engages a new IRO during the term of the CIA, this IRO shall also meet the requirements of this Appendix. If a new IRO is engaged, HMC shall submit the information identified in Section V.A.8 of the CIA to OIG within 30 days of engagement of the IRO. Within 30 days after OIG receives this information or any additional information submitted by HMC at the request of OIG, whichever is later, OIG will notify HMC if the IRO is unacceptable. Absent notification from OIG that the IRO is unacceptable, HMC may continue to engage the IRO.

B. IRO Qualifications

The IRO shall:

1. assign individuals to conduct the Systems Assessment, Claims Review, and Unallowable Cost Review who have expertise in the billing, coding, reporting, delivery of quality inpatient psychiatric care, and other requirements applicable to providers of inpatient psychiatric services and in the general requirements of the Federal health care program(s) from which HMC seeks reimbursement;

2. assign individuals to design and select the Claims Review sample who are knowledgeable about the appropriate statistical sampling techniques;

3. assign individuals to conduct the coding review portions of the Claims Review who have a nationally recognized coding certification and who have maintained this certification (e.g., completed applicable continuing education requirements); and

4. have sufficient staff and resources to conduct the reviews required by the CIA on a timely basis.

C. IRO Responsibilities

The IRO shall:

1. perform each Systems Assessment, Claims Review, and Unallowable Cost review, in accordance with the specific requirements of the CIA;
2. follow all applicable Medicare, Medicaid or other Federal health care programs rules and reimbursement guidelines in making assessments in each Systems Assessment and Claims Review;
3. if in doubt of the application of a particular Medicare, Medicaid or other Federal health care programs policy or regulation, request clarification from the appropriate authority (e.g., fiscal intermediary or carrier, or Medicaid);
4. respond to all OIG inquiries in a prompt, objective, and factual manner; and
5. prepare timely, clear, well-written reports that include all the information required by the CIA, including Appendix B to the CIA.

D. IRO Independence and Objectivity

The IRO must perform the Systems Assessment and Claims Review in a professionally independent and objective fashion, as appropriate to the nature of the engagement, taking into account any other business relationships or engagements that may exist between the IRO and HMC.

E. IRO Removal/Termination

1. *Provider and IRO.* If HMC terminates its IRO or if the IRO withdraws from the engagement during the term of the CIA, HMC must submit a notice explaining its reasons for termination or the reason for withdrawal to OIG no later than 30 days after termination or withdrawal. HMC must engage a new IRO in accordance with Paragraph A of this Appendix and within 60 days of termination or withdrawal of the prior IRO or at least 60 days prior to the end of the current Reporting Period, whichever is earlier.

2. *OIG Removal of IRO.* In the event OIG has reason to believe the IRO does not possess the qualifications described in Paragraph B, is not independent and objective as set forth in Paragraph D, or has failed to carry out its responsibilities as described in Paragraph C, OIG may, at its sole discretion, require HMC to engage a new IRO in accordance with Paragraph A of this Appendix. HMC must engage a new IRO within 60 days of termination of the prior IRO or at least 60 days prior to the end of the current Reporting Period, whichever is earlier.

Prior to requiring HMC to engage a new IRO, OIG shall notify HMC of its intent to do so and provide a written explanation of why OIG believes such a step is necessary. To resolve any concerns raised by OIG, HMC may present additional information regarding the IRO's qualifications, independence or performance of its responsibilities. OIG will attempt in good faith to resolve any differences regarding the IRO with HMC prior to requiring HMC to terminate the IRO. However, the final determination as to whether or not to require HMC to engage a new IRO shall be made at the sole discretion of OIG.

APPENDIX B

CLAIMS REVIEW

A. Claims Review. The IRO shall perform the Claims Review annually to cover each of the five Reporting Periods. The IRO shall perform all components of each Claims Review.

1. *Definitions*. For the purposes of the Claims Review, the following definitions shall be used:

- a. Overpayment: The amount of money HMC has received in excess of the amount due and payable under any Federal health care program requirements for inpatient services or items provided to patients in the Children and Adolescent Behavioral Health Services Unit at OSUMC (“the Unit”).
- b. Paid Claim: A claim submitted by HMC for inpatient psychiatric services or items provided to patients in the Unit and for which HMC has received reimbursement from Federal health care programs, including but not limited to, the Medicaid program.
- c. Population: The Population shall be defined as all Paid Claims during the 12-month period covered by the Claims Review.
- d. Error Rate: The Error Rate shall be the percentage of net Overpayments identified in the sample. The net Overpayments shall be calculated by subtracting all underpayments identified in the sample from all gross Overpayments identified in the sample. (Note: Any potential cost settlements or other supplemental payments should not be included in the net Overpayment calculation. Rather, only underpayments identified as part of the Discovery Sample shall be included as part of the net Overpayment calculation.)

The Error Rate is calculated by dividing the net Overpayment identified in the sample by the total dollar amount associated with the Paid Claims in the sample.

2. *Discovery Sample*. The IRO shall randomly select and review a sample of 50 Paid Claims (Discovery Sample). The Paid Claims shall be reviewed based

on the supporting documentation available at HMC's office or under HMC's control and applicable billing and coding regulations and guidance to determine whether the claim was correctly coded, submitted, and reimbursed.

If the Error Rate (as defined above) for the Discovery Sample is less than 5%, no additional sampling is required, nor is the Systems Review required. (Note: The guidelines listed above do not imply that this is an acceptable error rate. Accordingly, HMC should, as appropriate, further analyze any errors identified in the Discovery Sample. HMC recognizes that OIG or other HHS component, in its discretion and as authorized by statute, regulation, or other appropriate authority may also analyze or review Paid Claims included, or errors identified, in the Discovery Sample or any other segment of the universe.)

3. *Full Sample.* If the Discovery Sample indicates that the Error Rate is 5% or greater, the IRO shall select an additional sample of Paid Claims (Full Sample) using commonly accepted sampling methods. The Full Sample shall be designed to: (1) estimate the actual Overpayment in the population with a 90% confidence level and with a maximum relative precision of 25% of the point estimate; and (2) conform with the Centers for Medicare and Medicaid Services' statistical sampling for overpayment estimation guidelines. The Paid Claims selected for the Full Sample shall be reviewed based on supporting documentation available at HMC or under HMC's control and applicable billing and coding regulations and guidance to determine whether the claim was correctly coded, submitted, and reimbursed. For purposes of calculating the size of the Full Sample, the Discovery Sample may serve as the probe sample, if statistically appropriate. Additionally, the IRO may use the Paid Claims sampled as part of the Discovery Sample, and the corresponding findings for those Paid Claims, as part of its Full Sample, if: (1) statistically appropriate and (2) the IRO selects the Full Sample Paid Claims using the seed number generated by the Discovery Sample. OIG, in its sole discretion, may refer the findings of the Full Sample (and any related workpapers) received from HMC to the appropriate Federal health care program payor, including the Medicare contractor (e.g., carrier, fiscal intermediary, or DMERC), for appropriate follow-up by that payor.

4. *Systems Review.* If HMC's Discovery Sample identifies an Error Rate of 5% or greater, HMC's IRO shall also conduct a Systems Review. The Systems Review shall consist of the following:

- a. a review of HMC's billing and coding systems and processes relating to claims submitted to Federal health care programs (including, but not limited to, the operation of the billing system, the process by which claims are coded, safeguards to ensure proper coding, claims submission and billing; and

procedures to identify and correct inaccurate coding and billing);

- b. for each claim in the Discovery Sample and Full Sample that resulted in an Overpayment, the IRO shall review the system(s) and process(es) that generated the claim and identify any problems or weaknesses that may have resulted in the identified Overpayments. The IRO shall provide its observations and recommendations on suggested improvements to the system(s) and the process(es) that generated the claim.

5. *Other Requirements*

- a. Supplemental Materials. The IRO shall request all documentation and materials required for its review of the Paid Claims selected as part of the Discovery Sample or Full Sample (if applicable), and HMC shall furnish such documentation and materials to the IRO prior to the IRO initiating its review of the Discovery Sample or Full Sample (if applicable). If the IRO accepts any supplemental documentation or materials from HMC after the IRO has completed its initial review of the Discovery Sample or Full Sample (if applicable) (Supplemental Materials), the IRO shall identify in the Claims Review Report the Supplemental Materials, the date the Supplemental Materials were accepted, and the relative weight the IRO gave to the Supplemental Materials in its review. In addition, the IRO shall include a narrative in the Claims Review Report describing the process by which the Supplemental Materials were accepted and the IRO's reasons for accepting the Supplemental Materials.
- b. Paid Claims without Supporting Documentation. Any Paid Claim for which HMC cannot produce documentation sufficient to support the Paid Claim shall be considered an error and the total reimbursement received by HMC for such Paid Claim shall be deemed an Overpayment. Replacement sampling for Paid Claims with missing documentation is not permitted.
- c. Use of First Samples Drawn. For the purposes of all samples (Discovery Sample(s) and Full Sample(s)) discussed in this Appendix, the Paid Claims selected in each first sample shall

be used (i.e., it is not permissible to generate more than one list of random samples and then select one for use with the Discovery Sample or Full Sample).

6. *Repayment of Identified Overpayments.* HMC shall repay within 30 days any Overpayment(s) identified in the Discovery Sample or the Full Sample (if applicable), regardless of the Error Rate, to the appropriate payor and in accordance with payor refund policies. HMC shall make available to OIG all documentation that reflects the refund of the Overpayment(s) to the payor.

B. Claims Review Report. The IRO shall prepare a Claims Review Report as described in this Appendix for each Claims Review performed. The following information shall be included in the Claims Review Report for each Discovery Sample and Full Sample (if applicable).

1. *Claims Review Methodology*

- a. Claims Review Population. A description of the Population subject to the Claims Review.
- b. Claims Review Objective. A clear statement of the objective intended to be achieved by the Claims Review.
- c. Source of Data. A description of the specific documentation relied upon by the IRO when performing the Claims Review (e.g., medical records, physician orders, certificates of medical necessity, requisition forms, local medical review policies (including title and policy number), CMS program memoranda (including title and issuance number), Medicare carrier or intermediary or Medicaid manuals or bulletins (including issue and date), other policies, regulations, or directives).
- d. Review Protocol. A narrative description of how the Claims Review was conducted and what was evaluated.
- e. Supplemental Materials. A description of any Supplemental Materials as required by A.5.a., above.

2. *Statistical Sampling Documentation*

- a. A copy of the printout of the random numbers generated by the “Random Numbers” function of the statistical sampling software used by the IRO.
 - b. A copy of the statistical software printout(s) estimating how many Paid Claims are to be included in the Full Sample, if applicable.
 - c. A description or identification of the statistical sampling software package used to select the sample and determine the Full Sample size, if applicable.
3. *Claims Review Findings*
- a. Narrative Results
 - i. A description of HMC’s billing and coding system(s), including the identification, by position description, of the personnel involved in coding and billing.
 - ii. A narrative explanation of the IRO’s findings and supporting rationale (including reasons for errors, patterns noted, etc.) regarding the Claims Review, including the results of the Discovery Sample, and the results of the Full Sample (if any).
 - b. Quantitative Results
 - i. Total number and percentage of instances in which the IRO determined that the Paid Claims submitted by HMC differed from what should have been the correct claim (Correct Claim), regardless of the effect on the payment.
 - ii. Total number and percentage of instances in which the Claim Submitted differed from the Correct Claim and in which such difference resulted in an Overpayment to HMC.
 - iii. Total dollar amount of all Overpayments in the sample.
 - iv. Total dollar amount of Paid Claims included in the sample and the net Overpayment associated with the sample.

- v. Error Rate in the sample.
- vi. A spreadsheet of the Claims Review results that includes the following information for each Paid Claim: Federal health care program billed, beneficiary health insurance claim number, date of service, code submitted (e.g., DRG, CPT code, etc.), code reimbursed, allowed amount reimbursed by payor, correct code (as determined by the IRO), correct allowed amount (as determined by the IRO), dollar difference between allowed amount reimbursed by payor and the correct allowed amount.
- c. Recommendations. The IRO's report shall include any recommendations for improvements to HMC's billing and coding system based on the findings of the Claims Review

4. *Systems Review Findings*. The IRO shall prepare a Systems Review Report based on the Systems Review performed (if applicable) that shall include the IRO's observations, findings, and recommendations regarding:

- a. the strengths and weaknesses in HMC's billing systems and processes;
- b. the strengths and weaknesses in HMC's coding systems and processes; and
- c. possible improvements to HMC's billing and coding systems and processes to address the specific problems or weaknesses that resulted in the identified Overpayments.

5. *Credentials*. The names and credentials of the individuals who: (1) designed the statistical sampling procedures and the review methodology utilized for the Claims Review and (2) performed the Claims Review.