

**CORPORATE INTEGRITY AGREEMENT
BETWEEN THE
OFFICE OF INSPECTOR GENERAL
OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
EL CENTRO REGIONAL MEDICAL CENTER**

I. PREAMBLE

El Centro Regional Medical Center (ECRMC) 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, ECRMC is 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 ECRMC under this CIA shall be five years from the effective date of this CIA, unless otherwise specified. The effective date shall be the date on which the final signatory of this CIA executes this CIA (Effective Date). Each one-year period, beginning with the one-year period following the Effective Date, shall be referred to as a "Reporting Period."

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

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

1. "Covered Persons" includes:

a. all owners, officers, directors, and employees of ECRMC;

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b. all contractors, subcontractors, agents, and other persons who provide patient care items or services or who perform billing or coding functions on behalf of ECRMC, excluding vendors whose sole connection with ECRMC is selling or otherwise providing medical supplies or equipment to ECRMC and who do not bill the Federal health care programs for such medical supplies or equipment; and

c. all physicians and other non-physician practitioners who are members of ECRMC's active medical staff.

Notwithstanding the above, this term does not include part-time or per diem employees, contractors, subcontractors, agents, and other persons who are not reasonably expected to work more than 160 hours per year, except that any such individuals shall become "Covered Persons" at the point when they work more than 160 hours during the calendar year.

2. "Relevant Billing Covered Persons" includes Covered Persons involved in the preparation or submission of claims or cost reports for reimbursement from any Federal health care program.
3. "Relevant Clinical Covered Persons" includes Covered Persons involved in the delivery of patient care items or services.
4. "Relevant Care Management Covered Persons" includes Covered Persons who work in or for an ECRMC Care Management Department and who are involved in Care Management or Utilization Review functions relating to inpatient admission or discharge decisions.

III. CORPORATE INTEGRITY OBLIGATIONS

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

A. Compliance Officer and Committee.

1. *Compliance Officer.* Within 90 days after the Effective Date, ECRMC shall appoint an individual to serve as its Compliance Officer and shall maintain a

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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 and with Federal health care program requirements. The Compliance Officer shall be a member of senior management of ECRMC, shall report directly to the Chief Executive Officer of ECRMC, shall make periodic (at least quarterly) reports regarding compliance matters directly to the Board of Directors of ECRMC, and shall be authorized to report on such matters to the Board of Directors at any time. The Compliance Officer shall not be or be subordinate to the General Counsel or Chief Financial Officer. The Compliance Officer shall be responsible for monitoring the day-to-day compliance activities engaged in by ECRMC as well as for any reporting obligations created under this CIA. 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.

ECRMC shall report to OIG, in writing, any change 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 days after the change.

2. *Compliance Committee.* Within 90 days after the Effective Date, ECRMC shall appoint a Compliance Committee. The Compliance Committee shall, at a minimum, include 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 shall chair the Compliance Committee and the Committee shall support the Compliance Officer in fulfilling his/her responsibilities (e.g., shall assist in the analysis of the ECRMC's risk areas and shall oversee monitoring of internal and external audits and investigations). The Compliance Committee shall meet at least quarterly.

ECRMC 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.

B. Written Standards.

1. *Code of Conduct.* Within 90 days after the Effective Date, ECRMC shall develop, implement, and distribute a written Code of Conduct to all Covered Persons. ECRMC shall make the promotion of, and adherence to, the Code of Conduct an element in evaluating the performance of all employees. The Code of Conduct shall, at a minimum, set forth:

- a. ECRMC'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. ECRMC's requirement that all of its Covered Persons shall be expected to comply with all Federal health care program requirements and with ECRMC's own Policies and Procedures;
- c. the requirement that all of ECRMC's Covered Persons shall be expected to report to the Compliance Officer, or other appropriate individual designated by ECRMC, suspected violations of any Federal health care program requirements or of ECRMC's own Policies and Procedures;
- d. the possible consequences to both ECRMC and Covered Persons of failure to comply with Federal health care program requirements and with ECRMC's own Policies and Procedures and the failure to report such noncompliance; and
- e. the right of all individuals to use the Disclosure Program described in Section III.E, and ECRMC's commitment to nonretaliation and to maintain, as appropriate, confidentiality and anonymity with respect to such disclosures.

Within 90 days after the Effective Date, each Covered Person shall certify, in writing, or in electronic form, if applicable, that he or she has received, read, understood, and shall abide by ECRMC'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.

ECRMC 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 120 days after the Effective Date, ECRMC shall implement written Policies and Procedures regarding the operation of its compliance program, including the compliance program requirements outlined in this CIA, and ECRMC's compliance with Federal health care program requirements.

At a minimum, the Policies and Procedures shall address:

- a. the subjects relating to the Code of Conduct identified in Section III.B.1;
- b. billing and reimbursement: these Policies and Procedures shall be designed to ensure ECRMC complies with all Federal health care program requirements on billing and reimbursement, including:
 - i. ensuring proper and accurate submission of claims and cost reports to Federal health care programs;
 - ii. ensuring the proper and accurate documentation of medical records;
 - iii. ensuring the proper and accurate assignment and designation of patients into inpatient, outpatient, or observation status; and
 - iv. ensuring the necessary and appropriate length of stays and timely discharges for all patients;
- c. documentation of medical records: these Policies and Procedures shall be designed to ensure ECRMC complies with Federal

health care program requirements applicable to the documentation of medical records:

- i. ensuring proper and accurate documentation in the billing and coding and reimbursement process;
- ii. the personal obligation of each individual involved in the medical documentation process to ensure that such documentation is accurate;
- iii. the legal sanctions for violations of the Federal health care program requirements; and
- iv. examples of proper and improper medical documentation practices.

d. requirements for Care Management employees:

- i. the Policies and Procedures for determining the medical necessity and appropriateness of inpatient admissions, including applicable Medicare rules and regulations;
- ii. the role and function of the utilization review committee; and
- iii. Care Management Certification Requirements.

Within 120 days after the Effective Date, the relevant portions of the Policies and Procedures shall be distributed to all Covered Persons whose job functions relate to those Policies and Procedures. Appropriate and knowledgeable staff shall be available to explain the Policies and Procedures.

At least annually (and more frequently, if appropriate), ECRMC 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 Covered Persons.

C. Training and Education.

1. *General Training.* Within 120 days after the Effective Date, ECRMC shall provide at least two hours of General Training to each Covered Person. This training, at a minimum, shall explain ECRMC's:

- a. CIA requirements; and
- b. ECRMC's 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 120 days after the Effective Date, whichever is later. After receiving the initial General Training described above, each Covered Person shall receive at least a one hour of General Training in each subsequent Reporting Period.

2. *Specific Training.*

a. Billing and Reimbursement Training. Within 120 days after the Effective Date, each Relevant Billing Covered Person shall receive at least three hours of Billing and Reimbursement Specific Training in addition to the General Training required above. This Specific Training shall include a discussion of:

- i. the Federal health care program requirements regarding the accurate coding and submission of claims;
- ii. policies, procedures, and other requirements applicable to the documentation of medical records;
- iii. the personal obligation of each individual involved in the claims submission process to ensure that such claims are accurate;

- iv. applicable reimbursement statutes, regulations, and program requirements and directives (including those that define appropriate inpatient – outpatient status designations);
- v. the legal sanctions for violations of the Federal health care program requirements; and
- vi. examples of proper and improper claims submission practices.

b. Document Training. Within 120 days after the Effective Date, each Relevant Clinical Covered Person shall receive at least two hours of Document Specific Training in addition to the General Training required above. This Specific Training shall include a discussion of:

- i. policies, procedures, and other Federal health care program requirements applicable to the documentation of medical records;
- ii. the importance of accurate documentation in the billing and coding and reimbursement process;
- iii. the personal obligation of each individual involved in the medical documentation process to ensure that such documentation is accurate;
- iv. the legal sanctions for violations of the Federal health care program requirements; and
- v. examples of proper and improper medical documentation practices.

Relevant Billing Covered Persons who are also Relevant Clinical Covered Persons shall undergo both Billing and Reimbursement Specific Training and Documentation Specific Training.

c. Care Management Training. Within 120 days after the Effective Date, each Relevant Care Management Covered Person shall receive at least two hours of Care Management Specific Training in addition to the Billing and Reimbursement Specific Training, the Document Specific Training, and the General Training required above. This Care Management Training shall include a discussion of:

- i. the policies and procedures for determining the medical necessity and appropriateness of inpatient admissions, including applicable Medicare rules and regulations; and
- ii. the role and function of the utilization review committee.

New Relevant Billing Covered Persons, new Relevant Clinical Covered Persons, and new Relevant Care Management Covered Persons shall receive this training, as appropriate to their responsibilities, within 30 days after the beginning of their employment or becoming new Relevant Billing Covered Persons, new Relevant Clinical Covered Persons, or new Relevant Care Management Covered Persons, or within 120 days after the Effective Date, whichever is later. Each new Relevant Billing Covered Person, new Relevant Clinical Covered Person, and new Relevant Care Management Covered Person shall have his or her work reviewed by an ECRMC employee who has completed the Specific Training, to the extent that the work relates to (i) the delivery of patient care items or services, (ii) the preparation or submission of claims or cost reports for reimbursement from any Federal health care program, or (iii) any Care Management or Utilization Review function, until such time as the new Relevant Billing Covered Person, new Relevant Clinical Covered Person, or new Relevant Care Management Covered Person completes his or her Specific Training as required above.

After receiving the initial Specific Training described in this Section, each Relevant Billing Covered Person shall receive at least two hours of Billing and Reimbursement Specific Training in each subsequent Reporting Period, each Relevant Clinical Covered Person shall receive at least two hours of Documentation Specific Training in each subsequent Reporting Period, and each Relevant Care Management Covered Person shall receive at least two hours of Care Management Training in each subsequent Reporting Period.

d. Care Management Certification. Within 120 days, ECRMC will establish requirements for Care Management employees, and

ECRMC will maintain those requirements, as described in this paragraph, for the term of this CIA. In addition to receiving the General and Specific Training described above, each Relevant Care Management Covered Person must be a graduate of an accredited school of nursing and must have and for the term of this CIA maintain a current license as a registered nurse in California. Within one year of becoming eligible to take the exam, each Relevant Care Management Covered Person shall also obtain, and for the term of this CIA shall maintain, a current certification as either:

- i. Certified Case Manager; or
- ii. Any other comparable accreditation or certification program approved by ECRMC.

3. *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. These shall be made available to OIG, upon request.

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

5. *Update of Training.* ECRMC 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 the Inpatient Medical Necessity and Appropriateness Review, Unallowable Costs Review, and any other relevant information.

6. *Computer-based Training.* ECRMC may provide the training required under this CIA through appropriate computer-based training approaches. If ECRMC 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.

7. *Exception for Active Medical Staff Members.* ECRMC shall make the General Training and Specific Training (as appropriate) described in this Section III.C

available to all of ECRMC's active medical staff members and shall use its best efforts to encourage such active medical staff members to complete the training. The Compliance Officer shall maintain records of all active medical staff members who receive training, including the type of training and the date received. These records shall be made available to OIG, upon request.

D. Review Procedures.

1. *General Description.*

a. *Engagement of Independent Review Organization.* Within 90 days after the Effective Date, ECRMC shall engage an entity (or entities), such as an accounting, auditing, or consulting firm (hereinafter "Independent Review Organization" or "IRO"), to perform reviews to assist ECRMC in assessing and evaluating the medical necessity and appropriateness of inpatient admissions and certain other obligations pursuant to this CIA and the Settlement Agreement. The applicable requirements relating to the IRO are outlined in Appendix A to this CIA, which is incorporated by reference.

The IRO shall evaluate and analyze ECRMC's inpatient admissions, relevant length of stays (as identified in Section A.1.c. of Appendix B), associated billing, and claims submission to Medicare and the reimbursement received, and determine if such admissions and lengths of stays were medically necessary and appropriate under the applicable Medicare rules and regulations governing inpatient admission, treatment, discharge, billing, and reimbursement (Inpatient Medical Necessity and Appropriateness Review). The IRO shall analyze whether ECRMC sought payment for certain unallowable costs (Unallowable Cost Review).

b. *Frequency of Inpatient Medical Necessity and Appropriateness Review.* The Inpatient Medical Necessity and Appropriateness Review shall be performed annually and shall cover each of the Reporting Periods. The IRO(s) shall perform all components of each annual Inpatient Medical Necessity and Appropriateness Review.

c. *Frequency of Unallowable Cost Review.* The IRO shall perform the Unallowable Cost Review at the end of the first Reporting Period.

d. *Frequency of Systems Review.* If ECRMC's Discovery Sample of 50 Inpatient Admission Paid Claims (as defined in Appendix B) identifies an Error Rate (as defined in Appendix B) is 5% or greater, ECRMC's IRO shall also conduct a Systems Review, as specified in Appendix B.

In the first Reporting Period, regardless of the Error Rate of the Discovery Sample of 50 Inpatient Admission Paid Claims (as defined in Appendix B), the IRO shall conduct a Systems Review (as defined in Appendix B) of ECRMC's Case Management Protocol (as defined in Appendix B), and shall include its findings in the Inpatient Medical Necessity and Appropriateness Review Report, as specified in Appendix B.

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

2. *Inpatient Medical Necessity and Appropriateness Review.* The Inpatient Medical Necessity and Appropriateness Review shall include a Discovery Sample consisting of 50 Inpatient Admission Paid Claims (as defined in Appendix B). If the Error Rate for the Discovery Sample is 5% or greater, a Full Sample and Systems Review shall be conducted. The applicable definitions, procedures, and reporting requirements are outlined in Appendix B to this CIA, which is incorporated by reference.

3. *Inpatient Medical Necessity and Appropriateness Review Report.* The IRO shall prepare a report based upon the Inpatient Medical Necessity and Appropriateness Review performed (Inpatient Medical Necessity and Appropriateness Review Report). Information to be included in the Inpatient Medical Necessity and Appropriateness Review Report is described in Appendix B.

4. *Repayment of Identified Overpayments.* ECRMC 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. ECRMC shall make available to OIG all documentation that reflects the refund of the Overpayment(s) to the payor.

5. *Unallowable Cost Review.* In the first Reporting Period the IRO shall conduct a review of ECRMC's compliance with the unallowable cost provisions of the Settlement Agreement. The IRO shall determine whether ECRMC 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 ECRMC 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.

6. *Unallowable Cost Review Report.* The IRO shall prepare a report based upon the Unallowable Cost Review performed. The Unallowable Cost Review Report shall include the IRO's findings and supporting rationale regarding the Unallowable Cost Review and whether ECRMC 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.

7. *Validation Review.* In the event OIG has reason to believe that: (a) ECRMC's Inpatient Medical Necessity and Appropriateness Review or Unallowable Cost Review fails to conform to the requirements of this CIA; or (b) the IRO's findings or Inpatient Medical Necessity and Appropriateness Review or Unallowable Cost Review results are inaccurate, OIG may, at its sole discretion, conduct its own review to determine whether the Inpatient Medical Necessity and Appropriateness Review or Unallowable Cost Review complied with the requirements of the CIA and/or the findings or Inpatient Medical Necessity and Appropriateness Review or Unallowable Cost Review results are inaccurate (Validation Review). ECRMC 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 ECRMC's final Annual Report shall be initiated no later than one year after ECRMC's final submission (as described in Section II) is received by OIG.

Prior to initiating a Validation Review, OIG shall notify ECRMC 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, ECRMC may request a meeting with OIG to: (a) discuss the results of any Inpatient Medical Necessity and Appropriateness Review or Unallowable Cost Review submissions or findings; (b) present any additional information to clarify the results of the Inpatient Medical Necessity and Appropriateness Review or Unallowable Cost Review or to correct the inaccuracy of the Inpatient Medical Necessity and Appropriateness Review or Unallowable Cost Review; and/or (c) propose alternatives to the proposed Validation Review. ECRMC agrees to provide any additional information as may be requested by OIG under this Section III.D.7 in an expedited manner. OIG will attempt in good faith to resolve any Inpatient Medical Necessity and Appropriateness Review or Unallowable Cost Review issues with ECRMC 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.

8. *Independence and Objectivity Certification.* The IRO shall include in its report(s) to ECRMC a certification or sworn affidavit that it has evaluated its professional independence and objectivity, as appropriate to the nature of the engagement, with regard to the Inpatient Medical Necessity and Appropriateness Review and Unallowable Cost Review and that it has concluded that it is, in fact, independent and objective.

E. Disclosure Program.

Within 90 days after the Effective Date, ECRMC shall establish 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 ECRMC'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. ECRMC shall 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 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, ECRMC 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. The disclosure log shall be made available to OIG upon request.

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.* ECRMC shall ensure that all prospective and current Covered Persons are not Ineligible Persons, by implementing the following screening requirements.

a. ECRMC shall screen all prospective and current 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. ECRMC shall screen all Covered Persons against the Exclusion Lists within 90 days after the Effective Date and on an annual basis thereafter.

c. ECRMC 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 this Section affects ECRMC's responsibility to refrain from (and liability for) billing Federal health care programs for items or services furnished, ordered, or prescribed by excluded persons. ECRMC understands that items or services furnished by excluded persons are not payable by Federal health care programs and that ECRMC may be liable for overpayments and/or criminal, civil, and administrative sanctions for employing or contracting with an excluded person regardless of whether ECRMC meets the requirements of Section III.F.

3. *Removal Requirement.* If ECRMC has actual notice that a Covered Person has become an Ineligible Person, ECRMC shall remove such Covered Person from responsibility for, or involvement with, ECRMC'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 ECRMC 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, ECRMC 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, or resident, or any claims submitted to any Federal health care program.

G. Notification of Government Investigation or Legal Proceedings.

Within 30 days after discovery, ECRMC shall notify OIG, in writing, of any ongoing investigation or legal proceeding known to ECRMC conducted or brought by a governmental entity or its agents involving an allegation that ECRMC 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. ECRMC 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.

H. Repayment of Overpayments.

1. *Definition of Overpayments.* For purposes of this CIA, an "Overpayment" shall mean the amount of money ECRMC has received in excess of the amount due and payable under any Federal health care program requirements.

2. *Repayment of Overpayments.*

a. If, at any time, ECRMC identifies any Overpayment, ECRMC shall repay the Overpayment to the appropriate payor (e.g., Medicare fiscal intermediary, carrier, or Medicare Administrative Contactor) 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, ECRMC 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 ECRMC.

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

2. *Reporting of Reportable Events.* If ECRMC determines (after a reasonable opportunity to conduct an appropriate review or investigation of the allegations) through any means that there is a Reportable Event, ECRMC 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 the 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 ECRMC 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 ECRMC's actions taken to correct the Reportable Event; and
- e. any further steps ECRMC 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 ECRMC's actions taken to correct the Reportable Event;
- c. any further steps ECRMC 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 ECRMC 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 the OIG shall include documentation of the bankruptcy filing and a description of any Federal health care program authorities implicated.

IV. CHANGES TO BUSINESS UNITS OR LOCATIONS

A. Change or Closure of Unit or Location. In the event that, after the Effective Date, ECRMC changes locations or closes a business unit or location related to the furnishing of items or services that may be reimbursed by Federal health care programs, ECRMC shall notify OIG of this fact as soon as possible, but no later than within 30 days after the date of change or closure of the location.

B. Purchase or Establishment of New Unit or Location. In the event that, after the Effective Date, ECRMC purchases or establishes a new business unit or location related to the furnishing of items or services that may be reimbursed by Federal health care programs, ECRMC 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 ECRMC 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, ECRMC proposes to sell any or all of its business units or locations that are subject to this CIA, ECRMC shall notify OIG of the proposed sale at least 30 days prior to the sale of such business unit or location. This notification shall include a description of the business unit or location to be sold, 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 such business unit or location, unless otherwise determined and agreed to in writing by the OIG.

V. IMPLEMENTATION AND ANNUAL REPORTS

A. Implementation Report. Within 150 days after the Effective Date, ECRMC 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 and positions of the members of the Compliance Committee required by Section III.A;
3. a copy of ECRMC's Code of Conduct required by Section III.B.1;
4. 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);
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. 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;
 - b. the number of individuals required to be trained, percentage of individuals actually trained, and an explanation of any exceptions; and
 - c. with respect to active medical staff members, the number and percentage who completed the training, the type of training and the date received, and a description of ECRMC's efforts to encourage medical staff members to complete the training.

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

7. a description of the Disclosure Program required by Section III.E;
8. the following information regarding the IRO(s): (a) identity, address, and phone number; (b) a copy of the engagement letter; and (c) a summary and description of any and all current and prior engagements and agreements between ECRMC and the IRO;
9. a certification from the IRO regarding its professional independence and objectivity with respect to ECRMC;
10. a description of the process by which ECRMC fulfills the requirements of Section III.F regarding Ineligible Persons;
11. a list of all of ECRMC'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 and/or supplier number(s); and the name and address of each Medicare and state Medicaid program contractor to which ECRMC currently submits claims;
12. a description of ECRMC's corporate structure, including identification of any parent and sister companies, subsidiaries, and their respective lines of business; and
13. the certifications required by Section V.C.

B. Annual Reports. ECRMC shall submit to OIG annually a report with respect to the status of, and findings regarding, ECRMC'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. 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);

3. 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);

4. the following information regarding each type of training, licensure, or certification 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;

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; and

c. with respect to active medical staff members, the number and percentage who completed the training, the type of training and the date received, and a description of ECRMC's efforts to encourage medical staff members to complete the training.

d. a statement that all Relevant Care Management Covered Persons have obtained and properly maintained the licensure and certifications required by Section III.C.2, and an explanation of any exceptions.

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

5. a complete copy of all reports prepared pursuant to Section III.D, along with a copy of the IRO's engagement letter;

6. ECRMC's response to the reports prepared pursuant to Section III.D, along with corrective action plan(s) related to any issues raised by the reports;
7. a summary and description of any and all current and prior engagements and agreements between ECRMC and the IRO, (if different from what was submitted as part of the Implementation Report);
8. a certification from the IRO regarding its professional independence and objectivity with respect to ECRMC;
9. 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;
10. a report of the aggregate Overpayments that have been returned to the 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;
11. a summary of the disclosures in the disclosure log required by Section III.E that relate to Federal health care programs;
12. any changes to the process by which ECRMC fulfills the requirements of Section III.F regarding Ineligible Persons;
13. 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;
14. a description of all changes to the most recently provided list of ECRMC'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

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Medicare and state Medicaid program contractor to which ECRMC currently submits claims; and

15. 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 each Annual Report shall include a certification by the Compliance Officer that:

1. to the best of his or her knowledge, except as otherwise described in the report, ECRMC is in compliance with all of the requirements of this CIA;

2. 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

3. to the best of his or her knowledge, ECRMC 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. ECRMC 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. ECRMC 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:

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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

ECRMC: Andrea Hammond
Compliance Officer
El Centro Regional Medical Center
1415 Ross, El Centro, CA 92243
Telephone: 760.482.5088
Facsimile: 760.339.7363
Email: AHammond@ecrmc.org

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, ECRMC 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), either instead of or 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 ECRMC's books, records, and other documents and supporting materials and/or conduct on-site reviews of any of ECRMC's locations for the purpose of verifying and evaluating: (a) ECRMC's compliance with the terms of this CIA; and (b) ECRMC's compliance with the requirements of the Federal health care programs in which it participates. The documentation described above shall be made available by ECRMC 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 ECRMC's employees, contractors, or agents who consent to be

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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. ECRMC shall assist OIG or its duly authorized representative(s) in contacting and arranging interviews with such individuals upon OIG's request. ECRMC's employees may elect to be interviewed with or without a representative of ECRMC present.

VIII. DOCUMENT AND RECORD RETENTION

ECRMC shall maintain for inspection all documents and records relating to reimbursement from the Federal health care programs and 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 ECRMC prior to any release by OIG of information submitted by ECRMC pursuant to its obligations under this CIA and identified upon submission by ECRMC as trade secrets, or information that is commercial or financial and privileged or confidential, under the FOIA rules. With respect to such releases, ECRMC shall have the rights set forth at 45 C.F.R. § 5.65(d).

X. BREACH AND DEFAULT PROVISIONS

ECRMC 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, ECRMC 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 ECRMC fails to establish and implement any of the following obligations as described in Section III:

- a. a Compliance Officer;
- b. a Compliance Committee;

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- c. a written Code of Conduct;
- d. written Policies and Procedures;
- e. the training of Covered Persons and Relevant Covered Persons;
- 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 ECRMC fails to engage 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 ECRMC 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 ECRMC fails to submit any Inpatient Medical Necessity and Appropriateness 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 ECRMC fails to grant access as required in Section VII. (This Stipulated Penalty shall begin to accrue on the date ECRMC fails to grant access.)

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

7. A Stipulated Penalty of \$1,000 for each day ECRMC fails to comply fully and adequately with any obligation of this CIA. OIG shall provide notice to ECRMC stating the specific grounds for its determination that ECRMC has failed to comply fully and adequately with the CIA obligation(s) at issue and steps ECRMC shall take to comply with the CIA. (This Stipulated Penalty shall begin to accrue 10 days after ECRMC 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. ECRMC 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 ECRMC 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 ECRMC 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 ECRMC 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 ECRMC of: (a) ECRMC's failure to comply; and (b) OIG's exercise of its contractual right to demand payment of the Stipulated Penalties (this notification is referred to as the "Demand Letter").

2. *Response to Demand Letter.* Within 10 days after the receipt of the Demand Letter, ECRMC shall either: (a) cure the breach to OIG's satisfaction and pay the applicable Stipulated Penalties or (b) request a hearing before an HHS administrative law judge (ALJ) to dispute OIG's determination of noncompliance, pursuant to the agreed upon provisions set forth below in Section X.E. In the event ECRMC elects to request an ALJ hearing, the Stipulated Penalties shall continue to accrue until ECRMC 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.c, these provisions for payment of Stipulated Penalties shall not affect or otherwise set a standard for OIG's decision that ECRMC 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 ECRMC to report a Reportable Event, take corrective action, and make the appropriate refunds, as required in Section III.I;
- c. a failure to engage and use an IRO in accordance with Section III.D and Appendix B; or
- d. a failure to respond to a Demand Letter concerning the payment of Stipulated Penalties in accordance with Section X.C.

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

3. *Opportunity to Cure.* ECRMC 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. ECRMC 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) ECRMC has begun to take action to cure the material breach; (ii) ECRMC is pursuing such action with due diligence; and (iii) ECRMC has provided to OIG a reasonable timetable for curing the material breach.

4. *Exclusion Letter.* If, at the conclusion of the 30 day period, ECRMC fails to satisfy the requirements of Section X.D.3, OIG may exclude ECRMC from participation in the Federal health care programs. OIG shall notify ECRMC in writing of its determination to exclude ECRMC (this letter shall be referred to hereinafter 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 ECRMC'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, ECRMC 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 ECRMC of its Demand Letter or of its Exclusion Letter, and as an agreed-upon contractual remedy for the resolution of disputes arising under this CIA, ECRMC 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 to 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 ECRMC was in full and timely compliance with the obligations of this CIA for which OIG demands payment; and (b) the period of noncompliance. ECRMC 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 ECRMC to pay Stipulated Penalties, such Stipulated Penalties shall become due and payable 20 days after the ALJ issues such a decision unless ECRMC 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 ECRMC 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) ECRMC had begun to take action to cure the material breach within that period; (ii) ECRMC has pursued and is pursuing such action with due diligence; and (iii) ECRMC provided to OIG within that period a reasonable timetable for curing the material breach and ECRMC 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 ECRMC, only after a DAB

decision in favor of OIG. ECRMC's election of its contractual right to appeal to the DAB shall not abrogate OIG's authority to exclude ECRMC 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 ECRMC 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. ECRMC 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 ECRMC, ECRMC shall be reinstated effective on the date of the original exclusion.

4. *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

ECRMC and OIG agree as follows:

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

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 ECRMC's obligations under this CIA based on a certification by ECRMC that it is no longer providing health care items or services 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 bills any Federal health care program. If ECRMC is relieved of its CIA obligations, ECRMC will be required to notify OIG in writing at least 30 days in advance if ECRMC plans to resume providing health care items or services that are billed to any Federal health care program or to obtain an ownership or control interest in any entity that bills any Federal

health care program. At such time, OIG shall evaluate whether the CIA will be reactivated or modified.

E. The undersigned ECRMC 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 ECRMC

/David R. Green/

DAVID R. GREEN
Chief Executive Officer
El Centro Regional Medical Center

7/19/2010

DATE

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Corporate Integrity Agreement

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

/Gregory E. Demske/

7/20/16

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

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.

ECRMC 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 and Section V.A.9 of the CIA, OIG will notify ECRMC if the IRO is unacceptable. Absent notification from OIG that the IRO is unacceptable, ECRMC may continue to engage the IRO.

If ECRMC 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, ECRMC shall submit the information identified in Section V.A.8 and Section V.A.9 of the CIA to OIG within 30 days of engagement of the IRO. Within 30 days after OIG receives this information, OIG will notify ECRMC if the IRO is unacceptable. Absent notification from OIG that the IRO is unacceptable, ECRMC may continue to engage the IRO.

B. IRO Qualifications.

The IRO shall:

1. assign individuals to conduct the Inpatient Medical Necessity and Appropriateness Review and Unallowable Cost Review engagement who have expertise in billing, coding, reporting, and other requirements governing inpatient admissions of patients covered by Medicare, and other requirements applicable to ECRMC and in the general requirements of the Federal health care program(s) from which ECRMC seeks reimbursement;
2. assign individuals to design and select the Inpatient Medical Necessity and Appropriateness Review sample who are knowledgeable about the appropriate statistical sampling techniques;
3. assign individuals to conduct the coding review portions of the Inpatient Medical Necessity and Appropriateness 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 Inpatient Medical Necessity and Appropriateness Review and Unallowable Cost review, if applicable, in accordance with the specific requirements of the CIA;

2. follow all applicable Medicare rules and reimbursement guidelines in making assessments in the Inpatient Medical Necessity and Appropriateness Review;

3. if in doubt of the application of a particular Medicare policy or regulation, request clarification from the appropriate authority (e.g., fiscal intermediary or carrier);

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 Appendix B to the CIA.

D. IRO Independence and Objectivity.

The IRO must perform the Inpatient Medical Necessity and Appropriateness Review and the Unallowable Cost 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 ECRMC.

E. IRO Removal/Termination.

1. *Provider.* If ECRMC terminates its IRO during the course of the engagement, ECRMC must submit a notice explaining its reasons to OIG no later than 30 days after termination. ECRMC must engage a new IRO in accordance with Paragraph A of this Appendix.

2. *OIG Removal of IRO.* In the event OIG has reason to believe that the IRO does not possess the qualifications described in Paragraph B, is not independent and/or 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 ECRMC to engage a new IRO in accordance with Paragraph A of this Appendix.

Prior to requiring ECRMC to engage a new IRO, OIG shall notify ECRMC 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, ECRMC may request a meeting with OIG to discuss any aspect of the IRO's qualifications, independence or performance of its responsibilities and to present additional information regarding these matters. ECRMC shall provide any additional information as may be requested by OIG under this Paragraph in an expedited manner. OIG will attempt in good faith to resolve any differences regarding the IRO with ECRMC prior to requiring ECRMC to terminate the IRO. However, the final determination as to whether or not to require ECRMC to engage a new IRO shall be made at the sole discretion of OIG.

APPENDIX B

INPATIENT MEDICAL NECESSITY AND APPROPRIATENESS REVIEW

A. Inpatient Medical Necessity and Appropriateness Review.

1. *Definitions.* For the purposes of the Inpatient Medical Necessity and Appropriateness Review, the following definitions shall be used:

a. Overpayment: The amount of money ECRMC has received in excess of the amount due and payable under any Federal health care program requirements.

b. Inpatient Admission Paid Claim: A claim submitted by ECRMC and for which ECRMC has received reimbursement from the Medicare program, limited to the following categories of claims/patients:

i. “Zero-day” inpatient admissions (i.e., claims bearing the same calendar date for both the admission and discharge date) (Zero-Day Stays); and

ii. “One-day” inpatient admissions (i.e., claims bearing an admission date followed by a discharge date one day later) (One-Day Stays).

c. Population: The Population shall be defined as all Inpatient Admission Paid Claims during the 12-month period covered by the Inpatient Medical Necessity and Appropriateness 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 Inpatient Admission Paid Claims in the sample.

e. Case Management Protocol: The case management/utilization protocol used by ECRMC in determining whether Medicare patients are treated at ECRMC on an inpatient or outpatient (observation) basis.

2. *Discovery Sample.*

The IRO shall randomly select and review a sample of 50 Inpatient Admission Paid Claims (as defined in this appendix) (Discovery Sample). The Inpatient Admission Paid Claims shall be reviewed based on the supporting documentation available at ECRMC's office or under ECRMC's control and applicable admission and length of stay criteria and billing and coding regulations and guidance to determine whether the claim was correctly categorized, coded, submitted, and reimbursed as an inpatient admission or whether the patient should have been treated and billed to Medicare on an outpatient basis.

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, except that in the first Reporting Period, a Systems Review of ECRMC's Case Management Protocol will be required regardless of the Error Rate for the Discovery Sample. (Note: The guidelines listed above do not imply that this is an acceptable error rate. Accordingly, ECRMC should, as appropriate, further analyze any errors identified in the Discovery Sample. ECRMC 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 Inpatient Admission 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 Inpatient Admission 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 & Medicaid Services' statistical sampling for overpayment estimation guidelines. The Inpatient Admission Paid Claims selected for the Full Sample shall be reviewed based on supporting documentation available at ECRMC's office or under ECRMC's control and applicable admission criteria and billing and coding regulations and guidance to determine whether the claim was correctly categorized, coded, submitted, and reimbursed as an inpatient admission, or whether the patient should have been treated and billed to Medicare on an outpatient basis. 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 Inpatient Admission Paid Claims sampled as part of the Discovery Sample, and the corresponding

findings for those Inpatient Admission Paid Claims, as part of its Full Sample, if: (1) statistically appropriate and (2) the IRO selects the Full Sample Inpatient Admission 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 ECRMC to the appropriate Federal health care program payor, including the Medicare contractor (e.g., carrier, fiscal intermediary, DMERC, or Medicare Administrative Contactor (MAC)), for appropriate follow-up by that payor.

4. *Systems Review.*

If ECRMC's Discovery Sample identifies an Error Rate of 5% or greater, ECRMC's IRO shall also conduct a Systems Review. 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.

In the first Reporting Period, regardless of the Discovery Sample Error Rate, the IRO shall conduct a Systems Review of ECRMC's Case Management Protocol, or any other comparable protocol for determining the medical necessity and appropriateness of inpatient admissions, and shall include its findings in the Inpatient Medical Necessity and Appropriateness Review Report, as specified at B.4, below.

5. *Other Requirements.*

a. Supporting Documentation. The IRO shall request all documentation and materials required for its review of the Inpatient Admission Paid Claims selected as part of the Discovery Sample or Full Sample (if applicable), and ECRMC 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 ECRMC after the IRO has completed its initial review of the Discovery Sample or Full Sample (if applicable) (Supplemental Documentation), the IRO shall identify in the Inpatient Medical Necessity and Appropriateness Review Report the Supplemental Documentation, the date the Supplemental Documentation was accepted, and the relative weight the IRO gave to the Supplemental Documentation in its review. In addition, the IRO shall include a narrative in the Claims Review Report describing the process by which the Supplemental Documentation was accepted and the IRO's reasons for accepting the Supplemental Documentation.