



Compliance Plan

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I. Executive Summary

Why Have a Compliance Program?

Trillium's Compliance Program is necessary because it:

- Stops fraud;
- Protects patient privacy;
- Nurtures an ethical culture;
- Prevents conflicts of interest;
- Ensures proper credentialing;
- Identifies and prevents waste;
- Furthers accurate billing and coding;
- Assists in obeying state and federal laws;
- Maintains and promotes high quality care and;
- Strives to promote the use of best practices in management and board governance.

What you must do:

- Act fairly;
- Act ethically;
- Act honestly;
- Act as a team;
- Report a conflict of interest that you may have ;
- Treat patients and one another with respect at all times;
- Identify ways to do things better in your department and take action and;
- Report problems immediately to your supervisor, directly to the Compliance Director or the Chief Compliance Officer, or take advantage of our anonymous compliance hotline options.

Trillium Health's Compliance Program applies to:

- Vendors
- Contractors
- Consultants
- All staff no matter the title or position
- Board of Directors

II. Introduction

Trillium Health, Inc. ("the Organization") is a federally qualified health center look-alike with a mission to promote health equity by providing affordable and extraordinary primary and specialty care, including LGBTQ health care. We are strongly committed to and have a longstanding reputation for lawful and ethical conduct. We take pride in earning the trust of those we serve, government regulators and one another.

The Affordable Care Act requires organizations that participate in federal health programs to have a formal compliance program. New York's Office of the Medicaid Inspector General ("OMIG") requires Medicaid providers to have a compliance program as well. Additionally, in response to the many laws, rules and regulations governing healthcare, the Organization has established a comprehensive compliance program to help us live up to our commitment to adhere to the highest ethical

standards of conduct in all business practices. This compliance plan is modeled after the seven elements identified by OMIG for an effective compliance program. It also addresses concerns as outlined in the Deficit Reduction Act ("DRA"), which requires the Organization to establish written policies and procedures to inform employees and others about certain federal and state false claims and whistleblower laws.

The goal of the Organization's compliance program is to prevent fraud, waste, and abuse while at the same time advancing the mission of providing affordable and extraordinary primary and specialty care. Our compliance efforts are aimed at prevention, detection, and resolution of variances.

THE SEVEN ELEMENTS OF THE ORGANIZATION'S COMPLIANCE PLAN ARE:

1. Written policies and procedures
2. Designation of a Compliance Officer/Committee
3. Training and education programs
4. Open lines of communication to the responsible compliance position
5. Disciplinary policies to encourage good faith participation
6. A system for routine identification of compliance risk areas
7. A system for responding to compliance issues

The Compliance Plan applies to the following areas:

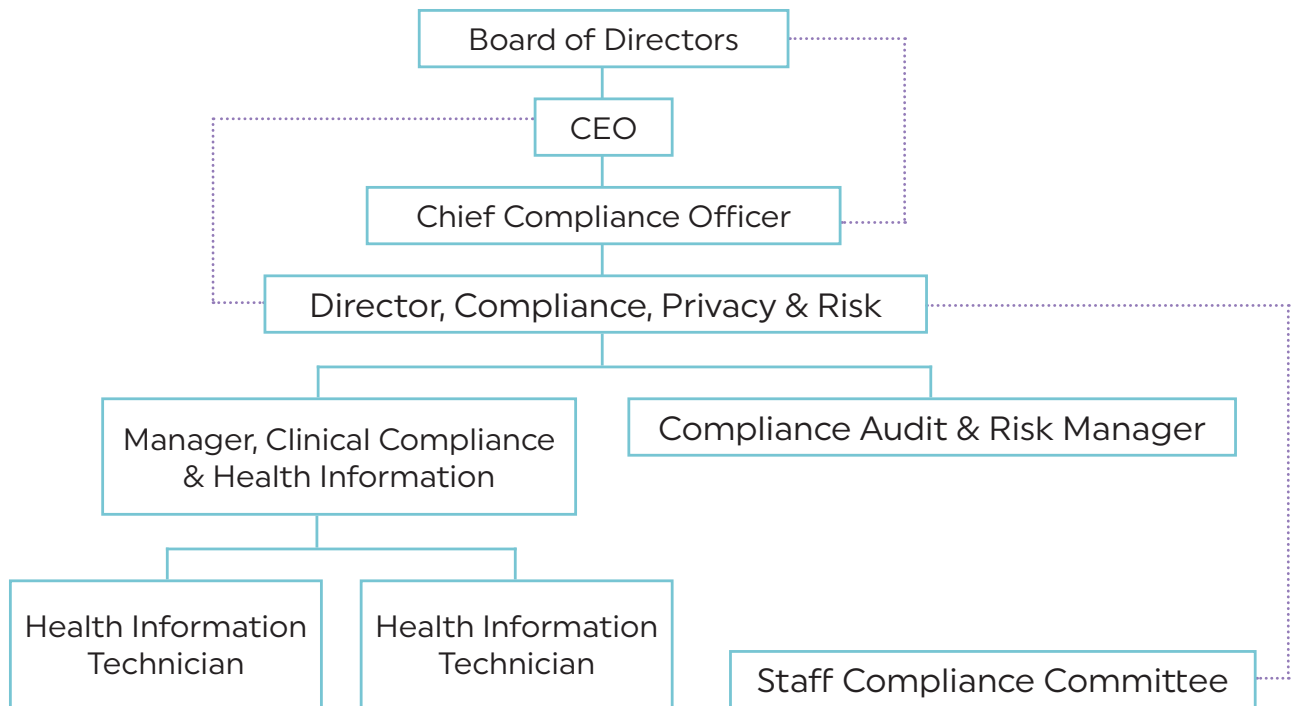
1. Billings,
2. Payments,
3. Ordered Services,
4. Medical necessity,
5. Quality of care,
6. Governance,
7. Mandatory reporting,
8. Credentialing, and
9. Contractor, subcontractor, agent, or independent contract oversight; and
10. Other risk areas that are or should reasonable be identified by the provider through "organizational experience."

III. Compliance Structure

The Organization is required to have an effective compliance program as a condition of receiving payments from the Medicaid program. The Organization's compliance program imposes compliance requirements for contractors, agents, subcontractors, and independent contractors (Contractors) within the scope of the contracted authority and affected risk areas.

The compliance program starts with its board of directors, who must assure the Organization operates in compliance with applicable Federal, state, and local laws and regulations. The board of directors provide direction to our CEO, who sets the tone for the Organization's compliance activities.

The Chief Compliance Officer works to ensure the Organization has the appropriate policies, procedures and processes in place to minimize its risk and further the Organization's mission to provide primary care services regardless of a person's ability to pay. In addition to the Chief Compliance Officer, the Compliance Team consists of the Director of Compliance, Privacy & Risk, a Compliance Audit & Risk Manager, a Manager of Clinical Compliance & Health Information and two Health Information Technicians. On a quarterly basis, the Chief Compliance Officer and the Director of Compliance meet with the staff compliance committee and provide updates on the department's activities and future plans.



How Key Compliance Activities Map to OMIG's Seven Steps of Compliance

Written Policies and Procedures	Designation of a Compliance Officer/ Committee	Training and Education Programs	Open Lines of Communication	Disciplinary policies to encourage good faith participation	A system for routine identification of compliance risk areas	A system for responding to compliance issues
Fraud, Waste & Abuse, Anti-Kickback Statute, False Claims Act and Stark Law policies	Compliance Officer job description Compliance Committee Chair	Annual compliance training Compliance on-boarding training	Open door policy Compliance Hotline: allows individuals to report perceived compliance issues anonymously either online, through email, fax or mail	All members of the organization are required to comply with applicable standards, laws, and procedures. Supervisors and/or Managers are accountable for the foreseeable compliance failures of their subordinates	Annual identification of top 5 risks Ongoing audit and monitoring activities Ad hoc audits	Internal investigations and reporting Review of Annual Conflict of Interest Disclosure Forms
Whistle Blower/ Non-retaliation policy	Prepare an Annual Compliance Report	Monthly Spotlight Department training events			Monthly exclusion screening	Process for reporting and resolving incidents
Clinical policies		Training at periodic all Staff meetings			Maintain anonymous outside Hotline.	
HIPAA					Annual OMIG risk assessment	
Conflict of Interest					Credentialing and peer review.	
Exclusion screening		Ad Hoc training to inform and train on recent events				

IV. Written Policies & Procedures

A. OVERVIEW

The Organization has a process for drafting, revising, and approving written policies. These policies must be accessible and applicable to all Affected Individuals. Affected Individuals means all persons who are affected by the organization's risk areas including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors and independent contractors and governing body and corporate officers.

The written compliance policies and procedures provide a clear explanation of the Organization's compliance and quality goals and provide clear and understandable mechanisms and procedures designed to achieve those goals in compliance with Federal, state, and other program requirements and standards.

The Organization has specific, individual policies for an array of matters ranging from proper documentation of services to whistle blower protections. These policies and procedures are available online at the Organization's Policy Tech site. In addition to compliance expectations, the Organization's policies also describe our fundamental principles and values, and commitment to conduct its business in an ethical manner. Also, the Organization's policies describe the structure of the compliance program, including the responsibilities of all Affected Individuals in carrying out the functions of the compliance program. Our written policies include specific guidance on dealing with potential compliance issues and communicating compliance issues to the appropriate compliance personnel. Lastly, the Organization's Investigation policy includes:

- a description of the procedures for documenting the investigation and the resolution or outcome; and
- the potential consequences to Affected Individuals who fail to comply with the Organization's written policies, or state and federal laws, rules, and regulations.

The Organization's Fraud, Waste and Abuse has written policies that address its compliance with all applicable Federal and State laws pertaining to fraud, waste, and abuse in Federal health care programs. These policies include Section 6032 of the Deficit Reduction Act of 2005 which requires the Organization to establish written policies that provide detailed information about fraud, waste, and abuse in Federal health care programs. These policies must be disseminated to employees, agents, and contractors. Additionally, the Organization's agents and contractors must adopt and abide by the policies.

The Organization reviews its policies on an annual basis.

B. CONFLICT OF INTEREST POLICY AND DISCLOSURE STATEMENT

The Organization is required to ensure that it adheres to the highest standards of ethical conduct by identifying instances which an independent observer might reasonably conclude that the potential for individual or institutional conflict could influence decision making or carrying out responsibilities. The Organization has a Conflict of Interest Policy that is based upon full disclosure and appropriate management of any possible conflict of interest. The policy requires staff members, including full-time, part-time, contract, consultants and those who provide goods and services to the health center, volunteers, Board of Directors and volunteers of a Board Committee to conduct their business according to the highest ethical standards of conduct and to comply with all applicable laws.

The Organization requires individuals to complete the Annual Conflict of Interest Disclosure Form to assist in identifying and evaluating potential conflicts of interests. Individuals also are required to disclose any actual, potential, or perceived conflicts as they arise during their affiliation or employment with the Organization. The forms are reviewed on an annual basis or when the need to complete the statement arises (new hires or changed circumstances). It is the responsibility of everyone to have a working knowledge of these policies and procedures and refer to them. Also, the Organization has a written process for addressing related party transactions as part of its Conflict of Interest policy.



V. Governance

A. OTHER WRITTEN POLICIES AND PROCEDURES

Annual Work Plan

Every year, the Chief Compliance Officer will prepare a Work Plan after reviewing the latest New York State Office of the Medicaid Inspector General and the United States Office of Inspector General priorities, recent enforcement activities, recent internal and external audit findings and hot topics that generate additional scrutiny. Additionally, the Chief Compliance Officer will obtain input from the Chief Executive Officer, the Director of Compliance, the staff Compliance Committee and various departments through interviews and a durable process for weighing the likelihood and impact of potential compliance issues. The Work Plan will include the top five risk areas of concern.

FOR 2022-2023, THE TOP FIVE RISK AREAS WERE:

- IT Security,
- HIPAA Privacy/Confidentiality,
- Billing
- Supportive Services – policies and procedures
- Harm Reduction – grant contract compliance

Additionally, the Work Plan includes a list of areas that the Compliance Department will audit and monitor. The Compliance Department may add additional monitoring audits to its duties in response to new and emerging risks. The Compliance Department and audited departments will review the audit findings and develop audit responses to address findings. The parties will develop remediation plans and associated timelines. The Compliance Department will conduct follow-up on remediation activities and report progress to the Chief Executive Officer and the Chief Compliance Officer. Additionally, the Compliance Department will provide assistance with external audits from federal, state and other oversight organizations.

Ad Hoc Policy, Procedure and Training Development

From time to time, the Compliance Department will work with other departments to develop and revise policies, procedures and training to reflect new legal requirements and new concerns that may arise.



Non-Intimidation and Non-Retaliation Policies

The Organization will protect whistle-blowers from retaliation. The Organization will not retaliate against employees who, in good faith, have raised a complaint against some practice of the Organization, or of another individual or entity with whom the Organization has a business relationship, on the basis of a reasonable belief that the practice is in violation of law, or a clear mandate of public policy.

Staff, vendors, interns, contractors, and Board Members are obligated to report to the Chief Compliance Officer any activity he, she or they believe to be inconsistent with the Organization's policies or state and federal law. The Organization has a Whistleblower policy which is intended to encourage and enable employees and others to raise serious concerns within the Organization, prior to seeking resolution outside of the Organization. The policy protects employees who in good faith reports an ethics violation from harassment, retaliation or adverse employment consequence. Any employee who retaliates against someone who has reported a violation in good faith is subject to discipline up to and including termination of employment.

Reports of violations or suspected violations will be kept confidential to the extent possible, consistent with the need to conduct an adequate investigation. The Chief Compliance Officer will notify the sender and acknowledge receipt of the reported violation or suspected violation within five business days. All reports will be promptly investigated, and appropriate corrective action will be taken if warranted by the investigation. Additionally, the Organization has a process for the anonymous submission of perceived violations.

VI. Designation of a Compliance Officer and/or a Compliance Committee

The OMIG requires the organization to designate a compliance officer to carry out and enforce compliance activities. The compliance officer is the focal point for the organization's compliance program and is responsible for the day-to-day operation of the compliance program. The compliance officer functions as an independent and objective person that reviews and evaluates organizational compliance and privacy/confidentiality issues and concerns. The compliance officer's main duties include coordination and communication of the compliance plan; this involves planning, implementing, and monitoring the program.

The compliance officer reports directly to and is accountable to the chief executive officer. However, such designation does not hinder the compliance officer in carrying out their duties and having access to the chief executive and governing body.

The Organization designates the Senior Vice President, Compliance, Technology, Privacy and Regulatory Affairs to serve as the Chief Compliance Officer and coordinator of all compliance activities.

A. CHIEF COMPLIANCE OFFICER

The Primary Responsibilities of the Chief Compliance Officer

- Chairing the Compliance Committee and serve as a spokesperson for the Committee.
- Overseeing and monitoring the adoption, implementation and maintenance of the compliance program and evaluating its effectiveness.
- Drafting, implementing, and updating no less frequently than annually or, as otherwise necessary, to conform to changes to Federal and State laws, rule, regulations, policies and standards, a compliance workplan which outlines the organization's strategy for meeting requirements in the coming year.
- Reporting directly, on a regular basis, but no less frequently than quarterly to the Compliance Committee, the Chief Executive Officer and the Board of Directors on the progress of implementation and maintenance of compliance initiatives, corrective actions and recommendations to reduce the vulnerability to allegations of fraud, waste, and abuse.
- Developing and distributing all written compliance policies and procedures to all affected employees.
- Reviewing and revising the compliance program and written policies and procedures and standards of conduct, to incorporate changes based on the organization's experience and promptly incorporate changes to Federal and State laws, rules, regulations, policies and standards.
- Developing, coordinating, and participating in a multifaceted educational and training program that focuses on the elements of the compliance program and seeks to ensure that

all employees are knowledgeable of, and comply with, pertinent federal, state, and private payer standards.

- Ensuring that employees, vendors, and Board of Directors do not appear on any of the Federal or State "excluded, debarred or suspended" listings published by Medicare and Medicaid.
- Ensuring that all Providers/Care Management Staff are informed of compliance program standards with respect to coding, billing, documentation, and marketing, etc.
- Investigating and independently acting on matters related to the compliance program, including designing and coordinating internal investigations and documenting, reporting, coordinating, and pursuing any resulting corrective action with all internal departments, contractors and the State.
- Reviewing the results of compliance audits, including internal reviews of compliance, independent reviews, and external compliance audits.
- Develop policies and programs that encourage managers and employees to report suspected fraud and other improprieties without fear of retaliation. (See Whistleblower Policy)
- Interact with external legal counsel to discuss the Organization's initiatives on regulatory compliance.
- Handle inquiries by employees, volunteers, affiliates, consumers and family members regarding compliance issues.



B. COMPLIANCE COMMITTEE

The Organization will designate a Compliance Committee to coordinate with and advise the Chief Compliance Officer to ensure that the organization is conducting its business in an ethical and responsible manner consistent with its compliance program. The Organization outlines the duties, responsibilities, membership, designation of a chair and frequency of meetings in a compliance committee charter.

The Compliance Committee membership at a minimum consists of senior managers and meet no less frequently than quarterly and shall no less frequently than annually review and update the compliance committee charter.

The compliance committee reports directly to and is accountable to the chief executive officer and board of directors.

The Functions of the Compliance Committee

- Analyze the Organization's regulatory environment, the legal requirements with which it must comply, and specific risk areas.
- Coordinate with the compliance officer to ensure that the written policies and procedures, and standards of conduct are current, accurate and complete and that the training topics are timely completed.
- Coordinate with the compliance officer to ensure communication and cooperation by Affected Individuals on compliance related issues, internal or external audits, or any other compliance function or activity.
- Advocate for the allocation of sufficient funding, resources, and staff for the compliance officer to fully perform their responsibilities.
- Recommend and monitor the development of internal systems and controls to implement standards, policies, and procedures as part of the daily operations.
- Determine the appropriate strategy/approach to promote compliance with the program and detection of any potential problems or violations.
- Develop a system to solicit, evaluate, and respond to complaints and problems.

VII. Conducting Effective Training and Education

An effective Compliance Program is rooted in an active and adaptive education and training program. Active education and training are designed to teach each person how to carry out their responsibilities effectively, efficiently and in compliance with statutory and regulatory compliance requirements. Adaptive education and training are designed to be responsive to the educational needs of the Organization's workforce identified through internal and/or external reviews, audits, or compliance assessments or by government notices, alerts, and/or other advisory statements.

The Organization maintains a training plan that outlines the topics, timing, and frequency, how it is tracked and how the effectiveness of the training is periodically evaluated. The organization requires all Affected Individuals to attend specific training as part of their orientation and no less frequently than on an annual and as needed basis thereafter.

Training includes training in federal and state statutes, regulations, program requirements, and corporate ethics. The training emphasizes the Organization's commitment to compliance with these legal requirements and policies.

The training programs will include sessions highlighting the Organization's Compliance Program, summaries of fraud and abuse laws, discussions of coding requirements, claim development, and claim submission processes that reflect current legal and program standards.

The Chief Compliance Officer or other designated staff member will document the attendees, the subjects covered, and any materials distributed at the training sessions.





Basic Training at a Minimum will Include:

- The organization's risk areas and organizational experience,
- The role of the compliance officer and the compliance committee,
- Overview of the Organization's regulatory environment;
- Fraud, waste, and abuse;
- The Organization's compliance structure;
- Coding and billing requirements, where applicable
- Claim development and the submission process, where applicable
- The seven elements of compliance;
- Where to find the compliance plan and policies and procedures on the Organization's SharePoint site;
- Key laws and regulations to be aware of;
- The Organization's commitment to non-retaliation;
- Compliance hotline information for making anonymous complaints; and
- How Affected Individuals can ask questions and their duty to report suspected or actual misconduct and compliance-related issues, to the compliance officer and senior management.

VIII. Developing Effective and Open Lines of Communication

A. OPEN LINES OF COMMUNICATION

Open lines of communication encourage everyone to express their compliance, quality, and other concerns and/or suggestions for improvement without fear of retaliation. Open communication is essential to maintaining an effective Compliance Program and enables the Organization to learn about issues that may arise, generating faster responses and quicker fixes. Additionally, open communications allow the Organization to address small problems before they become big ones.

Any potential problem or questionable practice which is, or is reasonably likely to be, in violation of, or inconsistent with, federal or state laws, rules, regulations, or directives or the Organization rules or policies relative to the delivery of healthcare services, or the billing and collection of revenue derived from such services, and any associated requirements regarding documentation, coding, supervision, and other professional or business practices must be reported to the Chief Compliance Officer.

Confidential lines of communication are accessible to all affected individuals and allow for questions to be asked and for compliance issues to be reported. The method of reporting allows for anonymous reporting of potential fraud, waste and abuse as well as allows for reporting issues directly to the compliance officer.

Confidentiality of persons reporting issues shall be maintained unless the matter is subject to a disciplinary proceeding, referred to, or under investigation by MFCU, OMIG or law enforcement, or disclosure is required during a legal proceeding, and such persons shall be protected under the organization's policy for non-intimidation and non-retaliation.

Any person who has reason to believe that a potential problem or questionable practice is or may be in existence should report the circumstance to the Chief Compliance Officer. Such reports may be made verbally or in writing, and may be made on an anonymous basis. The Organization utilizes an external vendor, The Compliance Hotline so that employees may anonymously consult with the Chief Compliance Officer with questions or report violations through the following mediums:

ONLINE: my.compliancehotline.com/report/trilliumhealth
EMAIL: reports@compliancehotline.com
PHONE: 1 (800) 561-0798
FAX: 1 (800) 519-6369
MAIL: Trillium Health c/o Exclusion Screening, 2121 e NW #C2E
Washington, DC 20007

Fraud or Abuse in connection with Federal health care programs may be confidentially reported to HHS-OIG Fraud Hotline: 1 (800) HHS-TIPS.

The Chief Compliance Officer will promptly document and investigate reported matters that suggest substantial violations of policies, regulations, statutes, or program requirements to determine their veracity.

The Chief Compliance Officer will work closely with legal counsel who can provide guidance regarding complex legal and management issues.

B. EXIT INTERVIEWS

As a further reflection of the organization's efforts to nurture an ethical culture, exit interviews with the Director, Compliance, Privacy & Risk are available to any employee or Board member leaving the Organization. Coding, supervision, and other professional or business practices must be reported to the Chief Compliance Officer.



IX. Disciplinary Standards

All members of the Organization will be held accountable for failing to comply with applicable standards, laws, and procedures. Supervisors and/or Managers will be held accountable for the foreseeable compliance failures of their subordinates.

The Supervisor or Manager will be responsible for taking appropriate disciplinary actions in the event an employee fails to comply with applicable regulations or policies. The disciplinary process for violations of compliance programs will be administered according to Organization protocols (generally verbal warning, written warning, suspension without pay, and may lead to termination) depending upon the seriousness of the violation. The Chief Compliance Officer is to be consulted, and may consult legal counsel in determining the seriousness of the violation. However, the Chief Compliance Officer should never be involved in imposing discipline.

If the deviation occurred due to legitimate, explainable reasons, the Chief Compliance Officer and supervisor/manager may want to limit disciplinary action or take no action. If the deviation occurred because of improper procedures, misunderstanding of rules, including systemic problems, the Organization should take immediate action to correct the problem.

When disciplinary action is warranted, it should be prompt, fairly and consistently applied to all levels of personnel according to written standards of disciplinary action.

Within 30 working days after receipt of an investigative report, the supervisor and/or V.P. of Human Resources or their designee shall determine the action to be taken upon the matter. The action may include, without limitation, one or more of the following:

1. Dismissal of the matter.
2. Verbal counseling.
3. Issuing a warning, a letter of admonition, or a letter of reprimand.
4. Entering into and monitoring a corrective action plan. The corrective action plan may include requirements for individual or group remedial education and training, consultation, proctoring, and/or concurrent review.
5. Reduction, suspension, or revocation of clinical privileges.
6. Suspension or termination of employment.
7. Modification of assigned duties.
8. Reduction in the amount of salary compensation.

The President, CEO or Sr. V.P., Chief Medical Officer shall have the authority to, at any time, suspend summarily the involved employee or contractor's privileges or to summarily impose consultation, concurrent review, proctoring, or other conditions or restrictions on the assigned duties of the involved party in order to reduce the substantial likelihood of violation of standards of conduct.

X. Auditing and Monitoring

The Chief Compliance Officer will conduct ongoing evaluations of compliance processes involving thorough monitoring and regular reporting to the officers of the Organization.

The Chief Compliance Officer will develop an annual audit plan that is designed to address the Organization's key compliance risks, including but not limited to laws governing kickback arrangements, physician self-referral prohibition, CPT and ICD coding and billing, claim development and submission, reimbursement, reporting, and record-keeping. The Pharmacy will have a Quality Assurance program in place to monitor medication errors and drug interactions. Reversed claims for unclaimed filled prescriptions will be tracked to ensure appropriate billing.

The audit work program steps will inquire into compliance with specific rules and policies that have been the focus of Medicaid and Medicare fiscal intermediaries or carriers as evidenced by the Medicare Fraud Alerts, OIG audits and work plans, OMIG audits and work plans and evaluations and publicly announced law enforcement initiatives. Audits should also reflect areas of concern that are specific to the Organization including results of all internal or external audits, or audits conducted by State or Federal government.

The design, implementation, and results of any internal or external audit is documented and the results shared with the compliance committee and governing body. The Chief Compliance Officer should be aware of patterns and trends in deviations identified by the audit that may indicate a systemic problem.

Annual Compliance Program Review

The organization has a process for reviewing at least annually, to determine the effectiveness of its compliance program and whether any revision or corrective action is required.

The review may be carried out by the compliance officer, compliance committee, external auditors or other designated staff with the necessary knowledge and expertise to evaluate the effectiveness of the components of the program and are independent from the functions being reviewed.

The review may include on-site visits, interviews with affected individuals, review of records, surveys or any other comparable method that the organization deems appropriate provide the method does not compromise the independence or integrity of the review.

The organization shall document the design, implementation and results of the effectiveness review and share the results with the chief executive officer, senior management, the compliance committee and the board of directors.

Excluded Providers

The organization will confirm the identity and determine the exclusion status of all affected individuals. In determining the exclusion status, the organization shall review the following State and Federal databases prior to hire contracting and at least every 30 days thereafter:

- NYS Office of the Medicaid Inspector General Exclusion List
- Health and Human Services Office of the Inspector General's List of Excluded Individuals and Entities.

The results of the screening activity is promptly shared with the appropriate personnel.

XI. Responding to Detected Offenses and Developing Corrective Action Initiatives

Violations of the Organization's compliance program, failure to comply with applicable state or federal law, and other requirements of government and private health plans, and other types of misconduct may threaten the Organization's status as a reliable, honest, and trustworthy provider, capable of participating in federal healthcare programs. Detected, but uncorrected, misconduct may seriously endanger the mission, reputation, and legal status of the Organization. Consequently, upon reports or reasonable indications of suspected noncompliance, the Chief Compliance Officer must initiate an investigation to determine whether a material violation of applicable laws or requirements has occurred.

Investigation Requirements

The organization shall take prompt action to investigate the conduct in question and determine what if any corrective action is required, and promptly implement such corrective action.

The steps in the internal investigation may include interviews and a review of relevant documentation. The organization will maintain:

- Records of the investigation shall contain:
 - Documentation of the alleged violation,
 - A description of the investigative process,
 - Copies of interview notes and key documents,
 - A log of witnesses interviewed, and
 - The documents reviewed,
 - Results of the investigation,
 - Corrective actions implemented and
 - Any disciplinary action taken.

If an investigation of an alleged violation is undertaken, and the Chief Compliance Officer believes the integrity of the investigation may be hampered by the presence of employees under investigation, those employees should be removed from their current work activities pending completion of that portion of the investigation. These employees will be temporarily suspended with pay pending the outcome of the investigation.

Additionally, the Chief Compliance Officer must take appropriate steps to secure or prevent the destruction of documents or other evidence relevant to the investigation.

If the results of the internal investigation identify a problem, the response may be immediate referral to criminal and/or civil law enforcement authorities, development of a corrective action plan, a report to the government, and submission of any overpayments, if applicable. If potential fraud or violations of the False Claims Act are involved, the Chief Compliance Officer should promptly report the potential violation to the Office of the Inspector General or the Department of Justice or other appropriate governmental entity where such reporting is otherwise required by law, rule or regulation.



XII. OMIG Self-Disclosure Program

Any person who has received an overpayment under the program either directly or indirectly shall report, return and explain the overpayment by submission of a Self-Disclosure Statement to OMIG's Self-Disclosure Program.

Deadline:

- The person shall report and return the overpayment and interest if applicable to the department and explain the reasons for the overpayment to OMIG by the later of:
 - The date which is sixty (60) days after the date on which the overpayment was identified or
 - The date any corresponding cost report is due, if applicable.
- A person has identified an overpayment when that person has or should have through the exercise of reasonable due diligence, determined that they have received an overpayment and quantified the amount of the overpayment.
 - Where a person fails to exercise reasonable due diligence, and the person in fact received an overpayment, they shall be subject to any enforcement action authorized by section 521-3.7 of this subpart of the Social Services Law and any applicable provisions of federal and state law including but not limited to Article XIII of the NYS Finance Law.

When making a repayment for an overpayment, the Organization should follow the direction from OMIG following the self-disclosure to inform the payer of the following: (1) the refund is being made pursuant to a voluntary compliance program; (2) a description of the complete circumstances prompting the overpayment; (3) the methodology by which the overpayment was determined; (4) any claim-specific information used to determine the overpayment; and (5) the amount of the overpayment.

The President, CEO of the Organization shall have the authority and responsibility to direct repayment to payers and the reporting of misconduct to enforcement authorities as is determined, in consultation with legal counsel, to be appropriate or required by applicable laws and rules.

If the President, CEO of the Organization discovers credible evidence of misconduct, and has reason to believe that the misconduct may violate criminal, civil, or administrative law, then the Chief Compliance Officer will promptly report the matter to the appropriate government authority within a reasonable time frame, but not more than 60 days after determining that there is credible evidence of a violation.

When reporting misconduct to the government, the Chief Compliance Officer should provide all evidence relevant to the potential violation of applicable federal or state laws and the potential cost impact.

XIII. Trillium's Commitment to Compliance

A. STANDARDS OF CONDUCT

The Organization's employees are bound to comply, in all official acts and duties, with all applicable laws, rules, regulations, and standards of conduct, including, but not limited to laws, rules, regulations, and directives of the federal government and the state of New York, in addition to rules and policies and procedures of the Organization. These current and future standards of conduct are incorporated by reference in this Compliance Plan.

All candidates for employment shall undergo a reasonable and prudent background investigation, including a reference and criminal background check. Due diligence will be used in the recruitment and hiring process to prevent the appointment to positions with substantial discretionary authority, persons whose record (professional licensure, credentials, prior employment, criminal record or specific "exclusion" from Medicaid funded programs) gives reasonable cause to believe the individual has a propensity to fail to adhere to applicable standards of conduct.

All new employees will receive orientation and training in compliance policies and procedures. Participation in required training is a condition of employment. Failure to participate in required training may result in disciplinary actions, up to and including, termination of employment.

Every employee is asked to sign a statement certifying they have received, read, and understood the contents of the compliance plan.

Every employee will receive an initial compliance orientation and periodic training updates in compliance protocols as they relate to the employee's individual duties.

Non-compliance with the plan or violations will result in sanctioning of the involved employee(s) up to, and including, termination of employment.

B. PATIENT/CLIENT RIGHTS

We treat our patients/clients with respect and dignity and provide care that is both necessary and appropriate. No distinction is made in the admission, transfer, discharge or care of individuals on the basis of race, creed, religion, national origin, gender, gender expression, sexual orientation, source of payment or disability. Clinical care is provided based on identified healthcare needs and Case Management is provided based on needs identified through a uniform assessment tool, not on financial criteria, and no treatment or action is undertaken without the informed consent of the patient or an authorized representative. Patients/clients are provided with a written statement of rights which conforms to all applicable laws, and their autonomy and privacy are respected within the context of a safe congregate setting.

Employees involved in patient/client care are expected to know and comply with all applicable laws and regulations and our policies and procedures governing their particular program.

C. PERSONAL HEALTH INFORMATION/HIPAA/ARTICLE 27-F COMPLIANCE

The Organization collects personal health information about our patients/clients to provide the best possible care. We realize the sensitive nature of this information, and are committed to safeguarding patients'/clients' privacy.

The Organization has created the Privacy Officer position in accordance with the HIPAA Privacy Rule. The Privacy Officer is responsible for development and implementation of policies, procedures and educational programs that will ensure that the Organization will continue to be compliant with the Privacy regulations and will also ensure that protected health information is secure.

In order to ensure that confidentiality is maintained, employees and their representatives must adhere to the following rules:

- Do not discuss protected health information (PHI)/ client information in public areas such as elevators, hallways, common gathering areas.
- Limit release of PHI/client information to the minimum reasonably necessary for the purpose of the disclosure.
- Do not disclose PHI without an appropriate consent signed by the patient/client unless it is related to the person's care, payment of care, or health care operations of the Organization. In an emergency situation, a patient's consent may not be required when a healthcare provider treating the patient requests information, but the name and affiliation of the person requesting the information must be confirmed and documented in the medical record.
- Honor any restrictions on uses or disclosure of information placed by the patient/client.
- Make sure PHI/client information stored in the computer system is properly secured.
- Be familiar with and comply with special confidentiality rules governing the disclosure of HIV/AIDS, alcohol, substance abuse and mental health treatment.

The Organization has created the Security Officer position in accordance with the HIPAA Security Rule. The Security Officer is responsible for the development and implementation of the policies and procedures required by the Security Rule.

The Security Officer is responsible for ensuring Trillium engages in the following activities:

- Maintain appropriate security measures to ensure the confidentiality, integrity and availability of patients' electronic protected health information (EPHI).
- Adhere to applicable federal and state security laws and standards.
- Provide security training and orientation to all employees, volunteers, medical and professional staff.
- Comply with Security Policies including periodic risk assessments.
- Monitor access controls to EPHI to ensure appropriate access to authorized personnel.
- Maintain hardware and software with the appropriate patches and updates.
- Maintain a validation of compliance with the Payment Card Industry Data Security Standards, a set of security controls that businesses are required to implement to protect credit card data

D. MEDICAL NECESSITY

The Organization will take reasonable measures to ensure that only claims for services that are reasonable and necessary, given the patient's condition/ client's needs are billed.

Documentation will support the determinations of medical necessity/client need when providing services.

The Organization is aware that private and governmental third party payers will only pay for tests that meet the coverage criteria and are reasonable and necessary to treat or diagnose a patient. Therefore, the Organization's Providers will use prudent ordering practices.

In requesting diagnostic procedures or tests, the Organization's Providers will make an independent medical necessity decision with regard to each item ordered. A diagnosis will be submitted for all tests ordered. Documentation of findings and diagnoses will support the medical necessity of the service.

The Organization's Providers understand that private and governmental third party payers generally have limitations on laboratory and diagnostic tests; therefore, the prior authorization process will be followed.

The Organization's providers will order tests or services that are medically necessary for the appropriate treatment of the patient.

E. BILLING

All claims for services submitted to private and governmental third party payers or other health benefits programs will correctly identify the services ordered. Only those tests ordered by an authorized Provider that are performed and that meet private and governmental third party payer's criteria will be billed.

Intentionally or knowingly up coding (the selection of a code to maximize reimbursement when such code is not the most appropriate descriptor of the service offered) may result in immediate termination. The Organization's providers must provide documentation to support the current CPT and ICD codes used based on medical findings and diagnoses.

Immediate disciplinary action, up to and including termination will be implemented for instances of intentional misrepresentation of any service provided that results in over billing.

All individuals who provide billing information and billing department employees who prepare or submit billing statements must comply with all applicable laws, rules and regulations and the Organization's policies.

The Organization will promptly return to payers any payments which we determine do not conform to our policies and applicable laws in accordance with the OMIG (above) or OIG Self-Disclosure Protocols as applicable.

As healthcare/human service Providers, our business involves reimbursement under government programs which require submission of certain reports of our costs of operations. The Organization complies with all federal and state laws and regulations relating to cost reports, which define what costs are allowable and describe the appropriate methodologies to claim reimbursement for the cost of services provided to program beneficiaries. Given the complexity of this area, all issues related to the completion and settlement of cost reports must be communicated through or coordinated with the Chief Financial Officer as well as the Chief Compliance Officer.



F. COMPLIANCE WITH APPLICABLE HHS FRAUD ALERTS

The Compliance Officer will review the Medicaid/Medicare Fraud Alerts.

The Compliance Officer will ensure that any conduct disparaged by the Fraud Alert is immediately ceased, implement corrective actions, and take reasonable actions to ensure that future violations do not occur.

G. ANTI-KICKBACK/INDUCEMENTS

The Organization will not participate in nor condone the provision of inducements or receipt of kickbacks to gain business or influence referrals. The Organization's Providers will consider the patient/client's interests in offering referral for treatment, diagnostic, or service options.

Federal and state laws prohibit any form of kickback, bribe or rebate, either directly or indirectly, in cash or in kind, to induce the purchase or referral of goods, services or items paid for by Medicare or Medicaid.

Self-referral laws prohibit a Provider from referring a patient for certain types of health services to an entity with which the provider or members of his or her immediate family has a financial relationship, unless there is an applicable exception under the self-referral law.

Since violations of these laws may subject both the Organization and the individual involved to civil and criminal penalties and exclusion from government-funded healthcare programs, all proposed transactions with healthcare providers must be reviewed with legal counsel.

Any employee involved in promoting or accepting kickbacks or offering inducements may be terminated immediately.

H. RELATIONSHIPS WITH VENDORS AND SUPPLIERS

The Organization is committed to employing the highest ethical standards in its relationships with vendors and suppliers with respect to source selection, negotiation, determination of contract awards, and administration of purchasing activities. All vendors and suppliers are to be selected solely on the basis of objective criteria; personal relationships and friendships play no part in the selection process. The Organization's vendors are screened on a monthly basis to ensure they are not on any federal or state exclusion list. Any vendor or supplier who has access to the Organization's PHI and is not a covered entity, will be required to enter into a Business Associate Agreement to comply with applicable federal and state confidentiality and data protections rules, including HIPAA and 42 C.F.R. Part 2, federal regulations that govern the confidentiality of drug and alcohol abuse treatment and prevention records. The Organization will maintain a vendor review program for selecting and assessing the appropriate safeguards and security controls for key vendors.



I. RETENTION OF RECORDS/DOCUMENTATION/DESTRUCTION

The Organization will ensure that all records required by federal and/or state law are created and maintained. All records will be maintained for a period of no less than seven (7) years. Records are available to the compliance department, OMIG, MFCU and other appropriate federal and state agencies upon request, copies of such records.

Documentation of compliance efforts will include staff meeting and committee minutes, audit reports, memoranda concerning compliance protocols, problems identified and corrective actions taken, the results of any investigations, and documentation supportive of assessment findings, diagnoses, treatments, and plan of care.

Hard copy data that is not necessary or which the Organization is no longer required to retain will be sent to a professional shredding company where the data will be shredded using a cross-cut shredder to effect 5/16 inch wide or smaller strips. Media containing sensitive data will be sanitized in a manner that is consistent with the standards set forth in National Institute of Science and Technology Special Publication 800-88 rev. 1, Guidelines for Media Sanitation.

J. MEDICAL RECORD DOCUMENTATION

Timely, accurate and complete documentation is important to clinical patient care. This documentation not only facilitates high quality patient care, but also serves to verify that billing is accurate as submitted.

The Organization requires that Providers follow these documentation guidelines:

- The medical record/ client record is complete and organized.
- Documentation is timely.
- The documentation of each patient encounter includes the reason for the encounter, any relevant history, physical examination findings, prior diagnostic test results, assessment, clinical impression or diagnosis, plan of care, date and legible identity of the observer.
- CPT and ICD-10 codes used for claims submission are supported by documentation in the medical record.
- Appropriate health risk factors are identified. The patient's progress, his, her, or their response to treatment.
- Care management encounters will be documented per New York State Department of Health guidelines.

The Organization will maintain a process for identifying and reviewing its billing and coding to ensure compliance with applicable state and federal requirements.

K. PRESCRIPTION DRUGS AND CONTROLLED SUBSTANCES

The Organization's employees routinely have access to prescription drugs, controlled substances and other medical supplies. In accordance with federal, state and local laws, it is strictly prohibited to divert prescription drugs and controlled substances to unauthorized individuals, to administer them without proper orders, to distribute adulterated, misbranded, mislabeled or expired drugs or devices, or to fail to report significant adverse events. Any employee of the Organization who becomes aware of a potential lapse in security or the improper diversion of drugs must report the incident immediately to his/her supervisor or the Chief Compliance Officer.



XIV. Response to Special Agents Visit For the Purpose of Investigating Allegations of Fraud and Abuse

In the event state and/or federal agents visit the Organization for the purpose of investigating fraud and abuse allegations:

- Request a copy of the search warrant and the affidavit supporting it.
- Record names of all agents and agencies they represent.
- Ask the agent to secure the premises but to delay the search until counsel can be notified. If this request is refused, do not deny admission to the premises, which could be construed as obstruction of justice.
- Ask for a delay until all patients have been seen.
- Accompany the agents during the search.
- Record beginning and ending times of the search, items taken, areas searched, types of documents taken, photographs taken, questions asked or comments made, and requests made by agents.
- Identify and request copies of items essential to daily operation.
- If employees are interviewed, debrief them after the search.

This plan has attempted to provide the foundation for development of an effective and cost-efficient compliance program.

This Compliance Plan may be altered or amended in writing only with the concurrence of the Compliance Committee of the Organization. The adoption of this Compliance Plan has been approved and authorized as designated below.

Trillium Health, Inc.

By: Gregory Ewing, SVP, Compliance, Technology, Privacy & Regulatory Affairs

Date: April 2023

