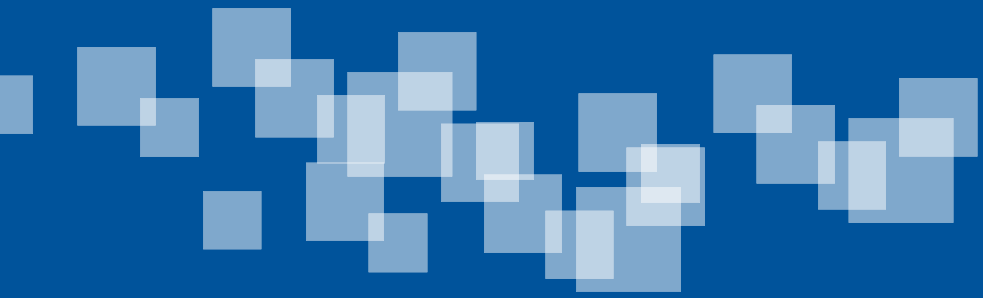
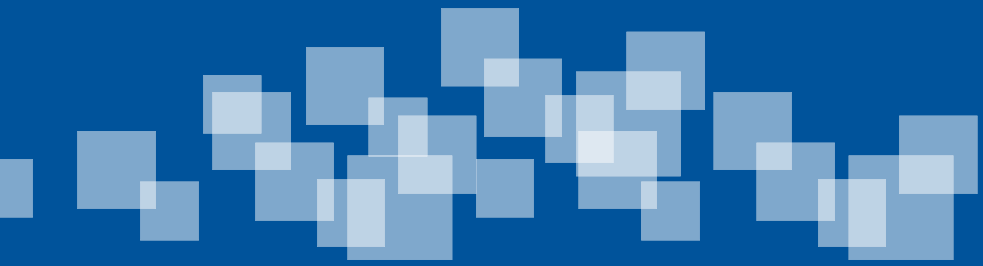
St. Joseph Health

Code of Conduct



We have developed the Code of Conduct to help you, a valued caregiver, understand requirements and fulfill your responsibilities in this important area



Integrity Hotline 1-888-294-8455

http://psjhealth.org/IntegrityOnline

Message From Rod Hochman, MD
Providence St. Joseph Health
President & CEO

Dear Colleague,

As caregivers of our communities, the people we serve place an enormous amount of trust in us. Our Code of Conduct is an important part of how we serve, and it represents our values in action.

The Sisters of St. Joseph of Orange and the Sisters of Providence set our ministry on a clear path from its earliest days as they served everyone in the community, especially the poor and vulnerable, with grace, compassion and integrity. With this legacy, we have thrived because of the continued commitment of the people of our organization to do the right thing right.

Maintaining the integrity of the heritage and tradition of our ministry is the responsibility of each person at our organization, and that's the purpose of our Compliance Program. It ensures we are following the ethical commitments, laws, rules and regulations that govern our business conduct, and it helps to discourage, prevent and identify violations.

Our Code of Conduct explains the expectations we have of our caregivers and the critical importance of being honest and just in all our interactions with our patients, members, colleagues, payers and vendors. It also details how to report a violation or concern about potential illegal or inappropriate actions.

Please review this Code of Conduct thoroughly and discuss any questions you may have about these standards with your supervisor. Every person in our organization is expected to take an active part in maintaining the integrity and compliance of our ministry. Thank you for your participation and your commitment.

Rod Hochman, MD
President & CEO

We exist to extend the Catholic health care ministry of the Sisters of St. Joseph of Orange. We seek to accomplish this mission by providing services in accordance with our values of Compassion, Dignity, Justice, Excellence and Integrity. In doing so, we rely on the Code of Conduct as the minimal guiding principles that govern the operations of our organization in achieving its three strategic areas of focus to Strengthen the Core, Be Our Communities Health Partner and Transform our Future. The overarching philosophy, as supported by the Code of Conduct, is that health care meets the Compliance Program goals when it is:

- High-quality, safe, timely, evidence-based, efficient, equitable, patient/family centered and spiritual;
- Respectful of the rights and dignity of patients and their families;
- Furthers the Mission and tax-exempt purpose of our organization;
- Furthers the best interests of patients and their families and free of undue influence;
- Documented, coded and billed in a manner that accurately reflects the services ordered and provided;
- Provided by appropriate and competent providers and staff; and
- Appropriately reimbursed by the government and other payers including self-pay patients and those who are eligible for discounts as provided for in our Financial Assistance Policy.

To achieve our Compliance Program goals, it is critical that we understand the laws impacting health care and how these laws directly impact our operations as a recipient of federal taxpayer money. The federal Medicare program reimburses health care providers, when we treat patients enrolled in federal health care programs such as Medicare, Medicaid and TRICARE.

As the population of individuals enrolled in government programs increases, there is concern over whether these programs will have sufficient funds to provide services for individuals in need of such services in the future. In response to this, the government has increased its monitoring and enforcement action and continues to closely scrutinize payments made to providers to determine the appropriateness of the payments to ensure that providers receiving federal money do not participate in fraudulent and abusive practices against the federal government or the federal payer systems such as Medicare and Medicaid.

In support of the federal government's position to continue protecting the valuable assets of the federal health care programs, **we have adopted a Code of Conduct, along with policies and procedures, to guide and direct the behavior of caregivers, officers, trustees, contractors and other individuals providing health care items or services on behalf of the organization** to reduce the risk of fraudulent and abusive practices. In addition to a program focused on compliance with applicable laws, our values commend us to also address how we conduct our business. Therefore, our Compliance Program addresses not only legal compliance, but ethical conduct as well.

The Role of the Compliance Program

Even though all Individuals are responsible for ensuring that practices are ethical and are performed in accordance with the Code of Conduct, our Compliance Program provides centralized resources to assist management in the implementation, communication and monitoring of the compliance function for all ministries throughout the organization. We have both a senior vice president of risk and integrity services/risk officer and a chief compliance officer who report to both the PSJH Board and CEO.

Additionally, the regional compliance director provides support and Program oversight for our ministries in Southern California and Northern California. The compliance director reports to the chief compliance officer and works directly with our management teams in various operational areas to assist with the integration of the Code of Conduct into key business operations.

In addition to the regional compliance director, a system coding director supports coding and patient financial services staff with the integration of compliant coding and billing practices and a director of physician practice compliance supports and provides Program oversight to our physician practices. Within each ministry the chief operating officer has been delegated responsibility for communicating, coordinating and monitoring the Program within the local ministry.

The Simple Definition of Compliance

We strive to be compliant. Individuals may ask what "being compliant" means. Compliance is simply knowing and following the ethical, legal and policy requirements that apply to an Individual's job and not engaging in fraudulent or abusive practices. Fraudulent practices are those that are intentionally deceptive or misrepresentative and that a person knows to be false and could result in an unauthorized benefit or payment.

Abusive practices consist of those that directly or indirectly result in unnecessary increased costs to patients or to health care payers and include misuse, overuse or inappropriate restrictions in the use of services.

The United States Department of Health and Human Services, Office of Inspector General has identified seven elements that, when integrated into an organization's compliance program, will demonstrate that the program is effective in promoting legal and ethical practices. We have implemented these elements into our Compliance Program:

- Written Code of Conduct that describe lawful and ethical business practices
- Oversight by individuals with independence and authority
- Educational requirements
- An anonymous reporting system without fear of retaliation
- Disciplinary guidelines that are consistently applied
- Auditing processes to proactively identify weaknesses
- Investigative and monitoring processes to ensure that violations are corrected

Expectations of Individuals and Management

An effective program is dependent upon Individuals having a practical, working knowledge of the laws and regulations affecting their specific job responsibilities and a commitment to apply this knowledge. **Individuals who do not understand something that is written in the Code of Conduct or who would like to learn additional information about a topic because it is specific to their job, should contact their manager or the Compliance Department to obtain further information and be directed to specific policies.**

Failure to follow the Code of Conduct or to report a suspected violation of the Code of Conduct or policies, will result in disciplinary action up to and including termination or disengagement of Individuals. Individuals are required to do the following as a condition of employment:

- Complete all assigned mandatory training (including on-line compliance education) regarding laws and the policies and procedures that affect the caregiver's specific job role;
- Be responsible for their own actions and refrain from blaming others;
- Promptly report potential or suspected violations of Code of Conduct, policy, procedure or applicable laws and regulations;
- Know, understand and comply with the Code of Conduct, policies, applicable laws and rules, including the applicable federal health care program requirements;
- When in doubt, seek guidance from management or regional compliance regarding roles and responsibilities;
- Refrain from participating in illegal, unethical or improper acts; and
- Assist in investigation of violations and corrective action as requested.

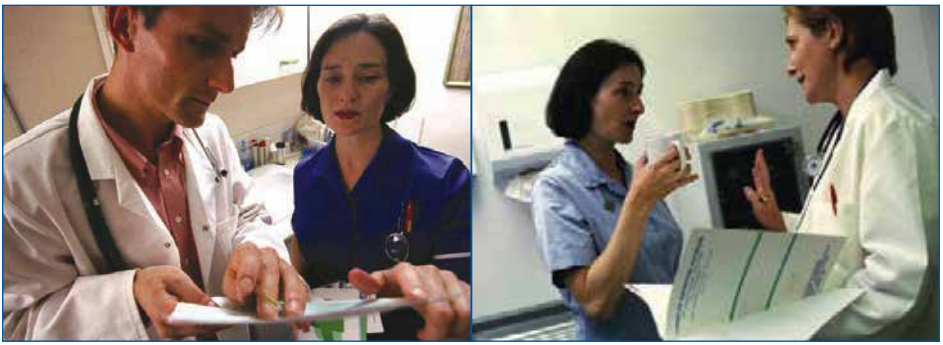
Higher Standard for Managers

Managers must set an ethical example and act when issues arise that require investigation or corrective action. Managers are responsible for ensuring that Individuals are aware and understand the Code of Conduct and must support those who report concerns regardless of how the Individual chooses to report and must promote the use of the Integrity Hotline as an approved reporting method. **Managers are encouraged to use the Integrity Hotline if in need of guidance for themselves or if they become aware of any retaliatory action that is being taken against them or any other Individuals.** Specifically, managers have a responsibility to do the following:

Coordinate with the Human Resources staff to ensure that Individuals are properly screened in all required areas prior to hire and that fair and consistent disciplinary action is carried out when a violation is substantiated;

Support Individuals in the completion of mandatory education requirements and take disciplinary action when Individuals fail to do so;

Maintain a safe environment that promotes confidentiality, is free from retaliation and promotes information sharing and reporting of work-related issues or concerns; Support requests for participation during investigations, audits or any other type of review that is necessary; and Promptly report any potential or suspected violations of the Code of Conduct or other concerns.



Responsibility to Report Violations of the Code of Conduct

Everyone is responsible for reporting violations of the Code of Conduct, other concerns or questions. There are several ways to do this and regardless of the reporting method chosen, the Individual can report anonymously. An Individual may be concerned about reporting something because they are unsure if it is a "compliance issue". Rest assured, **Individuals who think that something may be unlawful, unethical or in violation of the Code of Conduct are encouraged to speak up and to report concerns.**

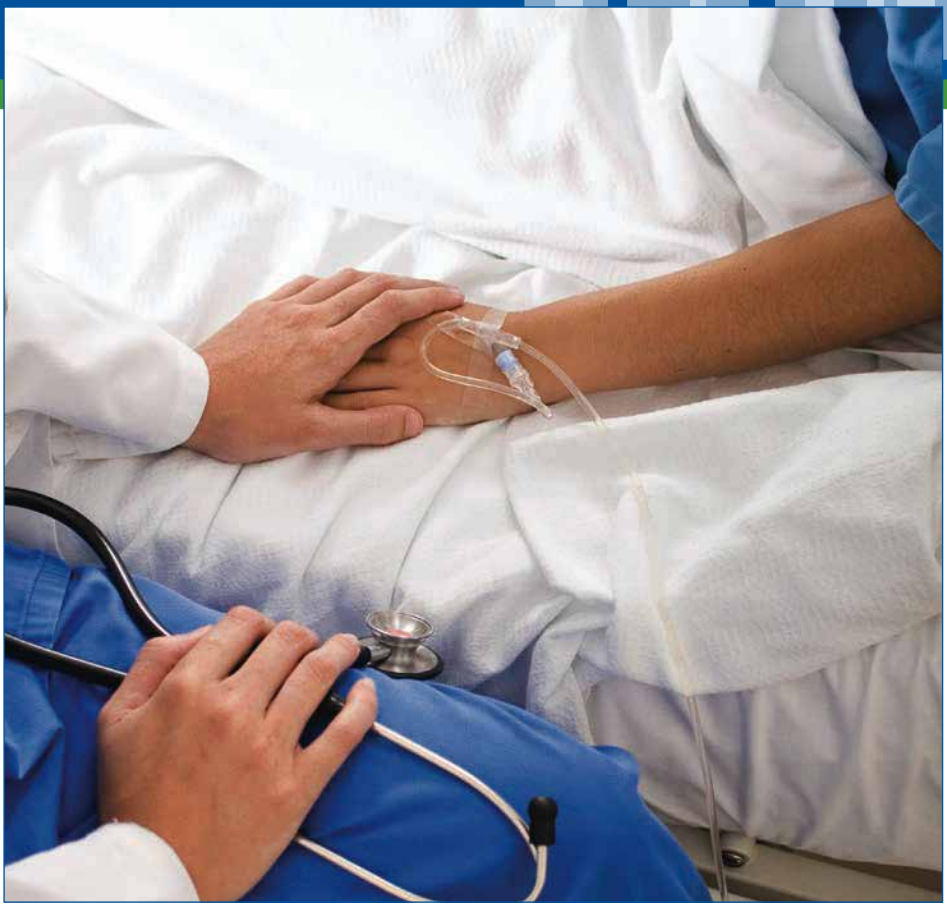
If an Individual is hesitant to report for fear of retaliation, he or she should remember that **committing or condoning retaliation for good faith reporting of a compliance concern will not be tolerated** and Individuals that cooperate or participate in compliance investigations are not subject to retaliation.

We take reports of retaliation very seriously. If an Individual feels that they have experienced retaliation, they should immediately report it to a manager who is not involved in the issue or contact the Integrity Hotline. Any time there is an allegation of retaliation, the allegation will be investigated and appropriate steps will be taken to protect those who report retaliation.

Reporting in "good faith" means that the Individual believes or perceives the information reported to be true. When making a report, Individuals should describe as many facts as possible so that the matter can be investigated thoroughly including the submission of identifying information such as the ministry and department name where the concern is happening. An Individual who intentionally provides false information may be subject to disciplinary action.

Individuals can report violations to supervisors/management; Human Resources; and/or the Compliance Department. In addition, violations can be reported to the Integrity Hotline at **1-888-294-8455**. Individuals are encouraged to call the Integrity Hotline to ask questions or to report concerns.

All reports are taken seriously and are reviewed and investigated promptly. The calls are answered by an outside firm that specializes in health care compliance. All calls are answered on a 24 hours-per-day, 7 days-per-week basis.



When an Individual calls the Integrity Hotline, the advisor will ask questions to better understand the issue that is being reported. The Integrity Hotline does not have a method to identify the phone number that an Individual is calling from so that concerns may be reported anonymously should the Individual choose to do so. Individuals making reports may call back and use a pin number to check on the status of the investigation or to learn whether the investigation is complete and if the issues were addressed.

The Web Submission Link/Integrity Online **http://psjhhealth.org/IntegrityOnline** is also available for Individuals to report concerns or ask questions. This link is also maintained by the outside firm and is accessible to Individuals at all times either through the network or through the Individual's home computer.

The Code of Conduct is intended to demonstrate that we are committed to doing the right thing right. The Code of Conduct not only apply to the way in which patient care is provided, but also to our daily business activities and the interactions with others. While the Code of Conduct is intended to be easily understood, individuals are encouraged to refer to the policies and procedures that define processes related to specific work areas. The Code of Conduct is categorized into four general areas that form the basis of what we represent and for which Individuals must be familiar:

- Patient Rights and Quality of Care
- Ethical Conduct
- Fiscal Responsibility
- Industry Regulations

1. Patient Rights and Quality of Care

We are committed to providing high-quality patient care and upholding the rights of patients. Just as we do not discriminate against our workforce and encourage an environment that is diverse and inclusive, we will never distinguish among patients based on race, ethnicity, religion, gender, sexual orientation, national origin, age, disability, veteran status or other characteristics protected by law. To comply with the Patient Rights and Quality of Care Standard, we will ensure the following:

- Patients are treated in a manner that affords them privacy, dignity and compassion. In doing so, patient information will be treated as confidential and communications with the patient and their families will be prompt, respectful and courteous.
- Patients are provided the right to choose who may visit them regardless of whether the visitor is a family member, a spouse or a domestic partner and are provided the right to withdraw consent for visitors.
- Medical procedures are reviewed to confirm that they are medically necessary according to good medical practices.
- Clinical services are provided within the provider's scope of practice by a person that has adequate licensure and training that is not suspended or revoked.
- The workforce will receive the required education and training that is necessary to maintain licenses and certificates and Individuals providing service on our behalf will have the knowledge to identify and correct practices that could lead to compliance violations or failures in patient care.
- A patient is provided the opportunity to consent to treatment, including treatment related to research studies or the patient's right to refuse care is respected.
- Patients are provided with a complete disclosure of all charges.
- Patients are given the opportunity to participate in and make their own health care decisions and both patients and families have the right to receive sufficient disclosure of the nature and consequences of the proposed treatment by their physician including those related to unanticipated outcomes.
- Patients enrolled in federal health care programs are provided with required written notices upon admission and at discharge in a format that they can understand.
- If a patient lacks capacity or is unable to understand the nature and consequences of proposed health care, the patient's agent is provided the opportunity to make health care decisions for the patient.
- Patients are provided with information regarding the availability of post-hospital services that they may require upon discharge in a manner that is compliant with applicable laws ensuring that the patient's choice is maintained.
- Patients with special needs guide policy making.

Emergency Services

In addition to the values that demand that patients be treated with compassion and receive necessary care, the federal law known as the Emergency Medical Treatment and Active Labor Act (EMTALA) prohibits the practice of "dumping" patients and carries severe penalties for failure to comply with the obligations to provide appropriate emergency services.

All individuals, regardless of ability to pay, must be provided an appropriate medical screening examination in accordance with hospital and medical staff policies to determine whether an emergency medical condition exists or, for pregnant women, active labor exists and, if so, provided appropriate stabilizing treatment within the capabilities of the hospital and if necessary, appropriate transfer to the appropriate level of care or another medical facility.

We will provide an appropriate medical screening examination and any stabilizing treatment required by individuals presenting with an emergency medical condition, including psychiatric medical conditions, prior to transferring the individual to another medical center for treatment. Individuals must comply with policies on screening, stabilization and transfer of patients. These policies are available in the emergency and labor and delivery departments, as well as other departments.

Privacy of Medical Information

Patients entrust us with their private medical and financial information when they receive services. In doing so, patients expect that this information will be safeguarded and used in an appropriate manner.

In addition to safeguarding a patient's information because it is the right thing to do, we are also obligated to comply with various state and laws such as the Confidentiality of Medical Information Act (CMIA), the privacy and security provisions of the Health Information Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology For Economic and Clinical Health Act (HITECH). These laws not only describe specific rights that patients have, but also the limitations that we must comply with regarding how Individuals access, use or disclose a patient's information.

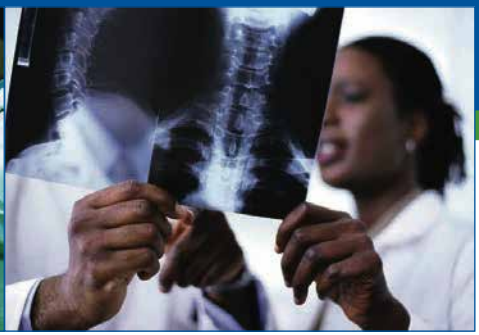
The **minimum necessary** rule is the foundation on which practices governing the use or disclosure of patient information for purposes of treatment, payment or health care operations stand. Individuals are responsible for protecting a patient's privacy, even after working hours. It is important to remember that just because an Individual can access information does not mean that they should unless they must use that information for the intended purpose relating to their job duties.

That is, Individuals must have a legitimate, job-related reason for looking at patient information. It is also important to know when and in what instances patient information is absolutely prohibited from being used and disclosed. For instance, Individuals are prohibited from uploading to social networking sites, pictures of patients or a patient's body part, stories or comments about an event with a patient or any other information that identifies or even has the potential to identify a patient.

Along the same lines, Individuals must not talk about patients unless the discussion is between Individuals that all have a direct treatment relationship with the patient and the discussion relates to said treatment. Individuals must also understand the appropriate use of electronic record systems that house patient medical records and information and only access those records for which the Individual has a need that is related to their job. Individuals are responsible for understanding the requirements, limitations and expectations relating to protecting a patient's information and securing it from unauthorized access and disclosure.

We perform random audits of access to ensure that Individuals accessing electronic medical information are doing so appropriately. Questions regarding the use and disclosure of patient information should be directed to the Individual's manager, human resources, the Privacy Director, the Compliance Department or to the Integrity Hotline.

Anyone found to have accessed patient information inappropriately or to have violated a patient's privacy in any way as described in the Code of Conduct or otherwise, will be subject to disciplinary action. Failure by Individuals to comply with the privacy laws not only subjects the organization to potential monetary fines, but may also subject an Individual to significant monetary fines (e.g., $250,000) and criminal penalties (e.g., up to ten years in prison). The maximum fines are generally associated with knowingly and willfully accessing patient information without the patient's authorization for which the Individual does not have the right.



Consider the case of a former employee of the University of California, Los Angeles School of Medicine who was sentenced in 2010 to four months in federal prison and ordered to pay a $2,000 fine for illegally snooping into the private records of patients including those of celebrities and co-workers.

Individuals found to be in violation may also be subject to referral by state agencies to professional licensing boards for disciplinary action. Individuals must also understand that a patient may bring a private legal action or lawsuit, against Individuals who violate privacy rights.

The Definition of Protected Health Information (PHI)-PHI is defined as follows:

- Individually Identified health information (including demographic information) **that identifies or can be used to identify** the individual;
- Information about an individual's health, health care or payment for health care that relates to the **past, present or future**, including information regarding individuals that are deceased; and
- Information that is held or transmitted in **any form or medium**, whether spoken, written or electronic.

Appropriate Use of PHI-PHI may be used for purposes of treatment, payment or internal health care operations without obtaining written authorization from the patient.

- **Treatment** means the provision, coordination or management of health care services.
- **Payment** means activities to obtain or provide reimbursement for health care, including eligibility, billing and claims.
- **Health care Operations** includes functions such as quality assessment activities, legal services, licensing functions and general business activities.

The Rights of Patients Related to Use and Disclosure of Their Information - In addition to the right to have their information remain private, patients are afforded other rights related to their personal information such as follows:

- To understand how we will use and disclose their information and to request restrictions;
- To see and get copies of their records, request amendment to their records and to receive an accounting of how has disclosed their information;
- To authorize the use or disclosure of information for purposes other than those related to treatment, payment and health care operations – and to revoke such authorization; and
- To file a formal complaint with the ministry privacy representative or with the Department of Health and Human Services when the patient believes that their privacy has been violated.

Breach Reporting

In some cases, we are required to notify an affected patient and report to state and federal government oversight agencies when a patient's privacy is used, accessed or disclosed in an unlawful or unauthorized manner. Sometimes the requirement to notify and to report will depend on how a ministry is licensed, the state in which the ministry is located or the facts surrounding the circumstances of the incident.

For example, a breach involving a patient's social security number may create a risk of financial harm to the patient and may be handled differently than a breach that involves a document containing a patient's name being faxed in error to the wrong department within our ministry. Under California reporting requirements, certain ministries are required to report instances of unlawful or unauthorized access of patient information within five business days to both the affected patient and to the California Department of Public Health.

Additionally while under federal reporting requirements, ministries are required to report events within 60 calendar days to the Office of Civil Rights, Department of Health and Human Services (HHS) and to the affected patient. There are very specific requirements for providing notification to individuals, to government oversight agencies and in some cases, to the media.

We understand that breaches may result because of a simple mistake. Still, Individuals must immediately report these types of events to management or to the Privacy representative at the ministry so that a prompt investigation can occur and any reporting and notification requirements are undertaken in a timely manner. Failure by the organization to report in a timely manner can result in daily monetary fines to the organization.

Safeguarding Patient Information

We are required and have implemented administrative, technical and physical safeguards to protect confidential and sensitive information from unlawful or unauthorized access, use or disclosure. For instance, technical controls such as passwords are used by most Individuals to access the network. Physical controls include locking file cabinets that may house sensitive business or patient information. Administrative controls include the policies that describe privacy related safeguards that all Individuals are required to understand and to comply with.

Individuals should understand and comply with the following requirements that are described in our policies and may contact the Helpdesk for assistance.

- Keep passwords secure and do not share them.
- Maintain the security of a workstation by not leaving it unattended without logging off.
- Encrypt all emails containing patient information that are sent outside of our network. For example, Individuals responsible for sending information to insurance companies or to other parties during obtaining payment relating to a patient's treatment should understand the process for email encryption.
- Store files containing electronic patient information on secure network locations. Individuals should understand which drives are considered to be "secure" before saving patient information on computers. For example, a desktop drive is not a secure location because it is not backed up to the network.

- Transmit only the minimum necessary amount of information or use information that is de-identified to the extent possible. For example, unless there is a strong business need for requesting sensitive information such as social security numbers, these types of elements should not be collected from patients.
- Protect electronic files containing patient information with a password when emailing them to other individuals within the organization or when uploading and storing them to a secure network folder. All passwords should be sent in a separate email to the intended recipient.
- Personal devices must not be used because these devices may not have the appropriate security features and safeguards that are required.

Harassment and Workplace Violence

We have a "zero-tolerance" policy for behavior that is considered by a reasonable person to be intimidating or disruptive and that jeopardizes a patient's right to access perfect care or a caregiver's right to work in an environment that is free of harassment and discrimination. Each individual has the responsibility to ensure that intimidating or disruptive conduct by others, including by physicians, is reported and to know that no retaliation will occur for doing so.

Examples of intimidating and disruptive behavior include any of the following that is otherwise directed at anyone including patients, families, nurses, physicians, caregivers, hospital personnel or the hospital:

- Threatening or abusive language
- Degrading or demeaning comments
- Profanity or similarly offensive language
- Inappropriate physical contact with another individual that is threatening or intimidating
- Public derogatory comments about the quality of care being provided by peers or the organization
- Inappropriate medical record entries concerning the quality of care being provided by the organization or any other individual

2. Ethical Conduct

Individuals must represent our organization accurately, honestly and with the best of intentions. **Any activity that is or has the appearance of being dishonest, false or misleading or that is intended to defraud anyone of money, property or services, including activity that is not in the best interest of the organization, is strictly prohibited.** The following describes the requirements to ensure that we comply with the Code of Conduct.

Conflicts of Interest

Individuals have a duty to put the interests of the organization before their own and to avoid conflicts of interest or situations where someone might question the Individual's loyalty to the organization. A conflict of interest may occur if an Individual's outside activities, financial interests or other personal interests impartially influence or appear to influence the Individual's decision making abilities in the course of their job-related responsibilities.

For instance, Individuals having a personal relationship with a vendor that we are proposing to do business with must disclose this relationship and not participate in the vendor selection process. Individuals may be required, in accordance with our Conflicts of Interest policy, to disclose conflicts of interest prior to making any decision or taking any action that is or may be affected by the conflict.

Examples of situations where disclosure is required include but not limited to:

- Part-time job that an Individual may hold outside of the organization
- An Individual owns a business or does consulting work that may compete with the organization
- Serving as an Expert Witness in a legal action
- Holding an elective office or serving on a community-based board

Examples of situations where disclosure is most likely not required:

- Serving as an officer for a church
- Membership with the Parent Teacher Organization (PTA)
- Membership in a professional organization or in a political party

Our Conflicts of Interest policy provides additional guidance in this area. Trustees, officers, senior managers and other key caregivers are required to submit a Conflict of Interest Disclosure Statement annually. All other caregivers are required to disclose to their immediate supervisors or to the Ministry compliance department, any real or potential conflict of interest prior to making any decision or taking any action that is or may be affected by the conflict. Supervisors may consult with the Chief Compliance Officer or Regional Compliance Director for assistance in resolving such conflict.

Proprietary Information

The term "proprietary information" refers to any information held by our organization that is valuable and, in some cases, kept confidential. Individuals must only use proprietary information in the performance of their specific job-related duties and must not share the information unless appropriately requested to do so and is in a manner that is consistent with legal requirements and policy.

Examples of proprietary information that may be held by our organization, that may not otherwise be available to the public include strategic plans, trade secrets, information about potential acquisitions, divestitures and investments, financial information related to patients or to the organization, passwords to computer systems, pricing and cost data, information relating to contracts/relationships that we have with third parties and proprietary computer software. Individuals are strictly prohibited from using any information held by the organization to personally benefit or to perpetrate identity theft.

Gifts, Gratuities and Business Courtesies

Individuals are prohibited from giving or accepting items of value such as personal gifts, business courtesies or services. Gifts that are intended to influence or may be reasonably perceived by anyone as having the potential to influence another's judgment in the decision-making process relative to the Individual's duties as employed must not be accepted. The following guidelines, as outlined in the Gifts, Gratuities and Business Courtesies Policy, must be followed:

Vendors

A department or clinical unit may accept a perishable gift such as a floral arrangement, baked goods or similar edible items. To the extent that staff and a consultant's staff are working together on a project for the organization and working through a meal is necessary, a meal of reasonable modest cost, such as pizza, is acceptable. Individuals are prohibited from accepting cash or equivalents in any amount from vendors, including gift certificates, stocks, etc.

Items such as mugs, pens and similar items may be accepted from a vendor if the item does not exceed nominal value and the aggregate amount per recipient does not exceed $100 annually. There are specific limitations around the acceptance of business courtesies that may be offered to Individuals by vendors. Meals may be accepted on occasion if within the limitations described in the policy, but business courtesies such as tickets to sporting events, theatrical events or golf outings may never be accepted.

Patients

Individuals are prohibited from accepting gifts such as money and personal gratuities from patients or a patient's family. Individuals should refuse such gifts. If the patient or patient's family is insistent, they can be directed to the ministry fund development office where the gift can be accepted on behalf of the ministry foundation in accordance with applicable policy governing such gifts. Individuals may accept perishable items, such as candy, that are given by patients as tokens of appreciation. A patient or patient's family must never be expected or encouraged to provide gifts and gratuities in exchange for care.

Physicians

Any gifts or entertainment involving physicians or other persons in a position to refer patients are subject to specific rules and limitations and individuals should contact management regarding these situations. We may provide narrowly defined items referred to as “non-monetary compensation” or “incidental benefit to physicians in strict accordance with the Non-Monetary Compensation and Medical Staff Incidental Benefits Policy detailing specific restrictions, considerations, annual and per occurrence caps, limitations and tracking requirements.

We are required to track any items provided to physicians under this policy. Individuals assigned to roles involving the provision of compensation or benefits to physicians should be familiar with this policy and procedure.

Employed Caregivers

We are required to report on the IRS Form W-2 certain items provided to caregivers or to the caregiver’s spouse or guests. When the organization or a department within the organization, provides a gift of property to a caregiver that is greater than nominal value, such as a floral arrangement, the caregiver will be subject to taxation on that item unless the item is refused. The caregiver will also be subject to taxation on all cash or cash equivalents of any value, including gift cards that are provided by our organization to a caregiver.

However, vouchers that are provided to caregiers that are redeemable for a specific item such as a turkey or a cup of coffee will be treated as tangible gifts and are not reportable for tax purposes if not more than nominal value. The Tax Treatment Gift Policy should be referred to for additional information regarding gift taxation.

Media Inquiries

Individuals must direct all media inquiries or requests to use the identity marks for PSJH and our family of organizations to the Marketing and Communication department.

3. Fiscal Responsibility

We retain accurate and complete records that represent our true financial position, actual financial results and cash flow in conformity with applicable law and Generally Accepted Accounting Principles (GAAP) and ensures that such records are available to support business practices and actions.

Tax-Exempt Status

As a tax-exempt organization, we have a legal and ethical obligation to comply with applicable tax laws, to engage in activities which further its charitable purpose and to ensure that resources are only used for charitable purposes rather than for the private or personal interest of any one private individual. Obligations under these laws require that we evaluate compensation arrangements to ensure that such arrangements are consistent with fair market value and that payments under these arrangements are appropriately reported.

Accuracy, Retention, and Disposal of Documents, Reports, and Records

We have implemented policies and procedures governing the way that business and patient records must be created, retained and destroyed in order to comply with generally accepted accounting principles, various regulatory requirements and to prevent false, fictitious or fraudulent claims from being made.

Individuals are expected to understand the policies and procedures that relate to their specific areas of work whether they relate to financial reports, accounting records, expense accounts, physician compensation or any other document.

Individuals have a personal responsibility to ensure that entries related to financial and business documents are complete, true and accurate and that requests for reimbursement or payments are supported by receipts, invoices or other documentation as required by policy.

4. Industry Regulations

We conduct our business in accordance with the spirit and letter of all applicable laws and regulations. We perform proactive auditing to ensure that payments to physicians are made in accordance with policy, overpayments received in error are processed timely and that documentation supporting the medical necessity of services performed is maintained appropriately. The following is a snapshot of areas that are perceived to be higher risk to us.

While Individuals are not expected to understand the intricacies of the various laws, they are expected to have a practical working knowledge of the laws in terms of the impact that the laws have on their specific job-related duties and area of work.

Ineligible and Excluded Persons

As the recipient of federal health care dollars, we are prohibited from contracting, employing or billing for services rendered by any individual or organization that is excluded, is pending exclusion or ineligible to participate in federal health care programs by the Department of Health and Human Services or the U.S. General Services Administration. Below are examples of offenses that could make an Individual ineligible and reportable to the organization, including but are not limited to the following events.

- A conviction for health care fraud
- A conviction related to the obstruction of an investigation
- Conviction of patient abuse
- License revocation or suspension
- Failure to repay federal loans

The False Claims Acts (Federal and State)

It is a crime for any person or organization to "knowingly" make a false record or file a false claim with the government for payment. Under certain circumstances, an inaccurate Medicare, Medicaid (MediCal), Veteran Administration, Federal Employee Health Plan or Workers' Compensation claim could become a false claim. This means that the person or organization knows the record or claim is false; or seeks payment while ignoring whether or not the record or claim is false; or seeks payment recklessly without caring whether or not the record or claim is false.

Under federal law, civil damages can consist of up to three times the payment that was made in error, plus additional penalties of $5,500 to $11,000 per false claim. Potential false claims may arise when documentation, coding and billing practices are not followed and Individuals providing services in these areas should understand these laws and regulations.

Documentation is Accurate and True

In addition to ensuring that patients can depend on us and their physicians to accurately document the care that is provided within their medical records, third party payers such as Medicare and Medicaid require that medical record entries be true and accurate. We will make every effort to ensure that medical record entries are clear and complete and reflect exactly the care that was provided to the patient and that any entries are free from exaggeration and do not lead others to document in a certain way that could result in falsified information.

Reporting is Timely and Accurate

We will ensure that all external reports are filed on time and are complete, accurate and understandable. These include cost reports, plans of correction and reports to accrediting bodies such as Joint Commission, OSHPD or other government oversight agency. We must follow through on all promises of corrective action that are made to any of these agencies.

Billing is Honest

We are committed to ensuring that any payment error made by government payers, commercial insurance payers and/or patients is promptly adjusted or refunded and that action is taken to prevent errors in the future. We will make every effort to submit bills that are accurate in describing services that were medically necessary, actually provided by qualified individuals, properly documented and accurately coded.

When a billing error is identified, we will correct the error prior to submitting the bill to the payer. If we have already billed the payer and an error is detected, we will take corrective action including issuing the appropriate refund within the required timeframe. Individuals should immediately notify their manager or the Integrity Hotline if they are not sure how to correct an error or feel that an error has not been corrected appropriately.

Failure to correct a billing error or to return identified overpayments resulting from the error, will result in disciplinary action up to and including termination. Specifically, Individuals must immediately report to their manager, to the Ministry Compliance Department or through the Integrity Hotline, events that are related to the following:

- Misrepresenting services actually provided such as the assignment of a code for a more complicated procedure than actually performed that may result in a higher level of reimbursement, known as "upcoding" or by assigning codes that divide a procedure or service typically billed as one procedure into multiple parts in order to increase reimbursement, known as "unbundling";
- Failure to accurately and completely code claims for hospital acquired conditions;
- Duplicate billing for a service that was rendered;
- Falsely certifying that services were medically necessary;
- Falsely certifying that an individual meets the Medicare requirements for home health or any other services;
- Retaining excessive funds from Medicare, Medicaid or other government payers;
- Seeking to collect amounts exceeding the co-payment and deductible from a federal health care beneficiary who has assigned his or her rights to benefits; and
- Permitting an Individual to prescribe, provide or oversee the delivery of goods or services to beneficiaries when that individual has been excluded from participating in federal health care programs (per the OIG/GSA exclusion lists).

False Claims Acts Whistleblower Provisions and Protections

A person who possesses and comes forward with information regarding false claims is authorized to file a case in Federal Court and sue, on behalf of the government, those entities that engaged in the fraud. These are called "qui tam" suits. The person coming forward is called a "relator" or "whistleblower."

Once the suit is filed by the relator, the Department of Justice then decides on behalf of the government whether to join the relator in prosecuting these cases. If the case is successful, the relator may share in the recovery amount. The amount of the relator's share in the recovery depends on multiple factors.

In addition, the False Claims Act provides protection and relief for contractors, caregivers or agents who are discharged, demoted, suspended, threatened, harassed or discriminated against by their employer or principal in retaliation for their lawful efforts to stop one or more violations of the False Claims Act.

If a court determines that a contractor, caregiver or agent was terminated or otherwise retaliated against for engaging in such acts, the contractor, caregiver or agent is entitled to reinstatement at the same level, two times the back pay owed plus interest, litigation costs and reasonable attorneys' fees and compensation for any "special damages" sustained as a result of the discrimination.

California, Texas and New Mexico have statutes similar to the federal False Claims Act which are applicable to the ministries and those associated with any ministry. For instance, California law provides that any entity or person who knowingly presents or causes to be presented a false claim for payment shall be liable for a civil monetary penalty of up to $10,000 for each false claim and the costs of any civil action brought to recover any penalties.

Additional penalties of not less than two times and not more than three times the amount of damages may be awarded in certain situations. Criminal penalties can range from imprisonment for one year in the county jail or a fine not exceeding $1,000 or both, to imprisonment in a state prison for one year or a fine not exceeding $10,000 or both. In addition to similar federal whistleblower protections, the California False Claims Act also permits punitive damages in appropriate circumstances.

In addition to similar federal protections, remedies for violations of the Texas equivalent of the False Claims Act include restitution, fines of $1,000 to $10,000 for each unlawful act and two times the value of the false claim. Depending upon the value of the payment made in violation of the Texas False Claims Act, criminal penalties can range from a misdemeanor to a felony in the first degree when amounts of $200,000 or more are involved. Texas offers "whistleblower" protection similar to the federal False Claims Act and California equivalent of the False Claims Act, but unlike California, does not contain a provision for recovery of punitive damages.

Similar to provisions in the federal False Claims Act, the New Mexico equivalent of the False Claims Act provides for penalties of triple the damages resulting from any false claims submitted, in addition to other civil penalties. New Mexico offers "whistleblower" protection similar to the federal False Claims Act and California

and Texas equivalents of the False Claims Act, but unlike California, does not contain a provision for recovery of punitive damages. The New Mexico equivalent of the False Claims Act does not contain specific criminal sanctions in addition to the civil penalties it provides, but does appear to contemplate the possibility of criminal charges based on other theories arising out of the false claim.

Anti-Kickback Law: Relationship with Physicians and other Referral Sources

We accept patient referrals and admissions based solely on the patient's medical needs and our ability to render the necessary services. Similarly, when making referrals to another provider, we do not consider the volume or value of referrals that the provider has made (or may make) to us.

The Anti Kickback law prohibits a provider from knowingly and willfully offering, paying, soliciting or receiving any money, gifts, kickbacks, bribes, rebates or any other type of value, remuneration or services in return for the referral of patients or to induce the purchase, lease or ordering of any item, good or service for which payment may be made by the federal or state government.

The organization and Individuals are subject to civil monetary penalties for failure to comply and potential implications under the federal and state false claims acts for any claims submitted pursuant to prohibited referrals.

Prohibited activities include, but are not limited to, the following:

- Payment by the organization is an incentive when a patient is referred to us;
- Provision or receipt by us, to or from third parties (i.e. physicians) of free or significantly discounted billing, rent, staff services or training in management (coding and laboratory) techniques;
- Payment by the organization for services in excess of fair market value;
- Forgiveness of a debt to the organization absent a charitable or risk management purpose as specified in a policy; and
- Preferential treatment of or by us in any form to obtain business.

Stark

In addition to the Anti-Kickback Statute, there are laws that prohibit a physician with a financial relationship with us from referring patients to us except where the relationship fits into a legal exception. These laws, (also known as the Stark Law,) are very complex and require strict adherence to our policies and procedure to ensure compliance.

We are committed to ensuring that all relationships with physicians are appropriate and in compliance with the various laws and regulations governing the relationship between hospitals and physicians who may refer patients to the facilities. We have developed several physician arrangements policies and a policy related to non-monetary compensation and medical staff incidental benefits, governing specific contractual arrangements and benefits provided to physicians.

Individuals interacting with physicians, particularly regarding making payments to physicians for services rendered, providing space or services to physicians, recruiting physicians to the community and arranging for physicians to serve in leadership positions, should be aware of the requirements of these policies. The Physician Arrangements Policy describes the appropriate process for engagement of physicians relative to medical directorships and administrative services, professional services, emergency call coverage, recruitment, leases, loans and lines of credit, etc.

The Non-Monetary Compensation and Medical Staff Incidental Benefit Policy describes the limitations and prohibitions on the provision of gifts and the payment of incidental benefits to physicians. Both policies provide a foundation for which transactions with physicians must be based and for which Individuals involved in the physician transaction process are obligated to refer when transacting business.

The following is a summary of the key requirements relating to physician transactions, though Individuals must refer to the specific policies governing the process as they may be modified from time to time.

- We are committed to maintaining positive working relationships with physicians and to providing a uniform and fair medical staff privileging process.
- All agreements involving payments or other compensation paid by us to physicians will be in writing and approved in advance by the Legal Department in accordance with the Physician Arrangements policies.
- The written agreement provided by the Legal Department will not be altered after review and approval and will be signed by our organization and the physician prior to the commencement of services by either party.
- A copy of the agreement that is signed by all parties, any community need documentation and any documentation establishing the reasonableness of compensation (e.g. survey data, hourly rate comparables, opinions from an independent valuation firm) will be maintained by us for a minimum of ten years.
- Payment or consideration will be set in advance for the term of at least one year.
- Services and items to be delivered are clearly described in the written agreement and determined to be reasonable and necessary for a legitimate business purpose.
- The agreement demonstrates that payment is not in any way conditioned on the value or volume of referrals.
- The agreement is prospective only.
- Payments to physicians pursuant to the written agreement will only be made once we have obtained adequate supporting written documentation in the form of a time sheet, invoice or other appropriate document.
- All renewals of an agreement where the compensation will be modified are prospective.

Political Activity and Political Contributions

As an organization exempt from federal income taxes pursuant to Section 501[c](3) of the Internal Revenue Code, we are prohibited from participating in intervening in any political campaign on behalf of or in opposition to any candidate for public office. Therefore, Individuals must not engage in activities, on behalf of the organization, that might jeopardize its tax-exempt status.

Further, corporate resources, including use of our premises or donation of goods, cannot be used for political purposes that promote or benefit any candidate or reward government officials. Individuals are permitted to participate in and personally contribute their own funds and resources to political organizations or campaigns if such activity is done on the caregiver's personal time and outside the premises of the organization.

Government Requests

We always cooperate with any requests from government agencies. To ensure that contacts with government agencies are handled appropriately, the General Counsel and the Chief Compliance Officer will be consulted before responses to non-routine requests are provided to government agencies. All responses will be clear and truthful. We will not alter or destroy records once it is aware of an existing or potential government inquiry.

Antitrust and Competition

We strive to promote fair competition and Individuals must support this by not engaging in activities or making agreements with competitors, on behalf of the organization, that illegally reduce or eliminate competition, control prices or exclude competitors. Individuals should report any attempts by a competitor to engage in inappropriate discussions to management.

Conduct that consists of bribery, improper use of trade secrets or that is deceptive or intimidating toward a customer or supplier is strictly prohibited. The Legal Department should be consulted on a proactive basis where collective activity or decision making will occur that may involve antitrust issues.

Conclusion

The Code of Conduct describes the minimal requirements that Individuals are required to comply with relating to job-related conduct. While these tools are intended to support Individuals in recognizing, understanding and fulfilling their responsibilities and to prevent and detect violations, not every situation can be anticipated that a caregiver may encounter in the workplace. As such, Individuals are expected to ask questions and obtain answers to those questions. Help us to be outstanding corporate citizens and contribute to the success of the Program by adhering to the Code of Conduct and by reporting any violations.

St. Joseph Health

I acknowledge that I have received a copy of the Code of Conduct and understand that it represents the policies and procedures of St. Joseph Health, which I am obligated to understand and comply with as these policies and procedures relate to my specific job role and work area.

Signature: _____

Position/Title: _____

Printed Name: _____

Date: _____

Ministry: _____

St. Joseph Health

Integrity Hotline 1-888-294-8455

http://psjhealth.org/IntegrityOnline

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