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POLICY INFORMATION

Policy Title: Auditing and Monitoring for Compliance Policy and Procedure

Departmental Owner: Corporate Compliance, Audit & Privacy Officer

Version Effective Date: 11/30/2024

Last Reviewed: 11/30/2024

SCOPE

This policy applies to the following individuals and/or groups:

☒All Covered Individuals (e.g., all Nuvance workforce members, business affiliates, and agents) as defined below under Definitions.

This policy applies to all above listed Nuvance Health workforce members including but not limited to the following locations:

☒All of the below entities

☐Nuvance Health Systems

☐ Danbury Hospital (including New Milford Hospital Campus)	☐ Health Quest Systems, Inc. "(HQSI)"	☐ Western Connecticut Home Care, Inc ("WCHN")
☐Northern Dutchess Hospital	☐ Health Quest Home Care, Inc	☐ Western Connecticut Health Network Physician Hospital Organization ACO, Inc.
☐Norwalk Hospital	☐ Hudson Valley Cardiovascular Practice, P.C. (aka The Heart Center) ("HVCP")	☐Western Connecticut Home Care, Inc
☐ Putnam Hospital	☐ Other HQSI-affiliated Entities Not Listed	☐ Other WCHN-affiliated Entities Not Listed
☐Sharon Hospital		☐Nuvance Health Medical Practices (NHMP PC, NHMP CT, ENYMS & HVCP)
☐Vassar Brothers Medical Center		

POLICY STATEMENT/PURPOSE

Nuvance Health and its affiliates ("Nuvance") developed and implemented a compliance program in an effort to promote adherence to applicable federal and state laws and other internal and external standards or requirements. An important component of the compliance program is the use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of potential risks. This policy focuses on the organization's resources to effectively and efficiently audit and monitor risk areas.

POLICY

Nuvance will conduct ongoing auditing and monitoring of identified risk areas related to compliance. It is the responsibility of the entire management team to ensure that ongoing auditing and monitoring is properly executed, documented, and evidenced. Nuvance will develop corrective action plans in response to the results of any internal audits performed and will track the implementation of the corrective action plans in order to assess the effectiveness of such plans.

DEFINITIONS

For purposes of this policy, the terms listed below shall have the following meanings:

Covered Individual: Any Nuvance Health ("Nuvance") workforce member, business affiliate, or agent, as those terms

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are described in subdivisions (i)-(iii) below:

i. *Workforce Members*

For purposes of this Policy, the term "workforce member" shall include any of the following individuals at Nuvance Health who, on a fulltime, part time or per diem basis, whether functioning remotely, onsite, or any combination thereof, performs, executes, or otherwise carries out Nuvance Health functions, duties, or services:

1. Members of the Nuvance Health Board of Directors, and Members of the Boards of any Nuvance related entity including, without limitation, any Nuvance entity first highlighted above in Section III of this policy;[1]
2. Chief Executive Officer;[2]
3. Corporate Officers;[3]
4. Executives and other senior managers regardless of title;[4]
5. Employees;[5]
6. Administrators;[6]
7. Managers;[7]
8. Affiliates;[8]
9. Medical Staff Members;[9]
10. Clinicians;[10]
11. Allied Health Professionals;[11]
12. Appointees;[12]
13. Volunteers;[13]
14. Personnel;[14]
15. Interns;[15]
15. Students;[16]
16. Trainees; **and**
17. Any individual whose performance or other conduct is under the

[1] For purposes of this Policy, "members of the Nuvance Health Board of Directors and Members of the Boards of any Nuvance Health related entity" shall be construed to include members of any associated Board committee.
[2] 18 NYCRR 521-1.2 [b][l]
[3] 18 NYCRR 521-1.2 [b][l]
[4] New York State Office of the Medicaid Inspector Genera1, Compliance Program Review Guidance, New York State Social Services Law 363-d and Title 18 New York Codes Rules and Regulations Part 521(10/26/16)(hereinafter 2016 OMIG Compliance Program Guidance), p.3
[5] 18 NYCRR 521-1.2 [b][l]
[6] 18 NYCRR 521-1.2 [b][l]
[7] 18 NYCRR 521-1.2 [b][l]; see also, generally, OIG Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8987, 8988, § [I] (1998)
[8] 2023 OMIG Compliance Program Guidance, p. 18
[9] See, generally,2016 OMIG Compliance Program Guidance, p.3; see also OIG Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8987, 8995-8996, § [II][E][l] (1998) and 18 NYCRR 521-1.2 [b][l] (last accessed on 9/3/24)
[10] 18 NYCRR 521-1.2 [b][l]
[11] *See, generally*, OMIG Required Risk Areas at 18 NYCRR §521-1.3(d) (last accessed on 9/3/24)
[12] 2016 OMIG Compliance Program Guidance, p.3 (last accessed on 9/3/24)
[13] 2016 OMIG Compliance Program Guidance, p.3 (last accessed on 9/3/24)
[14] See, generally, OIG Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8987, 8993, § [II][A][9] (1998) (last accessed on 9/3/24)
[15] 18 NYCRR 521-1.2 [b][l] (last accessed on 9/3/24)
[16] 18 NYCRR 521-1.2 [b][l] (last accessed on 9/3/24)

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direction and control of Nuvance Health, whether or not they are paid by Nuvance Health;

ii. *Business Affiliates*:

For purposes of this Policy, the term "Business Affiliate" shall include any non-workforce member contractor, independent contractor, vendor, subcontractor, consultant, third-party, or person (collectively "Contractors"), who or that, in acting on behalf of Nuvance Health:

(1) Delivers, furnishes, prescribes, directs, orders, authorizes, administers, or otherwise provides Federal healthcare program items, supplies, and services; [17]
(2) Performs coding or billing functions;[18]
(3) Monitors the healthcare provided by Nuvance Health;[19]
(4) Contributes to Nuvance Health's entitlement to payment under Federal healthcare programs or payment from private payors;[20]
(5) Is affected by any of the following Nuvance risk areas:[21]

(a) Medical record documentation;[22]
(b) Coding;[23]
(c) Billings;[24]

[17] *See* CMS, DRA 6032 - Employee Education About False Claims Recovery- Frequently Asked Questions, p.6 (available at: https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd032207attl .pdf (last accessed on 8/29/24); *See, also, generally* Department of Health and Human Services, Office of Inspector General, *OJG Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs* (Updated, 5/8/13) (available at: https://oig.hhs.gov/exclusions/files/sab-05092013.pdf)(last accessed on 9/3/24).

[18] See CMS, DRA 6032 - Employee Education About False Claims Recovery - Frequently Asked Questions (available at: https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd032207 attl.pdf)(last accessed on 8/29/24; *see also* CMS, Center for Medicaid and State Operations, Dear State Medicaid Director Letter dated 12/13/06): https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMDl 21306.pdf)(last accessed on 8/29/24)

[19] See CMS, DRA 6032 - Employee Education About False Claims Recovery - Frequently Asked Questions https:// downloads.ems.gov/cmsgov/archived-downloads/SMDL/downloads/smd032207att l.pdf (last accessed on 8/29/24; see also CMS, Center for Medicaid and State Operations, Dear State Medicaid Director Letter dated l 2/13/06): https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD121306.pdf)(last accessed on 8/29/24)

[20] 2016 OMIG Compliance Program Guidance, p.3

[21] Note, business affiliates affected by "other risk areas that are or should reasonably be identified by Nuvance through its organization experience" are also covered under this policy to the extent that the potential impact of such risk areas when exploited could reasonably lead to, or result in, a potential or actual overpayment. (10 NYCRR 521 -1.3 [d][l0]). (last accessed on 9/3/24)

[22] See 18 NYCRR 521-1.3 [d][l0]

[23] See 18 NYCRR 521-1.3 [d][l0]; see also CMS, DRA 6032- Employee Education About False Claims Recovery- Frequently Asked Questions (available at: https://downloads.cms.gov/cmsgov/archived- downloads/SMDL/downloads/smd032207attl .pdf)(last accessed on 8/29/24; *see also* CMS, Center for Medicaid and State Operations, Dear State Medicaid Director Letter dated 12/13/06): https://downloads.cms.gov/cmsgov /archived- downloads/SMDL/downloads/SMDl21306.pdf)(last accessed on 8/29/24)

[24] See 18 NYCRR 521-1.3 [d][l]

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(d) Claims preparation and submission;[25]
(e) Claims reimbursement;[26]
(f) Payments;[27]
(g) Patient collections;[28]
(h) Order services;[29]
(i) Medical necessity;[30]
(j) Quality of care;[31]
(k) Governance;[32]
(l) Mandatory reporting;[33]
(m) Credentialing;[34]
(n) Contractor oversight;[35]
(o) Identification and returning of overpayments;[36]
(p) Joint ventures;[37]
(q) Improper referrals, incentives, or financial arrangements;[38] or
(r) Cost reporting[39]

(6) Is otherwise affected by this policy due to their:
(a) duties, functions, role, or responsibilities; or[40]
(b) provision of goods or services to Nuvance.

iii. *Agents*: For purposes of this Policy, the term "Agent" shall mean individuals or entities that have entered into an agency relationship with Nuvance Health. Agents may fall under the categories of either Workforce Members or Business Affiliates.

PROCEDURE STATEMENT

Nuvance will conduct ongoing auditing and monitoring of identified risk areas related to compliance. It is the responsibility of the entire management team to ensure that ongoing auditing and monitoring is properly executed, document, and evidenced.

[25] See 18 NYCRR 521-1.3 [d][l0]
[26] See 18 NYCRR 521-1.3 [d][l0]
[27] See 18 NYCRR 521-1.3 [d][2]
[28] See 18 NYCRR 521-1.3 [d][10]
[29] See 18 NYCRR 521-1.3 [d][3]
[30] See 18 NYCRR 521-1.3 [d][4]
[31] See 18 NYCRR 521-1.3 [d][5]
[32] See 18 NYCRR 521-1.3 [d][6]
[33] See 18 NYCRR 521-1.3 [d][7]
[34] See 18 NYCRR 521-1.3 [d][8]
[35] See 18 NYCRR 521-1.3 [d][9]; see also 42 USC 1396a [a][68][A] (last accessed on 9/3/24)
[36] See 18 NYCRR 521-1.3 [d][l0]
[37] OIG Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8987, 8990, § [ll][A][2] (1998) (last accessed on 9/3/24)
[38] See 18 NYCRR 521-1.3 [d][l0]
[39] See 18 NYCRR 521-1.3 [d][l0]
[40] See 18 NYCRR 521-1.3 [d]; *see also* OIG Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8987, 8989 § [II][A] (last accessed on 9/3/24)

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PROCEDURE

1. The Chief Compliance, Audit & Privacy Officer ("CCAPO") will recommend and facilitate auditing and monitoring of identified risk areas related to compliance with laws and regulations, as well as organizational policies, procedures, and standards of conduct. (Risk areas may be identified through the regular course of business, external alerts, or internal reporting channels), including but not limited to the following:
    - Information technology risks;
    - Fraud risks;
    - Environmental, social and governance risks;
    - The following Federal healthcare program-related risk areas:
        - Billing cycle (medical record documentation, coding, billings, claims preparation and submission, payments, claims reimbursement, patient collections, cost reporting);
        - Ordered services;
        - Medical necessity and quality of care;
        - Governance;
        - Credentialing;
        - Mandatory reporting (including self-disclosure and returning of overpayments);
        - Contractor, subcontractor, agent or independent contractor oversight; and
        - Other risk areas that are or should be identified by Nuvance Health by way of organizational experience.
    - Risks related to compliance with the Stark Law and Anti-Kickback Statute that may stem from business and financial contracts, agreements or other arrangements that generate Federal healthcare program business.
    - The results of internal and external audits; and
    - The results of audits conducted by State or Federal governmental agencies of Nuvance Health.

2. The Nuvance Corporate Compliance Office will conduct internal and/or compliance reviews at each Nuvance Affiliate based upon risk areas identified and included in the Nuvance Health Audit & Compliance Annual Work Plans.

3. Auditors (including Internal Audit and/or Compliance Review) will prepare an engagement letter/Audit Scoping Document & Memorandum (“Memo”) for each review detailing the objective, risk factors (including certain fraud risks), scope, timing, and deliverables. The engagement letter/Audit Scoping Document & Memo will be addressed to the area under review with a copy to the appropriate Affiliate Senior Leadership (Note: All engagement letters should include the Affiliate President). The engagement letter/Audit Scoping Document & Memo will be distributed in no less than five (5) business days in advance of the opening meeting, if one is considered necessary.

4. At the beginning of an internal and/or compliance review, an opening meeting will be held with the management of the area being reviewed, if one is considered necessary. As a matter of professional courtesy, the Affiliate President will be invited to the meeting and can attend based upon his/her discretion.

5. The Corporate Compliance staff member assigned to the audit/review will be responsible for preparing an audit work program. The audit program will be reviewed by the Senior Compliance Officer/Executive Compliance Officer and/or the Lead Managing Internal Auditor prior to execution.

6. For any potential issues during the review, the auditor will bring them to the attention of department management for resolution, if possible, during the review.

7. At the conclusion of the review, a closing meeting will be held with the key stakeholder[s] related to the audit/review observation[s] and the same individuals that attended the opening meeting, if considered necessary. A written draft report will be provided to all responsible parties no less than ten (10) business days in advance of the meeting for preparation of management

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responses to any identified findings and for discussion at the meeting. The draft report will contain, at a minimum, audit observation, risk of observation, recommendation, and a section for management response. The goal of this meeting is to agree with the factual accuracy of the findings and start the process of obtaining management responses (Note: The draft report should be reviewed prior to the meeting by the Senior Compliance Officer/Executive Compliance Officer and/or the Lead Managing Internal Auditor).

8. The draft report should include: (i) Summary of audit results, dates completed, and any compliance issues identified; (ii) any other evidence of how auditor performed audits that focused on risk areas noted above; and (iii) any additional explanation, if needed.

9. All management identified in the compliance audit/review are responsible for developing formal written responses, including any process changes, education or other action plans necessary to address the recommendation(s) made by the auditor. Responses should include a description of the corrective action to be taken, estimated implementation date, and the name of the person responsible for the corrective action.

10. Management responses are to be provided to the appropriate Corporate Compliance staff within ten (10) business days of receiving the draft report, unless a request for extension is approved by the Compliance Office. Requests for extensions should not be routine but should be reserved for large-scale or complex issues that warrant additional time to review/respond. A request for extension may only be made after a good-faith and reasonable effort was made to review the findings and provide an appropriate response. In those cases where the department fails to provide a response or request a reasonable extension within the initial ten (10) days, the audit will be forwarded to the Senior Vice President for the relevant department indicating "no management response was provided".

11. Once management responses have been provided and reviewed, the auditor/reviewer presents the draft report to his/her team for review. Management responses are reviewed and discussed, findings are modified as appropriate, and a final findings risk is assigned.

12. The final report is distributed to all required parties, which may include:

    a. Primary Management Contact
    b. The Director of the Primary Management Contact
    c. The Assistant Vice President (AVP) / Vice President (VP) of the Primary Management Contact
    d. The President of the entity being audited / reviewed
    e. The Executive Compliance Committee (“ECC”)
    f. The CEO (at his discretion) of Nuvance
    g. The Audit & Compliance Committee (“ACC”) of the Nuvance Health Board of Directors

13. An effective system for the routine monitoring and identification of compliance risk has been established. The Corporate Compliance staff/auditor monitors/follows up on the reported findings. The purpose of the follow up is to ascertain that corrective action has been taken and is achieving the desired results with the stated implementation date[s].

    If a stakeholder believes that an action item is closed, the Corporate Compliance staff/auditor will request supporting evidence or conduct a brief review to ensure that the action item has been adequately remediated. Corporate Compliance staff/auditor will maintain a log of the supporting evidence/review performed and the reason why the action item was closed.

    The Senior Compliance Officer/Executive Compliance Office and/or Lead Managing Internal Auditor will report to the CCAPO and Audit & Compliance Committee on the status of Management Action Plans on a quarterly basis.

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ENFORCEMENT

All individuals whose responsibilities are affected by this process are expected to be familiar with the basic procedures and responsibilities created by this process. Failure to comply with this process will be subject to appropriate remedial and/or disciplinary action, up to and including termination of any employment or other relationship, in accordance with this process .

REFERENCES

Nuvance Health Compliance & Ethics Program Charter
Nuvance Health Internal Audit Charter

APPROVAL

Signed by:
Jared B Gaynor
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Signature

12/19/2024

Date

Original Effective Date: LWCHN: 3/22/01 LHQ: 9/9/2008
Revision Dates: 11/22/23, 11/22/24
Supercedes: 5.1.01 Auditing and Monitoring for Compliance Policy; 5.1.01 Auditing and Monitoring for Compliance Procedure; and Monitoring Activities Related to Compliance