

Kaweah Delta Health Care District Board of Directors Meeting

Health is our Passion. Excellence is our Focus. Compassion is our Promise.



DATE POSTED: May 18, 2026

NOTICE

Date: Friday, May 22, 2026

Location: Support Services Building, Granite Conference Room

Address: 520 West Mineral King Avenue, Visalia, California

Please join my meeting from your computer, tablet or smartphone.

<https://meet.goto.com/KelsieD/kaweahdeltahealthcaredistrictboardofdirectorsmeet>

You can also dial in using your phone.

Access Code: 460-561-181

United States: [+1 \(646\) 749-3122](tel:+16467493122)

SCHEDULE:

- **10:00 AM** – Open Session
- **Immediately following the open session** – Closed Session
Pursuant to:
 - Government Code §54956.9(d)(2) (Anticipated Litigation – Significant Exposure)

AMERICANS WITH DISABILITIES ACT (ADA) NOTICE:

In compliance with the Americans with Disabilities Act, if you need special assistance to participate in this meeting, please contact the Board Clerk at (559) 624-2330. Notification at least 48 hours prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to the meeting.

POSTING NOTICE:

All Kaweah Delta Health Care District regular Board and committee meeting notices and agendas are posted at least **72 hours** prior to the meeting (and **24 hours** prior to special meetings) in the Kaweah Health Medical Center, Mineral King Wing, near the Mineral King entrance, in accordance with Government Code §54954.2(a)(1).

PUBLIC RECORDS:

Disclosable public records related to this agenda are available for public inspection at:
Kaweah Health Medical Center – Acequia Wing, Executive Offices (1st Floor)

Mike Olmos • Zone 1
Board Member

Jonna Schengel • Zone 2
Board Member

Dean Levitan, MD • Zone 3
Secretary/Treasurer

David Francis • Zone 4
President

Armando Murrieta • Zone 5
Vice President

Kaweah Delta Health Care District

Board of Directors Meeting

Health is our Passion. Excellence is our Focus. Compassion is our Promise.



400 West Mineral King Avenue, Visalia, CA 93291

You may also request records by contacting the Board Clerk at (559) 624-2330 or

kedavis@kaweahhealth.org, or by visiting the District's website at www.kaweahhealth.org.

KAWEAH DELTA HEALTH CARE DISTRICT

David Francis, Secretary/Treasurer

Prepared by:

A handwritten signature in blue ink, appearing to read "Kelsie K. Davis".

Kelsie K. Davis

Board Clerk / Executive Assistant to the CEO

DISTRIBUTION:

Governing Board, Legal Counsel, Executive Team, Chief of Staff, www.kaweahhealth.org

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Board Member

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Kaweah Delta Health Care District Board of Directors Meeting

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This agenda is posted in compliance with the Ralph M. Brown Act, including amendments enacted under Senate Bill 707.

AUDIT AND COMPLIANCE COMMITTEE MEETING

Support Services Building – Granite Conference Room
520 West Mineral King Avenue, Visalia, CA

Friday, May 22, 2026 {Committee Meeting}

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OPEN SESSION – 10:00 AM

- 1. CALL TO ORDER**
- 2. PUBLIC / MEDICAL STAFF PARTICIPATION** – Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdiction of the Board are requested to identify themselves at this time.
- 3. MINUTES** - Review of February 17, 2026 open minutes.
Requesting Committee Recommendation
- 4. COMPLIANCE PROGRAM ACTIVITY REPORT** – Committee review and discussion of the Compliance Program Activity Report – *Jill Berry*
- 5. COMPLIANCE POLICIES** – Review, discussion and possible recommendation to the Kaweah Health Governing Board for approval of policies, as presented – *Ben Cripps*
 - 5.1. [CP.02 Review of Billing Practices](#)
 - 5.2. [CP.03 Physician Contracting and Professional Services Agreements](#)
 - 5.3. [CP.05 Compliance and Privacy Issues Investigation and Resolution](#)
 - 5.4. [CP.06 Compliance Program Education](#)
 - 5.5. [CP.07 Excluded Individuals/Entities](#)

Friday, May 22, 2026

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5.6. [CP.10 Compliance Reviews and Assessments](#)

5.7. [CP.15 Fair Market Value](#)

Requesting Committee Recommendation

6. ADJOURN TO CLOSED SESSION

CLOSED SESSION – Immediately following the open meeting

1. CALL TO ORDER

2. **MINUTES** – Review of February 17, 2026 closed minutes.

Requesting Committee Recommendation

3. **CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION** – Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) (3 cases) – *Ben Cripps and Rachele Berglund (Legal Counsel)*

4. ADJOURN CLOSED SESSION

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Agenda Posting and Public Records

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Friday, May 22, 2026

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Vice President

Agenda item intentionally omitted

Compliance Program Activity Report – Open Session

January 2026 through March 2026

Ben Cripps, Chief Compliance & Risk Officer



kaweahhealth.org



Education

Live Presentations

- Compliance and Patient Privacy – New Hire Orientation
- Compliance and Patient Privacy – Management Orientation
- PolicyTech System – Various Policy Reviewers, Approvers, and Owners
- Preventive Compliance Process – Various Department Leaders
- Patient Privacy Training – Clinic Leaders and Staff

Written Communications – Bulletin Board / Area Compliance Experts (ACE) / All Staff

- Compliance Matters – Preventive Compliance Process
- Compliance Matters – Code of Conduct
- Code of Conduct and Remote Non-Employee Medical Record System Access – Medical Executive Committee
- Compliance Policy Updates – Email Distribution
- Implementation of Privacy Manual and Relocation of Privacy Policies – Email Distribution

Web Based Training

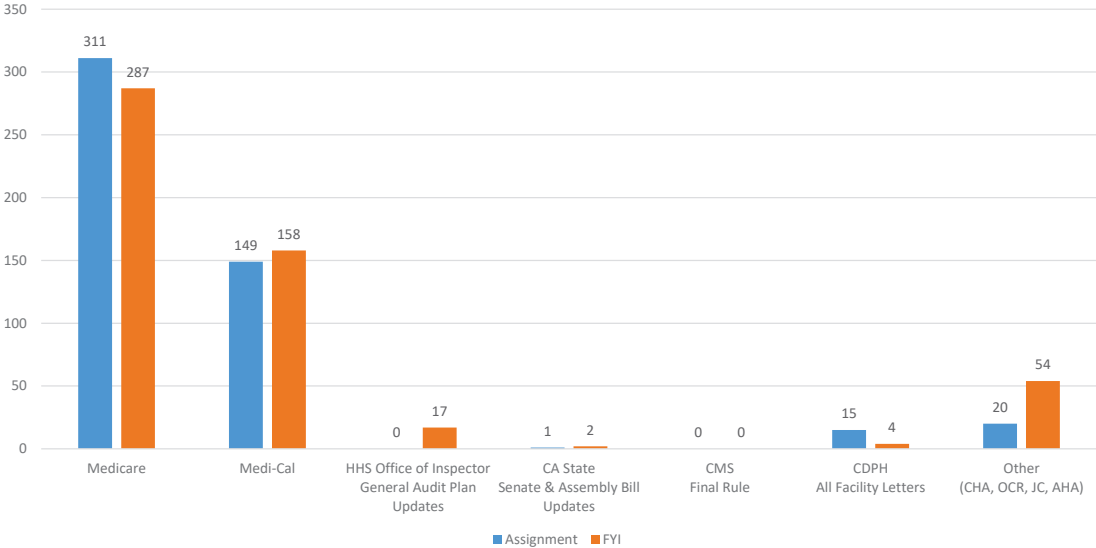
- Mandatory Annual Compliance and Privacy Training – All Staff
- 2026 Mandatory Privacy Training – Remote Non-Employee Medical Record System Users

Prevention & Detection

- **Review, Track, and Distribute Relevant Information on Regulatory Updates to Stakeholders Across the District**
 - Medicare Monthly Bulletins and Communications
 - Medi-Cal Monthly Bulletins and Communications
 - US HHS Office of Inspector General (OIG) Audit Plan Updates and Communications
 - California State Senate and Assembly Bill Updates
 - California Department of Public Health (CDPH) All Facility Letters (AFL)
 - US HHS Office of Civil Rights Activities and Focus Areas
 - California Hospital Association Communications
 - American Hospital Association Communications
 - Joint Commission Communications

Prevention & Detection - Issuance

Communications Issued
(January 2026 - March 2026)



Total Issued: 1018
Assignments: 496
FYIs: 522

Oversight

- **Fair Market Value (FMV) Oversight** – Ongoing oversight and administration of physician payment rate setting and contracting activities including Physician Recruitment, Medical Directors, Call Contracts, and Exclusive and Non-Exclusive Provider Contracts.
- **Electronic Medical Record (EMR) User Access Privacy Audits** – Monitoring of EMR user access through the use of FairWarning electronic monitoring technology which analyzes user and patient data to detect potential privacy violations.
 - An average of one hundred and forty-nine (149) daily alerts were received between January 1, 2026 – March 31, 2026.
 - Types of Alerts Received:
 - Same Last Name: 73.6%
 - Co-Worker: 23.4%
 - VIP: 2.8%
 - Self-Access: 0.1%
 - Same Household: 0.1%

Recovery Audit Contractor Activity

- **Medicare Recovery Audit Contractor (RAC) Activity** – Requests reviewed, records prepared and submitted, appeal timelines tracked, and results reported. The following RAC Audit Activity took place between January 2026 – March 2026:
 - New RAC Requests:
 - Fifteen (15) new RAC record requests were received.
 - Open/Ongoing RAC Requests:
 - Eight (8) were reviewed and closed by the RAC with no recovery after submission of documentation.
 - Twenty-one (21) were denied by the RAC and are pending appeal from Care Management.
 - Six (6) were denied by the RAC and are pending a decision from Care Management on whether to appeal.
 - Two (2) were denied by the RAC and closed; and will not be appealed.
 - Seven (7) are still pending documentation review and decision by the RAC.

Auditing and Monitoring

- **Office of Inspector General (OIG) Exclusion Report Verification** – Quarterly monitoring of OIG exclusion reports and attestations.
 - Medical Staff and Advanced Practice Providers – Review of reports and certification by Medical Staff Office of screening completion and no Excluded Individuals or Entities were identified.
 - Suppliers – Review of reports and certification by Finance Department of screening completion and no Excluded Individuals or Entities were identified.
 - Medicare Opt-Out List:
 - Eight (8) non-credentialed providers were identified on the Medicare Opt-Out list between January 1, 2026 – March 31, 2026. Findings were tracked and logged into the system. No additional action was required as providers were only referring and not treating.
 - Medicare Exclusion List:
 - Two (2) referring providers were identified as excluded from participation from Medicare. These exclusions had no effect on the services rendered at Kaweah, as the providers were excluded after the referral dates. The identified providers were removed from the master file.
 - One (1) referring provider was identified as excluded from participation in Medicare. This exclusion had no effect on the services rendered at Kaweah, as Worker’s Compensation was the payor of the services.

Compliance Policies and Procedures:

- New Policies:
 - CP.03 Physician Contracting and Professional Services Agreements
 - CP.15 Fair Market Value
- Review and Minor Revisions to Current Policies:
 - CP.02 Review of Billing Practices
 - CP.05 Compliance and Privacy Investigation and Resolution
 - CP.06 Compliance Program Education
 - CP.07 Excluded Individuals/Entities
 - CP.10 Compliance Reviews and Assessments

Compliance Program Processes:

- **Operational Compliance Committee:**
 - Inaugural committee meeting held in February 2026 with participation from Compliance, Patient Accounting, Revenue Integrity, ISS, Finance, Care Management, Pharmacy, and Physician Leadership.
 - The Committee's Charter was discussed, including membership, goals, expectations, and responsibilities were discussed.
 - Quarterly meetings are being scheduled.
- **Policy and Procedure Committee:**
 - Committee meetings discussions are ongoing.
 - Policy Review Ongoing:
 - AP.38 Policy Manual
 - BOD8 Promulgation of Kaweah Delta Health Care District Procedures
 - Leadership survey has been performed and results are being evaluated.
 - Committee is scheduled to meet with PolicyTech for a system evaluation in May 2026.

Licensing and Facility Enrollment

- **Licensing Applications** -- Forms preparation and submission of licensing applications to the California Department of Public Health (CDPH):
 - Four (4) applications related to facility licensure were submitted.
 - Two (2) applications for Program Flex Waivers were submitted.
- **Medicare/Medi-Cal Facility Enrollment** – Forms preparation and submission of facility enrollment applications for Medicare and Medi-Cal. Ongoing communications and follow-up regarding status of pending applications. Research and guidance provided to :
 - Twelve (12) applications for government payor enrollment and/or information changes were submitted.

The pursuit of healthiness



Policy Number: CP.02	Date Created: 01/27/2025
Document Owner: Jill Berry (Director of Corporate Compliance)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Compliance Committee, Ben Cripps (Chief Compliance & Risk Management Officer)	
Review of Billing Practices	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Purpose:

The purpose of this policy is to mitigate the risks associated with improper claims and billing practices.

Policy:

Kaweah Health will establish coding and billing policies, procedures, and practices that comply with relevant legal and regulatory requirements. Kaweah Health will conduct periodic coding and billing reviews to monitor compliance.

Kaweah Health will establish mechanisms to review the coding and billing processes, policies, and procedures that affect the billing and coding for all areas that provide billing-related services.

Procedure:

- A. All new or revised billing and coding policies should be submitted to the Compliance Department for review and approval.
- B. Periodic coding and billing reviews will be coordinated by the Compliance Department and completed by outside consultants or internal staff, as determined by the Compliance Department, based on the specific needs.
- C. Kaweah Health will regularly review billing risk areas and plan for reviews of identified risk areas in accordance with CP.16 Compliance Risk Assessment and Annual Compliance Workplan Development.
 1. Random account selections and/or targeted reviews, as appropriate, will be utilized by the Compliance Department based on the identified focus for each review.
 2. Audit results and reports will be shared with management in the respective Management for follow-up, education, and remediation, as appropriate.
 3. In situations where non-compliance is identified during the course of a review, the Compliance Department will follow the investigation and

- resolution processes outlined in CP.05 [Compliance and Privacy Issues Investigation and Resolution](#) to resolve the matter.
4. Audit results and reports, as appropriate, will be reported to the Audit and Compliance Committee.
- D. If leaders outside of the Compliance Department initiate internal coding and/or billing reviews in the course of their routine monitoring activities, the results of those reviews must be submitted to the Compliance Department for review and evaluation.
- E. All consultants evaluating billing or coding practices and compliance must be engaged through the Compliance Department. If appropriate, the Compliance Department will work with Legal Counsel to engage the consultants.

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

Policy Number: CP.02	Date Created: 01/27/2025
Document Owner: Jill Berry (Director of Corporate Compliance)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Compliance Committee, Ben Cripps (Chief Compliance & Risk Management Officer)	
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Kaweah Health will establish mechanisms to review the coding and billing processes, policies, and procedures that affect the billing and coding for all areas that provide billing-related services.

Procedure:

~~I. Kaweah Health shall establish mechanisms to review the coding and billing processes, policies, and procedures that affect the billing and coding for all areas that provide billing-related services. In addition, Kaweah Health shall follow the following processes:~~

~~A. All new or revised billing and coding policies and procedures should will~~ be submitted to the Compliance Department for review and approval.

~~A.~~

~~B. Periodic coding and billing reviews willshall~~ be coordinated by the Compliance Department and completed by outside consultants or internal staff, as determined by the Compliance Department, ~~-~~based on the specific needs.

~~C. Kaweah Health will regularly review billing risk areas and plan for reviews of identified risk areas in accordance with CP.16 Compliance Risk Assessment and Annual Compliance Workplan Development.~~

~~B.~~

1. Random account selections and/or targeted reviews, as appropriate, ~~(when appropriate)~~ will be utilized by the Compliance Department based on the identified focus for each review.
2. Audit results and reports will be shared with management in the respective appropriate area Management for follow-up, education, and remediation, as appropriate. ~~(when appropriate)~~.
3. In situations where non-compliance is identified during the course of a review, the Compliance Department will follow the investigation and resolution processes outlined in CP.05 Compliance and Privacy Issues Investigation and Resolution -to resolve the matter.
4. Audit results and reports, as appropriate, ~~(when appropriate)~~ will be reported to the Audit and Compliance Committee.

G.D. If leaders outside of the Compliance Department initiate internal coding and/or billing ~~Management initiates internal~~ reviews in the course of their routine monitoring activities, the results of those reviews must be submitted~~communicated~~ to the Compliance Department for review and evaluation.

D.E. All consultants evaluating billing or coding practices and compliance must be engaged through the Compliance Department. If appropriate, the Compliance Department will work with Legal Counsel to engage the consultants.

~~Kaweah Health~~

~~II. shall assume the following practices to protect against improper billings to government programs:~~

~~A. Medically Necessary Services~~

~~Kaweah Health shall regularly conduct audits to demonstrate that services provided to beneficiaries and claimed for reimbursement are medically necessary, as defined by government program regulations or payer contracts.~~

~~B. Acquisition Costs~~

~~Kaweah Health shall regularly conduct audits to confirm that billing programs accurately calculate the appropriate acquisition costs as required by government programs.~~

~~C. Research Grants~~

~~Kaweah Health shall maintain procedures to verify that any funds provided by Kaweah Health to support health care research are provided in a manner that clearly separates such payments from any referrals received by Kaweah Health, from any entity or physician, who may be a recipient of such funds, or who is affiliated with the recipient of such funds.~~

~~Kaweah Health shall comply with the terms of grants with regards to billing third party payers.~~

~~D. Education~~

~~The Compliance Department will provide annual education about the applicable laws and regulations pertaining to billing. It is the responsibility of the department leaders to identify employees who should be educated and trained.~~

~~E. Preventive Compliance~~

~~—The Compliance Department will review and distribute California Department of Public Health (CDPH), All Facility Letters (AFL), Medicare and Medi-Cal Monthly Bulletins, Office of Inspector General (OIG) Monthly Audit Plan Updates, and California State Senate and Assembly Bill Updates to areas potentially affected by the regulatory change and identify potential current/future risk. The Compliance department will monitor and track process changes related to regulatory requirements.~~

Operational Compliance

~~F. _____~~

~~The Compliance Department shall identify high-risk departments and hold monthly regularly scheduled meetings to discuss regulations, policies, auditing and monitoring, and educational efforts, and any compliance related concerns within the departments.~~

~~—Co-Payment Waiver and/or “balance billing”~~

~~Kaweah Health shall maintain procedures, including training programs for employees involved in marketing and reimbursement operations, to assure Kaweah Health’s co-payment collection policies for government funded health care programs comply with applicable regulations. What is “balance billing” (sometimes called “surprise billing”); When a patient receives emergency care and is treated by an out-of-network provider at an in-network hospital or ambulatory~~

~~surgical center, they are protected from balance billing. In these cases they should not be charged more than the plan's copayments, coinsurance and/or deductible.~~

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

Policy Number: CP.03	Date Created:
Document Owner: Ben Cripps (Chief Compliance and Risk Officer)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Compliance Committee, Ben Cripps (Chief Compliance & Risk Management Officer)	
Physician Contracting and Professional Services Agreements	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Purpose: To provide direction as to execution of professional services agreements between affiliates of Kaweah Health and physicians and/or physician entities and their immediate family members.

Policy: All Professional Services Agreements must be in writing, signed by the parties, and provide for fair market value payments that are set in advance for the services actually rendered. All Professional Services Agreements shall be entered into for a commercially reasonable purpose not related to a physician’s referrals. Payments shall not be determined in a manner that takes into account the volume or value of any referrals or other business generated between Kaweah Health and the physician. The contracts will contain a “no requirement to refer” provision, and there must be no written or oral understanding that patient referrals are a part of the arrangement.

A Professional Services Agreement must be signed by both the Contractor and the Kaweah Health CEO, or an approved delegate for the CEO, before any services are provided and before any payments are made. Services provided before both parties have signed the agreement will not be compensated, at the time of service or at any time in the future, unless approved by Legal Counsel.

The term of the agreement should be for at least one year. If the term is for less than one year or if the agreement is terminated with or without cause prior to the end of the first year of the agreement, then the parties must not enter into a similar contract until the one-year term has passed.

Time-based or unit-of-service-based payments are appropriate, even if the physician receiving the payment generated the payment through a referral to the facility, so long as the payment per unit is at fair market value at the inception of the agreement and does not subsequently change during the agreement term in any manner that takes into account referrals or other business generated between the parties.

The agreement shall specify with particularity the services to be rendered, which may be an addendum. Kaweah Health shall contract only for services actually needed by the facility. Kaweah Health shall not contract for services that are not required for the operation of the facility, or that regularly accompany the professional services being rendered by the physician or

other professional, or that are required pursuant to Kaweah Health's medical staff bylaws to be rendered by the physician without payment or that involve counseling or promoting activities that violate state or federal law. Kaweah Health must document and justify the need for the services being requested. In addition, the value to the facility of each professional services agreement should be periodically assessed.

Records and Invoices

The physician or physician group shall provide Kaweah Health with a written statement of the services which have been rendered prior to each payment. Such written statement (typically, a time sheet) should provide the level of detail of the services normally expected of an outside vendor of professional services (e.g., a law firm). Such statement would typically include the date of the service, the start and stop time, a description of the services rendered and, if appropriate, to whom the services were rendered. There should be an articulated expectation that all time should be recorded when worked and not reconstructed at end of week, month-end, or other interval. If the written documentation is not received, the payments will not be made. (This is a requirement for internal control). In addition, physicians should be encouraged to record and report all time worked pursuant to a professional services agreement, including any time that exceeds any applicable monthly cap.

Time sheets are to be carefully reviewed by an appropriate member of management to verify that the standards for completion of time sheets set forth herein are met. A pattern of time sheet submissions that routinely aggregate to the permitted maximum should be closely scrutinized for accuracy of timekeeping.

Under no circumstances may a physician be paid for the same hour under different agreements. For example, a physician who is performing paid clinical activities may not also be paid for time spent providing Medical Director or Faculty duties.

FMV

All Professional Services Agreements (PSA) must be fair market value, and all Professional Services Agreements must be reviewed and approved by Legal Counsel and the Compliance Department. Certain Professional Services Agreements will require additional review by the Legal Department.

A written fair market value appraisal by an approved, independent, third party is required for physician group professional or administrative services agreements with physicians if the compensation amount exceeds the 65th percentile. In addition, Legal Counsel may require Kaweah Health to obtain a report by an approved appraiser as to the fair market value of the proposed compensation in any agreement, including but not limited to those categories listed above as outside the ordinary course of business. In all

cases, the approved compensation structure must comply with the Fair Market Value Policy and with the FMV Guidelines established by the Executive Fair Market Value Committee annually.

As stated above, the payment terms must reflect the fair market value of the services being rendered. Kaweah Health must document how the payment terms reflect fair market value. Such FMV documentation must be by an independent third party appraisal if the arrangement meets the criteria listed above. Otherwise, such FMV documentation may be in any number of forms, including an independent third party appraisal or by another method consistent with the requirements of the Fair Market Valuation Policy. The payment amounts will be stated in the agreement on an hourly basis subject to a monthly and annual aggregate limit. Kaweah Health must be able to document that the payment amounts are reasonable in terms of the special services being rendered and the community norms. In no case will payment amounts increase or decrease depending on referral volume.

All separate arrangements between Kaweah Health and the physician and/or the physician's immediate family members must incorporate each other by reference or cross-reference a master list of contracts that is maintained and updated centrally and available for review by the Secretary of Health and Human Services upon request.

Whenever Kaweah Health renews or wishes to add a paid medical director such that there will be a second medical director position for a particular department or sub-department, the request must be reviewed and approved by the CEO and a written justification prepared by the Executive Leader overseeing the service.

Gifts. Gifts and financial benefits to a physician or their office shall not exceed the annual physician non-monetary compensation threshold as established by the Federal Stark Law. Any gift or benefit provided to physician(s) or a physician's office must first be approved, documented, and tracked through the Medical Staff Office.

1. Any employee/department must contact the Medical Staff Office prior to giving any gifts/financial benefit.
2. The Medical Staff Office must confirm that total financial benefits to the physician(s) and their office do not exceed the annual physician non-monetary compensation threshold for the current calendar year.
3. The Medical Staff Office will log the gift/financial benefit.
4. The value of a gift given to a group of physicians shall be divided and attributed to each physician equally.

Conflict of Interest

Prior to the execution of any PSA, the Physician/Physician Group shall inform District of any other arrangements which may present a conflict of

interest or materially interfere in Contractor's performance of duties under this Agreement. In the event a Physician/Physician Group pursues conduct which does in fact constitute a conflict of interest or which materially interferes with (or is reasonably anticipated to interfere with) Physicians performance under this Agreement, District shall immediately terminate the Agreement. This paragraph does not preclude Physician from referring patients to any facility or from practicing in any location.

Any violators may be subject to disciplinary action for violating Kaweah Health policy.

Procedure: The Physician Contracting Department shall maintain a PSA contracting checklist for all Physician Contracts. The Checklist shall be followed (when possible) and will be reviewed regularly and approved by the Executive FMV Committee.

- A. The Executive Leader entering into the agreement will be required to certify that:
 - a) except as disclosed in the certification and/or cross reference addendum, there are no other arrangements, oral or written, with the professional;
 - b) the payments pursuant to the agreement will represent the fair market value of the services to be rendered;
 - c) the required services are rendered prior to payment; and
 - d) the services to be provided do not exceed those that are reasonable and necessary for the arrangement's commercially reasonable business purposes.
- B. The fully executed Agreement shall be sent to the CCRO (or designee) to be uploaded into the Contract Database. Information on all fully executed Agreements will be maintained in the contract management database (see AP.69 Requirement for Contracting with Outside Service Providers).
 1. If Contractor is a new vendor at Kaweah Health, the following items shall be submitted along with the fully executed Agreement:
 - Completed W-9
 - Completed ACH Form
 - Voided Check, or letter from the banking institution reflecting the account and routing number
 - Contact Number and Email Address
- C. **Monitoring.** The Compliance and/or Internal Audit Departments may complete periodic audits of Medical Director and Physician Provider Agreements.

Policy Number: CP.03	Date Created: 07/30/2020
Document Owner: Ben Cripps (Chief Compliance & Risk Management Officer)	Date Approved: 03/08/2021
Approvers: Board of Directors (Administration), Compliance Committee, Ben Cripps (Chief Compliance & Risk Management Officer)	
Physician Contracts and Relationships	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Purpose:

The purpose of this Policy and Procedure is to establish guidelines for the orderly processing of negotiating, documenting, and administering contracts between Kaweah Delta Health Care District (“Kaweah Delta”) and physician(s) or physician groups. This policy must be followed prior to entering into any arrangement (i) in which Kaweah Delta engages physicians to provide services or space/items to Kaweah Delta, or (ii) in which Kaweah Delta provides any services, space, staff, equipment or items to physicians.

Policy:

It is the policy of Kaweah Delta to comply with all state and federal laws. Kaweah Delta shall execute contracts with physicians and physician groups (“physician(s)”) that comply with all applicable laws and regulations, including those designed to prevent the provision of improper payments, inappropriate referrals, and/or inappropriate inducements to refer. To that end, Kaweah Delta will negotiate, document, and administer Agreements that comply with the following standards:

- I. The Agreement shall be set out in writing and signed by all parties. The terms of the Agreements must be commercially reasonable.
- II. The arrangement must be commercially reasonable, and the compensation under the arrangement must be set in advance, established at fair market value through an arms-length transaction, and must not take into account the volume or value of referrals for an item or service reimbursable by a state or federal program or other business generated between the parties.
- III. All items and services covered by an Agreement with physician(s) must address a legitimate need of Kaweah Delta, must actually be provided by the physician(s), and must be specifically described in sufficient detail in the Agreement.
- IV. The Agreement shall specify the compensation terms in sufficient and measurable detail.
- V. The term of the Agreement shall be for not less than twelve (12) months, or longer than thirty-six (36) months unless approved by the Chief Executive Officer (CEO) and Board in consultation with Legal Counsel and allowable under District Law. Contracts shall not automatically renew.

- VI. The services performed under the Agreement shall not involve the counseling or promotion of a business arrangement or other activity that violates any state or federal law.
- VII. All Agreements between Kaweah Delta and physician(s) for any purpose shall be prepared by, or in collaboration with, Kaweah Delta's Legal Counsel for signature by the parties.
- VIII. Any payment to physician(s) shall be made only pursuant to an Agreement that has been formally executed between Kaweah Delta and the physician(s). Medical Director payments will be made only pursuant to approved time records submitted by the physicians. Likewise, payments to physician(s) will require documentation of availability and/or services rendered.
- IX. Gifts and financial benefits to a physician or their office shall not exceed the annual physician non-monetary compensation threshold as established by the Federal Stark Law. Any gift or benefit provided to physician(s) or a physician's office must first be approved, documented, and tracked through the Medical Staff Office.

Procedure:

- I. Fair Market Value (FMV) – State and federal law require a documented and objective determination that the payment between Kaweah Delta and physician(s) is consistent with FMV. Such determination may be evidenced by an approved vendor-written appraisal/valuation, an approved published third-party source, or as otherwise approved by Legal Counsel. The Chief Compliance Officer (CCO) (or designee) will oversee the management and administration of the FMV process.

The CCO (or designee) must be contacted before entering into negotiations of any physician Agreement to evaluate the FMV compensation needs. The negotiated rate must be reviewed and approved by the CCO (or designee) before Legal Counsel is engaged to draft or modify the Agreement. The FMV compensation process will be documented and administered in the following manner:

- A. Medical Director Agreements – The Compliance Department will maintain an updated listing of all Medical Director positions by specialty and the corresponding FMV range. Vice President(s) (VP) (or designee) may negotiate rates up to the 50th percentile. Negotiations between the 51st and 65th percentiles require documented justification and CEO approval. Negotiations beyond the 65th percentile require Executive FMV Committee approval (CEO, Board Chair, and CCO).
- B. Recruitment Agreements – The Compliance Department will maintain a listing of Board approved physician recruitment needs by specialty and the corresponding FMV range. The Chief Compliance Officer, VP Chief Strategy Officer, and Director of Physician Recruitment and Relations will make recommendations to the Physician Compensation Committee. The Physician Compensation Committee will approve the negotiated rates up to the 50th percentile. Negotiations between the 51st and 65th percentiles

require documented justification and CEO approval. Negotiations beyond the 65th percentile require Executive FMV Committee approval (CEO, Board Chair, and CCO).

- C. Exclusive and Non-Exclusive Provider Agreements – The FMV rate must be established through an independent and external FMV assessment. The VP (or designee) will work with the CCO (or designee) to engage Legal Counsel and a third-party valuation firm. The CCO (or designee) will facilitate the Fair Market Valuation process to ensure the data and assumptions are documented and appropriate.
 - 1. Changes to compensation terms and/or methodologies must be reviewed by the Executive Team and formally approved by the CCO and CEO. This provision and approval process applies to all Exclusive and Non-Exclusive Provider Agreements including new or potential agreements, contract renewals, and agreements that allow for compensation changes throughout the term of the agreement.
- D. Space Lease Agreement - The VP (or designee) will work with the CCO (or designee) and Legal Counsel to establish the FMV rate. The Space Lease calculation must be reviewed by the CCO (or designee) and approved by Legal Counsel.

II. Medical Director Agreements

- A. New and existing Medical Director Agreements shall be prepared and executed using the process outlined in Exhibit A.
- B. The VP is responsible for ensuring the necessity of a Medical Director position and ensuring the physician satisfies any qualification or training requirements and provides required services.
- C. Compliance will maintain a listing of Medical Director positions required by federal, state, or Joint Commission accreditation. Compliance must be contacted immediately of a statute, regulation, or other standard requiring a Medical Director position. If a new Medical Director position is not required, the VP must demonstrate the necessity and/or benefit to Kaweah Delta, and present the need to the Executive Team for review and approval.
- D. Semi-Annually, Compliance will provide a listing of all Medical Director positions to the Executive Team for review and evaluation. Medical Director positions not required by federal, state, or Joint Commission accreditation will be reviewed by the Executive Team to evaluate and demonstrate the necessity and/or benefit to Kaweah Delta.
- E. Monthly payments to Medical Directors must be supported by approved time records as follows:
 - 1. Physician(s) must track time spent on activities/responsibilities outlined in the Agreement.
 - 2. Physician(s) shall record activities by date in the electronic time record system. Physician(s) may use a method other than

- electronic to document and submit time records when approved by the responsible VP and by Finance Department.
3. Physician(s) time records submitted in any format must include an attestation statement signed by the physician(s) (electronic signature process is used in the electronic time record system).
 4. The responsible VP (or designee) must review and approve time records and approve the payment amount to authorize payment. Evidence of such approval must include an original or electronic signature by the VP.
 5. Upon receipt of the approved time record and payment amount, Accounts Payable will process the payment for the amount approved by the VP.
 6. The responsible VP (or designee) will promptly meet with the Medical Director if they fail to (i) submit time records in a timely manner or (ii) provide services in the manner set forth in the Agreement. Recurring performance issues shall be immediately reported to the CCO.
- III. New and existing and Exclusive and Non-Exclusive Physician Provider Agreements shall be prepared and executed using the processes outlined in Exhibits B, C, and D.
- IV. Physician Lease of Space Agreements shall be negotiated by the responsible VP (or designee).
- The proposed lease rate shall be at FMV.
1. Market analysis must be documented.
 2. Rate must be reviewed by the CCO (or designee) and approved by Legal Counsel.
- V. Physician Recruitment Agreements shall be negotiated by the Director of Physician Recruitment and Relations or responsible VP (or designee) consistent with AP.126 – [\(AP126\) Physician Recruitment Policy \(v.2\)](#).
- A. The terms of the Agreement shall follow current physician recruitment guidelines approved by the Board of Directors.
 - B. The proposed income guarantee shall be at FMV.
 1. Market analysis must be documented.
 2. Compensation arrangement must be approved by the CCO (or designee).
- IV. Information on all signed Agreements will be maintained in the contract database (see AP.69 [Requirement for Contracting with Outside Service Providers](#)).
- X. Modifications – In the event physician(s) requests any modifications to the Agreement language, the VP (or designee) shall forward the requests to Legal Counsel for consideration. If the changes are agreeable, a modified Agreement or Addendum will be provided to the VP (or designee). If changes are not agreeable, Legal Counsel will provide explanations to the VP (or designee).

- XI. Board Approval – Board Approval is required as described below:
 - A. Medical Director Agreements – New or established Medical Director Agreements do not require review and approval by the Board if the expense has been accounted for within the current fiscal budget.
 - B. Non-Exclusive Providers Agreements – New or established Non-Exclusive Provider Agreements do not require review and approval by the Board if the expense has been accounted for in the current fiscal year budget.
 - C. Exclusive Provider Agreements – All new or unbudgeted Exclusive Provider Agreements must be submitted to the Board of Directors for review and approval.

- VI. Monitoring –
 - A. The Compliance and/or Internal Audit Departments may complete periodic audits of Medical Directors and Physician Providers Agreements.
 - B. Prior to the expiration of the Agreement, the VP (or designee) is required to evaluate position duties, requirements, and hours, and to solicit input from key stakeholders including Kaweah Delta staff and/or Medical Staff as appropriate.

- VII. Gifts and other financial benefits given to a physician(s) or their office staff shall be recorded by the Medical Office.
 - A. Any employee/department must contact the Medical Staff Office prior to giving any gifts/financial benefit.
 - B. The Medical Staff Office must confirm that total financial benefits to the physician(s) and their office do not exceed the annual physician non-monetary compensation threshold for the current calendar year.
 - C. The Medical Staff Office will log the gift/financial benefit.
 - D. The value of a gift given to a group of physicians shall be divided and attributed to each physician equally.

Any violators may be subject to disciplinary action for violating Kaweah Delta policy.

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EXHIBIT A

MEDICAL DIRECTOR CONTRACT CHECKLIST

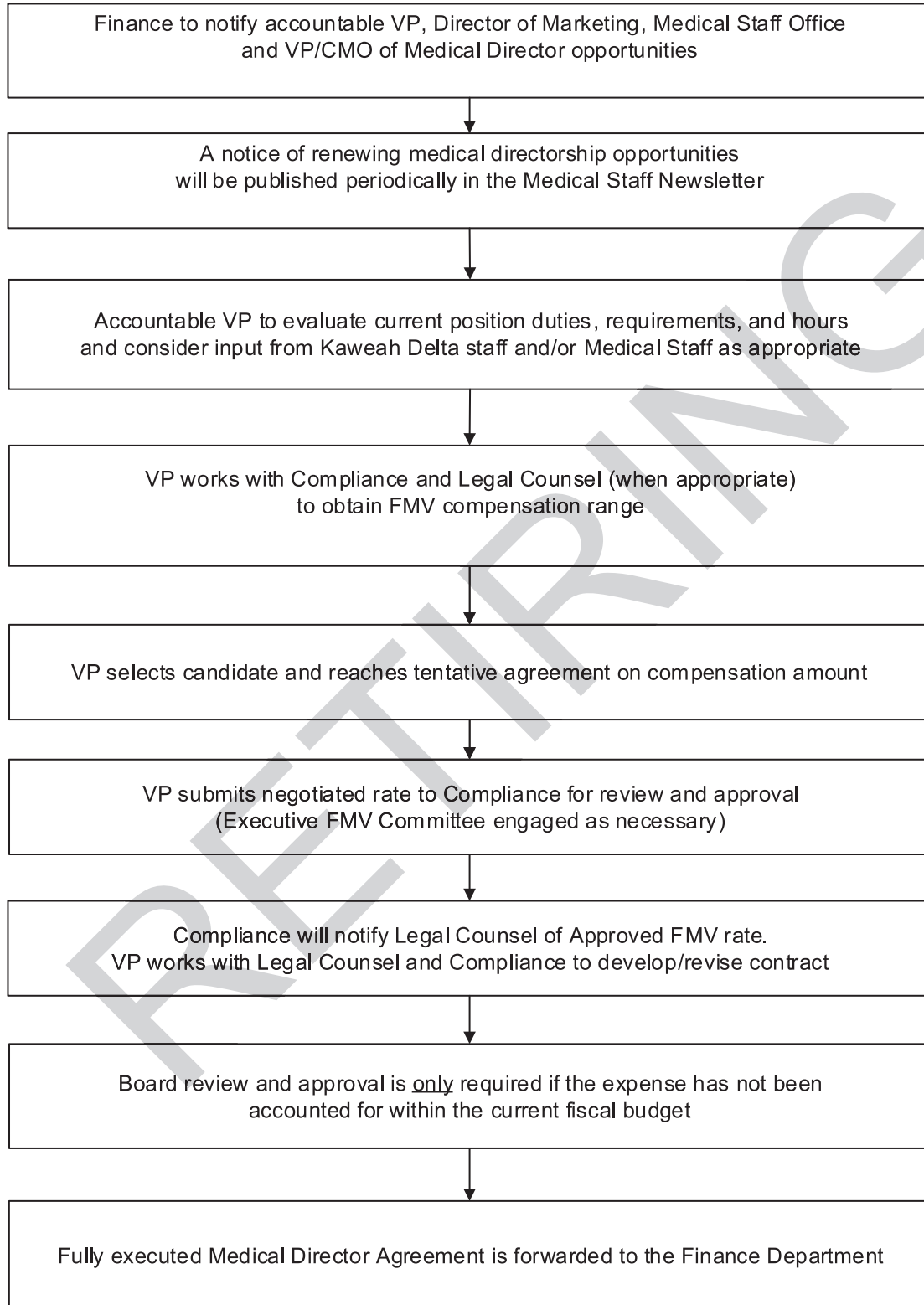


EXHIBIT B

PROVIDER CONTRACT RENEWALS

Exclusive and Non-Exclusive Provider Agreements

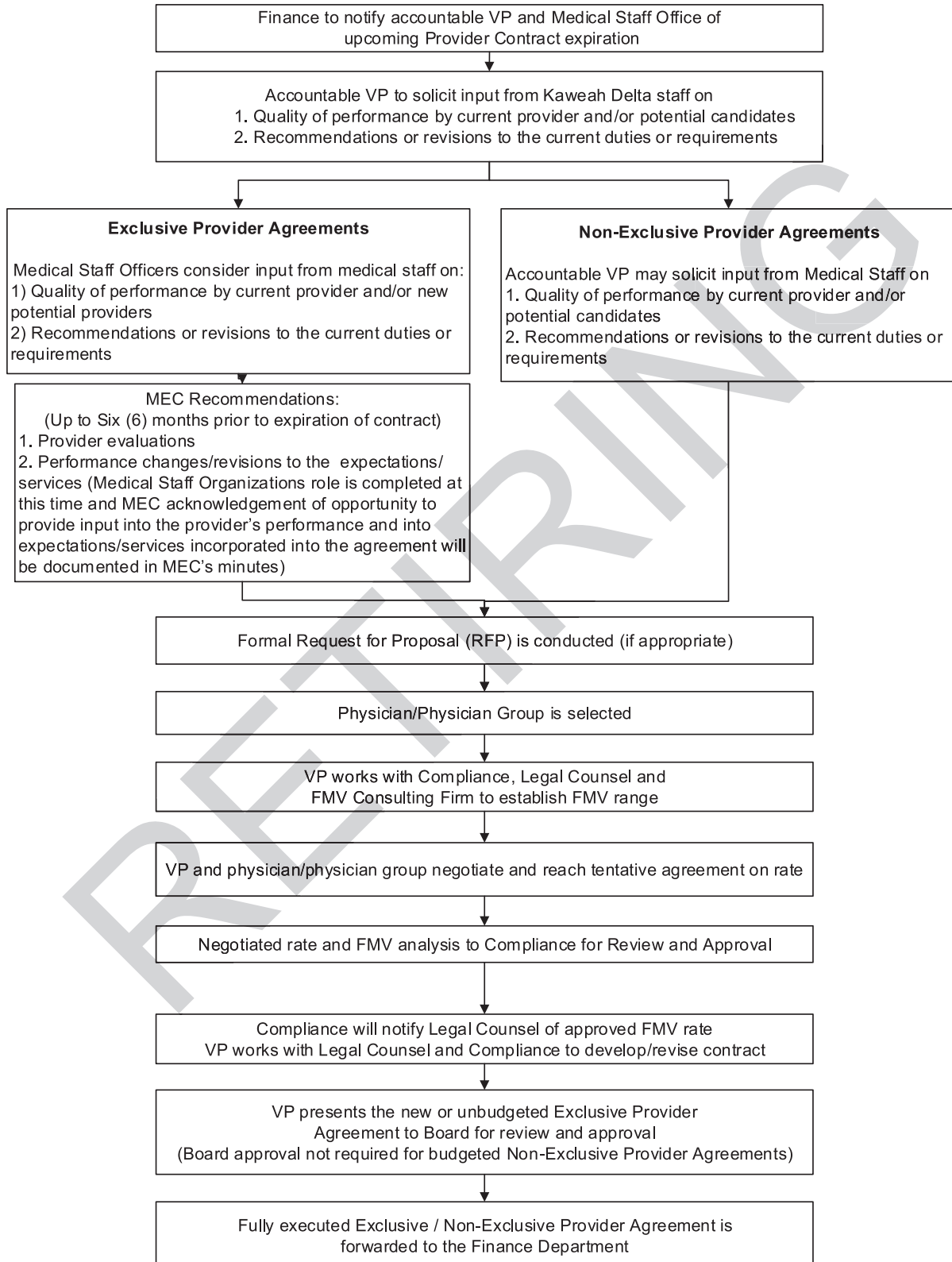


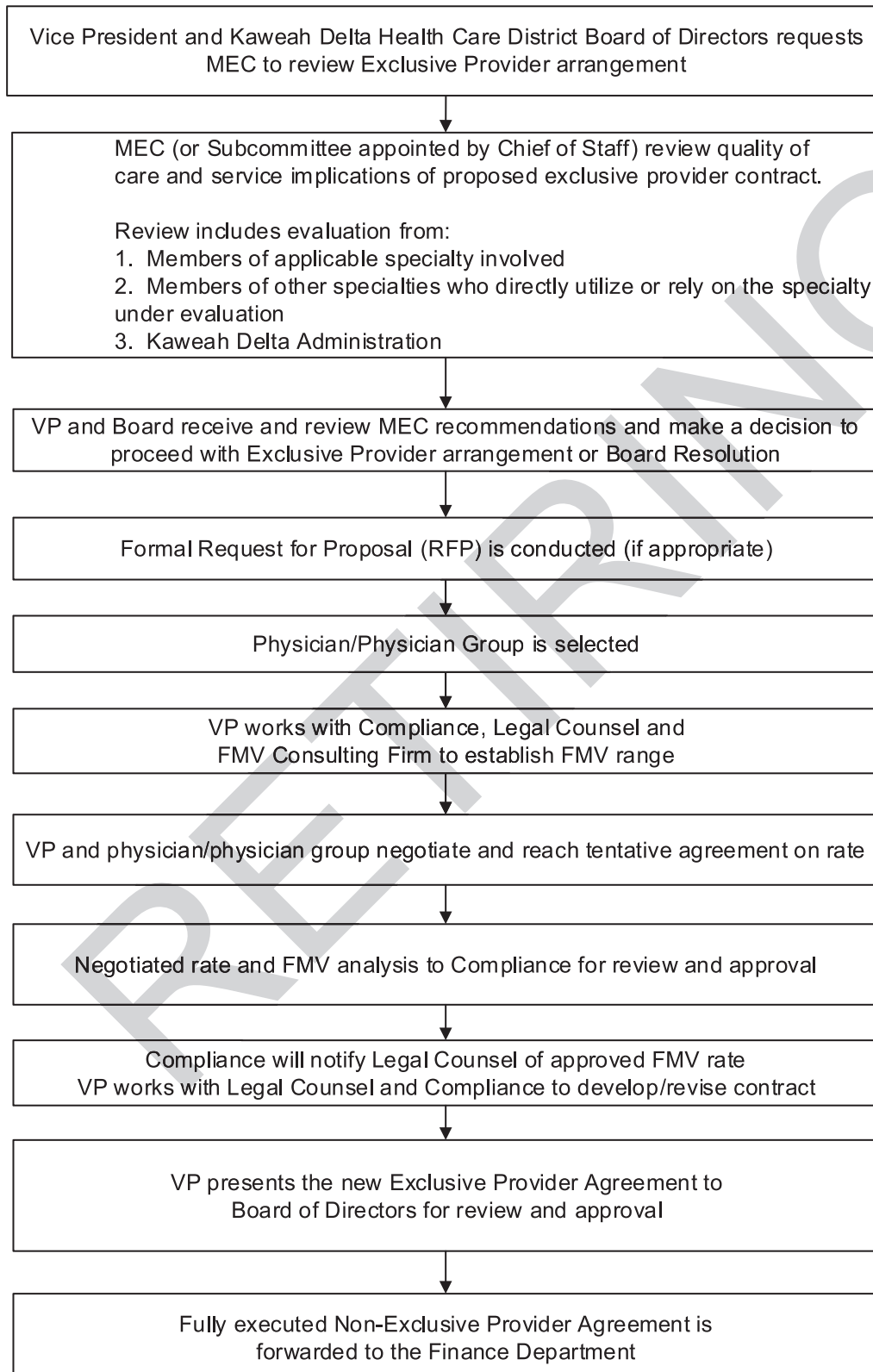
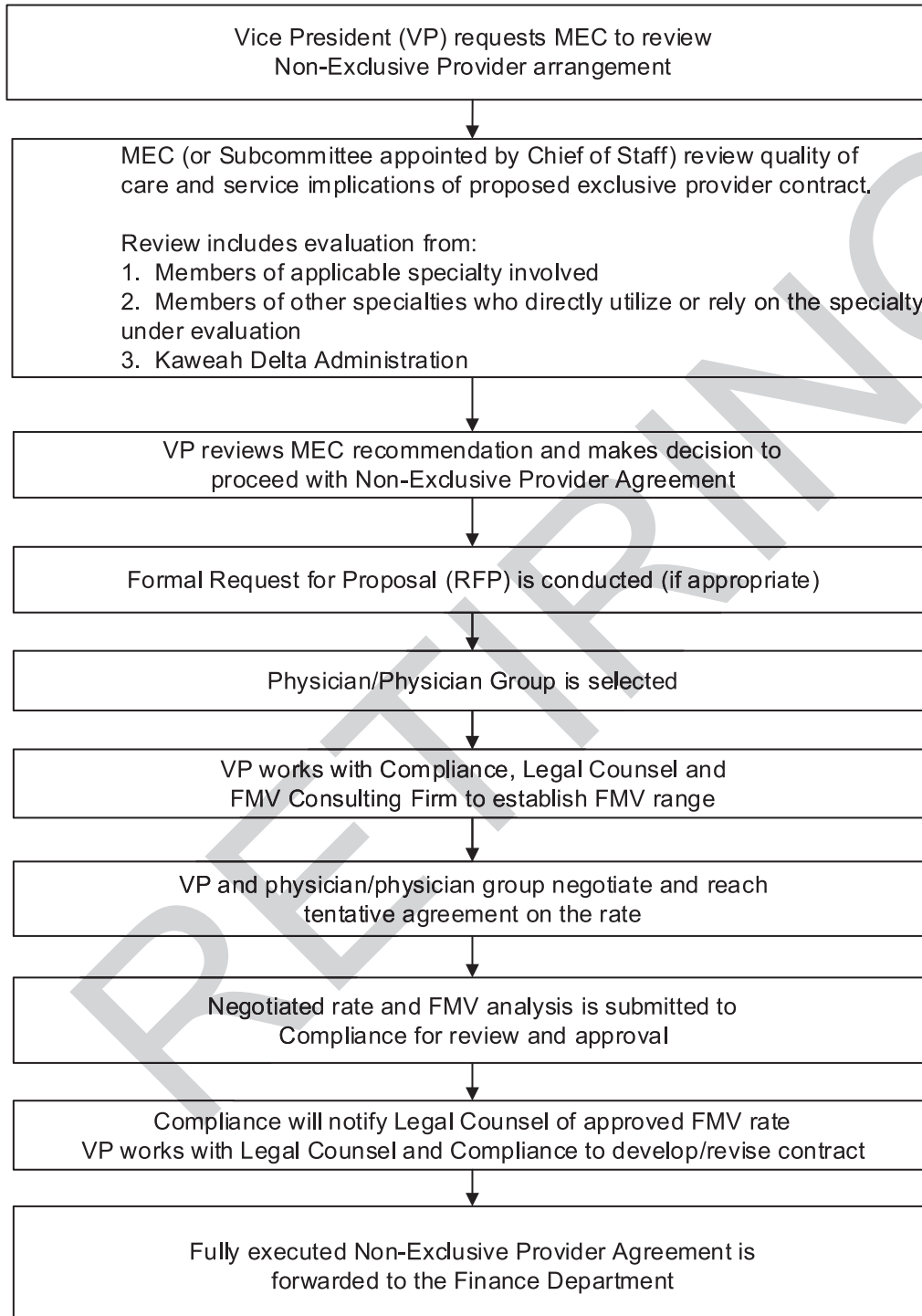
EXHIBIT C**NEW PROVIDER CONTRACT****Exclusive Provider Agreements**

EXHIBIT D**NEW PROVIDER CONTRACT****Non-Exclusive Provider Agreements**

Policy Number: CP.05	Date Created: 04/20/2026
Document Owner: Jill Berry (Director of Corporate Compliance)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Compliance Committee, Ben Cripps (Chief Compliance & Risk Management Officer)	
Compliance and Privacy Issues Investigation and Resolution	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Purpose:

The purpose of this policy is to promote the integrity of Kaweah Health’s Compliance Program by ensuring all compliance and privacy matters will be consistently handled, receive appropriate attention, and be brought to resolution.

Policy:

- A. It is the policy of Kaweah Health to conduct investigations of suspected illegal, unethical, or abusive conduct or wrongdoing; non-compliance with relevant health care laws or regulations; and/or Kaweah Health policies and procedures.
- B. Investigations shall be conducted by the appropriate person as determined by the Chief Compliance and Risk Officer (CCRO), the Director of Corporate Compliance, and/or the Kaweah Health Compliance Advocate.

Process:

- I. Issues shall be investigated when one or more of the following criteria are met:
 - A. Non-routine subpoena or search warrant received from a governmental or regulatory agency.
 - B. Outside regulatory site visit or audit resulting in deficiencies and/or citations, not including routine responses to the California Department of Health Care Services (CDPH).
 - C. Correspondence received from a governmental entity or government contractor regarding actual or potential billing errors or quality of care issues.
 - D. Allegation or indication from any source (including the Anonymous Information Line) that a law, regulation, or policy has been violated.
 - E. Indication from any source that overpayments have been received by Kaweah Health.
 - F. Indication from any source that current procedures or processes may result in a violation, or create a compliance risk due to ineffectiveness or lack of controls.
 - G. Ineffective processes that create actual or potential billing errors or other compliance risks.

- H. Concern raised regarding potential breaches of patient privacy, medical record security, or identity theft.
 - I. Request made by a member of the Leadership and/or Executive Team.
 - J. Request made by the Audit and Compliance Committee, Compliance Advocate, or a Board member.
 - K. Any other concern of suspected illegal, unethical, abusive conduct, wrongdoing, or non-compliance with laws, regulations, accreditation requirements and/or Kaweah Health policies and procedures not otherwise identified above.
- II. The following steps shall be used in an internal investigation when a concern is identified or reported:
- A. The CCRO (or designee) will investigate the concern to determine how the concern was identified and designate the person who will oversee the investigation. When necessary, the appropriate leadership team members shall be notified of the potential concern.
 - 1. Issues that are strictly operational in nature shall be referred back to the appropriate leadership team members for review and investigation. Once their review and investigation is complete, the leadership team members shall provide a summary of the resolution to the CCRO (or designee).
 - 2. Safety issues shall be referred to the Safety Officer with notification to the appropriate Executive Team member. Once their review and investigation is complete, the Safety Officer shall provide a summary of the resolution to the CCRO (or designee).
 - 3. Personnel issues shall be referred to Human Resources with notification to the appropriate Executive Team member. Once their review and investigation is complete, the Human Resources representative shall provide a summary of the resolution to the CCRO (or designee).
 - 4. Quality of care issues shall be referred to Patient Safety and Quality Department with notification to the appropriate Executive Team member. Once their investigation is complete, the Patient Safety and Quality representative shall provide a summary of the resolution to the CCRO (or designee).
 - 5. Risk Management issues shall be referred to the Risk Management Department. Once their investigation is complete, the Risk Management representative shall provide a summary of the resolution to the CCRO (or designee).
 - 6. Other issues shall be investigated by the CCRO (or designee) with notification to the appropriate Executive Team member.
 - B. The CCRO (or designee) will contact the Kaweah Health Compliance Advocate to invoke attorney-client privilege, as appropriate, in situations where a potential violation has been identified which could result in governmental intervention, self-reporting and/or re-payments to a third-party payer. In situations where the Kaweah Health Compliance Advocate invokes attorney-client privilege for investigation of an issue, all meetings, discussions and investigation activities related to that issue shall take place in the

- presence of, or under the direction of, the Kaweah Health Compliance Advocate or CCRO.
- C. When necessary, the CCRO (or designee) will place the issue on the Compliance Issue Log reviewed quarterly by the Audit and Compliance Committee and the Board. If the matter is a privacy concern or other compliance matter not requiring inclusion on the Compliance Issue Log, the CCRO (or designee) will document and log the concern for tracking and reporting purposes.
 - D. The CCRO (or designee) will determine the appropriate steps to investigate the issue and initiate these steps as soon as possible. The CCRO (or designee) will ensure Leadership places an immediate stop to any practice violating any federal or state law or regulation and/or accreditation standard; specifically those impacting billing or coding processes.
 - E. The CCRO (or designee) will discuss the issue with the appropriate Leadership and/or Executive Team members.
 - F. When appropriate, the CCRO (or designee) will retain outside opinions, other experts, or consultants to evaluate the information and provide guidance or recommendations.
 - G. The CCRO (or designee) will initiate specific steps to review the issue. These may include, but are not limited to:
 - 1. Review relevant policies and procedures.
 - 2. Identify and interview staff who may have knowledge of the problem. Analyze past history relevant to the problem.
 - 3. Research applicable laws.
 - 4. Review claims/medical records in question.
 - 5. Review relevant documents and files.
 - 6. Complete audits of patient records and system access.
 - H. The CCRO (or designee) will document all steps taken in the investigation and resolution of the issue, including interview/meeting notes, summaries of reviews, completed copies of policies, or other relevant documents and other pertinent information related to the issue.
 - I. The CCRO (or designee) will determine the appropriate course of action:
 - 1. Refer concerns about performance actions of specific individuals to Leadership and Human Resources.
 - 2. Work with appropriate Leadership and/or Executive Team members to implement new processes, policies and procedures, education, or other steps to ensure the problem does not persist or reoccur.
 - 3. Confirm the re-billing or repayment of any specific claims where a billing/payment error has been identified. If it is determined that an overpayment has been received from Medicare, the overpayment must be reported and returned to the appropriate agency within 60 days

after the date on which the overpayment amount is identified, or the date any corresponding cost report is due, if applicable. Failure to submit a timely report and return the overpayment may lead to False Claims Act liability. See CP.13 [Federal and State False Claims Act and Employee Protection Provisions](#) for additional information.

4. Determine whether self-disclosure and restitution is necessary; and, if so, work with the Kaweah Health Compliance Advocate and appropriate Executive Team member to make prompt restitution to the appropriate health care program/third-party payer.
 5. Schedule future monitoring and review activity to mitigate any future recurrence. The final resolution of the issue will be reported to the appropriate Executive Team member, the Audit and Compliance Committee, the Chief Executive Officer (CEO), and Board (when appropriate). The length of the investigation and final resolution will vary depending on the complexity and risk associated with the issue.
- III. When an investigation is initiated based upon a report of a problem by an employee, the CCRO (or designee) will provide a summary of the final resolution to that employee. If the employee still has concerns, the following steps will be taken:
- A. The CCRO will report the continuing concern to the Audit and Compliance Committee.
 - B. The CCRO or Compliance Advocate will contact the employee to request a written statement of their ongoing concerns.
 - C. The CCRO will prepare a written response to the employee's concerns.
 - D. The Audit and Compliance Committee will review the written statement and respond and instruct the CCRO whether to continue or to close the investigation.
 - E. A letter will be sent from the Compliance Advocate on behalf of the Audit and Compliance Committee to the employee stating the final decision of the Audit and Compliance Committee.
- IV. When Kaweah Health is required by Federal and/or State law to make notifications to Federal and/or State agencies or involved patients, the Compliance Department will be responsible for making the necessary notifications to involved patients and Federal and/or State agencies in accordance with applicable legal and regulatory requirements.

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

Policy Number: CP.05	Date Created: 04/20/2026
Document Owner: Jill Berry (Director of Corporate Compliance)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Compliance Committee, Ben Cripps (Chief Compliance & Risk Management Officer)	
Compliance and Privacy Issues Investigation and Resolution	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Purpose:

The purpose of this policy is to promote the integrity of Kaweah Health's ~~to establish a~~ Compliance Program ~~by ensuring in which all compliance and privacy matters issues will be are handled~~ consistently ~~handled, to ensure integrity of the Program and all matters~~ receive appropriate attention, and ~~be brought to~~ resolution.

Policy:

- A. ~~It is the policy of Kaweah Health to conduct~~ investigations of suspected illegal, unethical, ~~or~~ abusive conduct ~~or~~ wrongdoing; ~~or~~ non-compliance with ~~relevant health care laws or~~ regulations; ~~accreditation requirements~~ and/or Kaweah Health policies and procedures.
- B. ~~Investigations~~ shall be conducted by the appropriate person as determined by the ~~Vice President & Chief Compliance and Risk and Privacy Officer (VPCCRO), the Director of Corporate Compliance, (CPO)~~ and/or the Kaweah Health Compliance Advocate.

Process:

- I. Issues shall be investigated when one or more of the following criteria are met:
 - A. Non-routine subpoena or search warrant received from a governmental or regulatory agency.
 - B. Outside regulatory site visit or audit resulting in deficiencies and/or citations, not including routine responses to the California Department of Health Care Services (CDPH).
 - C. Correspondence received from a governmental entity or government contractor regarding actual or potential billing errors or quality of care issues.
 - D. Allegation or indication from any source (including the Anonymous Information Line) that a ~~law,~~ regulation, or policy has been violated.
 - E. Indication from any source that overpayments have been received by Kaweah Health.

- F. Indication from any source that current procedures or processes may result in a violation, or create a compliance risk due to ineffectiveness or lack of controls.
 - G. Ineffective processes that create actual or potential billing errors or other compliance risks.
 - H. Concern raised regarding potential breaches of patient privacy, medical record security, or identity theft.
 - I. Request made by a member of the Leadership and/or Executive Team.
 - J. Request made by the Audit and Compliance Committee, Compliance Advocate, or a Board member.
 - K. Any other concern of suspected illegal, unethical, abusive conduct, wrongdoing, or non-compliance with laws, regulations, accreditation requirements and/or Kaweah Health policies and procedures not otherwise identified above.
- II. The following steps shall be used in an internal investigation when a concern is identified or reported:
- A. The ~~VPCCROPO~~ (or designee) will investigate the concern to determine how the potential problem concern was identified and designate the person who will oversee the investigation. When necessary, the appropriate ~~Leadership team members and/or Executive Team members~~ shall be notified of the potential concern.
 - 1. Issues that are strictly operational in nature shall be referred back to the appropriate ~~Leadership and Executive Team~~ members for review and investigation. Once their review and investigation is complete, the ~~leadership team members Leadership and Executive Team member~~ shall provide a summary of the resolution to the ~~CPO-VPCCRO~~ (or designee).
 - 2. Safety issues shall be referred to the Safety Officer with notification to the appropriate Executive Team member. Once their review and investigation is complete, the Safety Officer shall provide a summary of the resolution to the ~~CPOVPCCRO~~ (or designee).
 - 3. Personnel issues shall be referred to Human Resources with notification to the appropriate Executive Team member. Once their review and investigation is complete, the Human Resources representative shall provide a summary of the resolution to the ~~CPO-VPCCRO~~ (or designee).
 - 4. Quality of care issues shall be referred to Patient Safety and Quality Department with notification to the appropriate Executive Team member. Once their investigation is complete, the Patient Safety and Quality representative shall provide a summary of the resolution to the ~~CPOVPCCRO~~ (or designee).
 - 5. Risk Management issues shall be referred to the Risk Management Department. Once their investigation is complete, the Risk Management representative shall provide a summary of the resolution to the CCRO (or designee).
 - 6. Other issues shall be investigated by the ~~CPOVPCCRO~~ (or designee) with notification to the appropriate Executive Team member.

- B. The CPO-VPCCRO (or designee) will contact the Kaweah Health Compliance Advocate to invoke attorney-client privilege, as appropriate, in situations where a potential violation has been identified which could result in governmental intervention, self-reporting and/or re-payments to a third-party payer. In situations where the Kaweah Health Compliance Advocate invokes attorney-client privilege for investigation of an issue, all meetings, discussions and investigation activities related to that issue shall take place in the presence of, or under the direction of, the Kaweah Health Compliance Advocate or CPO-VPCCRO.
- C. When necessary, the CPO-VPCCRO (or designee) will place the issue on the Compliance Issue Log reviewed quarterly by the Audit and Compliance Committee and the Board. If the matter is a privacy concern or other compliance matter not requiring inclusion on the Compliance Issue Log, the CPO-VPCCRO (or designee) will document and log the concern for tracking and reporting purposes.
- D. The CPO-VPCCRO (or designee) will determine the appropriate steps to investigate the issue and initiate these steps as soon as possible. The CPO-VPCCRO (or designee) will ensure Leadership places an immediate stop to any practice violating any federal or state law or regulation and/or accreditation standard; specifically those impacting billing or coding processes.
- E. The CPO-VPCCRO (or designee) will discuss the issue with the appropriate Leadership and/or Executive Team members.
- F. When appropriate, the CPO-VPCCRO (or designee) will retain outside opinions, other experts, or consultants, to evaluate the information and provide guidance or recommendations.
- G. The CPO-VPCCRO (or designee) will initiate specific steps to review the issue. These may include, but are not limited to:
1. Review relevant policies and procedures.
 2. Identify and interview staff who may have knowledge of the problem. Analyze past history relevant to the problem.
 3. Research applicable laws.
 4. Review claims/medical records in question.
 5. Review relevant documents and files.
 6. Complete audits of patient records and system access.
- H. The CPO-VPCCRO (or designee) will document all steps taken in the investigation and resolution of the issue, including interview/meeting notes, summaries of reviews, completed copies of policies, or other relevant documents and other pertinent information related to the issue.
- I. The CPO-VPCCRO (or designee) will determine the appropriate course of action:

1. Refer concerns about performance actions of specific individuals to Leadership and Human Resources.
 2. Work with appropriate Leadership and/or Executive Team members to implement new processes, policies and procedures, education, or other steps to ensure the problem does not persist or reoccur.
 3. Confirm the re-billing or repayment of any specific claims where a billing/payment error has been identified. If it is determined that an overpayment has been received from Medicare, the overpayment must be reported and returned to the appropriate agency within 60 days after the date on which the overpayment amount is identified, or the date any corresponding cost report is due, if applicable. Failure to submit a timely report and return the overpayment may lead to False Claims Act liability. See CP.13 [Federal and State False Claims Act and Employee Protection Provisions](#) for additional information.
 4. Determine whether self-disclosure and restitution is necessary; and, if so, work with the Kaweah Health Compliance Advocate and appropriate Executive Team member to make prompt restitution to the appropriate health care program/third-party payer.
 5. Schedule future monitoring and review activity to mitigate any future recurrence. The final resolution of the issue will be reported to the appropriate Executive Team member, the Audit and Compliance Committee, the Chief Executive Officer (CEO), and Board (when appropriate). The length of the investigation and final resolution will vary depending on the complexity and risk associated with the issue.
- III. When an investigation is initiated based upon a report of a problem by an employee, the ~~CCPO~~ ~~VPCCRO~~ (or designee) will provide a summary of the final resolution to that employee. If the employee still has concerns, the following steps will be [taken](#):
- A. The ~~GPO~~ ~~VPCCRO~~ will report the continuing concern to the Audit and Compliance Committee.
 - B. The ~~GPO~~ ~~VPCCRO~~ or Compliance Advocate will contact the employee to request a written statement of their ongoing concerns.
 - C. The ~~GPO~~ ~~VPCCRO~~ will prepare a written response to the employee's concerns.
 - D. The Audit and Compliance Committee will review the written statement and respond and instruct the ~~GPO~~ ~~VPCCRO~~ whether to continue or to close the investigation.
 - E. A letter will be sent from the Compliance Advocate on behalf of the Audit and Compliance Committee to the employee stating the final decision of the Audit and Compliance Committee.
- IV. When [Kaweah Health is](#) required by Federal and/or State law [to make notifications to Federal and/or State agencies or involved patients](#), the Compliance Department will [be responsible for making](#) the necessary notifications to [involved the](#) patients and Federal [and/or](#) State agencies in accordance with applicable legal and regulatory requirements.

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

Policy Number: CP.06	Date Created: 10/05/2023
Document Owner: Jill Berry (Director of Corporate Compliance)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Compliance Committee, Ben Cripps (Chief Compliance & Risk Management Officer)	
Compliance Program Education	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Purpose:

The purpose of this policy is to establish the framework for educating Kaweah Health (“Kaweah”) staff, leaders, volunteers, Medical Staff members, and other identified individuals on Kaweah’s Compliance Program and on topics including, but not limited to the Code of Conduct, False Claims Act (FCA), Anti-Kickback Statute (AKS), STARK, Criminal Health Care Fraud Statute, Federal Exclusion Statute, and Civil Monetary Penalties (CMP) Law, and patient privacy laws and regulations.

Policy:

- A. All staff members, leaders, volunteers, and Medical Staff members will receive regular training on Kaweah’s Compliance Program and relevant compliance and privacy topics. All employees shall receive mandatory Compliance and Privacy training upon hire, and annually thereafter. All employees and Medical Staff members will receive ongoing education on relevant compliance and patient privacy topics. Employees working in identified high compliance risk areas shall receive additional focused education related to their function and responsibility.

Process:

- I. **New Employees** – All employees will receive mandatory Compliance Program training upon hire. New Employees Compliance Program training will be conducted through the New Employee General Orientation process. Training content shall include an overview of the Kaweah Health Compliance Program, Code of Conduct, patient privacy laws and regulations, FCA, AKS, STARK, Criminal Health Care Fraud Statute, Federal Exclusion Statute, CMP Law, and other topics as deemed necessary.
- II. **Medical Staff Members** – New Medical Staff members will be oriented to the Kaweah Health Compliance Program through the Medical Staff Orientation Process. Training content shall include an overview of the Kaweah Health Compliance Program, Code of Conduct, patient privacy laws and regulations, FCA, AKS, STARK, Criminal Health Care Fraud Statute, Federal Exclusion Statute, CMP Law, and other topics as deemed necessary.

- III. **New Managers** – New managers shall meet with a member of the Compliance Department to receive a more detailed understanding of the Kaweah Health Compliance Program. The training will also include a review of the manager’s responsibility for compliance education and reporting.
- IV. **New Board Members** – New Board Members will meet with the CCRO to receive a comprehensive overview of the Kaweah Health Compliance Program. The training will also include a review of the Board member’s responsibility for compliance.
- V. **Continuing Education** - All employees shall receive on-going education about relevant compliance topics including updates to the Compliance Program, Code of Conduct, new laws and regulations, and new Compliance Program and patient privacy-related policies and procedures. The ways in which information and education shall be provided include:
 - A. Compliance and Privacy Mandatory Annual Training (MAT) shall be completed by all employees annually. Failure to complete MAT will result in disciplinary action pursuant to Kaweah Health’s Human Resources Policy HR.216 [Progressive Discipline](#).
 - B. Relevant compliance topics included periodically via the Kaweah Health Communication Boards, all staff e-mail communications, the employee newsletter, and the Medical Staff newsletter.
 - C. Periodically, Compliance staff may attend department staff meetings to present relevant compliance and privacy topics as required by law, the CCRO, or at the request of Department Management.
 - D. Each department/area will identify a representative to serve as their Area Compliance Expert (ACE). These individuals will help support their management by providing compliance and privacy-related education on an on-going basis at their department/area staff meetings. Relevant topics will include identified high-risk areas for compliance or information on new laws or regulations.
- VI. **Focused Education** - Employees working in Patient Access, Patient Accounting, Revenue Integrity, Health Information Management, and Case Management participate in the development and ongoing management of Operational Compliance Committee and are to provide regular training to their team members in their assigned areas on relevant compliance and privacy topics.

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Policy Number: CP.06	Date Created: 10/05/2023
Document Owner: Jill Berry (Director of Corporate Compliance)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Compliance Committee, Ben Cripps (Chief Compliance & Risk Management Officer)	
Compliance Program Education	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Purpose:

The purpose of this policy is to establish the framework for educating Kaweah Health (“Kaweah”) staff, leaders, volunteers, employees and physicians on the Medical Staff members, and other identified individuals on about the Kaweah’s Health-Compliance Program and on topics including, but not limited to, the Code of Conduct, Patient Privacy regulations, False Claims Act (FCA), Anti-Kickback Statute (AKS), STARK, Criminal Health Care Fraud Statute, Federal Exclusion Statute, and Civil Monetary Penalties (CMP) Laws, and patient privacy laws and regulations.

Policy:

A. All staff members, leaders, volunteers, and Medical Staff members will receive regular training on Kaweah’s Compliance Program and relevant compliance and privacy topics. All employees shall receive mandatory Compliance and Privacy training upon hire, and annually thereafter. All employees and Medical Staff members physicians will receive ongoing education on relevant compliance and Patient Privacy topics. Employees working in identified high compliance risk areas within the Revenue Cycle shall receive additional focused education related to their function and responsibility.

Process:

- I. **New Employees Orientation** – All employees will receive mandatory Compliance Program training upon hire. New Employees Compliance Program training will be conducted will be oriented to the Kaweah Health Compliance Program through the New Employee General Orientation process. Training content shall include an overview of the Kaweah Health Compliance Program, Code of Conduct, Patient Privacy laws and regulations, FCA, AKS, STARK, Criminal Health Care Fraud Statute, Federal Exclusion Statute, CMP Laws, and other topics as deemed necessary.
- II. **Medical Staff OrientationMembers** – New Medical Staff members physicians will be oriented to the Kaweah Health Compliance Program through the Medical Staff Orientation Process. Training content shall include

an overview of the Kaweah Health Compliance Program, Code of Conduct, ~~P~~atient ~~p~~Privacy laws and regulations, FCA, AKS, STARK, Criminal Health Care Fraud Statute, Federal Exclusion Statute, CMP Laws, and other topics as deemed necessary.

- III. **New Managers Orientation** – New managers shall meet with a member of the Compliance Department the CCRO (or designee) to receive a more detailed understanding of the Kaweah Health Compliance Program. The training will also include a review of the manager's responsibility for compliance education and reporting.
- IV. **New Board Members Orientation** – New Board Members will meet with the CCRO to receive a comprehensive overview of the Kaweah Health Compliance Program. The training will also include a review of the Board member's responsibility for compliance.
- V. **Continuing Education** - All employees shall receive on-going education about relevant compliance topics including updates to the Compliance Program, Code of Conduct, new laws and regulations, ~~and~~ new Compliance Program and patient pPrivacy-related policies and procedures. The ways in which information and education shall be provided include:
 - A. Compliance and Privacy Mandatory Annual Training (MAT) shall be completed by all employees annually. Failure to complete MAT will result in disciplinary action pursuant to Kaweah Health's Human Resources Policy HR.216 Progressive Discipline.
 - B. Relevant compliance topics included periodically via the Kaweah Health Communication Boards, all staff e-mail communications, the employee newsletter, and the Medical Staff newsletter.
 - C. Periodically, Compliance staff may attend department staff meetings to present relevant compliance and privacy topics as required by law, the CCRO, or at the request of Department Management.
 - D. Each department/area will identify a representative to serve as their Area Compliance Expert (ACE). These individuals will help support their management by providing compliance and privacy-related education on an on-going basis at their department/area staff meetings. Relevant topics will include identified high-risk areas for compliance or information on new laws or regulations.
- VI. **Focused Education** - Employees working in Patient Access, Patient Accounting, Revenue Integrity, ~~Radiology,~~ Health Information Management, ~~Clinical Documentation Improvement,~~ and Case Management participate in the development and ongoing management of Operational Compliance Committee and are to provide regular training to their team members in their assigned areas on relevant compliance and privacy topics, focused on the discussion of regulations, policies, auditing and monitoring, and educational efforts within the departments; including the development and implementation

~~of dashboards designed to develop focused goals and measure effectiveness of each committee.~~

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Policy Number: CP.07	Date Created: 02/09/1998
Document Owner: Jill Berry (Director of Corporate Compliance)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Compliance Committee, Ben Cripps (Chief Compliance & Risk Management Officer)	
Excluded Individuals/Entities	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Purpose:

To establish procedures to prevent Kaweah Delta Health Care District (herein after referred to as Kaweah Health) from employing, contracting with and/or granting Medical Staff privileges to anyone excluded from participation in a Federal or State Health Care Program.

Policy:

All current and prospective employees, independent contractors, vendors, suppliers, consultants, and Medical Staff members shall be searched against the Department of Health and Human Services/Office of Inspector General’s List of Excluded Individuals/Entities (OIG), the General Systems Administration (GSA) List of Excluded Individuals/Entities, and the California Medicaid Exclusion List (collectively referred to herein as the “Exclusion List(s)”) based on the frequency outlined in this policy.

Definition of an Excluded Person or Entity:

An employee, independent contractor, vendor, supplier, consultant, Medical Staff members, or entity who has been identified by the Federal or State government as committing an act that excludes them from participating in a Federal or State health care program and/or Federal or State procurement. The exclusion applies regardless of who submits the claims and applies to all administrative and management services furnished by the excluded person.

Procedure:

- I. Vendors/Suppliers/Contracted Services
 - A. Before entering into a contract or agreement, the person responsible for executing or renewing the contract shall ensure that the proposed vendor or supplier is not an Excluded Person/Entity. If the vendor or supplier is excluded from participation in a Federal or State Health Care Program, a contract shall not be executed.

All new or renewed contracts shall contain a clause, requiring the vendor to immediately notify Kaweah Health should they become ineligible /

excluded from participating in a Federal or State Health Care Program. The contract shall also specify Kaweah Health's authority to immediately terminate the agreement in the event the vendor becomes excluded. See AP69 [Requirement for Contracting with Outside Service Providers](#). All executed agreements shall be retained in the Contract Management System.

- B. The Director of Finance (or designee) shall perform Exclusion List screening quarterly to ensure that any Kaweah Health vendor/supplier is not an Excluded Person/Entity. Any vendor found to be excluded shall be immediately notified and their contract with Kaweah Health terminated.
- C. Any providers not credentialed with Kaweah Health, but whose patients utilize Kaweah Health for the fulfillment of services (Laboratory, Imaging, etc.) will undergo Exclusion List screening to validate exclusion status. A third-party vendor may be utilized to perform monthly monitoring of non-credentialed providers. Orders for non-credentialed providers who are found to be excluded will not be accepted at Kaweah Health for the fulfillment of medical services.
- D. Documentation of the review shall be forwarded to the Compliance Department and may be in the format in Exhibit A or other such format as agreed to by the Chief Compliance and Risk Officer (CCRO) or designee.

II. Medical Staff /Allied Health Staff

- A. Before approving a physician for Medical Staff privileges or authorizing an allied health staff person to provide services, the Medical Staff Director (or designee) shall ensure that the individual is not an Excluded Person. If a physician or allied health professional is identified on the Exclusion Lists, Medical Staff privileges/authorization to provide services shall not be granted. Any physician or Allied Health Professional with a change in status, such as an exclusion from Federal or State Health Care participation, shall immediately report such change to the Kaweah Health CCRO and Medical Staff Office.
- B. The Director of the Medical Staff Office (or designee) shall search the Exclusion Lists monthly to ensure that any Kaweah Health Medical Staff or Allied Health Professional is not an Excluded Person. In the event a physician or Allied Health Professional is on the Exclusion Lists, Medical Staff privileges/authorization to provide services shall be immediately revoked.
- C. Documentation of the review shall be forwarded quarterly to the CCRO (or designee) and may be in the format in Exhibit A or other such format as agreed to by the CCRO.

III. Employment Applicants

- A. Prior to making an offer of employment or contract, Human Resources staff shall search the Exclusion Lists to ensure that the applicant is not an Excluded Person. In the event the applicant is on the Exclusion Lists, no offer of employment or contract shall be made.
- IV. Kaweah Health Employees
- A. The Exclusion Lists shall be searched monthly to determine if a Kaweah Health employee has been identified as an Excluded Person. The review will also evaluate any published legal or license activity that might affect a person's status for professional licensure. Human Resources will be immediately notified of any potential situations that require further review and evaluation.
 - B. In the event an employee is identified as an Excluded Person, the Chief Human Resources Officer will review the finding and report the outcome of the review to the CCRO. Confirmation of the "excluded" status is cause for immediate termination of employment with Kaweah Health.
- V. Investigations of Excluded Person(s)
- A. In the event that an Excluded Person/party is identified, the Compliance Department will conduct an investigation following CP.05 [Compliance and Privacy Issues Investigation and Resolution](#).
 - B. In the event that an Excluded Person/party is identified, Insurance Plan Sponsors and/or Payor will be notified (when appropriate).

EXHIBIT A

Verification of review of OIG and GSA List of Excluded Individuals/Entities

Review completed for: _____
Vendors, Medical and Allied Health Staff, Consultants, Staff)

Review completed on: _____
(Date)

I certify that this review has been completed and no Excluded Individuals/Entities were found.

Signature: _____

Print Name: _____

I certify that this review has been completed and the following Individuals/Entities were found:

Signature: _____

Print Name: _____

Please forward the completed form to the CCRO or designee

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Policy Number: CP.07	Date Created: 02/09/1998
Document Owner: Jill Berry (Director of Corporate Compliance)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Compliance Committee, Ben Cripps (Chief Compliance & Risk Management Officer)	
Excluded Individuals/Entities	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Purpose:

To establish procedures to prevent Kaweah Delta Health Care District (herein after referred to as Kaweah Health) ~~from hiring, employing, contracting with and/or granting the provision of~~ Medical Staff privileges to anyone excluded from participation in a Federal or State Health Care Program.

Policy:

All current and prospective ~~new~~ employees, independent contractors, vendors, suppliers, consultants, and Medical Staff members shall be searched against the Department of Health and Human Services/Office of Inspector General’s List of Excluded Individuals/Entities (OIG), ~~and~~ the General Systems Administration (GSA) ~~list of Excluded Individuals/Entities, and the California Medicaid Exclusion List~~ (collectively referred to herein as the “Exclusion List(s)”) based on the frequency outlined in this policy.

Definition of an Excluded Person or Entity:

~~An excluded person can be an~~ An employee, independent contractor, vendor, supplier, consultant, Medical Staff members, or entity who has been identified by the Federal or State government as committing an act that excludes the m ~~individual/entity~~ from participating in a Federal or State health care program, ~~and/or~~ Federal or /State procurement. The exclusion applies regardless of who submits the claims and applies to all administrative and management services furnished by the excluded person.

Procedure:

- I. Vendors/Suppliers/Contracted Services
 - A. Before entering into a contract or agreement, the person responsible for executing or renewing the contract shall ensure that the proposed vendor or supplier is not an Excluded Person/Entity. If the vendor or supplier is excluded from participation in a Federal or State Health Care Program, a contract shall not be executed.

All new or renewed contracts shall contain a clause, requiring the vendor to immediately notify Kaweah Health should they become ineligible / excluded from participating in a Federal or State Health Care Program. The contract shall also specify Kaweah Health's authority to immediately terminate the agreement in the event the vendor becomes excluded. See AP69 [Requirement for Contracting with Outside Service Providers](#). All executed agreements shall be retained in the Contract Management System.

- B. The Director of Finance (or designee) shall ~~perform search the Exclusion List screening OIG/GSA List~~ quarterly to ensure that any Kaweah Health vendor/supplier is not an Excluded Person/Entity. Any vendor found to be excluded shall be immediately notified and their contract with Kaweah Health terminated.
- C. Any providers not credentialed with Kaweah Health, but whose patients utilize Kaweah Health for the fulfillment of services (Laboratory, Imaging, etc.) will ~~undergo Exclusion List screening be searched for on the OIG list~~ to validate exclusion status. A third-party vendor ~~may be utilized to perform will maintain the~~ monthly monitoring of non-credentialed providers. Orders for non-credentialed providers who are found to be excluded will not be accepted at Kaweah Health for the fulfillment of medical services.
- D. Documentation of the review shall be forwarded to the Compliance Department and may be in the format in Exhibit A or other such format as agreed to by the ~~Vice President & Chief Compliance and Risk and Privacy Officer (VPCCRO)~~ or designee.

II. Medical Staff /Allied Health Staff

- A. Before approving a physician for Medical Staff privileges or authorizing an allied health staff person to provide services, the Medical Staff Director (or designee) shall ensure that the individual is not an Excluded Person. If a physician or allied health professional is identified on the ~~OIG/GSA Exclusion Lists~~, Medical Staff privileges/authorization to provide services shall not be granted. Any physician or Allied Health Professional with a change in status, such as an exclusion from Federal or State Health Care participation, shall immediately report such change to the Kaweah ~~Delta Health (VPCCRO) Compliance Officer~~ and Medical Staff Office.
- B. The Director of the Medical Staff Office (or designee) shall search the ~~Exclusion OIG/GSA Lists~~ monthly to ensure that any Kaweah Health Medical Staff or Allied Health Professional is not an Excluded Person. In the event a physician or Allied Health Professional is on the ~~OIG/GSA Exclusion Lists~~, Medical Staff privileges/authorization to provide services shall be immediately revoked.

C. Documentation of the review shall be forwarded quarterly to the ~~VPCCRO Chief Compliance and Privacy Officer~~ (or designee) and may be in the format in Exhibit A or other such format as agreed to by the ~~VPCCRO Compliance and Privacy Officer~~.

III. Employment Applicants

A. Prior to making an offer of employment or contract, Human Resources staff shall search the ~~Exclusion OIG/GSA Lists~~ to ensure that the applicant is not an Excluded Person. In the event the applicant is on the ~~Exclusion OIG/GSA Lists~~, no offer of employment or contract shall be made.

IV. Kaweah Health Employees

A. The ~~OIG/GSA and State~~ Exclusion Lists shall be searched monthly to determine if a Kaweah Health employee has been identified as an Excluded Person. The review will also evaluate any published legal or license activity that might affect a person's status for ~~professional their California~~ licensure. Human Resources will be immediately notified of any potential situations that require further review and evaluation.

B. In the event an employee is identified as an Excluded Person, the ~~Vice President of~~ Chief Human Resources ~~Officer~~ will review the finding and report the outcome of the review to the ~~VPCCRO Compliance and Privacy Officer~~. Confirmation of the "excluded" status is cause for immediate termination of employment with Kaweah Health.

V. Investigations of Excluded Person(s)

~~V.~~

A. In the event that an Excluded Person/party is identified, the Compliance Department will conduct an investigation following CP.05 Compliance and Privacy Issues Investigation and Resolution.

~~A.~~

B. In the event that an Excluded Person/party is identified, Insurance Plan Sponsors and/or Payor will be notified (when appropriate).

EXHIBIT A

Verification of review of OIG and GSA List of Excluded Individuals/Entities

Review completed for: _____
Vendors, Medical and Allied Health Staff, Consultants, Staff)

Review completed on: _____
(Date)

I certify that this review has been completed and no Excluded Individuals/Entities were found.

Signature: _____

Print Name: _____

I certify that this review has been completed and the following Individuals/Entities were found:

Signature: _____

Print Name: _____

Please forward the completed form to the [VPCCRO Compliance and Privacy Officer or designee](#)

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Policy Number: CP.10	Date Created: 05/11/2026
Document Owner: Jill Berry (Director of Corporate Compliance)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Compliance Committee, Ben Cripps (Chief Compliance & Risk Management Officer)	
Compliance Reviews and Assessments	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Purpose:

To outline and evaluate the process of performing audits and/or monitoring to measure compliance and assist in process improvement.

Policy:

Kaweah Delta Health Care District (herein after referred to as Kaweah Health) acknowledges its responsibility to detect and prevent illegal, unethical, and abusive conduct. The Kaweah Health Compliance Program shall complete auditing and monitoring activities on a regular basis to evaluate compliance with specific laws, regulations, accreditation requirements and/or Kaweah Health policies and procedures. The Compliance Program shall evaluate and assess compliance risks through ongoing risk assessment process. The Compliance Program shall also audit and/or monitor high-risk areas and changing government standards or industry practices on a regular basis.

Process:

- I. **Closed Compliance Issues** – Risk areas identified for closed compliance issues will be evaluated and prioritized. Auditing and monitoring activities will be completed periodically based on the recommendation of the Chief Compliance and Risk Officer (CCRO) to the Audit and Compliance Committee. Follow-up audits or monitoring activity will be completed by Compliance staff or the applicable department leaders as determined by the Compliance Department. Reviews requiring independent detailed claim or record reviews will be completed by Compliance staff or contracted external audit firm.
- II. **Risk Prevention and Identification** – The CCRO (or designee) will review risk areas identified by the Office of Inspector General (OIG), Centers for Medicare and Medicaid Services (CMS), Medi-Cal, California Department of Public Health (CDPH), and other government agencies and audit contractors in accordance with CP.16 [Compliance Risk Assessment and Annual Compliance Workplan Development](#). Particular focus will be given to risk areas involving complex processes and to those areas new to Kaweah Health operations.
- III. **Billing and Coding Reviews** – Billing, coding and medical record reviews will be completed periodically as outlined in CP.02 [Review of Billing Practices](#). The

results of these reviews shall be monitored by the CCRO (or designee) and reported to the Audit and Compliance Committee.

- IV. **Corrective Action Monitoring** – The Compliance Department will periodically audit and/or monitor processes in risk areas where compliance investigations have been completed and corrective actions implemented. Periodic monitoring of risk areas will be used to validate the effectiveness of corrective actions and continued compliance.
- V. **Suspected Wrongdoing** – When an evaluation of a risk area identifies suspected wrongdoing, possible fraud and abuse, or non-compliance with laws, regulations, accreditation requirements and/or Kaweah Health policies and procedures, an investigation will be initiated pursuant to CP.05 [Compliance and Privacy Issues Investigation and Resolution](#).
- VI. **Recommended Audit and Monitoring Procedures**
 - A. Assignments of audit staff will be based on the particular expertise required to fully audit the specific area or standard being evaluated. All analysis and documentation related to each unscheduled audit shall be compiled at the direction of the CCRO (or designee) and/or legal counsel and shall be treated as attorney-client work product (when appropriate).
 - B. All audit reports shall be completed in a timely fashion, reported to the Audit and Compliance Committee, and at a minimum include the following information:
 - 1. Audit objectives and scope;
 - 2. Results obtained;
 - 4. Conclusions concerning accomplishment of the audit objectives;
 - 5. Details concerning any deficiencies noted; and
 - 6. Recommendations for corrective action or improvement.

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Document Owner: Jill Berry (Director of Corporate Compliance)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Compliance Committee, Ben Cripps (Chief Compliance & Risk Management Officer)	
Compliance Reviews and Assessments	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Purpose:

To outline and evaluate the process of performing audits and/or monitoring to measure compliance and assist in process improvement.

Policy:

Kaweah Delta Health Care District (herein after referred to as Kaweah Health) acknowledges its responsibility to detect and prevent illegal, unethical, and abusive conduct. The Kaweah Health Compliance Program shall complete auditing and monitoring activities on a regular basis to evaluate compliance with specific laws, regulations, accreditation requirements and/or Kaweah Health policies and procedures. The Compliance Program shall evaluate and assess compliance risks through ongoing risk assessment process. The Compliance Program shall also audit and/or monitor high-risk areas and changing government standards or industry practices on a regular basis.

Process:

- I. **Closed Compliance Issues** – Risk areas identified for closed compliance issues will be evaluated and prioritized. Auditing and monitoring activities will be completed periodically based on the recommendation of the ~~Vice President & Chief Compliance and Risk and Privacy Officer (VPCCRO)~~ to the Audit and Compliance Committee. Follow-up audits or monitoring activity will be completed by Compliance staff or the applicable department leaders as determined by the Compliance Department~~may be referred to Internal Audit~~. Reviews requiring independent detailed claim or record reviews will be completed by Compliance staff or contracted external audit firm.
- II. **Risk Prevention and Identification** – The ~~Chief Compliance Officer~~VPCCRO (or designee) will review risk areas identified by the Office of Inspector General (OIG), Centers for Medicare and Medicaid Services (CMS), Medi-Cal, California Department of Public Health (CDPH), and other government agencies and

audit contractors in accordance with CP.16 Compliance Risk Assessment and Annual Compliance Workplan Development. Particular focus will be given to risk areas involving complex processes and to those areas new to Kaweah DeltaHealth operations.

- III. —**Billing and Coding Reviews** – Billing, coding and medical record reviews will be completed periodically as outlined in CP.02 Review of Billing Practices. The results of these reviews shall be monitored by the Chief Compliance and Privacy Officer VPCCRO (or designee) and reported to the Audit and Compliance Committee.
- IV. —**Corrective Action Monitoring** – The Compliance Department will periodically and/or Internal Audit staff shall also audit and/or -monitor processes in risk areas where compliance investigations have been completed and corrective actions implemented. Periodic monitoring of ~~these~~ risk areas will be used to validate the effectiveness of corrective actions and continued compliance.
- V. **Suspected Wrongdoing** – When an evaluation of a risk area assessment identifies suspected wrongdoing, possible fraud and abuse, or non-compliance with laws, regulations, accreditation requirements and/or Kaweah DeltaHealth policies and procedures, an more thorough investigation will be initiated pursuant to CP.05 Compliance Policy Compliance and Privacy Issues Investigation and Resolution.

VI. **Recommended Audit and Monitoring Procedures**

VI.A. — Assignments of audit staff will be based on the particular expertise required to fully audit the specific area or standard being evaluated. All analysis and documentation related to each unscheduled audit shall be compiled at the direction of the Chief Compliance and Privacy Officer VPCCRO (or designee) and/or legal counsel and shall be treated as attorney-client work product (when appropriate).

B. All audit reports shall be completed in a timely fashion, reported to the Audit and Compliance Committee, and at a minimum include the following information:

1. ~~(1)~~ Audit objectives and scope;
2. ~~(2)~~ Audit procedures employed;
- ~~(3)~~ Results obtained;
4. ~~(4)~~ Conclusions concerning accomplishment of the audit objectives;
5. ~~(5)~~ Details concerning any deficiencies noted; and
6. ~~(6)~~ Recommendations for corrective action or improvement.

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Policy Number: CP.15	Date Created:
Document Owner: Error! No document variable supplied. Ben Cripps (Chief Compliance and Risk Officer)	Date Approved: Error! No document variable supplied. Not Approved Yet
Approvers: Error! No document variable supplied. Board of Directors (Administration), Compliance Committee, Ben Cripps (Chief Compliance & Risk Management Officer)	
Fair Market Value	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE: To provide direction as to Kaweah Health’s process of determining whether a transaction with a potential referral source is made at fair market value in order to comply with Stark Law and the Anti-kKickback Statute.

POLICY: Any transaction with a potential referral source is to be at fair market value. Whenever Kaweah Health requires a fair market valuation in order to comply with Federal or state laws and regulations or with its own policies and procedures, no conflict of interest, such as the ability of one party to refer patients or other business to the other, may affect the terms of the transaction or the valuation. Appraisal reports must clearly indicate that the definition of fair market value used for such appraisals is the regulatory definition of fair market value provided by Stark.

PROCEDURE: Prior to executing any transaction with a potential referral source, Kaweah Health must determine that any compensation given or received in the transaction is fair market value. At a minimum, the following considerations must be included in any fair market value analysis.

1. General

- a. **Defined.** So long as the price or compensation does not take into account the volume or value of anticipated or actual referrals from or to a party, fair market value of a transaction is:
 - i. the market price at which bona fide sales have been consummated for assets of like type, quality and quantity in a given market, or
 - ii. the compensation that has been included in bona fide service agreements with comparable terms at the time of the agreement.

Determination of the market price or compensation above will begin with a range of benchmark payments, as described below. The appropriate value to select from within the range for a given transaction depends on individual factors. For example, a physician with a considerable experience in an area could receive compensation on the

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Approvers: <u>Error! No document variable supplied.</u> Board of Directors (Administration), Compliance Committee, Ben Cripps (Chief Compliance & Risk Management Officer)	
Fair Market Value	

high end of the range of medical directorship compensation in that location for the service. Similarly, where office space to be leased is in below standard condition for the market, the lease rate charged may be in the low end of the range.

- b. **Term Covered.** A fair market valuation will have that useful life stated in it by the valuator. If a fair market valuation does not specify its useful life, the facility should request that the appraiser reissue the report specifying the period for which the valuation opinion is valid. In the event that no term is noted, it will be assumed that the valuation remains accurate for a term equal to the term of the subject agreement, as well as for the first 12 months of any subsequent agreement entered within six months of the termination of the underlying contract, so long as there has been no material change to the agreement terms or supporting facts and circumstances. If the term of a fair market valuation has passed on a current contract, a new valuation should be obtained.
- c. **Comprehensive.** Any fair market valuation must specifically list what is included in the valuation. Items and services included in the valuation must match those provided for in the agreement and must also match those items and services actually provided to the referral source.
- d. **Consideration of Facts and Circumstances.** All valuations should provide a thorough analysis of the facts and circumstances of the underlying transaction in comparison to industry benchmark data; merely comparing payments against objective benchmark measure or industry practices does not guarantee that a payment meets the standard of fair market value.
- e. **Selection of Benchmark Data.** Benchmark data includes information on transactions comparable in character, nature and value to the one in issue for which fair market value is to be determined. Consistent with Sullivan Cotters FMV guidelines, National Benchmark data shall be

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Policy Number: CP.15	Date Created:
Document Owner: <u>Error! No document variable supplied.</u> Ben Cripps (Chief Compliance and Risk Officer)	Date Approved: <u>Error! No document variable supplied.</u> Not Approved Yet
Approvers: <u>Error! No document variable supplied.</u> Board of Directors (Administration), Compliance Committee, Ben Cripps (Chief Compliance & Risk Management Officer)	
Fair Market Value	

used. Benchmark data generally should not include transactions between health care facilities and their referral sources.

2. Rental or Lease of Space or Equipment

- a. **Limitations.** For rental or lease agreements, the fair market value is the value of rental property for general commercial purposes, not taking into account the subject of the agreement's intended use. When Kaweah Health is the landlord, they should factor in the value to tenants of proximity or convenience to them when charging rent in leases with referral sources. In contrast, when Kaweah Health rents from referral sources, convenience or proximity shall not be a factor in the rental payment amount paid by the facility. Rental payments may reflect the value of any similar commercial property with improvements or amenities of a similar value, regardless of why the property was improved.
- b. **Calculating FMV for a Lease of Space.** The fair market value in a lease for space will equal the product of the number of square feet in the space leased and the market value of such property for general commercial purposes, with additional rental amounts prorated for any common areas.
- c. **Calculating FMV for a Lease of Equipment.** Generally, all of the above statements regarding a lease of space apply to a lease of equipment. However, in the case of equipment, due to the nature of medical equipment, sometimes all of the comparables or market values of a transaction type involve entities in a position to refer or generate business to each other. In such cases, one method of calculating fair market value would be to add to the cost a reasonable rate of return on investment of comparable medical equipment. Hospitals may not lease equipment alone on a per-click basis from any physician who makes referrals to the hospital for the service that uses that equipment.

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Approvers: Error! No document variable supplied. Board of Directors (Administration), Compliance Committee, Ben Cripps (Chief Compliance & Risk Management Officer)	
Fair Market Value	

3. **Personal Service Agreements, Recruiting Agreements, and Employment Agreements.** The fair market value of these agreements is the compensation that would be determined in an arms’ length transaction, consistent with the compensation that would be included in such an agreement as the result of bona fide bargaining between well-informed parties who are not otherwise in a position to generate business for the other party, at the time of the agreement

- a. **Hourly Rate.** Where the compensation is calculated by hourly payments and the services are provided personally by the physician, rather than by the physician’s employees or other persons or entities, compensation must be what the facility perceives is fair market value, but in no case shall it exceed the Fair Market Value Guidelines established by the Executive Fair Market Value Committee.
- b. **Independent Third Party Valuation Required.** Where a PSA for a Physician Group exceeds the 65th percentile in overall compensation, an independent third-party appraiser should determine the fair market value of the agreement pursuant to the Professional Services Agreements Policy [INSERT NEW POLICY NAME]. To ensure consistency across contracted services and to avoid scrutiny of “opinion shopping” by the Office of Inspector General, Kaweah Health shall use Sullivan Cotter as the third-party valuation firm for all PSA’s.

In calculating fair market value, the nature of the services to be provided must be considered. Please note that the fair market value of administrative services may not be the same as the fair market value of clinical services.

If an hourly rate is used to determine a physician’s annual salary, the rate should be multiplied by a number of hours that accurately reflects the number of hours actually worked by the physician each year.

- c. **Professional and Technical Components.** Where a physician provides the equipment (a technical service) pursuant to a personal services agreement, the fair market valuation shall take the rental

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value of the equipment into consideration in addition to the value of the physician’s professional services. The values of both the professional and technical services should be separately stated in one agreement.

4. **Assets.** The fair market value is the value that would be assigned to the asset in an arms’ length transaction, consistent with the price the asset would bring as the result of bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset. When acquiring or divesting a medical practice or medical practice assets of a physician, Medical Practice Asset Acquisitions require an independent third party valuator to determine the fair market value.
5. **Education and Training Hosted by Vendors.** Where a vendor or other third party hosts or produces a physician education or training event at the hospital, one method to determine fair market value is to set it equal to the price the vendor would ordinarily charge for each physician’s attendance plus the value of any materials, including the rental value for the time period of the training for any equipment used in the training session.
6. **Education and Training Hosted by the Hospital.** Where the hospital hosts or produces a physician education or training event, one method of ensuring fair market value is to require the physician to pay the price charged by similar training programs conducted by instructors of similar skill level, regardless of any price charged by the hospital.

Agenda item intentionally omitted