CORPORATE INTEGRITY AGREEMENT
BETWEEN THE
OFFICE OF INSPECTOR GENERAL
OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
COVENANT CARE

I. PREAMBLE

Covenant Care California, Incorporated, a California corporation ("Covenant Care") hereby enters into this Corporate Integrity Agreement ("CIA") with the Office of Inspector General ("OIG") of the United States Department of Health and Human Services ("HHS") to promote compliance by its Covenant Care and all Covered Persons (as these terms are defined herein) with the statutes, regulations and written directives of Medicare, Medicaid and all other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f))("Federal health care program requirements"). Contemporaneously with this CIA, Covenant Care is entering into a Settlement Agreement with the United States, and this CIA is incorporated by reference into the Settlement Agreement. The scope of this CIA shall be governed by the following definitions:

1. "Covenant Care:" Covenant Care, Southern Desert Clinic Pharmacy, Inc., an Arizona corporation, and any corporation, limited liability company, partnership, subsidiary, affiliate or any other legal entity or organization: (a) that is actively doing business; (b) for which there are claims for reimbursement from any federal health care program; and (c) that Covenant Care controls. Covenant Care controls another organization if Covenant Care directly or indirectly: (i) controls the day-to-day operations; (ii) has a controlling ownership interest; or (iii) has a contract to perform the organization's management or billing to a federal or state payor.

2. "Covered Persons:" officers, directors, employees, contractors, agents, third parties engaged to bill/submit reimbursement claims, and all other individuals that are, in each such case, responsible for the provision, marketing or documentation of items or services reimbursable by Federal health care programs, or in the preparation of claims, reports or other requests for reimbursement for such items or services.

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II. TERM OF THE CIA

The period of the compliance obligations assumed by Covenant Care under this CIA shall be three years from the effective date of this CIA (unless otherwise specified). The effective date of this CIA shall be the date on which the final signatory of this CIA executes this CIA.

Sections VII, VIII, IX, X and XI shall remain in effect until the OIG has completed its review of the final annual report and any additional materials submitted by Covenant Care pursuant to the OIG's request.

III. CORPORATE INTEGRITY OBLIGATIONS

Covenant Care hereby agrees to continue to maintain a Compliance Program that includes the following elements:

A. Compliance Officer and Committee.

1. *Compliance Officer.* Covenant Care shall continue to employ an individual to serve as its Compliance Officer. The Compliance Officer shall be responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements set forth in this CIA and with Federal health care program requirements. The Compliance Officer shall be a member of senior management of Covenant Care, or an individual otherwise designated in a position of authority, shall make periodic (at least quarterly) reports regarding compliance matters directly to the Board of Directors of Covenant Care, and shall be authorized to report on such matters to the Board of Directors at any time. The Compliance Officer shall be responsible for monitoring the day-to-day compliance activities engaged in by Covenant Care as well as for any reporting obligations created under this CIA.

Any changes in the identity or position description of the Compliance Officer, or any actions or changes that would affect the Compliance Officer's ability to perform the duties necessary to meet the obligations in this CIA, must be reported to the OIG, in writing, within 15 days of such a change.

2. *Compliance Committee.* Covenant Care shall continue to maintain a Compliance Committee. The Compliance Committee shall, at a minimum, include the Compliance Officer and any other members of senior management necessary to meet the requirements of this CIA (e.g., senior executives of each major department, such as billing, clinical, human resources, audit, and operations). The Compliance Officer shall

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chair the Compliance Committee and the Committee shall support the Compliance Officer in fulfilling his/her responsibilities (e.g., shall assist in the analysis of the organization's risk areas and shall oversee monitoring of internal and external audits and investigations).

Any changes in the composition of the Compliance Committee, or any actions or changes that would affect the Compliance Committee's ability to perform the duties necessary to meet the obligations in this CIA, must be reported to the OIG, in writing, within 15 days of such a change.

3. *Compliance Liaisons.* Covenant Care shall appoint an individual in each of its facilities to perform the duties of a Compliance Liaison. Compliance Liaisons shall be responsible for monitoring and ensuring execution of the Compliance Program and the relevant requirements of this CIA at their facility. Compliance Liaisons shall be responsible for: providing leadership and support regarding compliance issues; developing and distributing written compliance-related materials; ensuring the provision of appropriate training and the proper documentation of such training; ensuring the implementation of corrective action plans; ensuring proper reporting and responses to compliance-related issues; and monitoring the facility's staff in the execution of their compliance related functions. Each Compliance Liaison shall certify annually that all plans of correction related to identified problems in that facility or Covenant Care's operations for which they are responsible have been implemented and that all Compliance Program concerns have been reported. Such certifications shall be maintained by the Compliance Officer and shall be available to the OIG upon request. False certifications by the Compliance Liaison shall be grounds for disciplinary action, including termination of employment. Proper execution of Compliance Liaison duties shall be a major component of performance evaluations.

If Covenant Care has a vacancy in any of its Compliance Liaison positions, that it shall make good faith efforts to hire a new Compliance Liaison in a timely manner and during the interim shall appoint an individual to carry out the duties and responsibilities of the Compliance Liaison.

B. Written Standards.

1. *Code of Conduct.* Covenant Care shall continue to maintain a Code of Conduct. Within 120 days of the effective date of this CIA, the Code of Conduct shall bereviewed and amended to the extent necessary to meet the requirements of this CIA. To the extent amendments are required, the Code of Conduct shall then be redistributed within this 120 day period. Covenant Care shall make the promotion of, and adherence

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to, the Code of Conduct an element in evaluating the performance of all employees. The Code of Conduct shall, at a minimum, set forth:

a. Covenant Care's commitment to full compliance with all Federal health care program requirements, including its commitment to prepare and submit accurate claims consistent with such requirements;

b. Covenant Care's requirement that all of its Covered Persons shall be expected to comply with all Federal health care program requirements and with Covenant Care's own Policies and Procedures as implemented pursuant to Section III.B (including the requirements of this CIA);

c. the requirement that all of Covenant Care's Covered Persons shall be expected to report to the Compliance Officer or other individual designated by the Covenant Care suspected violations of any Federal health care program requirements or of Covenant Care's own Policies and Procedures;

d. the possible consequences to both Covenant Care and Covered Persons of failure to comply with all Federal health care program requirements and with Covenant Care's own Policies and Procedures or of failure to report such non-compliance; and

e. the right of all individuals to use the Disclosure Program described in Section III.E, and Covenant Care's commitment to maintain confidentiality, as appropriate, and non-retaliation with respect to disclosures.

To the extent not already accomplished, within 120 days of the effective date of the CIA, each Covered Person shall certify, in writing, that he or she has received, read, understood, and will abide by Covenant Care's Code of Conduct. New Covered Persons shall receive the Code of Conduct and shall complete the required certification within two weeks after becoming a Covered Person or within 120 days of the effective date of the CIA, whichever is later.

Covenant Care shall annually review the Code of Conduct to determine if revisions are appropriate and shall make any necessary revisions based on such a review. Any such revised Code of Conduct shall be distributed within 60 days of finalizing such

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changes. Covered Persons shall certify that they have received, read, understood and will abide by the revised Code of Conduct within 60 days of the distribution of such revisions.

2. *Policies and Procedures*. Within 120 days of the effective date of this CIA, Covenant Care shall implement written Policies and Procedures regarding the operation of Covenant Care's compliance program and its compliance with Federal health care program requirements. At a minimum, the Policies and Procedures shall address:

a. the subjects relating to the Code of Conduct identified in Section III.B.1;

b. measures designed to ensure that Covenant Care complies with all requirements applicable to Medicare's Prospective Payment System ("PPS") for nursing facilities, including, but not limited to: the collection of the clinical data required under the Minimum Data Set ("MDS") as specified by the Resident Assessment Instrument User's Manual; use of the current Resource Utilization Groups ("RUG") classification system; and billing and cost report preparation policies and procedures; and

c. measures designed to ensure that patients receive the appropriate number of nursing hours and level of care as required by the applicable RUG category, State requirements, and Federal health care program requirements.

Within 120 days of the effective date of the CIA, the relevant portions of the Policies and Procedures shall be made available to all individuals whose job functions are related to those Policies and Procedures. Appropriate and knowledgeable staff should be available to explain the Policies and Procedures.

At least annually (and more frequently if appropriate), Covenant Care shall assess and update as necessary the Policies and Procedures. Within 60 days of the effective date of any revisions, the relevant portions of any such revised Policies and Procedures shall be made available to all individuals whose job functions are related to those Policies and Procedures.

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C. Training and Education.

1. *General Training.* Covenant Care has represented to the OIG that it provides general training to each Covered Person. To the extent that it has not already been provided since March 1, 2001, Covenant Care shall, within 120 days of the effective date of this CIA, provide adequate and appropriate general training to each Covered Person who is an Employee of Medical Center or Contract Employee. This training, at a minimum, shall explain Covenant Care's:

a. CIA requirements; and

b. Compliance Program (including the Code of Conduct and the Policies and Procedures as they pertain to general compliance issues).

New Covered Persons shall receive the general training described above within 60 days of becoming a Covered Person or within 120 days after the effective date of this CIA, whichever is later. After receiving the initial training described above, each Covered Person shall receive at least one hour of general training annually.

2. *Specific Training.* Within 120 days of the effective date of this CIA, each Covered Person who is involved in the delivery of patient care items or services and/or in the preparation or submission of claims for reimbursement from any Federal health care program (hereinafter referred to as "Relevant Covered Persons") shall receive sufficient specific training in addition to the general training required above. This specific training shall include a discussion of the policies and procedures set forth in Section III.B.2 and:

a. the submission of accurate information (e.g., MDS, claims, bills, nursing hours, and cost reports) for services rendered to Federal health care program beneficiaries, including but not limited to, the requirements for an accurate clinical assessment, if relevant to the person's duties;

b. policies, procedures and other requirements applicable to the documentation of medical records;

c. the personal obligation of each individual involved in the billing process to ensure that such billings are accurate;

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d. applicable reimbursement statutes, regulations, and program requirements and directives, including, but not limited to, the requirement that accurate records for nursing hours spent with each patient be maintained;

e. the legal sanctions for improper billings; and

f. examples of proper and improper billing practices.

Persons providing the training must be knowledgeable about the subject area.

Relevant Covered Persons shall receive this training within 60 days of the beginning of their employment or becoming Relevant Covered Persons or within 120 days of the effective date of this CIA, whichever is later. A Covenant Care employee who has completed the specific training shall review a new Relevant Covered Person's work, to the extent that the work relates to the delivery of patient care items or services and/or in the preparation or submission of claims for reimbursement from any Federal health care program, until such time as the new Relevant Covered Person completes the applicable training.

After receiving the initial training described in this section, every Relevant Covered Person shall receive sufficient specific training on an annual basis.

3. *Certification.* Each individual who is required to attend training shall certify, in writing, that he or she has received the required training. The certification shall specify the type of training received and the date received. The Compliance Officer (or his or her designee) shall retain the certifications, along with all course materials. These shall be made available to the OIG, upon request.

D. Review Procedures.

1. *General Description.*

a. Retention of Independent Review Organization. Within 120 days of the effective date of this CIA, Covenant Care shall retain an entity (or entities), such as an accounting, auditing or consulting firm (hereinafter "Independent Review Organization" or "IRO"), to perform review engagements to assist Covenant Care in assessing and evaluating its billing, coding, and claims submission practices and its compliance obligations pursuant to this CIA and the

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Settlement Agreement. Each IRO retained by Covenant Care shall have expertise in the billing, coding, reporting and other requirements of the particular section of the health care industry pertaining to this CIA and in the general requirements of the Federal health care program(s) from which Covenant Care seeks reimbursement. Each IRO shall assess, along with Covenant Care, whether it can perform the IRO engagements in a professionally independent fashion taking into account any other business relationships or other engagements that may exist.

b. Types of Engagements. The Independent Review Organization(s) shall conduct two separate engagements. One engagement shall address Covenant Care's billing and coding to the Federal health care programs ("Billing Engagement"). The second engagement shall address Covenant Care's compliance with the obligations assumed under this CIA and the Settlement Agreement ("Compliance Engagement").

c. Frequency of Billing and Compliance Engagements. The Billing Engagement shall be performed annually and shall cover each of the one-year periods beginning with the effective date of this CIA. The IRO(s) shall perform all components of each annual Billing Engagement. The Compliance Engagement shall be performed by the IRO for the first one-year period beginning with the effective date of this CIA.

d. Retention of Records. The IRO and Covenant Care shall retain and make available to the OIG, upon request, all work papers, supporting documentation, correspondence, and draft reports (those exchanged between the IRO and Covenant Care), which include substantive changes, related to the engagements. The IRO shall retain and make available to the OIG, upon request, all supporting rationale for its findings.

2. *Billing Engagement.* The Billing Engagement shall be composed of two separate reviews, a "Claims Review" and a "Systems Review." The Claims Review and corresponding Claims Review Report are discussed in detail in Appendix A to this CIA, which is incorporated by reference.

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a. Claims Review. The IRO shall perform a Claims Review to identify any overpayments through an appraisal of Paid Claims submitted by Covenant Care to the Medicare program. The Claims Review shall be performed in accordance with the procedures set forth in Appendix A to this CIA.

b. Claims Review Report. The IRO shall prepare a report based upon each Claims Review performed ("Claims Review Report"). The Claims Review Report shall be created in accordance with the procedures set forth in Appendix A to this CIA.

c. Systems Review. The IRO shall perform process review at Covenant Care and those nursing facilities selected pursuant to Appendix A.4 for Covenant Care's claims, coding, billing and submission process and other compliance related activities (the "Systems Review"). The Systems Review shall include testing or verification of Covenant Care's systems, processes, and operations when required under the terms of this CIA. The Systems Review shall consist of a thorough review of the following:

i. Covenant Care's documentation, coding, billing and reporting operations relating to claims submitted to all Federal health care programs. As part of this review, the IRO is expected to evaluate the presence, application, and adequacy of:

(A) Covenant Care's billing and medical record documentation and coding process;

(B) Covenant Care's billing policies and procedures to ensure proper coding and billing;

(C) Covenant Care's internal controls to ensure accurate coding and claims submission;

(D) Covenant Care's reporting operations or mechanisms that ensure appropriate communication between Covenant Care and its fiscal intermediaries; and

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(E) corrective action plans to correct any inaccurate coding or billing.

ii. In the event the IRO identifies deficiencies in Covenant Care's medical record documentation, coding process, policies and procedures, internal controls, reporting mechanisms or corrective action plans (either through the Billing Engagement, Systems Review, or Compliance Review) which result, or could result, in inappropriate billing to the Federal health care programs, the IRO shall attempt to quantify any actual or potential underpayment or overpayment and shall make a report to Covenant Care (and to the OIG as described below) that shall include the IRO's recommendations to correct the identified deficiency. The IRO shall test the applicable Covenant Care system(s) to ensure the potential deficiency is not a systemic problem. Covenant Care shall correct any identified deficiency within 8 months of the discovery of the deficiency or provide the OIG with a reason why it cannot correct the deficiency within that time frame and verify that any identified deficiency is corrected. All findings regarding such deficiencies and correct action shall be reported in the Systems Review Report.

d. Systems Review Report. The IRO shall prepare a report based upon each Systems Review performed ("Systems Review Report"). The Systems Review Report shall include the IRO's findings and supporting rationale regarding:

i. any identified deficiencies in Covenant Care's medical record documentation, coding process, policies and procedures, internal controls, reporting mechanisms or corrective action plans;

ii. any weakness or potential weaknesses in Covenant Care's medical record documentation, coding process, policies and procedures, internal controls, reporting mechanisms or corrective action plans; and

iii. any recommendations the IRO may have to improve any of these systems, operations, or processes.

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3. *Compliance Engagement.*

a. Compliance Review. The IRO shall conduct a review of Covenant Care's compliance activities ("Compliance Review"). The Compliance Review shall consist of a review of Covenant Care's adherence to the obligations set forth in Sections I through VIII of this CIA, and a review of Covenant Care's compliance with certain provisions of the Settlement Agreement

i. CIA Obligations Review. The IRO shall assess and evaluate Covenant Care's compliance with the obligations set forth in each Section of this CIA.

ii. Unallowable Costs Review. The IRO shall determine whether Covenant Care has complied with its obligation not to charge to, or otherwise seek payment from, Federal or State payors for unallowable costs (as defined in the Settlement Agreement) and its obligation to identify to applicable Federal or State payors any unallowable costs included in payments previously sought from the United States, or any State Medicaid program. This unallowable cost analysis shall include, but not be limited to, payments sought in any cost reports, cost statements, information reports, or payment requests already submitted by Covenant Care or any of its subsidiaries, and to request, and agree, that such cost reports, cost statements, information reports or payment requests, even if already settled, be adjusted to account for the effect of the inclusion of the unallowable costs. In making this determination, the IRO may need to review cost reports and/or financial statements from the year in which of the Settlement Agreement was executed, as well as from previous years.

b. Compliance Review Report. The IRO shall prepare a report based upon the Compliance Review performed (the "Compliance Review Report"). The Compliance Review Report shall include:

i. the IRO's findings, supporting rationale, and a summary of such findings and rationale regarding Covenant Care's compliance with the terms of Sections I through VIII of the CIA, as applicable; and

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ii. the IRO's findings and supporting rationale regarding whether Covenant Care has complied with its obligation not to charge to, or otherwise seek payment from, Federal or State payors for unallowable costs (as defined in the Settlement Agreement) and its obligation to identify to applicable Federal or State payors any unallowable costs included in payments previously sought from such payor

4. *Validation Review.* In the event the OIG has reason to believe that: (a) Covenant Care's Billing or Compliance Engagement fails to conform to the requirements of this CIA; or (b) the findings or Claims Review results are inaccurate, the OIG may, at its sole discretion, conduct its own review to determine whether the Billing and Compliance Engagements comply with the requirements of the CIA and/or the findings or Claims Review results are inaccurate. Covenant Care agrees to pay for the reasonable cost of any such review performed by the OIG or any of its designated agents so long as it is initiated before one year after Covenant Care's final submission (as described in Section II) is received by the OIG.

Prior to initiating a Validation Review, the OIG shall notify Covenant Care of its intent to do so and provide an explanation for believing why such a review is necessary. In order to resolve any concerns raised by the OIG, Covenant Care may request a meeting with the OIG to discuss the results of any Engagement submissions or any Claims Review findings; present any additional or relevant information to clarify the results of the Engagements or to correct the inaccuracy of the Claims Review; and/or propose alternatives to the proposed Validation Review. Covenant Care agrees to provide any additional information as may be requested by the OIG under this section in an expedited manner. The OIG will attempt in good faith to resolve any Billing or Compliance Engagement and/or Claims Review issues with Covenant Care prior to conducting a Validation Review. However, the final determination as to whether or not to proceed with a Validation Review shall be made at the sole discretion of the OIG.

5. *Independence Certification.* Within 120 days from the effective date of this CIA, the IRO shall provide to Covenant Care a certification or sworn affidavit that it has evaluated its professional independence with regard to the Billing and Compliance Engagements and that it has concluded that it is, in fact, independent. Such certification shall be included in Covenant Care's Implementation Report submission.

E. Disclosure Program.

Covenant Care shall continue to maintain a Disclosure Program, that includes a mechanism (e.g., a toll-free compliance telephone line) to enable individuals to disclose,

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to the Compliance Officer or some other person who is not in the disclosing individual's chain of command, any identified issues or questions associated with Covenant Care's policies, conduct, practices, or procedures with respect to a Federal health care program, believed by the individual to be a potential violation of criminal, civil or administrative law. Covenant Care shall appropriately publicize the existence of the disclosure mechanism (e.g., via periodic e-mails to employees or by posting the information in prominent common areas).

The Disclosure Program shall continue to emphasize a non-retribution, non-retaliation policy, and shall include a reporting mechanism for anonymous, confidential communications. Upon receipt of a disclosure, the Compliance Officer (or designee) shall gather all relevant information from the disclosing individual. The Compliance Officer (or designee) shall make a preliminary, good faith inquiry into the allegations set forth in every disclosure to ensure that he or she has obtained all of the information necessary to determine whether a further review should be conducted. For any disclosure that is sufficiently specific so that it reasonably: (1) permits a determination of the appropriateness of the alleged improper practice; and (2) provides an opportunity for taking corrective action, Covenant Care shall conduct an internal review of the allegations set forth in such a disclosure and ensure that proper follow-up is conducted.

The Compliance Officer (or his or her designee) shall maintain a disclosure log, which shall include a record and summary of each disclosure received (whether anonymous or not), the status of the respective internal reviews, and any corrective action taken in response to the internal reviews. The disclosure log shall be available to the OIG, upon request.

F. Ineligible Persons.

1. *Definition.* For purposes of this CIA, an "Ineligible Person" shall be any individual or entity who: (a) is currently excluded, debarred or otherwise ineligible to participate in the Federal health care programs or in Federal procurement or non-procurement programs; or (b) has been convicted of a criminal offense that falls within the ambit of 42 U.S.C. § 1320a-7, but has not yet been excluded, debarred or otherwise declared ineligible.

2. *Screening Requirements.* Covenant Care shall not hire as employees or engage as contractors any Ineligible Person. To prevent hiring or contracting with any Ineligible Person, Covenant Care shall screen all prospective employees and prospective contractors prior to engaging their services by: (a) requiring applicants to disclose whether they are Ineligible Persons; and (b) reviewing the General Services Administration's List of Parties Excluded from Federal Programs (available through the

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Internet at http://epls.arnet.gov) and the HHS/OIG List of Excluded Individuals/Entities (available through the Internet at http://www.hhs.gov/oig) (these lists will hereinafter be referred to as the "Exclusion Lists").

3. *Review and Removal Requirement.* To the extent not already accomplished in the previous 120 days, within 120 days of the effective date of this CIA, Covenant Care shall review its list of current employees and contractors against the Exclusion Lists. Thereafter, Covenant Care shall review its list of current employees and contractors against the Exclusion Lists on an annual basis. In addition, Covenant Care shall require employees and contractors to disclose immediately any debarment, exclusion or other event that makes the employee an Ineligible Person.

If Covenant Care has notice that an employee or contractor has become an Ineligible Person, Covenant Care shall remove such person from responsibility for, or involvement with, Covenant Care's business operations related to the Federal health care programs and shall remove such person from any position for which the person's salary or the items or services rendered, ordered, or prescribed by the person are paid in whole or part, directly or indirectly, by Federal health care programs or otherwise with Federal funds at least until such time as the person is reinstated into participation in the Federal health care programs.

4. *Pending Charges and Proposed Exclusions.* If Covenant Care has notice that an employee or contractor is charged with a criminal offense related to any Federal health care program; or is proposed for exclusion during his or her employment or contract, the Covenant Care shall take all appropriate actions to ensure that the responsibilities of that employee or contractor have not and shall not adversely affect the quality of care rendered to any beneficiary, patient or resident, or the accuracy of any claims submitted to any Federal health care program.

G. Notification of Government Investigation or Legal Proceedings.

Within 60 days of discovery, Covenant Care shall notify the OIG, in writing, of any ongoing investigation or legal proceeding conducted or brought by a governmental entity or its agents involving an allegation that Covenant Care has committed a crime or has engaged in fraudulent activities. This notification shall include a description of the allegation, the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding. Covenant Care shall also provide written notice to the OIG within 60 days of the resolution of the matter, and shall provide the OIG with a description of the findings and/or results of the proceedings, if any.

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H. Reporting.

1. *Overpayments*

a. Definition of Overpayments. For purposes of this CIA, an "overpayment" shall mean the amount of money Covenant Care has received in excess of the amount due and payable under any Federal health care program requirements. Covenant Care may not subtract any underpayments for purposes of determining the amount of relevant "overpayments" for CIA reports.

b. Reporting of Overpayments. If, at any time, Covenant Care identifies or learns of any overpayments, Covenant Care shall notify the payor (e.g., Medicare fiscal intermediary or carrier) within 30 days of identification of the overpayment and take remedial steps within 60 days of discovery (or such additional time as may be agreed to by the payor) to correct the problem, including preventing the underlying problem and the overpayments from recurring. Also, within 30 days of identification of the overpayment, Covenant Care shall repay the overpayment to the appropriate payor to the extent such overpayment has been quantified. If not yet quantified, within 30 days of identification, Covenant Care shall notify the payor of its efforts to quantify the overpayment amount along with a schedule of when such work is expected to be completed. Notification and repayment to the contractor should be done in accordance with the contractor policies, and for Medicare contractors, must include the information contained on the Overpayment Refund Form, provided as Appendix B to this CIA. Notwithstanding the above, notification and repayment of any overpayment amount that routinely is reconciled or adjusted pursuant to policies and procedures established by the payor should be handled in accordance with such policies and procedures.

2. *Material Deficiencies.*

a. Definition of Material Deficiency. For purposes of this CIA, a "Material Deficiency" means anything that involves:

(i) a substantial overpayment;

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(ii) a matter that a reasonable person would consider a probable violation of criminal, civil, or administrative laws applicable to any Federal health care program for which penalties or exclusion may be authorized; or

(iii) a violation of the obligation to provide items or services of a quality that meets professionally recognized standards of health care where such violation has occurred in one or more instances and presents an imminent danger to the health, safety, or well-being of a Federal health care program beneficiary or places the beneficiary unnecessarily in high-risk situations.

A Material Deficiency may be the result of an isolated event or a series of occurrences.

b. Reporting of Material Deficiencies. If Covenant Care determines through any means that there is a Material Deficiency, Covenant Care shall notify the OIG, in writing, within 30 days of making the determination that the Material Deficiency exists. The report to the OIG shall include the following information:

(i) If the Material Deficiency results in an overpayment, the report to the OIG shall be made at the same time as the notification to the payor required in Section III.H.1, and shall include all of the information on the Overpayment Refund Form, as well as:

(A) the payor's name, address, and contact person to whom the overpayment was sent; and

(B) the date of the check and identification number (or electronic transaction number) on which the overpayment was repaid/refunded;

(ii) a complete description of the Material Deficiency, including the relevant facts, persons involved, and legal and Federal health care program authorities implicated;

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(iii) a description of Covenant Care's actions taken to correct the Material Deficiency; and

(iv) any further steps Covenant Care plans to take to address the Material Deficiency and prevent it from recurring.

IV. NEW BUSINESS UNITS OR LOCATIONS

In the event that, after the effective date of this CIA, Covenant Care changes locations or purchases or establishes new business units related to the furnishing of items or services that may be reimbursed by Federal health care programs, Covenant Care shall notify the OIG of this fact as soon as possible, but no later than within 30 days of the date of change of location, purchase or establishment. This notification shall include the location of the new operation(s), phone number, fax number, Medicare provider number(s) (if any), and the corresponding contractor's name and address that has issued each Medicare provider number. All Covered Persons at such locations shall be subject to the applicable requirements in this CIA (e.g., completing certifications and undergoing training).

V. IMPLEMENTATION AND ANNUAL REPORTS

A. Implementation Report. Within 120 days after the effective date of this CIA, Covenant Care shall submit a written report to the OIG summarizing the status of its implementation of the requirements of this CIA. This Implementation Report shall include:

1. the name, address, phone number, position description, and summary of other non-compliance job responsibilities of the Compliance Officer required by Section III.A;

2. the names and positions of the members of the Compliance Committee required by Section III.A;

3. a copy of Covenant Care's Code of Conduct required by Section III.B.1;

4. a copy of all compliance-related Policies and Procedures required by Section III.B.2 and a summary of all other Policies and Procedures required by Section III.B.2;

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5. a copy of all training materials used for the training required by Section III.C, a description of such training, including a description of the targeted audiences, length of sessions, which sessions were mandatory and for whom, percentage of attendance, and a schedule of when the training sessions were held;

6. a certification by the Compliance Officer that:

a. the Policies and Procedures required by Section III.B have been developed, are being implemented, and have been made available to all appropriate Covered Persons;

b. all Covered Persons have completed the Code of Conduct certification required by Section III.B.1; and

c. all Covered Persons have completed the applicable training and executed the certification(s) required by Section III.C.;

The documentation supporting this certification shall be available to the OIG, upon request.

7. a description of the Disclosure Program required by Section III.E;

8. the identity of the IRO(s), a summary/description of all engagements between Covenant Care and the IRO, including, but not limited to, any outside financial audits, compliance program engagements, or reimbursement consulting, and the proposed start and completion dates of the first annual review;

9. a certification from the IRO regarding its professional independence from the Covenant Care;

10. a summary of personnel actions (other than hiring) taken pursuant to Section III.F.;

11. a list of all of Covenant Care's locations (including locations and mailing addresses), the corresponding name under which each location is doing business, the corresponding phone numbers and fax numbers, each location's Medicare provider identification number(s) and the contractor's name and address that issued each provider identification number;

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12. to the extent not already furnished to the OIG, or if modified, a description of Covenant Care's corporate structure, including identification of any parent and sister companies, subsidiaries and their respective lines of business; and

13. the certification required by Section V.C.

B. Annual Reports. Covenant Care shall submit to the OIG Annual Reports with respect to the status of, and findings regarding, Covenant Care's compliance activities for each of the three one-year periods beginning on the effective date of the CIA. (The one-year period covered by each Annual Report shall be referred to as "the Reporting Period").

Each Annual Report shall include:

1. any change in the identity, position description, or other non-compliance job responsibilities of the Compliance Officer and any change in the membership of the Compliance Committee described in Section III.A;

2. a certification by the Compliance Officer that:

a. all Covered Persons have completed any Code of Conduct certifications required by Section III.B.1;

b. all Covered Persons have completed the applicable training and executed the certification(s) required by Section III.C;

c. Covenant Care has complied with its obligations under the Settlement Agreement: (i) not to resubmit to any Federal health care program payors any previously denied claims related to the Covered Conduct addressed in the Settlement Agreement, and not to appeal any such denials of claims; (ii) not to charge to or otherwise seek payment from Federal or State payors for unallowable costs (as defined in the Settlement Agreement); and (iii) to identify and adjust any past charges or claims for unallowable costs;

The documentation supporting this certification shall be available to the OIG, upon request.

3. a summary of any significant changes or amendments to the Policies and Procedures required by Section III.B and the reasons for such changes

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(e.g., change in contractor policy) and copies of any compliance-related Policies and Procedures;

4. a copy of all training materials used for the training required by Section III.C (to the extent it has not already been provided as part of the Implementation Report), a description of such training conducted during the Reporting Period, including a description of the targeted audiences, length of sessions, which sessions were mandatory and for whom, percentage of attendance, and a schedule of when the training sessions were held;

5. a complete copy of all reports prepared pursuant to the IRO's billing and compliance engagements, including a copy of the methodology used, along with a copy of the IRO's engagement letter;

6. Covenant Care's response and corrective action plan(s) related to any issues raised by the IRO(s);

7. a revised summary/description of all engagements between Covenant Care and the IRO, including, but not limited to, any outside financial audits, compliance program engagements, or reimbursement consulting, if different from what was submitted as part of the Implementation Report;

8. a summary of Material Deficiencies (as defined in III.H) identified during the Reporting Period and the status of any corrective and preventative action relating to all such Material Deficiencies;

9. a report of the aggregate overpayments that have been returned to the Federal health care programs. Overpayment amounts should be broken down into the following categories: inpatient Medicare, outpatient Medicare, Medicaid (report each applicable state separately) and other Federal health care programs;

10. a summary of the disclosures in the disclosure log required by Section III.E that: (a) relate to Federal health care programs; or (b) allege abuse or neglect of patients;

11. a description of any personnel actions (other than hiring) taken by Covenant Care as a result of the obligations in Section III.F, and the name, title, and responsibilities of any person that falls within the ambit of Section

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III.F.4, and the actions taken in response to the obligations set forth in that Section;

12. a summary describing any ongoing investigation or legal proceeding required to have been reported pursuant to Section III.G. The summary shall include a description of the allegation, the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding;

13. a description of all changes to the most recently provided list (as updated) of Covenant Care's locations (including locations and mailing addresses) as required by Section V.A.10, the corresponding name under which each location is doing business, the corresponding phone numbers and fax numbers, each location's Federal health care program provider identification number(s), and the contractor name and address that issued each provider identification number; and

14. the certification required by Section V.C.

The first Annual Report shall be received by the OIG no later than 120 days after the end of the first Reporting Period. Subsequent Annual Reports shall be received by the OIG no later than the anniversary date of the due date of the first Annual Report.

C. Certifications. The Implementation Report and Annual Reports shall include a certification by the Compliance Officer that: (1) except as otherwise described in the applicable report, Covenant Care is in compliance with all of the requirements of this CIA, to the best of his or her knowledge; and (2) the Compliance Officer has reviewed the Report and has made reasonable inquiry regarding its content and believes that the information is accurate and truthful.

D. Designation of Information: Covenant Care shall clearly identify any portions of its submissions that it believes are trade secrets, or information that is commercial or financial and privileged or confidential, and therefore potentially exempt from disclosure under the Freedom of Information Act ("FOIA"), 5 U.S.C. § 552. Covenant Care shall refrain from identifying any information as exempt from disclosure if that information does not meet the criteria for exemption from disclosure under FOIA.

VI. NOTIFICATIONS AND SUBMISSION OF REPORTS

Unless otherwise stated in writing after the effective date of this CIA, all notifications and reports required under this CIA shall be submitted to the following entities:

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OIG:

Civil Recoveries Branch - Compliance Unit
Office of Counsel to the Inspector General
Office of Inspector General
U.S. Department of Health and Human Services
Cohen Building, Room 5527
330 Independence Avenue, SW
Washington, DC 20201
Phone 202.619.2078
Fax 202.205.0604

Covenant Care:

Andrew F. Torok
General Counsel
27071 Aliso Creek Road
Suite 100
Aliso Viejo, California 92656
Phone 949.349.1244
Fax 949.349.1405

Unless otherwise specified, all notifications and reports required by this CIA may be made by certified mail, overnight mail, hand delivery or other means, provided that there is proof that such notification was received. For purposes of this requirement, internal facsimile confirmation sheets do not constitute proof of receipt.

VII. OIG INSPECTION, AUDIT AND REVIEW RIGHTS

In addition to any other rights the OIG may have by statute, regulation, or contract, the OIG or its duly authorized representative(s) may examine or request copies of Covenant Care's books, records, and other documents and supporting materials and/or conduct on-site reviews of any of Covenant Care's locations for the purpose of verifying and evaluating: (a) Covenant Care's compliance with the terms of this CIA; and (b) Covenant Care's compliance with the requirements of the Federal health care programs in which it participates. The documentation described above shall be made available by Covenant Care to the OIG or its duly authorized representative(s) at all reasonable times for inspection, audit or reproduction. Furthermore, for purposes of this provision, the OIG or its duly authorized representative(s) may interview any of Covenant Care's employees, contractors, or agents who consent to be interviewed at the individual's place of business during normal business hours or at such other place and time as may be mutually agreed upon between the individual and the OIG. Covenant Care agrees to assist the OIG or its duly authorized representative(s) in contacting and arranging

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interviews with such individuals upon the OIG's request. Covenant Care's employees may elect to be interviewed with or without a representative of Covenant Care present.

VIII. DOCUMENT AND RECORD RETENTION

Covenant Care shall maintain for inspection all documents and records relating to reimbursement from the Federal health care programs, or to compliance with this CIA, for six years (or longer if otherwise required by law).

IX. DISCLOSURES

Consistent with HHS's FOIA procedures, set forth in 45 C.F.R. Part 5, the OIG shall make a reasonable effort to notify Covenant Care prior to any release by the OIG of information submitted by Covenant Care pursuant to its obligations under this CIA and identified upon submission by Covenant Care as trade secrets, or information that is commercial or financial and privileged or confidential, under the FOIA rules. With respect to such releases, Covenant Care shall have the rights set forth at 45 C.F.R. § 5.65(d). Covenant Care shall refrain from identifying any information as exempt from release if that information does not meet the criteria for exemption from disclosure under FOIA.

X. BREACH AND DEFAULT PROVISIONS

Covenant Care is expected to fully and timely comply with all of its CIA obligations.

A. Stipulated Penalties for Failure to Comply with Certain Obligations. As a contractual remedy, Covenant Care and the OIG hereby agree that failure to comply with certain obligations set forth in this CIA may lead to the imposition of the following monetary penalties (hereinafter referred to as "Stipulated Penalties") in accordance with the following provisions. The OIG shall provide notice to Covenant Care when it has been found to be in non-compliance with the CIA. In its notice to Covenant Care, the OIG shall state the specific grounds for its determination that Covenant Care has failed to comply fully and adequately with the following provisions and the steps Covenant Care must take to comply with the CIA.

1. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day Covenant Care fails to have in place any of the obligations described in Section III:

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a. a Compliance Officer;

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b. a Compliance Committee;

c. a written Code of Conduct;

d. written Policies and Procedures;

e. a requirement that Covered Persons be trained; and

f. a Disclosure Program.

2. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day Covenant Care fails to retain an IRO, as required in Section III.D.

3. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day Covenant Care fails to meet any of the deadlines for the submission of the Implementation Report or the Annual Reports to the OIG.

4. A Stipulated Penalty of $2,000 (which shall begin to accrue on the date the failure to comply began) for each day Covenant Care employs or contracts with an Ineligible Person and that person: (i) has responsibility for, or involvement with, Covenant Care's business operations related to the Federal health care programs; or (ii) is in a position for which the person's salary or the items or services rendered, ordered, or prescribed by the person are paid in whole or part, directly or indirectly, by Federal health care programs or otherwise with Federal funds (the Stipulated Penalty described in this paragraph shall not be demanded for any time period during which Covenant Care can demonstrate that it did not discover the person's exclusion or other ineligibility after making a reasonable inquiry (as described in Section III.F) as to the status of the person).

5. A Stipulated Penalty of $1,500 for each day Covenant Care fails to grant access to the information or documentation as required in Section VII of this CIA. (This Stipulated Penalty shall begin to accrue on the date Covenant Care fails to grant access.)

6. A Stipulated Penalty of $1,000 for each day Covenant Care fails to comply fully and adequately with any obligation of this CIA. In its notice to Covenant Care, the OIG shall state the specific grounds for its determination that Covenant Care has failed to comply fully and adequately with the CIA obligation(s) at issue and steps Covenant Care must take to comply with the CIA. (This Stipulated Penalty shall begin to accrue 10 days after the date that the OIG provides notice to Covenant Care of the failure to comply.) A Stipulated Penalty as described in this paragraph shall not be demanded

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for any violation for which the OIG has sought a Stipulated Penalty under paragraphs 1-5 of this Section.

B. Timely Written Requests for Extensions. Covenant Care may, in advance of the due date, submit a timely written request for an extension of time to perform any act or file any notification or report required by this CIA. Notwithstanding any other provision in this Section, if the OIG grants the timely written request with respect to an act, notification, or report, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until one day after Covenant Care fails to meet the revised deadline set by the OIG. Notwithstanding any other provision in this Section, if the OIG denies such a timely written request, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until three business days after Covenant Care receives the OIG's written denial of such request or the original due date, whichever is later. A "timely written request" is defined as a request in writing received by the OIG at least five business days prior to the date by which any act is due to be performed or any notification or report is due to be filed.

C. Payment of Stipulated Penalties.

1. *Demand Letter.* Upon a finding that Covenant Care has failed to comply with any of the obligations described in Section X.A and after determining that Stipulated Penalties are appropriate, the OIG shall notify Covenant Care of: (a) Covenant Care's failure to comply; and (b) the OIG's exercise of its contractual right to demand payment of the Stipulated Penalties (this notification is hereinafter referred to as the "Demand Letter").

2. *Response to Demand Letter.* Within 10 days of the receipt of the Demand Letter, Covenant Care shall either: (a) cure the breach to the OIG's satisfaction and pay the applicable Stipulated Penalties; or (b) request a hearing before an HHS administrative law judge ("ALJ") to dispute the OIG's determination of noncompliance, pursuant to the agreed upon provisions set forth below in Section X.E. In the event Covenant Care elects to request an ALJ hearing, the Stipulated Penalties shall continue to accrue until Covenant Care cures, to the OIG's satisfaction, the alleged breach in dispute. Failure to respond to the Demand Letter in one of these two manners within the allowed time period shall be considered a material breach of this CIA and shall be grounds for exclusion under Section X.D.

3. *Form of Payment.* Payment of the Stipulated Penalties shall be made by Electronic Funds Transfer, and submitted to the OIG pursuant to the transmittal instructions received from the OIG.

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4. *Independence from Material Breach Determination.* Except as set forth in Section X.D.1.c, these provisions for payment of Stipulated Penalties shall not affect or otherwise set a standard for the OIG's decision that Covenant Care has materially breached this CIA, which decision shall be made at the OIG's discretion and shall be governed by the provisions in Section X.D, below.

D. Exclusion for Material Breach of this CIA

1. *Definition of Material Breach.* A material breach of this CIA means:

a. a failure by Covenant Care to report a material deficiency, take corrective action and make the appropriate refunds, as required in Section III.H;

b. a repeated or flagrant violation of the obligations under this CIA, including, but not limited to, the obligations addressed in Section X.A;

c. a failure to respond to a Demand Letter concerning the payment of Stipulated Penalties in accordance with Section X.C; or

d. a failure to retain and use an Independent Review Organization in accordance with Section III.D.

2. *Notice of Material Breach and Intent to Exclude.* The parties agree that a material breach of this CIA by Covenant Care constitutes an independent basis for Covenant Care's exclusion from participation in the Federal health care programs. Upon a determination by the OIG that Covenant Care has materially breached this CIA and that exclusion should be imposed, the OIG shall notify Covenant Care of: (a) Covenant Care's material breach; and (b) the OIG's intent to exercise its contractual right to impose exclusion (this notification is hereinafter referred to as the "Notice of Material Breach and Intent to Exclude"). The exclusion may be directed at the corporation, or one or more individual facilities, entities, or subsidiaries, depending upon the facts of the breach.

3. *Opportunity to Cure.* Covenant Care shall have 30 days from the date of receipt of the Notice of Material Breach and Intent to Exclude to demonstrate to the OIG's satisfaction that:

a. Covenant Care is in compliance with the obligations of the CIA cited by the OIG as being the basis for the material breach;

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b. the alleged material breach has been cured; or

c. the alleged material breach cannot be cured within the 30-day period, but that: (i) Covenant Care has begun to take action to cure the material breach; (ii) Covenant Care is pursuing such action with due diligence; and (iii) Covenant Care has provided to the OIG a reasonable timetable for curing the material breach.

4. *Exclusion Letter.* If at the conclusion of the 30-day period, Covenant Care fails to satisfy the requirements of Section X.D.3, the OIG may exclude Covenant Care from participation in the Federal health care programs. The OIG will notify Covenant Care in writing of its determination to exclude Covenant Care (this letter shall be referred to hereinafter as the "Exclusion Letter"). Subject to the Dispute Resolution provisions in Section X.E, below, the exclusion shall go into effect 30 days after the date of the Exclusion Letter. The exclusion shall have national effect and shall also apply to all other Federal procurement and non-procurement programs. Reinstatement to program participation is not automatic. If at the end of the period of exclusion, Covenant Care wishes to apply for reinstatement, Covenant Care must submit a written request for reinstatement in accordance with the provisions at 42 C.F.R. §§ 1001.3001-.3004.

E. Dispute Resolution

1. *Review Rights.* Upon the OIG's delivery to Covenant Care of its Demand Letter or of its Exclusion Letter, and as an agreed-upon contractual remedy for the resolution of disputes arising under this CIA, Covenant Care shall be afforded certain review rights comparable to the ones that are provided in 42 U.S.C. § 1320a-7(f) and 42 C.F.R. Part 1005 as if they applied to the Stipulated Penalties or exclusion sought pursuant to this CIA. Specifically, the OIG's determination to demand payment of Stipulated Penalties or to seek exclusion shall be subject to review by an HHS ALJ and, in the event of an appeal, the HHS Departmental Appeals Board ("DAB"), in a manner consistent with the provisions in 42 C.F.R. §§ 1005.2-1005.21. Notwithstanding the language in 42 C.F.R. § 1005.2(c), the request for a hearing involving Stipulated Penalties shall be made within 10 days of the receipt of the Demand Letter and the request for a hearing involving exclusion shall be made within 25 days of receipt of the Exclusion Letter.

2. *Stipulated Penalties Review.* Notwithstanding any provision of Title 42 of the United States Code or Chapter 42 of the Code of Federal Regulations, the only issues in a proceeding for Stipulated Penalties under this CIA shall be: (a) whether Covenant Care was in full and timely compliance with the obligations of this CIA for which the OIG demands payment; and (b) the period of noncompliance. Covenant Care

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shall have the burden of proving its full and timely compliance and the steps taken to cure the noncompliance, if any. If the ALJ agrees with the OIG with regard to a finding of a breach of this CIA and orders Covenant Care to pay Stipulated Penalties, such Stipulated Penalties shall become due and payable 20 days after the ALJ issues such a decision unless Covenant Care requests review of the ALJ decision by the DAB. If the ALJ decision is properly appealed to the DAB and the DAB upholds the determination of the OIG, the Stipulated Penalties shall become due and payable 20 days after the DAB issues its decision.

3. *Exclusion Review.* Notwithstanding any provision of Title 42 of the United States Code or Chapter 42 of the Code of Federal Regulations, the only issues in a proceeding for exclusion based on a material breach of this CIA shall be:

a. whether Covenant Care was in material breach of this CIA;

b. whether such breach was continuing on the date of the Exclusion Letter; and

c. whether the alleged material breach could not have been cured within the 30 day period, but that:

(i) Covenant Care had begun to take action to cure the material breach within that period;

(ii) Covenant Care has pursued and is pursuing such action with due diligence; and

(iii) Covenant Care provided to the OIG within that period a reasonable timetable for curing the material breach and Covenant Care has followed the timetable.

For purposes of the exclusion herein, exclusion shall take effect only after an ALJ decision favorable to the OIG, or, if the ALJ rules for the Covenant Care, only after a DAB decision in favor of the OIG. Covenant Care's election of its contractual right to appeal to the DAB shall not abrogate the OIG's authority to exclude Covenant Care upon the issuance of an ALJ's decision in favor of the OIG. If the ALJ sustains the determination of the OIG and determines that exclusion is authorized, such exclusion shall take effect 20 days after the ALJ issues such a decision, notwithstanding that Covenant Care may request review of the ALJ decision by the DAB. If the DAB finds in favor of the OIG after an ALJ decision adverse to the OIG, the exclusion shall take effect

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20 days after the DAB decision. Covenant Care agrees to waive its right to any notice of such an exclusion if a decision upholding the exclusion is rendered by the ALJ or DAB.

XI. EFFECTIVE AND BINDING AGREEMENT

Consistent with the provisions in the Settlement Agreement pursuant to which this CIA is entered, and into which this CIA is incorporated, Covenant Care and the OIG agree as follows:

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

B. This CIA shall become final and binding on the date the final signature is obtained on the CIA;

C. Any modifications to this CIA shall be made with the prior written consent of the parties to this CIA;

D. The OIG may agree to a suspension of Covenant Care's obligations under the CIA in the event of Covenant Care's cessation of participation in Federal health care programs. If Covenant Care withdraws from participation in Federal health care programs and is relieved from its CIA obligations by the OIG, Covenant Care agrees to notify the OIG 30 days in advance of Covenant Care's intent to reapply as a participating provider or supplier with the Federal health care programs. Upon receipt of such notification, the OIG will evaluate whether the CIA should be reactivated or modified.

E. The undersigned Covenant Care signatories represent and warrant that they are authorized to execute this CIA. The undersigned OIG signatory represents that he is signing this CIA in his official capacity and that he is authorized to execute this CIA.

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ON BEHALF OF COVENANT CARE

Robert A. Levin
President and CEO
Covenant Care

10/15/01
DATE

Judith A. Waltz
Counsel for Covenant Care
Foley & Lardner
One Maritme Plaza, Sixth floor
San Francisco, California 9411-3404

10/18/01
DATE

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

J Morris

LEWIS MORRIS
Assistant Inspector General for Legal Affairs
Office of Inspector General
U. S. Department of Health and Human Services

10/22/01
DATE

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APPENDIX A

MINIMUM DATA SET AUDIT GUIDELINES

A. General

1. The IRO shall conduct Minimum Data Set ("MDS") Audits pursuant to the schedule set forth herein. The IRO shall review paid Medicare Part A claims from Covenant Care's nursing facilities and shall focus on the MDS.

2. The MDS Audit shall consist of a variable appraisal sample (dollar amount in error). For purposes of determining dollar amounts associated with errors, the final sampling unit shall be a single UB-92 bill and all associated MDS information on the UB-92 bill shall be reviewed.

3. The audit period for the first year MDS Audits shall be begin on the Effective Date of the CIA and will end with the date the MDS Audit begins for each respective Claim Pool (as identified in the annual facility selection methodology of Section A.4. of this Appendix (the "Audit Period")). The Audit Period for each subsequent MDS Audit shall begin at the end of the preceding year's Audit Period for each Claim Pool and shall end 12 months later. For the first MDS Audit, the universe from which the IRO will randomly select the UB-92 bills to review will include those UB-92s that were paid and have a date of service during the relevant Audit Period. For the remaining MDS Audits, the universe from which the IRO will randomly select the UB-92 bills to review will include those UB-92s that were paid during the relevant Audit Period.

4. Each year, Covenant Care shall engage an IRO to conduct probe samples at 10% of all the nursing facilities that fell within the ambit of the definition of Covenant Care in Section I.1 of the CIA for at least three months of the previous 12 month review period. Each year, they shall be randomly selected through the use of RATS-STATS. After the first Audit Period, the facilities previously reviewed shall be excluded from the Audit Pool, except that one of the facilities shall be randomly selected from the

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Audit Pool of those facilities previously reviewed. Each facility and entity will be considered a separate universe for purposes of conducting the claims reviews set forth herein.

5. Covenant Care shall retain copies of all work papers, supporting documentation, correspondence and draft reports, if any, (those exchanged between the IRO and Covenant Care), which include substantive changes, used or created in connection with the MDS Audits and shall make such information available to the OIG upon request. The IRO shall retain and make available to the OIG, upon request, all supporting rationale for its findings.

6. If Covenant Care becomes aware that any facility (including those not selected to be included as part of an annual MDS Audit) is potentially experiencing non-compliance with the Federal health care program requirements for claims submissions, Covenant Care shall, after reasonably determining whether further review is warranted, in addition to its other CIA obligations, conduct a review of the potential area of non-compliance. If warranted, Covenant Care shall develop a corrective action plan and conduct appropriate follow-up to ensure that any inappropriate or improper practice(s) related to claims submission is appropriately addressed. All such instances of inappropriate or improper claims submission, regardless of whether the facility was selected in the MDS Audit, shall be reported to the OIG, pursuant to Section III.H. of this CIA.

7. Consistent with the definition of Overpayment as articulated in Section III.H.1. of the CIA, an Overpayment is the amount of money Covenant Care has received in excess of the amount due and payable under any Federal health care program requirements. For the purposes of the MDS Audit and all reporting to the OIG under this CIA, Covenant Care shall not subtract or "net out" underpayments when determining the amount of relevant Overpayments. Notwithstanding the above, notification and repayment of any overpayment amount that routinely is reconciled or adjusted pursuant to policies and procedures established by the payor should be handled in accordance with such policies and procedures.

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B. Stage 1 of the MDS Audit

1. Conducting the probe sample audit.

a. A statistically valid random sample of a minimum of 30 UB-92s shall be selected, using RAT-STATS, from each facility selected for review. If the reviewer chooses to stratify the probe sample, the strata shall be determined prior to selecting the random sample of UB-92s and an explanation of how the strata was determined shall be included in the MDS Audit Report.

b. For both the probe and full sample MDS Audits, the IRO shall perform the following steps:

i. For the first year reviews, the IRO shall obtain a computer download of the total Medicare Part A paid claims that had dates of service during the Audit Period for each of Covenant Care's randomly selected nursing facilities (if a computer download is not available, then a computer-generated printout can be used). For subsequent year reviews, the IRO shall obtain a computer download of the total Medicare Part A paid claims for each randomly selected facility;

ii. The IRO shall identify the universe of paid UB-92s for each nursing facility in the audit year in accordance with Section A.3 of this Appendix. Based on the results of the probe sample, the IRO shall select a sufficient number of sampling units to meet the parameters of Section C.1.b. of this Appendix from each nursing facility's total Medicare Part A claims population for the full sample; and

iii. The IRO shall notify each nursing facility of the paid UB-92s that were selected for review. The IRO shall obtain all appropriate medical records, billing and related supporting documentation. If Covenant Care cannot produce the medical records or any other supporting documentation necessary to make an accurate claim determination, the IRO shall consider the relevant portion of the UB-92 which lacks proper documentation to be billed in error.

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c. The probe sample, as a whole, shall not be used as part of the full sample during Stage 2 of the MDS Audit. The UB-92s reviewed in the probe sample shall be included in the universe from which the full sample is selected so that all UB-92s have an equal chance of selection in the full sample.

d. The dollar difference (i.e. the amount that was paid versus the amount that should have been paid) will be determined for each UB-92. Any underpayment identified in the probe sample shall be treated as a "zero" Overpayment. This dollar difference amount shall be the variable input into RAT-STATS to determine the full sample size.

e. The results of the probe sample (dollar difference) shall be used to identify nursing facilities that have exceeded a designated financial error rate and to determine the appropriate sample sizes for the full sample MDS Audits, when applicable. The reviewer shall input the dollar difference results of the probe sample into RAT-STATS in order to determine the full sample size.

f. If the financial error rate (i.e. total dollars identified as overpaid in the probe sample divided by total dollars paid to the facility based on the UB-92s selected in the probe sample) does not exceed the 5% threshold, the facility shall refund all identified Overpayments to the appropriate payor. If the financial error rate exceeds the 5% threshold, a full sample will be evaluated for that facility.

2. *Selection of facilities for Stage 2 of the MDS Audit.*

a. The IRO shall conduct Stage 2 of the MDS Audit for each individual nursing facility selected as part of the probe sample for which the financial error rate in Stage 1 was greater than 5%.

b. The 5% financial error threshold only applies to criteria for sample expansion, not for extrapolation of an error rate. If the financial error rate exceeds 5%, the universe shall be comprised of all sampling units for that facility, including those sampling units that were selected as part of the probe.

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C. **Stage 2 of the MDS Audit**

1. *Selecting the full sample.*

a. Stage 2 shall consist of reviewing a full sample of UB-92s that have been randomly selected from the applicable Audit Period using RAT-STATS.

b. The full sample shall contain a sufficient number of sampling units to generate results that provide, at a minimum, a 90% confidence interval and a maximum precision (relative precision i.e., semi-width of the confidence interval) of plus or minus 25% of the point estimate (i.e., the upper and lower bounds of the 90% confidence interval shall not exceed 125% and shall not fall below 75% of the midpoint of the confidence interval, respectively).

2. *Conducting the claims review.*

a. The IRO shall develop the necessary MDS Audit tools and execute the appropriate sampling methodology.

b. For each UB-92 selected in Stage 1 and Stage 2, the IRO shall review the MDS and the medical record documentation supporting the MDS. The review process shall entail an evaluation of the MDS and verification that each entry that affects the RUG code outcome for the MDS is supported by the medical record for the corresponding period of time consistent with the assessment reference date ("ARD") specified on the MDS.

c. The IRO shall perform the steps identified in Section B.1.b of this Appendix.

d. The IRO shall perform an evaluation of the data on the UB-92 and determine whether the variables that affect the RUG assignment outcome for the MDS are supported by the medical record for the corresponding time period consistent with the assessment reference date specified in the MDS. This shall include the following issues:

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i. The accuracy of the MDS coding and the resulting RUG category selection based on the documentation within the medical record. The review of the MDS and related documentation shall include the following:

- assessment reference date for accuracy;
- activities of daily living and the look-back period used;
- special treatments and procedures along with the look-back periods;
- nursing restorative with look-back periods;
- supplement for PPS with look-back periods used (e.g., estimated therapies and minutes for the 5-Day MDS); and
- resulting RUG category.

ii. The demonstration of medical necessity in the medical record by verifying the presence of physician orders for the services reflected as necessary in the MDS;

iii. The accuracy of the associated UB-92s. At a minimum these claims shall be reviewed for the following:

- coverage period;
- revenue codes;
- HIPPS codes (RUG categories and the modifiers for assessment type); and
- Units of service.

e. In those cases where an incorrect MDS has been identified, the IRO shall re-enter data from that MDS into Covenant Care's or the IRO's grouper software to verify that the correct RUG code assignment was properly assigned on the UB-92. If an incorrect RUG code was assigned, this shall be considered an error.

f. If there is insufficient support for an MDS data point(s) that results in a downward change in RUG assignment, the IRO should consider the dollar difference to be an Overpayment.

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g. If an incorrect RUG was used, but it did not result in an Overpayment, it will be noted in the Audit Report.

D. MDS Audit Report. The following information shall be included for each MDS Audit in the MDS Audit Report:

1. MDS Audit Methodology

a. MDS Audit Objective: A clear statement of the objective intended to be achieved by the MDS Audit.

b. Sampling Unit: A description of the Item, as that term is utilized for the MDS Audit. In accordance with Section A.2 of this Appendix, the sampling unit for the first year shall be paid UB92s with a date of service during the relevant Audit Period. For the remaining years, the sampling unit shall be paid UB-92s during the relevant Audit Period.

c. MDS Audit Population: A description of the Population subject to the MDS Audit.

d. Sampling Frame: A description of the sampling frame, which is the totality of Items from which the probe and full sample have been selected and an explanation of the methodology used to identify the sampling frame. In most circumstances, the sampling frame will be identical to the Population.

e. Sources of Data: A description of the documentation relied upon by the IRO when performing the MDS Audit (e.g., medical records, physician orders, certificates of medical necessity, requisition forms, local medical review policies, HCFA program memoranda, Medicare carrier or intermediary manual or bulletins, other policies, regulations, or directives).

f. Review Protocol: A narrative description of how the MDS Audit was conducted and what was evaluated.

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2. *Statistical Sampling Documentation*

a. The number of sampling units appraised in each probe sample and in each full sample.

b. A copy of all RAT-STATS printouts of the random numbers generated by the "Random Numbers" function.

c. A copy of all RAT-STATS printouts of the "Sample Size Estimators" results used to calculate the minimum number of Items for inclusion in the full samples.

d. A copy of all RAT-STATS printouts of the "Variable Appraisals," "Difference Values Only" function results for each Probe Sample, including a copy of the data files.

e. The Sampling Frame used in the probe sample(s) and full samples will be available to the OIG upon request.

3. *MDS Audit Results*

a. For each MDS Audit, the total number and percentage of instances in which the IRO determined that the paid UB-92s submitted by Covenant Care and reimbursed by the fiscal intermediary differed from what should have been submitted by Covenant Care and reimbursed by the fiscal intermediary (the "Correct UB-92"), regardless of the effect on the payment.

b. For each MDS Audit, the total number and percentage of instances in which the UB-92 submitted differed from the Correct UB-92 and in which such difference resulted in an Overpayment to Covenant Care.

c. For each MDS Audit, the total dollar amount of all paid claims in the MDS Audit Sample and the total dollar amount of Overpayments associated with the paid claims identified by the MDS Audit. (This is the total dollar amount of the Overpayments identified in Section D.3.b above.) The IRO may identify underpayments, but any underpayments identified during the MDS Audit shall not be offset or "netted out" of the total dollar amount of paid claims or of the

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Overpayments when reporting these amounts in the MDS Audit Report to the OIG.

d. The level of precision achieved by the MDS Audit at a 90% confidence level.

e. A spreadsheet of the MDS Audit results (for both the probe and full samples) that includes the following information for each paid claim appraised: Federal health care program billed, beneficiary health insurance claim number, date of service, MDS procedure code submitted (this will help with verification of MDS questions that affect the RUG class (i.e., therapy days/time, activities of daily living score)), procedure code reimbursed, allowed amount reimbursed by payor, correct procedure code (as determined by the IRO), correct allowed amount (as determined by the IRO), dollar difference between allowed amount reimbursed by payor and the correct allowed amount.

4. *Credentials.* The names and credentials of the individuals who: (1) designed the statistical sampling procedures and the review methodology utilized for the MDS Audit; and (2) performed the MDS Audit.

E. Annual Report

Covenant Care and IRO shall report the findings from all of the MDS Audits (the "MDS Audit Report") described above as part of its Annual Report. The OIG may obtain documentation from the IRO and Covenant Care regarding the work that has been performed on these audits, to assist the OIG in determining the appropriateness of the findings.

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Appendix B

OVERPAYMENT REFUND FORM

TO BE COMPLETED BY MEDICARE CONTRACTOR

Date: _____

Contractor Deposit Control # _____ Date of Deposit: _____

Contractor Contact Name: _____ Phone # _____

Contractor Address: _____

Contractor Fax: _____

TO BE COMPLETED BY PROVIDER/PHYSICIAN/SUPPLIER

Please complete and forward to Medicare Contractor. This form, or a similar document containing the following information, should accompany every voluntary refund so that receipt of check is properly recorded and applied.

PROVIDER/PHYSICIAN/SUPPLIERNAME _____

ADDRESS _____

PROVIDER/PHYSICIAN/SUPPLIER # _____ CHECK NUMBER# _____

CONTACT PERSON: _____ PHONE # _____

AMOUNT OF CHECK $ _____ CHECK DATE _____

REFUND INFORMATION

For each Claim, provide the following:

Patient Name _____ HIC # _____

Medicare Claim Number _____ Claim Amount Refunded $ _____

Reason Code for Claim Adjustment: _____ (Select reason code from list below. Use one reason per claim)

(Please list all claim numbers involved. Attach separate sheet, if necessary)

Note: If Specific Patient/HIC/Claim #/Claim Amount data not available for all claims due to Statistical Sampling, please indicate methodology and formula used to determine amount and reason for overpayment: _____

For Institutional Facilities Only:

Cost Report Year(s) _____

(If multiple cost report years are involved, provide a breakdown by amount and corresponding cost report year.)

For OIG Reporting Requirements:

Do you have a Corporate Integrity Agreement with OIG? _____ Yes _____ No

Reason Codes:

Billing/Clerical Error	MSP/Other Payer Involvement	Miscellaneous
01 - Corrected Date of Service	08 - MSP Group Health Plan Insurance	13 - Insufficient Documentation
02 - Duplicate	09 - MSP No Fault Insurance	14 - Patient Enrolled in an HMO
03 - Corrected CPT Code	10 - MSP Liability Insurance	15 - Services Not Rendered
04 - Not Our Patient(s)	11 - MSP, Workers Comp.(Including Black Lung	16 - Medical Necessity
05 - Modifier Added/Removed	12 - Veterans Administration	17 - Other (Please Specify)
06 - Billed in Error		_____
07 - Corrected CPT Code		

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