Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

The Massachusetts League of Community Health Centers, Inc.

Corporate Compliance Manual

Developed: **August 2026**	Implemented: **September 2026**	Revised:

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

Massachusetts League
of Community Health Centers

Massachusetts League
of Community Health Centers

Table of Contents

Introduction ..... - 5 -

Corporate Compliance Program Elements ..... - 6 -

Scope ..... - 6 -

Compliance Reporting and Whistleblower Protections ..... - 7 -

Effective Lines of Communication ..... - 7 -

Public Promotion of the Compliance Program ..... - 8 -

Investigations and Reported Incident Response Protocol ..... - 8 -

Code of Conduct ..... - 10 -

Conflict of Interest ..... - 11 -

Compliance with Laws & Regulations ..... - 11 -

Non-Harassment and Anti-Discrimination ..... - 12 -

Non-Harassment ..... - 12 -

Anti-Discrimination ..... - 13 -

Fraud, Waste, & Abuse ..... - 13 -

Purpose: ..... - 13 -

Definitions: ..... - 14 -

Preventing and Detecting Fraud, Waste, and Abuse ..... - 14 -

Reporting of Fraud, Waste, and Abuse ..... - 14 -

Corrective and Preventive Actions ..... - 14 -

Privacy & Security ..... - 15 -

Cybersecurity ..... - 15 -

Mandatory Compliance Education and Training ..... - 16 -

Research Compliance ..... - 17 -

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

MLCHC and Institute for Health Equity (IHE) Research Compliance Program ..... - 17 -

Documentation and Record Keeping ..... - 23 -

Lobbying ..... - 24 -

Purpose ..... - 24 -

Definitions ..... - 24 -

Federal and State Laws ..... **Error! Bookmark not defined.**

Federal Lobbying..... - 24 -

State Lobbying..... - 25 -

Monitoring and Reporting ..... - 25 -

Grants Management ..... - 26 -

Purpose ..... - 26 -

Federal Grant Funds ..... - 26 -

State Grant Funds ..... - 26 -

Municipal Grant Funds..... - 26 -

Contracts, Procurement, Group Purchasing ..... - 26 -

Contract Management ..... - 27 -

Procurement..... - 27 -

Financial Controls ..... - 27 -

The State Loan Repayment Program (SLRP) helps HRSA provide grant funding for states and territories to operate their own loan repayment programs. Through SLRP, each state and territory can design programs that address the most pressing health care needs of their residents. Primary medical, mental/behavioral, and dental clinicians who receive awards through SLRP-funded programs pay off their student debt in exchange for working in areas with provider shortages..... - 28 -

In addition to the MLCHC's WISP policy, the MLCHC must also comply with certain standards, policies, and application requirements pursuant to its participation in the SLRP. These minimum standards for compliance have been promulgated by the Executive Office of Technology Services and Security (EOTSS), in accordance with M.G.L. c. 7D, § 2, and may be found here: Enterprise Information Security Policies and Standards | Mass.gov. ..... - 28 -

CommonWealth Purchasing Group (CPG)..... - 28 -

Human Resources ..... - 29 -

Pay Equity & Transparency..... - 29 -

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

Salary Survey ..... - 30 -

Benefits (Insurance- Health, Dental, Leave Insurance- Short Term/Long Term disability) ..... - 30 -

Commonwealth Search Partners, LLC ("CSP") ..... - 31 -

Enterprise Risk Management ..... - 32 -

Liability Risk Insurance ..... - 33 -

Contractual Exposure ..... - 33 -

Periodic Review and Program Improvement- Standards Relating to Governance ..... - 33 -

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

Introduction

The Massachusetts League of Community Health Centers ("MLCHC") was founded in 1972 as one of the first state Primary Care Associations (PCAs) in the country. Established under the same federal authorizing legislation as the health center program (Section 330 of the Public Health Service Act), PCAs are organized around a set of core functions and competencies that provide a framework for support and assistance to health centers and the communities they serve. As such, the MLCHC is a nonprofit 501(c)(3) organization registered as a public charity with the Commonwealth's Secretary of State and maintains a professional staff at its headquarters in Boston and at its training center in Worcester.

The MLCHC provides training, technical assistance, and advocacy for Massachusetts Community Health Centers ("CHCs"), and is dedicated to maintaining the highest ethical standards while maintaining strict adherence to federal, state, and local laws, rules, and regulations applicable to our operations. It is required that all personnel cooperate fully with the Compliance program. As healthcare is a highly regulated industry, we must monitor compliance with a wide variety of complex rules that affect our or our members' day-to-day activities.

The MLCHC has designed and implemented a comprehensive Corporate Compliance Manual (Manual) that outlines the compliance framework that all personnel, and where applicable, members of the Board or committees, and independent contractors are expected to follow. The Manual applies to the MLCHC and its wholly-owned subsidiaries Commonwealth Purchasing Group, LLC (CPG), Commonwealth Search Partners (CSP), and the Institute for Health Equity Research, Evaluation & Policy, Inc. (IHE), unless otherwise specified.

The Manual serves as a roadmap to the Compliance Program with references to policies, standard operating procedure documents, and other documents, as appropriate, and contains tools that help us achieve our mission while ensuring adherence to applicable federal, state, and local laws. All individuals who work for the MLCHC or its subsidiaries have a responsibility to ensure they understand the policies and procedures that apply to their role and their department's operations. An effective compliance program cannot be successful without everyone's cooperation, and the first step is careful reading and understanding of the concepts outlined in this Manual.

Please note, the Manual is a compliance roadmap, not a policy, and there are policies and procedures outside of this document that you will be expected to follow. If you have questions about a particular situation, you must contact your supervisor or the Director of Compliance.

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

Corporate Compliance Program Elements

The purpose of the MLCHC's compliance program is to provide a compliance framework that ensures ethical behavior, understanding of personal responsibility and details regarding compliance expectations. The Manual establishes a corporate compliance framework that is consistent with the guidance of the United States Department of Health & Human Services Office of Inspector General Compliance Program Guidance, the U.S. Department of Justice Criminal Division Evaluation of Corporate Compliance Program guidance, and the Comptroller General of the United States Standards for Internal Control in the Federal Government. All MLCHC personnel are responsible for ethical and legal compliance applicable to their duties and must take steps to comply with the policies and procedures referenced herein. The Manual is not intended to set forth all the substantive operating procedures, policies, practices, or professional expectations of MLCHC, but rather it is designed to outline foundational expectations in relation to the MLCHC's activities.

MLCHC Corporate Compliance Program elements:

1. Formal Policies
2. The Appointment of a Chief Compliance Officer accountable directly to the Compliance Committee and the Board of Directors
3. The establishment of a Compliance Committee
4. Mandatory Compliance Education and Training
5. Effective Lines of Communication
6. Regulatory Filings
7. Disciplinary Standards
8. A System for Routine Monitoring and Identification of Compliance Risk Areas
9. Policy of Non-Intimidation and Non-Retaliation for Good faith participation in reporting potential compliance violations or otherwise participating in any activities under the Compliance Program

Scope

This Manual applies to the MLCHC, CPG, CSP, and the IHE, together with their respective Board of Directors, advisory boards, committees, officers, employees, agents, independent contractors, and volunteers. Sometimes the Manual may refer to the MLCHC, CPG, CSP, and the IHE collectively as "the MLCHC and subsidiaries."

1. CommonWealth Purchasing Group (CPG): a wholly-owned limited liability company subsidiary of the MLCHC with the MLCHC as its sole member and manager. CPG is a group purchasing organization for community health centers and health care organizations. CPG's operations are governed by the Anti-Kickback Statute, 42 USC 1320a-7b, the Group Purchasing Regulations at 42 CFR 1001 *et seq.,* the False Claims

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

Act, and other federal and state laws. More information on CPG's compliance expectations can be found on p. 17 of this Manual.

2. The Institute for Health Equity Research, Evaluation, and Policy, Inc. (IHE) is a 501(c)(3) non-profit organization designed to support emancipatory research driven by community health centers. The IHE convenes communities and supports the scientific infrastructure, implementation, program evaluation, and training needed to identify and sustain the most effective strategies for attaining equity in health and health care as defined by those with lived experience of health inequities.
3. CommonWealth Search Partners (CSP) is a recently established wholly-owned subsidiary of the MLCHC, with the MLCHC as its sole member and manager. CSP is an executive search firm focusing on assisting Massachusetts health centers with finding and recruiting highly qualified candidates for senior and executive level positions. CSP's operations are regulated by the Massachusetts Department of Labor Standards.

All MLCHC, CPG, IHE, and CSP employees, officers, directors, consultants, affiliates, and others to whom this Manual applies are responsible for ensuring that they understand this Manual and the policies and procedures that apply to their role. Conduct that does not conform to the requirements of this Manual or applicable policies will be subject to discipline.

Compliance Reporting and Whistleblower Protections

The MLCHC strives to ensure that compliance concerns reported through any of the many communication channels are carefully reviewed, thoroughly and thoughtfully investigated, and reasonably, timely and appropriately resolved. All staff must abide by the Compliance Program and report suspected misconduct, potential violations of Federal or State law, violations of the Compliance Program or MLCHC policies, and other compliance-related concerns. As part of its commitment to ethical and legal conduct, the MLCHC expects its employees to bring to management's attention all information about any ethical, financial or legal concerns about the MLCHC or about known or reasonably suspected violations of this commitment by other individuals. This standard is intended to ensure that employees of the MLCHC are encouraged to report any ethical or legal concerns without fear of reprisal or retaliation. Further information can be found in the Employee Handbook, Section 2-13 "Internal Reporting and Anti-Retaliation Standard."

Effective Lines of Communication

The MLCHC has established and implemented effective lines of communication, ensuring confidentiality, to the Chief Compliance Officer, Director of Corporate Compliance and Risk Management, Human Resources, managers, the Compliance Committee, and the Board. Staff may report suspected misconduct, potential violations of Federal or State law, violations of the Compliance Program, and other compliance-related concerns to the Chief Compliance Officer,

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

the Director of Corporate Compliance & Risk Management, the Compliance Hotline ("Hotline"), their supervisor, their Program Administrator, or to management.

MLCHC staff may report anonymously by calling the Hotline. For all reports, the reporting person's identity will remain confidential, whether requested or not, unless the matter is subject to a disciplinary proceeding, referred to or under Federal or State investigation, referred to law enforcement, or if disclosure is a requirement in connection with a legal proceeding or otherwise disclosure is required by law.

You may report through the following mechanisms:

Type	Contact Information
Personnel Matters	Human Resources: humanresources@massleague.org Shavon Andrews: sandrews@massleague.org
Noncompliance with MLCHC Manual and Policies	Danielle Martin-Joseph, Director of Corporate Compliance & Risk Management: dmartin-joseph@massleague.org
Anonymous Reporting	*[This information will be added once the Compliance Hotline implementation is finalized]*

Human Resources and/or the Director of Corporate Compliance may reach out to you with questions related to your inquiry or ask for additional information.

Public Promotion of the Compliance Program

The MLCHC website will include information regarding the Compliance Program, including the Code of Conduct and the Compliance Hotline.

Investigations and Reported Incident Response Protocol

The Chief Compliance Officer and the Director of Corporate Compliance and Risk Management are responsible for overseeing and monitoring implementation and operation of the Compliance Program. This includes the responsibility to independently investigate and act on matters of noncompliance reported through the above mechanisms.

While the MLCHC encourages a reporting individual to reveal their name to facilitate an investigation, concerns reported anonymously will be investigated to the fullest extent possible under the circumstances. The HHS Office of Inspector General (OIG) recommends the Chief Compliance Officer or his designee act promptly upon receipt of reports of potential noncompliance received through the above disclosure processes.

If any reports of noncompliance are made to a supervisor, management, or anyone other than the Chief Compliance Officer or Director of Corporate Compliance and Risk Management, that

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

person must in turn immediately inform the Director of Corporate Compliance & Risk Management so that issue may be addressed.

- Cyber Incident:
  - MLCHC employees should immediately report suspected cyber incidents to the IT Department via email, phone, or Zoom chat.
  - The IT team will complete the initial incident classification and assessment, and manage the Incident Response using the Containment, Eradication, and Recovery phased approach, and initiate internal and external communication.
- Reported non-compliance with Compliance Manual, League Policies, or Employee Handbook Violations will be assessed immediately upon receipt, and investigated using a risk-based approach, following the process outlined below:
  - Upon receipt of a report, the Director of Corporate Compliance & Risk Management will evaluate the report and, if necessary, promptly conduct a thorough investigation in such a way as to maintain the confidentiality of the individuals involved to the extent possible under the circumstances.
  - Timely investigations will be conducted in accordance with the risk level of the reported incident. Reports will be assessed for risk level upon receipt and investigated using a risk-based approach.
    - Higher Risk: Allegations that, if substantiated, could cause immediate and significant harm, create safety concerns, expose the organization to legal or regulatory liability, or seriously damage employee or membership trust in organizational leadership. Higher Risk reported events may involve, for instance, safety hazards, discrimination, harassment, fraud, major policy violations, or leadership misconduct. High risk reports will be responded to within 2 business days.
    - Moderate Risk: Reports with moderate potential for harm or employee impact and may require formal investigation with a focus on resolution and prevention. Moderate risk reports will be responded to within 5 business days.
    - Lower Risk: Issues such as minor policy breaches, misunderstandings, or conduct that, even if substantiated, would be unlikely to cause ongoing harm. Lower risk reports will be responded to within 7 business days of receipt.
  - If it is determined that an investigation should be privileged, the Director of Corporate Compliance & Risk Management will engage legal counsel. If counsel or the Director of Corporate Compliance & Risk Management believe the integrity of the investigation may be at stake because of the presence of employees under investigation, those employees will be removed from their current work activity until the investigation is complete.

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

- The Compliance Director will determine, in conjunction with legal counsel, on a case-by-case basis, whether a material violation of applicable law exists and subsequently whether reporting of a violation to a regulatory body (for instance, reporting a data breach to the Massachusetts Attorney General's Office) is necessary.
- If there is credible evidence of misconduct from any source and the Compliance Director believes such misconduct may constitute a criminal act or otherwise a civil infraction, MLCHC counsel will be consulted to promptly notify the appropriate government authority of the misconduct (not more than 60 days after the determination that credible evidence of a violation exists).
- The Director of Corporate Compliance & Risk Management as primary incident investigator will keep a contemporaneous record of the investigation which shall include: documentation of the alleged violation, description of the investigative process, copies of interview notes and key documents, logs of the witnesses interviewed and documents reviewed, results of the investigation, and any disciplinary or corrective action taken or implemented.

Code of Conduct

The MLCHC's Code of Conduct (The Code) is integral to the culture of the MLCHC and the activities of all employees and members of the Board. The MLCHC endeavors to maintain and relies on each employee to foster a positive work environment. Accordingly, all employees are expected to abide by certain rules of conduct. Unacceptable conduct may subject the offender to disciplinary action, up to and including termination. Further details of the MLCHC's Code of Conduct can be found in the Employee Handbook's various policies on Non-Harassment (2-8), Workplace Violence (2-11), Internal Reporting and Anti-Retaliation (2-13), General Standards of Conduct (Section 4), and Federal Contractors (Workplace Conduct, (3-12).

The following are examples of prohibited conduct: discriminatory language or behavior, offensive language, intimidation, telephone and/or verbal harassment, sexual harassment, physical or emotional threats, stalking, working while impaired, smoking on MLCHC premises or in MLCHC vehicles, and soliciting other employees for personal business. Violations of acceptable conduct outlined in the Employee Handbook constitute violations of the workplace code of conduct. If you have experienced any of the above-mentioned code of conduct violations, please contact your supervisor or Human Resources as soon as possible.

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

Conflict of Interest

It is the MLCHC's standard that all employees avoid any conflict between their personal interests and those of the MLCHC. The purpose of this standard is to ensure that the MLCHC's integrity is not compromised. The fundamental principle guiding this standard is that no employee should have personal interests or relationships that actually or potentially conflict with the interests of the MLCHC.

Employees are required to disclose any potential or actual conflicts of interest (COI) that may arise in the course of their duties annually through the submission of the COI form. The MLCHC maintains a conflict of interest policy to ensure that all business decisions are made in the best interest of the organization and not influenced by self-interest. The MLCHC will further comply with HRSA's COI policy, (pursuant to 2 CFR § 200.112 and 2 CFR §300.112) requiring HHS awardees to disclose potential or actual conflicts of interest within 30 calendar days of discovery of the potential COI. The Conflict of Interest and Business Ethics Policy is further outlined in the Employee Handbook Section 4-11.

Compliance with Laws & Regulations

MLCHC is committed to complying with all relevant federal, state, and local laws, as they may be amended from time to time, including but not limited to:

- False Claims Act (31 U.S.C. §§ 3729–3733): This federal law imposes liability on individuals and organizations that knowingly submit false claims for payment to the government.
- Health Insurance Portability and Accountability Act (HIPAA): Establishes regulations for the protection of patient information and confidentiality, including penalties for fraudulent use of such data.
- Massachusetts False Claims Law (MGL Chapter 12, Section 5B): Prohibits fraudulent claims for payment and false statements in connection with healthcare services in Massachusetts.
- Generally Accepted Accounting Principles (GAAP)
- 2 C.F.R. Part 200: Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards
- Americans with Disabilities Act (ADA)
- Title VII Civil Rights Act of 1964 (as amended)
- Title IX
- Section 504 of the Rehabilitation Act
- Genetic Information Nondiscrimination Act (GINA)

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

- M.G.L. c. 93H, 201 CMR 17.00: Standards for the Protection of Personal Information of Residents of the Commonwealth

Non-Harassment and Anti-Discrimination

Non-Harassment

The MLCHC is an equal opportunity employer. It is the MLCHC's operational standard and policy (outlined in the Employee Handbook Section 2-8, 2-9) to prohibit intentional and unintentional harassment of any individual by another person on the basis of race (including on the basis of hair texture or hairstyles associated with race), color, national origin, ancestry, sex, disability, age, religion, veteran status, uniformed military service, sexual orientation, genetic information, pregnancy, marital status, gender identity, or any other classification protected by law. The MLCHC is dedicated to this standard with respect to all aspects of employment including recruitment, hiring, placement, promotion, transfer, training, work assignment, compensation, benefits, employee activities and general treatment during employment. Violation of this standard including any improper retaliatory conduct will result in disciplinary action, up to and including discharge. All employees must cooperate with all investigations.

Examples of harassment include, but are not limited to, the following:

- Verbal or written harassment, including writings through email, text messages, or social media: e.g., suggestive, insulting or derogatory comments, epithets, innuendoes, sounds, jokes, teasing, slurs or threats.
- Physical harassment: e.g., assault, impeding or blocking movement, or movement including touching, pinching, brushing the body, inappropriate contact or assault; and
- Nonverbal harassment: e.g., derogatory posters, cartoons, suggestive objects, pictures, letters or drawings; also, such actions as leering, whistling or obscene gestures.

Harassment is strictly prohibited regardless of the identity of the alleged harasser or recipient of harassment. This includes, for example, employees, managers, clients, vendors, etc. The purpose of this standard is to ensure that at the MLCHC, no one harasses another individual. In addition, this standard in no way limits the MLCHC's expectations that employees act in a professional manner at all times while working or while in any capacity representing the MLCHC. This standard does not limit the MLCHC's ability to discipline an employee for violation of any expectation or standard of appropriate workplace behavior.

If an employee feels they have been subjected to conduct which violates this standard, they should immediately report the matter to their supervisor and Human Resources or the COO. If the person toward whom the complaint is directed is one of the individuals above, the employee should contact any higher-level manager in their reporting hierarchy. Every report of perceived harassment shall be fully investigated, and corrective action will be taken where appropriate. All

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

complaints will be kept confidential to the extent possible, but confidentiality cannot be guaranteed. In addition, the MLCHC will not allow any form of retaliation against individuals who report unwelcome conduct to management or who cooperate in the investigations of such reports in accordance with this standard. If the employee feels they have been subjected to any such retaliation, they should report it in the same manner in which the employee would report a claim of perceived harassment under this standard.

Anti-Discrimination

The MLCHC does not discriminate on the basis of race, color, national origin, ancestry, sex, disability, age, religion, veteran status, uniformed military service, sexual orientation, genetic information, pregnancy, marital status, gender identity, or any other classification protected by law.

The MLCHC will endeavor to provide reasonable accommodation to the known physical or mental limitations of qualified employees with disabilities unless, in accordance with the Americans with Disabilities Act and G. L. c. 151B, § 4, Para. 16, unless the accommodation imposes an undue hardship. If an employee needs a reasonable accommodation, they should contact Human Resources and/or the COO for further assistance.
Any employee with questions or concerns about equal employment opportunities in the workplace is encouraged to bring these issues to the attention of Human Resources and/or the COO.

The MLCHC will not allow any form of retaliation against individuals who raise issues of equal employment opportunity. If an employee feels they have been subjected to any such retaliation, they should contact Human Resources and/or the COO. To ensure our workplace is free of artificial barriers, consistent with Section 2-13—Internal Reporting & Anti-retaliation Standard in the Employee Handbook, violations of this standard including any improper retaliatory conduct will lead to discipline, up to and including discharge. The MLCHC requires all employees to complete an annual non-harassment training on an annual basis and requires all supervisors to complete a supervisor training before assuming supervisory duties. In addition, all new employees must attend an employee orientation where non-harassment and other important policies are discussed. Attendance or completion of mandatory trainings will be checked as part of the annual performance evaluation process as well as the probationary evaluation.

Fraud, Waste, & Abuse

Purpose:

The MLCHC and subsidiaries are committed to maintaining the highest ethical standards and ensuring the proper use of all resources. The Employee Handbook provides guidelines for

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

detecting, preventing, and addressing fraud, waste, and abuse in the organization. The policies within outline the roles and responsibilities of MLCHC employees, contractors, and stakeholders in maintaining integrity in all aspects of the organization's operations. MLCHC will not tolerate any form of fraud, waste, or abuse and will take appropriate corrective action to prevent or address any instances of wrongdoing. This policy also ensures compliance with federal, state, and local laws and regulations.

Definitions:

1. ***Fraud:*** Any type of intentional deception or misrepresentation made by an individual or entity with the knowledge that the deception could result in an unauthorized benefit, typically financial gain, for themselves or others.
2. ***Waste:*** The overutilization or misuse of resources, services, or funds in a manner that is inconsistent with accepted business or healthcare practices. Waste may result from inadequate management, oversight, or mismanagement, but it is not necessarily intentional.
3. ***Abuse:*** Practices that are inconsistent with accepted medical, business, or fiscal practices and result in unnecessary costs or improper reimbursement.

Preventing and Detecting Fraud, Waste, and Abuse

- Employee Training and Awareness: The MLCHC will conduct regular training for all employees, volunteers, contractors, and providers to raise awareness about fraud, waste and abuse, recognize potential indicators of fraud, waste, and abuse, and understand the reporting process.
- Internal Controls: MLCHC will implement internal controls and audits to prevent, detect, and correct fraud, waste, and abuse. This includes, but is not limited to, regular financial audits and monitoring of program activities.

Reporting of Fraud, Waste, and Abuse

- Reporting Mechanism: MLCHC encourages employees, volunteers, contractors, and clients to report any suspected incidents of fraud, waste, or abuse immediately. Reports can be made to the Chief Compliance Officer and/or Human Resources.
- The MLCHC prohibits retaliation against anyone who reports suspected fraud, waste, or abuse in good faith. Retaliation may include, but is not limited to, adverse employment actions, threats, or discrimination. Any retaliation will result in disciplinary action.
- Reports of fraud, waste, or abuse will be kept confidential to the extent possible, and the identity of the reporting individual will be protected to avoid retaliation.

Corrective and Preventive Actions

- The MLCHC is committed to investigating all reports of suspected fraud, waste, and abuse. Following an investigation, MLCHC will perform a root cause analysis to

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

understand the underlying reasons for fraud, waste, or abuse incident. This analysis will help determine what changes are needed to prevent recurrence.

- Based on the findings of the investigation, MLCHC will revise its policies, procedures, and internal controls as necessary to prevent future occurrences of fraud, waste, and abuse.
- Individuals found to have engaged in fraud, waste, or abuse will be subject to disciplinary actions, including but not limited to verbal or written warnings, suspension or termination of employment or contracts, and civil or criminal legal action, as appropriate.

Privacy & Security

The MLCHC is dedicated to maintaining the privacy, confidentiality, and security of all personally identifiable information (PII) and other sensitive data. Personnel have access to a variety of sensitive information, the confidentiality of which must be protected. All Personnel must adhere to the appropriate laws, regulations, policies, and procedures (including MLCHC HIPAA security and confidentiality policies and procedures located in Appendix 6 of the Employee Handbook) to ensure that confidential information is properly maintained, and that inappropriate or unauthorized release is prevented.

The MLCHC ensures that its operations comply with all relevant state and federal laws concerning privacy/data security and will only collect and retain the minimum amount of sensitive data necessary for the specific purposes for which it is required. Data will be retained for the duration required by law and will be securely disposed of when no longer necessary. Minimum Necessary Standard: Only authorized individuals, based on their role and need to know, are allowed to access sensitive data. Employees must only access information that is required for the performance of their job-related duties.

Cybersecurity

The MLCHC seeks to prevent unauthorized access, use, or disclosure of personal identifiable information (“PII”) and Protected Health Information (“PHI”) electronically or otherwise, and to maintain privacy and security measures to protect the confidentiality of PII and PHI. Personally identifiable “PI” is defined by applicable state law(s) and “PHI” by the Health Insurance Portability and Accountability Act (HIPAA) Rules and Regulations. MLCHC has implemented reasonable and appropriate safeguards to protect the confidentiality, security, and privacy of PI, PII, and PHI in its possession. Staff have the responsibility to report any incidents upon discovery to their manager, IT, and HIPAA Privacy Officer and a duty to complete the annual training provided.

The MLCHC defines a cyber incident as any unauthorized access, use, disclosure, disruption, modification, or destruction of information or information systems, or any event that

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

compromises the confidentiality, integrity, or availability of data or systems. This includes, but is not limited to, malware infections, unauthorized access attempts, data breaches, denial-of-service attacks, and phishing attempts.

The Cyber Incident Response Plan ("CIRP") establishes the systematic approach for preparing for, detecting, analyzing, containing, eradicating, recovering from, and learning from cybersecurity incidents affecting the Massachusetts League of Community Health Centers' information systems, networks, applications, and data, whether on-premises or in cloud environments. Aligned with the National Institute of Standards and Technology (NIST) Cybersecurity Framework (CSF) and NIST SP 800-66 Rev. 2 (Computer Security Incident Resource Guide), this plan applies to all employees, contractors, and third-party entities with access to Massachusetts League of Community Health Center's IT assets and protected information, ensuring a consistent and effective response to minimize impact and restore normal operations.

The MLCHC Artificial Intelligence (AI) Policy outlines the guidelines for the responsible and ethical use of AI systems by all MLCHC and subsidiary employees and consultants. The policy aims to ensure compliance with applicable Federal and State laws and regulations, protect the privacy and security of PHI and PII, promote the effective and ethical use of AI to enhance MLCHC's mission, and establish a process for evaluating and approving new AI applications.

Mandatory Compliance Education and Training

All MLCHC employees will receive comprehensive trainings covering compliance issues/risk areas, expectations, MLCHC policies, procedures, and relevant state/federal laws and regulations (e.g., HIPAA, fraud prevention, Anti-harassment, Procurement). At a minimum, such training will take place annually and will be made apart of orientation for all new employees upon hire. To remain compliant with evolving regulations, Human Resources requires all staff to participate in ongoing training and education related to updates to applicable laws and best practices. Employees with questions or concerns regarding training compliance should contact Human Resources.

Trainings required annually (may differ by staff role or department):

- HIPAA
- Cybersecurity, and Security Awareness
- PI Data
- Supervisor Training
- Anti-Harassment & Sexual Harassment
- Procurement
- Time and Effort
- Anti-Fraud

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

- Whistleblower
- Security Awareness Trainings
- Conflict of Interest

Research Compliance

The MLCHC and IHE (collectively, the "Institutions") are committed to maintaining a comprehensive research compliance framework that aligns with industry best practices and legal requirements. The MLCHC & IHE Joint Policy for Investigating Research Misconduct, and the MLCHC & IHE Joint Financial Conflicts of Interest in Research Policy are intended to establish guidelines and procedures to ensure that all research activities conducted by the MLCHC and the IHE comply with federal, state, and local laws and regulations, as well as ethical standards in healthcare research. These policies aim to protect the rights, safety, and welfare of human subjects (defined as an individual who is, or becomes a participant in research, either as a recipient of the test article or as a control)[1], and ensure that all research is conducted with the highest level of integrity, transparency, and compliance.

MLCHC and Institute for Health Equity (IHE) Research Compliance Program

The policies held within the employee handbook are intended to ensure ethical, legal, and regulatory compliance, as well as highlight the MLCHC's commitment to the protection of human subjects through thorough compliance efforts. These policies apply to all MLCHC and IHE employees, researchers, contractors, affiliates, and any individuals involved in conducting, overseeing, or supporting research activities under the MLCHC or IHE's auspices. This includes observational studies, community-based research, and other forms of health-related research.

The MLCHC & IHE Joint Policy for Investigating Research Misconduct is intended to ensure that the Institutions adhere to the Public Health Service of the U.S. Department of Health and Human Services' regulations on research misconduct and to ensure that the Institutions' employees engaged in conducting PHS-sponsored research adhere to the highest standards of ethics, integrity, and adherence to laws, regulations, policies and standards governing the conduct of their activities covered by these policies and procedures. To the extent there is a conflict between this Policy and 42 CFR Part 93, 42 CFR Part 93 shall prevail.

Definitions:

- Clinical Trial: HHS regulations define the term clinical trial as a research study in which one or more human subjects are prospectively assigned to one or more interventions (which may include a placebo or other control) to evaluate effects of interventions on

[1] 21 C.F.R. §§ 50.3(g), 312.3(b), and 812.3(p).

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

biomedical or behavioral health related outcomes (45 C.F.R. § 46.102(b)). The terms clinical trial and clinical research refer generally to research studies that enroll a human subject. However, investigators also conduct clinical research using only data without any direct human subject contact.

- Research: Under HHS regulations, research refers to a systematic investigation including research development, testing, and evaluation designed to develop or contribute to generalizable knowledge (45 C.F.R. § 46.102(l)).
- Clinical Investigation: FDA regulations generally define a clinical investigation as any experiment that involves a test article, and one or more human subjects, and that is either:
  - Subject to requirements for prior submission to FDA.
  - Not subject to requirements for prior submission to FDA, but the results of which are intended to be submitted later to, or held for inspection by, FDA as part of an application for a research or marketing permit.
    - A test article includes any drug, biological product for human use, or medical device for human use. (21 C.F.R. §50.3(c), (j).)
- Investigator: An investigator is an individual who conducts the investigation (and under whose immediate direction the test article is administered, dispensed, or used) involving a subject. Under FDA regulations, in the case of a team of individuals, the investigator is the responsible leader of the team (21 C.F.R. §§ 50.3(d), 312.3(b), and 812.3(i)).
- Human Subject: A human subject is an individual who is, or becomes, a participant in research, either as a recipient of the test article or as a control. A subject may be a healthy human or a patient. (21 C.F.R. §§ 50.3(g), 312.3(b), and 812.3(p).)
- The Office for Human Research Protections (OHRP) oversees research conducted or supported by HHS. OHRP monitors compliance with regulations related to the ethical standards of research involving human subjects. The principles enforced by OHRP are:
  - Respect for Persons. This means that: research subjects must provide voluntary informed consent (see Informed Consent); researchers must always protect the privacy and confidentiality of research subjects (see Subject's Right to Research Privacy); and researchers must provide additional protections to research subjects who cannot act autonomously (such as incapacitated or incarcerated persons, or children).
  - Beneficence. This means that: potential benefits to the individual and society outweigh the research risks; and researchers must avoid the risk of direct physical or psychological harm to the subjects.
  - Justice. This means that researchers: must equitably distribute the risks and benefits among those who may benefit from the research; and do not systematically exclude potential beneficiaries of the research or target vulnerable subjects for convenience.

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

The Compliance framework for the MLCHC & IHE includes the following key components:

1. **Regulatory Compliance:** Ensuring compliance with federal, state, and local research regulations, such as:
    - **A.** Required Government Filings: Compliance and timely submission of required federal and state form filings
        - US DHHS Certification
        - IRS Form 990 (8868)
        - Civil Rights (441)
        - Handicapped Individuals (641)
        - Sex Discrimination (639-A)
        - Age Discrimination (680)
        - Federal Wide Assurance (FWA): An agreement that the research will comply with HHS regulations for protection of human subjects. HHS regulations require that any institution conducting research involving human subjects must have a FWA containing written procedures, a statement of principles, a commitment to comply with the Common Rule, laws, regulations, policies, and guidelines, and specific reporting commitments to OHRP.
    - **B.** Health Insurance Portability and Accountability Act (HIPAA)
    - **C.** Food and Drug Administration (FDA) regulations: FDA's oversight of human subject research involves the clinical investigation of drugs, biologics, and medical devices (21 C.F.R. §§ 50.1 to 50.56).
    - **D.** The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research – Belmont Report (HHS)
    - **E.** 45 CFR Part 46 Subpart A- The "Common Rule" refers to the Federal Policy for the Protection of Human Subjects outlining the basic provisions for IRBs, informed consent, and Assurances of Compliance. The Common Rule and FDA regulations place an affirmative duty on researchers to make privacy obligations part of the informed consent process (see Informed Consent). These regulations require researchers to inform subjects of their privacy rights and require IRBs to ensure research plans contain adequate provisions to protect subject privacy and confidentiality. The three sources of research privacy protection (HIPAA, the Common Rule, and FDA regulations) all rely on written permission authorizing the researcher to use PHI or private information as a safeguard against unauthorized use or disclosure.
        - Subpart B- Protections for pregnant women, human fetuses, and neonates
        - Subpart C- Protections for prisoners
        - Subpart D- Protections for children

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

2. **Clinical Trial and Human Subjects Research Compliance:** This section establishes the compliance framework for any human subjects research that the Institutions may conduct and outlines the governance, policies, procedures, and oversight mechanisms necessary to ensure compliance throughout the research lifecycle.
    - **A.** Institutional Review Board: An IRB is a board, committee, or other group formally appointed by an institution to review biomedical research involving humans as subjects, approve the initiation of research, and conduct periodic review of the research[2]. All research involving human subjects must undergo review by an Institutional Review Board (IRB) or equivalent ethics committee to ensure that research protocols meet ethical standards. HHS requires that an:
        - IRB must have at least five members with varying backgrounds.
        - IRB's composition reflects various types of experience or expertise necessary for federal registration; an interest in diversity and experience with vulnerable populations; independence from the research organization; and members who are not conflicted.[3] IRB members with a conflict of interest (COI) must recuse themselves from reviewing projects related to their interest.
        - The IRB is charged with assuring a number of requirements are met. The duties and limits on the IRB include minimizing risk to subjects, ensuring selection of subjects is equitable considering the research….
        - The IRB should ensure that the clinical billing process reflects informed consent and human subject protection.

    - **B.** Informed Consent
        - The Common Rule and FDA regulations place an affirmative duty on researchers to make privacy obligations part of the informed consent process. These regulations require researchers to inform subjects of their privacy rights and require IRBs to ensure research plans contain adequate provisions to protect subject privacy and confidentiality. The three sources of research privacy protection (HIPAA, the Common Rule, and FDA regulations) all rely on written permission authorizing the researcher to use PHI or private information as a safeguard against unauthorized use or disclosure. A research institution should obtain written authorization before use or disclosure of PHI or other personal information.
        - In obtaining and documenting informed consent, the investigator should comply with the applicable regulatory requirements, adhere to Good Clinical Practice (GCP), and to the ethical principles that have their origin in the Belmont Report.

[2] 21 C.F.R. §§ 50.3(i) and 56.102(g); 45 C.F.R. § 46.108
[3] 45 C.F.R. § 46.107(a), (b), and (c)

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

- The IRB may waive the requirement for the investigator to obtain a signed consent form for some or all subjects if it finds **any** of the following: A) The only record linking the subject and the research would be the informed consent form and the principal risk would be potential harm from a breach of confidentiality; B) The research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context; C) If the subjects are members of a distinct cultural group or community in which signing forms is not the norm, that the research presents no more than minimal risk of harm to subjects and provided there is an appropriate alternative mechanism for documenting that informed consent was obtained.

C. Human Subjects Protections

- Ethical Standards: Adherence to ethical research practices as outlined in the Belmont Report, the Declaration of Helsinki, and other relevant ethical guidelines to protect human subjects and ensure research integrity.
- Policies and Procedures: The MLCHC has multiple written standards for research conduct, data management, conflict of interest, standard protocols for submission and IRB review processes, privacy and confidentiality. These include The MLCHC & IHE Joint Policy for Investigating Research Misconduct, and the MLCHC & IHE Joint Financial Conflicts of Interest in Research Policy.
- Training and Education: Anyone that will have direct interaction with research participants and/or access to identifiable information or specimens *must* complete HHS compliant Human Subjects Protection Training. In addition, Principal Investigators, Co-Investigators, and those meeting the definition of NIH "Key Personnel" must complete human subjects research training regardless of whether or not they have direct interaction with participants and/or access to identifiable information/specimens.
    - Human subjects research training certification is valid for a three-year period from date of completion, regardless of which institution it was completed through. When current training expires, a refresher course or additional training is required.
- Recruitment: The Institutions may use a variety of methods to recruit potential subjects. Before recruitment begins, the IRB must review any direct advertising or outreach to potential subjects for form, content, and communication method.

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

- Monitoring and Quality Assurance: Established processes of routine internal audits of research protocols and activities, risk-based monitoring plans, corrective action procedures for noncompliance, and tracking of time and effort requirements.
    - A regulatory binder is a centralized collection of essential clinical trial documents used to support regulatory compliance, inspection readiness, and Good Clinical Practice (GCP) standards throughout a research study. A comprehensive regulatory binder helps demonstrate compliance with study protocols, informed consent requirements, safety reporting obligations, and investigator oversight responsibilities throughout the clinical trial lifecycle.
- Governance and Oversight: Establishment of the MLCHC Compliance Committee with clearly delineated roles and responsibilities for leadership, investigators, and staff.
- The Principal Investigator (PI) is ultimately responsible for the protection of the human subjects participating in research they conduct or oversee. The PI is expected to abide by the highest ethical standards when developing a research plan and to incorporate the principles of the Belmont Report. The PI is expected to conduct research in accordance with the IRB approved research plan and to personally conduct or oversee all aspects of the research. Researchers and PIs are responsible for ensuring compliance with this policy and all applicable laws and regulations, including:
    - Study Design and Protocols
    - Informed Consent
    - Protection of Human Subjects
    - Reporting and Recordkeeping

D. Adherence to Funding Requirements

- The MLCHC and IHE will follow federal requirements for management of research funding, ensuring their separation from general operating funds, are properly accounted for, and reported in compliance with both human subjects' protection policies and federal cost principles. In situations where the Institutions apply for multiple awards or grants in a single research area, MLCHC Accounting systems must identify and separate each separate source of funding. Further information on MLCHC accounting practices and policies can be found in the MLCHC Financial Management and Accounting Policies and Procedures Manual .

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

- Time and Effort Reporting: Researchers and institutions must accurately report research time and effort. The Institutions must accurately report the compensation allocated to each research project. Failure to accurately report time and effort causes overcharges to funding sources, and sometimes, FCA liability.

E. Research Recordkeeping: HHS and FDA require that clinical research records, including IRB meeting minutes, be maintained for three years after completion of the clinical research. These records must be accessible for inspection by OHRP and FDA.[4] Researchers, legal and compliance staff should also review state laws and regulations which may require that the records be maintained for longer than three years. The FDA Good Clinical Practice (GCP) website provides further guidance to researchers about creating and maintaining research records.

F. Reporting and Investigations: Existence and communication of confidential reporting channels, whistleblower protections, clear investigation protocols for alleged violations, documentation and resolution tracking, and written standards for notification to federal agencies and departments.

G. Conflict of Interest Management and Reporting of Financial Interests: To minimize the actual or potential conflicts of interest in Human Research, all individuals involved in the design, conduct, or reporting of the research must report financial interests related to the research to the IRB. In addition to principal investigators and co-investigators, individuals involved in the design, conduct, or reporting of the research may include study coordinators, data coordinators, and other support staff who are possibly not captured.

- Conflicts of interest (COI) in research can be broadly described as any interest that competes with an organization or individual's obligation to protect the rights and welfare of research subjects, the integrity of a research study, or the credibility of the research program. Conflicts of interest can be financial or non-financial.

Documentation and Record Keeping

The MLCHC acknowledges its responsibility to preserve information relating to litigation, audits and investigations, and to retain records and documentation necessary to confirm the effectiveness of the MLCHC Compliance Program and satisfaction of all regulatory requirements related therein. To demonstrate compliance, the MLCHC will keep comprehensive records of compliance activities, including training logs, audit results, and policy revisions, though this is not an exhaustive list of all records to be retained.

[4] 21 C.F.R. § 56.115(b); 45 C.F.R. § 46.115(b)

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

Failure on the part of employees to follow the standards set forth in MLCHC's Record Retention & Destruction Policy (located in Appendix 7 of the Employee Handbook) can result in possible civil and criminal sanctions against the MLCHC and its employees and possible disciplinary action against responsible individuals (up to and including discharge of the employee). Each employee has an obligation to contact the Legal & Compliance Department to inform them of potential or actual litigation, external audits, investigations or similar proceedings involving the MLCHC.

Lobbying

Purpose

The MLCHC Employee Handbook contains policies on Political Activities and Legislative Mandates (Appendix 3, Section 2-16) to ensure that all advocacy efforts by the MLCHC are carried out transparently, ethically, and in full compliance with applicable laws and regulations. This includes both direct and grassroots lobbying efforts aimed at influencing legislation, regulation, and public policy that impacts the provision of care by community health centers in Massachusetts. By adhering to the lobbying policies, the MLCHC ensures that its advocacy efforts remain aligned with legal standards while effectively supporting community health centers across Massachusetts. The MLCHC will ensure that all lobbying activities comply with both Massachusetts and Federal lobbying regulations.

Definitions

- Lobbying: Any attempt to influence the decisions of public officials, including legislators, regulatory agencies, and government entities, regarding public policy, lawmaking, or regulation.
- Direct Lobbying: Communication with a public official or government entity about specific legislation or administrative rules that affect the interests of the MLCHC.
- Grassroots Lobbying: Efforts to encourage the public to contact legislators or government officials in support of or opposition to specific policy proposals or legislative actions.
- Expenditure Limits: The limits on spending for lobbying activities, as specified under both Massachusetts state law and federal regulations.

Federal Lobbying

The MLCHC is a 501(c)(3) organization and must comply with the Internal Revenue Code (IRC), which restricts the amount of lobbying a nonprofit can engage in, to preserve its tax-exempt status.

- Substantial Part Test: The MLCHC may engage in lobbying activities if it does not constitute a "substantial part" of its total activities. While the IRS does not define a specific percentage, it evaluates lobbying based on time and resources devoted to such activities.

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

- Expenditure Test: If the MLCHC opts to use the expenditure test, it may lobby up to a defined percentage of its total annual budget, based on IRS thresholds.
- Lobbying Disclosure Act (LDA) of 1995: The MLCHC will adhere to federal lobbying registration and reporting requirements, as set forth by the LDA, if the organization's lobbying activities exceed certain thresholds. This includes filing quarterly reports detailing lobbying expenditures and the issues lobbied on.
- Political Campaign Activities: As a 501(c)(3) organization, the MLCHC is prohibited from engaging in political campaign activities that support or oppose political candidates. This includes direct or indirect involvement in election campaigns.
- Lobbying with Federal Funds: The MLCHC will not use federal grant funds or federal resources for direct lobbying activities, in compliance with the Byrd Amendment (31 U.S.C. § 1352), which prohibits the use of federal funds for lobbying.

State Lobbying

Under Massachusetts General Laws Chapter 3, Section 39, the MLCHC must comply with the state's lobbying regulations if it engages in lobbying activities that exceed specific financial thresholds or if its staff directly communicates with state legislators or executive branch officials.

- Registration Requirement: Any individual who, for compensation, makes at least one direct lobbying communication, and spends 25 hours or more on, or earns $2,500 or more from, legislative lobbying during a six-month reporting period must register as a lobbyist. (Note that the 25 hours threshold includes prep time and grassroots lobbying time.)
- Individual staff members who do only grassroots lobbying and have no direct communication with public officials will not need to register as an individual lobbyist. Grassroots lobbying expenditures do count towards the organizational expenditure threshold, however, so organizations with grassroots programming may need to register as a Section 44 organization.
- Lobbying Reports: The MLCHC must file bi-annual reports with the State Ethics Commission detailing the issues lobbied, expenditures, and payments made to lobbyists. These reports will be made available to the public and will be updated regularly as required by state law.

Monitoring and Reporting

By adhering to the lobbying policy, the MLCHC ensures that its advocacy efforts remain aligned with legal standards while effectively supporting community health centers across Massachusetts. The MLCHC will maintain accurate records of its lobbying activities, including:

- Time spent on lobbying activities by staff
- Expenses related to lobbying efforts, including communications and outreach
- Documentation of meetings and correspondence with policymakers

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

Grants Management

Purpose

The purpose of the Grants Management Policy is to provide clear guidelines and procedures for the effective management, administration, and oversight of grants received by the MLCHC and the IHE. This policy is designed to ensure compliance with all applicable federal, state, and local laws and regulations, promote transparency, ensure accountability, and enhance the capacity of the MLCHC and the IHE to manage grants responsibly and efficiently. This policy applies to the MLCHC and the IHE, together with all their respective boards of directors, officers, employees, independent contractors, and volunteers (whether compensated or not).

Federal Grant Funds

The MLCHC maintains a Policy to support routine monitoring, review, and upgrading of its overall policies to comply with current requirements and upgrades to policies applicable to the MLCHC, our mission and service provision. The MLCHC's Federal Grant Funds Policy (Employee Handbook Appendix 3) has been adopted by the MLCHC Board of Directors in order to guide MLCHC staff, service delivery, and assure compliance with the "Legislative Mandates" included in the fiscal year 2026 Consolidated Appropriations Act (Public Law 119-75), signed into law on February 3, 2026, as well as any limitations included in the subsequent Legislative Mandates where the compliance list for HRSA award recipients remains the same and includes provisions that restrict grantees from using their federal grant funds to support certain defined activities. This policy may be amended to comport with revised Legislative Mandates.

State Grant Funds

Grant documents for any State grant should be carefully reviewed to determine whether Federal or State regulations apply. If the funding is purely municipal or private, the conditions of the grant in any executed agreement govern its use.

Municipal Grant Funds

Municipal grants are often funded with either Federal or State dollars. The grant documents for any municipal grant should be carefully reviewed to determine whether Federal or State regulations apply. If the funding is purely municipal or private, the conditions of the grant in any executed agreement govern its use.

Contracts, Procurement, Group Purchasing

All procurement decisions are to be made with strict adherence to the most current version of the MLCHC's Procurement Checklist. This Checklist serves as a key tool to ensure that each procurement process is conducted in compliance with established policies, legal requirements, and best practices. By utilizing the Checklist, the MLCHC and IHE seek to maintain consistency,

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

transparency, and accountability in decision-making, ensuring that all procurement activities align with organizational goals and standards.

Contract Management

Per the Mass League's Policy on Contract Review and Execution, in order to streamline and make uniform Mass League's contracting processes and to eliminate circumstances where agreements are executed without the necessary prior review, all contracts, of any nature whatsoever, must be forwarded via e-mail to the General Counsel or his designee for his review and approval, with a courtesy copy to the Chief Operating Officer, prior to being executed. This applies to contracts originating from other entities, as well as those originating at the Mass League. No contracts, including addendums or revisions to any aspect of the agreement, are to be executed by Mass League unless the General Counsel or his designee has first reviewed it, indicated that it is approved for execution, and determined the appropriate executive to sign on behalf of Mass League. Mass League staff shall request the General Counsel's assistance in drafting and preparing all agreements as early as possible when it becomes clear that an agreement will be necessary. In order to allow sufficient time for the General Counsel to review and revise agreements and/or discuss with staff as necessary, absent an extraordinary circumstance, please ensure that draft agreements (or requests to draft agreements) are sent to the General Counsel no fewer than two weeks prior to the deadline for the contract to be executed.

Procurement

The MLCHC Procurement Policy is detailed in the Financial Management and Accounting Policies and Procedures Manual (p. 10-16). It is MLCHC's policy to acquire property and services in a manner that balances quality, price, and administrative efficiency to arrive at "best value" for MLCHC and the community it serves. It is further MLCHC's policy to comply with all pertinent legal requirements, including, when applicable, the Federal Procurement Standards set forth within Uniform Guidance (2 C.F.R. Part 200, as codified by the Department of Health and Human Services at 45 C.F.R. Part 75). The Procurement Policy maintains Standards of Conduct with which all directors, officers, employees and agents must comply with respect to procurement actions.

Financial Controls

The Financial Management and Accounting Policies and Procedures Manual has been developed under the authority of the MLCHC to establish and adopt policies for financial management practices, and to ensure that accountability practices have been put in place that include basic accounting, billing, and cash control policies and procedures designed to protect and secure the MLCHC, ensure the maintenance of accurate records of financial activities, and ensure compliance with governmental and private funding source reporting requirements. Where this Manual conflicts with specific federal or State regulations or with the MLCHC or other Board of Directors (the "Board") policy, the regulations or Board policy shall prevail.

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

The MLCHC Employee Handbook maintains multiple policies to guide and authorize all staff activity, service delivery and strategy adoption and to implement strategic plans and seek resources consistent with our mission. See Appendix 3- Legislative Mandates restricting the Uses of Federal Grant Funds MLCHC Policy and Procedure.

Student Loan Repayment Program Compliance

The State Loan Repayment Program (SLRP) helps HRSA provide grant funding for states and territories to operate their own loan repayment programs. Through SLRP, each state and territory can design programs that address the most pressing health care needs of their residents. Primary medical, mental/behavioral, and dental clinicians who receive awards through SLRP-funded programs pay off their student debt in exchange for working in areas with provider shortages.

In addition to the MLCHC's WISP policy, the MLCHC must also comply with certain standards, policies, and application requirements pursuant to its participation in the SLRP. These minimum standards for compliance have been promulgated by the Executive Office of Technology Services and Security (EOTSS), in accordance with M.G.L. c. 7D, § 2, and may be found here: Enterprise Information Security Policies and Standards | Mass.gov.

CommonWealth Purchasing Group (CPG)

CommonWealth Purchasing Group is a group purchasing organization for community health centers and health care organizations. As many CHCs in Massachusetts and across the United States serve low-income or uninsured populations operating on tight budgets, cost savings found through CPG are critical for financial stability and access to high-quality products and services. CPG negotiates contracts with various suppliers to secure lower prices, favorable terms, and reliable supply for everything from medical supplies, pharmaceuticals, and equipment to office supplies, food services, and IT solutions.

All contents of this Manual apply to CPG, a wholly-owned limited liability company subsidiary of the MLCHC, however there are specific elements applicable especially to CPG's regulatory compliance.

- Policies, Procedures, Standards of Conduct: MLCHC Policies (Handbook) and The Code of Conduct in this Manual apply to employees of CPG.
    - Anti-Kickback Statute
    - Stark Law
    - MLCHC Financial Management and Accounting Policy Manual

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

- Written Agreements: specifying services, administrative fee details, and certification of fees usage exclusively for administering the contract, mandatory disclosure of fees, compliance with 3% Fee Limit Rule
- Oversight and Management: Appointment of Advisory Board members
- Training and Education: MLCHC Education and Training Program applies to CPG employees, ensuring regular, mandatory, and effective training for all relevant employees and new hires on the Code of Conduct, Anti-Kickback Statute, GPO Safe Harbor requirements, internal reporting mechanisms
- Communication and Reporting: MLCHC policies on reporting non-compliance, whistleblower protections, and anti-retaliation apply to CPG Program
- Monitoring and Auditing: Periodic internal compliance and risk management audits
    - Affordable Care Act (ACA) Nondiscrimination testing

Human Resources

Pay Equity & Transparency

The MLCHC strives for equal pay for equal work and is committed to complying with state and federal laws on pay equity, including the Massachusetts Equal Rights Act (MERA) and the long-established federal Equal Pay Act, which requires that men and women be given equal pay for equal work in the same establishment, as well as all state and federal anti-discrimination laws applicable to employment, including those within M.G.L. c. 149 and 151B and Title VII of the Civil Rights Act. These laws allow pay differentials when they are based on seniority, merit, quantity or quality of production, education, training or experience related to the particular job, necessary travel, or a lawful factor other than sex. In accordance with Massachusetts Pay Transparency Law, effective Oct. 29, 2025, the MLCHC and subsidiaries includes the salary ranges for open positions in job postings and discloses salary ranges for positions to employees or applicants for open positions, promotions, transfers, or commencing a new position, upon request.

Where the MLCHC and subsidiaries employed 100 employees or more in the prior calendar year, the MLCHC will annually submit its EEO-1 data report to the Secretary of the Commonwealth no later than February 1 of the following year.

In accordance with MLCHC Policy 2-16- Internal Reporting & Anti-Retaliation Standard (found in the MLCHC Employee handbook), retaliation shall be prohibited against any individual who exercises their rights under the Pay Transparency Law to request disclosure of a salary range for a position they occupy or for which they are being considered for hire or promotion. Any employee engaging in retaliation may be disciplined, up to and including termination, consistent with the anti-retaliation provisions outlined in the MLCHC Anti-Retaliation Policy.

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

Salary Survey

The MLCHC is committed to fostering a fair and competitive compensation structure that supports employee recruitment and retention while maintaining fiscal responsibility. In accordance with this effort, the MLCHC will conduct a salary survey at a cadence to be established by executive leadership. The salary survey will provide benchmark data for comparing the MLCHC's compensation packages with those offered by peer organizations in the healthcare and nonprofit sectors.

HR will compile the findings into a comprehensive salary survey report. The report will include a summary of key findings, including salary trends and comparisons; recommendations for adjustments to salary structures, if necessary; and an overview of benefits and compensation practices, including health insurance and retirement plans. The salary survey report and recommendations will be presented to the MLCHC's Board of Directors for review and approval. The survey results will be used to inform compensation decisions and adjust salary ranges as necessary to remain competitive and compliant with applicable laws, including the Massachusetts Equal Pay Act (MEPA) and the Fair Labor Standards Act (FLSA), as necessary.

Benefits (Insurance- Health, Dental, Leave Insurance- Short Term/Long Term disability)

In addition to good working conditions and competitive pay, it is the MLCHC's goal to provide a combination of supplemental benefits to all eligible employees. These benefits include time-off benefits, such as vacations and holidays, insurance, and other plan benefits. The MLCHC is constantly studying and evaluating its benefits programs and standards to better meet present and future requirements. In keeping with this goal, each benefit program has been carefully devised and complies with a range of federal and state laws, including the non-discrimination requirements under the Affordable Care Act (ACA), Title VII of the Civil Rights Act, the Americans with Disabilities Act (ADA), the Age Discrimination in Employment Act (ADEA), and the Employee Retirement Income Security Act (ERISA). These standards and practices have been developed over the years and continue to be refined to keep up with changing times and needs.

The descriptions of the insurance and other plan benefits merely highlight certain aspects of the applicable plans for general information only. The details of those plans are spelled out in the official plan documents that change from time to time and are available for review upon request from the COO. Additionally, the provisions of the plans, including eligibility and benefits provisions, are summarized in the summary plan descriptions ("SPDs") for the plans (which may also be revised from time to time). In the determination of benefits and all other matters under each plan, the terms of the official plan documents shall govern over the language or any descriptions of the plans, including the SPDs and this Handbook. The MLCHC also sponsors a Section 125 Plan providing for some pretax benefits. Details are available upon request from Finance and Administration.

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

Further, the MLCHC (including the officers and administrators who are responsible for administering the plans) retains full discretionary authority to interpret the terms of the plans, as well as full discretionary authority with regard to administrative matters arising in connection with the plans and all issues concerning benefit terms, eligibility and entitlement.

Commonwealth Search Partners, LLC ("CSP")

All contents of this Manual apply to CSP, a limited liability company (LLC) operating as a wholly-owned subsidiary of the MLCHC, with MLCHC as the sole member and manager of the LLC (i.e., a disregarded entity for Internal Revenue Control purposes). CSP assists community health centers in recruitment efforts for executive and senior level staff positions. The firm provides, for a fee, the following services: position profile development, candidate sources and outreach, screening and candidate assessment, interview and selection support, offer, negotiation, and acceptance. While this Manual applies to all MLCHC subsidiaries, as a placement agency in the Commonwealth, there are specific elements applicable especially to CSP's regulatory compliance with all federal and local laws of the Commonwealth of Massachusetts.

- Employment Agency Law, M.G.L. c. 140, §46A-46R and 454 CMR 24.00
    - The Employment, Placement, and Staffing Agencies Program within the Massachusetts Department of Labor Standards (DLS). Under Massachusetts law, placement agencies must be registered by the Commonwealth of Massachusetts in order to establish and conduct a placement agency.
- Compliance with MA Department of Labor Standards
    - Annual Renewal of MA Placement Agency Registration: to be submitted no later than 14 days before the date of expiration.
    - Regular inspections by DLS may occur, typically once a year. During inspections, a compliance officer will review employee files, payroll, and confirm compliance with the Temporary Worker Right to Know Law (TWRTK), if applicable.
- Tax Obligations under M.G.L. c. 62C, § 49(a)
- License Renewal Application Requirements and Compliance M.G.L. c. 151A, §19A
- Massachusetts Anti-Discrimination Statute (M.C.L. c. 151B)
- Workers Compensation Insurance (M.G.L. c. 152, §25A and 25C(6))
- Massachusetts Wage Act (M.G.L. c. 149, §148-150)
- Worker Adjustment and Retraining Notification (WARN) Act (Federal WARN Act provisions apply to employees in Massachusetts through the MA WARN Act)
- The posting of Massachusetts minimum wage and hour laws within MLCHC offices
- Federal Equal Pay Act ("EPA") of 1963 (29 CFR Part 1620) and Massachusetts Equal Pay Act ("MEPA")(M.G.L. c. 149 §105A)
- Older Workers Benefit Protection Act (29 U.S.C. §621)
- Fair Labor Standards Act (29 U.S.C. § 201 et seq.) (FLSA)
- Equal Employment Opportunity (EEO) Act of 1972 (29 CFR Part 1607)

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

- Family and Medical Leave Act (FMLA) (29 U.S.C. § 2601 et seq)
- Americans with Disabilities Act (ADA) of 1990 (42 U.S.C. § 12101 et seq)
- Patient Protection and Affordable Care Act (ACA) (Pub. L. No. 111-148)
- Occupational Safety and Health Act of 1970 (29 U.S.C. § 654) (OSHA)
    - Massachusetts Right to Know Law (M.G.L. c. 111F)

Enterprise Risk Management

The MLCHC risk management program is an overarching, conceptual framework that guides the development of a systematic approach to the management of risk initiatives and activities. The Risk Management Plan is designed to identify, assess, and mitigate risks to ensure that the MLCHC and its subsidiaries appropriately manage exposure to regulatory and compliance risk, liability events and claims, financial and contractual risks, and reputational risk.

Oversight of the risk management program is shared among executive leadership, the Finance department, the Office of the General Counsel, and the Board through its established governance and committee structures. The purpose of the Risk Management Plan and Schedule is to provide independent, risk-based assurance over key organizational risks, internal controls, and compliance obligations. The Plan outlines the audits and oversight activities annually and establishes expectations for execution, reporting, and management follow-up.
The Plan supports a consistent and transparent approach to risk management by:

- Identify and assess risks with impacts across the MLCHC and its subsidiaries
- Prioritize and coordinate risk mitigation activities
- Promote governance practices that reduce the likelihood of risk exposure
- Provide independent, risk-based assurance over key organizational risk, internal controls, and compliance obligations
- Providing the executive leadership team and the Board with a clear view of the organization's audit plan and schedule
- Supporting Board and Committee oversight of planned audit activities
- Allowing for adjustment of audit coverage in response to emerging risks, audit findings, or Board direction

Together, the Risk Management Plan and Schedule serve to strengthen decision-making, establish clear accountability, and organizational resilience by providing independent assurance and oversight of key risks, controls, and compliance obligations that support MLCHC's strategic objectives.

Docusign Envelope ID: A52C6D6D-6D45-88DF-8381-502C6770D39A

Liability Risk Insurance

The MLCHC has a liability risk insurance program in place to provide coverage in the event of liability events that require coverage; in addition, the MLCHC, where appropriate, shifts liability and risk to other entities in its contracts by requiring insurance, defense, and indemnification in contracts.

The MLCHC maintains commercial, general liability, umbrella/excess, errors and omissions liability, officer and director liability, worker's compensation, clinical research malpractice, and cybersecurity insurance policies that are reviewed on an annual basis by risk insurance staff, brokers, and risk counsel. The MLCHC Finance department manages the claims process in consultation with the Office of the General Counsel.

Contractual Exposure

The MLCHC's legal team reviews all agreements that contractually bind the organization for the risk of legal liability and exposure to administrative or other legal proceedings. Prior to approval for execution, a risk analysis is performed for each contract, reviewing factors including, but not limited to, the activities required under the contract, the source of the funding and applicable funding regulations, the regulatory environment of the other party, access to data, if any, required pursuant to the terms of the contract and the type of data, and whether subcontractors will be required to perform some required activities.

Periodic Review and Program Improvement

The MLCHC's Corporate Compliance Program will be reviewed at least annually to assess its effectiveness and identify areas for improvement. Feedback from staff, audits, and monitoring results will be used to refine and improve the Program on an ongoing basis. In that regard, the Board of Directors shall regularly receive reports from the Chief Compliance Officer and the Compliance Director regarding the effectiveness of the Program.

Signatures

Signed by:
Sue Levine
C64F359659634DF...

9/23/2026

Susan Levine
Chair, Board of Directors, MLCHC — Date

DocuSigned by:
Michelle Nadow
2ED72C6F23064A9...

9/30/2026

Michelle Nadow, Secretary, Board of Directors, MLCHC — Date