COMMUNITY HEALTH AND HOME CARE

Community Health and Home Care

A licensed agency Serving Tompkins, Schuyler, Cayuga, Tioga, Cortland and Broome Counties

Corporate Compliance Program and Standards of Conduct

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COMMUNITY HEALTH AND HOME CARE

Board Resolution
Endorsing and Authorizing the Revision of an Updated Effective Corporate Compliance Program

Community Health and Home Care (herein known as CHHC) is a New York State Licensed Home Care Agency. CHHC is committed to providing high quality healthcare in compliance with local, state and federal law. We meet this commitment through the leadership efforts from our highly skilled governance and team members. Each person of our team and organizations with whom and which we do business fulfills our mission and philosophy by conducting themselves with honesty and integrity in addition to adhering to all applicable regulations and standards.

To assist all concerned in making the right choices when confronted with difficult situations, the Board believes that CHHC will benefit from an effective corporate compliance program. The Board's action directs CHHC management to proceed with the ongoing enhancement and implementation of our corporate compliance program required for all New York State Licensed Home Care Agencies. This corporate compliance program is part of CHHC's continuing effort to improve the quality of our services, further our mission to eligible community beneficiaries and meet the letter and spirit of all Federal, State and local regulations.

In this regard, the Board also recognizes that the Department of Health and Human Services of the Office of Inspector General (OIG), the federal agency charged with enforcing the Medicaid and Medicare laws as well as the New York State Office of the Medicaid Inspector General (OMIG) has recently published and updated a series of updated compliance program guidelines for members of the healthcare industry mandating the enhancement of all provider corporate compliance initiatives.

Wherefore the Board resolves that:

The leadership and management of CHHC will dedicate such resources as are necessary to effectuate enhanced corporate compliance initiatives to promote adherence to all applicable and updated Federal, State and local regulations and standards.

1. The compliance program will continue to meet or exceed all the components of an effective compliance program and the changes of NYS 18 NYCRR Part 521 Sections 1-4 published December 22, 2022.

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2. The Compliance Program will cover the business operations of CHHC including the provision of all professional and skilled homecare services as well as non-skilled homecare services such as those of Home Health Aides (HHAs).
3. The Board recognizes that ongoing compliance initiatives may be costly. The Agency's compliance focus is to identify, prevent and mitigate all fraud, waste and abuse. Identified high risk elements will be audited and monitored on a regular basis.
4. Based upon the foregoing, the Board directs management to educate all employees, vendors, consultants, contractors, agents and volunteers on the Agency's Standards of Conduct and updated Corporate Compliance initiatives.
5. The Board will adhere to the Compliance Program attached as updated for the NYS 18 NYCRR Part 521 changes.

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COMMUNITY HEALTH AND HOME CARE

Corporate Compliance Officer Job Description

Department: Corporate Compliance

Reports to: CEO & Governing Authority

Job Summary
The Corporate Compliance Officer (CCO) is vested with the responsibility of developing, implementing and monitoring the effectiveness of the Corporate Compliance Program. The CCO reports directly to the CEO and the Governing Authority and has reporting responsibilities to a Compliance Committee, which is comprised of members of the Senior Management Team, regarding the operation of the Compliance Program as well as compliance activities including but not limited to the identification and mitigation of potential compliance issues.
The CEO, Corporate Compliance Officer and designated staff are collectively known as the Office of Corporate Compliance and collaboratively implement the day-to-day operations of the Compliance Program

Qualifications
The Corporate Compliance Officer may be a Juris doctorate (JD), Master of Arts (MA), Master of Public Health (MPH), Medical Director (MD), Registered Nurse (RN), or equivalent education and/or experience in medical, ethical and legal issues in the health care and/or home care environment.

Knowledge, Skills and Expertise

- Possess strong knowledge and understanding of all federal, state and local regulations and statutes that govern the operations of home health care. Additional expertise in Public Health Law and theory, as well as standards of relevant accrediting bodies.
- Strong oral and written communication and organizational skills, planning and problem-solving skills, conflict resolution and change management skills.
- Strong interpersonal skills including diplomacy and sensitivity to multiple, complex variables and situations.

Essential Responsibilities as it applies to Community Health and Home Care (CHHC).

Primary Responsibilities:
Under the general supervision of the CEO and Governing Authority the Corporate Compliance Officer will:

1. Develop, maintain and support the implementation of the Corporate Compliance Program and Plan for the Organization.
2. Facilitate the development and updating of Compliance Policies. Policies will be updated no less frequently than annually, or as otherwise needed, to conform with Federal and State laws, rules, regulations, policies and standards.

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3. Develop and implement a compliance work plan on an annual basis to outline the agency's strategy for overseeing, implementing, monitoring and identifying potential compliance risks having required approvals from the Governing Authority.
4. Report at least on a quarterly basis, or more frequently as necessary, to the Compliance Committee on the status of the Compliance Program implementation, the identification and resolution of potential or actual instances of non-compliance, as well as compliance auditing and monitoring activities and outcomes.
5. Institute and maintain an effective compliance communication program for the agency including promoting: (a) use of the compliance hotline; (b) heightened awareness of the Standards of Conduct; (c) understanding of new and existing compliance issues and related policies and procedures.
6. Create and coordinate Annual Compliance Training and other educational outreach to ensure all employees and contractors and/or agents acting on behalf of the organization are knowledgeable of the program, its written standards of conduct, policies and procedures, and applicable regulatory requirements.
7. Track and report to the Compliance Committee the status of the compliance training initiatives.
8. Develop and implement methods and programs to encourage all employees to report suspected fraud, waste, abuse and other misconduct without fear of retaliation or intimidation.
9. Ensures timely response to all reports of fraud, waste, and abuse or other misconduct, including the coordination of internal investigations and the development of appropriate corrective and/or disciplinary actions, if necessary.
10. Report any potential fraud, waste, and abuse or misconduct related to Medicare or Medicaid to the health plans, CMS, NYS, OMIG, their designee and/or law enforcement, when appropriate, in accordance with applicable law and legal counsel.
11. Maintain a record for each incident of potential or substantiated fraud, waste, and abuse or misconduct received through any reporting methods. Maintain clear documentation of the timeline of events, actions taken, interviews conducted, investigation outcomes, and all corrective and/or disciplinary actions taken as a result of the investigation.
12. Oversee the development and monitor the implementation of all compliance corrective action plans.
13. Monitor compliance with all privacy policies and procedures regarding the safe use and handling of protected health information in compliance with HIPAA regulations and security requirements, including the investigation and reporting of any breach incidents.
14. Provide oversight of the sanction screening process to ensure that the federal and state exclusion lists have been checked with respect to all workforce members to assure they are not included on such lists. This process is performed in collaboration with Human Resources and performed prior to hire and on a monthly basis thereafter.
15.. Consult with legal counsel as needed to resolve difficult legal compliance issues including NYS Self-disclosure requirements.
16. Implements and documents the annual assessment of the effectiveness of the Corporate Compliance Program measuring efficacy and making recommendations for improvements to enhance the effectiveness of the Program, as necessary or appropriate.

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16. Coordinate the implementation of an investigation with the CEO and the lead investigator of the MLTC/MMCO special investigation unit pursuant to SubPart 521-2, if applicable.
17. Submit required annual certifications to the Department of Social Services and participating providers including each MMCO as required by law.
18. Reports to the CEO and Governing Authority on at least an annual basis, the effectiveness of the Corporate Compliance Program.
19. Maintains access with the New York State Office the Medicaid Inspector General's website for compliance alerts and current trends, practices and updated standards.

The provider shall additionally:

1. Ensure the compliance officer is allocated sufficient staff and resources to satisfactorily perform their responsibilities for the day-to-day operation of the compliance program based on the required provider's risk areas and organizational experience.
2. Ensure that the compliance officer and appropriate compliance personnel have access to all records, documents, information, facilities and affected individuals that are relevant to carrying out their compliance program responsibilities.
3. Ensure the compliance officer not be the general counsel or chief financial officer, or report to positions, or be involved in activities that conflict with compliance activities. As such, it is reasonable to maintain flexibility for providers who may not be able to separate the compliance officer from these functions. If it is not feasible for the agency to separate the compliance function, then a procedure for addressing conflicts of interest or potential risks are in place to achieve a system of checks and balances, when needed.
4. Evaluate in concert with the compliance officer and compliance committee the need to revise the compliance work plan to enhance the compliance program based on the organizational experiences including but not limited to external audits and other provider investigations and risk factors.
5. Provide the compliance officer flexibility to develop a work plan that best meets the agency's characteristics and risk environment.

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Compliance Officer Acknowledgement

____________________has been designated the Compliance Officer for Community Health and Home Care Licensed Home Care Agency (herein known as CHHC). This position will follow the Compliance Office Job Description and responsibilities attached. This position will ensure that all affected individuals', staff, contractors, agents, subcontractors, and independent contractors:

(i) are well-integrated into the company's operations and supported by the highest levels of the organization, including the Chief Executive, Senior Management and the Governing Body.
(ii) promote adherence to the required provider's legal and ethical obligations; and
(iii) are reasonably designed and implemented to prevent, detect, and correct noncompliance with program requirements including fraud, waste and abuse most likely to occur for the provider's risk areas and organizational experience.

Acknowledgement: ____________________________________

Date: _______________

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COMMUNITY HEALTH AND HOME CARE

Corporate Compliance Program

INTRODUCTION

Community Health and Home Care (herein known as CHHC) is a New York State Certified Home Healthcare Agency. CHHC offers a comprehensive range of superior professional and paraprofessional services and support in the comfort, security and privacy of community residents' home setting. Our compassion and concern for our patients' welfare gives families the peace of mind that their loved one is in good hands. CHHC has a professional staff with years of experience in providing warm, friendly and professional care and service to promote and support the health and sustain the independence of residents in the communities we serve. Every health care professional is exceptionally trained and has been screened and tested to ensure the highest level of service to our patients. Our agency is staffed by our team of outstanding nurses, physical, occupational therapists as well as speech-language pathologists and medical social workers. CHHC Home Health Aides are selected and specialty trained with New York State Certification.

The mission of the Corporate Compliance Department is to protect and promote our integrity and enhance our ability to achieve our business and strategic objectives in a manner consistent with the mission and values of CHHC. The mission of the Compliance Office is to assist and advise all leadership, staff, contractors and affected individuals to ensure compliance with all applicable Federal, State and local laws. In this capacity the compliance office is committed to providing clear guidelines to train and educate all affected individuals and affiliated professionals regarding applicable laws, regulations, policies and procedures as they pertain to compliance.

The Corporate Compliance Office will promote a culture in concert with agency leadership and staff, that encourages all affected individuals and affiliated professionals to conduct activities with integrity and in compliance with laws, regulations and CHHC policies and procedures and to report instances of non-compliance to the Corporate Compliance Department. The Compliance Office and agency leadership are committed to educating officers, directors, staff, all affected individuals, and affiliate professionals of CHHC concerning the legal risks of certain business practices. To encourage CHHC managers to seek appropriate counsel regarding business practices and to conduct those activities within the requirements of the law and ethical standards of conduct for all of CHHC affected individuals and to secure compliance with the New York State updated Office of Inspector General's (OMIG) compliance standards and Federal Sentencing Guidelines.

In addition to being trained to meet the physical needs of our clients, all affected individuals are selected to meet the language, religious and cultural needs of the client as well. We strive to provide qualified and compassionate individuals with the special needs of the client in mind. Both our field staff and office staff represent various cultural and ethnic groups with a command of numerous languages so that we can assist in making your transition to home care as easy as possible.

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COMMUNITY HEALTH AND HOME CARE

CHHC provides quality home health care for recovering and chronic patients, serving a wide range of patients, from infants through geriatrics. In recognition of the complexity and constant changes in various federal and state laws and regulations governing the health care industry, the implementation of compliance plans has become an important part of ensuring conformity with existing law. A compliance plan is a series of internal controls that promote the prevention, detection and resolution of conduct that is illegal or that does not conform to CHHC's ethical standards. This compliance plan is integrated into the daily operations of all care and services rendered by CHHC.

Agencies and departments of the U.S. and New York State government have publicized a number of instances of fraud, abuse and waste in federally funded health care programs including Medicaid. The management of this agency recognizes the seriousness of the issues detailed by the government and recognizes that failure to comply with applicable laws and regulations could threaten the agency's continuing participation in these health care programs.

The agency, therefore, has directed that the Compliance Officer continue to refine an integrity program that demonstrates ongoing commitment to high standards of conduct, honesty and reliability in all service and business practices. This integrity program is called a Corporate Compliance Program. The purpose of the Corporate Compliance Program is to promote understanding of and adherence to applicable federal and state laws and regulations and to make a sincere effort to prevent, detect and correct any fraud, abuse or waste in connection with federally and state funded health care programs and private health plans. There are several parts to the Corporate Compliance Program, each of which is important. The Program applies to *all affected individuals*. **"All affected individuals" means all persons who are affected by the required provider's risk areas including the required provider's employees, the chief executive and other senior administrators, associate and assistant administrators, managers, department directors, supervisors, contractors, agents, subcontractors, independent contractors, governing authority, corporate officers and any other person or individual hired by and in the paid service of the agency.**

The Compliance Program will address:

1. Written Policies and Procedures
2. Designation of a Compliance Officer and Compliance Committee
3. Compliance Officer's Roles and Responsibilities
4. Compliance Committee Roles and Responsibilities
5. Compliance Committee Charter
6. Annual Compliance Work Plan
7. Training and Education
8. Communication Lines to the Compliance Officer
9. Disciplinary Policies
10. Identification of Expanded Compliance Risk Areas
11. Protocol for Contractor, Agent, Subcontractor and Independent Contractor Oversight
12. Responding to Compliance Issues
13. Policy of Non-intimidation and Non-retaliation
14. Policy for Self-Disclosure
15. Compliance Program Reviews

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COMMUNITY HEALTH AND HOME CARE

I. WRITTEN POLICIES

Standards of Conduct

CHHC business affairs must be conducted in accordance with federal, state and local laws, professional standards, applicable federally funded health care program regulations and policies and with honesty, fairness and integrity. The agency is committed to delivering the highest quality of care consistent with standards of professional practice and relevant federal, state and local laws, rules and regulations. All affected individuals should perform their duties in good faith, in a manner that he or she reasonably believes to be in the best interest of the agency and its patients and with the same care that a reasonably prudent person in the same position would use under similar circumstances. To further these overall goals, a number of policies or standards of conduct have been adopted by the agency. See the separate standards of conduct policy and employee acknowledgement.

Hiring Package: All affected individuals are provided a letter from the Compliance Officer detailing their personal and professional responsibilities for understanding and adhering to the Agency's Standards of Conduct. It indicates who is the responsible compliance officer and phone number to reach him, how to report a violation and all the elements of an effective Compliance Program.

The staff package given to each employee sets out several types of conduct which are unacceptable. These include but are not limited to:

1. Intentionally or knowingly making false or erroneous entries on reports, patient charts or other agency records.
2. Dishonesty or omitting information.
3. Unauthorized alteration or destruction of agency records including patients' charts.
4. Coding or billing which violates Medicare and Medicaid rules or regulations or other federal rules or regulations.
5. Behavior detrimental to the operation of the agency.
6. Behavior that violates our relationship and trust with our patient population, including absenteeism, stealing, sharing private or misleading information.

Other unacceptable conduct may be found in the Hiring Package and is reviewed during orientation and on an annual basis during mandatory annual updates.

Conflict of Interest. In order to perform their duties with honesty and fairness and in the best interest of the agency all affected individuals must avoid conflicts of interest in their employment. Conflicts of interest may arise from having a position or interest in or furnishing managerial or consultative services to any concern or business from which the agency obtains goods or services or with which it competes or does business, from soliciting or accepting gifts, excessive entertainment or gratuities from any person or entity that does or is seeking to do business with the agency and from using agency property for personal or private purposes. Conflicts may also arise in other ways. If an employee has any doubt or any question about any of his or her proposed activities, guidance or advice should be obtained from administration. The agency has a policy on and prohibiting conflicts of interest. A copy may be obtained from administration.

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Confidentiality of Information. All patient information and their health care record shall be maintained to serve the patient, necessary health care providers, the institution, and payors such as Medicaid and other third-party payors in accordance with legal, accrediting and regulatory agency requirements. The information contained in the health care record belongs to the patient and the patient is entitled to the protection of that information. All patient care information is regarded as confidential and available only to authorized users and all affected individuals who may be providing patient care and to third party payors in order to facilitate reimbursement. The operations, activities, business affairs and finances of the agency should also be kept confidential and discussed or made available only to authorized users. All patient information is a "need to know" basis only when reviewing care plans or sharing patient information with any other employee or affected individual. A breach of confidentiality may result in disciplinary action including termination.

Fraud and Abuse. All affected individuals shall refrain from conduct, which may violate the fraud and abuse laws. These laws prohibit (1) direct, indirect or disguised payments in exchange for the referral of patients; (2) the submission of false, fraudulent or misleading claims to any government entity or third party payor, including claims for services not rendered, claims which characterize the service differently than the service actually rendered or claims which do not otherwise comply with applicable program or contractual requirements; and (3) making false representations to any person or entity in order to gain or retain participation in a program or to obtain payment or excessive payment for any service.

Business Ethics. All affected individuals must accurately and honestly represent the agency and should not engage in any activity or scheme intended to defraud anyone of money, property or honest services.

Financial Reporting. All financial reports, accounting records, research reports, expense accounts, time sheets and other documents must accurately and clearly represent the relevant facts or the true nature of a transaction. Improper or fraudulent accounting, documentation or financial reporting is not only contrary to agency policy but is also in violation of applicable laws. Sufficient and competent evidential matter or documentation shall support all statistical and/or cost reports.

Protection of Assets. The agency will make available to all affected individuals, assets and equipment necessary to conduct agency business including such items as computer hardware and software, billing and medical records, both hardcopy and in electronic format, fax machines, office supplies and various types of medical equipment. All affected individuals should strive to use agency assets in a prudent and effective manner. The agency's property should not be used for personal reasons or be removed from the agency without approval from a departmental manager. An employee who believes that any medical equipment is not operating properly or has an inaccurate calibration should immediately report the problem to his or her supervisor.

Anti-Competitive Conduct. The agency will not engage in anticompetitive conduct that could produce an unreasonable restraint of trade or a substantial lessening of competition. Evaluation of anti-competitive conduct requires legal guidance. Communication by all affected individuals

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with competitors about matters that could be perceived to have the effect of lessening competition or could be considered as collusion or an attempt to fix prices should take place only after consultation with legal counsel.

Financial Inducements. No employee shall offer any financial inducement, gift, payoff, kickback, or bribe intended to induce, influence or reward favorable decisions of any government personnel or representative, any customer, contractor or vendor in a commercial transac tion or any person in a position to benefit the agency or the employee in any way. All affected individuals are strictly prohibited from engaging in any corrupt business practice either directly or indirectly. No employee shall make or offer to make any payment or provide any other thing of value to another person with the understanding or intention that such payment or other thing of value is to be used for an unlawful or improper purpose. Appropriate commissions, rebates, discounts and allowances are customary and acceptable business inducements provided that they are approved by the Administration and that they do not constitute illegal or unethical payments. Any such payments must be reasonable in value, competitively justified, properly documented, and made to the business entity to which the original agreement or invoice was made or issued. Such payments should not be made to individual all affected individuals or agents of business entities.

Additional standards. The agency has adopted a number of other agency-wide policies and procedures. All affected individuals may obtain copies in administration. Additional standards and policies may be applicable only to particular departments and copies may be obtained from supervisors or directors in those departments. It is particularly important that coding, billing and submission of claims to Medicaid and other third-party payers, be appropriate, accurate and in compliance with applicable laws and regulations. Standards relating to billing will be found in a later section of this Program. These Standards of Conduct apply to *all affected individuals*, including staff, supervisors, managers, directors and administrators. They also apply to temporary, and contract individuals and where practical to independent contractors doing business with the agency and to physicians. These Standards are not intended to cover every situation which may be encountered, and all affected individuals should comply with all applicable laws and regulations whether or not specifically addressed in the Standards.

Accurate Bills and Records. Bills for federally funded health care programs, as well as to other payors, must be true, accurate and complete and for services believed to be medically necessary, and that were ordered by a physician or other appropriately licensed person. All professional services should be documented timely, correctly and properly. Patient records and other documentation which support the bills should also be true, accurate and complete in accordance with professional standards and available for audit and review. **See Policy 15 Billing and Claims.**

The following ***should not*** occur:

Billing for services not rendered,
Misrepresenting services provided (inappropriate coding, inflating units of service),
Billing for services rendered to patients that do not meet admission criteria,
Duplicate billing for the same service,

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Falsifying billing or medical records in any way,
Entering into business agreements that pose a conflict of interest,
Any cash payment made in return for client, referrals,
Billing for services that are not medically necessary,
Billing for services that are substandard in quality,
Participation in any Anti-kickback schemes as prohibited by law
Participation in any Self-Referrals as prohibited by law

The following ***should occur*** **annually**:

Review of Written Policies and Procedures and Standards of Conduct to Determine:

i. If such policies, procedures and standards of conduct have been implemented;
ii. Whether affected individuals are following the policies, procedures, and standards of conduct;
iii. Whether such policies, procedures and standards of conduct are effective; and
iv. Whether any updates are required.

Compliance Committee Charter Updates
Compliance Work Plan Updates
Compliance Plan Risk Assessment
Credentialing
OMIG Assessment Form
Reporting at year-end to the Office of the Medicaid Inspector General (OMIG)

Training and Incentives. Training, education and documents necessary for accurate code assignment is and will continue to be made available to all affected individuals involved in coding. Billing department coders and billing consultants will not be provided any financial incentive to improperly up code claims or otherwise improperly increase revenue.

Fiscal Reports. The Controller shall prepare or cause to be prepared policies and procedures ensuring against submission of false or inaccurate fiscal reports and ensuring that costs are not claimed unless based on appropriate and accurate documentation and unallowable costs are not claimed for reimbursement.

Retention of Records. Records and documents shall include: (i) clinical and medical records and claims documentation required by federal or state law for participation in federal health care programs; and (ii) records relating to the Compliance Program such as documentation related to employee training, reports from the hotline, the nature and results of any investigations, and results of the agency auditing and monitoring efforts. The provider shall make available to the department, OMIG or Medicaid Investigation Unit up on request, copies of such records.

Records shall be retained: (i) for a period not less than six (6) years from the date such program was implemented, or any amendments thereto, were made; or (ii) by Medicaid Managed Care Organizations in accordance with the retention periods specified in their contract with the department to participate as a Medicaid Managed Care Organization.

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II. COMPLIANCE OFFICER AND COMPLIANCE COMMITTEE

Officer: The Governing Authority and the Chief Executive Office shall appoint an individual with expertise and training to serve as the Compliance Officer.

Duties:
The Compliance Officer is responsible for the day-to-day operation of the compliance program. The Compliance Officer and the Compliance Committee shall prepare, and revise as necessary, a job description for the Compliance Officer. The Compliance Officer's primary responsibilities set out in the job description shall include:

1. Develop, maintain and support the implementation of the Corporate Compliance Program and Plan for the Organization.
2. Facilitate the development and updating of Compliance Policies. Policies will be reviewed and updated no less frequently than annually, or as otherwise needed, to conform with Federal and State laws, rules, regulations, policies and standards.
3. Develop and implement a compliance work plan on an annual basis to outline the agency's strategy for overseeing, implementing, monitoring and identifying potential compliance risks.
4. Report at least on a quarterly basis, or more frequently as necessary, to the Compliance Committee and Governing Authority on the status of the Compliance Program implementation, the identification and resolution of potential or actual instances of non-compliance, as well as compliance auditing and monitoring activities and outcomes.
5. Institute and maintain an effective compliance communication program for the agency including promoting: (a) use of the compliance hotline; (b) heightened awareness of the Standards of Conduct; (c) understanding of new and existing compliance issues and related policies and procedures.
6. Create and coordinate Annual Compliance Training and other educational outreach to ensure all employees and contractors and/or agents acting on behalf of the organization are knowledgeable of the program, its written standards of conduct, polices and procedures, and applicable regulatory requirements.
7. Track and report to the Compliance Committee the status of the compliance training initiatives.
8. Develop and implement methods and programs to encourage all employees to report suspected fraud, waste, abuse and other misconduct without fear of retaliation or intimidation.
9. Ensure timely response to all reports of fraud, waste, and abuse or other misconduct, including the coordination of internal investigations and the development of appropriate corrective and/or disciplinary actions, if necessary.
10. Report any potential fraud, waste, and abuse or misconduct related to Medicare or Medicaid to the health plans, CMS, NYS, OMIG, their designee and/or law enforcement, when appropriate, in accordance with applicable law and legal counsel.
11. Maintain a record for each incident of potential or substantiated fraud, waste, and abuse or misconduct received through any reporting methods. Maintain clear

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documentation of the timeline of events, actions taken, interviews conducted, investigation outcomes, and all corrective and/or disciplinary actions taken as a result of the investigation.

12. Oversee the development and monitor the implementation of all compliance corrective action plans.
13. Monitor compliance with all privacy policies and procedures regarding the safe use and handling of protected health information in compliance with HIPAA regulations and security requirements, including the investigation and reporting of any breach incidents.
14. Provide oversight of the sanction screening process to ensure that the federal and state exclusion lists have been checked with respect to all workforce members to assure they are not included on such lists. This process is performed in collaboration with Human Resources and performed prior to hire and on a monthly basis thereafter.
15. Consult with legal counsel as needed to resolve difficult legal compliance issues including NYS Self-disclosure requirements.
16. Implements and documents the annual assessment of the effectiveness of the Corporate Compliance Program measuring efficacy and making recommendations for improvements to enhance the effectiveness of the Program, as necessary or appropriate.
17. Submit required annual certifications to the Department of Social Services and participating providers including each MMCO as required by law.
18. Reports to the CEO and Governing Authority on at least an annual basis, the effectiveness of the Corporate Compliance Program.
19. Maintains access with the New York State Office the Medicaid Inspector General's website for compliance alerts and current trends, practices and updated standards.

Authority: The Compliance Officer shall have direct access to the Chief Executive Officer and, as required, to the Governing Authority. The Compliance Officer shall have access to all documents and information relevant to compliance activities including but not limited to patient records, billing records, marketing records and contracts and written arrangements or agreements with others. The Compliance Officer may seek advice of legal counsel and with consent of the Compliance Committee, may retain necessary consultants or experts.

Reports: The Compliance Officer shall report to the Board at least quarterly on the status of compliance in the agency. Such reports will be in a written format. The annual Compliance Risk Assessment will be provided in a written format as well.

Compliance Committee: The role of the Compliance Committee (the "Committee") shall be to support executive management and the Governing Authority in overseeing the Agency's compliance program and the management's identification and evaluation of the Agency's principle and regulatory compliance risks. The Compliance Committee with the coordination of the Compliance Officer will advise management on maintaining compliance, monitoring and reporting on compliance performance and the provision of compliance training to all staff.

Compliance is a second line of defense and does not relieve executive management of their responsibility for effective control.

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The Compliance function is established by the Governing Authority. Compliance responsibilities are agreed and periodically reviewed on at least an annual basis, and more frequently as indicated by regulatory updates, by the Committee as part of its oversight role.

Committee Composition: The Committee members are Senior Management and appointed by the Governing Authority and may be removed by the Governing Authority at its sole discretion. The Chair of the Compliance Committee is the Chief Executive Officer who coordinates compliance activities with the Compliance Officer. The Governing Authority shall designate a Compliance Committee consisting of 5- 9 members of the agency and shall include representatives from:

Compliance Officer
Administration
Finance
Information Technology
Human Resources
Clinical and
Quality Program Services

Any vacancy on the committee, whether by resignation, illness, death or otherwise, shall be promptly filled by appointment by the Chief Executive Officer and each such appointee shall serve for the remainder of the unexpired term of his or her predecessor.

Committee Meetings and Procedures: The Committee shall meet no less frequently than quarterly and designate one member of the Committee as its Chairperson in the absence of the Chief Executive Officer by a majority vote of the Committee.

The Committee may request that any directors, officers or employees of the agency, or other people who advise and counsel are sought by the Committee, attend any meeting of the Committee to provide relevant information to the Committee's requests. The Compliance Committee may adopt additional written guidelines for holding meetings and conducting the activities and operations of the committee.

Following each meeting the Committee will deliver a report on the meeting to the Governing Authority, including a summary description of actions taken by the Committee at the meeting. The Committee shall keep written minutes of its meetings, which shall be maintained with the books and records of the agency for at least six years, or as indicated by applicable federal and/or state law.

Duties: In performing these responsibilities, the Committee shall, among such other activities it deems appropriate and necessary:

1. Coordinate with the Compliance Officer to ensure that the written policies and procedures, and standards of conduct are current, accurate and complete and reviewed on at least an annual basis.

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2. Coordinate with the Compliance Officer that the compliance training topics are relevant and completed on a timely basis and at the minimum of annually.
3. Coordinate with the Compliance Officer to ensure communication and cooperation by affected individuals on compliance related issues, internal or external audits, or other functions or activities required by the Compliance Plan and New York State Law.
4. Advocate for the allocation of sufficient funding, resources and staff for the Compliance Officer to fully perform their responsibilities.
5. Ensure that the Agency has effective systems and processes in place to identify compliance program risks, overpayment and other issues, and effective policies and procedures for correcting and reporting such issues.
6. Advocate for adoption and implementation of required modifications to the compliance programs.
7. Report directly to and be accountable to the Agency's Chief Executive Officer and the Governing Authority.

Investigations and Authority: The Committee may conduct, commission, or authorize investigations into or studies, analyses, review and/or surveys of matters within the Committee's scope of responsibilities to evaluate the Agency's compliance with regulatory requirements, as well as to evaluate the quality of the personnel, committees and entities providing compliance and regulatory services to the Agency. The Committee shall have the authority to the extent it deems necessary or appropriate, at the Agency's expense, to retain independent legal, accounting or other advisors.

The Committee may require management to conduct audits on compliance, regulatory and/or legal concerns and where appropriate, direct management to provide the results of such audits to the Committee directly. The Committee may also request and meet privately with any member of the Agency's Senior Management Team or any other Agency employee.

Limitation of Compliance Committee's Role: Although the Committee has the duties and responsibilities set forth in the Compliance Committee Charter, the Committee is not responsible for determining whether the Agency's Compliance Program is effective. Management is responsible for designing programs to comply with all applicable laws and regulations in the scope of all applicable home health care federal, state and local regulations and standards. The Compliance Officer is responsible to perform an annual compliance assessment to determine the effectiveness of the Agency's compliance program. This assessment and recommendations will be used to revise and update the Compliance Plan on at least an annual basis, and as necessary by Agency circumstances, incidents, investigations and/or regulatory updates.

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III. TRAINING AND EDUCATION

CHHC will establish and implement an effective compliance training and education program for its compliance officer, leadership, staff and all affected individuals. The agency's compliance training and education program shall meet the following requirements:

A. Include, at a minimum, the following topics:

i. the agency's risk areas and organizational experience;
ii. the agencies written policies and procedures identified in the Compliance Plan;
iii. the role of the Compliance Officer and the Compliance Committee;
iv. how all staff and affected individuals can ask questions and report potential compliance-related issues to the compliance officer and senior management, including the obligation of all individuals to report suspected illegal or improper conduct and the procedures for submitting reports, and the protection from intimidation and retaliation for good faith participation in the compliance program;
v. disciplinary standards with an emphasis on those standards related to the required compliance program and prevention of fraud, waste and abuse;
vi. how the agency responds to compliance issues and implements corrective action plans; requirements specific to the Medicaid program and the provision of aide services;
vii. coding and billing requirements and best practices, if applicable;
viii. claim development and the submission process, if applicable.

B. The Agency shall develop and maintain a Compliance Training Plan. The Training Plan will include:

i. An outline of the subjects and topics for training and education;
ii. The timing and frequency of the training;
iii. Which staff and affected individuals are required to attend;
iv. How attendance will be tracked;
v. How the effectiveness of the training will be periodically evaluated.

C. **Necessity.** It is imperative that coding and billing of federal health care claims be truthful and accurate and within appropriate guidelines. This service is provided by an outside vendor and will be periodically tested for compliance and accuracy. Not only are severe penalties available to the government but honesty and integrity in agency operations are right and proper. Proper and continuing training and education of all affected individuals at all levels is, therefore, a significant element of an effective compliance program.

D. **Initial Education.** Mandatory new employee orientation and the hiring package will provide an overview of fraud and abuse laws, a summary of the standards of conduct, an explanation of the elements of the Compliance Program, including the complaint or reporting process and highlight the agency commitment to integrity in its business operations and compliance with applicable laws and regulations.

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E. **General Rules**. Periodically, as necessary, and at least annually, appropriate all affected individuals will be retrained on all required topics listed in Part A above to include (i) on the agency's Compliance Program; (ii) the fraud and abuse laws as they relate to the claim development and submission process and the agency business relationships; (iii) relevant federal and state requirements; and (iv) the consequences both to the agency and individuals of failing to comply with applicable laws and regulations. Such training must emphasize the importance of the Compliance Program and the agency's commitment to honesty and integrity in its business dealings. This training will also be specific to the individual's roles and responsibilities with CHHC.

F. **Types.** Training and education may occur in sessions with individual all affected individuals, in mandatory in-service meetings or incorporated into special or regular departmental meetings or in some other effective manner. Training may consist of live presentations, videos, question and answer sessions and written material and may occur in-house or through attendance at external workshops and seminars.

G. **Amount of Training.** All affected individuals need not have the identical amount of training and education, nor will the focus of training and educational efforts be the same for all affected individuals. The actual amount of training should reflect necessity, an analysis of risk areas or areas of concern identified by the agency or the Office of the Inspector General, the agency compliance experience and the results of periodic audits or monitoring.

H. **Documentation.** The training provided to each employee shall be documented in their Personnel file. The documentation shall include the date and a brief description of the subject matter of the training activity or program.

I. **Failure to Attend.** Failure to comply with training requirements or to attend scheduled training sessions of the agency or of each department may result in job transfer and/or disciplinary action.

J. **Evaluation.** There will be periodic evaluations of training and education programs to determine, and if necessary improve, the value, effectiveness and appropriateness of any such program.

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IV. COMMUNICATION

A. **Reason.** Open communications between *all affected individuals* and the Compliance Officer or Compliance Committee are important to the success of this Compliance Program and to the reduction of any potential for fraud, abuse and waste. Without help from all affected individuals it may be difficult to learn of possible compliance problems and make necessary corrections. Confidentiality of communication is critical in the implementation of effective lines of communication. **See Policy 5**.

B. **Questions.** At any time *all affected individuals and recipients of services from this agency* may seek clarification or advice from the Compliance Officer or members of the Compliance Committee in the event of any confusion or question with regard to this Program or any element of this Program or any agency policy or procedure related to this Program. Questions and responses should be documented and, if appropriate, shared with other affected individuals for informational and educational purposes. *All affected individuals and recipients of services from this agency* should be encouraged to contact the Compliance Officer and any member of the committee for this purpose. The Compliance Officer will develop or cause to be developed for all affected individuals publicity and notices regarding his or her name, location and e-mail address and the names of members of the committee and their location.

C. **Reporting.** All affected individuals who are aware of or suspect acts of fraud, abuse, waste or violations of the Standards of Conduct should report such acts or violations. Several independent reporting paths are available:

1. *All affected individuals* may but are not required to report to their supervisor or department director or manager. Supervisors and managers will thereafter promptly pass on the report to the Compliance Officer or member of the committee.

2. *All affected individuals* may report directly to the Compliance Officer or to a member of the committee. The Compliance Officer will post this number in one or more prominent locations in the agency.

3. *All affected individuals* may also report compliance issues anonymously to the Compliance Officer. Anonymous methods of reporting compliance issues include the use of the agency compliance hotline, suggestion box, or anonymous report form mailed into the agency's Compliance Officer. The Compliance Officer will ensure publicizing the anonymous report methods.

4. *All affected individuals* may also call the hotline or the Office of the Inspector General of the Health and Human Services Department, 1-800-HHS-TIPS (447-8477), or the NYS Office of Medicaid Inspector General Compliance main line at 518-408-0401 or the Fraud Hotline at 1-877-87-FRAUD. The Compliance Officer will post this number in one or more prominent locations in the agency.

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D. **Confidentiality.** Reports received will be treated confidentially to the extent possible under applicable law. However, there may be a time when an individual's identity may become known or have to be revealed if governmental authorities become involved or in response to subpoena or other legal proceeding.

E**. Non-Retaliation/ Non-Intimidation.** There will be no reprisals, retaliation ***nor intimidation*** against all affected individuals who in good faith report acts or suspected acts of fraud, abuse or waste or violations or suspected violations of the Standards of Conduct or other wrongdoing or misconduct.

However, an employee who makes an intentional false report or a report not in good faith may be subject to disciplinary action. **See Policy 8.**

F. **Documentation.** Reports that suggest substantial violation of this Program, violation of the Standards of Conduct or violation of relevant law or regulation should be documented by the Compliance Officer. Information about such reports should be furnished periodically to the Governing Authority, Chief Executive Officer and to the Compliance Committee at its regular meetings. Investigations and analysis of any and all reports will be tracked and trended to ensure corrective actions have been implemented and effectively addressed agency process or procedure issues impacting compliance adherence.

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V. DISCIPLINE AND DISCLAIMER

A. **Other Reasons:** In addition to possible disciplinary action mentioned elsewhere in this Program all affected individuals may be subject to disciplinary action for:

1. Failure to perform any obligation or duty required of all affected individuals relating to compliance with this Program or applicable laws or regulations.
2. Failure of supervisory or management personnel to detect non-compliance with applicable policies and legal requirements and this Program where reasonable diligence on the part of the manager or supervisor would have led to the discovery of any violations or problems.

B. **Procedure**. Disciplinary standards and procedures for taking such actions will be published and disseminated to all affected individuals and will also be incorporated into the agency's compliance training programs. Disciplinary standards will be fairly and consistently applied to all levels of personnel and affected individuals. Possible disciplinary action will follow the existing disciplinary policies and procedures. Progressive discipline is not required. **See Policy 14 on Discipline**.

C. **Disclaimer.** Nothing in this Program shall (i) constitute a contract of or agreement for employment; or (ii) modify or alter in any manner any employee's at-will employment status. Any part of this Program may be changed or amended at any time without notice to any employee.

D. **Contractors, Agents, Subcontractors and Independent Contractors:** Are subject to disciplinary actions up to and including termination of contracts. These contracts will be updated to include termination provisions for failure to adhere to the Agency's compliance program requirements.

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VI. IDENTIFICATION OF COMPLIANCE RISK AREAS

A. **Process.** Audits will be undertaken in order to identify compliance deficiencies in the delivery of care and services and in the claim development and submission process. The agency will devote such resources as are reasonably necessary to ensure that audits are adequately staffed by persons with appropriate knowledge and experience. Annually, a work plan will be prepared and updated from the prior year's areas reviewed and the OMIG current work plan issues. **See Appendix 1-*2* for the List of Expanded Risk Areas.**

B. **Time.** The Compliance Committee will approve the annual Compliance Work Plan that designates the time and frequency for audits and the departments and functions to be audited. Audits will be performed to determine the overall effectiveness of the compliance program. Audits conducted by both internal and external sources will focus on the identified risk areas detailed in the Agency's annual updated Compliance Work Plan.

C. **All affected individuals.** It is the responsibility of each department manager to ensure that all affected individuals who are new to a position, which has a direct impact on the claim development and submission process, are provided adequate and appropriate training and education. To verify that each new employee understands the essential elements of his or her job function, the work of such new all affected individuals should be audited or reviewed until the director or manager is satisfied that the accuracy of the employee's work is adequate to justify cessation of the audit or review. Directors or managers may rely on other competent and experienced all affected individuals to assist in such reviews.

D. **Periodic Tests and Audits.** The agency, under the direction of the Compliance Officer, will conduct periodic tests of claims submitted to Medicaid and other federal health care plan and audits of the claims development and submission process. Audits shall also cover the agency relationship with third party contractors, and compliance with laws governing kickback arrangements. The Compliance Office may request that the director or manager of each affected department prepare and submit testing, audit and monitoring plans for his or her department. **See Appendix 2 for Sample List.**

E. **Access.** Auditors and reviewers shall have access to all necessary documents including those related to claim development and submission, patient records, e-mail and the contents of computers and word processors. Auditors and reviews shall at all times bear in mind confidentiality requirements.

F. **Action.** The Compliance Officer will be notified of the results of all audits. Further action, if any, by the Compliance Officer with respect to any deviation or discrepancy revealed by an audit will be taken. Any overpayments by the Medicaid program will be reported, returned and explained in accordance with the updated Self-Disclosure Policy. **See Policy #12.**

G. **Documents.** All audits shall be thoroughly documented and shared with the Compliance Committee and the Governing Authority. Such documents shall be maintained in the permanent files of the Compliance Officer and adequately secured. All Agency corporate compliance

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documents shall be maintained for ten years. No other agency employee or agent is authorized to maintain a copy of any of the compliance documents. These documents include compliance investigative reports, compliance corrective action plans and documentation of completed corrective action plans and statements of understanding.

VII. RESPONDING TO COMPLIANCE ISSUES

RESPONSE TO GOVERNMENT INQUIRIES

A. **Cooperation.** Federal agencies have available a number of investigation tools including search warrants, subpoenas and civil investigation demands. Actions also may be brought against the agency to exclude it from participating in Medicaid if the agency fails to grant immediate access to agencies conducting surveys or reviews. It is, therefore, the policy of the agency to cooperate with and properly respond to all governmental inquiries and investigations.

B. **Process.** *All affected individuals* who receive a search warrant, subpoena or other demand or request for investigation, or if approached by a federal agency, should attempt to identify the investigator, if any, and immediately notify the Compliance Officer or, in that Officer's absence, a member of the Compliance Committee or the employee's supervisor. All affected individuals should request the government representative to wait until the Compliance Officer or his or her designee arrives before conducting any interview or reviewing documents. The Compliance Officer in consultation with outside legal counsel is responsible for coordinating the agency's response to warrants, subpoenas, inquiries and investigations by federal agencies. If appropriate, the agency also may provide legal counsel to all affected individuals.

C. **Documents.** The agency's response to any warrant, subpoena, investigation or inquiry must be complete and accurate. No employee shall alter, destroy or mutilate any document or record or alter, delete or download any material from any computer, word processor, disk or tape. Documents and records must be preserved in their original form.

D**. Internal Investigations and Reports**

The Compliance Officer shall conduct prompt investigations of all potential and/or reported compliance issues. The Compliance officer will investigate and determine if corrective action is required. Implementation of corrective actions is prompt. The Compliance Officer will provide written evaluation reports on compliance activities including reports or complaints received from all affected individuals, investigations, audits and monitoring to the Board, Chief Executive Officer and members of the Compliance Committee on at least a quarterly basis or as indicated by investigation results. Reports to the Board shall be at least annually or more often as necessary or advisable. **See Policy #2.**

E. **Screening**

1. New Employees. The agency will conduct a background investigation of all new direct care all affected individuals, and / or at the discretion of the agency, applicants for employment, who have or will have discretionary authority to make decisions that or whose job function may materially impact the Medicaid claim development and submission process. The purpose of the

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background investigation is to determine whether any such employee or applicant has been convicted of a criminal offense related to health care or has been excluded from the Medicare or Medicaid program in which case employment will not be considered. This will be performed when being considered and every 30 days thereafter in accordance with the organization's exclusion policy.

2. Vendors and Contractors. Background investigations will be conducted for vendors and contractors to determine if any such vendor or contractor has a criminal conviction related to health care or has been disbarred or excluded by a federal agency. This will be performed when being considered and monthly thereafter in accordance with the organization's exclusion policy. See P**olicy #11**.

3. Process. The Compliance Officer will implement and maintain policies and procedures for developing relevant applications for employment and for conducting such background investigations. The application for employment should require the applicant to disclose any criminal conviction related to health care programs or exclusion action. The background investigations can utilize the OIG Cumulative Sanction Report. OMIG Work plan www.omig.state.ny.us, GSA exclusion list www.epls.gov, Federal OIG list http://oig.hhs.gov/fraud/exclusions.asp.

4. Prohibition. The agency will not hire or retain an employee in a position which has or will have discretionary authority to make decisions or whose job functions may materially impact the Medicaid claim development and submission process or the agency's relations with its staff if such prospect or employee has been convicted of a crime related to health care or has been excluded. The agency will not contract with any person or entity which has been so convicted or excluded or debarred and will attempt to terminate its contract arrangements with any such person or entity, subject to legal constraints such as damages for breach of contract. The agency will make a reasonable and prudent effort not to submit any claim for service ordered or furnished by any person or entity excluded from participation.

F. Evaluations
Adherence to and promotion of this Compliance Program will be a factor in evaluating the performance of all affected individuals, including staff, supervisory, managerial and administrative personnel.

G. Confidentiality and HIPAA requirements

A central part of the agency's Compliance Program is adhering to the laws and requirements pertaining to patient privacy, protected health information and the general principles of confidentiality. The agency expects all affected individuals to maintain the confidentiality and security of both employee and client health information at all times.

Due to the importance of compliance with HIPAA regulations, a separate HIPAA Training Program and acknowledgement is required for all newly hired affected individuals. HIPAA and Confidentiality Training will also be conducted on an annual basis.

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Any employee who observes or suspects any violation of the confidentiality policy or a HIPAA violation should immediately report their concerns to the Compliance Officer or a member of the agency's Compliance Committee.

Privacy & Security Compliance

Confidentiality of Patient Information is mandated by Federal and State Law.
As providers of healthcare, the agency's affected individuals have access to highly private and confidential individually identifiable information. Affected individuals shall conduct themselves in a manner that will maintain the confidentiality of patient information. Agency's all affected individuals shall not disclose any patient specific information unless it is done pursuant to the patient's written authorization or for purposes of treatment, payment or healthcare operations. Upon employment, all agency's affected individuals shall sign a confidentiality statement to assure patient confidentiality.

Privacy Rights of Patients
Contained within regulations for the Health Insurance Portability and Accountability Act (HIPAA) are specific rights that patients have regarding the privacy of their protected health information. The agency complies with all HIPAA privacy regulations including:

The Right to Inspect and Request a Copy of Your Protected Health Information

The Right to Ask Us to Amend the Information in Your Record

The Right to Request an Accounting of Disclosures of Your Health Information

The Right to Request Restrictions or Limitations on Your Health Information

The Right to Request Confidential Communications

The Right to a Paper Copy of the Agency's Notice of Privacy Practices

The Right to Authorize Someone to Act on Your Behalf to Exercise Your Rights and Make Choices About Your Health Information

The Right to Request How We Share Protected Health Information in Certain Situations

Retention and Disposal of Documents and Records
State and federal laws require that providers and others within the agency keep certain records for specified periods of time. It is the policy of the agency to keep records for as long as the law requires.

The legal requirements are many and varied; therefore, before documentation is discarded, the employee shall verify the standard with his/her supervisor or department head.

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All confidential records must be destroyed so that the information contained in the document is not legible or identifiable. Any third party engaged to destroy such documents shall agree to maintain the confidentiality of such records during the destruction process.

VIII. NON-INTIMIDATION AND NON-RETRIBUTION FOR REPORTING

The agency understands that all affected individuals may not report concerns if they feel that they will be subject to retaliation or retribution or harassment for reporting the concern. To reassure all affected individuals who wish to report concerns through the Compliance Line, or directly to the Compliance Department, a non- retaliation /non-retribution policy has been established.

Supervisors, managers or all affected individuals are not permitted to engage in retaliation, retribution or any form of harassment directed against an employee who reports a Compliance concern. Anyone who is involved in any act of retaliation or retribution against an employee or any affected individual that has reported suspected misconduct in good faith will be subject to disciplinary action.

All affected individuals have the responsibility to report, in good faith, concerns about actual or potential wrongdoing.

The agency is committed to a policy that encourages timely disclosure of such concerns and prohibits any action directed against an employee, manager or staff member for making a good faith report of a concern. Any manager, supervisor or employee who engages in retribution, retaliation or harassment against a reporting employee is subject to discipline up to and including dismissal on first offense. All instances of retaliation, retribution or harassment against reporting all affected individuals will be brought to the attention of the Compliance Officer who will, in conjunction with legal counsel, investigate and determine the appropriate discipline, if any.

If an employee reports a concern regarding his or her own inappropriate or inadequate actions, reporting those concerns does not exempt him or her from the consequences of those actions. Prompt and forthright disclosure of an error by an employee, even if the error constitutes inappropriate or inadequate performance, will be considered a positive constructive action by the employee.

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IX. ANNUAL COMPLIANCE REVIEWS

The Agency will develop and undertake a process for reviewing, at least annually, to determine the effectiveness of this Compliance Program and whether any revision or corrective action is required.

The reviews may be carried out by the Compliance Officer, Compliance Committee, External Auditors, or other staff designated by the Agency provided other staff have the necessary knowledge and expertise to evaluate the effectiveness of the components of the Compliance Program and are independent from the functions being reviewed.

The reviews should include:

a. On site visit;
b. Internews with affected individuals;
c. Record review;
d. Or any other comparable agency method that does not compromise the integrity of the review.

The Agency will document the design, implementation and results of its effectiveness review, and any corrective action implemented.

The results of the annual program reviews must be shared with the Chief Executive Office, Senior Management, the Compliance Committee and the Governing Authority.

THE FALSE CLAIMS ACT

The Federal False Claims Act is a law *31 USC §§ 3729 – 3733,* that prohibits a person or entity, such as the agency from "knowingly" presenting or causing to be presented a false or fraudulent claim for payment or approval to the Federal Government and from "knowingly" making, using or causing to be made a false record or statement to get a false or fraudulent claim paid or approved by the Federal Government. These prohibitions extend to claims submitted to federal health care programs, such as Medicare or Medicaid. The terms "knowing "and knowingly" is having knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information and acts in reckless disregard of the truth or falsity of the information. *Due to adjustments made by Congress, the civil penalty is now not less than $5,500 and not more than $11,000.* A person or entity found guilty of violation can be obligated to civil penalty up to $11,000 plus three times the amount of actual damages. A person or entity can also find themselves excluded from the Medicare/Medicaid programs if found in violation.

New York State law makes it unlawful to knowingly make a false statement or representation (or deliberate concealment of any material fact or other fraudulent scheme or device) to attempt to obtain Medicaid payments for services or supplies furnished under the New York State Medical Assistance Program. A violation of this Act can result in civil damages three times overstated

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amount or $5,000 whichever is greater. The agency or individual may also be required to pay civil monetary penalty to the Medicaid program if it was known that the services or supplies were not medically necessary, not provided as claimed, if the person requesting such was excluded from the program or the services or supplies for which payment was received were not provided. New York State may also impose the threat of criminal prosecution who had the intent to defraud the State program a Class A misdemeanor punished in accordance with the penalties fixed by such law.

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Appendix 1: Risk Areas for Home Care Agencies

1. Billing for items or services not actually rendered or not ordered by an authorized practitioner.
2. Billing for medically unnecessary services.
3. Billing for services without the required Face-to-Face Encounter medical documentation.
4. False cost reports.
5. Credit balances – failure to refund.
6. Agency incentives to actual or potential referral sources (e.g., physicians, hospitals, patients, etc.) that may violate the anti-kickback statute or other similar Federal or State statute or regulation.
7. Joint ventures between parties, one of whom can refer Medicare or Medicaid business to other.
8. Stark physician self-referral law.
9. Billing for services provided to patients who are not confined to their residence or ("homebound"), when required by law or payer.
10. Billing for visits to patients who do not require a qualifying service.
11. Over-utilization and under-utilization.
12. Knowing billing for inadequate or substandard care.
13. Insufficient documentation to evidence that services were performed and to support reimbursement.
14. Billing for unallowable costs of home care coordination.
15. Billing for services provided by unqualified or unlicensed clinical personnel.
16. False dating of amendments to nursing notes.
17. Falsified plans of care.
18. Untimely and/or forged physician certifications on plans of care.
19. Forged beneficiary signatures on visit slips/logs that verify services were performed.
20. Improper patient solicitation activities and high-pressure marketing of uncovered or unnecessary services.
21. Inadequate management and oversight of subcontracted services, which results in improper billing.
22. Discriminatory admission and discharge of patients.
23. Billing for unallowable costs associated with the acquisition and sale of home health agencies.
24. Compensation programs that offer incentives for number of visits performed and revenue generated.
25. Improper influence over referrals by hospitals that own home health agencies.
26. Patient abandonment in violation of applicable statutes, regulations, and Federal health care program requirements.
27. Knowing misuse of provider certification numbers, which results in improper billing.
28. Duplication of services provided by assisted living facilities, hospitals, clinics, physicians, and other home health agencies.
29. Knowing or reckless disregard of willing and able caregivers when providing home health services.
30. Failure to adhere to home care agency licensing requirements and Medicaid regulation or Medicare Conditions of Participation.
31. Knowingly failure to return overpayments made by any Health Insurance Programs.

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32. Lack of Governance to Meet Regulatory Standards.
33. Credentialing of all personnel and affected persons of the agency including contractors, agents and subcontractors.
34. Contractor oversight for compliance with all applicable compliance standards.
35. Mandatory reporting to Federal and State Regulators.
36. Billing for substandard care and services.
37. Other risk areas that are or should be reasonably identified by the Agency through ongoing surveys and/or organizational experience.

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Appendix 2. Periodic Internal Audits

These may be performed no less than annually and by utilizing either internal or external resources and supervised by the Compliance Officer. The following methods may be utilized:

1. Visiting with and interviewing patients, physicians and personnel.
2. Reviewing financial, medical/clinical and personnel records and documentation.
3. Analyzing utilization patterns and trend analysis.
4. Re-evaluation of NYS DOH survey findings and results.
5. Assessing existing relationships of referral resources.
6. Assessing relationships with vendors and suppliers.
7. Conducting unannounced mock surveys and investigations.
8. Utilizing written questionnaires and written testing mechanisms.
9. Examination of logs.
10. Validation of credentials of those providing services to the agency.
11. Evaluation of policy and procedures.
12. Unannounced supervisory home visits.
13. Verification of services with patients and verification of signature of patients.
14. Verification of non-EVV patient visits by reviewing the manual visit verification system.
15. Reviewing documentation related to wage parity and labor laws.

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COMMUNITY HEALTH AND HOME CARE

Compliance Program - Standards of Conduct

Introduction

Community Health and Home Care Licensed Home Care Agency (herein known as CHHC) updates at a minimum on an annual basis, the Corporate Compliance Program in order to embody its commitment to conducting its business in compliance with all applicable laws, rules, regulations and other directives of the federal, state and local governments and agencies. An expression of this commitment is the standards of conduct ("Standards of Conduct") described herein which is applicable to all individuals, including the agency managers, members, officers, directors, employees, volunteers and independent contractors working for or providing services to or for the agency.

The Standards of Conduct are intended to provide general guidelines to assist staff members to understand and appreciate the way the agency wishes to conduct business. Although the Standards of Conduct can neither cover every situation in the daily conduct of our many varied activities nor substitute for common sense, individual judgment, or personal integrity, it is the duty of every staff member to adhere to, without exception, the principles set forth herein.

The Standards of Conduct shall be distributed and reviewed during orientation and at least annually, to all staff members and affected individuals who shall be responsible for ensuring that their behavior and activity is consistent with the standards embodied in this Standards of Conduct.

A. Compliance with Laws and Regulations

It is the duty of CHHC and its staff members to uphold all applicable federal, state and local laws, rules, regulations and standards ("laws and regulations"). Each individual must be aware of the legal requirements and restrictions applicable to his or her respective position and duties.

While the duty remains the responsibility of each individual, the agency shall implement programs necessary to foster further awareness of applicable laws and regulations and to monitor and promote compliance with such laws and regulations. Any questions about the legality or propriety of any actions undertaken by or on behalf of the agency should be referred immediately to an individual's supervisor, the Administrator or the Compliance Officer.

B. Fraud and Abuse

CHHC expects its staff members to refrain from any conduct which may violate applicable federal and state laws and regulations, with special emphasis on those related to fraud and/or abuse.

These laws generally prohibit: (1) the transfer of anything of value in order to induce the referral of patients or any government program business (i.e., Medicare, Medicaid and other federal or

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state health care programs); and (2) the making of false representations or the submission of false, fraudulent or misleading claims to any government entity or third party payor, including claims for services not rendered, claims which characterize the service differently than the service actually rendered, or claims which do not otherwise comply with applicable program or contractual requirements.

More specific guidance with respect to laws and regulations applicable to fraud and abuse can be found in the agency Compliance Manual. You will also receive a summary of various federal and state laws applicable to the fraud and abuse area.

C. **Professional and Ethical Standards**

As professionals, all staff members have a duty to support the agency's goals to provide nursing and other home care services of the highest quality that respond to the needs of our patients. The services provided must be reasonable and necessary for the care of each patient, and such care must be provided by properly qualified individuals. All such care must be properly documented as required by law and regulation, payor requirements, professional standards and the policies and procedures of CHHC.

CHHC and its staff members shall conduct all activities in accordance with the highest ethical standards of their respective professions at all times and in a manner which shall uphold the agency's reputation and standing in the community it serves.

D. **Confidentiality**

CHHC and its staff members are in possession of, or have access to, a wide variety of confidential and sensitive information.

It is the duty of the agency and its staff members to protect the privacy rights of the patients. CHHC and its staff members shall maintain the confidentiality of patient medical records and information, as well as proprietary information, by actively protecting and safeguarding such information in a manner designed to prevent the unauthorized disclosure of such information.

If there are any questions or concerns concerning the disclosure of information, the question or concern should be referred to an individual's supervisor, the Administrator, the Compliance Officer, or the Privacy Officer.

E. **Business Practices**

CHHC's business practices must be conducted with honesty and integrity and in a manner that upholds the agency's reputation with patients, payors, vendors, competitors and the community. CHHC expects its staff members to be loyal to the agency's interests. Staff members should not use their positions to profit personally or to assist others in profiting in any way at the expense of the agency. Staff members must refrain from activities which create conflicts of interest with the agency or give the appearance of impropriety.

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Staff members involved in business transactions on behalf of the agency shall not offer or pay, or solicit or receive any gifts, favors or other improper inducements in exchange for influence or assistance in a transaction or the referral of business. If there is any doubt or concern about whether specific conduct or activities are ethical or otherwise appropriate, the doubt or concern should be referred immediately to an individual's supervisor, the Administrator, or the Compliance Officer.

When the agency decides to enter into an agreement or arrangement with another healthcare entity or practitioner to provide services, that decision must be free of any improper influence. Thus, if you or any immediate family member is already an employee, consultant, owner, contractor or even a passive investor of an entity that: (i) engages in any business or maintains any relationship with the agency, (ii) provides to, or receives from the agency any patient referrals, or (iii) competes with the agency, you must complete a "Conflict of Interest Disclosure Statement Form" and submit it to the Compliance Officer. If you or your family member intends to become such an employee, consultant, owner, contractor or an investor, you must first obtain written permission from the Administrator or Compliance Officer by completing a "Conflict of Interest Disclosure Statement Form". In this way, the agency can be assured that our business relationships are free from improper influences.

F. **Employment Practices**

CHHC is committed to providing equal employment opportunities for all persons, without regard to race, color, creed, religion, sexual orientation, national origin, age, sex, marital status, handicap, or disability. The agency is committed to providing patient care and a workplace environment which emphasizes the dignity and respect of every individual. In that regard, harassment and/or other types of prohibited discrimination in any form or context will not be tolerated.

Violence in the workplace will not be tolerated and such behavior will result in immediate disciplinary action, which may include termination.

The agency is committed to providing a healthy and safe workplace. The agency and its staff members will comply with federal, state and local laws and regulations that promote the protection of health and safety. Staff members are expected to report workplace injuries or any situation presenting a danger of injury.

The agency will ensure compliance with all local and state wage parity and labor laws. The agency will ensure all employees receive written notice of wage and labor requirements as required by law. The agency will comply with local and state reporting wage and labor requirements.

G. **Reimbursement**

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The agency and its staff members have a duty to create and keep records and documentation which conform to legal, professional and ethical standards. Such individuals shall ensure that billings for reimbursement for care are reasonable, necessary and appropriate, that services are provided by properly qualified persons, and that services are billed correctly and supported by adequate documentation.

All claims for reimbursement to government and to private insurance payors must be true and accurate and conform to all applicable laws and regulations. The agency and its staff members are prohibited from knowingly presenting or causing to be presented claims for payment or approval which are false, fictitious, fraudulent or otherwise not in compliance with applicable laws and regulations.

H. **Administration and Application of this Standards of Conduct**

CHHC expects that the Standards of Conduct will be a part of the daily activities of its staff members. The Standards of Conduct is in addition to, and does not limit, specific policies and procedures of the agency. Staff members must perform their duties in accordance with all such policies and procedures.

It is the duty of every manager, member, officer, director, employee, independent contractor, volunteer and agent to uphold the standards set forth in the Standards of Conduct and to report violations by following the reporting procedures outlined in the Compliance Manual. Alleged violations of the Standards of Conduct or other policies and procedures of CHHC will be investigated by persons designated by, and pursuant to procedures established by the agency. The agency will make efforts to maintain the confidentiality of the identity of any individual who reports perceived or actual violations. However, confidentiality of identity cannot be guaranteed.

It shall be a violation of the Standards of Conduct to take any action in reprisal against anyone who reports suspected violations of the Standards of Conduct or other the agency policies and procedures, assists in the investigation of a compliance issue or assists with remedial actions in good faith.

Failure to abide by the Standards of Conduct or the guidelines for behavior which the Standards of Conduct represents may lead to disciplinary action. Disciplinary action will be determined on a case-by-case basis and may, in the agency's discretion, range from a warning to termination. If the agency determines that a violation may have included criminal violations of law or regulation, the agency will seek the advice of legal counsel and cooperate with law enforcement authorities in connection with the investigation and prosecution of the offender.

<u>How to Report a Violation of the Standards</u>

Staff members should report any violation of the Standards of Conduct to your immediate supervisor, the Administrator, the agency Compliance Officer and/or via the Compliance Hotline. The Hotline is particularly helpful if you prefer not to report such matter to your

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supervisor, or the Administrator, because you believe they may be involved in the actual or perceived violation, if you otherwise have a legitimate reason to be concerned about a reprisal, or if your previous reports have not been acted upon, but you may use it for any reason. The number of **CHHC Compliance Hotline is 315-255-6035**. Hotline calls may be made anonymously. However, supplying your name may assist in the investigation of your report but you are under no obligation to do so. Please note that it is an explicit violation of the agency policy to retaliate in any way against a staff member who, in good faith, reports an actual or potential violation of applicable laws, rules, regulations, or the Standards of Conduct.

Please note that nothing in the Standards of Conduct is intended to, nor shall be, construed as providing any additional employment or contract right to staff members or other persons.

CHHC will generally attempt to communicate changes to the Standards of Conduct prior to the implementation of such changes. However, CHHC reserves the right to modify, amend or alter the Standards of Conduct and its policies and procedures without prior notice to any person.

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FEDERAL & NEW YORK STATUTES RELATING TO FILING FALSE CLAIMS

I. FEDERAL LAWS

False Claims Act (31 USC §§3729-3733)

The False Claims Act ("FCA") provides, in pertinent part, that:

(a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government; . . or (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government, is liable to the United States Government for a civil penalty of not less than *$5,500 and not more than $11,000*, plus 3 times the amount of damages which the Government sustains because of the act of that person . . . .

(b) For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

31 U.S.C. § 3729. While the False Claims Act imposes liability only when the claimant acts "knowingly," it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, also can be found liable under the Act. 31 U.S.C. 3729(b).

In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The False Claims Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor who submits records that he knows (or should know) are false and that indicate compliance with certain contractual or regulatory requirements. The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records in order to retain the money. An example of this so-called "reverse false claim" may include a hospital that obtains interim payments from Medicare throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare program.

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In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States. 31 U.S.C. 3730 (b). These private parties, known as "*qui tam* relators," may share in a percentage of the proceeds from an FCA action or settlement.

Section 3730(d)(1) of the FCA provides, with some exceptions, that a qui tam relator, when the Government has intervened in the lawsuit, shall receive at least 15 percent but not more than 25 percent of the proceeds of the FCA action depending upon the extent to which the relator substantially contributed to the prosecution of the action. When the Government does not intervene, section 3730(d)(2) provides that the relator shall receive an amount that the court decides is reasonable and shall be not less than 25 percent and not more than 30 percent.

Administrative Remedies for False Claims (31 USC Chapter 38. §§ 3801 – 3812)

This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false or contains false information, or omits material information, then the agency receiving the claim may impose a penalty of up to $5,500 for each claim. The agency may also recover twice the amount of the claim.

Unlike the False Claims Act, a violation of this law occurs when a false claim is submitted, not when it is paid. Also, unlike the False Claims Act, the determination of whether a claim is false, and the imposition of fines and penalties is made by the administrative agency, not by prosecution in the federal court system.

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II. NEW YORK STATE LAWS

New York's false claims laws fall into two categories: civil and administrative; and criminal laws. Some apply to a recipient of false claims and some apply to a provider of false claims, and while most are specific to healthcare or Medicaid, some of the "common law" crimes apply to areas of interaction with the government.

A. CIVIL AND ADMINISTRATIVE LAWS

NY False Claims Act (State Finance Law, §§187-194)

The NY False Claims Act closely tracts the federal False Claims Act. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. The penalty for filing a false claim is $6,000 -$12,000 per claim and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false claim filer may have to pay the government's legal fees.

The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties. If the suit eventually concludes with payments back to the government, the person who started the case can recover 25-30% of the proceeds if the government did not participate in the suit of 15-25% if the government did participate in the suit.

Social Services Law §145-b False Statements

It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The State or the local Social Services district may recover three times the amount incorrectly paid. *In addition, the Department of Health may impose a civil penalty of up to $10,000 per violation. If repeat violations occur within 5 years, a penalty up to $30,000* per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.

Social Services Law §145-c Sanctions

If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the person's, *the person's family's needs are not taken into account for 6 months to 5 years if a first offense, 12 months if a second (or once if benefits received are over $3,900) and five years for 4 or more offenses.*

B. CRIMINAL LAWS

Social Services Law §145 Penalties

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Any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

Social Services Law § 366-b, Penalties for Fraudulent Practices.

a. Any person who obtains or attempts to obtain, for himself or others, medical assistance by means of a false statement, concealment of material facts, impersonation or other fraudulent means is guilty of a Class A misdemeanor.

b. Any person who, with intent to defraud, presents for payment and false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation or knowingly submits false information in order to obtain authorization to provide items or services is guilty of a Class A misdemeanor.

Penal Law Article 155, Larceny.

The crime of larceny applies to a person who, with intent to deprive another of his property, obtains, takes or withholds the property by means of trick, embezzlement, false pretense, false promise, including a scheme to defraud, or other similar behavior. It has been applied to Medicaid fraud cases.

a. Fourth degree grand larceny involves property valued over $1,000. It is a Class E felony.

b. Third degree grand larceny involves property valued over $3,000. It is a Class D felony.

c. Second degree grand larceny involves property valued over $50,000. It is a Class C felony.

d. First degree grand larceny involves property valued over $1 million. It is a Class B felony.

Penal Law Article 175, False Written Statements.

Four crimes in this Article relate to filing false information or claims and have been applied in Medicaid fraud prosecutions:

a. §175.05, Falsifying business records involves entering false information, omitting material information or altering an enterprise's business records with the intent to defraud. It is a Class A misdemeanor.

b. § 175.10, Falsifying business records in the first degree includes the elements of the §175.05 offense and includes the intent to commit another crime or conceal its commission. It is a Class E felony.

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c. §175.30, Offering a false instrument for filing in the second degree involves presenting a written instrument (including a claim for payment) to a public office knowing that it contains false information. It is a Class A misdemeanor.

d. §175.35, Offering a false instrument for filing in the first degree includes the elements of the second degree offense and must include an intent to defraud the state or a political subdivision. It is a Class E felony.

Penal Law Article 176, Insurance Fraud,

Applies to claims for insurance payment, including Medicaid or other health insurance and contains six crimes.

a. Insurance Fraud in the 5th degree involves intentionally filing a health insurance claim knowing that it is false. It is a Class A misdemeanor.

b. Insurance fraud in the 4th degree is filing a false insurance claim for over $1,000. It is a Class E felony.

c. Insurance fraud in the 3rd degree is filing a false insurance claim for over $3,000. It is a Class D felony.

d. Insurance fraud in the 2nd degree is filing a false insurance claim for over $50,000. It is a Class C felony.

e. Insurance fraud in the 1st degree is filing a false insurance claim for over $1 million. It is a Class B felony.

f. Aggravated insurance fraud is committing insurance fraud more than once. It is a Class D felony.

Penal Law Article 177, Health Care Fraud,

Applies to claims for health insurance payment, including Medicaid, and contains five crimes:

a. Health care fraud in the 5th degree is knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions. It is a Class A misdemeanor.

b. Health cam fraud in the 4th degree is filing false claims and annually receiving over $3,000 in aggregate. It is a Class E felony.

c. Health care fraud in the 3rd degree is filing false claims and annually receiving over $10,000 in the aggregate. It is a Class D felony.

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d. Health care fraud in the 2nd degree is filing false claims and annually receiving over $50,000 in the aggregate. It is a Class C felony.

e. Health care fraud in the 1st degree is filing false claims and annually receiving over $1 million in the aggregate. It is a Class B felony.

II. WHISTLEBLOWER PROTECTION

Federal False Claims Act (31 U.S.C. §3730(h))

The FCA provides protection to *qui tam* relators who are discharged, demoted, Suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA. 31 U.S.C. 3730(h). Remedies include reinstatement with comparable seniority as the *qui tam* relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

NY False Claim Act (State Finance Law §191)

The False Claim Act also provides protection to *qui tam* relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the Act. Remedies include reinstatement with comparable seniority as the *qui tam* relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

New York Labor Law §740

An employer may not take any retaliatory action against an employee if the employee discloses information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that the employer is in violation of a law that creates a substantial and specific danger to the public health and safety or which constitutes health care fraud under Penal Law §177 (knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions). The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of $10,000 on the employer.

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New York Labor Law §741

A health care employer may not take any retaliatory action against an employee if the employee discloses certain information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that, in good faith, the employee believes constitute improper quality of patient care. The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation, unless the danger is imminent to the public or patient and the employee believes in good faith that reporting to a supervisor would not result in corrective action. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of $10,000 on the employer.

III. **Reference: New York State Office of Medicaid Inspector General (OMIG) Updated Program Guidance (Reference 1)**

IV. **Reference: New York State Codes, Rules and Regulations (18 NYCRR) Appendix B (Reference 1)**

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COMMUNITY HEALTH AND HOME CARE

Policy 1. Response to Governmental Inquiries

PURPOSE:
To provide guidance on the agency's response to all governmental inquiries and investigations, as well as the process that is to be used and the proper handling of documents.

POLICY:

A. **Cooperation.**
It is the policy of this agency to cooperate with and properly respond to all governmental inquiries and investigations. Federal and State agencies have available a number of investigation tools including search warrants, subpoenas and civil investigation demands. Actions may be brought against the agency to exclude it from participating in Medicaid if the agency fails to grant immediate access to agencies conducting surveys or reviews.

B. **Process.**
Employees who receive a search warrant, subpoena or other demand or request for investigation, or if approached by a federal or State agency, should attempt to identify the investigator, if any, and immediately notify their supervisor, the Compliance Officer or, in that Officer's absence, the CEO or other member of the Compliance Committee. Employees should request the government representative to wait until the Compliance Officer or his or her designee arrives before conducting any interview or reviewing documents. The Compliance Officer, in consultation with General Council and, as necessary, outside legal counsel, is responsible for coordinating the agency's response to warrants, subpoenas, inquiries and investigations by federal agencies. If appropriate, the agencies also may provide legal counsel to employees.

C. **Documents.**
The agency's response to any warrant, subpoena, investigation or inquiry must be complete and accurate. No employee shall alter, destroy or mutilate any document or record or alter, delete or download any material from any computer, word processor, disk or tape, except in accordance with the agency records retentions policies. If a document is required to be retained, it must be preserved in its original form.

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COMMUNITY HEALTH AND HOME CARE

Policy 2. Investigating Compliance Concerns

PURPOSE:
To provide guidance on the requirements for promptly investigating and reporting compliance concerns.

POLICY:

A. Requirement for Managers and Directors.
Each manager and director is responsible for promptly reporting any report or reasonable indication of violations of this Program, the Standards of Ethical Conduct, agency policies or procedures or violations of applicable law or regulation by employees or others within his or her supervision to the Compliance Officer. Any report or reasonable indication of a violation of law or regulations must be reported to the Compliance Officer prior to initiation of any investigation. The Compliance Officer will report to the Governing Authority and work with legal counsel, when indicated. In the case of other violations, the managers and directors should consult with the Compliance Officer and the Office of Human Resources, when indicated.

B. **Compliance Office Investigation**.
In any case where there is a report or reasonable indication of a violation of applicable laws or regulations, the Compliance Office shall have the primary responsibility for conducting the investigation of the alleged situation or problem under the direction of legal counsel, when indicated. The investigation shall commence promptly, but in no event more than ten (10) business days following the receipt of the report. The purpose of the investigation shall be to ascertain whether the report of misconduct or violation of the Compliance Program has merit, and if so, the extent and scope of such violation. In undertaking investigations, the Compliance Officer shall consult with the respective manager and/or member of the Compliance Committee who has responsibility for the department. The Compliance Officer may utilize other agency's employees (consistent with appropriate confidentiality), outside attorneys, outside accountants and auditors or other consultants or experts for assistance or advice. The purpose of the investigation is to determine whether or not there is reasonable cause to believe an individual(s) may have knowingly or inadvertently participated in violations of applicable laws or regulations; to facilitate corrective action; and to implement procedures necessary to ensure future compliance. The Compliance Officer will promptly implement corrective action(s) when indicated.

C. Relationship of Compliance Investigations to the Agency General Disciplinary Procedures
The investigation by the Compliance Officer shall be preliminary to the initiation of disciplinary proceedings under government regulations. In the event reasonable cause to believe a violation exists, the Compliance Officer or respective manager or director shall initiate a complaint against the employee and the adjudication of such complaint shall proceed in accordance with the applicable policies and procedures of the agency.

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D. **Process.**

The Compliance Officer, or his or her designee, may conduct interviews with any agency employee and with other persons and may review any agency document including but not limited to those related to the claim development and submission process, patient records, e-mail and the contents of computers and word processors and may undertake other processes and methods as the Compliance Officer deems necessary.

E. **Documentation.**

The Compliance Officer will document the investigation to include:

1. Defines the nature of the situation or problem which may include any alleged violations;
2. Describe the investigative process;
3. Maintain copies of interview notes and other documents essential in demonstrating a complete and thorough investigation of the issues;
4. Summarize the investigation process including interviews;
5. Identify any person whom the investigator believes to have acted deliberately or with reckless disregard or intentional indifference, particularly toward the Medicaid laws, regulations and policies;

6.Detail the disciplinary actions taken and the corrective actions implemented to prevent future occurrences, when indicated;

7. Estimate the nature and extent of any credible evidence or credible conclusions that indicates a violation of State or Federal law and requires the agency to promptly report such violations to the appropriate government entity.

5. Estimate the nature and extent of the resulting overpayment by the government or another entity, if applicable. Complete the required self-disclosure protocols per State and/or Federal law with legal counsel, when indicated.

F. **Response.**

The response to an investigation will be determined by the type of noncompliant activity that is suspected.

1. **Possible Criminal Activity.** In the event the investigation reveals or uncovers what appears to be criminal activity on the part of any employee, the following action will be taken:

a. All billing involved in the situation or problem will be discontinued until such time as appropriate corrections are made.

b. A summary of the results of the investigation shall be discussed with the CEO and Human Resources. The employee may be removed from any position with oversight of or impact upon the claims development and submission process.

c. Upon completion of the investigation, State and federal agencies will be notified as deemed appropriate by legal counsel, the Chief Executive Officer and the Governing Authority. The agency may attempt to negotiate a voluntary disclosure agreement prior to the disclosure.

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2. Other Non-Compliance. In the event the investigation reveals claims development and submission problems, which do not appear to be the result of criminal activity on the part of any employee, the following action will be taken:

a. If duplicate payments have been made by Medicaid or other health care program or excessive payments made because of coding or other agency's errors or mistakes (i) the defective practice or procedure will be corrected as quickly as possible; (ii) the duplicate or improper payments will be calculated and repaid to the appropriate payor or fiscal intermediary; and (iii) a program of education will be undertaken with appropriate employees to prevent future similar problems.

b. If no duplicate or excessive payments have been made because of the agency's errors or mistakes (i) the defective practice or procedure will be corrected as quickly as possible; (ii) a program of education will be undertaken with appropriate employees to prevent future similar problems.

c. A summary of the results of the investigation shall be sent for appropriate disciplinary action, if any, to the department director or manager (or the appropriate assistant or associate administrator if the director or manager is implicated) of any employee whose conduct may be wrongful or inappropriate under the circumstances.

3. Voluntary Disclosures.

All voluntary self-disclosures will be guided by the OIG's Provider Self-Disclosure Protocol 63 Fed. Reg. 58399 (October 21, 1998) and the NYS OMIG Self-Disclosure Guidelines.

G. **Reports by Compliance Officer.**

The Compliance Officer periodically shall furnish information (bearing in mind issues of confidentiality) about such investigations to the CEO, the Compliance Committee at its regular quarterly meetings and periodically to the Audit and Compliance Committee of the Governing Authority.

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Policy 3. Compliance Responsibilities of Management and Directors

PURPOSE:

To describe the responsibilities of management and directors throughout the agency with regards to compliance and enforcement of agency policy and procedure.

POLICY:

Each director or manager of an affected department is responsible for:
1. Implementing and maintaining compliance standards and policies and procedures and manuals specific to their departments in consultation with the Compliance Officer;

2. Providing training to all his or her employees in compliance standards, policies, procedures, laws and regulations applicable to employees of the department in consultation with the Compliance Officer;

3. Enforcing this Program, the Standards of Ethical Conduct, the agency's policies and procedures, and all applicable laws and regulations;

4. Investigating reports or reasonable indications of violations of this Program, the Standards of Ethical Conduct, agency policies or procedures;

5. Reporting to the Compliance Officer any reports or reasonable indication of violations of applicable law or regulation by any member of the department;

6. Initiating and/or implementing corrective or disciplinary action in the event of violation of the Compliance Program, the Standards of Ethical Conduct, agency policies, procedures and applicable laws and regulations; and

7. Taking all measures reasonably necessary to ensure compliance with this Program and applicable laws and regulations.

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Policy 4. Compliance Training and Education

PURPOSE:

To provide guidance to all affected individuals on the training required of: Governance, Management and staff within the organization, including initial training, training on general compliance rules and standards of conduct, and training on substantive rules. This also includes contractors, agents, subcontractors, independent contractors, vendors and marketing representatives. Compliance training will be provided on hire and on an annual basis thereafter, or as needed with compliance policy updates.

POLICY:

CHHC will establish and implement an effective compliance training and education program for its compliance officer, leadership, staff and all affected individuals. The agency's compliance training and education program shall meet the following requirements:

A. Include, at a minimum, the following topics:

i. the agency's risk areas and organizational experience;
ii. the agencies written policies and procedures identified in the Compliance Plan;
iii. the role of the Compliance Officer and the Compliance Committee;
iv. how all staff and affected individuals can ask questions and report potential compliance-related issues to the compliance officer and senior management, including the obligation of all individuals to report suspected illegal or improper conduct and the procedures for submitting reports, and the protection from intimidation and retaliation for good faith participation in the compliance program;
v. disciplinary standards with an emphasis on those standards related to the required compliance program and prevention of fraud, waste and abuse;
vi. how the agency responds to compliance issues and implements corrective action plans; requirements specific to the Medicaid program and the provision of aide services;
vii. coding and billing requirements and best practices, if applicable;
viii. claim development and the submission process, if applicable.

B. The Agency shall develop and maintain a Compliance Training Plan. The Training Plan will include:

i. An outline of the subjects and topics for training and education;
ii. The timing and frequency of the training;
iii. Which staff and affected individuals are required to attend;
iv. How attendance will be tracked;
v. How the effectiveness of the training will be periodically evaluated.

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C. **Necessity.** Training is required in order to provide all affected individuals with the knowledge and skills to carry out their responsibilities in compliance with all requirements. Proper and continuing training and education of all affected individuals at all levels is, therefore, a significant element of an effective compliance program. Rules and regulations relating to delivery of healthcare and the conduct of research are complex. The consequences of failure to comply with these requirements, particularly in the areas of coding and billing of federal and state health care claims and federal and state research grant claims, can be severe. Sometimes conduct undertaken with good intentions but with inadequate knowledge may violate applicable laws and regulations.

D. **Initial Education.** Mandatory orientation for new employee orientation and the hiring package will provide an overview of fraud and abuse laws, a summary of the standards of conduct, an explanation of the elements of the Compliance Program, including the complaint or reporting process and highlight the agency commitment to integrity in its business operations and compliance with applicable laws and regulations.

E. **General Rules**. Periodically, as necessary, and at least annually, appropriate all affected individuals will be retrained on all required topics listed in Part A above to include (i) on the agency's Compliance Program; (ii) the fraud and abuse laws as they relate to the claim development and submission process and the agency business relationships; (iii) relevant federal and state requirements; and (iv) the consequences both to the agency and individuals of failing to comply with applicable laws and regulations. Such training must emphasize the importance of the Compliance Program and the agency's commitment to honesty and integrity in its business dealings. This training will also be specific to the individual's roles and responsibilities with CHHC.

F. **Substantive Rules.** All affected individuals will be trained and, as necessary, retrained in the specific federal and other health care program rules (e.g. Medicaid) that relate to their particular job functions. This training will include, but not be limited to the following types of training:

1. Patient Access personnel will receive training regarding their role in obtaining the necessary demographic, insurance and other information to support proper application of advanced beneficiary notification.

2. Providers of Patient Care will receive training that includes clinical documentation requirements, medical necessity considerations, and confidentiality of patient information, and other training regarding their activities affecting the claim submission process.

3. Patient Financial Services personnel will receive training that includes many of the subjects identified above, plus additional training regarding specific requirements such as claim composition, credit balance reporting and disposition, billing only for items and services actually rendered and avoiding duplicate billing.

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4. Financial and other administrative management personnel will receive training applicable to their role. For finance personnel, these areas include submission of cost reports.

Types. Training and education may occur in sessions with individual all affected individuals, in mandatory in-service meetings or incorporated into special or regular departmental meetings or in some other effective manner. Training may consist of live presentations, videos, question and answer sessions and written material and may occur in-house or through attendance at external workshops and seminars.

G. **Amount of Training.** All affected individuals need not have the identical amount of training and education, nor will the focus of training and educational efforts be the same for all affected individuals. The actual amount of training should include the minimum required topics and also reflect necessity, an analysis of risk areas or areas of concern identified by the agency or the Office of the Medicaid Inspector General, the agency compliance experience and the results of periodic audits or monitoring.

H. **Documentation.** The training provided to each employee shall be documented in their Personnel file. The documentation shall include the date and a brief description of the subject matter of the training activity or program.

I. **Failure to Attend.** Failure to comply with training requirements or to attend scheduled training sessions of the agency or of each department may result in job transfer and/or disciplinary action.

J. **Evaluation.** There will be periodic evaluations of training and education programs to determine, and if necessary, improve the value, effectiveness and appropriateness of any such program.

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Policy 5. Compliance Communication

PURPOSE:

Open communications between *all affected individuals* and the Compliance Officer or Compliance Committee are important to the success of this Compliance Program and to the reduction of any potential for fraud, abuse and waste. Without help from all affected individuals it may be difficult to learn of possible compliance problems and make necessary corrections. Confidentiality of communication is critical in the implementation of effective lines of communication.

POLICY:

A. **Questions.** At any time *all affected individuals and recipients of services from this agency* may seek clarification or advice from the Compliance Officer or members of the Compliance Committee in the event of any confusion or question with regard to this Program or any element of this Program or any agency policy or procedure related to this Program. Questions and responses should be documented and, if appropriate, shared with other affected individuals for informational and educational purposes. *All affected individuals and recipients of services from this agency* should be encouraged to contact the Compliance Officer and any member of the committee for this purpose. The Compliance Officer will develop or cause to be developed for all affected individuals publicity and notices regarding his or her name, location and e-mail address and the names of members of the committee and their location.

B. **Reporting.** All affected individuals who are aware of or suspect acts of fraud, abuse, waste or violations of the Standards of Conduct should report such acts or violations. Several independent reporting paths are available:

1.All affected individuals may but are not required to report to their supervisor or department director or manager. Supervisors and managers will thereafter promptly pass on the report to the Compliance Officer or member of the committee.

2. All affected individuals may report directly to the Compliance Officer or to a member of the committee. The Compliance Officer will post this number in one or more prominent locations in the agency.

3. All affected individuals may also report compliance issues anonymously to the Compliance Officer. Anonymous methods of reporting compliance issues include the use of the agency compliance hotline, suggestion box, or anonymous report form mailed into the agency's Compliance Officer. The Compliance Officer will ensure publicizing the anonymous report methods.

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4.All affected individuals may also call the hotline or the Office of the Inspector General of the Health and Human Services Department, 1-800-HHS-TIPS (447-8477). And the NYS Office of Medicaid Inspector General Compliance main line at 518-408-0410 or the Fraud Hotline at 1-877-87-FRAUD. The Compliance Officer will post these numbers in one or more prominent locations in the agency.

C. **Confidentiality.**
Reports received will be treated confidentially to the extent possible under applicable law. However, there may be a time when an individual's identity may become known or have to be revealed if governmental authorities become involved or in response to subpoena or other legal proceeding.

D. **Non-Retaliation.**
There will be no reprisals, retaliation ***nor intimidation*** against all affected individuals who in good faith report acts or suspected acts of fraud, abuse or waste or violations or suspected violations of the Standards of Conduct or other wrongdoing or misconduct. However, an employee who makes an intentional false report or a report not in good faith may be subject to disciplinary action.

F. **Documentation.** Reports that suggest substantial violation of this Program, violation of the Standards of Conduct or violation of relevant law or regulation will be documented by the Compliance Officer. Information about such reports will be provided to the Governing Authority, Chief Executive Officer and to the Compliance Committee as needed, or during the regular scheduled meetings. Investigations and analysis of any and all reports will be tracked and trended to ensure corrective actions have been implemented and effectively addressed agency process or procedure issues impacting compliance adherence.

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Policy 6. Prohibition against Employing or Contracting with Ineligible Persons

POLICY:
In order to avoid the imposition of civil monetary penalties we must ensure compliance with regulations applicable to all federal and state programs. Therefore, it is the policy of this agency:

1. Not to employ any individual who is an Ineligible Person;
2. Not to contract or do business with any individual or entity who is an Ineligible Person;
3. Not to appoint or reappoint to the Medical Director position any physician or allied health professional who is an Ineligible Person, and
4. To comply with all reporting requirements governing Ineligible Persons.

The policy covers all personnel, employees and candidates for employment; physicians and allied health professionals; contractors, agents; subcontractors; independent contractors; current vendors and consultants and entities/individuals seeking to become vendors or consultants.

DEFINITIONS:
An **Ineligible Person** means an individual or entity who/which has been excluded, suspended, debarred or otherwise deemed ineligible to participate in a federally and/or state funded healthcare program and has not been reinstated after a period of exclusion, suspension, debarment or ineligibility.

PROCEDURE:
Candidates for Employment. All candidates for employment are required to disclose on the employment application whether he/she is an Ineligible Person. Staff may not be appointed unless confirmed that the individual is not an Ineligible Person. Employee responsibility to disclose if they become an Ineligible Person and is subject to dismissal regardless of whether the employee discloses such fact. Requests for Proposals and contracts will specifically ask about disclosure as an Ineligible Person.

RESPONSIBILITES:
Human Resources is responsible for performing the initial exclusion checks prior to hiring or rehiring of staff. Nurse Recruitment is responsible for performing the exclusion checks. The Compliance Officer or designee is responsible for:

1. Performing exclusion checks for all employees every thirty (30) days.
2. Notifying the Director of Human Resources or designee upon learning of an employee who is an Ineligible Person.
3. Performing exclusion checks for prospective contractors, agents, subcontractors, independent contractors and vendors.
4. Performing annual exclusion checks for all current vendors, **see Policy 11**.
5. Works with counsel to terminate the contract of a vendor who becomes an Ineligible Person.

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DOCUMENTATION:

All materials printed regarding the search of Ineligible Persons must be maintained by the Compliance Officer and Human Resource designee.

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Policy 7. Fraud and Abuse. The False Claims Act

POLICY:
To establish a policy for all employees including management and for any contractor or agent of the organizations. This policy provides detailed information about the Federal False Claims Act established under sections *3729 through 3733 of title 31*, United States Code and any New York State laws pertaining to civil or criminal penalties for false claims and statements and whistle blower protections under such laws.

SCOPE:
Governing Authority, Leadership, Medical Staff, Management, Employees and Parties who do business with the agency.

FORMS: Conflict of Interest
DEFINITIONS:
False Claims Act – FCA 31 U.S.C. 3729 sets forth the bases for liability for Fraud and Abuse and delineates the penalties that maybe levied.

Medicaid Integrity Program – Title XIX of the Social Security Act created as part of the Deficit Reduction Act of 2005 to halt the diversion of critical funds and the misuse of taxpayer funds used for providing healthcare.
Anti-Kickback – provides a critical effective tool for criminal enforcement of health care laws.
Knowing and knowingly – having actual knowledge of information, acts of deliberate ignorance of truth or falsity of the information or acts of reckless disregard of the truth.

PROCEDURE:
Any person who knowingly presents, uses, conspires to defraud, is in the possession, custody or control of information and uses that information for the inappropriate benefit of oneself or the organization is liable to the United States Government for a civil penalty of not less than *$5,500 and not more than $11,000* plus 3 times the amount of damages which the Government sustains because of the act of that person. Except if:

-the person committing the violation furnishes information within 30 days of the violation the defendant first obtained the information.
-such person fully cooperated with the Government investigation of such violation.
-at the time such person furnished the information no criminal prosecution, civil action or administrative action had commenced.

The court may assess not less than two (2) times the amount of damages the Government sustains because of the act of the person. Such persons will be subject to the organization's disciplinary policies.

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Policy 8. Non-Retaliation, Non-Retribution and Non-Intimidation for Reporting

PURPOSE:
The organization understands that employees may not report concerns if they feel that they will be subject to ***retaliation, retribution or intimidation*** or harassment for reporting the concern.

To reassure employees who wish to report concerns through the Compliance Line, or directly to the Compliance Department, Compliance Officer or a member of the management staff or Compliance Committee a non-retaliation, non-retribution or non-intimidation policy has been established including but not limited to reporting potential issues, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials as provided in Sections 740 and 741 of the New York State Labor Law.

POLICY Supervisors, managers or employees are not permitted to engage in ***retaliation, retribution or intimidation*** or any form of harassment directed against an employee or any individual who reports a Compliance concern.

Anyone who is involved in any act of retaliation, retribution or intimidation against an employee or any individual that has reported suspected misconduct in good faith will be subject to disciplinary actions as prescribed in the Human Resources Manual. These disciplinary actions may be incremental up to and including suspension and/or termination.

PROCEDURE Employees have the responsibility to report, in good faith, concerns about actual or potential wrongdoing to their supervisor and upward to the Compliance Officer.

The organization is committed to a policy that encourages timely disclosure of such concerns and prohibits any action directed against an employee, manager or staff member for making a good faith report of a concern.

Any manager, supervisor or employee who engages in ***retaliation, retribution or intimidation*** or harassment against a reporting employee and any reporting individual is subject to discipline up to and including dismissal on first offense.

All instances of ***retaliation, retribution or intimidation*** or harassment against reporting employees will be brought to the attention of the Compliance Officer who will, in conjunction with Legal and Human Resources, investigate and determine the appropriate discipline, if any.

If an employee reports a concern regarding his or her own inappropriate or inadequate actions, reporting those concerns does not exempt him or her from the consequences of those actions. Prompt and forthright disclosure of an error by an employee, even if the error constitutes inappropriate or inadequate performance, will be considered a positive constructive action by the employee.

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COMMUNITY HEALTH AND HOME CARE

Policy 9. Detecting and Preventing Fraud, Waste and Abuse

Purpose: To outline the organization's response to a report of fraud, waste, or abuse.

Policy: This policy sets forth the procedures used by the organization to respond to a report that any officer, employee, consultant or vendor is engaging in activity that may be contrary to applicable federal or state law or the requirements of the agency's policies. Federal False Claims Act law, *31 USC §§ 3729 – 3733.* **Reference Policies # 1 & #2.**

Implementation:

Investigation.

A. Purpose of Investigation.

The purpose of an investigation is to identify situations in which applicable federal or state laws, including the laws, regulations and standards of the Medicare / Medicaid programs, or the organization policies, may not have been followed; to identify individuals who may have knowingly or inadvertently violated the law or the organization policies; to facilitate the correction of any violations or misconduct; to implement procedures necessary to ensure future compliance; to protect the organization in the event of civil or criminal enforcement actions; and to preserve and protect the organization assets.

B. Conduct of Investigations.

All reports of alleged fraud, waste, or abuse must be forwarded to the Compliance Officer. Serious or otherwise sensitive matters or investigations should be conducted by, or under the direction of, the organization's legal counsel.

C. Investigation Process. Reference Policy #2.

Upon receipt of information concerning alleged fraud, waste, or abuse, the Compliance Officer will, at a minimum, take the following actions:

Prepare a report that includes, if known, the name of the employee who made the report, the date of the report, and a detailed narrative of the employee's concern and the nature of the alleged conduct. Anonymity of the individual who made the report (if requested) and confidentiality will be maintained. Retaliation or reprisal against anyone for reporting a good faith belief that fraud, waste, or abuse has been committed is strictly prohibited.

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1. If the involvement of legal counsel is warranted, contact legal counsel to initiate direct investigation.

2. Ensure that the investigation is initiated promptly, but in any event not more than five (5) business days following receipt of the information. The investigation may include:

a. Interviews of persons who may have knowledge of the alleged conduct and a review of the applicable laws, regulations and standards to determine whether or not a violation has occurred.

b. Identification and review of relevant documentation, including, where applicable, representative bills or claims submitted to the Medicare/Medicaid programs, to determine the specific nature and scope of the violation and its frequency, duration, and potential financial magnitude.

c. Interviews of persons who appear to have played a role in the suspected activity or conduct. The purpose of the interviews is to determine the facts surrounding the conduct, and may include, but shall not be limited to, determining:

- **i.** The person's understanding of the applicable laws, rules and standards;
- **ii.** Identification of relevant supervisors or managers;
- **iii.** Training that the person received;
- **iv.** The extent to which the person may have acted knowingly or with reckless disregard or intentional indifference of applicable laws.

d. Preparation of a summary report labeled as "Confidential and Privileged" that (1) defines the nature of the alleged misconduct, (2) summarizes the investigation process, (3) identifies any person who is believed to have acted deliberately or with reckless disregard or intentional indifference of applicable laws, (4) assesses the nature and extent of potential civil or criminal liability, and (5) where applicable, estimates the extent of any resulting overpayment by the government.

3. For all investigations in which the organization's legal counsel is not involved determine whether the organization's legal counsel should be contacted.

4. Establish a due date for the summary report or otherwise ensure that the investigation is completed in a reasonable and timely fashion and that the appropriate disciplinary or corrective action is taken, if warranted.

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Misconduct or Suspected Criminal Activity.

In the event the investigation identifies employee misconduct or suspected criminal activity, the organization will undertake the following steps.

1. The organization will, as quickly as possible, terminate the offending practice. If the conduct involves the improper submission of claims for payment, the organization will immediately cease all billing potentially affected by the offending practice.

2. The organization will consult with legal counsel to determine whether voluntary reporting of the identified misconduct to the appropriate governmental authority or law enforcement agency is warranted.

3. If applicable, the organization will calculate and repay any duplicate or improper payments made by the federal or state government program as a result of the misconduct.

4. Initiate appropriate disciplinary action, which may include, but is not limited to, reprimand, demotion, suspension and/or termination. If the investigation uncovers what appears to be criminal conduct on the part of an employee, appropriate disciplinary action against the employee or employees who authorized, engaged in or otherwise participated in the offending practice will include, at a minimum, the removal of the person from any position of oversight and may include, in addition, suspension, demotion, termination, and/or reporting for criminal prosecution.

5. Where the employee or employees are not terminated, promptly undertake appropriate actions and education to prevent a recurrence of the misconduct.

6. Conduct a review of applicable organization policies and procedures to determine whether revisions or the development of new policies and/or procedures are needed to minimize future risk of noncompliance.

7. Conduct, as appropriate, follow-up monitoring and auditing to ensure effective resolution of the offending practice.

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Policy 10. Conflict of Interest Policy

No Officer, Director, committee member, supervisory staff or any Agency personnel serving in a leadership capacity shall take personal advantage of his or her leadership role by allowing a situation to exist that may be construed as a conflict of interest. Any activities which do not serve the best interest of the Agency or which favor the personal advantage of another person or corporation over those of the Agency are inconsistent with duties and responsibilities owed to the Agency. Leaders shall avoid any conflict between their own respective individual interests and the interests of the Agency, in any and all actions taken by them on behalf of the Agency.

Conflicts of Interest Defined

Conflicts of interest include, but are not limited to:

Direct financial or close personal interests in a company or product which could be affected by a decision of a Board, Committee, or other Agency governing body on which the Manager serves,
Acceptance of any gift, entertainment, services, loans, or promises of future benefits from any person or organization that might benefit because of the Managers connection with the Agency (NB: this does not apply to gifts or entertainment of nominal value), and
Compensation in the form of fees or salaries if such payment is affected directly or indirectly by the Managers work with the Agency.

Annual Disclosure of Potential Conflicts: Board and Committee Members and Supervisory Staff

Annually, at the meeting of the Governing Authority, all members of the Governing Authority, committee members and Supervisory Staff shall disclose any direct or indirect relationships with organizations, either for-profit or not-for-profit, that may, during their term of office or tenure, be involved with the Agency in a formal capacity. Such disclosure shall be on the Agency Disclosure Form attached.

Ongoing Disclosure of Potential Conflicts: All Leaders

In the event any Manager may stand to derive a personal gain or benefit from a transaction with the Agency or shall have any direct or indirect interest in or relationship with any individual or organization which:

- Proposes to enter into any transaction with the Agency for the sale, purchase, lease or rental of property,
- Proposes to render or employ services, personal or otherwise, to the Agency, or
- May be seen as competing with the interests or concerns of the Agency, such Manager shall forthwith give the Governing Authority of the Agency notice of such interest or relationship and shall, therefore, refrain from voting or otherwise

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attempting to affect any decision for the Agency to participate or not to participate in such transaction and the manner or terms of such participation.

Minutes of appropriate meetings of the Governing Authority and its committees shall reflect that such disclosure was made by the Governing Authority or committee member, and that such member abstained from voting and absented him or herself from the final review and vote on the matter.

Dissemination of Conflict of Interest Policy

A copy of this Article with the Disclosure Form shall appear in the orientation materials for newly elected Governing Authority members and committee members and shall be shared with the Nominating Committee for distribution to all prospective candidates. A copy of this Article shall also be distributed to all other Managers of the Agency upon employment.

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COMMUNITY HEALTH AND HOME CARE

Employee Standards of Conduct and Conflict of Interest Declaration

Employee's Name (Print) _

Department____

I acknowledge that I have received and read Community Health and Home Care Licensed Home Care Agency (herein known as CHHC) Standards of Employee Conduct and Conflict of Interest Policy.

I further acknowledge that I will abide by the "Agency's Compliance Plan" and will refrain from any behavior that may result in a conflict of interest regarding the Agency's established ethical standards. I understand that I will be subject to disciplinary action if I violate the principles in the Corporate Compliance Plan and Standards of Conduct. I further understand that the Corporate Compliance Plan is not a contract of employment. I will report any and all potential Conflicts of Interest as they arise during my employment with CHHC.

________________________________ ____________________

Employee Signature Date

Return this signed acknowledgement to Human Resources.

This form, or a copy of it, will remain in the employee's Personnel file.

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Policy 11. Medicaid Excluded Employees and Contractors

Policy:

CHHC complies with federal and state exclusion regulations by conducting verifications that a provider, vendor, staff member, or planned hire is not in any of the Medicare/Medicaid excluded party databases. The verifications will be conducted directly by the agency and/or through a company contracted and authorized by the agency to conduct the verifications. The exclusion verification will occur at initial hire and/or contracting and every thirty days thereafter to ensure that existing employees or contractors' status have not changed.

The Federal OIG and NYS OMIG require that healthcare providers that receive reimbursement, directly or indirectly, from a federally or state financed health care program, preclude employment of an excluded individual.

All agency contractual vendor agreements will require that the contractor ensure that their employees have been screened, by a check with the three exclusion lists before hiring and every thirty (30) days thereafter and have not been excluded from Medicaid.

Exclusion Lists utilized by CHHC and its contractors are:
Excluded Parties List System (EPLS) maintained by the General Service Administration (https://www.epls.gov) The GSA web site contains debarment actions taken by various Federal agencies, including exclusion actions taken by the OIG.

The Office of Inspector General's List of Excluded Individuals/Entities (LEIE). Provides information to the health care industry, patients and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid and all Federal health care programs. Individuals and entities who have been reinstated are removed from the LEIE. The LEIE contains just the exclusion actions taken by the OIG.
(http://www.oig.hhs.gov/fraud/exclusions/about.asp)

New York State Office of Medicaid Inspector General (OMIG) (www.omig.state.ny.us)

General Information

Definitions:
Employee: Anyone who provides a service for which a claim is submitted to Medicaid, or anyone who is compensated out of Medicaid funds, would be considered an employee.
Background Information:

The effect of an OIG exclusion from participating in federally financed health care programs is that no federal health care program payment may be made for any items or services: (1) furnished by an excluded individual or entity, or (2) directed or prescribed by an excluded physician. The prohibition also extends to payment for administrative and management services

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not directly related to patient care, but that are necessary component of providing items and services to federally financed health care program beneficiaries.

Under 18 NYCRR Part 521, each provider who receives $1,000,000 or more in Medicaid funding annually must have an effective compliance program in place and certify to that fact annually. OMIG has begun reviewing compliance program to assess their effectiveness, and as part of the review, OMIG will, in appropriate cases, include assessing whether or not effective exclusion screening were done.

The NYS OMIG recommends:
If a potential employee's resume indicates that he or she has worked in another state, the agency should also check that state's individual list. The verification should include all employees, contractors or service providers who are involved in generating a claim to bill for services or being paid by Medicaid (including if their salaries are included on a cost report submitted to the Medicaid program).
The thirty (30) day requirement is not in a regulation or statute but is contained in a letter from the Center for Medicare and Medicaid Studies (CMS). Providers should follow that directive which recommends that each Medicaid provider checks each employee as a "foundation," then quarterly thereafter; using the thirty (30) day list to determine whether to provider knew or should have known about exclusion. Any employee who causes a claim to be generated, and whose income derives all or in part from Medicaid funds must be checked at initial hiring and on a monthly (every 30 day) basis for exclusion.

Examples that demonstrate the kinds of items and services that excluded parties may be furnishing which will subject their employer or contractor to possible liability.

Services performed by excluded nurses, technicians or other excluded individuals who work for a hospital, nursing home, home health agency or physician practice, where such services are related to administrative duties, preparation of surgical trays or review of treatment plans is such services are reimbursed directly or indirectly (such as through a PPS or a bundled payment) by a Federal health care program, even if the individuals do not furnish direct care to Federal program beneficiaries;

Services performed by excluded pharmacists or other excluded individuals who input prescription information for pharmacy billing or who are involved in any way in filling prescriptions for drugs reimbursed, directly or indirectly, by any Federal health care program;

Services performed by excluded social workers who are employed by health care entities to provide services to Federal program beneficiaries, and whose services are reimbursed, directly or indirectly, by a Federal health care program;

Administrative services, including the processing of claims for payment, performed for a Medicare intermediary or carrier, or a Medicaid fiscal agent, by an excluded individual;

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Services performed by an excluded administrator, billing agent, accountant, claims processor or utilization reviewer that are related to and reimbursed, directly or indirectly, by a Federal health care program;

Items or services provided to a program beneficiary by an excluded individual who works for an entity that has a contractual agreement with, and is paid by, a Federal health care program; and

Items or equipment sold by an excluded manufacturer or supplier, used in the care or treatment of beneficiaries and reimbursed, directly or indirectly, by a Federal health care program.

Procedure:

Employees:

All current/active employees will be screened by use of the three exclusion lists addressed above. Documentation resulting from the review that identifies an employee to be on a list will be submitted to the Administrator/Designee for review and resolution. Documentation will be filed in the employees' personnel file.

At hire, all applicants will be screened by use of the three exclusion lists as part of the background check. Documentation of the screening will be submitted to the Administrator /Designee for review, any applicant found to be on any of the three exclusion lists will be precluded from employment at Agency.

Every thirty days, the agency HR department will review the updated exclusion list to identify any change in current employee status involving the exclusion lists. Results will be forwarded to the Administrator/Designee for any necessary action.

The Administrator will report any change in the status of current employees to OMIG. (See attached disclosure reporting guidance brochure and reporting form). Failure to disclose your employment of or contract with an excluded individual can be the basis for a False Claims Act liability.

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Policy 12. Self-Disclosure Protocol

Purpose:

It is the policy of this organization to address and report compliance issues other than financial to the NYS Department of Health (NYS DOH) and/or the NYS Office of Medicaid Inspector General (NYS OMIG) and to self-disclose any credit balances, or other areas where the organization was paid erroneously, upon discovery as required by the Health Reform Act and the NYS Office of the Medicaid Inspector General. **Self-disclosure is also required of all Medicaid Entities/Providers to report damages, lost or destroyed records detailing the services provided for Medicaid claims.**

Policy:

OMIG Disclosure:
The organization will disclose as required by the OMIG, within 60 days after an "overpayment is identified" as follows to the OMIG electronically via https://omig.ny.gov/self-disclosure-regulatory-authority.

If the Provider is a Network Provider for a Medicaid Managed Care Plan (MMCO) the Network Provider, should self-disclose all overpayments to the MMCO per the MMCO's self-disclosure policies and procedures. If the MMCO is unresponsive to the Network Provider's self-disclosure the provider should document their attempts to contact the MMCO and submit a full self-disclosure form electronically to the NYS OMIG.

Description of actual or potential issue:

- Name and address of disclosing party and any related affiliates or entities.
- Description of the nature of the matter being disclosed or any other noncompliance issue
- A description of the nature of the disclosed matter the federal program affected and relevant time period.
- The names of entities and individuals believed to be implicated in the matter and their role in the matter.
- The circumstances under which the disclosed matter was discovered and the measures taken upon discovery to address the issue and prevent future abuses.

Financial analysis:

- Summarize by year the potentially due and owing based upon the look-back period.
- Describe the methodology used to set forth the amount that is potentially due and owing.
- Provide a summary of the auditing activity undertaken and a summary of the documentation relied upon.

Certification:

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The disclosing parties, either the Chief Executive Officer or the Chief Financial Officer, must submit to CMS a signed certification stating to the best of their knowledge all the information has been truthful and presented in good faith to bring to CMS attention for proper resolution.

OMIG Self-Disclosure:
Under the ACA Medicare/Medicaid overpayments must be reported and returned to OMIG by the later of:

(a) the date which is 60 days after the date on which the overpayment was identified; or
(b) the date any corresponding cost report is due, whichever is later.

Each incident stands on its own and is considered separately. Claims covered by self-disclosure will not be audited again for the same issue and dates of service.

Services performed by an excluded administrator, billing agent, accountant, claims processor or utilization reviewer that are related to and reimbursed, directly or indirectly, by a Federal health care program.

Provider performs the Self-Disclosure audit electronically on the OMIG Web Site.
Extended repayment terms are possible for demonstrated hardship.
No penalties or sanctions.
The look-back period is six (6) years by date of service.

The **issues appropriate for self- disclosure** may include:

- Substantial routine errors
- Systematic errors
- Patterns of errors
- Potential violation of fraud and abuse laws

Submission Guidelines:

- Submission Letter
- Complete description of circumstances surrounding the disclosure including:
- Provider name
- Medicaid MMIS ID and NPI number of the billing provider
- The error that occurred
- How the error was found
- Any relevant facts including total amount billed and amount of overpayment by Medicare/Medicaid

At a **minimum gather** the following information:

- The time period the claims error encompasses
- Actions taken to stop the error and prevent recurrence
- Personnel involved in the error occurrences, those who discovered the problem, and those involved in
- Rectifying the problem
- Legal and Medicaid program rules implicated

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- Disclosure contact person name, phone number, and both correspondence and email Addresses.

OMIG has enacted self-disclosure processes to afford Medicaid Entities/Providers a mechanism to report, return and explain overpayments from the Medicaid Program. These processes cover all Medicaid enrolled Providers, MMCOs and other Entities involved in the billing or receipt of Medicaid funds.

MMCOs are required to establish Self-Disclosure Programs including policies and procedures for participating providers and other subcontractors to report, return and explain Managed Care overpayments. Network Provides including Licensed Home Care Services Agencies should self-disclose identified Managed Care overpayments to their MMCO in accordance with the MMCO's policies and procedures.

If the MMCO is unresponsive, the Network Provider should submit their documentation along with a completed electronic Full Self-Disclosure to OMIG's Self Disclosure Program. OMIG staff will notify the Medicaid Entity/Provider within twenty days (20) from receipt of the self-disclosure on the status of the submission outcome.

Abbreviated Self-Disclosure: A Medicaid enrolled Provider would submit a completed Abbreviated Self-Disclosure to OMIG through the secure online portal available in the Self-Disclosure section of the OMIG Web Site. The Provider may submit an Abbreviate Self-Disclosure Form each month for overpayments identified and voided or adjusted in the previous month.

- This process may be used to disclose FFS claims overpaid due to routine or transactional errors.
- These claims have been voided or adjusted as repayment and
- These claims are self-disclosed with sixty (60) days from the date the overpayments were identified.

The Provider will receive an automatic confirmation reply notifying them the abbreviated disclosure was submitted. This automatic reply will contain a unique code for the submission to be used as a reference if needed. This notice constitutes final action and confirmation of the Provider's obligation to report and explain an overpayment.

Self-Disclosure for Damaged, Lost or Destroyed Records: The Medicaid Provider must submit a completed Statement of Damaged, Lost or Destroyed Records with any accompanying documentation to OMIG's Self Disclosure Unit via the uplink on OMIG's Website. **The Provider should report to OMIG as soon as practicable but no later than thirty (30) calendar days after discovery.** A Notice of Acceptance will be issued to the Provider upon submission. In the event of a Medicaid audit or investigation in which sought records were not maintained OMIG will evaluate the Provider Statements on a case-by-case basis whether there are mitigating circumstances for the failure to maintain these documents.
Filing of Self-Disclosure is performed by the CEO, CFO of the company or Attorney representing the provider or the corporate compliance officer.

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Contact the OMIG Attn: Provider Self-Disclosure, 800 Pearl Street Albany, New York 12204 518-473-3782. **E-mail:** **selfdisclosures@omig.ny.gov**

Returning the Overpayment

Once OMIG has completed its review and verified the amount of the overpayment OMIG will notify the provider of the amount of the overpayment and interest, if applicable, and such notification will contain instructions for remitting payment to the department. Interest may be waived at the sole discretion of OMIG.

(a) The notification will be issued in accordance with the provisions of subdivisión (a) of section 521-3.6 of SubPart 521.

(b) The provider will submit the full amount of the overpayment and interest within fifteen (15) days of the date of OMIG's notification of the determination of the amount of the overpayment, and interest, unless the provider has been approved by OMIG to repay the overpayment through installments.

(c) Where a provider has been approved to repay the overpayment and interest through installment payments, OMIG's notification of the overpayment will also include an agreement (SDCA) which the provider will execute and return to OMIG within the timeframe specified in order to remain eligible to participate in OMIG's Self-Disclosure Program including the schedule of repayments.

(d) The full amount of any repayment shall become immediately due and payable, with interest, if: (i) the provider fails to remit payment as scheduled pursuant to the scheduled installment plan; (ii) participation in the Self-Disclosure Program is terminated in accordance with OMIG's participation requirements.

Enforcement: A provider who fails to report, return and explain an overpayment by the deadline sspecified may be subject to monetary penalties pursuant to the Social Services Law and any other sanction or penalty authorized by law.

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Policy 13. Social Media

Definition:

Social media is the practice of posting information to the Internet. This policy is meant to provide guidelines to the agency workforce, administration and staff. The agency respects an employee's right to use social media as a medium of self-expression. But the agency's policy is as follows:

Policy:

Social media is not a business-related activity and should be done during personal (non-work) time only.

In the event that employees participate in social media, the following applies:

- They are personally responsible for their posts. Threats to agency management, staff or patients, will be dealt with disciplinary action and dismissal. (Disciplinary Policy #14)
- If employees publish or post to Facebook, Twitter or other social media and it has something to do with the work they do, or with subjects relating to the agency, they must make it clear that the views expressed are solely their personal views and do not necessarily represent the views of the agency.
- Won't disclose confidential or proprietary agency information. Consult the company's confidentiality policy for guidance about what constitutes confidential information.
- Do not cite or reference the agency patients / client's names or pictures, as that is a breach of patient privacy.
- Since an employee site is a public space, the agency requires that all will be respectful to the company, our employees, our customers, our partners and affiliates, and others (including our competitors). Threats to agency management, staff or patients, will be dealt with disciplinary action and dismissal. (Disciplinary Policy #14)

No link may be provided link from your site to the company's website without express written permission from Public Relations / Marketing.

If there are any questions about these guidelines or any matter related to public site that these guidelines do not address, please direct them to the organization's Compliance Officer, or Chief Operating Officer.

Compliance:

Failure to comply with this policy will result in corrective or disciplinary action including, where appropriate, employment termination and legal recourse.

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Policy 14. Disciplinary Action

Policy:
Employees are expected to conduct themselves in a manner that upholds the agency's values and complies with the standards of conduct and ethical business practices. Candidates for employment are subject to inquiry about past compliance violations. Continued employment will be conditioned upon compliance with the Corporate Compliance Program. Violations of the Standards of Conduct and /or failure to adhere to the requirements of the corporate program will result in disciplinary action, up to and including termination.

General Information
Disciplinary actions can range from verbal to suspension, revocation of privileges (pursuant to any applicable peer review procedures), termination, or financial penalties.

Procedure:
Investigations will be conducted on compliance related issues with the assistance of, but not limited to:
The caller, if self-identified
    Management
    Human Resources
    Compliance Officer
    Clinical personnel
    External Legal Counsel, if applicable.

Progressive counseling will be used in accordance with policy and procedure as an effective method to encourage employees to correct deficiencies in their conduct or performance. Disciplinary actions up to and including termination, will be determined on a case-by-case basis and will be taken appropriately, equitably and consistently, based on the degree of severity.

All calls are identified by code based on the information presented in the call.

The agency's Corporate Compliance Officer will be responsible for collaborating with the agency's Administration and the Human Resource Manager regarding appropriate action. Some disciplinary actions may be handled by managers, whereas others may need to be resolved by administration (e.g., issues involving high-level personnel or Health Care Professionals).

All employees are subject to the same disciplinary action for committing similar offenses. The consequences of noncompliance will be consistently applied and enforced. The commitment to compliance applies to all personnel levels within the organization.

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All contractual arrangements require the contractor to comply with the healthcare organization's standards and policies and procedures and all applicable laws and regulations. Contracts spell out the consequences of non-compliance on the part of the contractor, including immediate termination of the contract if serious non-compliance issues occur.

Agency staff are educated on the organization's disciplinary policies in order to fully comprehend the consequences of non-compliance. Supervisors are educated on their responsibilities in disciplining employees appropriately and consistently.

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Policy 15. Billing and Claim Development

Policy:

The agency submits claims based on true and accurate information in compliance with coverage criteria for those services rendered by the organization. The agency avoids any system of compensation or financial incentive that induces inaccurate or fraudulent billing practices.

Procedure:

1. Billing personnel may not be compensated in a manner that offers any financial incentive for the submission of claims without regard to whether they meet applicable coverage criteria for reimbursement or accurately represent the services rendered.

2. Each area will establish and maintain a process for pre and/or post-submission review of a sample of claims to ensure that claims submitted for reimbursement accurately represent services actually provided and are supported by sufficient documentation, are in conformity with any applicable coverage criteria for reimbursement.

3. The agency will bill only for those services that it has directly rendered or were rendered on its behalf by another organization under a contractual agreement.

4. The agency will not bill for any services that are the financial responsibility of another organization for which another organization has accurately billed.

5. A claim/bill may be submitted only when appropriate clinical documentation supports the claim and only when such documentation is maintained appropriately organized in a legal form, and available for audit and review. The documentation should record the activity that lead to the record entry, the identity and discipline of the individual providing the service and any information needed to support medical necessity and other applicable reimbursement/coverage criteria. Documentation may include but is not limited to the following:

   a. Plan of Care or Plan of Treatment

   b. Verbal orders

   c. Clinical Notes – all disciplines for each visit

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d. Progress notes – all disciplines

e. Aide Plan of Care

f. Orientation and/or supervision to the Aide Plan of Care

g. Conference Records (if applicable)

h. Documentation of telephone conferences

i. Comprehensive assessment at prescribed frequencies

j. Discharge Summary

k. History and Physical

l. Medication Profile

m. Time and activity report.

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Policy 16. Attendance

Policy:

CHHC is aware of the difficulties in monitoring attendance of field/direct care staff. To ensure that patients are serviced during the assigned schedule, the Agency utilizes a telephonic system to clock in and out all field/direct care employees at the start and end of the assigned shift/assignment. All field/direct care employees are provided with in-service education as to the operation of the system and are expected to log in and out each day of service.

The agency's nursing and/or coordinating staff also implement a secondary attendance check which involves unannounced home visits and random telephone audit calls. Documentation of these activities is maintained in the patient record progress note and coordinator telephone logs.

Procedure:

1. All agency field staff is in-serviced in the use and expectations of the telephonic attendance program. Reinforcement of the system is included in subsequent in-services and employee conferences.

2. At the direct care staff's arrival at the client home the employee calls the "800" number and enters his/her unique ID number.

3. At the end of the assigned shift, the employee again calls the "800" number accesses the system and clocks out and enters the duty codes assigned to the client care provided during that specific day.

4. Daily, the office staff prints out reports to identify any exceptions to the system. This will identify any employee not clocking in or out or entering care provided. The exceptions will be addressed by the appropriate staff i.e. nursing/administration etc.

5. Based on nursing or administrative selection, the nursing staff and/or coordinating staff will conduct client home visits to evaluate attendance compliance. This visit will be documented and maintained in the client records.

6. Daily, the coordinating staff will conduct random telephone contact with the employee at their assigned client home; client satisfaction with the services will also be included in the contact. This activity will be documented in call logs.

7. Any concerns regarding attendance will be submitted to the Director of Patient Services for investigation and/or resolution.

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Policy 17. Sanction Policy

Introduction

CHHC has adopted this Sanction Policy to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as modified by the Health Information Technology for Economic and Clinical Health Act ("HITECH Act") (hereinafter HIPAA); the Department of Health and Human Services ("DHHS") and NYS Office of Medicaid Inspector General (OMIG) fraud and abuse regulations.

All agency personnel must comply with this policy. Familiarity with the policy and demonstrated competence in the requirements of the policy are an important part of every agency employee's responsibilities. This policy outlines sanctions for participating in non-compliant behavior, encouraging, directing, facilitating or permitting non-compliant behavior for all affected individuals.

Assumptions:

This Sanction Policy is based on the following assumptions:

- The agency has adopted a Security Policy requiring the agency and its officers, employees and agents to protect the integrity and confidentiality of medical and other sensitive information pertaining to our patients.
- In addition, the agency and its departments have adopted policies and standards to carry out the objectives of the Security Policy.
- All affected individuals of the organization, it's officers, employees, and agents are encouraged good-faith participation in the compliance program, report compliance issues, suspected compliance problems, non-compliant behavior.
- Each of these policies and standards notes that all officers, employees, and agents of the agency must adhere to these policies and standards, that the agency will not tolerate violations of these policies and standards, and that such violations constitute grounds for disciplinary action up to and including termination, professional discipline, and criminal prosecution.

Policy:

- All affected individuals of the organization that believes that another officer, employee, or agent of the agency that believes that another officer, employee, or agent of the agency has breached the agency Compliance and /or Security Policy or the policies and standards promulgated to carry out the objectives of the Compliance and /or Security Policy or otherwise breached the integrity or confidentiality of patient or other sensitive information should immediately report such breach to his or her superior or to the Compliance / Privacy/Security Officers.

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- The Compliance / Privacy/Security Officers will conduct a thorough and confidential investigation into the allegations. The agency will inform the complainant of the results of the investigation and any corrective action taken the agency will not retaliate against or permit reprisals against a complainant. Allegations not made in good faith, however, may result in discharge or other discipline.
- As noted in the agency employee handbook, the agency has a progressive discipline policy under which sanctions become more severe for repeated infractions. This policy, however, does not mandate the use of a lesser sanction before the agency terminates an employee. In the discretion of management, the agency may terminate an employee for the first breach of the agency compliance and security policy or individual policies and standards if the seriousness of the offense warrants such action. An employee could expect to lose his or her job for a willful or grossly negligent breach of confidentiality, the initiation or conduct of fraudulent acts, willful or grossly negligent destruction of computer equipment or data or knowing or grossly negligent violation of the Compliance program and HIPAA policies and procedures. For less serious breaches, management may impose a lesser sanction, such as a verbal or written warning, verbal or written reprimand, loss of access, suspension without pay, demotion, or other sanction. In addition, the agency will seek to include such violations by contractors as ground for termination of the contract and/or imposition of contract penalties.
- Violation of the agency compliance program and HIPAA policies and standards may constitute a criminal offense under Compliance regulations and HIPAA, other federal laws and State laws. Any employee or contractor that violates such laws may expect that the agency will provide information concerning the violation to appropriate law enforcement personnel and will cooperate with any law enforcement investigation or prosecution.
- Violations of the agency compliance and HIPAA policies and standards may violate professional ethics and be grounds for professional discipline. Any individual subject to professional ethics guidelines and/or professional discipline should expect the agency to report such violations to appropriate licensure/accreditation agencies and to cooperate with any professional investigation or disciplinary proceedings.

Enforcement

All affected individuals of the organization including officers, agents, and employees of the agency must adhere to this policy, and all supervisors are responsible for enforcing this policy. The agency will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with the agency's medical information sanction policy and personnel rules and regulations.

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COMMUNITY HEALTH AND HOME CARE

Corporate Compliance Staff Training

DEFINITION:
Compliance can be described as conducting a business and oneself in an ethical, moral, and legal manner, an aspect of quality improvement, and an insurance investment, most importantly:

THE RIGHT THING TO DO

FACTS:
Compliance involves both the Federal and State governments. If convicted penalties can be invoked and can include Criminal prosecution, Civil proceedings, Sanctions with fines up to $11,000 per claim, treble damages, imprisonment, exclusion from Federal program.

REQUIREMENTS OF OUR AGENCY:

Designate a Compliance Officer
Develop Open Lines of Communications
Perform Internal Monitoring and Auditing
Enforce Disciplinary Actions
Develop Policies and Procedures
Provide Training and Education
Respond to Detected Deficiencies
Establish Whistleblower Protection

OUR COMPLIANCE PROGRAM CONTAINS:

Standards of Conduct
Compliance Officer Responsibilities
Federal / State False Claims Act
Compliance Committee Responsibilities

WHAT TO REPORT TO OUR COMPLIANCE HOTLINE:

Breeches of confidentiality
Fraudulent or false actions
Unethical staff behavior
Bribes or kickbacks
Unethical relationships
Improper billing practices
Unethical/ Impropriate care
Falsifying documentation of care

COMPLIANCE AND JOB PERFORMANCE:

Compliance is an element of job performance. Employees are expected to be up to date on policies and legal requirements that apply to their position. Failure to do these can result in disciplinary action or termination.

COMPLIANCE SUCCESS:

It requires that every employee to be honest, and aware of the consequences of a non-compliant act. To be vigilant of actions around you and the impropriety that may result. Know who to discuss your concerns and the proper reporting mechanism. Know that there is non-retaliation for concerns reported in good faith that is our policy.

HOW TO REPORT:

- Talk to your supervisor first. If you are unable to do that:
  Contact the Compliance Officer at ______________

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COMMUNITY HEALTH AND HOME CARE

SELECTED REFERENCES AND AUTHORITIES

The following are some references and authorities that were considered in the preparation of this guidance document.

NYS Social Services Law § 363-d
NYS Social Services Law § 145-b
18 NYCRR SubPart 521-1, Scope and applicability
18 NYCRR SubPart 521-2, Definitions
18 NYCRR SubPart 521-3, Required provider duties
18 NYCRR Part 504, Medical Care – Enrollment of Providers
18 NYCRR Part 515, Provider Sanctions
18 NYCRR Part 516, Monetary Penalties
18 NYCRR Part 519, Provider Hearings
42 United States Code 1396a(a)(68), State plans for medical assistance
2007 DRA 6032 - Employee Education About False Claims Recovery - Frequently Asked Questions
2023 New York State OMIG Compliance Program Guidance Updates
2017 HCCA-OIG Measuring Compliance Program Effectiveness: A Resource Guide

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