ANCHOR HOME CARE

COMPLIANCE AND ETHICS PROGRAM MANUAL

Reporting Requirements

Code of Conduct

Compliance Program Structure and Guidelines

Revised 9/18/2024

Introduction

Anchor Home Care, a licensed home care services agency ("the Agency") is committed to compliance with all applicable federal and state laws, rules and regulations, including Federal health care program requirements (e.g., Medicare and Medicaid). In accordance with these requirements, the Agency has designed and implemented a comprehensive Compliance and Ethics Program that outlines the standards of conduct that all "Personnel" (as defined below) are expected to follow in their employment or course of dealings with the Agency. The principle components of the Compliance and Ethics Program include:

(A) **Compliance and Ethics Program's Code of Conduct**. The Code of Conduct sets forth the Agency's mission and the general standards of conduct that all the Agency Personnel are expected to follow. Must adhere to.

(B) **Compliance and Ethics Program Structure and Guidelines**. The Compliance and Ethics Program Structure and Guidelines describe the elements of the Program and how the Program operates day-to-day.

(C) **Specific Compliance Policies and Procedures**. Certain compliance issues require further detail and instruction. Personnel are required to review and be familiar with the requirements outlined in this Manual and any of our Program policies and procedures that relate to your responsibilities at the Agency. These documents are available upon request from the Compliance Officer. They are also available at the Agency Offices.

(D) **Compliance Training.** The Agency has established a compliance and education program for Personnel. Annual participation in compliance training is mandatory. In addition, the Agency may require Personnel to participate in additional training from time to time, as necessary to address compliance issues or new developments in law or regulation.

The Agency is dedicated to ensuring a culture of compliance and quality. As such, we require that all Personnel cooperate fully with the requirements of the Program. Once you have reviewed these documents, please sign and return the attached Acknowledgment of Receipt to the Compliance Officer.

If you have any questions regarding the Agency's Program, please refer to the Code of Conduct, the Structure and Guidelines, the compliance policies, or speak with the Compliance Officer for more detailed information regarding any aspect of the Program.

The Agency is dedicated to maintaining high standards of care in compliance with all applicable laws, rules and standards. We are, in short, committed to doing the right thing and our Compliance and Ethics Program is designed to assist us in effectively keeping to that commitment.

Key Definitions

(1) ***"Compliance Committee"*** means the group of senior employees that the Agency has designated to coordinate with and assist the Compliance Officer in carrying out certain aspects of the Program.

(2) ***"Compliance Officer"*** means the individual designated by the Agency with oversight responsibility for the Program.

(3) ***"Compliance Program"*** or ***"the Program"*** means the comprehensive program and organization policies and procedures implemented by the Agency which together, set forth the standards of conduct that all Personnel are expected to follow in their employment or course of dealings with the Agency.

(4) ***"Federal health care program"*** means any plan or program that provides health benefits whether directly, through insurance or otherwise, which is funded directly, in whole or in part, by the United States Government, and includes certain State health care programs. Examples include, but are not limited to: Medicare, Medicaid, Veterans' programs and the State Children's Health Insurance Programs.

(5) ***"Good faith participating in the Compliance and Ethics Program"*** includes, but is not limited to the following actions:

- Reporting potential compliance issues to appropriate Personnel (*e.g.*, the Compliance Officer);
- Cooperating with/participating in the investigation of potential compliance issues;
- Assisting the Agency with self-evaluations and audits;
- Assisting the Agency with implementing remedial actions;
- Reporting instances of intimidation or retaliation; and
- Reporting potential fraud, waste or abuse to appropriate state or federal entities.

(6) ***"Governing Body"*** refers to all owners of the Agency.

(7) ***"Affected Individuals"*** or ***"Personnel"*** means all persons affected by the Agency's compliance risk areas, including employees, the Administrator, senior managers, owners (*i.e.*, the Members of the Governing Body), contractors, agents, subcontractors, independent contractors, and vendors.

(8) ***"Risk Areas."*** Compliance "risk areas" may change from time-to-time based on the Agency's organizational experience. However, the Program continually addresses the following risk areas:

- Billings and payments;
- Ordered services;
- Medical necessity and quality of care;
- Governance;
- Mandatory reporting;
- Credentialing; and
- Contractor, subcontractor, agent and/or independent contractor oversight.

REPORTING REQUIREMENTS

Personnel of the Agency must abide by the Program and are required to report suspected misconduct or possible violations of the Program to the Compliance Officer, another member of senior management, or to their supervisor. Personnel may also report issues anonymously to the Compliance Helpline.

Disclosure is required if any Personnel have knowledge of any potential violations of criminal, civil or administrative law related to the Federal health care programs. Personnel are also required to raise any compliance issues or questions about the Agency's Program, policies, conduct, practice or procedures.

Personnel may report anonymously if they choose (by way of the Compliance Helpline). The identity of the reporting Personnel will be kept confidential, whether requested or not, unless the matter is subject to a disciplinary proceeding, referred to or under investigation by the NY State Medicaid Fraud Control Unit (MFCU), the Office of Medicaid Inspector General (OMIG) or law enforcement or if disclosure is a requirement in connection with a legal proceeding.

Retaliation or intimidation in any form against an individual who in good faith reports possible unethical or illegal conduct is strictly prohibited. Acts of retaliation or intimidation should be immediately reported to the Compliance Officer or to the Compliance Helpline and, if substantiated, will be disciplined appropriately.

Name	Contact Information
Compliance Officer Aziza Aminova	Ph: 718-537-2000 ext. 109 Email: aziza@anchorhc.org
Compliance Helpline Calls to the Helpline can be made **anonymously**	Ph: 718-840-3554

ANCHOR HOME CARE

COMPLIANCE AND ETHICS PROGRAM

CODE OF CONDUCT

The Code of Conduct

This Code of Conduct sets forth the Agency's mission and the standards of conduct that all Personnel must adhere to and follow. If you have any questions or concerns about anything covered by the Code of Conduct or about any other matter relating to the Compliance and Ethics Program, or if you wish to report a concern or problem, please contact the Compliance Officer, your direct supervisor, or other senior management.

I. CODE OF CONDUCT: MISSION AND VALUES

o The Agency is committed not only to providing clients/members with high quality services, but also to providing those services pursuant to high ethical, business, and legal standards.

o We do not and will not tolerate any form of unlawful or unethical behavior by anyone associated with the Agency. We follow the letter and spirit of applicable laws and regulations, conduct our business ethically and honestly, and act in a manner that enhances our standing in the community.

II. CODE OF CONDUCT: STANDARDS

► General Standards

o Personnel must be honest and act lawfully in all of their business dealings.

o Personnel must comply with this Code; report any action they think may be potentially unlawful, inappropriate or in violation of the Code; cooperate with compliance-related investigations; and work to correct any improper practices that are identified.

o Each supervisor and manager is responsible for ensuring that the Personnel within their supervision are acting ethically and in compliance with applicable law and regulations and the Code.

o Personnel may not engage in any adverse action that intimidates or retaliates against anyone who has engaged in good faith participation in the Program. Retaliatory and intimidating actions violate this Code and will not be tolerated.

o Personnel who violate the Code or commit illegal acts are subject to discipline up to and including termination of employment or contract. Personnel who report their own illegal acts or improper conduct, however, will have such self-reporting taken into account when the Agency, in its discretion, determines the appropriate disciplinary action.

► Standards Relating to Quality of Care and Medical Necessity

o The Agency is fully committed to providing high quality of services in accordance with all applicable laws, rules and regulations, including Federal health care requirements. As part of this commitment, we ensure that necessary quality assurance systems are in place and functioning effectively. Moreover, the Agency is committed to providing and ensuring that each client / member receives all care and services needed to attain and maintain their highest practicable level of physical, emotional and psychosocial well-being, in accordance with individual assessments and care plans. In keeping with our

mission and values, the following principals have been incorporated into the Compliance and Ethics Program:

(1) All clients / members will have access to services without regard as to race, color, religion, sex, national origin, disability, sexual orientation, source of payment, or sponsorship.

(2) Clients / members' service needs will be assessed in accordance with all applicable federal and state regulations and time limits.

(3) The rights of all clients / members, including, privacy, dignified existence, self-determination, and to participate in their own care and treatment are at all times respected.

(4) The Compliance Officer or designee will ensure that quality assurance reviews are conducted, issues are addressed, and corrective actions are implemented.

► **Standards Related to Credentialing**

○ The Agency has processes in place for the on-going and continuous credentialing and competency reviews of the Agency's clinical and non-clinical staff.

○ the Agency conducts appropriate background checks pursuant to federal and state law (which may include, but is not limited to, criminal history checks for all Personnel involved in client/member care or have access to clients'/members' possessions, and whether any Personnel are excluded from participation in Federal health care programs).

○ It is the on-going and continuous obligation of all Personnel to alert the Human Resources Director in writing, within two days, of any criminal conviction, exclusion from participation in a Federal health care program (*e.g.*, Medicare and Medicaid), or any other finding that would disqualify them from providing services.

○ Employees are required to certify annually that since their last employee evaluation, they have not been (i) excluded, debarred, or declared otherwise ineligible for participation in any Federal health care programs (*e.g.*, Medicare and Medicaid); or (ii) convicted of a crime. Employees are further required to certify annually that their New York State certifications/licenses and registrations to practice their profession are current (if applicable).

► **Standards Related to Billing, and Payments**

○ All billing must be accurate and truthful and based on adequate documentation of the medical justification for the services provided.

(1) All plans of care must be fully, timely, and accurately completed in accordance with all applicable federal, state, and local rules and regulations, as applicable.

(2) Personnel should never misrepresent charges to, or on behalf of, a client/member or third-party payor. Deliberate or reckless misstatements to government agencies or other payors will expose Personnel involved to termination or employment or contract and potential criminal penalties.

(3) Only those services provided to clients/members that are consistent with acceptable standards of care may be billed.

(4) Personnel must comply with all Federal and New York State laws, including false claims laws and regulations that apply to the operations of the Agency. A discussion of these laws is contained in a separate policy, entitled "Compliance with Applicable Federal and State False Claims Acts: Overview of the Laws Regarding False Claims and Whistleblower Protections." All Personnel will receive a copy of this policy.

(5) the Agency does not retain any payments to which it is not entitled. The Agency will timely report, return and explain any identified overpayments in accordance with applicable laws, rules, regulations, and contractual requirements. For more information, see "Mandatory Reporting," below.

► **Standards Relating to Governance**

o The Governing Body maintains oversight of the Agency's compliance with Federal health care program requirements and this Program. In that regard, the Governing Body regularly receives reports from the Compliance Officer and the Compliance Committee regarding the effectiveness of the Program.

o The Governing Body also oversees the Agency's procedures for evaluating potential or actual conflicts of interest. Personnel must exercise the utmost good faith in all transactions that touch upon their duties and responsibilities for, or on behalf, of the Agency. Even the appearance of illegality, impropriety, conflicts, or duality of interests can be detrimental to the Agency and must be avoided. Personnel who are in a position to influence any substantive business decision must complete an annual Conflict of Interest Disclosure Statement, disclosing all direct and familial interests which compete or do business with the Agency.

► **Standards Relating to Referrals**

o In compliance with federal and state anti-referral laws, the Agency does not pay incentives to any Personnel based upon the number of clients / members enrolled or the value of services provided. Any bonuses given to W-2 employees will be based on the quality and quantity of work provided to the Agency and will not consider the volume or value of referrals. Nor does the Agency pay physicians, or anyone else, either directly or indirectly, for client / member referrals. The Agency also does not accept any form of remuneration in return for referring our clients/members to other health care providers. The Agency at all times respects and honors a client's/member's freedom to choose a health care provider.

► **Standards Relating to Ordered Services**

o the Agency strives to ensure that services are provided in accordance with a physician order and certification for a client/member.

► **Standards Relating to Business Practices**

o the Agency will forego any business transaction or opportunity that can only be obtained by improper and illegal means and will not make any unethical or illegal payments to anyone to induce the use of our services.

(1) Payments and Gifts. Personnel may not be involved with gifts or benefits that are undertaken: (i) in return for or to induce referrals, or (ii) in return for or to induce the purchasing, leasing, ordering or arranging (or the recommending of any of the foregoing) of any item or service. Any questions regarding whether or not an item or situation falls within the scope of this policy must be raised immediately with the Compliance Officer. In addition:

- Personnel are strictly prohibited from soliciting any gifts or benefits of any kind from any person or entity, either individually or on behalf of the Agency.

- Personnel may not accept any personal gifts, gratuities or tips from any client/member or client's/member's family member.

- Personnel may not offer or give any gifts or benefits to a person if the gift or benefit is likely to influence the person to select us as their provider of care.

- Personnel may provide or receive, however, ordinary and reasonable business entertainment and gifts of nominal value, if those gifts are not given for the purpose of influencing the business behavior of the recipient.

- Gifts of cash or cash equivalents are strictly prohibited.

(2) Marketing. In marketing our services, Personnel must be truthful and honest in all representations they make and never agree to offer anything of value in return for referrals.

► **Standards Relating to Confidentiality and Security**

○ The Agency maintains the privacy and security of information related to its clients/members. Personnel must adhere to the Agency's policies and standards regarding such standards of privacy and security.

○ Personnel must keep client/member information in the strictest of confidence and secure. Such information must not be disclosed to anyone unless authorized by the client/member or otherwise permitted by law. **This includes, without limitation, disclosure of pictures or any client/member information on any form of social media.**

○ Personnel may not disclose or release, without prior authorization of the appropriate supervisor, any confidential information relating to the following: the Agency's operations, pending or contemplated business transactions, trade secrets, and confidential Personnel information. All confidential information pertaining to the Agency is to be used for the benefit of the clients / members and is not to be used for the personal benefit of Personnel, their families, or friends.

○ Any and all HIPAA and Privacy Rule obligations will apply to all Personnel at all times. The Agency's HIPAA, Confidentiality, and Privacy policies are incorporated into this Code of Conduct by reference. All Personnel will be trained on the Agency's privacy, confidentiality, and HIPAA policies at the time of hire and at least once per year.

► **Standards Relating to Mandatory Reporting**

o As part of its commitment to providing high quality care and services, the Agency complies with all applicable Federal and State mandatory reporting laws, rules and regulations. To this end, the Agency will ensure that all incidents and events that are required to be reported are done so in timely manner and will monitor compliance with such requirements.

o Allegations of client/member abuse, mistreatment, exploitation and neglect or misappropriation of client/member property must be immediately reported to the appropriate supervisor and investigated in accordance with all applicable rules and regulations.

o the Agency also ensures that it complies with annual certification requirements that apply to its Compliance and Ethics Program in accordance with New York Social Services Law and the Federal Deficit Reduction Act of 2005.

o the Agency will ensure that all identified overpayments are timely reported, returned and explained. It is our policy to exercise reasonable diligence in identifying overpayments and quantifying overpayment amounts, not retain any funds which are received as a result of overpayments and to report, return and explain any overpayments from Federal health care programs (e.g., Medicare, Medicaid and Medicaid managed care organizations or plans) within 60 days from the date the overpayment was identified. Such funds are refunded to the appropriate party (*e.g.*, the Medicaid managed organization or plan or the New York State Office of the Medicaid Inspector General, etc.).

o Moreover, in some circumstances (*e.g.*, if an internal investigation confirms possible fraud, waste, abuse, or inappropriate claims), and with the assistance of legal counsel, as necessary and appropriate, the Agency will avail itself of the appropriate self-disclosure and/or refund process (*e.g.*, to the New York State Department of Health, Office of Medicaid Inspector General, Federal Office of Inspector General, etc.).

► **Standards Relating to Contractor Oversight**

o The Compliance Officer will ensure that arrangements with contractors, agents, subcontractors, and independent contractors ("Contractors") specify in writing that such individuals/entities are subject to the Agency's Program, to the extent that such Contractors are affected by the Agency's compliance risk areas and only within the scope of the contracted authority and affected risk areas. The Agency will confirm the identity and determine the exclusion status of Contractors affected by the Agency's compliance risk areas. All such contracts must include termination provisions for failure to adhere to the Agency's Program requirements.

► **Government Inquiries**

o Personnel may speak voluntarily with government agents, and the Agency will not attempt to obstruct such communication. It is recommended, however, that Personnel contact the Compliance Officer before speaking with any government agents. See Appendix A – Government Inquiries policy.

o ***However, Personnel must check with the Compliance Officer who will consult with counsel as necessary and appropriate, before responding to any request to disclose the Agency documents to any outside party.***

- It is the Agency's policy to comply with the law and cooperate with legitimate governmental investigations or inquiries. All responses for information must be accurate and complete. Any action by Personnel to destroy, alter, or change any Agency records in response to a request for such records is prohibited and will subject the individual to immediate discharge and possible criminal prosecution.

ANCHOR HOME CARE

COMPLIANCE AND ETHICS PROGRAM

STRUCTURE AND GUIDELINES

Compliance and Ethics Program Structure and Guidelines

The following elements comprise the Agency's Compliance and Ethics Program's Structure and Guidelines with which all Personnel should be familiar. Each element governs a different and important aspect of the Agency's Program.

► **Written Policies and Procedures**

○ **Formal Policies Adopted by the Governing Body.** The Code of Conduct, the Compliance and Ethics Program Structure and Guidelines, and related policies and procedures have all been formalized in writing and adopted by the Governing Body. The Compliance Officer will, no less than annually, review these documents to determine if they (i) have been implemented; (ii) are being followed by Personnel; (iii) are effective; and (iv) require any updates.

○ The Agency's Code of Conduct and Compliance policies and procedures are designed to:

(1) Articulate the Agency's commitment and obligation to compliance with all applicable federal and state standards;

(2) Describe the compliance expectations as embodied in the standards of conduct;

(3) Document the implementation and operation of the Program;

(4) Provide guidance to Personnel on dealing with potential compliance issues, including the methods and procedures for communicating compliance issues to the appropriate compliance personnel;

(5) Describe how potential compliance issues are investigated and resolved;

(6) Include a policy of non-intimidation and non-retaliation for good faith participation in the Program;

(7) Establish disciplinary standards for Personnel who fail to comply with the written policies and procedures, standards of conduct, or state and federal laws, rules and regulations; and

(8) Include all requirements listed under Section 6032 of the Federal Deficit Reduction Act of 2005 (42 U.S.C. § 1396a[a][68]) as to maintaining and disseminating policies regarding false claims laws and whistleblower protections.

► **Designation of Compliance Officer and the Compliance Committee**

○ **Duties of the Compliance Officer. The** Agency has designated a Compliance Officer who maintains day-to-day oversight responsibility of the Compliance and Ethics Program. Among other things, the Compliance Officer is responsible for ensuring that all elements of the Program described herein are in effect and fully operational. The Compliance Officer reports directly and is accountable to the Governing Body regarding compliance issues.

○ **Compliance Committee Responsibilities**. The Compliance Committee will assist the Compliance Officer in overseeing and executing various aspects of the Program. The Compliance

Committee is responsible for coordinating with the Compliance Officer to ensure that the Agency is conducting its business in an ethical and responsible manner, consistent with its Program. The Compliance Committee meets at least quarterly and also directly reports and is accountable to Administrator.

- **For more information see:** The Compliance Assurance Policy.

► **Training and Education**

- the Agency's compliance training and education program is designed to train and educate the Compliance Officer and all affected individuals.

- Training and education covers, among other things, compliance issues/risk areas, expectations, disciplinary standards and the operation of the Program.

- Participation in such training is mandatory for all Personnel.

- Training will take place no less than annually and will be promptly provided as part of the orientation for new Personnel.

- **For more information see:** The Compliance Training Plan.

► **Effective Lines of Communication**

- the Agency has established and implemented effective lines of communication, ensuring confidentiality between the Compliance Officer, members of the Compliance Committee, the Governing Body and Personnel. These lines of communication are available to all Personnel and all clients/members receiving services from the Agency.

- **Reporting and Confidentiality.** All Personnel are required to report suspected misconduct or possible violations of the Code of Conduct to the Compliance Officer (available at phone number 718-537-2000 ext. 109 or via email at aziza@anchorhc.org), another member of senior management, or their supervisor. Personnel may also report issues to the Compliance Helpline anonymously, if they choose. The identity of any Personnel reporting will be kept confidential unless the matter is subject to a disciplinary proceeding, referred to or under investigation by the NY State Medicaid Fraud Control Unit (MFCU), the Office of Medicaid Inspector General (OMIG) or law enforcement, or if disclosure is a requirement in connection with a legal proceeding.

- **Informing the Compliance Officer.** Upon receiving information regarding a possible violation, the individual informed (if other than the Compliance Officer) must immediately inform the Compliance Officer so that the issue may be addressed.

- **Public Promotion of the Compliance and Ethics Program. The** Agency's website contains information regarding its Program, including the Code of Conduct.

► **Disciplinary Standards to Encourage Good Faith Participation in the Compliance Program**

- the Agency has established well-publicized disciplinary standards to encourage good faith participation in the Program by all affected individuals.

- Personnel will be subject to disciplinary action, ranging from verbal warnings to termination of employment or contract, regardless of their level or position, if they fail to comply with any applicable laws or regulations, or any aspect of the Program. This includes, but is not limited to:

(1) Failing to report suspected problems;

(2) Participating in non-compliant behavior;

(3) Encouraging, directing, facilitating or permitting non-compliant behavior;

(4) Failure by a violator's supervisor(s) to detect and report a compliance violation, if such failure reflects inadequate supervision or lack of oversight;

(5) Refusal to cooperate in the investigation of a potential violation;

(6) Refusal to assist in the resolution of compliance issues; and retaliation against, or intimidation of, an individual for reporting such acts of retaliation or intimidation or for good faith participation in the Program.

(7) Retaliation against, or intimidation of, an individual for reporting a compliance violation or otherwise participating in good faith in the Program.

- **For more information see**: The Protocols for Investigations, Implementing Corrective Action and Discipline Policy.

► **The System for On-going Monitoring and Identification of Compliance Risk Areas**

- the Agency has established a system for the on-going identification and assessment of compliance risk areas relevant to its operations. This process includes internal, as well as external audits, to evaluate the Agency's continuous compliance with Federal health care program requirements and the effectiveness of the Program.

- **Monitoring and Auditing.** The Compliance Officer (or designee) will ensure that internal and external audits, as appropriate, are conducted by auditors with expertise in Federal health care program requirements and applicable laws, rules and regulations, or have expertise in the audit subject areas. The Compliance Officer and Compliance Committee will also monitor the operation of the Program to determine its effectiveness.

- **Tracking New Developments.** The Compliance Officer or designee will ensure that all relevant publications issued by government or third-party payers regarding compliance rules or protocols are reviewed and appropriately implemented. Through this, the Compliance Officer or designee will identify specific compliance risk areas specific to provider type and regularly incorporate these issues into the Annual Work plan, or conduct a focused audit, as appropriate. In addition, the Compliance Officer or designee will monitor the Compliance Helpline and any other reports of Compliance issues or violations that might be raised. All current issues will be raised and addressed by the Compliance Officer or his designee.

- **Specific Risk Areas.** The Compliance Officer will monitor areas where there is potential for fraud, waste or abuse. This includes, but is not limited to, reviews of the Agency's documentation, billing and payment practices, business practices, quality of care/medical necessity issues, mandatory reporting requirements; the credentialing process, governance standards, contractor oversight and other compliance risk areas that may arise.

- **Risk Assessment and Annual Work Plan.** The Compliance Officer, in conjunction with the Compliance Committee, will formulate an annual Compliance Work Plan based on the developments arising from internal reviews and issues and external areas of compliance concern. The annual Work Plan will be reviewed and approved by the Governing Body.

- **For more information see:** Compliance Monitoring and Risk Assessment Policy.

► **The System for Promptly Responding to Compliance Issues**

- the Agency has established and implemented procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of internal auditing and monitoring, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensuring on-going compliance with Federal health care program requirements.

- **Investigation by Compliance Personnel.** All compliance issues, however raised (i.e., whether reported or discovered through audit or other activity), must be brought to the attention of the Compliance Officer. The Compliance Officer (or designee) will conduct or oversee an inquiry of the issue. All Personnel are expected to cooperate in such investigations.

- **Corrective Action and Responses to Suspected Violations.** Personnel are also expected to assist in the resolution of compliance issues. Corrective actions will be determined by the Compliance Officer and the Compliance Committee and will be implemented promptly and thoroughly. Corrective actions may include but are not limited to: conducting training; revising or creating appropriate forms; modifying or creating new policies and procedures; conducting internal reviews, audits or follow-up audits; imposing discipline, as appropriate; and making a voluntary disclosure or refund to appropriate governmental agencies. Corrective action plans will be monitored after they are implemented to ensure they have been effective.

- **For more information see:** Protocols for Investigations, Implementing Corrective Action and Discipline Policy.

► **Policy of Non-Intimidation and Non-Retaliation.**

○ **Intimidation and Retaliation Are Prohibited.** All Personnel are expected to comply with the Program, including the reporting requirements related to any potential misconduct, violation or other compliance issue. Retaliation in any form against an individual who in good faith reports potential compliance issues for other good faith participation in the Program is strictly prohibited and is itself a serious violation of the Code of Conduct. Acts of retaliation should be immediately reported to the Compliance Officer and, if substantiated, will be disciplined appropriately.

○ **For more information see:** The Non-Retaliation and Non-Intimidation for Good Faith Participating in the Compliance and Ethics Program Policy.

COMPLIANCE COMMITTEE CHARTER

This Charter governs the operations of Anchor Home Care ("the Agency") Compliance Committee.

PURPOSE: The Compliance Committee's purpose is to coordinate with the Compliance Officer to ensure that the Agency is conducting its business in an ethical and responsible manner, consistent with its Compliance and Ethics Program.

COMPOSITION OF THE COMPLIANCE COMMITTEE: The Compliance Committee is chaired by the Compliance Officer. Permanent members of the Compliance Committee are the Director of Patient Services and the Billing and Payroll Supervisor. Other senior managers (including, but not limited to, the Administrator) may be invited to join the Committee on either a permanent or an ad hoc basis based on an analysis of the Agency's compliance risk areas or other relevant factors.

MEETINGS: The Compliance Committee meets at least quarterly and may meet more frequently, as is necessary. Minutes of each meeting are recorded and include a list of attendees, the date of each meeting and a summary of the issues discussed.

REPORTING/ACCOUNTABILITY: The Compliance Committee reports directly and is accountable to Administrator and the Governing Body.

RESPONSIBILITIES: The Compliance Committee is responsible for the following general Compliance and Ethics Program activities:

- Coordinating with the Compliance Officer to ensure that the written policies and procedures, and standards of conduct are current, accurate and complete, and that the training topics for the Compliance training and education program are timely completed;
- Reviewing the Agency's compliance training plan at least annually and ensuring that it is updated as necessary;
- Coordinating with the Compliance Officer to ensure communication and cooperation by Personnel on compliance related issues, internal or external audits, or any other required Compliance and Ethics Program function or activity;
- Advocating for allocation of sufficient funding, resources and staff for the Compliance Officer to fully perform their responsibilities;
- Ensuring that the Agency has effective systems and processes in place to identify compliance program risks, overpayments and other issues, and effective policies and procedures for correcting and reporting such issues;
- Advocating for adoption and implementation of required modifications to the Compliance and Ethics Program; and
- Reviewing and assessing the adequacy of this Charter at least annually. Any proposed changes or updates to the Charter are presented to the Administrator for approval.

This Charter has been approved and adopted by the Compliance Committee.
Date: 9/18/2024

COMPLIANCE MONITORING AND RISK ASSESSMENT
Revised March 2023

POLICY

It is the policy of the Agency to conduct routine risk assessments by having processes in place to continually monitor compliance with the Agency's Code of Conduct, its Compliance and Ethics Program policies and procedures, and all applicable Federal and State laws, rules and regulations. To this end, the Agency has established and implemented an effective system for routine monitoring and identification of compliance risks and detection of potential criminal, civil, and administrative violations. The system includes internal monitoring and audits and, as appropriate, external audits to evaluate the Agency's compliance with Federal health care program requirements (e.g., Medicare and Medicaid) and the overall effectiveness of the Agency's Compliance and Ethics Program. The Compliance Committee is responsible for ensuring that the risk assessment and specific compliance reviews are conducted in accordance with the following procedures and protocols.

PROCEDURES

Routine Risk Assessment and Monitoring. The Agency's system for conducting risk assessment and monitoring consists of the following elements:

- Identification and prioritizing of risks;
- Development of work plans or audit plans (as appropriate) related to the identified risk areas;
- Implementation of the work plans and audit plans;
- Development of corrective action plans in response to the results of audits performed;
- Tracking of the work plans and correction action and assessment of the effectiveness of such plans.
- Data will be collected and analyzed on a regular basis to assess the Agency's compliance with established standards of practice. The Compliance Officer is responsible for coordinating formal audits; however, the audits may be performed by internal or external auditors who: (i) possess the necessary qualifications and expertise to adequately identify potential compliance issues in Federal health care programs or the subject area of the audit; (ii) are objective and independent of management; (iii) have access to relevant Personnel, records, and areas of operation; and (iv) present a written evaluation or report of results to the Compliance Officer.
- Auditing and monitoring is conducted regularly and written reports are presented to the Compliance Officer and Compliance Committee at least quarterly.
- The Compliance Officer and Compliance Committee are responsible for analyzing the results of the auditing and monitoring to determine the root cause of potential issues or violations. On the basis of these reports, the Compliance Officer and Compliance Committee determine an appropriate response.

Annual Self-Assessment of Risk. Each year, Personnel in different areas (*e.g.*, nursing, home health aides, billing) complete internal risk assessments that identify their risk areas. These risk areas are shared with the Compliance Officer and Compliance Committee. Periodic reports on the improvement in the risk areas identified are required. The Compliance Committee is responsible for monitoring such improvement and compliance with applicable laws and regulations. The Compliance Committee established specific

schedules for the frequency of each type of review activity including incidents, accidents, client/member satisfaction surveys, sampling of client records and billing records for conformity with applicable laws and regulations governing coding and documentation for services provided and billed. In addition, the Agency may utilize the following techniques:

- Periodic interviews with management regarding their perceived levels of compliance within their areas of responsibilities;

- Questionnaires developed to poll personnel regarding compliance matters as well as the effectiveness of individual training techniques; and/or

- Periodic written report of managers, utilizing assessment tools developed to track specific areas of compliance; and/or

Chart and Billing Reviews. The Compliance Committee has oversight responsibility and monitors the risks associated with the submission of claims for items and services furnished to Federal health care program (e.g., Medicare and Medicaid) beneficiaries.

- The Agency Compliance Committee will conduct reviews that will consist of an examination of a sample of medical records, plans of care, and certifications to test the adequacy of documentation and services being billed by the Agency. These reviews will focus on those records and will look at several issues, including, but not limited to billing reviews. Any potential billing issues identified will be brought to the attention of the Compliance Officer.

Accuracy and Billing. The Compliance Committee will conduct reviews to determine whether each individual document or form has been properly and accurately filled out and justifies the number of services rendered or billed by the Agency. This review will require examination of time cards and bills submitted by the Agency to third-party payers.

- As appropriate, each of these reviews may be conducted in conjunction with reviews already being conducted by the Compliance Committee and/or the Agency.

- If the review uncovers billing, coding or documentation errors, the Compliance Officer, working with the Compliance Committee, will determine the scope of any problem, expand the scope of the reviews as necessary and appropriate, and take appropriate corrective action.

Quality of Care. The Director of Patient Services is responsible for overseeing quality of care issues. Reviews of these issues will be conducted by the Compliance Committee. Reviews may include, but not be limited to, audits of time sheets for errors/omissions and to ascertain if services were in fact provided. Lapses in quality of care or significant concerns are reported to the Compliance Officer who works with the Director of Patient Services to ensure such irregularities are appropriately addressed.

Governance. The Compliance Officer will ensure that the Governing Body and key persons are educated regarding the Agency's Conflict of Interest Policy and that annual disclosure statements are completed and reviewed in accordance with the policy. Moreover, the Compliance Officer will regularly report directly to the Governing Body regarding compliance issues that may arise.

Contractor Oversight. The Compliance Officer or designee will conduct reviews to ensure that all contracts with contractors, agents, subcontractors, and independent contractors who are subject to the Agency's Compliance and Ethics Program (that is to the extent that the Program is related to their contracted role and responsibilities within the Agency's compliance risk areas) specify that they are subject to the Agency's Compliance Program and that all contracts include termination provisions for failure to adhere to the Compliance Program requirements. The Compliance Officer or designee will ensure that the Agency's contractors are not excluded from participating in Federal health care programs.

Mandatory Reporting. The Compliance Officer will conduct reviews to ensure that all regulatory reporting obligations are met. Moreover, the Governing Body will ensure that all applicable New York and Federal annual compliance certifications are timely completed. This includes providing certifications of compliance with the requirements of NY Social Services Law § 363-d and the 8 NYCRR Part 521 regulations pertaining to having an effective compliance program to the NYS Department of Health and to each Medicaid Managed Care Organization/Managed Long Term Care Plan ("MLTCP") with which the Agency participates.

Credentialing. The Compliance Officer or designee will ensure that all Personnel are appropriately credentialed (i.e., properly licensed/certified and registered) and not listed on any Federal or state exclusion list.

Review of Billing Denials and Client/Member Complaints. The Compliance Officer will perform periodic reviews of denials from Medicaid and other third-party payors in order to determine whether any patterns of improper billing exist. In addition, billing complaints from clients/members of the Agency also be tracked to determine whether such complaints reflect a possible pattern of improper billing or other compliance problems.

Response to Third Party Audits. Following resolution of an audit by a third-party payor, the results of the audit will be reviewed to determine whether those results reflect any systemic deficiency or problem in the Agency's compliance with state or federal rules, regulations, or laws. If a problem is identified, appropriate corrective action, as outlined above, will be taken.

Review of Compliance Issues. Periodically, the Compliance Officer will review reports received of suspected violations of the Code to determine if a pattern of violations exists that may indicate broader compliance issues.

Business Reviews. Periodically, the Compliance Committee will periodically check the Agency's business practices to ensure compliance with applicable laws, rules and regulations. Such checks might include a review of the Agency's credit balances, its practice of waiving co-payments, and the fair market value of leases, equipment rental agreements, or personal service contracts with physicians or providers.

Other Risk Areas. The Compliance Officer or designee will conduct reviews of such other risk areas that may arise, whether through reports from Personnel, monitoring activities or from tracking new developments.

Annual Compliance Program Effectiveness Reviews.

The Compliance Officer, the Compliance Committee, external auditors or other staff will review and evaluate the effectiveness of the operation of the Compliance Program and determine whether it meets

regulatory requirements.[1] Staff undertaking this review must have the necessary knowledge and expertise to evaluate the effectiveness of the components of the compliance program they are reviewing and be independent from the functions being reviewed. Based on such reviews, the Compliance Officer will recommend appropriate modification(s) to the Compliance Program, the Manual or the policies and procedures. The reviews should include on-site visits; interviews with Personnel; review of records, surveys; or any other comparable method the Agency deems appropriate, provided that such method does not compromise the independence or integrity of the review.

If the Compliance Officer has other duties, the governing body must demonstrate that they have assessed whether the other duties hinder the Compliance Officer in carrying out his or her primary responsibilities, and whether the Compliance Officer is able to satisfactorily perform his or her responsibilities. In addition to completing this assessment during the annual compliance program effectiveness review, it should be completed whenever the Compliance Officer's duties change.

the Agency's governing body must demonstrate that it has assessed whether the Compliance Officer is allocated sufficient staff and resources to satisfactorily perform his or her responsibilities for the day-to-day operation of the Compliance Program.

Responses to Reviews. If any of these reviews indicate that possible compliance concerns might exist, the Compliance Officer and Compliance Committee, senior management and counsel, as appropriate, will determine whether further investigation is required and whether the Agency's practices require modification or improvement to ensure continuing compliance.

TRACKING NEW DEVELOPMENTS

On a continuing basis, the Compliance Officer or designee will ensure that all new regulatory or legal requirements issued by the Federal or State government are reviewed by appropriate personnel. This includes the following:

- reviewing all new rules governing the documentation, coding and billing of services provided by the Agency;
- receiving and reviewing all Medicaid updates, annual updates to applicable Medicaid and MCO/MLTCP relevant announcements;
- Medicaid updates are available at:
  https://www.health.ny.gov/health_care/medicaid/program/update/main.htm
- reviewing all new revisions to Medicaid Manuals and applicable MLTCP manuals governing the documentation, coding, and billing of services provided by the Agency; and
- communicating with the appropriate professional society as to recent initiatives or developments that might affect the Agency, or new practices that might assist the Agency in complying with rules and regulations that specifically apply to its areas of practice.
- reviewing all new Special Fraud Alerts issued by the Office of the Inspector General, available at: https://oig.hhs.gov/compliance/alerts/index.asp

[1] Specifically, 18 NYCRR Part 521.

- reviewing all new Compliance Alerts issued by the Office of the Medicaid Inspector General (OMIG), available at: http://www.omig.ny.gov/compliance-alerts reviewing Model Compliance Guidelines and Agency Work Plans (e.g., OIG and OMIG)
- The OIG Work Plan is available at: https://oig.hhs.gov/reports-and-publications/workplan/
- The OMIG Work Plan is available at: https://omig.ny.gov/information-resources/work-plans

Based on any relevant new developments, the Compliance Officer or his/her designee in conjunction with the Compliance Committee will review existing policies and procedures to ensure that the Agency is in compliance with the requirements of Federal and State law. If necessary, the Compliance Committee will then work to ensure that appropriate corrective action is taken.

Compliance Training Plan

POLICY

the Agency is committed to providing high quality skilled services to our clients in compliance with all Federal health care program requirements and applicable federal and state laws and regulations. As an integral part of our Compliance and Ethics Program, the Agency provides training and education to all Personnel[2] to assist Personnel in complying with Federal health care program requirements and to prevent, detect and correct fraud, waste and abuse.

It is the Agency's policy that all Personnel participate in compliance training and education activities no less frequently than annually. Such training will also be provided promptly as part of the orientation for new employees, the Compliance Officer, the Administrator and other senior managers, and the Governing Body. Failure to comply with education and training requirements may result in disciplinary action consistent with our Compliance and Ethic Program disciplinary standards.

PROCEDURES

The Agency has developed the following Training Plan:

Training Topics. The Agency's Compliance and Ethics Program's training and education includes, but is not limited to, the following topics:

- **Compliance Risk Areas**. Risk areas include but are not limited to: billings; payments; ordered services; medical necessity; quality of care; governance; mandatory reporting; credentialing; contractor oversight; and other risk areas that are or should reasonably be identified by the Agency through its organizational experience.[3]

- **Applicable Fraud and Abuse Laws.** This includes an overview of the False Claims Act, the Anti-kickback Statute, and the requirements for reporting, returning and explaining overpayments.

- **The Agency's Compliance Policies and Procedures.** Training materials include a listing of all compliance-related policies and procedures and information regarding how to access these documents.

- **Compliance Program Operations.** Training materials discuss how the Compliance Program works, including:

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[2] "Personnel" means all persons who are affected by the Agency's compliance risk areas, including employees, the Administrator, senior managers, contractors, agents, subcontractors, independent contractors, the Governing Body and corporate officers.

[3] "Organizational experience" means the Agency's: (i) knowledge, skill, practice and understanding in operating its Compliance Program; (ii) identification of any issues or risk areas in the course of its internal monitoring and auditing activities; (iii) experience, knowledge, skill, practice and understanding of its participation in Federal health care programs (*e.g.*, Medicaid) and the results of any audits, investigations, or reviews to which the Agency has been subject; or iv) awareness of any issues the Agency should have reasonably become aware of for the home health services it provides.

- the roles of the Compliance Officer and the Compliance Committee;

- how Personnel can ask questions and report potential compliance-related issues to the Compliance Officer, senior management, and the Compliance Helpline, including the obligation of Personnel to report suspected illegal or improper conduct and the procedures for submitting such reports; and the protection from intimidation and retaliation for good faith participation in the Compliance Program;

- disciplinary standards, with an emphasis on those standards related to the Agency's Compliance Program and prevention of fraud, waste and abuse;

- how the Agency responds to compliance issues and implements corrective action plans;

- requirements specific to Federal health care programs (e.g., Medicare and Medicaid and related managed care plans) and the services the Agency provides; and

- Claim development and submission process/coding and billing requirements and best practices, as applicable.

Frequency and Format of the Training. Personnel must participate in appropriate education and training programs appropriate to their role at the Agency no less frequently than annually. New employees will be trained as part of their job orientation within 30 days of start date. Training will also be provided within 30 days of start date upon new appointment of an Administrator, manager or Governing Body member.

- **Training Schedule.** Personnel must participate in appropriate education and training programs appropriate to their role(s) at the Agency no less frequently that annually. New employees will be trained as part of their job orientation within 30 days of their start date. Training will also be provided within 30 days of the start date upon new appointment of an administrator, manager or Governing Body member. Contractors are provided with copies of the Agency's Compliance Manual and/or information for accessing the same, and are required to abide by the Compliance Program. Contractors may also attend in-person training sessions or request self-study training materials. The Agency requests that all contractors submit an acknowledgment of training. They are also advised that they may contact the Compliance Officer with any questions regarding the Compliance Program.

- **Format of the Training.** Training is presented in various formats, which may include PowerPoint presentations, live training, recorded electronic training, written handouts, and memos.

- **Accessibility.** Training and education is provided in a form and format accessible and understandable to all Personnel, consistent with federal and state language and other access laws, rules or policies.

- **Questions/Clarifications.** Personnel will be provided with the opportunity to seek clarification or more information on any aspect of the Compliance Program. Trainers who are

not able to answer specific questions will arrange for follow-up to be conducted by the Compliance Officer or a member of senior management.

Mandatory Participation. Attendance and participation in training and educational programs is mandatory and is an important part of the Agency's business and professional environment. All Personnel must participate in mandatory training and education.

- **Sanctions for Failing to Attend/Participate.** Adherence to the Agency's requirements regarding compliance education and training will be considered in the overall evaluation of the performance for each individual associated with the Agency. Failure to comply with education and training requirements may result in disciplinary action consistent with the Agency's Compliance Program Disciplinary Standards and may range from verbal warnings to termination of employment or contract. Disciplinary actions are subject to due process, legal and contractual rights, if any, applicable to such individual.

- **Tracking Attendance.** The Compliance Officer has a process in place to track attendance and to follow up with any Personnel that miss scheduled training sessions.

Code of Conduct/Policies & Procedures. The Compliance Officer is responsible for ensuring that the Compliance Program Manual which contains the Reporting Requirements, Code of Conduct and the Compliance Program Structure and Guidelines, are distributed to all Personnel and for maintaining a file containing each person's signed acknowledgment form. All newly hired/contracted Personnel also receive a copy of the Compliance Manual during orientation and must sign and return the acknowledgment form to the Compliance Officer. The Compliance Officer also must ensure that specific Compliance Program policies and procedures are distributed to appropriate Personnel, as relevant to their job responsibilities at the Agency and that all Compliance Program policies and procedures are accessible to any Personnel upon request and located at the Agency's office locations.

Evaluation of Training and Education. The Compliance Committee monitors, evaluates and annually assesses the effectiveness of the Agency's education and training programs and revises such programs as necessary. The Compliance Committee reviews the Training Plan (as outlined in this Policy) at least annually and updates the Plan as necessary.

Recordkeeping. The Compliance Officer is responsible for maintaining records of the type of training and education program offered, the dates offered, and proof of those who attended the program. Educational and training files, including copies of all written materials, are retained for a period of no fewer than ten (10) years from the date the materials were last used.

PROTOCOLS FOR INVESTIGATION, REVIEW AND IMPLEMENTATION OF CORRECTIVE ACTION

POLICY

To be effective and to combat fraud, waste and abuse in the course of operations, a Compliance and Ethics Program must institute procedures for investigating compliance issues and implementing appropriate corrective action promptly and thoroughly. Therefore, the Agency has established and implemented procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensure ongoing compliance with Federal health care programs requirements (*e.g.*, Medicare and Medicaid). Below are the procedures that the Agency has adopted to prevent and detect fraud, waste and abuse in the course of its operations.

PROCEDURES

Investigations

A compliance problem may be uncovered as the result of a report to the Compliance Officer, an internal monitoring, new regulations or guidance from government agencies or from another source.

Upon receiving a report or otherwise learning of a possible compliance issue (including, for example, reports of unethical or illegal conduct, possible improper or incorrect billing practices, or other compliance-related issues), the Compliance Officer will bring such report to the attention of the Administrator and compliance counsel, as appropriate. The Compliance Officer will work under the supervision and direction of outside compliance counsel, as necessary, to investigate whether a compliance concern exists or whether the Code of Conduct or applicable legal rules have been violated and take all necessary and appropriate actions. All Personnel are expected to cooperate in such investigation.

Investigative Tools. Depending on the nature of the potential compliance issue, an investigation may include interviews with Personnel, documentation reviews and a root cause analysis.

If the issue related to possible improper billing, a review may include selection of a small, random sampling of claims for services, along with the supporting medical documentation. Only claims that are still "in the pipeline" and being processed within the Agency will be selected. If the review of these claims warrants, the sample will be expanded to additional claims "in the pipeline" for a more accurate assessment of the problem. During these reviews, any claims that appear to be improper will be held and not submitted for payment until all questions regarding them have been resolved.

Documentation. The Compliance Officer or his/her designee(s) will sufficiently document their investigative steps, including the alleged violation(s), a description of the investigative process, copies of interview notes and other documents essential for demonstrating a thorough investigation of the issue was completed.

CORRECTIVE ACTION AND RESPONSES TO SUSPECTED VIOLATIONS

Corrective Action – Generally

Whenever a compliance issue is identified, the Compliance Officer, working with the Compliance Committee, will ensure that appropriate and effective corrective action is implemented promptly and thoroughly. The Compliance Officer will consult with the Administrator, Compliance Committee and compliance counsel and others (*e.g.*, outside experts, auditors), as appropriate, to correct the problem. All Personnel are expected to assist in the resolution of compliance issues.

The corrective action must be designed to ensure that the violation or problem does not recur (or to reduce the likelihood that it will recur) and must be based on an analysis of the root cause of the issue. In addition, corrective action plans are tracked and reviewed for assessment of the effectiveness of the corrective action following its implementation. If such a review establishes that the corrective action plan has not been effective, then additional or new corrective actions must be implemented.

Corrective Action - Examples

Corrective actions may include, but are not limited to, the following:

- Informing and discussing with the offending person the violation and how it should be avoided in the future;
- Providing remedial education, either formally or informally, to ensure that the offending person understands the applicable rules, regulations and requirements;
- Conducting a follow-up review to ensure that the problem is not reoccurring;
- Having Personnel go through a cycle or cycles of remedial education and focused audits;
- Refunding any past payments that resulted from improper billing (as set forth in Section D, below);
- Imposing discipline (as set forth in Section C, below);
- Suspending all billing, in whole or in part, of the services provided by a provider;
- Self-disclosing to an appropriate governmental agency or other payer, to the extent required by law, rule, or regulation or otherwise appropriate (including but not limited to, the New York State Department of Health, Office of the Medicaid Inspector General, U.S. Department of Health and Human Services, Office of Inspector General, Medicaid Fraud Control Unit, U.S. Attorney's Office, etc.), if credible evidence exists that a federal or state law, rule or regulation has been violated[4];
- Refunding overpayments (as set forth in Section D, below);
- Modifying or improving the Agency's business practices; and/or
- Modifying or improving the Compliance Program to better ensure continuing compliance with applicable Federal and State Laws, rules, regulations and/or contractual requirements.

If it is determined that a larger, systemic problem may exist, then the Compliance Officer will consider possibly modifying or improving the Agency's compliance or billing practices. Such action might include, creating new procedures or modifying existing procedures, to ensure that similar errors will not reoccur in the future. Other corrective actions that may be considered might also include formulating new or revised policies or procedures and conducting formal or informal training on specific issues for an entire

[4] The Compliance Officer must receive copies of any reports submitted to governmental entities.

department, as applicable. Possible changes or additions to procedures will be reviewed by the Compliance Officer and will be approved by the Governing Body.

Discipline

All Agency Personnel are expected to adhere to the Code of Conduct, the Compliance Program and applicable Compliance Policies and Procedures. If the Compliance Officer concludes, after an appropriate investigation, that there has been a violation, appropriate discipline may be imposed.

Discipline may include, but is not necessarily limited to, verbal warnings, suspension and/or termination from employment, contract and/or affiliation with the Agency, suspension of billing and/or other appropriate action.

Disciplinary action will be fairly and consistently imposed regardless of the offending Personnel's level or position as appropriate for actions, including, but not limited to:

- Failing to report suspected problems;
- Authorizing or participating in non-compliant behavior;
- Failing to attend mandatory training;
- Failing to cooperate in the investigation of a potential violation;
- Failing to assist in the resolution of compliance issues;
- Intimidating or retaliating against an individual for good faith reporting of a compliance violation or for other good faith participating in the Compliance and Ethics Program; and/or
- Failing to report instances of intimidation or retaliation.

Determination of Disciplinary Sanctions. The type of disciplinary sanctions imposed will be determined by the Agency, in its discretion, and will depend on a variety of factors. Such factors may include, but are not limited to: (1) the nature of the violation; (2) the time period affected; (3) the amount involved; (4) whether the violation was committed intentionally, recklessly, negligently or mistakenly; (5) whether the individual has committed any other violations in the past; (6) whether the individual self-reported his or her misconduct; and/or (7) whether (and the extent to which) the individual cooperated in connection with the investigation of the misconduct. The Agency will escalate disciplinary actions as warranted based on the severity of the misconduct, with intentional or reckless behavior subject to more significant sanctions.

Fair, Consistent and Firm Enforcement/Types of Disciplinary Sanctions. The Agency's Compliance and Ethics Program Disciplinary Policy, Standards and Procedures, and any sanctions taken hereunder, will be fairly, consistently and firmly enforced, without regard to the individual's title or position at the Agency. The following outlines the types of sanctions that may be imposed for violating the Agency's Compliance and Ethics Program standards:

Employee Sanctions. Employees (including senior management) will be subject to sanctions which may include, but are not necessarily limited to: education, verbal or written warnings, suspension with or without pay, and/or termination of employment, among other things. It is the Agency's policy that employees' rights to due process under applicable laws, rules and regulations (if any) are respected, as are employee or other applicable contractual arrangements (if any), and all other laws, rules and regulations that apply in a given situation.

Independent Contractor Sanctions. Independent contractors will be subject to sanctions which may include, but are not necessarily limited to: contractual or financial penalties and/or termination of the contractor's relationship with the Agency, among other things. It is the Agency's policy that contracts governing its relationships with independent contractors, and all applicable laws, rules and regulations governing the relationship, are respected.

The foregoing is not intended, and shall not be viewed, as a limitation on the Agency's right or ability to impose more than one disciplinary sanction in a particular situation, to impose any other or additional disciplinary sanctions that may be appropriate and permissible in a particular situation, or to take any other actions, measures or sanctions that may be appropriate and permissible in a particular situation.

Guidelines for Refunding Overpayments

Reports or other information indicating that an overpayment may have been received must be immediately brought to the Compliance Officer's attention. It is the Agency's policy:

- to not retain any payments to which it is not entitled;
- to exercise reasonable diligence in timely investigating and quantifying any and all potential overpayments; and
- to promptly report, return and explain any identified overpayments in writing to the appropriate government agency, contractor or payer, (including but not limited to, the New York State Department of Health or the New York State OMIG).

Government agencies and private payers may have different rules concerning when and how identified overpayments must be handled. For example, under Medicare Part A and Part B, an overpayment is considered to have been "identified" when a person has or should have, through the exercise of "reasonable diligence," determined that an overpayment has been received and has quantified the amount of the overpayment. "Reasonable diligence" includes both proactive compliance activities conducted in good faith to monitor the receipt of overpayments, as well as investigations conducted in good faith and in a "timely manner" in response to obtaining "credible information" about a potential overpayment. Medicare considers a "timely manner" to be at most six (6) months from receipt of credible information, except in extraordinary circumstances. Once an overpayment has been "identified," the overpayment must be reported, returned and explained in writing within 60 days.

With regard to Medicaid, the Agency will, exercise reasonable diligence to determine whether it has received any overpayments and, if so, to quantify the amount of the overpayment. The Agency will report, return and explain in writing any identified Medicaid overpayments within 60 days of identifying the overpayment, to the NY State OMIG, through its self-disclosure program. The requirements of OMIG's self-disclosure program and related information may be found at: https://omig.ny.gov/provider-resources/self-disclosure.

Documentation/Reporting

The Compliance Officer will document the corrective action implemented, including any disciplinary action taken. The Compliance Officer will report to the Administrator and governing body regarding

which corrective actions have been implemented and whether the compliance problem was corrected within a reasonable amount of time.

RECORD RETENTION

The Compliance Officer or a designee will maintain a record of all investigations, corrective action and disciplinary sanctions imposed pursuant to this policy. All such records shall be maintained for no fewer than ten (10) years from the later of the conclusion of the investigation or the imposition of the corrective action or disciplinary sanction(s), or for such longer period of time as may be required by applicable law, regulation or requirement.

ANTI-REFERRAL LAWS AND RELATIONSHIPS WITH OTHER HEALTH CARE PROVIDERS

I. POLICY

the Agency is committed to providing high quality home health services to our clients/members in compliance with all Federal health care program requirements and applicable federal and state laws and regulations, including the Federal Anti-kickback Statute and the Prohibition on Physician Self-Referrals (commonly referred to as the "Stark law"), as well as the New York Anti-kickback and Stark laws (collectively, the "anti-referral laws"). It is the Agency's policy that all Personnel (as defined below) be familiar with the anti-referral laws and not enter into any transaction or arrangement that may be in violation of such laws.

The anti-referral laws are complex and have several exceptions for arrangements that are deemed a minimal risk to Federal health care programs. If any Personnel has a general or specific question or concern about how the anti-referral laws apply to a potential or current transaction or arrangement, you are required to consult with the Compliance Officer.

Below is an overview of the anti-referral laws and the Agency's general compliance policy regarding the anti-referral laws.

II. DEFINITIONS

Federal Health Care Program. The term "Federal health care program" means any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government. It also includes certain specified State health care programs. Some of the better known "Federal health care programs" include the Medicare and Medicaid programs, Tricare, and the Veterans programs.

Immediate Family Member. For purposes of the Stark Law, "immediate family member" or "member of a physician's immediate family" means husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

Personnel. "Personnel" means all persons who are affected by the Agency's compliance risk areas, including employees, the Administrator, senior managers, contractors, agents, subcontractors, independent contractors, the Governing Body and corporate officers.

III. THE ANTI-REFERRAL LAWS – OVERVIEW OF THE FEDERAL AND STATE ANTI-KICKBACK STATUTES AND STARK LAWS

A. <u>The Federal Anti-Kickback Statute ("AKS")</u>

The Basic Rule. Under the Federal AKS, it is a crime to knowingly and willfully solicit, receive, offer or pay any remuneration (including any kickback, bribe or rebate), directly or indirectly, overtly or

covertly, in cash or in kind: (i) in return for or to induce the referral of an individual for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or (ii) in return for or to induce the purchasing, leasing, ordering or arranging (or the recommending of such) of any good, facility, item or service for which payment may be made in whole or in part under a Federal health care program.

Exceptions/"Safe Harbors." There are a number of statutory exceptions as well as a series of regulatory "Safe Harbors" under the Federal AKS. If each aspect of an arrangement meets every requirement of an applicable exception or "Safe Harbor" (*i.e*., fits "squarely" within), it will be protected from the risk of criminal, civil or administrative action pursuant to the AKS. Failure to fall squarely within a Safe Harbor or exception, however, does not necessarily render an arrangement illegal per se or otherwise actionable. Instead, in such cases, the arrangement will be analyzed in light of the governing law and regulations and, in particular, the intent of the parties.

The Potential Penalties. Violation of the Federal AKS may result in significant fines (of up to $100,000) and/or imprisonment (of up to ten years) for both sides of an illegal kickback arrangement. In addition, conviction under the Federal AKS will also lead to exclusion from Federal health care programs (including Medicare and Medicaid) and may lead to the imposition of substantial civil monetary penalties and damages, among other possibilities.

False Claims Act Liability. A claim for items or services that resulted from a violation of the Federal AKS that is submitted to a Federal health care program constitutes a false or fraudulent claim for purposes of the Federal False Claims Act.

B. The New York Anti-Kickback Law

New York State's anti-kickback law is similar to the Federal AKS (and, indeed, compliance with the Federal law may well equate to compliance with New York's law). In general, New York's laws prohibit a Medicaid provider or any person acting in concert with a Medicaid provider from soliciting, receiving, accepting, agreeing to receive or accept, or offering, agreeing to give, or giving, any payment or other consideration in any form: (i) for the referral of services for which payment is made under the Medicaid program, or (ii) to purchase, lease or order any good, facility, service or item for which payment is made under the Medicaid program. Jail time, fines and/or other consequences may be imposed when these laws are violated.

C. The Federal Stark Law

The General Rule. In general terms, the Federal physician self-referral law (commonly referred to as the "Stark" law) prohibits a physician from making a referral for certain specified "designated health services" that are paid for by Medicare or Medicaid to an entity with which the physician (or an immediate family member) has a "financial relationship" (this is, an ownership interest, an investment interest, or a compensation arrangement) unless an exception to the law is squarely met. If the referral is prohibited so too is the submission of any claim for payment by the entity that received the prohibited referral.

Strict Liability. Unlike the Federal AKS, the Federal Stark law is a strict liability law. In other words, it does not matter if the parties intend to violate the law: Either you are in compliance with the law or you are not. In other words, under Stark, the intent of the parties is irrelevant).

Designated Health Services. The Federal Stark law presently covers the following "designated health services" (or "DHS"): (i) clinical laboratory services; (ii) physical therapy, occupational therapy and outpatient speech-language pathology services; (iii)) radiology and certain other imaging services; (iv) radiation therapy services and supplies; (v) durable medical equipment and supplies; (vi) parenteral and enteral nutrients, equipment and supplies; (vii) prosthetics, orthotics, and prosthetic devices and supplies; (viii) home health services; (ix) outpatient prescription drugs; and (x) inpatient and outpatient hospital services.

Exceptions. The Federal Stark law contains a number of statutory and regulatory exceptions that are similar (although not identical) to the "safe harbor" regulations under the Federal AKS. Like the AKS exceptions/Safe Harbors, the "Stark" exceptions are often very complex and very detailed. If the Stark law is implicated, all relevant exceptions must be squarely met, or the law will have been violated.

The Penalties. The penalties for violating the Federal Stark law include: (i) the denial of, or the requirement to refund, any payments for services that resulted from an unlawful referral; (ii) civil monetary penalties of up to $15,000[5] for each service for which a person presents or causes to be presented a bill or claim that they know or should know results from a prohibited referral, or for which a required refund has not been made, plus an assessment of up to three times the amount claimed in lieu of damages; and (iii) exclusion from the Medicare and Medicaid programs as well as other Federal and State health care programs.

D. The New York Stark Law

The New York State Stark Law prohibits a practitioner (which includes a licensed or registered physician, dentist, podiatrist, chiropractor, nurse, midwife, physician assistant or specialist assistant, physical therapist, or optometrist) from making Referrals for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services covered by any payor (i.e., not just Medicare or Medicaid) to a health care provider authorized to provide such services where such practitioner (or an immediate family member) has a financial relationship with such health care provider.

IV. COMPLIANCE WITH THE ANTI-REFERRAL LAWS

A. Generally

In compliance with the anti-referral laws and the Agency policy, it is prohibited for any Personnel to pay incentives to any person based upon the number of clients referred or the value of services provided. It is also prohibited for any Personnel to pay physicians, or anyone else, either directly or indirectly, for client referrals. The decision to refer clients is a separate and independent clinical decision made by the health care provider and or Managed Long Term Care ("MLTC") Plan, as applicable. Moreover, Personnel must not accept any form of remuneration in return for referring its clients/members to other health care providers. To the extent that the Agency refers clients to other providers, such referrals are based on

[5] Administrative penalties under the Civil Monetary Penalties Law may be imposed by the Federal Office of Inspector General. These penalties are subject to adjustments for inflation and have increased to $27,750, for each service, as of March 17, 2022.

clients' documented medical needs for the referred services and the ability of the referred provider to meet those needs. Personnel must, at all times, respect and honor a client's freedom to choose a health care provider.

B. Relationships with Other Health Care Providers

In compliance with the Anti-Referral laws, all contracts, leases, and other financial relationships with other providers who have a referral relationship with the Agency will be based on the fair market value of the services or items being provided or exchanged, and not on the basis of the volume or value of referrals of Medicare or Medicaid business between the parties.

Personnel must not engage in any practice that violates the Anti-Referral laws or tends to create an appearance of illegality or impropriety, including, but not limited to:

- Free Services. We will not provide free services or items to, or accept free services or items from, another provider with whom a referral relationship exists.

- Fair Market Value. We will not pay or charge excessive amounts above fair market value for providing equipment, space or personnel services, to or from, another provider. We will not pay or charge amounts below fair market value for providing equipment, space or personnel services, to or from, another provider.

- Joint Ventures. We will not enter into joint ventures with other providers when applicable Safe Harbors or exceptions under the Anti Referral laws do not apply, or pursuant to which benefits are conferred on one party in a manner that could be interpreted as an inducement to refer.

All contracts, leases, and other financial relationship with providers with whom the Agency has a referral relationship will be reviewed to ensure compliance with the federal and state Anti-Kickback and Stark Laws, and compliance with any applicable Safe Harbor or Exception under those laws.

C. Marketing Activities

All marketing activities and advertising must be based on the merits of the services provided and not on any promise, expressed or implied, of remuneration for referrals. In addition, all marketing activities and advertising must be truthful and not misleading, and must be supported by evidence to substantiate any claims made. The Agency's best advertisements pertain to the quality of its services. Personnel should not disparage the service or business of a competitor through false or misleading representations.

COMPLIANCE OFFICER AND PERSONNEL

Revised March 2023

POLICY

The Agency has (i) appointed a Compliance Officer to oversee the day-to-day operation of the Agency Compliance and Ethics Program (the "Program"); and (ii) established a Compliance Committee comprised of senior management to provide oversight and assistance to the Compliance Officer in performing designated responsibilities. The Agency ensures that the Compliance Officer is allocated sufficient staff and resources to satisfactorily perform the designated responsibilities of the day-to-day operation of the Program based on the Agency's risk-areas and organizational experience.

It is the Agency's policy to ensure that the Compliance Officer and the Compliance Committee have access to all records, documents, information, facilities and personnel that are relevant to carrying out their responsibilities. The Compliance officer has the authority to review all documents and other information relevant to the Agency's compliance activities including, but not limited to: residents' records, billing records, records concerning marketing efforts, and records of arrangements with other parties. The Compliance Officer must be informed of, and have access to, all information concerning any overpayments made to the Agency and all pertinent audits, reviews, or investigations by any federal or state agency.

PROCEDURES

I. THE COMPLIANCE OFFICER'S PRIMARY RESPONSIBILITIES

The Compliance Officer reports directly and is accountable to the Administrator and the governing body. The Compliance Officer will know and understand all aspects of the Program and ensure that all responsibilities under the Program are delegated to persons who are morally fit, honest, and capable of making decisions required under the Program. The Compliance Officer will consult with legal counsel, when necessary, to clarify requirements under the Program, rework any requirements that are outdated or vague or make changes to the Program as circumstances may dictate.

The Compliance Officer's primary responsibilities include, but are not limited to:

1. Overseeing and monitoring the adoption, implementation and maintenance of the Program and evaluating its effectiveness;

2. Drafting, implementing, and updating no less frequently that annually, or as otherwise necessary to confirm to changes to federal and state laws, rules and regulations, policies, procedures and standards, a Compliance Work Plan which outlines the proposed strategy for meeting the regulatory requirements for the coming year, with a specific emphasis on ensuring that the Agency has:

   a. Implemented all required policies, procedures and standards of conduct and made them available and accessible to all affected individuals;

b. Established and implemented an effective compliance training and education program;

c. Established and implemented an effective system for the routine monitoring and identification of compliance risks; and

d. Established and implemented procedures and systems for promptly responding to compliance issues as they are raised.

3. Reviewing and revising the Program and the written policies and procedures and standards of conduct, to incorporate changes based on the Agency's organizational experience. The Compliance Officer ensures that changes to federal and state laws, rules and regulations and standards are promptly incorporated into the Program;

4. Reporting directly, on a regular basis, but no less than quarterly to the Administrator, governing body and the Compliance Committee on the program of adopting, implementing, and maintaining the Program;

5. Assisting the Agency in establishing methods to improve its' efficiency, quality of services, and reducing any vulnerabilities to fraud, waste and abuse; and

6. Investigating and independently acting on matters related to the Program, including designing and coordinating internal investigations and documenting, reporting, coordinating, and pursuing any resulting corrective action with all internal departments, contractors, agents, subcontractors, independent contractors, and applicable government agencies (e.g., the New York State Department of Health or the Office of the Medicaid Inspector General).

The Compliance Officer is also responsible for ensuring that any issues identified are appropriately address. Upon learning of a possible compliance issue, whether through audit processes, reports from personnel or other means, the Compliance Officer must investigate the issue, and implement corrective action if necessary. The Compliance Officer will also be responsible for various audit and educational activities, including activities under the direction of legal counsel, as necessary.

II. THE ROLE OF THE COMPLIANCE COMMITTEE

The designated Compliance Committee reports directly and is accountable to the governing body and the Administrator. The permanent members of the Compliance Committee are the Compliance Officer, the Director of Patient Services and the Billing and Payroll Supervisor. Additional the Agency Personnel may serve on the Compliance Committee as may be appropriate. The Compliance Committee meets quarterly and is responsible for coordinating with the Compliance Officer to ensure that the Agency is conducting its business in an ethical and responsible manner, consistent with its Compliance Program. The Administrator and members of the governing body may attend the meetings. The Compliance Committee is responsible for implementation and oversight of the Agency's risk assessment and internal review process.

The Compliance Committee has adopted a Compliance Program and Plan which outlines, among other items, the duties and responsibilities of the Compliance Committee, including:

1. Coordinating with the Compliance Officer to ensure that written policies, procedures and standards of conduct are current, accurate and complete, and that the training topics for the Compliance Program Training and Education Program are timely completed;

2. Coordinating with the Compliance Officer to ensure communication and cooperation by affected individuals on compliance-related issues, internal or external audits, or any other required Program function or activity;

3. Advocating for the allocation of sufficient funding, resources and staff for the Compliance Officer to fully perform designated responsibilities;

4. Ensuring that the Agency has effective systems and processes in place to identify compliance program risks, overpayments, and other issues, and effective policies and procedures for correcting and reporting such issues; and

5. Advocating for required modifications to the Program.

No less frequently that annually, the Compliance Committee reviews and updates the Compliance Program.

Compliance Reviews of Clinical Staff Credentials

Revised March 2023

I. POLICY

the Agency is committed to ensuring that all individuals employed by, or who contract with us have the proper credentials, experience and expertise required to discharge their responsibilities. To this end, the Agency is committed to using good faith efforts to not employ or contract with physicians, nurses or other practitioners who are not currently licensed and registered with the State to practice their profession.

II. PROCEDURES

In order to ensure compliance with the above Policy Statement, the Agency will, at minimum, take the following actions:

A. **New Employees / Contractors – Criminal History Record Check**. All candidates for employment are required to disclose on the employment application whether he / she has been convicted of any criminal offense. For all prospective employees or contractors, the Agency will conduct criminal history record checks ("CHRC") unless such person is exempt from the criminal history record check requirement. Non-exempt prospective employees will be hired on a temporary basis pending receipt of a "clean" CHRC report, under appropriate supervision. Individuals who received a negative determination letter or pending denial determination must be immediately removed from providing direct care.

B. New Employees/Contractors – Other Background Checks. Before hiring or retaining any individual, the Agency will appropriately query available websites, including, but not limited to (as applicable):

- http://www.health.state.ny.us/professionals/doctors/conduct/ (links to the NYS Office of Professional Conduct and Physician Discipline web page);
- http://www.op.nysed.gov/opd/ (links to the NY State Education Department's web page for disciplinary action against professional licensees, including nurses and rehabilitative therapists);
- http://www.op.nysed.gov/opsearches.htm (links to the NY State Education Department's web page for license verification); and
- https://registry.prometric.com/registry/public (New York Nurse Aide Registry).

C. **Annual Reviews**. Appropriate website searches (and / or searches/diligence of other appropriate information or resources) will be performed on all individuals and entities then employed by, or contracted with, the Agency upon initiation of their affiliation with the Agency. The Agency will track the expirations of applicable licensures, credentials and/or registrations, and will notify its contracted agencies of upcoming expirations. The Agency will obtain appropriate documentation regarding the applicable renewals and/re-registrations.

In addition, the Agency will require each current employee to annually certify that he/she (a) has not been convicted of a crime; (b) has not been excluded, debarred or declared otherwise ineligible for participation in any Federal health care programs, including Medicare and Medicaid; and (c) (as appropriate) that his/her New York State license and registration to practice his/her profession are current.

D. **Corrective Action**. Should the Agency determine that: (a) any individual is or has been convicted of a crime; (b) has been excluded, debarred or declared otherwise ineligible for participation in any federal health care programs, including Medicare and Medicaid; or (c) that an individual's New York state license and/or registration is not current, then the following action will be taken:

- First, the Compliance Officer will be immediately notified.

- Second, if the determination relates to an individual that has an existing relationship with the Agency, the individual will be immediately suspended from providing any services to, or on behalf of, the Agency (including, but not limited to, direct client care services) pending the outcome of the investigation provided for below. In addition, any billing by, or related directly or indirectly to, that individual will be immediately suspended.

- Third, an investigation of the matter will be immediately undertaken (with the assistance of compliance counsel, as necessary), and appropriate corrective and disciplinary action will be promptly implemented in accordance with our Compliance and Ethics Program (including, but not necessarily limited to, the return of monies improperly received and the termination of the relationship).

- Fourth, if the determination relates to an individual that does not have an existing relationship with the Agency that person will not be hired or retained, or otherwise become affiliated with the Agency.

E. **Documentation Retention**. Records of the above reviews and any investigations, corrective action and/or disciplinary action taken will be maintained by the Compliance Officer or designee in the individual's personnel file or in another appropriate file.

COMPLIANCE REVIEWS FOR EXCLUDED INDIVIDUALS/ENTITIES
Revised March 2023

POLICY

the Agency is committed to using good faith efforts to not employ, contract or affiliate with individuals or entities that are currently excluded, debarred or otherwise ineligible to participate in Federal health care programs (including, but not limited to, Medicare and Medicaid) or in Federal procurement or non-procurement programs.

This Policy applies to: (1) all employees and candidates for employment with the Agency; (2) all physicians, other practitioners, and Managed Long Term Care Plans ("MLTCPs") who refer clients for services to the Agency (hereinafter collectively referred to as "referring providers"); and (3) all vendors and contractors who do, or seek to do, business with the Agency (hereinafter collectively referred to as "vendors").

DEFINITIONS

Ineligible Person. An "Ineligible Person" means an individual or entity who/which has been excluded, debarred, suspended, terminated from, or is otherwise ineligible to participate in, any Federal health care program or any Federal procurement or non-procurement program and has not been reinstated after the period of exclusion, debarment, suspension, termination or ineligibility.

Federal Health Care Program. A "Federal Health Care Program" is defined as any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program), or any State health care program. For example, some of the better known Federal Health Care Programs include, but are not limited to, Medicare, Medicaid, Tricare and the Veterans programs.

Exclusion Lists. The "Exclusion Lists" include the following two Internet sources that must be checked in accordance with this Policy to determine whether any employees, referring providers, vendors, or other persons providing services on behalf of the Agency are Ineligible Persons :

- https://oig.hhs.gov/exclusions/ (the United States Department of Health and Human Services, Office of Inspector General's ("OIG") List of Excluded Individuals/Entities); and

- https://www.omig.ny.gov/fraud/medicaid-exclusions (the New York State Office of the Medicaid Inspector General's ("OMIG" Medicaid Exclusion List).

PROCEDURES

In order to ensure compliance with the above Policy, the Agency will, at minimum, take the following procedures:

I. RESPONSIBILITY FOR SCREENING PROCESS

the Agency has contracted with vendor(s) who will perform monthly screenings of Exclusion Lists for all employees, medical staff, referring providers and vendors.

PROCEDURES FOR DETERMINING INELIGIBILITY

I. Employees, Medical Staff and Referring Providers.

► Candidates for Employment. All candidates for employment or appointment are required to disclose whether he or she is an Ineligible Person. Any applicant who is an Ineligible Person will not be hired, appointed, retained or otherwise become affiliated with the Agency.

► New Employees and Referral Sources. Before hiring or contracting with any individual or accepting orders or referrals from a referring provider, the Agency will, at minimum, check their names against each of the Exclusion Lists. If an individual name appears on any of the Exclusion Lists: (1) any offer of employment made to him or her will be withdrawn; (2) he or she will not serve as a referral source to the Agency unless satisfactory evidence is presented that:

- He or she is not the individual or entity who appears on the Exclusion List(s); or
- The matters leading to their appearance on the Exclusion Lists(s) have been finally resolved and it is clear that the individual or entity is no longer an Ineligible Person.

► Monthly Checks of Current Employees and Referral Sources. At least monthly, the vendor(s) with which the Agency has contracted will check the names of all current employees and referring providers against each of the Exclusion Lists. If an individual's or entity's name appears on any Exclusion List, the procedures set forth in this Policy will be followed.

In addition to conducting monthly checks of each of the Exclusion Lists, which will be conducted by the contracted vendor(s), the Agency will require each current employee to certify annually that he or she is not currently and has not been at any time since the date of the last such certification, an Ineligible Person.

II. Vendors

► Preliminary Exclusion Checks of Potential Vendors and Its Staff. Prior to doing business with, or entering into a contract with, any potential vendor (including a vendor that has previously had a contract with the Agency), the Agency will check the vendor's name against each of the Exclusion Lists. If the proposed vendor appears on any of the Exclusion Lists, the Compliance Officer or designee will be notified. The Agency may not enter into a contract with the vendor unless the vendor provides satisfactory evidence that:

- It is not the individual/entity that appears on the Exclusion List(s); or

- The matters leading to its appearance on the Exclusion Lists(s) have been finally resolved and it is clear that the individual/entity is no longer an Ineligible Person.

In addition, prior to doing business with, or entering into a contract with, any potential vendor, such vendor must certify that it has checked all of its employees or contractors who will be providing services on behalf of the Agency, against each of the Exclusion Lists and that none appear on the Exclusion Lists.

► Monthly Checks of Current Vendors and Its Staff. On a monthly basis, the vendor with which the Agency has contracted will check the names of all current vendors against each of the Exclusion Lists on behalf of the Agency. If the vendor's name appears on any Exclusion List, the procedures set forth in this Policy will be followed.

the Agency will require its vendors to timely perform the required monthly checks of each of the Exclusion Lists for all of the vendors' existing employees or contractors who are providing services on behalf of the Agency and to maintain documentation demonstrating compliance with this requirement. If the vendor or any of its staff becomes an Ineligible Person, the vendor will be required to immediately disclose such information to the Compliance Officer, or his or her designee.

Recommended Contract Provisions. In order to require the vendors to perform the monthly checks of its employees and contractors who are providing services, contracts/agreements with the vendors should include a representation/warranty that the vendor and its staff are not Ineligible Persons. In addition, contracts/agreements should also include a provision requiring the vendors to check each of the Exclusion Lists before hiring staff and every 30 days thereafter for all of its current employees and contractors who are providing services on behalf of the Agency. To this end, it is recommended that any vendor agreement/contract that the Agency is expected to sign also include provisions which:

- Require the vendor to timely perform the required checks of each of the Exclusion Lists for all of its employees and contractors who are providing services on behalf of the Agency and to maintain documentation that it will make available at the Agency request;

- Require the vendor to immediately disclose to the Compliance Officer or his or her designee if it, or any of its staff or contractors, becomes an Ineligible Person at any time during the term of the agreement/contract or at any time relating to its performance of services for the Agency; and

- Give the Agency the right to immediately terminate the agreement/contract in the event the vendor or any of its staff or contractors becomes an Ineligible Person at any time during the term of the agreement/contract.

C. RESPONSE TO DETERMINATION OF ELIGIBILITY

Should any of the disclosure or review processes set forth above result in the determination that any individual/entity is, or has been, an Ineligible Person, then the following procedures will be followed:

III. Notification of the Compliance Officer. The Compliance Officer will be immediately notified.

IV. Internal Investigation. The Compliance Officer or designee will immediately undertake an investigation of the matter, with the assistance of counsel (as necessary). The Compliance Officer or designee will engage in a discussion with the individual/entity who has been named on the Exclusion List(s), and if they dispute the finding, will permit them to provide evidence that:

- He/she/it is not the individual/entity that appears on the Exclusion List(s); or
- The matters leading to the appearance on the Exclusion Lists(s) have been finally resolved and it is clear that the individual/entity is no longer an Ineligible Person.

V. Corrective Action. Appropriate corrective and disciplinary action will be promptly implemented, including, but not necessarily limited to: suspension without pay or termination of an individual's employment or contract; termination of a vendor's contract; not accepting referrals from the referring provider; the prompt return of monies improperly received, in accordance with applicable law and / or contractual obligation; and / or disclosure or reporting to the appropriate government agency or agencies, in accordance with applicable law.

Removal Requirement. If the Ineligible Person cannot provide sufficient evidence that he/she/it is not an Ineligible Person, the Compliance Officer, in consultation with legal counsel, as appropriate, will, at minimum, remove that individual/entity from responsibility for, or involvement with, the Agency's business operations related to Federal Health Care Programs. The Agency will also remove such individual/entity from any position for which his/her/its compensation, or the items or services furnished, ordered is prescribed by such individual/entity, are paid in whole or in part, directly or indirectly, by a Federal Health Care Program or otherwise with Federal funds until such time as the individual/entity is reinstated into the applicable Federal Health Care Program(s) and no longer an Ineligible Person.

Suspension of Billing. In addition to removing the Ineligible Person from his/her/its job responsibilities, any billing by or on behalf of the Agency that is related (whether directly or indirectly) to the services provided by, or as a result of an order or referral from, that individual/entity will be immediately suspended.

VI. Proposed Ineligibility. If the Agency has actual notice that an individual / entity is the subject of an action that proposes to make the individual/entity an Ineligible Person, the Agency will take all appropriate actions to ensure that the responsibilities of such individual/entity have not and will not adversely affect either the quality of care rendered to any Federal Health Care Program beneficiary or the integrity of any claim submitted to any Federal Health Care Program.

VII. **Reports.** At least quarterly and more frequently as appropriate, the Compliance Officer will report to the Governing Body whether the results of the checks of the Exclusion Lists revealed any Ineligible Persons, and if so, what corrective or other action was or will be instituted.

DOCUMENTATION

The Search Results page of the Exclusion Lists or other appropriate proof that the required checks of the Exclusion Lists have been performed will be maintained by the Compliance Officer or designee. Such documentation will be maintained for no less than ten (10) years.

Records of any investigations, corrective action and / or disciplinary action taken in accordance with this Policy will also be maintained by the Compliance Officer or designee, and a copy will also be maintained in the individual's personnel or credentialing file, the entity's contract file or other appropriate file.

QUESTIONS

If any questions arise concerning the applicability of this Policy to any individual/entity, the results of the checks of the Exclusion Lists, or any other matter relating to this Policy, they should be promptly brought to the Compliance Officer or designee, who will review the matter. The Compliance Officer may consult with counsel, as necessary and appropriate.

COMPLIANCE WITH APPLICABLE FEDERAL AND STATE FALSE CLAIMS ACTS: OVERVIEW OF THE LAWS REGARDING FALSE CLAIMS AND WHISTLEBLOWER PROTECTIONS

Revised March 2023

BACKGROUND/PURPOSE

the Agency is committed to complying with the requirements of Section 6032 of the Federal Deficit Reduction Act of 2005, and preventing and detecting any fraud, waste, or abuse. To this end, the Agency maintains a Compliance and Ethics Program and strives to educate its work force on fraud and abuse laws, including the importance of submitting accurate claims and reports to the Federal and State governments. The Agency has instituted various procedures, which are set forth in our Compliance Manual and various Compliance and Ethics Program policies, to ensure compliance with these laws and to assist us in preventing fraud, waste and abuse in Federal health care programs.[6] In furtherance of this policy and to comply with the Deficit Reduction Act, the Agency disseminates this policy to all Personnel (including employees, management, contractors and other agents)[7] to ensure that such persons are aware of certain relevant Federal and State laws, and that submission of a false claim can result in significant administrative and civil penalties under the Federal False Claims Act and other New York State laws.

POLICY

To assist the Agency in meeting its legal and ethical obligations, any Personnel who reasonably suspects or is aware of the preparation or submission of a false claim or report or any other potential fraud, waste, or abuse related to a Federal health care program is required to report such information to his/her supervisor or the Compliance Officer. Personnel who report such information will have the right and opportunity to do so anonymously and will be protected against retaliation for coming forward with such information both under our internal compliance policies and procedures and Federal and State law. If any Personnel intentionally and maliciously makes a false report or falsely accuses someone of filing a false claim, in violation of Federal law, State law, or the Agency policy, the Agency retains the right to take appropriate action against that individual.

the Agency commits itself to investigating any suspicions of fraud, waste, or abuse swiftly and thoroughly and requires all Personnel to assist in such investigations. If any Personnel believes that the Agency is not responding to their report within a reasonable period of time, the individual shall bring these concerns about the perceived inaction to the Compliance Officer. Failure to report and disclose or assist in an investigation of fraud and abuse is a breach of the Personnel's obligations to the Agency and may result in disciplinary action, up to, and including termination of employment, contract or affiliation.

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[6] "Federal health care program" means any plan or program that provides health benefits whether directly, through insurance or otherwise, which is funded directly, in whole or in part, by the United States government and includes certain State health care programs. Medicare, Medicaid, Veterans' programs and the State Children's Health Insurance Program are some examples of Federal health care programs.

[7] Personnel" means all persons who are affected by the Agency's compliance risk areas, including employees, the Administrator, senior administrators, managers, contractors, agents, subcontractors, independent contractors, the Governing Body and corporate officers.

RELEVANT LAWS:

I. FEDERAL LAWS

FEDERAL FALSE CLAIMS ACT (31 USC §§3729-3733)

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

(1) any person who (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; (C) conspires to commit [the above violations] ; . . . or (G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases 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 $5,000 and not more than $10,000[8] […] plus 3 times the amount of damages which the Government sustains because of the act of that person….

For purposes of this section--

(1) the terms "knowing" and "knowingly" (A) mean that a person, with respect to information--(i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information; and (B) require no proof of specific intent to defraud; and

(2) the term "claim"(A) means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that-- (i) is presented to an officer, employee, or agent of the United States; or (ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government (I) provides or has provided any portion of the money or property requested or demanded; or (II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and

(3) the term "obligation" means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment; and

(4) the term "material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property. *31 U.S.C. § 3729.*

While the FCA 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

[8] Although the statutory provisions of the Federal False Claims Act authorizes a range of penalties of from between $5,000 and $10,000, those amounts have been adjusted for inflation and increased by regulation to not less than $13,508 and not more than $27,018 for penalties assessed after January 30, 2023, whose associated violations occurred after November 2, 2015. *See 28 C.F.R. §85.5.*

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 FCA imposes liability on any person who submits a claim to the federal government or a contractor of 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 FCA 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 healthcare facility which obtains interim payments from Medicare or Medicaid 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 or Medicaid program.

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.

The Program Fraud Civil Remedies Act ("PFCRA")

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, the agency receiving the claim may impose a penalty of up to $5,000[9] for each claim. The agency may also recover twice the amount of the claim.

Unlike the FCA, a violation of this law occurs when a false claim is submitted rather than when it is paid. Also unlike the FCA, 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.

II. NEW YORK STATE LAWS

New York's false claims laws fall into two categories: civil and administrative and criminal laws. Some apply to recipient false claims and some apply to provider false claims, and while most are specific to

[9] Although the statutory provisions of the Program Fraud Civil Remedies Act authorizes a penalty up to $5,000, that amount has been adjusted for inflation and increased by regulation to not more than $13,508 for penalties assessed January 30, 2023, whose associated violations occurred after November 2, 2015. *See 28 C.F.R. §85.5.*

healthcare or Medicaid. Yet some of the "common law" crimes apply to areas of interaction with the government.

A. CIVIL AND ADMINISTRATIVE LAWS

New York False Claims Act (State Finance Law §§187-194)

The New York False Claims Act closely tracks the federal FCA. It imposes penalties and fines upon individuals and entities who knowingly file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. It also has provisions regarding reverse false claims similar to the federal FCA such that a person or entity will be liable in those instances in which the person obtains money from a state or local government to which he may not be entitled, and then uses false statements or records in order to retain the money.

The penalties that may be imposed for violations of the NY False Claims Act are equal the amount that may be imposed under the Federal FCA, as may be adjusted for inflation. 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, or 15-25% if the government did participate in the suit.

Social Services Law, Section 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 of up to $30,000 per violation may be imposed if the repeat violations involve more serious violations of Medicaid rules, billing for services not rendered, or providing excessive services.

Social Services Law, Section 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 needs of the individual or that of his family shall not be taken into account for the purpose of determining his or her needs or that of his family for 6 months if a first offense, for 12 months if a second offense (or if benefits wrongfully received are at least $1,000 but not more than $3,900), for 18 months if a third offense (or if benefits wrongfully received are in excess of $3,900), and 5 years for 4 or more offenses.

B. CRIMINAL LAWS

Social Services Law, Section 145 - Penalties

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, Section 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 a 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.

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

This law applies to claims for insurance payments, 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

This law applies to claims for health insurance payment, including Medicaid, and contains 5 crimes:

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

b. Health care 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 aggregate. It is a Class D felony.

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

e. Health care fraud in the 1st degree is filing false claims and annually receiving over $1,000,000. It is a Class B felony.

III. WHISTLEBLOWER PROTECTIONS

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

The Federal 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.

New York State False Claim Act (State Finance Law §191)

The New York State 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 State Labor Law, Section 740

Section 740 prohibits employers from taking retaliatory action against an employee (including former employees and natural persons working as independent contractors), whether or not the employee is acting within the scope of his or her job duties, because the employee does any of the following:

1. discloses or threatens to disclose to a supervisor or to a public body an activity, policy or practice of the employer that the employee reasonably believes is in violation of law, rule, or regulation or that the employee reasonably believes poses a substantial and specific danger to the public health or safety;

2. provides information to, or testifies before, any public body conducting an investigation, hearing, or inquiry into any such activity, policy or practice by such employer; or

3. objects to, or refuses to participate in, any such activity, policy or practice.

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. However, such employer notification is not required where:

- there is an imminent and serious danger to the public health or safety;
- the employee reasonably believes that reporting to the supervisor would result in a destruction of evidence or other concealment of the activity, policy or practice;
- such activity, policy or practice could reasonably be expected to lead to endangering the welfare of a minor;
- the employee reasonably believes that reporting to the supervisor would result in physical harm to the employee or any other person; or
- the employee reasonably believes that the supervisor is already aware of the activity, policy or practice and will not correct it.

New York State Labor Law, Section 741

Section 741 prohibits certain defined health care employers from taking retaliatory action against an employee because the employee does any of the following:

1. discloses or threatens to disclose to a supervisor, to a public body, to a news media outlet, or to a social media forum available to the public at large, an activity, policy or practice of the employer or agent that the employee, in good faith reasonably believes constitutes improper quality of patient care or improper quality of workplace safety; or

2. objects to, or refuses to participate in, any activity, policy or practice of the employer or agent that the employee, in good faith reasonably believes constitutes improper quality of patient care or improper quality of workplace safety.

Similar to Section 740, an employee may not be protected under Section 741 unless the employee has first brought the improper quality of patient care or improper quality of workplace safety to the attention of a supervisor and has given the employer a reasonable opportunity to correct the activity, policy or practice.

Also similar to Section 740, notice to the employer is not required where it presents an imminent threat to public health or safety or to the health of a specific patient or specific health care employee and the employee reasonably believes in good faith that reporting to a supervisor would not result in corrective action.

Under both Sections 740 and Section 741, an employee who has been the subject of retaliatory action may bring a civil action within two years after the alleged retaliatory action was taken. If the employee's action is successful, a court may order one or more of the following: an injunction to restrain continued violation of

the law; the reinstatement of the employee to the same position held before the retaliatory action, or to an equivalent position, or "front pay;" the reinstatement of full fringe benefits and seniority rights; the compensation for lost wages, benefits and other remuneration; the payment by the employer of reasonable costs, disbursements and attorneys' fees; a civil penalty not to exceed $10,000; and/or the payment by the employer of punitive damages, if the violation was willful, malicious or wanton.

Whistleblower and Non-Retaliation/Non-Intimidation Policy

Revised March 2023

POLICY AND PURPOSE

the Agency has instituted a Compliance and Ethics Program (the "Program") to ensure that all of our business practices are in line with our commitment to providing high quality home health services to our clients in compliance with Federal health care program requirements and applicable civil and criminal laws, rules and regulations.

A key element of our Program is the ability of all Personnel (defined below) to express problems, concerns or opinions without fear of retaliation or reprisal. At the same time, employees have an affirmative duty to report issues or concerns that come to their attention through the appropriate channels. Failure to do so can result in disciplinary action up to and including termination of employment, contract or affiliation with the Agency.

In furtherance of the Program the purpose of this Policy is to ensure that all Personnel understand the Agency's commitment to prohibiting intimidation and retaliation for "good faith participation in the Compliance Program" (as that term is defined below). Intimidation and other retaliatory action in any form by any individual associated with the Agency is strictly prohibited and is itself a serious violation of the Conde of Conduct and this Policy. This includes, but is not limited to, any adverse employment action or any other negative treatment resulting from good-faith participation in the Compliance Program.

APPLICABILITY

This Policy applies to all Personnel.

Managers should maintain an environment whereby Personnel feel comfortable raising issues or asking questions. Managers should also take appropriate steps to address concerns that are raised and communicate the results of corrective action whenever possible and appropriate.

Personnel must understand that intimidation or retaliation in response to reporting an issue or concern or otherwise participating in the Compliance and Ethics Program will not be tolerated. Reports of intimidation and retaliation will be investigated thoroughly and addressed expeditiously with implementation of appropriate disciplinary action, up to and including termination of employment.

Personnel will be advised of the Non-Retaliation and Non-Intimidation Policy at the time of employment, and during Corporate Compliance and other employee training.

DEFINITIONS

I. "Good faith participation in the Compliance Program" includes, but it no limited to:

- Reporting potential compliance issues to appropriate Personnel;
- Cooperating with/participating in investigations of potential compliance issues;

- Assisting the Agency with self-evaluations and audits;
- Assisting the Agency with implementing remedial actions;
- Reporting instances of intimidation or retaliation; and
- Reporting potential fraud, waste or abuse to the appropriate State or Federal entities.[10]

II. "Personnel" means all persons who are affected by the Agency's compliance risk areas, including employees, the Administrator, senior managers, contractors, agents, subcontractors, independent contractors, the Governing Body and corporate officers.

PROCEDURES

I. Reporting and Confidentiality

Communication is critical to the success of the Compliance and Ethics Program. Thus, we maintain open lines of communication between the Agency Compliance Officer, Compliance Committee, and Personnel, and between the Compliance Officer, Compliance Committee and the Governing Body. It is the duty and obligation of all Personnel to report any good faith belief of suspected or actual Compliance and Ethics Program violations. Personnel are also encouraged to freely seek clarification and interpretation of applicable laws, regulations, policies or procedures to which the Agency is subject.

- **How to Report**. Personnel are required to report or raise questions they may have about compliance issues either orally or in writing to a supervisor or the Compliance Officer. All reports of suspected or actual non-compliance should contain as much detail as possible, including names, dates, times, location and the specific conduct the individual feels may violate the law or the Agency's policies and procedures. If the individual who has reported an instance of suspected or actual non-compliance believes that his/her disclosure has not resulted, or will not result, in a timely and appropriate disposition of the matter, the individual should disclose the matter to a supervisory person who the individual believes will take appropriate action.
- **Compliance "Helpline."** The Hotline, a dedicated voice mail telephone line, is monitored by the Compliance Officer. In addition to raising questions directly with the Compliance Officer, all Personnel may call the Hotline to report possible violations, ask questions, or raise compliance concerns. The Hotline number is (718) 0840-3554.
- **Confidentiality.** The identity of the individuals reporting will be kept confidential, whether requested or not, unless the matter is subject to a disciplinary proceeding, referred to or under investigation by the NY State Medicaid Fraud Control Unit (MFCU), the Office of Medicaid Inspector General (OMIG) or law enforcement or if disclosure is a requirement in connection with a legal proceeding.

[10] For a brief summary of New York Labor Law §§ 740-741 as of March 2023, please see the Appendix to this policy. For a summary of additional federal and state whistleblower protection laws, please see the policy entitled: Compliance with Federal and State False Claims Laws: Overview of the Laws Regarding False Claims and Whistleblower Protections.

- **Non-Retaliation/Non-Intimidation.** Intimidation of or retaliation in any form against an individual who in good faith reports possible unethical or illegal conduct is strictly prohibited and is a serious violation of the Code of Conduct. If an employee or contractor feels that he or she is being retaliated against, that individual should contact the Compliance Officer immediately. Any employee who commits or condones any form of retaliation will be subject to discipline up to and including termination.

1. Name	2. Contact Information
1. Compliance Officer Aziza Aminova	2. Ph: (718) 537-2000 ext. 109 Email: aziza@anchorhc.org
3. Compliance Helpline Calls to the Helpline can be made **anonymously**	4. Ph: (718) 840-3554

II. Investigation and Corrective Action

Personnel should inform the Administrator or the Compliance Officer regarding any incidents of retaliation or intimidation related to their participation in the Compliance and Ethics Program.

- All allegations of intimidation or retaliation resulting from good faith participation in the Compliance Program will be promptly and thoroughly investigated. The Compliance Officer, or designee, will oversee any investigations and take all necessary and appropriate actions in connection with any investigation. The Compliance Officer will be assisted by internal staff and/or may solicit the support of external resources (including counsel), as necessary and appropriate.

- If legal, fraud, or abuse issues arise, the Compliance Officer will determine if outside legal counsel should be consulted.

- All individuals who may have relevant information will be promptly interviewed. At the outset of the interview process, the interviewee will be reminded that retaliation and intimidation is unlawful and a violation of the Agency's Code of Conduct and this Policy. The interviewee will also be reminded of the Agency's disciplinary policy for failure to cooperate.

- All documentation related to the investigation will be kept secured in a central location under the control of the Compliance Officer and designated staff. Such investigative files will be kept separate from personnel files and will be maintained for no fewer than ten years from the date of the conclusion of the investigation, or the imposition of disciplinary sanctions or corrective actions resulting therefrom, or for such longer period of time as may be required by applicable law.

III. Corrective Action. Any resulting disciplinary action will be done in conjunction with the Administrator.

- If the Compliance Officer determines that an employee was improperly intimidated or retaliated against for good faith participation in the Compliance and Ethics Program, the Agency will promptly take all appropriate corrective action as to the individual who was intimidated or retaliated against. The Compliance Committee will retain oversight of all such corrective action.

- If the Compliance Officer determines that an individual was intimidated or retaliated against for good faith participation in the Compliance and Ethics Program, appropriate disciplinary action will be taken against the offending person.

- the Agency may terminate contracts and affiliations as a result of improper retaliation or intimidation.

- In order to prevent retaliation or intimidation against employees who in good faith participate in the Compliance Program, the Agency will take the following preventative steps:

    - All terminations of employment must be approved by the Administrator, after discussion with appropriate staff, prior to being effectuated.

    - The Administrator must be advised of the employee's participation in the Compliance and Ethics Program prior to the termination decision being made.

IV. Reporting Requirements

The Compliance Officer will provide periodic reports on retaliatory acts to the Agency Compliance Committee. The Compliance Officer is also authorized to report to the Administrator and the Governing Body.

APPENDIX: A BRIEF SUMMARY OF NEW YORK STATE LABOR LAW §§ 740 & 741

New York State Labor Law §§ 740 and 741 are laws that provide protection to "whistleblowers" in certain cases.

New York State Labor Law, Section 740

Section 740 prohibits employers from taking "retaliatory action" against an employee (including former employees and natural persons working as independent contractors), whether or not the employee is acting within the scope of his or her job duties, because the employee does any of the following:

1. discloses or threatens to disclose to a supervisor or to a public body an activity, policy or practice of the employer that the employee reasonably believes is in violation of law, rule, or regulation or that the employee reasonably believes poses a substantial and specific danger to the public health or safety;

2. provides information to, or testifies before, any public body conducting an investigation, hearing, or inquiry into any such activity, policy or practice by such employer; or

3. objects to, or refuses to participate in, any such activity, policy or practice.

Under Section 740, "retaliatory action" is defined to mean an adverse action taken by an employer or his or her agent to discharge, threaten, penalize, or in any other manner discriminate against any employee or former employee exercising his or her rights under Section 740. This includes: (i) adverse employment actions or threats to take adverse employment actions against an employee in the terms of conditions of employment (including but not limited to discharge, suspension, or demotion); (ii) actions or threats to take actions that would adversely impact a former employee's current or future employment; or (iii) threatening to contact or contacting U.S. immigration authorities or otherwise reporting or threatening to report an employee's suspected citizenship or that of an employee's family or household member to a federal, state, or local agency.

An employee's disclosure to a public body under this law will not be protected unless the employee has made a good faith effort to notify the employer by bringing the activity, policy or practice to the attention of a supervisor and giving the employer a reasonable opportunity to correct the matter. However, such employer notification is not required where:

- there is an imminent and serious danger to the public health or safety;
- the employee reasonably believes that reporting to the supervisor would result in a destruction of evidence or other concealment of the activity, policy or practice;
- such activity, policy or practice could reasonably be expected to lead to endangering the welfare of a minor;
- the employee reasonably believes that reporting to the supervisor would result in physical harm to the employee or any other person; or
- the employee reasonably believes that the supervisor is already aware of the activity, policy or practice and will not correct it.

New York State Labor Law, Section 741

Section 741 prohibits certain defined health care employers from taking "retaliatory action" against an employee because the employee does any of the following:

1. discloses or threatens to disclose to a supervisor, to a public body, to a news media outlet, or to a social media forum available to the public at large, an activity, policy or practice of the employer or agent that the employee, in good faith reasonably believes constitutes improper quality of patient care or improper quality of workplace safety; or

2. objects to, or refuses to participate in, any activity, policy or practice of the employer or agent that the employee, in good faith reasonably believes constitutes improper quality of patient care or improper quality of workplace safety.

Section 741 defines "retaliatory action" to mean the discharge, suspension, demotion, penalization or discrimination against an employee, or other adverse employment action taken against an employee in the terms and conditions of employment.

An employee will not be protected under Section 741 unless he or she has brought the improper quality of patient care or improper quality of workplace safety to the attention of a supervisor and has given the employer a reasonable opportunity to correct the activity, policy or practice.

However, such notice and opportunity to correct is not required in connection with disclosures or threats to disclose an activity, policy or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety where it presents an imminent threat to public health or safety or to the health of a specific patient, or specific health care employee and the employee reasonably believes, in good faith, that reporting to a supervisor would not result in corrective action.

Employees May File Civil Actions Under Both New York Labor Law Sections 740 and 741

An employee who has been subject to retaliatory action in violation of either Section 740 and Section 741 may bring a civil lawsuit against the employer but must do so within two years after the alleged retaliatory action occurred.

If the court rules in the employee's favor, the court may order: an injunction to restrain continued violation of the law; the reinstatement of the employee to the same position held before the retaliatory action, or to an equivalent position, or "front pay"; the reinstatement of full fringe benefits and seniority rights; compensation for lost wages, benefits and other remuneration; the payment by the employer of reasonable costs, disbursements and attorneys' fees; a civil penalty not to exceed $10,000; and/or the repayment by the employer of punitive damages, if the violation was willful, malicious or wanton.

Under Section 740, a court may also order that reasonable attorneys' fees and court costs and disbursements be awarded to an employer if the action the employee brings is without basis in law or fact.

Acknowledgment of Receipt

I acknowledge that I have received the Agency's Compliance and Ethics Program Manual, containing the Reporting Requirements, Code of Conduct and Compliance and Ethics Program Structure and Guidelines. I affirm the following:

- I will follow the standards set forth in the Manual and will ask questions if I do not understand my responsibilities under the Program.
- If I become aware of any possible violations of the Program, or if I have concerns or questions about the appropriateness of any practices at the Agency, I will report such issues to the Compliance Officer, my supervisor, other Senior Management, or via the Compliance Helpline.
- I understand that I may be subject to discipline (or other corrective action) if I violate the standards and requirements set forth in the Manual, related Compliance Program policies and procedures, or any other aspect of the Program.
- I acknowledge receipt of the following: (i) the Compliance and Ethics Program Manual; (ii) the Compliance with Federal and State False Claims Laws Policy, and (iii) the Non-Retaliation and Non-Intimidation for Good Faith Participation in the Compliance and Ethics Program Policy.

Gershon Kopel

Sign Name

05/26/2025

Date

Gershon Kopel

Print Name

Employee Certification

I hereby certify that since the date of my last employee evaluation,

(a) I have not been excluded, debarred or declared otherwise ineligible for participation in any Federal health care programs, including Medicare and Medicaid;

(b) I have not been convicted of a crime; and

(c) (if applicable) My New York State certification/license and registration to practice a profession are current.

Gershon Kopel

Sign Name

05/26/2025

Date

Gershon Kopel

Print Name

Notice of Employee Rights, Protections, and Obligations Under Labor Law Section 740

Prohibited Retaliatory Personnel Action by Employers
Effective January 26, 2022

§ 740. Retaliatory action by employers; prohibition.

1. Definitions. For purposes of this section, unless the context specifically indicates otherwise:
   (a) "Employee" means an individual who performs services for and under the control and direction of an employer for wages or other remuneration, including former employees, or natural persons employed as independent contractors to carry out work in furtherance of an employer's business enterprise who are not themselves employers.
   (b) "Employer" means any person, firm, partnership, institution, corporation, or association that employs one or more employees.
   (c) "Law, rule or regulation" includes: (i) any duly enacted federal, state or local statute or ordinance or executive order; (ii) any rule or regulation promulgated pursuant to such statute or ordinance or executive order; or (iii) any judicial or administrative decision, ruling or order.
   (d) "Public body" includes the following:
      (i) the United States Congress, any state legislature, or any elected local governmental body, or any member or employee thereof;
      (ii) any federal, state, or local court, or any member or employee thereof, or any grand or petit jury;
      (iii) any federal, state, or local regulatory, administrative, or public agency or authority, or instrumentality thereof;
      (iv) any federal, state, or local law enforcement agency, prosecutorial office, or police or peace officer;
      (v) any federal, state or local department of an executive branch of government; or
      (vi) any division, board, bureau, office, committee, or commission of any of the public bodies described in subparagraphs (i) through (v) of this paragraph.
   (e) "Retaliatory action" means an adverse action taken by an employer or his or her agent to discharge, threaten, penalize, or in any other manner discriminate against any employee or former employee exercising his or her rights under this section, including (i) adverse employment actions or threats to take such adverse employment actions against an employee in the terms of conditions of employment including but not limited to discharge, suspension, or demotion; (ii) actions or threats to take such actions that would adversely impact a former employee's current or future employment; or (iii) threatening to contact or contacting United States immigration authorities or otherwise reporting or threatening to report an employee's suspected citizenship or immigration status or the suspected citizenship or immigration status of an employee's family or household member, as defined in subdivision two of section four hundred fifty-nine-a of the social services law, to a federal, state, or local agency.
   (f) "Supervisor" means any individual within an employer's organization who has the authority to direct and control the work performance of the affected employee; or who has managerial

authority to take corrective action regarding the violation of the law, rule or regulation of which the employee complains.

2. Prohibitions. An employer shall not take any retaliatory action against an employee, whether or not within the scope of the employee's job duties, because such employee does any of the following:
   (a) discloses, or threatens to disclose to a supervisor or to a public body an activity, policy or practice of the employer that the employee reasonably believes is in violation of law, rule or regulation or that the employee reasonably believes poses a substantial and specific danger to the public health or safety;
   (b) provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any such activity, policy or practice by such employer; or
   (c) objects to, or refuses to participate in any such activity, policy or practice.
3. Application. The protection against retaliatory action provided by paragraph (a) of subdivision two of this section pertaining to disclosure to a public body shall not apply to an employee who makes such disclosure to a public body unless the employee has made a good faith effort to notify his or her employer by bringing the activity, policy or practice to the attention of a supervisor of the employer and has afforded such employer a reasonable opportunity to correct such activity, policy or practice. Such employer notification shall not be required where:
   (a) there is an imminent and serious danger to the public health or safety;
   (b) the employee reasonably believes that reporting to the supervisor would result in a destruction of evidence or other concealment of the activity, policy or practice;
   (c) such activity, policy or practice could reasonably be expected to lead to endangering the welfare of a minor;
   (d) the employee reasonably believes that reporting to the supervisor would result in physical harm to the employee or any other person; or
   (e) the employee reasonably believes that the supervisor is already aware of the activity, policy or practice and will not correct such activity, policy or practice.
4. Violation; remedy.
   (a) An employee who has been the subject of a retaliatory action in violation of this section may institute a civil action in a court of competent jurisdiction for relief as set forth in subdivision five of this section within two years after the alleged retaliatory action was taken.
   (b) Any action authorized by this section may be brought in the county in which the alleged retaliatory action occurred, in the county in which the complainant resides, or in the county in which the employer has its principal place of business. In any such action, the parties shall be entitled to a jury trial.
   (c) It shall be a defense to any action brought pursuant to this section that the retaliatory action was predicated upon grounds other than the employee's exercise of any rights protected by this section.
5. Relief. In any action brought pursuant to subdivision four of this section, the court may order relief as follows:
   (a) an injunction to restrain continued violation of this section;
   (b) the reinstatement of the employee to the same position held before the retaliatory action, or to an equivalent position, or front pay in lieu thereof;
   (c) the reinstatement of full fringe benefits and seniority rights;

(d) the compensation for lost wages, benefits and other remuneration;
(e) the payment by the employer of reasonable costs, disbursements, and attorney's fees;
(f) a civil penalty of an amount not to exceed ten thousand dollars; and/or
(g) the payment by the employer of punitive damages, if the violation was willful, malicious or wanton.

6. Employer relief. A court, in its discretion, may also order that reasonable attorneys' fees and court costs and disbursements be awarded to an employer if the court determines that an action brought by an employee under this section was without basis in law or in fact.
7. Existing rights. Nothing in this section shall be deemed to diminish the rights, privileges, or remedies of any employee under any other law or regulation or under any collective bargaining agreement or employment contract.
8. Publication. Every employer shall inform employees of their protections, rights and obligations under this section, by posting a notice thereof. Such notices shall be posted conspicuously in easily accessible and well-lit places customarily frequented by employees and applicants for employment.

Notice of Employee Rights, Protections, and Obligations Under Labor Law Section 741

Prohibited Retaliatory Action by Employers
Effective January 26, 2022

§ 740. Prohibition; health care employer who penalizes employees because of complaints of employer violations.

1. Definitions. For purposes of this section, unless the context specifically indicates otherwise:
   (a) "Employee" means any person who performs health care services for and under the control and direction of any public or private employer which provides health care services for wages or other remuneration.
   (b) "Employer" means any partnership, association, corporation, the state, or any political subdivision of the state which: (i) provides health care services in a facility licensed pursuant to article twenty-eight or thirty-six of the public health law; (ii) provides health care services within a primary or secondary public or private school or public or private university setting; (iii) operates and provides health care services under the mental hygiene law or the correction law; or (iv) is registered with the department of education pursuant to section sixty-eight hundred eight of the education law.
   (c) Agent" means any individual, partnership, association, corporation, or group of persons acting on behalf of an employer.
   (d) "Improper quality of patient care" means, with respect to patient care, any practice, procedure, action or failure to act of an employer which violates any law, rule, regulation or declaratory ruling adopted pursuant to law, where such violation relates to matters which may present a substantial and specific danger to public health or safety or a significant threat to the health of a specific patient.
   (e) "Improper quality of workplace safety" means, with respect to employees, any practice, procedure, action or failure to act of an employer which violates any law, rule, regulation, or declaratory ruling adopted pursuant to law where such violation relates to matters which may present an unsafe workplace environment or risk of employee safety or a significant threat to the health of a specific employee.
   (f) "Public body" includes the following:
      (i) the United States Congress, any state legislature, or any elected local governmental body, or any member or employee thereof;
      (ii) any federal, state, or local court, or any member or employee thereof, or any grand or petit jury;
      (iii) any federal, state, or local regulatory, administrative, or public agency or authority, or instrumentality thereof;
      (iv) any federal, state, or local law enforcement agency, prosecutorial office, or police or peace officer;
      (v) any federal, state or local department of an executive branch of government; or
      (vi) any division, board, bureau, office, committee, or commission of any of the public bodies described in subparagraphs (i) through (v) of this paragraph.

(e) "Retaliatory action" means the discharge, suspension, demotion, penalization or discrimination against an employee, or other adverse employment action taken against an employee in the terms and conditions of employment.

(f) "Supervisor" means any individual within an employer's organization who has the authority to direct and control the work performance of the affected employee; or who has managerial authority to take corrective action regarding the violation of the law, rule or regulation of which the employee complains.

2. Retaliatory action prohibited. Notwithstanding any other provision of law, no employer shall take retaliatory action against any employee because the employee does any of the following:
   (a) discloses or threatens to disclose to a supervisor, to a public body, to a news media outlet, or to a social media forum available to the public at large, an activity, policy or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety; or
   (b) objects to, or refuses to participate in any activity, policy or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety.
3. Application. The protection against retaliatory personnel action provided by subdivision two of this section shall not apply unless the employee has brought the improper quality of patient care or improper quality of workplace safety to the attention of a supervisor and has afforded the employer a reasonable opportunity to correct such activity, policy or practice. This subdivision shall not apply to an action or failure to act described in paragraph (a) of subdivision two of this section where the improper quality of patient care or improper quality of workplace safety described therein presents an imminent threat to public health or safety or to the health of a specific patient or specific health care employee and the employee reasonably believes in good faith that reporting to a supervisor would not result in corrective action.
4. Enforcement. A health care employee may seek enforcement of this section pursuant to subdivisions four and five of section seven hundred forty of this article.
5. Relief. In any court action brought pursuant to this section it shall be a defense that the personnel action was predicated upon grounds other than the employee's exercise of any rights protected by this section.
6. Publication. Every employer shall inform employees of their protections, rights and obligations under this section, by posting a notice thereof. Such notices shall be posted conspicuously in easily accessible and well-lit places customarily frequented by employees and applicants for employment.

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Gershon Kopel (gershkopel@gmail.com)