Able Health Care Service, Inc.

1240 Broadcast Plaza, Merrick, N.Y. 11566 / Tel. 516-546-8000 / Fax. 516-868-7394

Corporate Compliance Program

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A Professional Home Health Care Service by People who Care
Providing care since 1976

COMPLIANCE
MANUAL INDEX

Able Health Care Service, Inc.
Board Resolution
Endorsing and Authorizing the Development and
Implementation of a
Corporate Compliance Program

Able Health Care Services, Inc.is committed to providing high quality and cost-effective healthcare in compliance with the law. We meet the commitment only through the efforts of our highly skilled governance and staff. Each must earn the trust and respect of our clients and the individuals and organizations with whom and which we do business by conducting ourselves with honesty and integrity and adhering to the laws applicable. To assist all concerned in making the right choices when confronted with difficult situations, the Board believes that the organization will benefit from an effective corporate compliance program.

The Board's action directing **Able Health Care Services, Inc.** management to proceed with the development and implementation of a corporate compliance program should not be interpreted as a concern that present management systems are inadequate. Rather, develop and implementation of a corporate compliance program is part of the organization's continuing effort to improve the quality of our services and further our mission.

In this regard, the Board also recognizes that the Department of Health and Human Services of the Office of Inspector General (OIG), the federal organization charged with enforcing the Medicaid and Medicare laws as well as the New York State Offices of Medicaid Inspector General (OMIG) has published a series of compliance program guidance's for members of the health care industry for the implementation of corporate compliance program.

Wherefore the Board resolves that:
The management of **Able Health Care Services, Inc.** will dedicate such resources as are necessary to develop and implement an effective corporate compliance program to promote adherence to all applicable Medicare and Medicaid programs.

1. The compliance program will meet or exceed all the components of an effective compliance program **changes of NYS Part 521 Sections 1-4 published December 29, 2022.**
2. The Board recognizes that the implementation may be costly. It must focus on its implementation and set a priority that identifies areas of risk that will be made part of the constant monitoring and reviews that are required by the federal and state agencies.
3. Based upon the forgoing, the Board directs management to inform all employees, vendors, consultants and volunteers advising them of the compliance program that has been implemented.
4. The Board will follow the Compliance Program attached **as updated for the Part 521 changes**.

_____/ _____ _____

Name / Title Date

Able Health Care Services, Inc.
Compliance Officer

Position Title: Compliance Officer
Reports to: Governing Body

General Purpose: The Compliance Officer establishes and implements an effective compliance program to prevent illegal, unethical, or improper conduct. The Compliance Officer acts as staff to the Administrator and Governing Board by monitoring and reporting results of the compliance and ethics efforts of the company and in providing guidance for the Board and senior management team on matters relating to compliance. The Corporate Compliance Officer will spend at least _% of their time together with the Compliance Committee and is authorized to implement all necessary actions to ensure achievement of the objectives of an effective compliance program. The provider shall designate an individual to serve as its compliance officer. The compliance officer is the focal point for the required provider's compliance program and is responsible for the day-to-day operation of the compliance program. The required provider's designation of a compliance officer shall meet the following requirements:

Responsibilities:

1. Maintains and revises policies and procedures for the general operation of the compliance program and its related activities to prevent illegal, unethical, or improper conduct, managing day-to-day operation of the Program. **The policies and procedures must be reviewed at least annually. Section 521-1.4(a)**

2. Drafts, implements, and updates **no less frequently than annually** or, as otherwise necessary, to conform to changes to Federal and State law reviews and updates Standards of Conduct to ensure continuing currency and relevance in providing guidance to management and employees.

3. Consults with Outside Counsel as needed to resolve difficult legal compliance issues **including NYS Self-disclosure requirements.**

4. Responds to alleged violations of rules, regulations, policies, procedures, and Standards of Conduct by evaluating or recommending the initiation of investigative procedures.

5. Identifies potential areas of compliance vulnerability and risk **and implements and updates a compliance workplan annually having approvals from the Governing Board.**

6. Provides reports as needed, reporting directly, on a regular basis, but **no less frequently than quarterly**, to the required provider's governing body, chief executive, and compliance committee on the progress of adopting, implementing, and maintaining compliance

program. Keeping the Compliance Committee of the Board and senior management informed of the operation and progress of compliance efforts. **Section 521-1.4(b)-(c).**

7. Ensures proper reporting of violations or potential violations to duly authorized enforcement agencies as appropriate or required. Assisting the required provider in establishing methods to improve the required provider's efficiency, quality of services, and reducing the required provider's vulnerability to fraud, waste, and abuse.

8. Institutes and maintains an **effective compliance communication** program for the organization, including promoting: (a) use of the compliance hotline; (b) heightened awareness of Standards of Conduct, and (c) understanding of new and existing compliance issues and related policies and procedures.

9. Works with the others as appropriate to develop an effective **compliance training program**, including appropriate introductory training for new employees and ongoing training for all employees and managers. **Section 521-1.4(d) at least annually.**

10. Monitors the performance of the Compliance Program and relates activities on a continuing basis, taking appropriate steps to improve its effectiveness.

11. The compliance officer shall be responsible for coordinating the implementation of the fraud, waste, and abuse prevention program with the director and **lead investigator of the MMCO's special investigation unit** pursuant to SubPart 521-2 of this Part, if applicable.

12. The compliance officer must submit an **annual certification** Section 521-1.3(f) to the Department of Social Services that maintains a compliance program. Participating providers that are also required providers pursuant to this shall provide a copy of the certification, required under the preceding paragraph, **to each MMCO for which they are a participating provider upon signing the provider agreement with the MMCO, and annually thereafter.** MMCOs shall maintain a method for submitting such certification the MMCO's website, which may include a dedicated email address, and shall retain such certification in accordance with the requirements of subdivision (b) of this section.

The provider shall additionally:

1. Ensure that the compliance officer is allocated sufficient staff and resources to satisfactorily perform their responsibilities for the day-to-day operation of the compliance program based on the required provider's risk areas and organizational experience.

2. The provider shall ensure that the compliance officer and appropriate compliance personnel have access to all records, documents, information, facilities and affected individuals that are relevant to carrying out their compliance program responsibilities.

3. The compliance officer should not be the general counsel or chief financial officer, or report to those positions, or be involved in activities that conflict with compliance activities. As such, we believe it is reasonable to maintain flexibility for providers who may not be able to separate the compliance officer from these functions. If it is not feasible for the provider to separate the compliance function, then a procedure for addressing conflicts of interest or potential risks to achieve an appropriate system of checks and balances is recommended.

4. The annual compliance work plan prepared by the compliance officer along with the compliance committee is an organizational tool and a working document, which assists providers in documenting and tracking their strategy for identifying and addressing risk areas specific to their operations. A work plan is a valuable tool in evaluating the degree to which a provider is engaged in enhancing its compliance program based on its "organizational experience," a risk area identified in Section 521-1.3(d). As such, the compliance work plan is a key component in demonstrating that a provider has an effective compliance program.

5. Provide the compliance officer with the flexibility to develop a work plan that best meets their characteristics and risk environment. While drafting, implementing, and updating a compliance work plan is a primary responsibility for the Compliance Officer, it is a reasonable expectation that the Compliance Officer should be the person coordinating the implementation of the work plan, and there will be other individuals involved in completing auditing and monitoring activities identified in such a work plan.

Able Health Care Services, Inc.

Compliance Officer

Rivka Shapiro has been designated the Compliance Officer. This position will follow the Compliance Officer Job description attached. This position will ensure that **all affected individuals' Contractors, agents, subcontractors, and independent contractors:**

(i) is well-integrated into the company's operations and supported by the highest levels of the organization, including the chief executive, senior management, and the governing body.

(ii) promotes adherence to the required provider's legal and ethical obligations; and

(iii) is reasonably designed and implemented to prevent, detect, and correct noncompliance with MA program requirements, including fraud, waste, and abuse most likely to occur for the required provider's risk areas and organizational experience.

(iv) Oversees the Compliance Committee.

Acknowledgement: _____

Date: _____

Able Health Care Services, Inc.

Corporate Compliance Program

INTRODUCTION

Able Health Care Services, Inc.'s mission is to provide home care services that meet the needs of the consumers, and which are an integral part of the overall healthcare delivery system within the region we serve. **Able Health Care Services, Inc.** *is a provider of care in the home, in New York, Long Island and Westchester, including Home Health Aides, Personal Care Aides, Registered Nurses, and Therapists. We offer a quality service of tailored home health care visits from 30 minutes to full live-in support.* We are committed to upholding, providing, and meeting the safety interests, health care needs and rights of the consumers we serve. We strengthen our community by providing a continuum of vital services and activities that enrich the lives of individuals of all ages. **Able Health Care Services, Inc.** *has been a privately owned and operated agency, providing a service since 1976. Our longevity has given us the knowledge and experience to keep current with the ever-changing health care environment. Our commitment to quality and good service has played an important role in our success.* Our vision is to be a pioneer in the provision of integrated services that address the complex and changing needs of the community dedicated to furnishing quality home health care services in accordance with all pertinent laws and professional standards of care.

In recognition of the complexity and constant changes in various federal and state laws and regulations governing the health care industry, the implementation of compliance plans has become an important part of ensuring conformity with existing law. A compliance plan is a series of internal controls that promote the prevention, detection and resolution of conduct that is illegal or that does not conform to a company's ethical standards. A compliance plan is intended to be a routine part of a company's operations.

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

The agency, therefore, has directed that the Compliance Officer undertake an integrity program in order to continue the commitment to high standards of conduct, honesty and reliability in its business practices. This integrity program is called a Compliance Program. The purpose of the Compliance Program is to promote understanding of and adherence to applicable federal and state laws and regulations and to make a sincere effort to prevent, detect and correct any fraud, abuse or waste in connection with federally funded health care programs and private health plans. There are several parts to the Compliance Program, each of which is important. The Program applies to ***all affected individuals*** is defined as the **Board of Directors,** Administrator, any associate and assistant administrators, department directors and managers, supervisors and any other person or individual hired by and in the paid service of the agency**.**

The Compliance Program will address the **Seven** elements of an effective compliance program:

1. Written Policies and Procedures
2. Designation of a Compliance Officer and Committee

3. Training and Education
4. Communication lines to the Compliance Officer
5. Disciplinary Policies
6. Identification of compliance risk areas
7. Responding to Compliance Issues

I. WRITTEN POLICIES

Standards of Conduct

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

Orientation Package*:* The employees are provided a Compliance Program package from the *Human Resources* summarizing their responsibility to be personally and professionally responsible for understanding and carrying out the Standard of Conduct. It indicates who is the responsible compliance officer and phone number, how to report a violation and all the elements of an effective Compliance Program. There is a required acknowledgment of training signature sheet that is maintained in each employee's personnel file.

The staff package given to each employee sets out several types of conduct which are unacceptable. These include:

1. Intentionally or knowingly making false or erroneous entries on reports, patient charts or other center records.
2. Dishonesty.
3. Unauthorized alteration or destruction of organization records including patients' charts.
4. Coding or billing which violates Medicaid rules or regulations or other federal rules or regulations.
5. Behavior detrimental to the operation of the organization.
6. Other unacceptable conduct may also be found in the orientation package.

Conflict of interest. In order to perform their duties with honesty and fairness and in the best interest of the organization, a***ll affected individuals*** must avoid conflicts of interest in their employment. Conflicts of interest may arise from having a position or interest in or furnishing managerial or consultative services to any concern or business from which the center obtains goods or services or with which it competes or does business, from soliciting or accepting gifts, excessive entertainment or gratuities from any person or entity that does or is seeking to do business with the organization and from using organization property for personal or private purposes. Conflicts also may arise in other ways. If an employee has any doubt or any question about any of his or her proposed activities, guidance or advice should be obtained from the administration. The organization has a policy on and prohibiting conflicts of interest. **Policy #10 of Compliance Manual.**

Confidentiality of information. A patient's health care record is the property of the organization and shall be maintained to serve the patient, necessary health care providers, the institution and payors such as Medicare/Medicaid and other third-party payors in accordance with legal, accrediting and regulatory organization requirements. The information contained in the health care record belongs to the patient and the patient is entitled to the protection of that information. All patient care information is regarded as confidential and available only to authorized users and employees who may be providing patient care and to third party payors in order to facilitate reimbursement. The operations, activities, business affairs and finances of the organization should also be kept confidential and discussed or made available only to authorized users.

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

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

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

Protection of assets. The organization will make available to employees, assets and equipment necessary to conduct organization business including such items as computer hardware and software, billing and medical records, both hardcopy and in electronic format, fax machines, office supplies and various types of **all** equipment. Employees should strive to use organizational assets in a prudent and effective manner. The organization's property should not be used for personal reasons or be removed without approval from a departmental manager. An employee who believes that any medical equipment is not operating properly nor has an inaccurate calibration should immediately report the problem to his or her supervisor.

Anti-competitive conduct. The organization will not engage in anticompetitive conduct that could produce an unreasonable restraint of trade or a substantial lessening of competition. Evaluation of anti-competitive conduct requires legal guidance. Communication by employees with competitors about matters that could be perceived to have the effect of lessening competition or could be considered as collusion or an attempt to fix prices should take place only after consultation with legal counsel.

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

which the original agreement or invoice was made or issued. Such payments should not be made to individual employees or agents of business entities.

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

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

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

- **Billing for services not rendered,**
- **Receiving payments misrepresenting services provided** (inappropriate coding, inflating units of service),
- **Billing for ordered services rendered to clients that do not meet admission criteria**,
- **Duplicate billing for the same service,**
- **Falsifying billing or medical records in any way,**
- **Entering into business agreements that pose a conflict of interest,**
- **Billing for services that are not medically necessary.**
- **Participation in Anti-kickback schemes as prohibited by law**
- **Participation in any Self-Referrals as prohibited by law**
- **Ordered services not monitored**
- **Contract oversight services not monitored**

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

- **Updating Completion of OMIG Assessment form**
- **Certifying at year-end to the MCMC and Office of the Medicaid Inspector General** on the **anniversary date of Medicaid Billing and filed with NYS DOH**
- Credentialing of nursing staff
- Risk Assessment defining the potential areas of fraud and abuse
- Updating Work plan utilized by the compliance committee

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

Fiscal Reports. The CFO/ Fiscal director shall prepare or cause to be prepared policies and procedures ensuring against

submission of false or inaccurate fiscal reports and ensuring that costs are not claimed unless based on appropriate and accurate documentation and unallowable costs are not claimed for reimbursement.

Retention of Records. Records and documents shall include: (i) clinical and medical records and claims documentation required by federal or state law *(see attached appendix 3)* for participation in federal health care programs; and (ii) records relating to the Compliance Program such as documentation related to employee training, reports from the hotline, the nature and results of any investigations, and results of the organization auditing and monitoring efforts. **The provider shall make available to the department, OMIG, or MFCU upon request, copies of such records. Records shall be retained by required providers for a period not less than six (6) years from the date such program was implemented, or any amendments.**

I. COMPLIANCE OFFICER AND COMPLIANCE COMMITTEE

A. **Officer.** The CEO or designee shall appoint a high-level employee as Compliance Officer.
B. **Duties.** The Compliance Officer and the Compliance Committee shall prepare, and revise as necessary, a job description for the Compliance Officer. The Compliance Officer's primary responsibilities set out in the job description shall include:
1. Overseeing and monitoring the implementation of the Compliance Program.
2. Reporting on a regular basis to the CEO and **quarterly** to the Board of Directors and **quarterly** to the Compliance Committee on the progress of implementation, and assisting the Board, the CEO and the committee in establishing methods to improve the organization efficiency and quality of services, and to reduce the organization vulnerability to fraud, waste and abuse. .
3. Periodically revising the Compliance Program as required by changes in the law and policies and procedures of government and private payor health plans.
4. Developing, coordinating, and participating in an educational and training program that focuses on the elements of the Compliance Program, and seeks to ensure that all appropriate employees are knowledgeable of, and comply with, pertinent federal and state standards.
5. Ensuring that independent contractors and agents who furnish medical services to the organization are aware of the requirements of the Compliance Program with respect to coding, billing and marketing, among other things.
6. Assisting in coordinating internal compliance review and monitoring activities, including annual or periodic reviews of departments and audits.
7. Independently investigating and acting on matters related to compliance.
8. Implementing policies and programs that encourage managers and employees to report suspected fraud and other improprieties without fear of retaliation.
9. The compliance officer shall be responsible for coordinating the implementation of the fraud, waste, and abuse prevention program with the director and lead investigator of the MMCO's special investigation unit pursuant to SubPart 521-2.
10. The compliance officer should not be the general counsel or chief financial officer, or report to those positions, or be involved in activities that conflict with compliance activities. If it is not feasible for the provider to separate the compliance function, then a procedure for addressing conflicts of interest or potential risks to achieve an appropriate system of checks and balances is recommended.

Authority. The Compliance Officer shall have direct access to the CEO and as required, to the Board of Directors. The Compliance Officer shall have access to all documents and information relevant to compliance activities including but not limited to patient records, billing records, human resources records, marketing records and contracts and written

arrangements or agreements with others. The Compliance Officer may seek advice of legal counsel and with consent of the Compliance Committee, may retain necessary consultants or experts.

Reports. The Compliance Officer shall report to the Board at least annually or as necessary, on the status of compliance in the organization. Such reports may be written or oral. The Compliance Officer reports incidents to the CEO and the Governing Board quarterly and as needed.

Compliance Committee. The Compliance Committee shall consist of approximately 5-9 members of the organization **meeting quarterly** prior to reporting to the Board and shall include:

- Governance/Administration
- Compliance Officer / Quality Review, Clinical
- Human Resources
- Finance,
- IT.

Any vacancy on the committee, whether by resignation, illness, death or otherwise, shall be promptly filled by appointment by the CEO or designee and reported to the Governing Board and each such appointee shall serve for the remainder of the unexpired term of his or her predecessor.

Duties. The duties of the Compliance Committee shall include:

1. Advising the Compliance Officer and assisting in the implementation and maintenance of the Compliance Program.
2. Determining the appropriate strategy and/or approach to promote adherence to the Compliance Program and the detection of potential violations.
3. Develop a system to solicit, evaluate and respond to complaints and problems.
4. Oversee the education and training of employees and systems for communication with and by employees.
5. Establishing confidentiality standards and requirements for committee members and those persons requested to provide assistance to the committee.

Guidelines. The Compliance Committee may adopt written guidelines for holding meetings and conducting the activities, and operations of the committee. **See the separate Compliance Committee Charter *Appendix 4*.**

I. TRAINING AND EDUCATION

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

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

C. **General Rules**. Annually, as necessary, a***ll affected individuals*** will be retrained (i) on the organization's

Compliance Program; (ii) the fraud and abuse laws as they relate to the claim development and submission process and the organization business relationships; (iii) relevant federal and state requirements; and (iv) the consequences both to the organization and individuals of failing to comply with applicable laws and regulations. Such training must emphasize the importance of the Compliance Program and the organization's commitment to honesty and integrity in its business dealings.

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

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

F. **Documentation.** The training provided to ***all affected individuals*** shall be documented. The documentation shall include the date and a brief description of the subject matter of the training activity or program.

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

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

I. COMMUNICATION

A. **Reason.** Open communication between ***all affected individuals*** and the Compliance Officer or Compliance Committee are important to the success of this Compliance Program and to the reduction of any potential for fraud, abuse and waste. Without help from employees it may be difficult to learn of possible compliance problems and make necessary corrections. See ***policy 5 Communications***.

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

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

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

2. ***All affected individuals*** may report directly and anonymously to the Compliance Officer- **Rivka Shapiro** or the Confidential Hotline number **516-394-3288** or to a member of the committee.

3. ***All affected individuals*** may also call the hotline or the Office of the Inspector General of the Health and Human Services Department, 1-800-HHS-TIPS (447-8477). The Compliance Officer will post this number in one or more prominent locations in the organization.

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

E. **Non-Retaliation/ Non-Intimidation.** There will be no reprisals, retaliation ***nor intimidation*** against ***all affected individuals*** who in good faith reports acts or suspected acts of fraud, abuse or waste or violations or suspected violations of the Standards of Conduct or other wrongdoing or misconduct. However, an employee who makes an intentional false report or a report not in good faith may be subject to disciplinary action. See **policy 8**.

F. **Documentation.** Reports that suggest substantial violation of this Program, violation of the Standards of Conduct or violation of relevant law or regulation should be documented and maintained by the Compliance Officer. Information about such reports should be furnished periodically to the Board and the CEO and to the Compliance Committee at its regular meetings.

J. **DISCIPLINE AND DISCLAIMER**

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

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

B. **Procedure**. Possible disciplinary action will follow the existing disciplinary policies and procedures. Progressive discipline is not required. **See *policy 14 on Discipline***.

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

K. **Identification of Compliance Risk Areas**

A. Process. Reviews will be undertaken in order to identify deficiencies in the claim development and submission process. The organization will devote such resources as are reasonably necessary to ensure that audits are adequately staffed by persons with appropriate knowledge and experience. Annually, a work plan will be prepared and updated from the prior year's areas reviewed and the OIG / OMIG current work plan issues. **See *appendixes 1- 2***

B. Time. The Compliance Committee shall designate the time for audits and the departments and functions to be

audited.

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

D. Periodic Tests and Audits. The organization, under the direction of the CEO and Compliance Officer, will conduct periodic tests of claims submitted to Medicaid and other federal health care plans and audits of the claims development and submission process. Audits shall also cover the organization relationship with third party contractors, and compliance with laws governing kickback arrangements. The Compliance Officer may request that the director or manager of each affected department prepare and submit testing, audit and monitoring plans for his or her department. **See *appendix 1 and 2*.**

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

F. Action. The Compliance Officer will be notified of the results of all audits. Further action, if any, by the Compliance Officer with respect to any deviation or discrepancy revealed by an audit will be taken.

G. Documents. All audits shall be thoroughly documented. Such documents shall be maintained in the permanent files of the Compliance Officer and adequately secured.

I. RESPONDING TO COMPLIANCE ISSUES

RESPONSE TO GOVERNMENTAL INQUIRIES

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

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

C. **Documents.** The organization's response to any warrant, subpoena, investigation or inquiry must be complete and

accurate. No employee shall alter, destroy or mutilate any document or record or alter, delete or download any material from any computer, word processor, disk, removable drive or tape. Documents and records must be preserved in their original form.

D. **Reports**

The Compliance Officer shall make written evaluation reports on compliance activities including reports or complaints received from employees, investigations, and audits and monitoring to the Board, CEO, and members of the Compliance Committee on a regular basis. Reports to the Board shall be at least **annually** or more often as necessary or advisable.

E. **Screening**

1. New Employees. The organization will conduct a background investigation of all new direct care employees, and / or at the discretion of the organization, applicants for employment, who have or will have discretionary authority to make decisions that or whose job function may materially impact the Medicaid claim development and submission process. The purpose of the background investigation is to determine whether any such employee or applicant has been convicted of a criminal offense related to health care or has been excluded from the Medicare or Medicaid program in which case employment will not be considered. This will be performed when being considered and monthly thereafter in accordance with the organization exclusion policy.

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

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

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

F. Evaluations

Adherence to and promotion of this Compliance Program, will be a factor in evaluating the performance of employees, including supervisory, managerial and administrative personnel.

G. Confidentiality and HIPAA requirements and HITECH rule

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

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

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

Privacy & Security Compliance

Confidentiality of Patient Information
As providers of healthcare, the organization's employees have access to highly private and confidential individually identifiable information.

Organizational employees shall conduct themselves in a manner that will maintain the confidentiality of patient information. The employees shall not disclose any patient specific information unless it is done pursuant to the patient's written authorization or for purposes of treatment, payment or healthcare operations. Upon employment, all agencies' employees shall sign a confidentiality statement to assure patient confidentiality.

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

The The Right to Inspect and Copy

The Right to Amend

The Right to an Accounting of Disclosure

The Right to Request Restrictions

The Right to Request Confidential Communications

The Right to a Paper Copy of the Notice of Privacy Practices Retention and

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

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

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

H. NON-INTIMIDATION AND NON-RETRIBUTION FOR REPORTING

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

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

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

potential wrongdoing.

The organization is committed to a policy that encourages timely disclosure of such concerns and prohibits any action directed against **all affected individuals** for making a good faith report of a concern **reporting and does not include investigating issues, self-evaluations, audits, remedial actions and reporting to appropriate officials as provided in sections 740 and 741 of the NYS Labor Law.**

Any manager, supervisor or employee who engages in retribution, retaliation or harassment against a reporting employee is subject to discipline up to and including dismissal on the first offense. All instances of retaliation, retribution or harassment against reporting employees will be brought to the attention of the Compliance Officer who will, in conjunction with Legal will investigate and determine the appropriate discipline, if any.

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

THE FALSE CLAIMS ACT

The Federal False Claims Act law, *31 USC §§ 3729 – 3733*, is a law that prohibits a person or entity, such as the organization from "knowingly" presenting or causing to be presented a false or fraudulent claim for payment or approval to the Federal Government and from "knowingly" making, using or causing to be made a false record or statement to get a false or fraudulent claim paid or approved by the Federal Government. These prohibitions extend to claims submitted to federal health care programs, such as Medicare or Medicaid. The terms "knowing "and knowingly" is having knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information and acts in reckless disregard of the truth or falsity of the information. *Due to adjustments made by Congress, the civil penalty is* ***now not less than $10,781 and not more than $21,563.*** A person or entity found guilty of violation can be obligated to civil penalty up to ***$21,563*** plus three times the amount of actual damages. A person or entity can also find themselves excluded from the Medicare/Medicaid programs if found in violation.

New York State law makes it unlawful to knowingly make a false statement or representation (or deliberate concealment of any material fact or other fraudulent scheme or device) to attempt to obtain Medicare/Medicaid payments for services or supplies furnished under the New York State Medical Assistance Program. A violation of this Act can result in civil damages three times overstated amount or ***$5000*** whichever is greater. The organization or individual may also be

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

Standard of Conduct

- **Program Description**

Able Health Care Services, Inc. compliance program embodies its commitment to conducting business in the manner proscribed by the applicable laws, rules, regulations, and other directives of the federal, state and local governments and agencies. An expression of this commitment is the Standard of conduct ("Standard") described herein which is applicable to **all affected individuals**, including **Able Health Care Services, Inc.** Board members, CEO, officers, directors, employees, volunteers, and independent contractors working for or providing services to **Able Health Care Services, Inc.** This Standard is intended to provide general guidelines to assist **all affected individuals** in understanding and appreciating the high standards with which **Able Health Care Services, Inc.** conducts its business. Although the Standard of Conduct can neither cover every situation in the daily conduct of our many varied activities nor substitute for common sense, individual judgment or personal integrity, it is the duty of every staff member to adhere, without exception, to the principles set forth herein. The Standard includes information regarding the program and its implementation, and the investigation and resolution process.

The Standard identifies the Compliance Officer as the employee responsible for monitoring the program on a daily basis and performing periodic audits of its policies and procedures and outlines the additional duties of the position as pertains to the Standard. **Able Health Care Services, Inc.** shall respond to and investigate issues brought to its attention, via employee reports or company audits are detailed within. How actual or potential issues will be addressed in the present and what steps shall be taken to mitigate their impact in the future is also contained in the Standard. Policies regarding the appropriate methods for reporting issues to the overseeing agencies, and procedures related to overpayments are also included.

Included in the Standard are details of the training and education programs offered by **Able Health Care Services, Inc.** through which all affected individuals can ensure they understand their responsibilities and duties under the Standard, and the professional standards which **Able Health Care Services, Inc.** expects all its employees to conduct themselves. Training curricula will include information regarding compliance issues, expectations, and the compliance program operation. Sessions will be conducted on a periodic basis, as dictated by necessity, and will be included in employee orientations.

The Standard articulates the expectations for reporting compliance issues and assisting in their resolution and the procedures by which employees can fulfill these duties. Specifics of the reporting process - how employees may make reports and to whom - are outlined as well. Further enumerated are the lines of communication via which reports may be made and the protections afforded employees in this process. Information regarding the disciplinary policies of the Standard is included as well.

The Standard of Conduct shall be emended and updated as necessary. At such times **Able Health Care Services, Inc.** will notify all affected individuals that changes have been made, and the policy shall be made available for all employees to review if they wish. A staff member will be made available to assist any employee in accessing and understanding the changes. However, the final responsibility to comply with thestandards, policies and procedures contained in these Standard falls on each individual. As such all **Able Health Care Services, Inc.** affected individuals must take great care to understand the Standard and conduct themselves to the high standards expected of them.

Able Health Care Services, Inc. encourages **all affected individuals** to raise questions or concerns and seek clarification regarding these laws or related policy issues with the Compliance Officer or designated party.

This compliance program is more fully described and can be found in its entirety in the **Able Health Care Services, Inc.** Compliance Program Manual ("Compliance Manual"), available for review in the office of the CEO or Compliance Officer.

Able Health Care Services, Inc. expects that the Standard of Conduct will be a part of the daily activities of its all affected individuals. The Standard of Conduct is in addition to, and does not limit, specific policies and procedures of **Able Health Care Services, Inc.** All affected individuals must perform their duties in accordance with all such policies and procedures.

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

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

Failure to abide by the Standard of Conduct or the guidelines for behavior which the Standard of Conduct represents may lead to disciplinary action. Disciplinary action, up to and including termination, will be determined on a case-by-case basis. If **Able Health Care Services, Inc.** determines that a violation may have included criminal violations of law or regulation, **Able Health Care Services, Inc.** will seek the advice of counsel and cooperate with law enforcement authorities in connection with the investigation and prosecution of the offender.

While the duty remains the responsibility of each individual, **Able Health Care Services, Inc.** shall implement programs necessary to foster further awareness of applicable laws and regulations and to monitor and promote compliance of such laws and regulations. Any questions about the legality or propriety of any actions undertaken by, or on the behalf of **Able Health Care Services, Inc.** should be referred immediately to the Compliance Officer.

- **Application**

It is the duty of **Able Health Care Services, Inc.** and **all affected individuals** to uphold all applicable Federal, State and

Local laws, rules, regulations, and standards ("laws and regulations"). Each individual must be aware of the legal requirements and restrictions applicable to his or her respective position and duties. To ensure all incoming hires are aware of the scope of these regulations, a packet containing the laws will be made available to them at their orientation. **Able Health Care Services, Inc.** employees who conduct employee orientations have been educated in the specifics of the laws so they can answer any questions new hires may have. The Compliance Officer will be available in the event further assistance is required. Training and educational sessions will be conducted as needed, but no less frequently then annually, to ensure all employees are aware of their responsibilities under the law.

The following policies and procedures govern the application of this Standard of Conduct:

Reporting Procedures:

It is the policy of **Able Health Care Services, Inc.**to provide all its members, managers, officers, directors, staff, contractors, and agents with the means to report actual or perceived violations of Able Health Care Services, Inc.'s Standard of Conduct, Compliance Program, policies and procedures and applicable laws and regulations.

Anyone with knowledge of an event, occurrence or activity that appears to violate applicable laws and regulations, **Able Health Care Services, Inc.** Standard of Conduct or any of its policies or procedures should promptly communicate the actual or perceived violation to the Compliance Officer. Reports can be made anonymously by calling the compliance hotline at **516-394-3288.**

Non-Retaliation Non-Intimidation and Non-Retribution for Reporting In compliance with law, Able Health Care Services, Inc. policy prohibits retaliatory action, in any form, against any individual who makes a report, in good faith, to the agency or any governmental official or agency. The Federal False Claims Act, New York False Claims Act, and New York State Labor Law §740 specifically prohibit and provide remedies for such retaliatory action. Improper retaliation includes actual or threatened discharge, demotion, suspension, harassment, discrimination, or other adverse employment action. Activities protected against retaliation by Federal and State law and regulation include: disclosing or reporting - or making a threat of such - to a supervisor, the agency or to a governmental official or agency an activity, policy, or practice that is in violation of the law; testifying or providing information for a hearing, investigation or inquiry; initiating or assisting in any action or investigation; and/or objecting to or refusing to participate in any such illegal activity.

Able Health Care Services, Inc. has a zero-tolerance policy regarding retaliation, as **Able Health Care Services, Inc.** will aggressively investigate such matters and disciplinary action will be taken when appropriate. **Able Health Care Services, Inc.** expects its all affected individuals, managers, officers, directors, employees, contractors and agents to promptly report any possible instances of retaliatory action immediately to the CEO the Compliance Officer or other designated party.

All members, managers, officers, directors, employees, contractors and agents are required to promptly report all known or suspected violations of **Able Health Care Services, Inc.** billing and claims submission policies to the CEO, Compliance Officer, immediate supervisor or other designated party, in writing or through the anonymous telephone hotline at **516-394-3288.**

In the event that an issue does arise, it is the policy of **Able Health Care Services, Inc.**to promptly disclose all relevant information to any and all appropriate agencies.

Investigation and Resolution Processes:

It is the policy of **Able Health Care Services, Inc.**to make a prompt and thorough inquiry into any report concerning activity which may be contrary to applicable laws or regulations. Upon receipt of a report which suggests that improper conduct has occurred, and investigation either under the direction and control of legal counsel or the Compliance Officer shall be commenced. The investigative techniques used shall be implemented in order to facilitate the correction of any practices not in compliance with applicable laws or regulations.

Billing and Claims Reimbursement

It is the policy of **Able Health Care Services, Inc.**to comply with all relevant billing and claim reimbursement rules, regulations and requirements. All personnel involved in coding, billing and claims submissions must maintain high ethical standards and must know and adhere to all requirements for the health care industry, including all rules and regulations pertaining to coding, billing, claims submission and reimbursement, including, among others, Medicare and Medicaid regulations. All billing personnel are expected to attend training and education sessions. Billing personnel will be regulatory monitored to ensure that they are not engaging in any activity which may be fraudulent or abusive under the Medicare and Medicaid regulations. Billing department personnel and billing consultants will not offer any financial incentive to submit claims regardless of whether they meet applicable coverage criteria for reimbursement or accurately represent the services rendered.

All affected individuals are required to promptly report all known or suspected violations of billing policies to their immediate supervisor, Compliance Officer or CEO, or other designated party.

Able Health Care Services, Inc. and **all affected individuals** have a duty to create and maintain records and documentation in accordance with legal, professional and ethical standards. Any individuals whose job duties involve billing procedures, whether it be a part of their specific job description or in an executive role, shall ensure that all filings for reimbursement for care are reasonable, necessary, and appropriate, that services are provided by properly qualified persons, and that services are billed correctly and supported by adequate documentation.

All claims for reimbursement to government and to private insurance payers must be true and accurate and conform to all applicable laws and regulations. **Able Health Care Services, Inc.** and **all affected individuals** are prohibited from knowingly presenting or causing to be presented claims for payment or approval which are false, fictitious, fraudulent, or otherwise not in compliance with applicable laws and regulations.

Activities That May Violate the Law:

The following is a non-exhaustive list of examples of improper billing and claims activities:

- Billing for services or supplies that were not provided.
- Submitting a claim containing known false information or omitting material information.

- Filing a claim for services that are not medically necessary, or, if medically necessary, not to the extent rendered.
- Altering claim forms to increase payments.
- Arranging to get paid twice for the same service by billing two payers (i.e. duplicated billing);
- Revising a claim for a service that is not covered so it will be covered.
- Misrepresenting the services performed, the fee for the services, the date of the services, or the identity of the patient.
- Falsifying records to appear to meet conditions of participation or conditions of coverage.
- Omitting material information when making a claim or when submitting a written statement in support of such claim.
- Scheming with another person to manipulate claims and increase payments (e.g. upcoding);
- Using the adjustment payment process to generate fraudulent payments.
- Billing services over a period of days when all treatment occurred over one visit.
- Improperly completing or obtaining certificates of medical necessity (CMN);
- Providing incomplete, false, or misleading information about ownership of an agency.
- Repeatedly charging patients more than the permitted amounts or repeatedly violating a participation agreement or assignment agreement.
- Excessive charges for services or supplies.
- Improper billing practices, including submission of bills to Medicare instead of third-party payers which are primary insurers for Medicare beneficiaries.
- Increasing charges to Medicare beneficiaries but not to other patients.
- False or misleading documentation regarding services provided; and
- Billing for home health services without meeting the program requirements.

Fraud and Abuse:

Able Health Care Services, Inc. has adopted Policies and Procedures for preventing and detecting fraud, waste and abuse of the Federal health care programs, including Medicare and Medicaid. All members, managers, officers, directors, employees, contractors and agents must strictly follow these policies. These policies and procedures are available for review upon request. To review these policies and procedures, contact the Compliance Officer.

In accordance with the requirements of relevant false claims laws, and to further ensure the accuracy and appropriateness of claims submitted, **Able Health Care Services, Inc.** affected individuals, managers, officers, directors, employees, contractors and agents must strictly adhere to the following:

- The filing of claims for services not rendered is strictly prohibited. All documentation must be reviewed and checked for accuracy by clinical staff prior to submission. Furthermore, billing staff must review the completeness and check for inconsistencies in the documentation supporting the bill prior to submitting a claim. Diagnosis and procedure Standards reported on claims must be based on the medical record and other documentation and must comply with appropriate coding guidelines. Coding must accurately describe the

services ordered by the physician and performed by the agency.

- The filing of claims and services rendered that were not medically necessary. Documentation submitted by the staff must record the activity leading to the record entry, the identity of the individual providing the service, and any information needed to support medical necessity and other reimbursement coverage criteria. All clinical and billing staff shall communicate effectively to ensure that documentation is consistent.
- Detect and prevent the submission of any claim which contains false information.
- Detect and prevent any claim for inadequate or substandard services. Clinicians must review services rendered and supporting documentation to determine that the level of services provided is adequate to support a claim for payment.

All documentation utilized to support claims for reimbursement shall be periodically reviewed by the clinical and billing staff, in coordination with the Compliance Officer or other designated party, to assess adherence to these standards. The agency will maintain a process for pre- and post-submission review of claims to ensure that claims submitted for reimbursement accurately reflect medically necessary services actually provided, are supported by sufficient documentation, and are in conformity with any applicable coverage criteria for reimbursement.

Able Health Care Services, Inc. expects its **all affected individuals** to refrain from any conduct which may violate applicable federal and state laws and regulations, with special emphasis on those related to fraud and/or abuse.

These laws generally prohibit:

- The transfer of anything of value in order to induce the referral of patients or any government program business (I.e., Medicare, Medicaid and other federal or state health care programs); and
- The making of false representations or the submission of false, fraudulent or misleading claims to any government entity or third-party payer, including claims for services not rendered, claims which characterize the service differently than the service actually rendered, or claims which do not otherwise comply with applicable program or contractual requirements.

More specific guidance with respect to laws and regulations applicable to fraud and abuse can be found in **Able Health Care Services, Inc** Compliance Manual. A compendium of applicable federal and state laws applicable to the fraud and abuse area will be included in the orientation package and will be available to **all affected individuals** by contacting the HR department or the Compliance Officer.

Retention of Records:

It is the policy of **Able Health Care Services, Inc. that all affected individuals** associated with the agency maintain and preserve all documents, including compliance, business, and medical records, and secure them against loss, destruction, unauthorized access, unauthorized reproduction, corruption or damage.
Able Health Care Services, Inc. will also comply with regulations concerning document retention periods.

The primary components of **Able Health Care Services, Inc.** record maintenance, access and retention policies and procedures include, but are not limited to, the following:

- Records will only be accessible by authorized personnel on a need-to-know basis or legally authorized individuals, and in strict conformance with applicable federal, state, and local laws and regulations, including those relating to privacy and confidentiality.
- Patient medical records may only be accessed by authorized individuals and personnel. Questions as to whether medical records should be released and/or distributed should be directed to the agency's Privacy Officer and/or Compliance Officer as they arise.
- Records will be stored in a systemized manner that preserves confidentiality and takes into consideration environmental elements. Security of electronic records shall be in compliance with HIPAA regulations.

- **Administration**

The Compliance Officer shall be accountable for the Compliance Policy; its content, implementation and application, the response to - and investigation of - reports, the ongoing monitoring, periodic auditing and updating of the policies contained therein and its lawfulness, are responsibilities attached to that position.

The Compliance Officer is further tasked with the duty to report compliance issues to the governing authority and maintain compliance to the applicable laws.

The monitoring of the compliance policy shall include the following daily tasks:

- Frequent checking of the compliance hotline voicemails.
- Observation of the **Able Health Care Services, Inc.** working environment to uncover conditions which may foster or facilitate the occurrence of violations; and
- Assessing the efficacy of agency responses to and investigations and the resolution of, reports;

Able Health Care Services, Inc. shall conduct periodic audits designed to address relevant compliance issues: audits will generally be conducted internally but will be referred to external investigative bodies when deemed necessary. Audits shall be conducted in four stages:

- Past occurrences shall be examined to evaluate the efficacy and timeliness of agency responses. Further assessments shall be conducted to uncover the root causes of occurrences. In addition, the use of metrics shall be employed to measure and compare: the number of reports made by employees as opposed to those uncovered by management; the use of each reporting outlet; and the number of issues that were uncovered prior to actual violations having occurred and those which were only brought to light after a violation had occurred.
    - Self-evaluations shall be conducted to identify future risk areas.
    - Procedures and policies shall be amended to address issues uncovered in the prior steps; and
- Upon its completion, the auditing process itself will be evaluated, and augmented as needed. Particular attention shall be paid to identifying and addressing potential conflicts of interest among the Compliance Staff which may affect their ability to effectively conduct future audits.

- **Training and Education**

  Able Health Care Services, Inc. employees will receive comprehensive training and education regarding compliance issues, expectations, and the compliance program operation. The compliance program will be explained in depth to all incoming employees as part of their orientation. Current **Able Health Care Services, Inc.** staff including members, managers, officers, directors, employees, contractors, agents, and other health care practitioners shall be required to participate in a minimum of one (1) hour of basic compliance training and education annually. Attendance at all sessions is mandatory and failure to participate will result in disciplinary action, up to and including termination. Individuals involved in specialty fields such as coding, claims development and billing will require additional compliance training and education addressing documentation, claims, billing, and fraud and abuse issues. Additional training attendance may be required as part of an employee performance improvement measure or action plan. In addition to periodic training and in-service programs, **Able Health Care Services, Inc.** will notify it's all affected individuals whenever compliance standards change and any relevant documentation will be made available to all.

- **Professional and Ethical Standards**

As professionals, **all affected individuals** have a duty to support **Able Health Care Services, Inc.** goals to provide nursing and other home care services of the highest quality that respond to the needs of our patients. The services provided must be reasonable and necessary for the care of each patient, and such care must be provided by properly qualified individuals. All such care must be properly documented as required by law and regulation, payer requirements, professional standards and the policies and procedures of **Able Health Care Services, Inc.**

Able Health Care Services, Inc. and **all affected individuals** shall conduct all activities in accordance with the highest ethical standards of their respective professions at all times and in a manner which shall uphold **Able Health Care Services, Inc.** reputation and standing in the community it serves.

- **Confidentiality**

Able Health Care Services, Inc. and **all affected individuals** are in possession of, or have access to, a wide variety of confidential and sensitive information. Pursuant to the relevant laws, statutes, rules and regulations, among them the provisions of HIPAA regulations as mandated by Federal Law, dissemination of any confidential information, patient information especially, to any unauthorized persons is strictly forbidden.

It is the duty of **Able Health Care Services, Inc.** and **all affected individuals** to protect the privacy rights of the patients. **Able Health Care Services, Inc.** and it's all affected individuals shall maintain the confidentiality of patient medical records and information, as well as proprietary information, by actively protecting and safeguarding such information in a manner designed to prevent the unauthorized disclosure of such information.

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

- **Business Practices**

Able Health Care Services, Inc., business practices must be conducted with honesty and integrity and in a manner, that upholds **Able Health Care Services, Inc.'s reputation** with patients, payers, vendors, competitors, and the community.

Able Health Care Services, Inc. expects all affected individuals to be loyal to Able Health Care Services, Inc. interests. All affected individuals should not use their position to profit personally or to assist others in profiting in any way at the expense of **Able Health Care Services, Inc.** All affected individuals must refrain from activities which create conflicts of interest with **Able Health Care Services, Inc.** or give the appearance of impropriety.

All affected individuals involved in business transactions or behalf of **Able Health Care Services, Inc.** shall not offer or pay, nor solicit or receive any gifts, favors or other improper inducements in exchange for influence or assistance in a transaction or the referral of business. If there is any doubt or concern about whether specific conduct or activities are ethical or otherwise appropriate, the doubt or concern should be referred immediately to an individual's supervisor, the CEO, or the Compliance Officer.

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

- **Conflicts of Interest**

It is the policy of **Able Health Care Services, Inc.** that **all affected individuals** avoid any and all activities that conflict with their responsibilities and obligations to Able Health Care Services, Inc. and its Patients.

The policies and procedures relating to conflicts of interest include, but are not limited to, the following:

- All affected individuals must not have an interest in or serve as director, officer, manager, or member of any entity in competition with **Able Health Care Services, Inc**. without permission.
- Any members, manager, officer, director, employee, contractor or agent who performs work or renders services for any competitor of **Able Health Care Services, Inc**. or for any organization which does business with or seeks to do business with **Able Health Care Services, Inc** .outside of the normal course of his or her employment or other engagement with **Able Health Care Services, Inc.** shall notify the Corporate Compliance Officer or CEO.
- Business with any **Able Health Care Services, Inc.** vendor, supplier, contractor, or agency, or any of their officers or employees that is not conducted on behalf of Able Health Care Services, Inc.is prohibited, unless previously authorized by the Compliance Officer or CEO.
- All affected individuals shall not permit their names to be used in any fashion that would tend to indicate a business connection with any organization which does business with or seeks to do business with **Able Health Care Services, Inc**. without the prior approval of the Compliance Officer or CEO.
- **Able Health Care Services, Inc**. shall not be represented by a member, manager, officer, director, employee, contractor or agent in any transaction in which he or she or an immediate family member has a personal

financial interest.

- All affected individuals should not discuss any confidential information with anyone outside of **Able Health Care Services, Inc.** This confidential information includes, but is not limited to, personnel data, patient lists, clinical information, financial data, research data, techniques, computer software, and information with a copyright, financial results or business dealings.
- All affected individuals shall not accept any gifts, including discounts, from prospective or current suppliers and/or contractors.
- All affected individuals shall not engage in any activities or outside interests that influence their ability to make objective decisions in the course of their job responsibilities.
- All affected individuals are expected to disclose potential conflicts of interest involving themselves or their immediate family members (spouse, parents, brothers, sister, and children) to the Compliance Officer or CEO using the agency's "Conflict of Interest Disclosure Statement" form.

- **Employment Practices**

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

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

Able Health Care Services, Inc.is committed to providing a healthy and safe workplace. Able Health Care Services, Inc. and **all affected individuals** will comply with federal, state, and local laws and regulations that promote the protection of health and safety. All affected individuals are expected to report workplace injuries or any situation presenting a danger of injury.

Employee and Other Association with the Agency Screening:

It is the policy of **Able Health Care Services, Inc.** to ensure that its members, managers, officers, directors, employees; agents and independent contractors are properly screened in accordance with agency procedures, and in compliance with applicable laws and regulations, prior to employment or engagement with **Able Health Care Services, Inc**. and periodically during their tenure with **Able Health Care Services, Inc.** Offers of employment or engagement, as well as continued employment and engagement, shall be contingent upon satisfactory screening.

Individuals Excluded from Federal and State Health Care Benefits Programs:

It is the policy of **Able Health Care Services, Inc.** not to enter into employment, contractual or business arrangements, in any capacity, with individuals or entities that are barred or excluded from participating in federal or state health care benefit programs. This shall be accomplished through screening programs, which include reviewing the U.S. Office of Inspector General's (OJG) List of Excluded Individuals/Entities (LEJE), the Office of Medicaid Inspector General's

Providers Not Allowed to Bill list and other applicable sources of such information prior to hiring, engaging or otherwise transacting business with any person or entity, and by conducting such review periodically after employing, contracting with or otherwise engaging any individual or entity.

- **Employee Compliance Verification**

Able Health Care Services, Inc. verifies employee compliance as follows:

- **Home Health Aide Training Certificates are verified with the training school by fax or mail and on the Home Care Registry.**
- **Social Security Numbers are verified with the Social Security Administration.**
- **All employees must complete an application including work history.**
- **All employees must have to verified letters of reference preferably with a work reference.**
- **All employees will be checked through the OMIG website.**
- **All employees must have a physical exam with a toxicology screen (if applicable), Rubeola and Rubella titers and a TB screening before beginning work.**
- **All employees must complete an orientation before beginning work.**
- **All employees must complete 12 hours HHA's and 6 hours for PCA's in service training.**
- **All employees must submit proof of an annual health assessment.**
- **All employees must have a photo ID**

Please note that nothing in this Standard of Conduct is intended to nor shall be construed as providing any additional employment or contract right to all affected individuals or other persons.

Employees may stop by in person and speak to the Compliance Officer Rivka Shapiro or call the Confidential Hotline number **516-394-3288**

Able Health Care Services, Inc.

FEDERAL & NEW YORK STATUTES RELATING TO FILING FALSE CLAIMS

I. FEDERAL LAWS

False Claims Act (31 USC §§3729-3733)

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

> (a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government; . . or (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government, is liable to the United States Government for a civil penalty of not less than *$10,781 and not more than $21,563*, plus 3 times the amount of damages which the Government sustains because of the act of that person.
>
> (b) For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

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

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

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

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

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

II. NEW YORK STATE LAWS (Amended June 17, 2020)

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

A. CIVIL AND ADMINISTRATIVE LAWS

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

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

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

Social Services Law §145-b False Statements

It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other

fraudulent scheme or device. The State or the local Social Services district may recover three times the amount incorrectly paid. *In addition, the Department of Health may impose a civil penalty of up to $10,000 per violation. If repeat violations occur within 5 years, a penalty up to $30,000* per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.

Social Services Law §145-c Sanctions

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

A. CRIMINAL LAWS

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

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

b. Any person who, with intent to defraud, presents for payment and false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation or knowingly submits false information 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,

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

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

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

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

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

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

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

Penal Law Article 177, Health Care Fraud,

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

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

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

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

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

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

II. WHISTLEBLOWER PROTECTION

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

The FCA provides protection to *qui tam* relators who are discharged, demoted, Suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment because 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 because of the discrimination, including litigation costs and reasonable attorneys' fees.

NY False Claim Act (State Finance Law §191)

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

New York Labor Law §740 (Amended October 28, 2021 effective January 26, 2022 S4394A/A.5144A)

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

New York's Amended Healthcare Whistleblower Law (June 17, 2020)

The new amendment expands the statutory protections to encompass complaints about workplace safety issues. As

amended, the statute prohibits retaliatory employment action because a healthcare employee discloses or threatens to disclose, or objects to or refuses to participate in, "improper quality of workplace safety," which means violations that relate to matters that "may present an unsafe workplace environment or risk of employee safety or a significant threat to the health of a specific employee." Additionally, the amendment expands protection to encompass disclosures to news and social media outlets about both patient and employee health and safety issues.

As under the current law, a health care employee may seek enforcement in a civil action for an injunction, reinstatement, with back pay and benefits, and legal costs. The employee generally must bring the matter to the employer's attention and give the employer a chance to correct the practice. This notice requirement does not apply, however, to a situation involving an imminent threat to public health or safety, to the safety or health of a specific patient – or, under the amendment, of a specific healthcare employee – in cases where the employee reasonably believes that a complaint would not result in correction.

The New Expanded Whistleblower Law effective January 26, 2022, S4394A/A.5144A)

The new expanded law significantly bolsters protections for private-sector employees alleging retaliation and exposes employers to significant additional liability.

Expanded Definition of "Employee"

The amended law adds "former employees" and "independent contractors" to those "employees" permitted to bring whistleblower claims.

Change to Reasonable Belief Standard

The amended **law removes the previous requirement** that there be an actual violation of the law. Employees are now protected if they "reasonably believe" an employer's activity or conduct is:

a. in violation of a "law, rule or regulation," including executive orders and judicial or administrative decisions, rulings, and orders; or

b. (ii) "poses a substantial and specific danger to the public health or safety."

Expansion of Protected Activity

The **prior law** required that employees first report violations to their employers before disclosing violations to a public body, thereby providing a reasonable opportunity to correct the alleged violation. The **amended law** now requires employees to make a "good faith effort" to notify their employer. Employer notification is not necessary if**:**

(i) there is imminent and serious danger to public health.

(ii) the employee reasonably believes reporting of the violation to the employer would result in the destruction of evidence, concealment, or harm to the employee; or

(iii) the employee reasonably believe that their supervisor is already aware of the violation and will not correct it.

Expansion of Prohibited Retaliatory Conduct

The amended law expands the definition **of prohibited "retaliatory actions**" to include:

(i) adverse employment actions against current employees, such as discharge, suspension, or demotion.

(ii) actions or threats that would adversely impact a former employee's current or future employment; or

(iii) contacting or threatening to contact immigration authorities on an employee or their family member.

Additional Remedies, Longer Statute of Limitations, and Right to Jury Trial

The amended law expands the remedies potentially available to whistleblowers to include front pay, civil penalties not to exceed $10,000, and punitive damages (in addition to back pay). The statute of limitations is extended from one year to two years, and whistleblowers now have the right to a jury trial.

Notification

Employers must notify employees of their rights under the whistleblower law by posting a notice in a conspicuous place.

Implications

New York's expanded whistleblower law exposes New York employers to a dramatically altered regulatory environment. Internal compliance mechanisms as well as whistleblower policies and procedures are thus of even greater importance than before.

New York Labor Law §741

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

If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of $10,000 on the employer. ***The term "improper quality of patient care," as defined in § 741, means violations that relate 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.***

F. Compliance Policies

1. **Response to government inquiries**
2. **Investigating compliance concerns and complaint form**
3. **Compliance responsibilities of management and directors**
4. **Compliance training and education**
5. **Compliance communication**
6. **Prohibition against employing or contracting with ineligible persons**
7. **Federal false claims act**
8. **Non-retaliation, non-retribution non-intimidation for reporting**
9. **Detecting and preventing fraud, waste, and abuse**
10. **Conflict of Interest**
11. **Check for Excluded Providers**
12. **Self-disclosure policy**
13. **Social Media**
14. **Disciplinary Actions**
15. **Billing and Claim Development**
16. **Sanctions**
17. **Home Care Worker Attendance and Fraud Prevention Policy**
18. **Attendance Verification**

Policy 1

Response to Governmental Inquiries

PURPOSE:

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

POLICY:

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

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

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

Investigating Compliance Concerns **Policy 2**

PURPOSE:

To provide guidance on the requirements for investigating and reporting compliance concerns *that should be performed to insure proper investigation of any reported and non-reported concerns. This policy articulates the expectations for assisting in the resolution of compliance issues for all affected individuals.*

POLICY:

A. **Requirements for Managers and Directors**.
Each manager and director is responsible for investigating promptly any report or reasonable indication of violations of this Program, the Standard of Ethical Conduct, center's policies or procedures or violations of applicable law or regulation by employees or others within his or her supervision. Any report or reasonable indication of a violation of law or regulations must be reported to the Compliance Officer prior to initiation of any investigation. In the case of other violations, the managers and directors should consult with the Office of Human Resources.

B. **Compliance Office Investigation**.
In any case where there is a report or reasonable indication of a violation of applicable laws or regulations, the Compliance Office shall have the primary responsibility for conducting the investigation of the alleged situation or problem under the direction of the Counsel. In undertaking investigations, the Compliance Officer shall consult with the respective manager and/or member of the Compliance Committee who has responsibility for the unit. The Compliance Officer may utilize other organization's employees (consistent with appropriate confidentiality), outside attorneys, outside accountants and auditors or other consultants or experts for assistance or advice.

NOTE: *"all affected individuals are expected to assist in the investigation and resolution of compliance issues"*. The purpose of the investigation is to determine whether or not there is reasonable cause to believe an individual(s) may have knowingly or inadvertently participated in violations of applicable laws or regulations; to facilitate corrective action; and to implement procedures necessary to ensure future compliance.

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

D. **Process.**
The Compliance Officer, or his or her designee, may conduct interviews with any agency employee and with other persons and may review any agency document including but not limited to those related to the

claim development and submission process, patient records, e-mail and the contents of computers and word processors, and may undertake other processes and methods as the Compliance Officer deems necessary.

E. **Documentation.**

The Compliance Officer may prepare a report which:

1. Defines the nature of the situation or problem
2. Summarizes the investigation process
3. Identifies any person whom the investigator believes to have acted deliberately or with reckless disregard or intentional indifference, particularly toward the Medicaid laws, regulations and policies,
4. Estimates the nature and extent of the resulting overpayment by the government or another entity, if this is possible.

F. **Response.**

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

If Investigating Compliance Concerns for Possible Criminal Activity and in the event the investigation reveals or uncovers what appears to be criminal activity on the part of any employee, the following action will be taken:

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

A summary of the results of the investigation shall be sent for appropriate disciplinary action to the department director or manager (or the appropriate assistant or associate CEO if the director or manager is implicated) of any employee whose conduct appears to have been intentional, willfully indifferent or with reckless disregard for Medicare/Medicaid or other applicable laws and regulations. Pending disciplinary action, any such employee may be removed from any position with oversight of or impact upon the claim's development and submission process. State and federal agencies will be notified as deemed appropriate by legal counsel, the CEO and the Board. Agency may attempt to negotiate a voluntary disclosure agreement prior to the disclosure.

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

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

The expectation for prompt and thorough resolution in the investigating of compliance concerns, *additional* education will be undertaken with appropriate employees to prevent similar future problems.

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

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

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

G. **Reports by Compliance Officer.**
The Compliance Officer periodically shall furnish information (bearing in mind issues of confidentiality) about such investigations to the CEO, the Compliance Committee at its regular meetings and periodically to the Audit and Compliance Committee of the Board of Directors.

Policy 3

Compliance Responsibilities of Management and Directors

PURPOSE:

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

POLICY:

Each director or manager of an affected department is responsible for:

1. Implementing and maintaining compliance standards and policies and procedures and manuals specific to their departments in consultation with the Compliance officer.

2. Providing training to all employees on compliance standards, policies, procedures, laws and regulations applicable to employees of the department in consultation with the Compliance officer.

3. Enforcing this Program, the Standard of Ethical Conduct, the organization's policies and procedures, and applicable laws and regulations.

4. Investigating reports or reasonable indications of violations of this Program, the Standard of Ethical Conduct, organizations policies or procedures.

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

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

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

Policy 4

Compliance Training and Education

PURPOSE:

To provide guidance on the training required of: ***"all affected individuals associated with the provider shall receive training at orientation and periodically thereafter on compliance issues, expectations and the operation of the compliance program. All affected individuals include*** *the* ***Board of Directors,*** *Administrator, any associate and assistant administrators, department directors and managers, supervisors and any other person or individual hired by and in the paid service of the agency.*

POLICY:

A. **Necessity**.

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

B. **Initial Education.**

Mandatory orientation for ***all affected individuals*** orientation *will be conducted within 90 days of hiring* and a hiring package will provide an overview of fraud and abuse laws, a presentation on the importance of coding and billing issues, including research related billing, a summary of the standards of conduct, an explanation of the elements of the Compliance Program, including the complaint or reporting process, and highlight the agency commitment to integrity in its business operations and compliance with applicable laws and regulations.

C. **General Rules**.

Periodically, ***all affected individuals*** will be retrained (i) in the agency Compliance Program; (ii) the fraud and abuse laws as they relate to the claim development and submission process and center business relationships; (iii) relevant Medicaid and other federal and state requirements; and (iv) the consequences both to the agency and to individuals of failing to comply with applicable laws and regulations. Such training must emphasize the importance of the Compliance Program and the agency's commitment to honesty and integrity in its business dealings.

D. **Substantive Rules**.

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

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

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

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

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

E. **Amount of Training**.

All affected individuals need not have the identical amount of training and education, nor will the focus of training and educational efforts be the same for all employees. Targeted training and education will be provided to employees whose actions may affect the accuracy of claims submitted to the government.
The actual amount of training should reflect necessity, an analysis of risk areas or areas of concern identified by the center or the Office of the Inspector General, the agency compliance experience and the results of periodic audits or monitoring.

F. **Documentation.**

The training provided to ***all affected individuals*** shall be documented. The documentation shall include the date and a brief description of the subject matter of the training activity or program.
Documentation is important and will be retained on file for a minimum of seven (7) years.

G. **Failure to Attend.**

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

Policy 5

Compliance Communication

PURPOSE:
To provide guidance on the open communication that is a necessity in maintaining an effective compliance program and reducing any potential for fraud abuse and waste.

POLICY:

A. **Questions.**
At any time, any ***all-affected individuals*** may seek clarification or advice from the Compliance Officer or members of the Compliance Committee in the event of any confusion or question with regard to this Program or any element of this Program or any organizational policy or procedure related to this Program. Questions and responses should be documented and, if appropriate, shared with other employees for informational and educational purposes.

All affected individuals are encouraged to contact the Compliance Officer and any member of the Committee and for this purpose the Compliance Officer will develop or cause to be developed publicity and notices regarding his or her name, location and e-mail address and the names of members of the committee and their location.

B. **Reporting.**
All affected individuals or physicians who are aware of or suspect acts of fraud, abuse or waste or violations of the standards of conduct are required to report such acts or violations.

Several independent reporting paths are available:

1. ***All affected individuals*** may but are not required to report to their supervisor or department director or manager. If a supervisor or manager receives such a report, he or she will promptly pass on the report to the Compliance Officer or member of the Compliance Committee.

2. ***All affected individuals*** or physicians may report directly to the Compliance Officer or to a member of the Compliance Committee.

3. The agency has a compliance officer **Rivka Shapiro** or the Confidential Hotline number **516-394- 3288** ***all affected individuals*** may use this line anonymously at any time, day or night. The phone number of the Helpline has been posted at various places throughout the center and employees will be reminded of the number and of their duty to report actual or suspected wrongdoing through training, posters, the intranet and other methods. Employees are encouraged to use the Helpline.

4. ***All affected individuals*** may also call the hotline of the Office of the Inspector General of the Health and Human Services Department, 1-800-HHS-TIPS (447-8477) the NYS Office of Medicaid Inspector General

Compliance main line at 518-408-0401 or the Fraud Hotline at 1-877-87-FRAUD. The Compliance Officer will post this number in one or more prominent locations in the organization.

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

D. **Non-Retaliation.**
There will be no reprisals or retaliation against any employee who in good faith reports acts or suspected acts of fraud, abuse or waste or violations or suspected violations of the standards of conduct or other wrongdoing or misconduct. However, an employee who makes an intentional false report or a report not in good faith may be subject to disciplinary action.

E. **Documentation.**
The Compliance officer will maintain a record of reports of violation of this Program, or of the standards of conduct, or of relevant law or regulations, received by the Compliance Officer. The compliance Officer will periodically furnish a summary of such reports to the CEO, the Compliance Committee and the Audit and Compliance Committee of the Board of Directors.

Policy 6

Prohibition against Employing or Contracting with Ineligible Persons

POLICY:

In order to avoid the imposition of civil monetary penalties we must ensure compliance with regulations applicable to the federal programs. Therefore, it is the policy of the organization:

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

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

DEFINITIONS:

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

PROCEDURE:

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

RESPONSIBILITES:

1. Human Resources is responsible for performing the initial exclusion checks prior to hiring or rehiring of staff.

2. Nurse Recruitment is responsible for performing the exclusion checks.

3. The Compliance Officer is responsible for:

    a. Performing monthly exclusion checks for all employees

    b. Notifying the Director of Human Resources or designee upon learning of an employee who is an Ineligible Person.

    c. Performing exclusion checks for prospective vendors.

    d. Performing monthly exclusion checks for all current vendors

    e. Works with counsel to terminate the contract of a vendor who becomes an Ineligible Person.

DOCUMENTATION:

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

Policy 7

FRAUD AND ABUSE The False Claims Act

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

SCOPE:
Board of Directors, Medical Staff, Management, Employees and Parties who do business with the agency.

FORMS: Conflict of Interest

DEFINITIONS:

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

Medicaid Integrity Program – Title XIX of the Social Security Act created as part of the Deficit Reduction Act of 2005 to halt the diversion of critical funds and the misuse of taxpayer funds used for providing healthcare.

Anti-Kickback – provides a critical effective tool for criminal enforcement of health care laws.

Knowing and knowingly – having actual knowledge of information, acts of deliberate ignorance of truth or falsity of the information or acts of reckless disregard of the truth.

PROCEDURE:
Any person who knowingly presents, uses, conspires to defraud, is in the possession, custody or control of information and uses that information for the inappropriate benefit of oneself or the organization is liable to the United States Government for a civil penalty of not less than *$10,781 and not more than $21,563* plus 3 times the amount of damages which the Government sustains because of the act of that person. Except if:

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

The court may assess not less than 2 times the amount of damage the Government sustains because of the act of the person. Such persons will be subject to disciplinary policies.

Policy 8

Non-Retaliation, Non-Retribution and Non-Intimidation for Reporting

PURPOSE:

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

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

POLICY:

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

Anyone who is involved in any act of ***retaliation, retribution or intimidation*** against an employee that has reported suspected misconduct in good faith will be subject to disciplinary actions as prescribed in the ***Human Resources Manual***.

PROCEDURE:

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

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

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

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

If an employee reports a concern regarding his or her own inappropriate or inadequate actions, reporting those concerns does not exempt him or her from the consequences of those actions.

Prompt and forthright disclosure of an error by an employee, even if the error constitutes inappropriate or inadequate performance, will be considered a positive constructive action by the employee.

Policy 9

DETECTING AND PREVENTING FRAUD, WASTE, AND ABUSE

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

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

Implementation:

Investigation

A. Purpose of Investigation.

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

B. Conduct of Investigations.

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

C. Investigation Process.

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

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

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

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

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

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

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

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

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

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

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

Misconduct or Suspected Criminal Activity.

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

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

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

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

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

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

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

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

Policy 10

Conflict of Interest Policy

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

Conflicts of Interest Defined

Conflicts of interest include, but are not limited to:

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

Annual Disclosure of Potential Conflicts: Management, Committee Members and Supervisory Staff

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

Ongoing Disclosure of Potential Conflicts: All Leaders

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

- Proposes to enter into any transaction with the organization for the sale, purchase, lease or rental of property,
- Proposes to render or employ services, personal or otherwise, to the organization, or
- May be seen as competing with the interests or concerns of the organization, such shall forthwith give the Board of Directors of the organization notice of such interest or relationship and shall, therefore, refrain from voting or otherwise attempting to affect any decision for the organization to participate or not to participate in such transaction and the manner or terms of such participation.

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

Dissemination of Conflict-of-Interest Policy

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

COMPLIANCE PROGRAM

ACKNOWLEDGMENT OF RECEIPT

EMPLOYEE AND CONFLICT OF INTEREST DECLARATION

Employee's Name (Print) _____

Department_____

I acknowledge that I have received and read the Conflict-of-Interest Policy.

I further acknowledge that I will abide by the "Organizations Compliance Plan" and will refrain from any behavior that may result in a conflict of interest regarding the organization's established ethical standards. I will also recuse myself from any voting in an area that is potentially deemed a conflict of interest where I may be rewarded with personal gain.

Conflicts to Note: Currently I have ownership in the following organizations that **Able Health Care Services, Inc.** does business with:

1. _____
2. _____

_____ _____

Signature Title / Date

Return this signed acknowledgement to Human Resources. This form, or

a copy of it, will remain in the Personnel file.

Policy 11

Check for Excluded/Terminated Employees/Contractors

PURPOSE:

To implement a policy that will incorporate the requirements of the Federal Office of the Inspector General and the Office of the Medicaid Inspector General, Corporate Compliance Programs.

POLICY:

It is the policy of the organization to conduct on a periodic basis, subsequent to hire and or contracting for services a background check that includes a review for exclusion from the Medicare and Medicaid programs. Employing or working with contractors that have an unfavorable status with government agencies can result in the removal from the Medicare and Medicaid programs.

Reference: OMIG Work plan www.omig.state.ny.us Federal OIG list http://oig.hhs.gov/fraud/exclusions.asp GSA exclusion list www.sams.gov

PROCEDURE:

Initial Hiring of Staff and Contractors: Human Resources and Administration during the conduct of the normal hiring procedures will obtain clearances and background checks. In addition to this and other normal hiring procedures, HR/ Finance will be responsible for conducting an exclusion test from government sponsored programs. Utilizing **ALL** the websites noted above.

Current Employees and Contractors: Human Resources will conduct on a periodic basis a search on **ALL** the above web sites for any exclusion that may warrant the termination of employment or contract with outside vendors.

DOCUMENTATION AND REPORTING:

Human Resources will maintain documentation of their reviews and report to the Compliance Officer the status of these reviews and any adverse outcomes. These remarks will be summarized by the Compliance Officer for the report to the Board on a quarterly basis.

Policy 12

Self- Disclosure Protocol

PURPOSE: It is the policy of this organization *address reporting compliance issues other than financial to the NYS Department of Health or the NYS Office of Medicaid Inspector General and to self-disclose* any credit balances, or other areas where the organization was paid erroneously, this upon discovery as required by the Health Reform Act and the NYS Office of the Medicaid Inspector General.

POLICY:

OIG disclosure:

The organization will disclose as required by the OIG, within 60 days after an "overpayment is identified" as follows to the OIG' Assistant Inspector General via electronically to 1877SRDP@ems.hhs.gov

Description of actual or potential issue:

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

Financial analysis:

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

Certification:

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

OMIG self-disclosure:

Under the ACA Medicare/Medicaid overpayments must be reported and returned to OMIG by the later of:
(a) the date which is 60 days after the date on which the overpayment was identified; or (b) the date any corresponding cost report is due, if applicable. Each incident stands on its own and considered separately. *Claims covered by self-disclosure will not be audited again for the same issue and dates of service.*
*There is a **Six-year** look-back period! The provider performs the audit not OMIG! Extended repayment terms possible for demonstrated hardship! No penalties or sanctions!*

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

- Substantial routine errors

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

Submission Guidelines:

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

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

- The time period the claims error encompasses
- Actions taken to stop the error and prevent recurrence
- Personnel involved in the error occurrences, those who discovered the problem, and those involved
- Rectifying the problem
- Legal and Medicaid program rules implicated
- Disclosure contact person name, phone number, and both correspondence and email addresses

Filing of Self Disclosure is performed by the Administrator, CFO of the company or Attorney representing the provider or the corporate compliance officer. **The Self-Disclosure Statement shall be signed by the person's compliance officer, where the person is a required provider pursuant to SubPart 521-1 of this Part. Where the person is not a required provider pursuant to SubPart 521-1 of this Part, the Self-Disclosure Statement may be signed by one of the following, the person's chief executive officer, chief operating officer, a senior manager of the person, or the person, where the person is a sole practitioner.**

(i) An estimate of the amount of the overpayment. The person shall calculate the estimated overpayment and provide information to OMIG which supports the calculated overpayment amount. OMIG has the sole discretion to approve the methodology used for the calculation and to determine the overpayment amount and interest if applicable.

(ii) A detailed explanation of the reason the person received the overpayment, which shall, at a minimum include: (a) a description and explanation of the circumstances that gave rise to the overpayment; (b) how the circumstances giving rise to the overpayment were discovered; (c) the date the overpayment was identified; (d) how the person calculated the amount of the overpayment;
(e) the date(s) the overpayment(s) were received; and (f) the action taken to correct the error which caused the overpayment.

(iii) the person's contact information.

(iv) data file, in the form and format specified by OMIG.

(v) whether the person is requesting to repay through installment payments.

(vi) whether the person is requesting the waiver of any applicable interest.

(vii) the person's agreement to return the full amount of the overpayment and interest if applicable, as determined by OMIG; and

(viii) any other data, documentation, or information OMIG shall require through the issuance of guidance or in response to its review of the submission.

A person requesting to repay through installment payments may be required to furnish OMIG with financial records and other documentation in support of the request. OMIG shall approve or reject a person's request based on a review of the person's financial documentation, participation in the MA program, and any other factors OMIG identifies.

If OMIG determines that no overpayment was made, it shall notify the person in writing of the determination.

A person who has received and disclosed an overpayment or has received notice of the overpayment amount due, and interest if applicable, pursuant to section 521-3.5 of this SubPart is required to return the overpayment and interest if applicable, in accordance with section 521-3.3 of this SubPart

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

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

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

(2) The person shall remit the full amount of the overpayment and interest within fifteen (15) days of the date of OMIG's notification of the determination of the amount of the overpayment, and interest, unless the person has been approved by OMIG to repay the overpayment through installments.

(3) Where a person has been approved to repay the overpayment and interest through installment payments, OMIG's notification of the amount of the overpayment shall also include an SDCA which the person shall execute and return to OMIG within the timeframe specified in paragraph (3) of subdivision (e) of section 521-3.4 of this SubPart. (i) In order to remain eligible to participate in OMIG's Self-Disclosure Program the person must comply with all the terms of the SDCA, including the schedule of repayments.

(4) Notwithstanding any provision tolling the deadline to report, return and explain, in no event shall the person be required to repay the full amount of the overpayment and interest prior to the expiration of the deadline to report, return and explain, as set forth in paragraph (1) of subdivision
(b) of section 521-3.3 of this SubPart. (b) The full amount of any overpayment shall become

immediately due and payable, with interest, if: (1) the person fails to remit payment, either for the full amount of the overpayment or any scheduled installment payment pursuant to the terms of an SDCA, or (2) participation in the Self-Disclosure Program is terminated in accordance with the provisions of subdivision (f) of section 521-3.4 of this SubPart. (c) Where the person is required to pay interest, interest shall accrue on the amount of the overpayment as determined by OMIG, in whole or in part, in accordance with the provisions of section 518.4 of this Title. (d) OMIG may recover the overpayment in accordance with Part 518 of this Title or by any other mechanism authorized by law.

Enforcement. (a) A person who fails to report, return and explain an overpayment by the deadline specified in subdivision (b) of section 521-3.3 of this SubPart may be subject to monetary penalties pursuant to section 145-b(4) of the Social Services Law and Part 516 of this Title, and any other sanction or penalty authorized by law.

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

Policy 13

Social Media

DEFINITION:

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

POLICY:

- Social media is not a business-related activity and should be done during personal (non- work) time only.
- In the event that you participate in social media, the following applies:
  - You are personally responsible for your posts. Threats to **agency's** management, staff or patients, will be dealt with disciplinary action and dismissal. (***Disciplinary policy #14***)
  - If you publish or post to Facebook, Twitter or other social media and it has something to do with the work you do, or with subjects relating to the **agency**, you must make it clear that the views expressed are solely your personal views and do not necessarily represent the views of the **agency**.
  - Do not disclose confidential or proprietary information from the agency. Consult the **agency** confidentiality policy for guidance about what constitutes confidential information.
  - Do not cite or reference the **agency** patients / client's names or pictures, as that is a breach of patient privacy.
  - Since your site is a public space, we require that you will be respectful to the **agency**, our employees, our customers, our partners and affiliates, and others (including our competitors). Threats to **agency** management, staff or patients, will be dealt with disciplinary action and dismissal. (***Disciplinary policy #14***)
- You may not provide a link from your site to the company's website without express written permission from Public Relations / Marketing.
- If you have any questions about these guidelines or any matter related to your site that these guidelines do not address, please direct them to the agency's Compliance Officer.

COMPLIANCE:

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

Policy 14

Disciplinary Action

POLICY:

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

General Information:

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

PROCEDURE:

Investigations will be conducted on compliance related issues with the assistance of, but not limited to: The caller, if self-identified:

- Management
- Human Resources
- Compliance Officer
- Clinical personnel
- External Legal if applicable

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

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

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

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

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

All affected individuals are educated on the organization's disciplinary policies in order to fully comprehend the consequences of non-compliance. Supervisors should be aware of their responsibilities in disciplining employees appropriately and consistently.

DISCIPLINARY ACTIONS

1. When *all affected individuals* unable or unwilling to perform duties of his/her assigned position in a satisfactory manner either through omission or commission, the supervisor or director has the authority to take whatever action warranted. The action taken may extend to:

    a) termination from service

    b) reduction in pay

    c) reprimand (oral or written)

    d) probation

    e) counseling (oral and/or written)

2. In any case of reduction in pay, the director must furnish *all affected individuals* with a written statement citing the reason.

3. If an employee receives a written reprimand, the reprimand shall become a permanent part of his/her personnel file.

4. An oral reprimand may also become a permanent part of an employee's personnel file.

5. Conduct unbecoming a professional or paraprofessional health team member shall be cause for termination from service. Such conduct may include, but is not limited to:

    a) theft, fraud or unauthorized possession of property belonging to the client, organization or family member.

    b) intoxicated or drugged while on the job

    c) making untrue statements with intent to deceive

    d) absence from job without reporting to organization

    e) slovenly appearance

f) unprofessional actions

g) disruptive behavior

h) falsification of records or time slips

i) threatening, intimidating or assaulting a client, family member or supervisor

j) use of vile or abusive language, or acting in a disrespectful manner to a supervisor, client or family member

k) immoral or illegal conduct

l) substitution of personnel

m) unauthorized use of client's telephone

n) gross insubordination

o) sexual harassment

p) *"improper quality of patient care,"*

Policy 15

Billing and Claim Development

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

PROCEDURE:

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

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

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

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

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

    a. Plan of Care or Plan of Treatment

    b. Verbal orders

    c. Clinical Notes – all disciplines for each visit

d. Progress notes – all disciplines

e. Conference Records (if applicable)

f. Documentation of telephone conferences

g. Comprehensive assessment at prescribed frequencies

h. Discharge summary

i. History and physical

j. Medication Profile

k. Time and activity Report

Policy 16

Sanction Policy

INTRODUCTION:

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

All affected individuals of the organization *are required to adhere to the corporate compliance program and standards of conduct and* ***with this policy failure to report a compliance issue would result in disciplinary actions.*** Familiarity with the policy and demonstrated competence in the requirements of the policy are an important part of every organization employee's responsibility. *This policy outlines sanctions for participating in non-compliant behavior, encouraging, directing, facilitating or permitting non-compliant behavior for all affected individuals.*

ASSUMPTIONS:

This Sanction Policy is based on the following assumptions:

Able Health Care Services, Inc. has adopted a Security Policy requiring organization and its officers, employees, and agents to protect the integrity and confidentiality of medical and other sensitive information pertaining to our patients.

- In addition, the organization and its departments have adopted policies and standards to carry out the objectives of the Security Policy.
- ***All affected individuals*** of the organization, its officers, employees, and agents are encouraged good- faith participation in the compliance program, report compliance issues, suspected compliance problems, non-compliant behavior.
- Each of these policies and standards notes that all officers, employees, and agents of the organization must adhere to these policies and standards, that the organization will not tolerate violations of these policies and standards, and that such violations constitute grounds for disciplinary action up to and including termination, professional discipline, and criminal prosecution.

POLICY

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

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

ENFORCEMENT

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

Policy 17

Home Care Worker Attendance and Fraud Prevention Policy

PURPOSE: To ensure that quality homecare service is provided to patients with the absence of fraud

Medicaid Fraud: - **Able Health Care Service, Inc.** is serious about preventing Medicaid Fraud. Aides must clock In and out to be paid for services rendered. Anytime there is a missing clock, **Able Health Care Service, Inc.** may verify time with patient or may request a timesheet.

Timesheets: Timesheets are discouraged; however, it will be required If a patient does not have a working telephone. Timesheets will be checked for accuracy, completion, and patient's signature comparison. If a timesheet is incomplete or inaccurate, the patient will be contacted for verification. The timesheet may or may not be returned. Payment for services will not be made if the timesheet cannot be verified or corrected.

. Timesheet cases will be included in the monthly call verification and visit verification program.

Verification Calls

1. Every week a random sample of 5% active case will be taking from the computer
2. Compliance manager will contact their assigned cases once during the week. Depending on the schedule.
3. Compliance manager will record their verification calls on the Home Care W o r k e r .
4. If no one in the home answers the call, a message should be left for the HA to return the call to the agency. If the call is not returned during business hours and no one is found in the home, then a follow up call or a home visit will be conducted some time during the m o n t h .
5. In the case where attendance cannot be verified, Coordinators should immediately inform Compliance manager.

Verification Visits

1. Every Month a random sample of 2 % cases will be taken from the computer
2. Compliance manager will randomly assign cases to be visited by a **Able Health Care Service, Inc.** employee
3. If a home attendant is not present in the home during their scheduled time an investigation will take place to determine whether the home attendant had a valid reason for being out of the home. The Compliance manager will head the investigation and determine with the program director whether the home attendant had a valid reason. In the case where HA does not have a valid acceptable reason, he/she will face disciplinary actions including termination.
4. The agency visitor will record the information regarding the visits on the Home Care Worker Verification Form.
5. In the case where Attendance cannot be verified, Coordinators should immediately inform Compliance manager so that an unannounced visit can be scheduled.

Consequence of fraud

1. If an employee of **Able Health Care Service, Inc.** commits Medicaid fraud, that employee will face disciplinary actions including termination
2. Employees may be required to pay money back and be put in the HCR and OMIG database
3. Agency will have to reimburse and notify insurance company of fraudulent activities.

Policy 18

Attendance Verification

PROCESS:

1) Daily service coordinators shall review their "Missed In's from the HHA exchange software program to confirm the status of their HHA/PCA's attendance.

2) The Service Coordinator will contact any HHA/PCA that failed to clock in to his/her shift and ascertain the reason.

3) Service Coordinator shall confirm the visit time with the patient and document in the HHA software program. Coordinator will select the appropriate OMIG reason code.

4) If no one in the home answers the call, a message should be left for the HHA/PCA to return the call to the agency. If the call is not returned during business hours and one is found in the home, then the patients' emergency contact shall be called.

5) In a case where attendance cannot be verified, the coordinator will discuss with the Branch Manager for a solution.

G Forms:

1. **Anonymous Complaint**
2. **Patient grievance procedure /complaint form**
3. **Conflict of Interest**
4. **Compliance Reporting form**
5. **Employee acknowledgement**
6. **Internal Investigation form**
7. **Letter to Vendor False Claims Act- Contractors**
8. **Sample Letter on Fraud and Abuse to Clients**

Form 1

Anonymous Reporting Form

Able Health Care Services, Inc. continually strives to provide high quality care to our clients. The agency maintains high standards of integrity in our dealings with our client's families, as well as our own all affected individuals and those with whom we do business. It is our philosophy that we provide all of our services in full compliance with all laws and regulations. This requires the highest standard of conduct from all of our all-affected individuals.

If there is reasonable doubt as to the appropriateness of an activity, all affected individuals or any concerned customer or member of the public are encouraged to report such activity to the Compliance Officer, or to anyone in the **agency** chain of command.

If for any reason such a direct report is not comfortable for the person who is concerned, **the agency** is providing this form for reporting to the Compliance Officer and other key managers. The contact information located on the bottom of this form may be left blank. If you wish to enter your contact information you may do so and the Compliance Officer will respond to and contact the reporter as requested.

Which service, person, area, or individual is the complaint about? Include: Title and name of person in question; and the area that they work in (e.g. Management, Intake, Case Coordinator, Nursing, Finance, Office Support, Fiscal, Human Resources, and Compliance)

_____

- ☐ You are requesting clarity on a task, process, or policy, regulation, or law.
- ☐ If a specific complaint is regarding how services are being provided and you believe that it is not being done as per regulation, policy or law.

Describe your concern and give example(s)

_____

_____

_____

_____

_____

Have you already spoken to anyone about your complaint?

- ☐ Yes
- ☐ No If yes, to whom? _____(Name & Title)

THE BELOW INFORMATION IS NOT REQUIRED:

Additional information might be needed in order to complete an investigation and be able to ensure the most appropriate outcome. Insufficient information may result in an inability to address your concern in its entirety.

Title: _____
First Name _____
Last Name _____
Address: _____
City: State: _____
Zip Standard: Daytime _____
Phone Number

_____

Cell Phone Number: _____
What are the best hours to contact you?_____

PLACE THIS FORM IN A SEALED ENVELOPE AND ADDRESS TO:
COMPLIANCE OFFICER

Form 2

PATIENT GRIEVANCE PROCEDURE /COMPLAINT FORM

Patients have the right to voice their grievance and recommend changes in policies and service without fear of reprisal, or unreasonable interruption of service.

PROCEDURE:

1. Complaints can be made to the agency by calling **Rivka Shapiro, Compliance Officer** or the Confidential Hotline number **516-394-3288.** The Agency will make every effort to resolve complaints to client's satisfaction. Reports shall be maintained in agency file.

2. The Agency will investigate all complaints and respond with a written report to all written complaints and to oral complaints, if requested by the individuals making the oral complaint.

3. Complaint investigation findings and the decisions rendered to date by the agency will be made within 15 business days of the receipt of the complaint.

   If the complaint cannot be resolved to the client's satisfaction, you have the right to appeal the outcome of the investigation by mailing a letter to **Able Health Care Services, Inc. 1240 Broadcast Plaza Merrick New York, 11566 attention: Rivka Shapiro 516-394-3288.**

4. The agency will review the complaint as part of the appeal process and respond to the client in writing within 30 business days of receipt of the appeal.

5. If you are not satisfied with the agency's response, you may complain to: *New York State Department of Health, Metropolitan Regional Office*, *90 Church Street*, *New York, New York 10007* or call *1-800-663-6114*.

STANDARD COMPLAINT FORM

Date received: _____

Complaint filed by: Name_____

Address**:** _____

Telephone: _____ *E-mail* _____

Is the individual filing the complaint a patient: _____ Yes _____No _____

If not: Patient name: _____

Relationship to patient: _____

*Complaint description including persons, Protected Health Information involved, and date(s) of incident(s):

_____

_____

_____

_____

* Follow up and disposition:

_____

* Date complaint closed: _____was the complainant satisfied ___Yes ___No

If "No", explain: _____

_____

_____

_____

Person responsible for receiving the complaint: **Handling the complaint:**

Employee Name: _____ _____

Title: _____ _____

***Use more pages if more space is needed.**

Form 3

ACKNOWLEDGMENT OF RECEIPT

EMPLOYEE STANDARD OF CONDUCT AND CONFLICT OF INTEREST DECLARATION

Employee's Name (Print) _____

Department_____

I acknowledge that I have received and read Able Health Care Services, Inc. Standards of Employee Conduct and Conflict of Interest Policy.

I further acknowledge that I will abide by the "Organizations Compliance Plan" and will refrain from any behavior that may result in a conflict of interest regarding the organizations established ethical standards. I will also recuse myself from any voting in an area that is potentially deemed a conflict of interest where I may be rewarded with personal gain.

_____ _____

Employee Signature Date

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

Form 4

Compliance Program - Reporting Form

Date: _____

Please state the nature of your concern. Be as specific as possible. Attach extra sheets if necessary.

This Compliance Program Reporting Form may be submitted anonymously. Supplying your name may assist in the investigation of your report but you are under no obligation to do so. It is an explicit violation of the facility's policy to retaliate in any way against a staff member who, in good faith, reports an actual or potential violation of applicable laws, rules, regulations, or the Standard of Conduct. If you wish to provide your name, please do so.

_____ _____

Name Phone Number

Please submit this Compliance Program Reporting Form to the Compliance Officer. Alternatively, you may mail it anonymously to the Compliance Officer, or insert it in the suggestion/comment box located in the Lobby or the Staff Lounge.

Form 5

Compliance Acknowledgement

I _____have received **Able Health Care Services, Inc.** training on the compliance program and acknowledge that I will comply with such standards as presented. This form will be maintained in my personnel file and updated as warranted.

Employee Name: _____

Date: _____

Form 6

Internal Investigation Form

Date:

Name of Individual Reporting: _____ □ Not Applicable (see below)

Department:_____ Title:_____ Contact Number: _____

Report was filed: □ Anonymous via □ Hot Line □ Suggestion. Box

Narrative of Report:

Disposition or Action Taken:

Investigation conducted by: _____

Reviewed by:

CEO _____ Compliance Officer _____ Department Director _____

Form 7

Letter to Vendors False Claims Act

To Whom It May Concern:

As part of **Able Health Care Services, Inc.** efforts to comply with the Deficit Reduction Act of 2005 and our Corporate Compliance Policy - **Prohibition Against Employing or Contracting with Ineligible Persons** (attached) hereby requests the following:

1. Confirm that you and your organization have not been designated an "Ineligible individual or organization" as defined: An **Ineligible Person** means an individual or entity who/which has been excluded, suspended, debarred or otherwise deemed ineligible to participate in a federally funded healthcare program and has not been reinstated after a period of exclusion, suspension, debarment or ineligibility.

I confirm that _____individually or _____the organization I represent has not been deemed ineligible to participate in a federally funded healthcare program.

_____ _____ _____

Name **Title** **Date**

Form 8

Sample Letter to Patients **_____, 202_**

Dear Patient/Consumer:

Medicaid is a program for New York State residents that provides medical care. Medicaid recipients are very important to the New York State Office of the Medicaid Inspector General (OMIG). OMIG's job is to protect recipients and the resources of the Medicaid program. Medicaid fraud is not a victimless crime. Intentionally deceiving or misrepresenting others for unauthorized benefits can jeopardize your medical care, waste taxpayer dollars, and is against the law.

When a Medicaid provider misrepresents his or her credentials and services, it can jeopardize your health. By falsifying or exaggerating a diagnosis, you could be subjected to unnecessary or unsafe medical procedures, receive the wrong medical treatment, or find that your health benefits have been depleted for a condition you don't even have.

We at _____are concerned with the recent increase in Fraud and Abuse in the health care industry. Fraud occurs when there is a misuse of Federal and State money by Providers, Professionals or Beneficiaries of Medicaid or Medicare funds. Every day there are numerous prosecutions and convictions involving healthcare fraud and we want to make sure that you the beneficiary know what fraud is and how to avoid being a part of a fraudulent action. Below is how you and your family members can help avoid and report and potential fraudulent actions.

Examples of fraud or abuse by health care providers	Examples of fraud or abuse by patients consumers
• Billing for Medicare/Medicaid services when you did not get all the services you were supposed to get • Giving out or selling prescriptions when you do not need them • Ordering tests that you do not need • Giving money or presents to consumers in return for agreeing to get medical care from someone • Accepting kickbacks for patient referrals	• Doctor shopping or visiting emergency rooms to get controlled drugs • Getting medical help that is not needed • Receiving gifts or money for getting medical services • Getting paid by a doctor for receiving medical services • Receiving Medicaid when you are ineligible • Forging a prescription • Not reporting other health insurance • Altering bills or receipt • Bribing a Health Care Worker (Aide) • Falsifying an Aides timesheet that services were provided • Utilizing an ineligible family member as an aide and receiving payment • Lending your or using someone else's Medicaid card could be penalized with up to ten years in prison and fined up to $500,000.

If you hear of any of these actions, please call **516-394-3288** and investigation and report will be performed. All conversations will be confidential. If we are approached by one of our aides who suspects fraudulent actions by you the beneficiary, we are required to notify the NYS Office of Medicaid Inspector General. Tips can be completely anonymous and OMIG investigates all reported information.
To report fraud, waste, or abuse, file an allegation or call the
Medicaid Fraud Hotline at 1-877-87-FRAUD (1-877-873-7283).

Thank You.

_____

CEO

Appendix 1

Typical risk areas for home health agencies:

1. Billing for items or services not actually rendered.
2. Billing for medically unnecessary services.
3. Duplicate billing.
4. False cost reports.
5. Credit balances – failure to refund.
6. Home health agency incentives to actual or potential referral sources (e.g., physicians, hospitals, patients, etc.) that may violate the anti-kickback statute or other similar Federal or State statute or regulation.
7. Joint ventures between parties, one of whom can refer Medicare or Medicaid business to the other.
8. Stark physician self-referral law.
9. Billing for services provided to patients who are not confined to their residence (or "homebound").
10. Billing for visits to patients who do not require a qualifying service.
11. Over-utilization and under-utilization.
12. Knowing billing for inadequate or substandard care.
13. Insufficient documentation to evidence that services were performed and to support reimbursement.
14. Billing for unallowable costs of home health coordination.
15. Billing for services provided by unqualified or unlicensed clinical personnel.
16. False dating of amendments to nursing notes.
17. Falsified plans of care.
18. Untimely and/or forged physician certifications on plans of care.
19. Forged beneficiary signatures on visit slips/logs that verify services were performed.
20. Improper patient solicitation activities and high-pressure marketing of uncovered or unnecessary services.
21. Inadequate management and oversight of subcontracted services, which results in improper billing.
22. Discriminatory admission and discharge of patients.
23. Billing for unallowable costs associated with the acquisition and sale of home health agencies.
24. Compensation programs that offer incentives for number of visits performed and revenue generated.
25. Improper influence over referrals by hospitals that own home health agencies.
26. Patient abandonment in violation of applicable statutes, regulations, and Federal health care program requirements.
27. Knowing misuse of provider certification numbers, which results in improper billing.
28. Duplication of services provided by assisted living facilities, hospitals, clinics, physicians, and other home health agencies.
29. Knowing or reckless disregard of willing and able caregivers when providing home health services.
30. Failure to adhere to home health agency licensing requirements and Medicaid conditions of participation.
31. Knowing failure to return overpayments made by Federal health care programs.

Appendix 2

Periodic Internal Audits:

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

1. Visiting with and interviewing patients, physicians and personnel.
2. Audit financial, medical/clinical and personnel records and documentation.
3. Analyzing utilization patterns and trend analysis.
4. Re-evaluation of survey findings and results.
5. Assessing existing relationships of referral resources.
6. Assessing relationships with vendors and suppliers.
7. Conduct unannounced mock surveys and investigations.
8. Utilizing written questionnaires and written testing mechanisms.
9. Examination of logs.
10. Validation of credentials of those providing services to the organization.
11. Evaluation of policy and procedures.
12. Unannounced supervisory home visits.
13. Verification of services with patients and verification of signature of patients.

Appendix 3

RECORD RETENTION SCHEDULES

ACCOUNTING RECORDS

1.	Annual financial statements	Permanent
2.	Data for acquired/divested	Permanent
3.	Chart of accounts	Permanent
4.	General Ledger	20 years
5.	Annual audit records	10 years
6.	A/R/ invoices	8 years
7.	Journal entries	8 years
8.	Special reports	8 years
9.	Canceled checks	8 years
10.	A/P paid invoices	8 years
11.	Business expense records	8 years
12.	Accounts payable	7 years
13.	Accounts receivable	7 years
14.	Audit reports	7 years
15.	Expense reports	7 years
16.	Inventory records	7 years
17.	Loan documents	7 years after final paymt.
18.	Sales records	7 years
19.	Purchase orders	7 years
20.	Data for non-acquired/non divested	5 years
21.	Credit card receipts	3 years
22.	Cash receipts	3 years
23.	Monthly financial statements	3 years
24.	Stop payment orders	3 years
25.	Bank reconciliation’s	3 years

TAX RECORDS

1.	Federal tax return (not payroll)	Permanent
2.	State & local tax returns	Permanent
3.	Form 990 & supporting documentation	Permanent
4.	Form 990-T & supporting documentation	Permanent
5.	Payroll taxes (W2, W3)	Permanent
6.	Payroll taxes (Form 941, state w/h forms, state unemployment returns)	8 years (or longer)
7.	Unclaimed property filings & supporting documents	6 years (or longer)
8.	City & State excise tax reports & supporting documents	5 years (or longer)
9.	Supporting documentation for taxes	4 years
10.	1099 forms 8 years Magnetic tape & similar records	1 year

PAYROLL RECORDS

1.	Payroll registers	Permanent

2.	State unemployment tax records	Permanent
3.	W-2 forms	8 years
4.	W-4 forms	8 years
5.	Cancelled payroll checks	8 years
6.	Changes or adjustments to salary	8 years

7.	Deductions register	8 years
8.	Earnings records	8 years
9.	Wage	6 years
10.	Salary	6 years
11.	Payroll deductions	6 years
12.	Time cards or forms	5 years
13.	Garnishments	4 yrs after unemployment
14.	State employment forms	4 years
15.	Wage rate tables	3 years
16.	Cost of living tables	3 years

INSURANCE RECORDS

1.	Policies (including expired)	Permanent
2.	Claims for loss/damage, accident reports, appraisals	5 years

WORKPLACE RECORDS

1.	Incorporation & Reorganization records	Permanent
2.	(Articles of Incorporation, By-laws, etc)Meeting minutes	Permanent
3.	Corporate Records	Permanent
4.	Policy Statements	10 years
5.	Employee directories	5 years

LEGAL RECORDS

17.	Trademark registration	Permanent
18.	Copyright registration	Permanent
19.	Patents	Permanent
20.	Real estate contracts & records	20 yrs – Permanent
21.	Personal injury records	8 years
22.	Leases	6 yrs after termination
23.	Court documents & records	5 yrs following close
24.	Deposition transcripts	5 yrs following close
25.	Litigation claims	5 yrs following close
26.	General contracts	3 yrs after termination
27.	Discovery materials	3 yrs following close

PERSONNEL RECORDS

1.	Employment & termination agreements	Permanent
2.	Accident reports	6 years
3.	Incentive plans (after expiration)	6 years
4.	Medical and safety records	6 years
5.	Pension plans (after expiration)	6 years
6.	Retirement plans (after expiration)	6 years
7.	Disciplinary warnings, demotion, lay-off & discharge	5 years following emplymt
8.	Promotions, raises, reclassifications & job descriptions	5 years following emplymt
9.	Beneficiary information	3 years following emplymt.
10.	Employment applications (persons hired)	3 years following emplymt

11. Employee resumes & employment history	3 years following emplymt
12. Evaluations	3 years following emplymt
13. Promotions & raises	3 years following emplymt
14. Employment applications (persons not hired)	1 year
15. Education assistance	While employed
16. Sick leave benefits	While employed

CLIENT FILES

1. Case Notes and Billing files payment received IAW NYS and Federal guidelines	7 years following the
2. MLTC	10 years
3. Children up to	21 + 3 years

Appendix 4

Able Health Care Service, Inc.
COMPLIANCE COMMITTEE CHARTER

The committee shall assure that the **Able Health Care Service, Inc.** has an effective compliance program. The committee shall create, approve, and oversee the compliance program, which shall include specific policies and procedures and related monitoring activities. The compliance program shall ensure compliance with applicable federal and state laws and regulations, as well as compliance with reporting requirements under applicable private arrangements. The compliance program will assist **Able Health Care Service, Inc.** to operate an ethical and compliant operation. The committee shall direct the appropriate resources of **Able Health Care Service, Inc.** to assure that appropriate creation and execution of the compliance program, including the proper records maintenance to document material compliance matters undertaken by the committee. The committee shall receive regular reports from a compliance officer appointed by the committee regarding the discharge of duties, including, but not limited to, the status of internal compliance programs and processes and reported violations of the compliance program and the response to any such alleged violations.

The committee shall have the authority to sanction individual employees responsible under the compliance program and to undertake any investigations it deems appropriate related to the operation of the compliance program. Upon request, the committee shall provide periodic reports to the executive committee or the board of directors.

Guidelines. The Compliance Committee may adopt written guidelines for holding meetings and conducting the activities, and operations of the committee.

The Compliance Committee shall consist of approximately **5-7 members** of the organization **meeting quarterly** prior to reporting to the Board and shall include:

- Governance/Administration
- Compliance Officer / Quality Review, Clinical
- Human Resources
- Finance,
- IT.

Any vacancy on the committee, whether by resignation, illness, death or otherwise, shall be promptly filled by appointment by the Governing Authority/designee and reported to the Governing Board and each such appointee shall serve for the remainder of the unexpired term of his or her predecessor.

Duties. The duties of the Compliance Committee shall include:

1. Designating a compliance committee which shall be responsible for coordinating with the compliance officer to ensure that **Able Health Care Service, Inc.** is conducting its business in an ethical and responsible manner, consistent with its compliance program. **Able Health Care Service, Inc. shall outline the duties and responsibilities, membership, designation of a chair and frequency of meetings in as per this compliance committee charter.**

2. Oversee **training and education** required by **Able Health Care Service, Inc.** and implementing an effective compliance training and education program for its compliance officer and all affected individuals.

3. **Able Health Care Service, Inc.** shall establish and implement effective **lines of communication** which ensure confidentiality for the required provider's affected individuals.

4. **Able Health Care Service, Inc.** shall establish **disciplinary standards** and shall implement procedures for the enforcement of such standards to address potential violations and encourage good faith participation in the compliance program by all affected individuals.

5. **Able Health Care Service, Inc.** shall establish and implement an effective system for the **routine monitoring** and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, external audits, to evaluate the organization's compliance with the requirements of the MA program and the overall effectiveness of the required provider's compliance program.

6. **Able Health Care Service, Inc.** shall establish and implement procedures and systems for **promptly responding to compliance issues** as they are raised, investigating potential compliance problems as identified in the course of the internal auditing and monitoring conducted pursuant to subdivision (g) of this section, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensuring ongoing compliance with State and Federal laws, rules and regulations, and requirements of the MA program.

7. **Able Health Care Service, Inc.** shall establish a set **quarterly meeting** with the Board to discuss the committee's findings and recommendations.

COMPLIANCE COMMITTEE CHARTER

Committee Members	Department/Date