Ethics & Compliance Program

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Responsible Person:	Chief Compliance Officer
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HUDSON HEADWATERS HEALTH NETWORK

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Definition of Ethics & Compliance

Hudson Headwaters Health Network (the "Network") is committed to operating under the highest ethical and moral standards, and ensures that the Network, in all of its activities, complies with applicable federal, state and local laws, regulations and guidelines.

The Network Ethics & Compliance Program (the "Program") is rooted in the Network's organizational Mission, quality Vision and core Values. All compliance-related activities are designed to detect and prevent accidental or intentional noncompliance throughout the organization.

The Program assures ensures that the Directors and Officers of the Network meets the duty of care by making prudent decisions which exercise care, truth, skill and caution on behalf of the Network in good faith; meets the duty of loyalty and stewardship by always acting in the best interests of the Network, the patients and the communities served; and meets the duty of obedience by making sure that the organization acts within its purpose, pursues its mission and complies with all applicable laws, rules and regulations.

The Program is well integrated into the Network's operations, supported by the Executive leadership team and promotes the adherence to the Network's legal and ethical obligations. The program is designed to prevent, detect and correct non-compliance. Including fraud, waste and abuse most likely to occur for the Network's Risk Areas and Organizational Experience, as these terms are defined herein.

Purpose

The purpose of the Network's Ethics & Compliance Program is to:

1. Continuously improve patient safety to prevent or minimize the occurrence of errors, incidents, or procedural breakdowns.
2. Create a culture of non-retaliation and non-intimidation for the reporting of quality, safety, compliance or privacy concerns.
3. Implement measures that detect, correct, and prevent fraud, waste and abuse.
4. Facilitate organizational compliance with regulatory, legal, and accrediting agency requirements.
5. Ensure that privacy and security standards of protected health information are upheld.
6. Protect human and intangible resources (e.g., reputation).

Compliance Definitions

Affected Individuals - all covered persons who are affected by the Network's Risk Areas, including but not limited to Network employees, Chief Executive Officer, other senior administrators, officers, Board of Directors, managers, vendors, contractors, agents, subcontractors, independent contractors and affiliates. Contractors, agents, subcontractors, and independent contractors (collectively, "contractors") are considered Affected Individuals subject to the Network's Program, to the extent that such contractors

are affected by the Network's Risk Areas and only within the scope of the contracted authority and affected Risk Areas.

Effective Compliance Program - compliance program adopted and implemented by the Network that, at a minimum, satisfies the requirements of the compliance regulations (18 NYCRR Part 521-1) and that is designed to be compatible with the Network's mission, vision, and characteristics, including size, complexity, resources, and culture. An Effective Compliance Program:

1. Is well-integrated into the company's operations and supported by the highest levels of the organization, including the chief executive, senior leadership, and the governing body;
2. Promotes adherence to the required Network's legal and ethical obligations;
3. Is designed and implemented to prevent, detect, and correct noncompliance with Medicaid program requirements, including fraud, waste, and abuse most likely to occur for the Network's Risk Areas and Organizational Experience.

Organizational Experience - the Network's:

1. Knowledge, skill, practice and understanding in operating its Program;
2. Identification of any issues or Risk Areas in the course of its internal monitoring and auditing activities;
3. Experience, knowledge, skill, practice and understanding of its operations as well as the results of any audits, investigations, or reviews it has been the subject of; or
4. Awareness of any issues it should have reasonably become aware of for its category or categories of service.

Risk Area - those areas of operation affected and monitored by the Program.

Scope of Program

The scope of the Program is comprehensive and includes all departments and activities of Hudson Headwaters Health Network. This scope includes all Affected Individuals and Network services current or anticipated.

Risk Areas

The program encompasses the following Risk Areas as required in 18 NYCRR § 521-1.3(d):

- Billing;
- Payments;
- Medical necessity;
- Quality of care;
- Governance;
- Mandatory Reporting;

- Credentialing;
- Ordered Services; and
- Contractor, subcontractor, agents, or independent contract oversight.

The Network's Program also encompasses the following additional Risk Areas identified by the Network through its Organizational Experience:

- 340B;
- Ryan White;
- Facilities;
- Privacy;
- Information Security; and
- Staffing/Recruitment.

Other Applicable Policies, Plans, and Programs

Quality Management Plan: The purpose of Hudson Headwaters Health Network's Quality Management ("QM") Plan is to assess the appropriateness of the utilization of service and the quality of services provided by the Network. The goal of the program is to enhance the health of Network patients and to enable the Network to achieve its vision of quality in all that it does, by continuously improving the degree of excellence of processes, provider and support staff performance, decisions, and human interactions.

Risk Management & Safety Program: The Risk Management & Safety Program is designed to support the mission and vision of the Network as it pertains to quality improvement, clinical risk, and patient safety as well as visitor, third party, volunteer, and employee safety and potential business, operational, and property risks.

340B Plan: Hudson Headwaters Health Network's 340B Program Plan contains written policies and procedures which include elements of program requirements to oversee 340B Program operations, provide oversight of entity-owned and contract pharmacies, and maintain a compliant 340B Program.

Program Accountabilities and Responsibilities

The responsibility for upholding the Program is a shared obligation among all Affected Individuals. Each Affected Individual has a responsibility to ensure that their conduct complies with the Program.

The Network's Board of Directors is ultimately accountable for the operation of the Program. The Board exercises reasonable oversight and holds the Chief Executive Officer responsible for the efficient and effective functioning of the Network. The Board receives and acts upon reports presented by the Compliance Officer, reviews and approves the Program and its effectiveness annually, and ensures the availability of resources and systems to support the Program.

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Leadership

Leadership plays a pivotal role in fostering and promoting a just and compliant culture at Hudson Headwaters Health Network. The Program requires leaders to act as role models, demonstrating ethical behavior and unwavering dedication to compliance in their actions and decisions. The Program recognizes compliance as the foundation of ethical governance and the credibility of the Network. Compliance plays a role in the Network's building a sustainable future, influencing decision-making, and safeguarding integrity. The Network's organizational structure includes an Executive Team, Senior Leadership Team, and management. The Executive Team sets the tone at the top, where ethical values and compliance principles are communicated and prioritized as indispensable elements of the Network's mission. Accountable to the Executive Team, Senior Leadership demonstrates adherence to ethical and legal standards in their areas of oversight and promotion of systems, policies, and processes that address challenges, adapt to evolving regulations, and ensure alignment with the Program's goals. The Program tasks all members of the Network's management team with fostering transparency, encouraging open communications and ensuring that employees feel empowered to report issues without fear of retribution.

Chief Compliance Officer

A member of the Network's Senior Leadership Team, the Chief Compliance Officer reports and is accountable to the Network's Chief Medical Informatics Officer. The Chief Compliance Officer has access to the Chief Executive Officer and Board of Directors. The Chief Compliance Officer's primary responsibilities to the Program include:

1. overseeing and monitoring the adoption, implementation and maintenance of the compliance program and evaluating its effectiveness;

2. drafting, implementing, and updating no less frequently than annually or, as otherwise necessary, to conform to changes to Federal and State laws, rule, regulations, policies and standards, a compliance work plan which shall outline the required provider's proposed strategy for meeting the requirements of this section for the coming year, with specific emphasis and considerations for the Network's risk areas;

3. reviewing and revising the compliance program, as well as its written policies and procedures and standards of conduct, in accordance with state and federal regulation

4. assisting in establishing methods to improve efficiency, quality of services, and reducing vulnerability to fraud, waste and abuse;

5. investigating and independently acting on matters related to the compliance program, including designing and coordinating internal investigations and documenting, reporting, coordinating, and pursuing any resulting corrective action with all internal departments, contractors and the State; and

6. coordinating the implementation of the fraud, waste, and abuse prevention program

In addition to the responsibilities to the Program, the Chief Compliance Officer oversees the Network's Risk Management & Compliance team which is responsible for ensuring the Network's Risk Management, Privacy, Safety, and 340B Program are integrated into Network operations.

Network Compliance Committee

The Network Compliance Committee is responsible for ensuring that the Network is conducting its practices in an ethical and responsible manner, consistent with the Program. The Committee proactively oversees the creation, assessment and maintenance of an Effective Compliance Program that encompasses the 7 elements of compliance. The Network Compliance Committee:

1. Coordinates with the Chief Compliance Officer to ensure that the written policies and procedures, and standards of conduct are current, accurate, and complete;

2. Ensures that the training topics are completed by Affected Individuals on compliance-related issues;

3. Assures communication and cooperation by Affected Individuals on compliance related issues, internal or external audits, or any other function or activity required by the regulations;

4. Advocates for the allocation of sufficient funding, resources and staff for the Chief Compliance Officer to fully perform their responsibilities;

5. Ensuring that the Network has effective systems and processes in place to identify Program risks, overpayments and other issues, and effective policies and procedure for correcting and reporting such issues; and

6. Advocates for adopting and implementing required modifications to the Program as needed.

7. The Network Compliance Committee meets at least quarterly and is comprised of the Chief Compliance Officer and Executive Team members including

    - CEO;
    - CMO; and
    - CMIO.

    Other staff members may be invited to attend one or more meetings of the Network Compliance Committee on an as needed basis.

8. The Committee has the direct responsibility and authority of the Board to perform the following duties:

    - Oversee the information, policies, procedures and reporting systems the Network employs to provide reasonable assurance that the operations of the Network comply with all federal and state laws and regulations applicable to health care providers, and

that the Network provides quality medical care to patients while fostering and promoting patient safety;
- Oversees and ensures that all Affected Individuals complete compliance training and education during orientation and annually thereafter; and
- Review, as appropriate, information relating to quality, clinical risk, patient safety and performance improvement.

The Compliance Committee reports directly to, and is accountable to, the Network's CEO and Board of Directors. The duties, responsibilities, membership, designation of a chair, and frequency of meetings of the Compliance Committee are outlined in the Network's Compliance Committee Charter, which is reviewed and updated on at least an annual basis.

Compliance Representation

The Network is committed to fostering a strong culture of compliance by ensuring that the Compliance department is actively represented across key committees that are within the scope of the department. The presence of Compliance in these committees ensures that oversight and integration of the Compliance Program is addressed through a collaborative, interdisciplinary lens.

There is representation from the Risk Management & Compliance team at the following committees which oversee key risk areas and are fundamental to the Program's effectiveness:

- **Network Quality, Risk & Compliance Committee**
  Chaired by the Chief Compliance Officer, this committee addresses Network-wide issues related to quality, risk, and compliance. It brings together leaders from across departments to support a coordinated, multidisciplinary approach to these critical areas. The compliance department provides Risk Management and Compliance related data which is presented to this committee on a quarterly basis.

- **Information Privacy & Security Committee**
  Co-chaired by the Chief Compliance Officer, this committee oversees the implementation and enforcement of policies, procedures, and standards that safeguard the privacy and security of all Hudson Headwaters systems and sensitive information.

- **Safety & Security Committee**
  Co-chaired by the Chief Compliance Officer, this committee is responsible for ensuring the physical safety and security of all Network facilities. It addresses infrastructure, environmental risks, and emergency preparedness across the organization.

- **Peer Review Committee**
  The Risk Manager is the facilitator of this meeting. The Compliance department plays a key role in this committee by identifying events that require review, monitoring the investigation process to ensure it is ethical and unbiased, and verifying that follow-up actions are complete and appropriate.

- **Clinical Performance Improvement Committee**
  The Compliance department plays a key role in this committee escalating areas for process and system improvements, recommending policy amendments if needed, and determining circumstances that may require additional patient consents.

- **Pharmacy Therapeutics & Treatment Committee**
  The Compliance department plays a key role in this committee ensuring adherence to regulations, mitigating risk, optimizing 340B compliance, considering FTCA coverage and privileging, as well as assisting in the creation of compliant workflows.

- **Value Based Payment Committee**
  The Compliance department plays a key role in this committee ensuring adherence to regulations, mitigating risk, suggesting auditing and monitoring activities, and assuring the creation of compliant workflows.

Project-Specific Workgroups

Multi-disciplinary ad-hoc workgroups are convened as new Network-wide initiatives are introduced and implemented. The workgroups meet at frequencies and for durations deemed necessary, depending on the complexity of the specific initiative.

Integration and Coordination

The Network's Program is fully integrated into the Network's ongoing operations through the participation of all departments, disciplines, and cross-functional groups/teams.

The CEO is responsible for the Program with active assistance from the Chief Compliance Officer, the Network Compliance Committee, the Network Quality, Risk & Compliance Committee, and the Board of Directors.

Essential Components

Written Policies and Procedures

The Network has established written policies, procedures, and standards of conduct. The Network's Program policies, procedures, and standards of conduct are applicable to, and must be followed by, all Affected Individuals. The Program and the related policies, procedures, and standards of conduct are specific to the mission, vision, organizational history, lines of business and corporate culture of the Network.

The Network's written policies and procedures:

1. Articulate the Network's commitment and obligation to comply with all applicable federal and state standards;
2. Identify governing laws and regulations, and Medicaid program policies and procedures, that are applicable to the Network's Risk Areas and categories of service;
3. Describe the Network's compliance expectations as embodied in standards of conduct (See the Network's Code of Conduct), which serve as a foundational document that describes the

Network's fundamental principles and values, and commitment to conduct its business in an ethical manner;

4. Guide the Network's implementation of the Program, document the Network's implementation of each of the regulatory requirements applicable to the Program, and outline the ongoing operation of the Program, including, at a minimum, a description of the structure of the Network's Program, including the responsibilities of all Affected Individuals in carrying out the Program's functions;
5. Provide guidance to Affected Individuals on dealing with potential compliance issues that, at a minimum, assists Affected Individuals in identifying potential compliance issues, questions, and concerns, sets fort the Network's expectations for reporting compliance issues, and explains how to report compliance issues, questions, and concerns to the Network's Chief Compliance Officer;
6. Establish the expectation that all Affected Individuals will act in accordance with the Network's standards of conduct, that they must refuse to participate in unethical or illegal conduct, and that they must report any unethical or illegal conduct to the Chief Compliance Officer;
7. Identify how to communicate compliance issues to appropriate compliance personnel, including the methods and procedures for such communication;
8. Describe how potential compliance problems are investigated and resolved by the Network, including the procedures for documenting investigations and the resolution or outcome;
9. Include a policy of non-intimidation and non-retaliation for good faith participation in the Network's Program, including, but not limited to, reporting potential compliance issues to appropriate personnel, participating in investigation of potential compliance issues, self-evaluations, audits, remedial actions, reporting instances of intimidation or retaliation, and reporting potential fraud, waste, or abuse to the appropriate state or federal entities;
10. Include a written statement regarding the Network's disciplinary standards, which sets out the Network's policy regarding Affected Individuals who fail to comply with the Network's Program policies, procedures, and standards of conduct or state and federal laws, rules, and regulations, establishes standards for escalating disciplinary actions that must be taken in response to non-compliance, and outlines the procedures for taking disciplinary action and sanctioning Affected Individuals; and
11. Provide training and education to Affected Individuals on the federal and state laws and regulations regarding false claims and whistleblower protections, consistent with the requirements of the federal Deficit Reduction Act ("DRA") of 2005 and 42 USC § 1396a(a)(68).

The Program and the related policies, procedures, and standards of conduct are developed in a collaborative fashion, and incorporate all legal requirements with the business methodology embraced by the Network. The Program and the related policies, procedures, and standards of conduct are reviewed and approved by Network leadership and the Board of Directors. The Chief Compliance Officer is responsible for reviewing and revising the Network's Program, including the written policies, procedures, and standards of conduct, and the Network Compliance Committee coordinates with the Chief Compliance Officer to ensure that the written policies, procedures, and standards of conduct are current, accurate, and complete.

The Network reviews the written Program policies, procedures, and standards of conduct on at least an annual basis in order to determine whether:

1. The written policies, procedures, and standards of conduct have been implemented;
2. Affected Individuals are following the policies, procedures, and standards of conduct;
3. The policies, procedures, and standards of conduct are effective; and
4. Any updates are required.

The Network's written policies, procedures, and standards of conduct are available to, and accessible by, all Affected Individuals. Copies of the Program and the related policies, procedures, and standards of conduct are located on the Network's intranet site, and are otherwise made available to those Affected Individuals who do not have access to the Network's intranet site. In addition to providing the compliance-related information outlined above, the Network's policies and procedures also address specific areas of potential fraud, waste, and abuse, such as billing and claims processing. Any new or revised Program policies and procedures are disseminated to all Affected Individuals by the Risk & Compliance Department.

The Network has established and maintained a process for drafting, revising, and approving the written policies, procedures, and standards of conduct applicable to the Program. The Network Policy management process and related requirements are outlined in the **Network's Policy on Policies.**

Designation of a Compliance Officer

The Vice President of Risk Management & Compliance has been designated as the Network's Compliance Officer and has the responsibility to administer and manage all tasks related to establishing, monitoring and updating the Program with oversight from the CEO and the Board of Directors. The Chief Compliance Officer is the focal point of the Network's Program and is responsible for the day-to-day operation of the Program. The Chief Compliance Officer reports directly to, and is accountable to, the CEO, CMIO and the Board of Directors. The Chief Compliance Officer provides reports directly to the Board, the CEO, and the Network Compliance Committee on the activities of the Program, including the progress of adopting, implementing, and maintaining the Program, on a regular basis and as needed, but no less than quarterly. The CEO may designate another senior manager whom the Chief Compliance Officer may report directly to for reporting purposes, so long as such designation does not hinder the Chief Compliance Officer in carrying out their duties and having access to the CEO and the Board.

Specifically, the Chief Compliance Officer's primary responsibilities include:

1. Overseeing and monitoring the adoption, implementation, and maintenance of the Network's Program and evaluating its effectiveness;
2. Overseeing the completion of a compliance risk analysis to identify Risk Areas specific to the Network;
3. Supervising the implementation and maintenance of the Program, coordinating existing Program policies and procedures, developing new Program policies and procedures, and ensuring that all revisions and new policies and procedures are disseminated as outlined in this Program;
4. Drafting, implementing, and updating a compliance work plan which outlines the Network's proposed strategy for meeting the applicable regulatory requirements for the coming year, with a specific emphasis on written policies and procedures, training and education, auditing and monitoring, and responding to compliance issues, with such updates occurring no less frequently

than annually or, as otherwise necessary, to conform to changes to federal and state laws, rules, regulations, policies, and standards;

5. Reviewing and revising the Program and the written policies, procedures, and standards of conduct (i.e., the Code of Conduct) to incorporate changes based on the Network's Organizational Experience and to promptly incorporate changes to federal and state laws, rules, regulations, policies, and standards;
6. Reporting directly, on a regular basis, but no less frequently than quarterly, to the Board, the CEO, and the Network Compliance Committee on the progress of adopting, implementing, and maintaining the Program;
7. Providing oversight for and evaluating the monitoring and auditing of procedures related to the Program and applicable compliance standards;
8. Assisting the Network in establishing methods, such as periodic audits, to improve the Network's efficiency and quality of services, and to reduce the Network's vulnerability to fraud, waste, and abuse;
9. Monitoring the Program's training and education requirements, and ensuring that Affected Individuals receive training and education on the basic principles of corporate compliance and ethical business practices;
10. Implementing and maintaining a means for anonymous communication for reporting compliance issues, receiving help and assistance regarding potential compliance issues/violations, and receiving general information about corporate compliance and the Network's Program;
11. Establishing and maintaining open lines of communication with all Network departments, including the billing department, and all Affected Individuals in order to ensure that the Network has effective and efficient compliance policies and procedures;
12. Investigating and independently acting on matters related to the Program, including designing and coordinating internal investigations of any report or allegation of a compliance issue, including any possible unethical or improper business practices, and documenting, reporting, coordinating, pursuing, and monitoring any subsequent corrective action and/or compliance with all internal departments, contractors, and the state;
13. Working closely with regulatory body auditors where appropriate and being available as needed during annual Network audits;
14. Preparing and forwarding compliance reports as required by the Network Quality, Risk & Compliance Committee and the Network Compliance Committee, and on at least \a semi-annual basis, and submitting an annual summary and evaluation report to the CEO, Network Leadership, and the Board of Directors; and
15. Coordinating the Network Compliance Committee and ensuring the annual review of the Committee's charter.

All questions and concerns regarding compliance with any of the directives set forth within this Program are to be directed to the Chief Compliance Officer. The Network is responsible for ensuring that the Chief Compliance Officer has sufficient staff and resources available to maintain the satisfactory performance of their responsibilities for the day-to-day operation of the Program, based on the Network's Risk Areas and Organizational Experience. The Chief Compliance Officer and appropriate compliance personnel

have access to all records, documents, information, facilities, and Affected Individuals that are relevant to carrying out their Program responsibilities, and the Network is responsible for ensuring such access.

All Affected Individuals are required to fully cooperate with and assist the Chief Compliance Officer in the performance of their duties. The Chief Compliance Officer may be assigned other duties however those duties must not hinder the primary responsibilities of the Chief Compliance Officer. Decisions regarding whether the Chief Compliance Officer will be assigned other duties will be based on the Network's size, complexity, resources, and culture, as well as the complexity of the tasks to be assigned. All Affected Individuals should bring any questions regarding the Program or compliance issues to the attention of the Chief Compliance Officer for assistance and direction.

Note: The Compliance Officer is not required to be an employee of the Network, but the Network may decide to designate an employee to act in this role.

Designation of a Compliance Committee

As set out in further detail above, the Network has designated the Network Compliance Committee as the compliance committee with responsibility for coordinating with the Chief Compliance Officer to ensure that the Network is conducting its business in an ethical and responsible manner, consistent with its Program.

Effective Education & Training

The Network ensures that ethics and compliance training and education is provided to all Affected Individuals, including employees and associated persons, as well as the Network's officers, Board members, and Chief Compliance Officer. The training and education provided by the Network will include, at a minimum, the following topics:

1. The Network's Risk Areas and Organizational Experience;
2. The Network's written policies, procedures, and standards of conduct (i.e., the Code of Conduct) applicable to the Program;
3. The role of the Chief Compliance Officer and the Network Compliance Committee;
4. How Affected Individuals can ask questions and report potential compliance-related issues to the Chief Compliance Officer and senior management, including Affected Individuals' obligation to report suspected illegal or improper conduct and the procedures for submitting such reports, and the protection from intimidation and retaliation for good faith participation in the Program;
5. Disciplinary standards, with an emphasis on the Network's standards related to the Program and the prevention of fraud, waste, and abuse;
6. How the Network responds to compliance issues and implements corrective action plans;
7. Requirements specific to the Medicaid program and the Network's categories of service;
8. Coding and billing requirements and best practices, if applicable; and
9. Claim development and the submission process, if applicable.

Training and education are provided by the Network in an accessible and understandable manner, and in a form and format that is accessible and understandable to all Affected Individuals, consistent with federal and state language and other access laws, rules, and/or policies.

Training and education occur at least annually, and is a part of the orientation for new Chief Compliance Officers and Affected Individuals. Orientation training and education on the Program is provided to:

- Network employees promptly upon hiring, and no later than 30 days after the start of employment;
- Affected Individual contractors promptly upon contracting or otherwise initiating a relationship with the Network, and no later than 30 days after the start of the contract or the contractor's relationship with the Network; and
- Board of Directors members promptly upon appointment to the Network's Board, and no later than 30 days after the start of the Board member's term on the Board of Directors.

Training and education is provided through mandatory training programs and by disseminating publications that explain, in a practical manner, the requirements of the Program to all Affected Individuals. All employees receive training on how to perform their jobs in compliance with the standards of the Network and any applicable laws and regulations, and each employee must understand that compliance is a condition of continued employment.

Coders, billers and coding managers are educated regularly on the following topics: Medicare reimbursement principles, coding and billing requirements and best practices, and billing practices that are vulnerable to fraud, waste, and abuse, including billing Medicare and Medicaid for services not rendered, misrepresenting the nature of services rendered, alterations of medical records, billing in violation of the Medicare/Medicaid bundling regulations, medical necessity of services provided, contracts/conflict of interest, credit balance, failure to refund, and patients' freedom of choice.

Initial and annual training and education on compliance and the Network's Program is conducted, both with respect to the Program itself and applicable statutes and regulations. This training and education is a component of all Affected Individuals' orientation, including Board member, provider and staff orientation.

Compliance and Program-related training and education is also provided to all Affected Individuals on at least an annual basis. In addition to the training and education topics set out above, the items included in the Risk and Compliance Annual In-Service include:

- The Network as an FQHC;
- Purpose and Components of the Risk and Compliance Program;
- Outline of Network Policies, Programs and Plans;
- Incident Reports;
- Privacy & Security, including:
    - HIPAA;
    - Unauthorized Access to PHI;
    - PHI Self Disclosure; and
    - Consent for the Treatment of Minors;
- Fraud, Waste, and Abuse, including:
    - Code of Conduct;

  - DRA-Required Training and Education Topics;
  - Federal Administrative Remedies for False Claims;
  - False Claims Act;
  - Stark Law;
  - Anti-Kickback Statute;
  - Hyde Amendment;
  - Relevant NYS Laws and Regulations;
  - Legislative Mandates; and
  - Conflicts of Interest;
- Safety, including:
  - Emergency Preparedness Plans/Business Continuity Plan;
  - Safety Advisors;
  - OSHA Requirements/Employee Rights;
  - Network Plain Language Code System;
  - Safety Data Sheets;
  - Active Shooter Response; and
  - Other Topics, including Hazard Recognition, Fire Drills, Workplace Violence and Harassment, Domestic Violence, and Human Trafficking.

Training is provided in an understandable manner to assure all Affected Individuals, including staff, are aware of and know the requirements of the Network's Code of Conduct and the steps to alert management and the Chief Compliance Officer to any concerns or problems. Training and education on compliance and the Network's Program is modified/customized for different types of Affected Individuals in order to reflect the level of risk an Affected Individual, such as a staff member or agent, possesses, or may encounter, with additional training and education being provided to providers, managers, supervisors, Board members and those individuals working with billing and accounting processes. Such customized training will be provided in addition to the core compliance and Program-related training and education requirements set out above.

Evaluation of management promotion of, and adherence to, the Program and any other compliance issues are a component of the annual performance appraisal of Affected Individuals, as applicable. Attendance records of orientation and annual training and education are maintained, with annual performance appraisals based, in part, on receipt of compliance information as offered by the Network.

The Network develops and maintain a training plan to ensure compliance with the training and education requirements set out in this Program, and in applicable regulations. The Network's training plan will, at a minimum, outline:

1. The subjects or topics for training and education;
2. The timing and frequency of the training;
3. Which Affected Individuals are required to attend;
4. How attendance will be tracked; and
5. How the effectiveness of the training will be periodically evaluated.

Reference: The Orientation Programs Policy, and the Risk Management & Compliance Training Policy. In addition to the information set out in this Program, the Network Annual Training Plan outlines the training provided to all Affected Individuals.

Fraud, Waste & Abuse Program

Affected Individuals (via written or verbal contract and/or statement or representation of material fact in agreement) shall not knowingly and willfully make or cause to be made, any false claim or application for benefits under any federal, state or other health care program. Network personnel and agents shall not, with knowledge and fraudulent intent, retain federal, state or other health care benefit program funds, which have not been properly paid. The Program includes activities to detect, correct and prevent fraud, waste, and abuse.

> ***Fraud:*** The intentional deception or misrepresentation that an individual knows to be false or does not believe to be true, knowing that deception could result in some unauthorized benefit to the individual or other party
>
> ***Waste:*** Acting with gross negligence or reckless disregard for the truth in a manner resulting in any unnecessary cost or consumption of health care resources.
>
> ***Abuse:*** Practices that are inconsistent with sound fiscal, medical, business or professional practices and which result in unnecessary costs to the Medicaid program, payments for services which were not medically necessary, or payments for services which fail to meet recognized standards for health care.

Examples of Fraud, Waste & Abuse

Fraud, waste, and abuse includes activities such as embezzlement, misuse or misappropriation of funds or property, and false statements or claims. Common examples of Fraud Waste & Abuse are as follows:

Provider

- Billing for Medicaid/Medicare services that were not provided;
- Providing and/or billing for unnecessary services;
- Selling prescriptions;
- Ordering unnecessary tests; or
- Giving money or presents to consumers in return for agreeing to get medical care from someone.

Patient

- Lending a Medicaid identification card to another person;
- Forging or altering a prescription or fiscal order;
- Using multiple Medicaid identification cards;
- Intentionally receiving duplicative, excessive, contraindicated, or conflicting health care services or supplies; or
- Re-selling items provided by the Medicaid program.

Affected Individuals

- Theft of award funds for personal use
- Using funds for non-award-related purposes
- Theft of federally owned property or property acquired or leased under an award
- Charging inflated building rental fees for a building owned by the recipient
- Submitting false financial report
- Submitting false financial data in bids submitted to the recipient

Any fraud, waste, or abuse related to HHS awards or use of award funds should be reported to HHS.

The federal government may pursue administrative, civil, or criminal action under a variety of statutes that relate to fraud and false statements or claims. Even if no award is made, you may be subject to penalties if information submitted as part of an application is found to be false, fictitious, or fraudulent.

Effective Lines of Communication

The Network has established and implemented effective lines of communication which ensure confidentiality for the Network's Affected Individuals.

Communication lines to the Network's Chief Compliance Officer or their designee are accessible to all Affected Individuals and allow Affected Individuals to report compliance issues and ask questions regarding compliance issues.

The Network's communication lines include an anonymous "Compliance Hotline," which can be used to anonymously report potential fraud, waste, and abuse, and other compliance issues, directly to the Chief Compliance Officer. The Compliance Hotline may be accessed by dialing (855) 210-4119. Anonymous reports of potential fraud, waste, and abuse, and other compliance issues, can also be made by mailing a written report without a return address to the Chief Compliance Officer at Attn: Chief Compliance Officer, Hudson Headwaters Health Network, George Purdue Administration Building, 9 Carey Road, Queensbury, New York 12804. Individuals who choose to make an anonymous report are encouraged to provide as many details as possible for the Network to conduct a proper investigation.

These lines of communication are available to all individuals who receive services from the Network and who are enrolled in the Medicaid program. Affected Individuals are required to promptly report compliance issues, including actual or suspected improper or unethical conduct, upon awareness by reporting to:

- Anonymous Compliance Hotline at (855) 210-4119;
- Risk Management & Compliance Department by telephone at (518) 409-8642;
- Chief Compliance Officer, Jill Coombes, by:
    - telephone at (518) 761-0300 ext. 31101
    - email at jcoombes@hhhn.org
    - or in writing Attn: Chief Compliance Officer, Hudson Headwaters Health Network, George Purdue Administration Building, 9 Carey Road, Queensbury, New York 12804 (anonymously or otherwise);

- A member of the Network Compliance Committee.

The Network will keep all reports of fraud, waste, or abuse, or other compliance issues, confidential to the greatest extent possible, regardless of whether confidentiality is requested by the reporter. The Network will ensure that the confidentially of persons reporting compliance issues is maintained unless:

- The matter is subject to a disciplinary proceeding;
- The matter is referred to, or under investigation by, the New York State Attorney General's Medicaid Fraud Control Unit ("MFCU"), the New York State Office of the Medicaid Inspector General ("OMIG"), or law enforcement; or
- Disclosure is required during a legal proceeding.

Individuals who report problems or concerns in good faith will be protected from retaliation, retribution, intimidation, or harassment. Affected Individuals who engage in retribution, harassment, or any other type of retaliatory action will be subject to disciplinary action up to and including termination of employment (for employees), termination of contract or relationship (for contractors), and removal from the Board of Directors (for Board members).

The lines of communication to the Network's Chief Compliance Officer are publicized by the Network. Additionally, posters containing information about the anonymous Compliance Hotline are posted in employee break rooms throughout the Network and on the Network's Intranet site with the compliance policies and procedures. The Network also makes information concerning the Program and the Network's standards of conduct available on its website.

Disciplinary Policies/Enforcement of Standards & Discipline

The Network requires good faith participation in the Program by all Affected Individuals as a condition of employment/contract. Policies outline expectations for reporting compliance issues and assisting in their resolution. The policies outline actions for failing to report suspected problems, participating in non-compliant behavior, and/or encouraging, directing, facilitating, or permitting, either actively or passively, non-compliant behavior, including the failure to comply with the Network's Program policies, procedures, and standards of conduct, or state and federal laws, rules, and regulations. Such disciplinary policies shall be fairly, firmly, and consistently enforced, and the same disciplinary actions will apply to all levels of the Network's personnel.

Through its systematic reporting, monitoring, and auditing systems, the Network investigates and remediates identified systematic and personnel problems. Discipline of an individual responsible for the failure to detect a violation and/or an individual who commits a violation is conducted. Upon determination that an Affected Individual has violated the conduct requirements as set forth in the Program, the individual case is handled by the Network's disciplinary processes. These disciplinary processes outline the procedures for taking disciplinary action and sanctioning Affected Individuals, and conform with collective bargaining requirements, when applicable.

Management personnel are responsible for the conduct of their contractors and subordinates and as such, must ensure appropriate compliance training for respective roles, responsibilities, and areas of oversight.

The Network's disciplinary processes establish standards for escalating disciplinary actions that must be taken in response to non-compliance, and intentional or reckless behavior is subject to more significant sanctions. Sanctions may include oral or written warnings, suspension, and/or termination. The following additional standards apply to the Network's disciplinary processes:

- All Affected Individuals are informed that adherence to the Program will be an element of any annual performance evaluation and that willful violation or failure to comply with the Network's organizational policies/procedures and the Program plan will be grounds for immediate termination of employment, contractual or other relationship, or Board membership.
- All disciplinary actions are conducted in such a manner that affords the Affected Individual confidentiality and due process.
- Self-disclosure of misconduct is encouraged, and Affected Individuals are advised that while self-reporting will not result in immunity from discipline, it will be considered as a strong mitigating factor when corrective action is required.
- No individual who has engaged in illegal or unethical behavior and/or who has been convicted of health care-related crimes is allowed to occupy any position within the Network which involves the exercise of discretionary authority.
- Any individual applying for a position of discretionary authority must have a background evaluation performed prior to hire. Upon discovery of any state or federal sanctions, the potential staff member will no longer be considered for hire.
- Any personnel in a position of discretionary authority who displays evidence that they are unwilling to comply with the Program plan will be removed from that position.

Any Affected Individual who is found to be sanctioned under federal or state statutes or laws can be immediately terminated.

The written policies and procedures which establish the Network's disciplinary standards, as well as the procedures for taking such actions, are published by the Network and are disseminated to all Affected Individuals. These written policies and procedures are also incorporated into the Network's training plan for purposes of compliance training and education.

Compliance Champions Program

The Network has established the Compliance Champion Program to reward employees who are alert to compliance and ethics issues, and who exhibit desired behaviors such as raising questions and concerns when they see something that is not right or assisting in the prevention, detection or remediation of policy violations. Rewards may also be provided specifically for contributions to the Program, and for those who show leadership in promoting the Code of Conduct. The award criteria used to select Compliance Champions includes the following:

- Uses the Code of Conduct and encourages others to do the same;

- Actively takes steps to implement the Program and the Code of Conduct;
- Attends appropriate compliance training and education, and helps to ensure others get appropriate training and education, and know the rules that apply to their jobs;
- Takes ongoing steps to reinforce compliance and ethics training and education;
- Assists in the investigation and remediation of events;
- Reports questionable conduct or proposals;
- Encourages openness and transparency in raising issues and concerns;
- Has an active management style, pays attention to details, and positively influences others to act with integrity;
- Promotes safe and environmentally sound work practices; and
- Places the health and safety of our patients/staff above all.

Auditing and Monitoring

The Network has established and implemented an effective system for routine monitoring and identification of compliance Risk Areas and for self-evaluation of such Risk Areas. The Network's system includes, but is not limited to, internal monitoring and audits and, as appropriate, external audits, in order to evaluate the Network's compliance with the requirements of the Medicaid Program and the overall effectiveness of the Network's Program.

The Network has taken reasonable steps to achieve compliance with its standards, i.e., by utilizing monitoring and auditing systems designed to detect actual or potential compliance issues by Affected Individuals, and by having in place and publicizing a reporting system whereby Affected Individuals can report compliance issues without fear of retribution. The purpose of the ongoing auditing and monitoring processes is to identify actual or potential issues in a timely manner so that systemic checks and balances can be imposed quickly to prevent future recurrences.

Reference: The *Network Audit Plan* that outlines the Network's audit and monitoring activities.

Auditing

The Network will conduct regular internal monitoring and periodically conduct self-audits to determine whether it is operating in compliance with legal, regulatory, and other applicable requirements, as well as with its written standards and policies and procedures and to assess the effectiveness of its Compliance Program. This is outlined in detail in the Network's Compliance Monitoring & Auditing policy. Key points regarding the coding and billing audits conducted by the Network are as follows:

- Documentation must be consistent, timely, and authenticated.
- Should instances of potentially improper billing code assignments be identified, all pertinent policies/procedures, including official coding guidelines and billing manuals, are reviewed with the individual who incorrectly coded the encounter.
- A statistically valid, random sample of cases is reviewed to determine whether the problem is an isolated issue, and whether the problem occurred during an isolated time period or is a widespread, ongoing problem.

- Staff are interviewed to obtain more information about how and why the particular billing or coding practice in question occurred. Other Affected Individuals, such as contractors and Board members, are also interviewed to obtain additional information, if relevant. A trend analysis is conducted, and re-training is conducted as needs are identified.
- An annual financial audit is conducted to check for possible violations of laws or regulations, such as those related to the Medicare and Medicaid fraud and abuse statutes, including but not limited to the Medicare and Medicaid Anti-Kickback Statute, limitations on certain physician referrals (the Stark Law), and the False Claims Act in any jurisdiction whose effects should be considered for disclosure in the financial statements or as a basis for recording a loss contingency (other than those disclosed or accrued in the financial statements).
- The design, implementation, and results of any internal or external audits will be documented, and the results will be shared with the Network Compliance Committee and the Board of Directors; and

An independent audit of the Network's consolidated financial statements is conducted annually (including 330 Grant funds) to check for compliance for each major federal program and report on internal control over compliance required by the Uniform Guidance. An independent audit is conducted periodically to check for compliance with the rules and regulations of the US Department of Health and Human Services Office of Pharmacy Affairs Drug Pricing Program ("Section 340B"). The audit is conducted in compliance with attestation standards established by the American Institute of Certified Public Accountants.

The Network Board of Directors includes an Audit Committee. The Network's routine audits are performed by internal or external auditors who have expertise in state and federal Medicaid program requirements and applicable laws, rules, and regulations, or who have expertise in the subject area of the audit.

In addition to the standards set out above, audits of the Network's programs and services will also meet the following requirements:

- Internal and external compliance audits will focus on the Network's compliance Risk Areas;
- The results of all internal or external audits, or audits of the Network conducted by the state or federal government, will be reviewed for Risk Areas that can be included in updates to the Network's Program and compliance work plan;
- Any Medicaid program overpayments identified will be reported, returned, and explained in accordance with the Medicaid self-disclosure requirements, and the Network will promptly take corrective action to prevent recurrence.

Monitoring

Monitoring provides an ongoing system of internal coding and billing review. Monitoring is conducted on a regular basis and focuses on compliance with the Program and performance measures. The purpose of monitoring is to assure that the Network's policies and procedures have been properly followed.

Monitoring techniques include, but are not limited to health center visits, interviewing staff members and other Affected Individuals (as relevant), interviewing management, review of operations, billing and related functions and trend analysis studies.

Exclusions

The Network confirms the identity and determines the exclusion status of all current and prospective Affected Individuals, including Network Board members, providers, employees, volunteers, vendors, suppliers, contractors, and any Business Associates (as such term is defined in HIPAA). In determining exclusion status, the Network reviews the following federal and state databases: the HHS/OIG List of Excluded Individuals and Entities, the Systems for Award Management (SAM) database, and the NYS Office of the Medicaid Inspector General Exclusion List.

Exclusion monitoring is conducted upon hire and every 30 days and the results of all exclusion screenings are promptly shared with the Chief Compliance Officer and appropriate compliance personnel. Reports are also provided to the Network Quality, Risk & Compliance Committee quarterly if an exclusion is detected.

Reference: *The Excluded Persons policy*.

Annual Compliance Program Review

The Network has developed and undertakes a process for reviewing whether the requirements of the Medicaid compliance program regulations have been met. This review occurs at least annually, and the purpose of the review is to determine the effectiveness of the Network's Program, and whether any revision or corrective action is required.

The annual review of carried out by the Chief Compliance Officer, Network Compliance Committee, external auditors, or other staff designated by the Network, so long as such staff have the necessary knowledge and expertise to evaluate the effectiveness of the components of the Network's Program they are reviewing and are independent from the functions being reviewed. The reviews include on-site visits, interviews with Affected Individuals, review of records, surveys, or any other comparable method deemed appropriate by the Network, so long as the method does not compromise the independence or integrity of the review.

The design, implementation, and results of the annual effectiveness review are documented by the Network. Any corrective action implemented is also documented by the Network. The results of the annual Program review are shared with the Network's CEO and senior management, the Network Compliance Committee, and the Board of Directors.

Prompt Response to Detected Offenses

The Network encourages prompt reporting, at the earliest reasonable opportunity, by Affected Individuals of any activity or conduct in violation of any Network compliance policy or any federal, state, or local laws or regulations pertaining to compliance-related matters. The Network has established and implemented procedures and systems for:

- Promptly responding to compliance issues as they are raised;
- Investigating potential compliance problems as identified in the course of internal auditing and monitoring;
- Correcting such problems promptly and thoroughly to reduce the potential for recurrence; and
- Ensuring ongoing compliance with state and federal laws, rules, and regulations, as well as Medicaid program requirements.

The Chief Compliance Officer promptly investigates all potential compliance risks and compliance issues detected, including those identified through reports of potential violations or non-compliance, or as a result of the auditing and monitoring conducted by the Network under the Program. Prompt action is taken in order to investigate the conduct in question and determine what, if any, corrective action is required, and promptly implement such corrective action. During the course of the investigation, the Chief Compliance Officer will review available evidence with the relevant supervisor, manager, director, or senior manager and the Board of Directors. Where appropriate, the Network and the Chief Compliance Officer may retain outside experts, auditors, or counsel to assist with the investigation.

The Chief Compliance Officer's investigation of the compliance issue will be documented, and the documentation will include any alleged violations, a description of the investigative process, copies of interview notes, and any other documents essential for demonstrating that a thorough investigation of the issue was completed by the Network. Any disciplinary action taken and the corrective action implemented will also be documented.

Policy of Non-Intimidation & Non-Retaliation

The Network has established a policy of non-intimidation and non-retaliation for good faith participation in the Program including, but not limited to, reporting potential compliance issues to appropriate personnel, participating in the investigation of potential compliance issues, self-evaluations, audits, remedial actions, reporting instances of intimidation or retaliation, and reporting potential fraud, waste, or abuse to the appropriate state or federal entities and/or officials.

Reporting to Government Entities

As required by the Medicaid compliance program regulations (18 NYCRR § 521-1.4(h)(4)), if the Network identifies credible evidence or credibly believes that a state or federal law, rule, or regulation has been violated, the Network must promptly report the violation to the appropriate governmental entity, when such reporting is otherwise required by law, rule, or regulation. The Chief Compliance Officer will receive copies of any reports that are submitted to governmental entities.

Regulatory Compliance

At all times, the Network's definition and resulting application of compliance remains consistent with the compliance requirements promulgated by the U.S. Department of Health and Human Services Office of Inspector General (OIG) and the New York State Office of the Medicaid Inspector General (OMIG), the Health Resources and Services Administration (HRSA) Bureau of Primary Health Care (BPHC) Program Expectations, HRSA BPHC Compliance Manual, the appropriate guidelines of the Federal Tort Claims

Act (FTCA), the rules, policies, and standards promulgated by all applicable accrediting entities, and federal and state laws, rules, and regulations.

Federal Laws Regarding the Prevention of Fraud, Waste, and Abuse

The False Claims Act (31 USC §§ 3729 – 3733; 18 USC § 287)

Under the federal civil False Claims Act, any person who knowingly and/or willfully submits a false or fraudulent claim for payment to the federal government may be subject to civil penalties, including monetary penalties, treble damages, exclusion from participation in the Medicare and Medicaid programs, and fines of up to three times the government's loss plus up to $11,000 per claim filed (i.e., each instance of an item or service billed to a government health care program). Examples of prohibited conduct include billing for services not rendered, upcoding claims, double billing, misrepresenting services that were rendered, falsely certifying that services were medically necessary, making false statements to the government, failing to comply with conditions of payment, and failing to refund overpayments made by a federal health care program. Notably, no specific intent to defraud the government is required, as "knowing" is defined to include not only actual knowledge but also instances in which the person acted in deliberate ignorance or reckless disregard of the truth or falsity of the information. The civil False Claims Act also contains a whistleblower provision that permits private citizens ("relators") to file suits on behalf of the government ("qui tam suits") against those who have defrauded the government and the relator, if successful, may receive a portion of the government's recovery.

Federal law also establishes criminal liability against individuals or entities that knowingly submit, or cause to be submitted, a false or fraudulent claim for payment to the federal government. Criminal False Claims Act liability can result in imprisonment of up to five years and/or substantial fines.

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

Federal law allows for administrative recoveries by federal agencies related to false claims. The laws penalize any person who makes, presents, or submits (or causes to be made, presented, or submitted) a claim that the person knows or has reason to know:

1. Is false, fictitious, or fraudulent;
2. Includes or is supported by any written statement which asserts a material fact which is false, fictitious, or fraudulent;
3. Includes or is supported by any written statement that omits a material fact, is false, fictitious, or fraudulent as a result of such omission, and is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact; or
4. Is for payment for the provision of property or services which the person has not provided as claimed.

The federal agency receiving the false claim may impose a penalty of up to $5,000 for each claim, as well as an assessment of up to twice the amount of the claim in violation of the False Claims Act. In these instances, the determination of whether a claim is false and the imposition of fines and penalties is made by the federal administrative agency, rather than by a court. Moreover, in contrast to the False Claims Act, a violation of these laws occurs when a false claim is submitted, rather than when it is paid.

The Anti-Kickback Statute (42 USC § 1320a-7b(b))

The federal Anti-Kickback Statute is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service that is payable by a federal health care program. Remuneration includes kickbacks, bribes, and rebates paid director or indirectly, overtly or covertly, in cash or in kind (i.e., anything of value), and items or services includes drugs, supplies, or health care services provided to Medicare or Medicaid patients. The statute covers both the payers and recipients of kickbacks. No intent to violate the statute is required, and the statute has been interpreted to cover any arrangement where one purpose of the remuneration was to obtain money for the referral of services or to induce further referrals.

An individual or entity that is found to have violated the Anti-Kickback Statute may be subject to criminal penalties and administrative sanctions including fines, imprisonment, and exclusion from participation in federal health care programs, including the Medicaid and Medicare programs. Safe harbors protect certain payment and business practices from criminal and civil prosecution that could otherwise implicate the Anti-Kickback Statute. To be protected by a safe harbor, the arrangement must fit squarely within the safe harbor and must satisfy all of its requirements.

The Physician Self-Referral Law (Stark Law) (42 USC § 1395nn)

The federal Physician Self-Referral Law, commonly referred to as the "Stark Law," prohibits physicians—including medical doctors, doctors of osteopathy, psychologists, oral surgeons, dentists, podiatrists, optometrists, and chiropractors—from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless the ownership or compensation arrangement is structured to fit within a regulatory exception.

Financial relationships include both ownership/investment interests and compensation arrangements, and "designated health services" are any of the following services, other than those provided as emergency physician services furnished outside of the United States, that are payable in whole or in part by the Medicare program:

1. Clinical laboratory services;
2. Physical therapy, occupational therapy, and outpatient speech-language pathology services;
3. Radiology and certain other imaging services;
4. Radiation therapy services and supplies;
5. Durable medical equipment and supplies;
6. Parenteral and enteral nutrients, equipment, and supplies;
7. Prosthetics, orthotics, and prosthetic devices and supplies;
8. Home health services;
9. Outpatient prescription drugs; and
10. Inpatient and outpatient hospital services.

The Stark Law is a strict liability statute, and therefore, proof of specific intent to violate the law is not required. The Law also prohibits the submission, or causing the submission, of claims in violation of the

law's restrictions on referrals. Penalties for physicians who violate the Stark Law include fines, civil penalties, repayment of Medicare and/or Medicaid reimbursement, and exclusion from participation in the federal health care programs.

Exclusion Statute (42 USC § 1320a-7)

The federal Exclusion Statute requires the United States Department of Health and Human Services, Office of Inspector General ("HHS-OIG") to exclude individuals and entities convicted of certain types of criminal offenses from participation in all federal health care programs (including the Medicare and Medicaid Programs), and gives HHS-OIG the discretion to exclude individuals and entities on several other grounds. The following types of criminal offenses require exclusion:

1. Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare or Medicaid;
2. Patient abuse or neglect;
3. Felony convictions for other health-care-related fraud, theft, or other financial misconduct; and
4. Felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

Physicians who are excluded from participation in federal health care programs are barred from receiving payment from programs such as Medicaid and Medicare for items or services furnished, ordered, or prescribed. Additionally, individuals and entities providing health care services may not employ or contract with excluded individuals or entities in any capacity or setting in which federal health care programs may reimburse for the items or services furnished by those employees or contractors. Employing or contracting with an excluded individual or entity may result in civil monetary penalties and an obligation to repay any amounts paid by a federal health care program attributable to the excluded individual or entity's services.

The Civil Monetary Penalties Law (42 USC § 1320a-7a)

The federal Civil Monetary Penalties Law authorizes HHS-OIG to seek civil monetary and other penalties against individuals and entities for a wide variety of conduct, including presenting a claim that a person knows or should know is for an item or service that was not provided as claimed or is false or fraudulent, presenting a claim that the person knows or should know is for an item or service that is not payable, or making false statements or misrepresentations on applications or contracts to participate in federal health care programs, among others. Violations of the False Claims Act, Anti-Kickback Statute, and Stark Law implicate the Civil Monetary Penalties Law and can lead to civil monetary and other penalties.

The amount of the penalties and assessments that HHS-OIG is authorized to seek under the Civil Monetary Penalties Law differs depending on the type of violation at issue. Specifically, the Civil Monetary Penalties Law authorizes penalties in the amount of $100,000 for each act in violation of the Anti-Kickback Statute, in addition to any other penalty that may be prescribed by law. Regulations also permit HHS-OIG to impose a penalty up to $50,000 for each offer, payment, solicitation or receipt of remuneration, and violations of the Anti-Kickback Statute can result in assessments of up to three times the total amount of the remuneration offered, paid, solicited, or received. Remuneration under the Civil

Monetary Penalties Law includes waivers of coinsurance and deductible amounts (including partial waivers), and transfers of items or services for free or for amounts other than fair market value. In addition to civil monetary penalties, persons or entities may also be excluded from participation in federal health care programs, fines, treble damages, denial of payment, and repayment of amounts improperly paid.

Criminal Health Care Fraud Statute (18 USC § 1347)

The federal criminal health care fraud statute prohibits knowingly and willfully executing, or attempting to execute, a scheme or artifice in connection with the delivery of or payment for health care benefits, items, or services to defraud any health care benefit program; or obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. In general, a person demonstrates the intent to defraud under this statute when they use false pretenses, misrepresentations, or false promises to obtain either money or services to which they would not otherwise be entitled. Importantly, however, neither actual knowledge of the health care fraud statue nor specific intent to commit a violation of the statute are required.

S.1932(109th): Deficit Reduction Act

The Deficit Reduction Act (DRA) of 2005 requires entities receiving $5 million or more in annual Medicaid payments to establish written policies educating their workforce about the Federal False Claims Act, state-specific false claims acts, and whistleblower protections. These policies are crucial for preventing and detecting fraud, waste, and abuse within the Medicaid program and must be disseminated to employees, contractors, agents, and others involved in billing, coding, or monitoring healthcare services.

New York State Laws Regarding the Prevention of Fraud, Waste, and Abuse

New York Social Services Law (NY Social Services Law § 363-d)

Section 363-d of the New York Social Services Law requires certain providers of Medicaid program items and services to adopt and implement a compliance program (in the case of the Network, the Ethics & Compliance Program). The law provides that the purpose of the compliance program is to organize provider resources to resolve payment discrepancies and detect inaccurate billings, among other things, as quickly and efficiently as possible, and to impose systemic checks and balances to prevent future recurrences. For a compliance program to be effective, Section 363-d requires the program to be designed to be compatible with the provider's characteristics. The program must, at a minimum, be applicable to billings to and payments from the Medicaid program, and the program may be a component of more comprehensive compliance activities by the Medicaid provider, so long as the requirements of Section 363-d are met.

The compliance program required by Section 363-d must include measures that prevent, detect, and correct non-compliance with Medicaid program requirements, as well as measures that prevent, detect, and correct fraud, waste, and abuse. Under the law, compliance programs must include the following elements:

1. Written policies, procedures, and standards of conduct;

2. Designation of a compliance officer and a compliance committee who report directly and are accountable to the organization's chief executive or other senior management;
3. Establishment and implementation of effective training and education for the organization's compliance officer, employees, chief executive, other senior administrators, managers, and governing body members;
4. Establishment and implementation of effective lines of communication, ensuring confidentiality, between the compliance officer, members of the compliance committee, the organization's employees, managers, and governing body, and the organization's first tier, downstream, and related entities;
5. Well-publicized disciplinary standards through the implementation of procedures which encourage good faith participation in the compliance program by all affected individuals;
6. Establishment and implementation of an effective system for routine monitoring and identification of compliance risks; and
7. Establishment and implementation of procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensuring ongoing compliance with the Medicaid program's requirements.

The adoption and implementation of a compliance program that meets the requirements of Section 363-d is a condition of Medicaid program payment, and providers must certify that they satisfactorily meet the compliance program requirements upon enrollment in the Medicaid program. Providers who fail to adopt and implement a satisfactory compliance program may be subject to sanctions or penalties including exclusion from the Medicaid program and financial penalties ranging from $5,000 to $10,000 per month, for a maximum of 12 calendar months. Section 363-d also obligates providers to report, return, and explain overpayments received from the Medicaid program.

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

The New York State False Claims Act closely tracks the federal False Claims Act, and 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 the Medicaid program. Specifically, the Act penalizes any person or entity who, among other conduct:

1. Knowingly presents, or causes to be presented, to any employee, officer, or agent of the state or a local government a false or fraudulent claim for payment or approval, or conspires to do the same;
2. Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim, or conspires to do the same;
3. Conspires to defraud the state or a local government by getting a false or fraudulent claim allowed or paid; or
4. 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 state or a local government.

The penalty for filing a false claim is $6,000 to $12,000 per claim and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the person or entity that filed the false claim may have to pay the government's legal fees, including the costs of a civil action brought to recover any penalties or damages and attorneys' fees. The New York State False Claims Act also allows private individuals ("relators") to bring an action on behalf of the state or local government ("qui tam suits"). If the lawsuit results in a recovery or settlement, the relator may share in a percentage of the proceeds.

New York Social Services Law § 145

Under Section 145 of the New York Social Services Law, any person who makes false statements or representations, deliberately conceals any material fact, impersonates another, or through another fraudulent device obtains, or attempts to obtain, or aids or abets any person to obtain, public assistance or care to which the person is not entitled, including Medicaid program benefits, is guilty of a misdemeanor. However, if the act constitutes a violation of a provision of the New York Penal Law, the person will be punished in accordance with the penalties fixed by the applicable law.

New York Social Service Law § 145-b

Section 145-b of the New York Social Services Law makes it unlawful to knowingly make a false statement or representation, to deliberately conceal any material fact, or to engage in any other fraudulent scheme or device to obtain or attempt to obtain public funds, including Medicaid program funds. In instances where a violation of this law occurs, the local Social Services District or the state may recover civil damages equal to three times the amount by which any figure is falsely overstated. In the case of non-monetary false statements, the local Social Services District or state may recover three times the damages sustained by the government due to the violation or $5,000, whichever is greater. The Department of Health may also impose a civil penalty of up to $2,000 per violation, and if repeat violations occur within five years, a penalty of up to $7,500 per violation may be imposed if the conduct involves more serious violations of Medicaid rules, billing for services not rendered, or providing excessive services.

New York Social Services Law § 145-c

Under Section 145-c of the New York Social Services Law, any person who applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the needs of the person or their family are not taken into account for various periods of time based on the offense committed. Specifically, the person's or their family's needs will not be taken into account for six months on the first offense, 12 months on the second offense or a single offense that resulting in the wrongful receipt of benefits in an amount of between $1,000 and $3,900, 18 months on the third offense or upon an offense that results in the wrongful receipt of benefits in an amount in excess of $3,900, and five years for any subsequent occasion of any such offense. These sanctions are in addition to any sanctions which may be provided for by law with respect to the offenses involved.

New York Social Services Law § 366-b

Under Section 366-b of the Social Services Law, any person who obtains or attempts to obtain, for themselves 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. Additionally, any person who, with intent to defraud, presents for payment a false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation, or knowingly submits false information in order to obtain authorization to provide items or services is guilty of a Class A misdemeanor. Finally, if an act also constitutes a violation of a provision under the New York Penal Law, the person committing the act will be punished in accordance with the penalties fixed by such law.

New York Penal Law Article 155

Article 155 of the New York Penal Law establishes the crime of Larceny, which occurs when a person, with intent to deprive another of their property, obtains, takes, or withholds the property by means of trick, embezzlement, false pretense, false promise, a scheme to defraud, or other similar behavior. The four crimes of Larceny have been applied to Medicaid fraud cases. These crimes include:

1. Penal Law § 155.30, Grand Larceny in the Fourth Degree, which involves property valued over $1,000, and is a Class E felony;
2. Penal Law § 155.35, Grand Larceny in the Third Degree, which involves property valued over $3,000, and is a Class D felony;
3. Penal Law § 155.40, Grand Larceny in the Second Degree, which involves property valued over $50,000, and is a Class C felony; and
4. Penal Law § 155.42, Grand Larceny in the First Degree, which involves property valued over $1 million, and is a Class B felony.

New York Penal Law Article 175

The four crimes in Article 175 of the New York Penal Law, Offenses Involving False Written Statements, relate to filing false information or claims and have been applied in Medicaid fraud prosecutions. These crimes include:

1. Penal Law § 175.05, Falsifying Business Records, which involves entering false information, omitting material information, or altering an enterprise's business records with the intent to defraud, and is a Class A misdemeanor;
2. Penal Law § 175.10, Falsifying Business Records in the First Degree, which includes the elements of Penal Law § 175.05 and the intent to commit another crime or conceal its commission, and is a Class E felony;
3. Penal Law § 175.30, Offering a False Instrument for Filings in the Second Degree, involves presenting a written instrument (including a claim for payment) to a public office knowing that it contains false information, and is a Class A misdemeanor; and
4. Penal Law § 175.35, Offering a False Instrument for Filing in the First Degree, which includes the elements of Penal Law § 175.30 and an intent to defraud the state or a political subdivision, and is a Class E Felony.

New York Penal Law Article 176

Article 176 of the New York Penal Law, Insurance Fraud, applies to claims for insurance payment, including Medicaid or other health insurance, and contains six crimes. The crimes include:

1. Penal Law § 176.10, Insurance Fraud in the Fifth Degree, which involves intentionally filing a health insurance claim knowing that it is false, and is a Class A misdemeanor;
2. Penal Law § 176.15, Insurance fraud in the Fourth Degree, which involves filing a false insurance claim for over $1,000, and is a Class E felony;
3. Penal Law § 176.20, Insurance Fraud in the Third Degree, which involves filing a false insurance claim for over $3,000, and is a Class D felony;
4. Penal Law § 176.25, Insurance Fraud in the Second Degree, which involves filing a false insurance claim for over $50,000, and is a Class C felony;
5. Penal Law § 176.30, Insurance Fraud in the First Degree, which involves filing a false insurance claim for over $1 million, and is a Class B felony; and
6. Penal Law § 176.35, Aggravated Insurance Fraud, which involves committing insurance fraud more than once, and is a Class D felony.

New York Penal Law Article 177

Article 177 of the New York Penal Law establishes the crime of Health Care Fraud, and applies to claims for health insurance payment, including claims submitted to the Medicaid program and other health plans, including non-government plans, and contains five crimes. The crimes include:

1. Penal Law § 177.05, Health Care Fraud in the Fifth Degree, involves knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions, and is a Class A misdemeanor;
2. Penal Law § 177.10, Health Care Fraud in the Fourth Degree, involves filing false claims and annually receiving over $3,000 in the aggregate, and is a Class E felony;
3. Penal Law § 177.15, Health Care Fraud in the Third Degree, involves filing false claims and annually receiving over $10,000 in the aggregate, and is a Class D felony;
4. Penal Law § 177.20, Health Care Fraud in the Second Degree, involves filing false claims and annually receiving over $50,000 in the aggregate, and is a Class C felony; and
5. Penal Law § 177.25, Health Care Fraud in the First Degree, involves filing false claims and annually receiving over $1 million in the aggregate, and is a Class B felony.

Employee Whistleblower Protections

The Network is prohibited from discharging, demoting, threatening, harassing, or otherwise discriminating against an employee as a reprisal when an employee discloses information in compliance with any of the following laws.

For more information, reference the *Employee Handbook*.

Federal False Claims Act (31 USC §§ 3730(h))

The civil False Claims Act provides protection to 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 False Claims Act. Remedies include reinstatement with comparable seniority as the 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. However, if the qui tam action has no merit or is for the purpose of harassing the person or entity, the individual may have to pay the person or entity for its legal fees and costs in defending the suit.

New York State False Claims Act (NY State Finance Law § 191)

The New York State False Claims Act provides protection to an employee of any private or public employer who is discharged, demoted, suspended, threatened, harassed, or otherwise discriminated against in the terms and conditions of employment by their employer because of lawful acts taken by the employee in furtherance of an action under the New York State False Claims Act. Remedies can include reinstatement to the same position or an equivalent position, two times back pay, reinstatement of full fringe benefits and seniority rights, and compensation for any special damages sustained, including litigation costs and reasonable attorneys' fees.

New York Labor Law § 740

An employer may not take any retaliatory action against an employee (including former employees) if the employee discloses, or threatens to disclose, information about the employer's policies, practices, or activities to a regulatory, law enforcement, or another similar agency or public official. Protected disclosures include disclosures of an activity, policy, or practice of the employer that the employee reasonably believes are in violation of law, rule, or regulation, or that the employee reasonably believes pose a substantial and specific danger to the public health or safety. The employee's disclosure is protected only if the employee first raised the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. However, employer notification is not required where:

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

Employees are also protected from retaliatory action if the employee objects to, or refuses to participate in, any activity that is in violation of law, rule, or regulation or that the employee reasonably believes poses a substantial and specific danger to the public health or safety. Additionally, employees are protected when the employee provides information to, or testifies before, any public body conducting an investigation, hearing, or inquiry into an employer's activity, policy, or practice. If an employer takes retaliatory action against the employee, the employee may sue in state court for reinstatement to the same

position held before the retaliatory action, or to an equivalent position, any back wages and benefits, and attorneys' fees, among other remedies. If the employer's violation was willful, malicious, or wanton, punitive damages may be imposed.

New York State Labor Law § 741

A health care employer may not take any retaliatory action against a health care employee if the health care employee discloses, or threatens to disclose, certain information about the health care employer's policies, practices, or activities to a regulatory, law enforcement, or other similar agency or public official, to a news media outlet, or to a social media forum available to the public at large. Under the law, a "health care employee" is any person who performs health care services for, and under the control and director of, any public or private employer that provides health care services for wages or other remuneration.

Protected disclosures include disclosures of an activity, policy, or practice of the health care employer that the health care employee, in good faith, reasonably believes constitute improper quality of patient care or improper quality of workplace safety. Health care employees are also protected from retaliatory action if the health care employee objects to, or refuses to participate in, any activity, policy, or practice of the health care employer that the health care employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety.

The health care employee's disclosure is protected only if the health care employee first raised the matter with a supervisor and gave the health care employer a reasonable opportunity to correct the activity, policy, or practice. However, employer notification is not required where the improper quality of patient care or workplace safety presents an imminent threat to public health or safety, to the health of a specific patient, or to the health of a specific health care employee and the health care employee reasonably believes, in good faith, that reporting to a supervisor would not result in corrective action.

If a health care employer takes retaliatory action against the health care employee, the health care employee may sue in state court for reinstatement to the same position held before the retaliatory action, or to an equivalent position, any back wages and benefits, and attorneys' fees, among other remedies. If the health care employer's violation was willful, malicious, or wanton, punitive damages may be imposed.

HIPAA Requirements

Patient Rights, Responsibilities, & Privacy Practices

The Network is committed to ensuring the privacy and confidentiality rights of its patients by educating workforce members, including staff and providers, and the Network's Business Associates on these rights and their responsibilities for maintaining the privacy and confidentiality of patient information. The Network's Patient Rights, Responsibilities & Privacy Practices are made available to every patient of the Network through the following channels:

- New Patient Packets;
- The Network's website;

- Posted in prominent locations throughout the Health Centers and the exam rooms; and
- Printed handouts are available to patients upon request.

Reference: The *Patient Rights, Responsibilities, & Privacy Practices Policy.*

Privacy & Security

The Network restricts access to all patient protected health information ("PHI"), including electronic PHI, to individuals who have a specific, job-related need to know the information and the required permission for access. Patient privacy and confidentiality must be safeguarded by restricting the use or disclosure of PHI obtained from and about a patient to only those instances where the Network is permitted by applicable law to use or disclose such information. Information from the patient's medical record shall be secured by departmental policies regarding authorized users and authorized release of patient and clinical data. PHI is not allowed off the premises unless in an encrypted electronic form.

Consistent with its obligations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations, the Network has identified a Privacy and Security Officer who has the responsibility to oversee all ongoing activities related to the development, implementation, and maintenance of the Network's privacy and security policies in accordance with applicable federal and state laws, rules, and regulations.

Reference: The *Confidentiality of Protected Health Information Policy*.

Releases of Information

The Network ensures compliance with, and adherence to, all applicable laws, rules, and regulations which govern the release, use, and disclosure of medical records/PHI, while ensuring continuity of care and that patient confidentiality is maintained. Medical records are secured when the Network is responding to requests for releases of confidential information.

Reference: The *Release and Disclosure of Protected Health Information Policy*.

Health Information Management

The Network achieves continued excellence with respect to its medical records. These records are maintained in a manner that is current, detailed, secure, and which enables effective, confidential patient care and quality review. Medical records reflect all aspects of care and are complete, accurate, systematically organized, legible, authenticated, and readily available to all appropriate health care practitioners and other necessary parties, in strict accordance with HIPAA's guidelines for the privacy and security of PHI.

Conflict of Interest and Code of Conduct

It is the policy of the Network to outline the standards of conduct expected of all Affected Individuals, including employees, officers, Board directors and appropriate agents. It is expected that during the performance of duties on behalf of the Network, conflicts of interest will be avoided. In the event that an Affected Individual is involved in a conflict of interest, it is expected that the conflict will be disclosed so that resolution of the conflict may occur.

Board members, Network employees, agents, consultants, volunteers, and others who act on the Network's behalf have a responsibility to patients, federal and state governments, other Network funders and the communities served by the Network to conduct themselves prudently, responsibly, in furtherance of, and consistent with the Network's charitable purposes and non-profit, tax-exempt status, and in the best interests of the Network's patients.

The Program is implemented in such a manner as to ensure organizational compliance with appropriate policies concerning confidentiality and conflict of interest, as well as with all HIPAA requirements concerning patient/staff confidentiality and privacy issues.

Reference: The *Conflict-of-Interest Policy* and *Standards of Conduct Policy*.

Record Creation and Retention

A permanent written record of any communication (verbal, written or electronic) reporting a real or potential noncompliance issue, must be generated.

All records regarding corporate compliance and any of the issues outlined in this Program are kept in a locked file cabinet. Records must be available upon request for any authorized state or federal official requesting review, including the Department of Health, the Office of the Medicaid Inspector General, or the Attorney General's Medicaid Fraud Control Unit.

Reports, as outlined earlier in this Plan, are forwarded to the Board of Directors, the CEO, senior leadership, and/or the Network Compliance Committee, consistent with the reporting requirements set out above. The Chief Compliance Officer keeps an original copy of all reports. All copies of reports disseminated for review are collected and disposed of in a confidential manner.

All documentation related to the corporate compliance issues as outlined in the Program, as well as all records demonstrating that the Network has adopted, implemented, and operated an Effective Compliance Program and has satisfied the requirements of the Medicaid compliance regulations (18 NYCRR Part 521-1) are retained for a period of not less than six years from the date the Program was implemented or any amendments thereto were made.

Reference: The *Record Retention Policy* for more specifics on record retention.