CAReS Corporate Compliance Policy

POLICY STATEMENT

This Compliance Program (the "Program") reflects commitment to quality of care on the part of the Council on Addiction Recovery Services, Inc. (CAReS). As used in this document, unless the context clearly requires otherwise, the name CAReS includes all entities and locations associated with CAReS, Inc.

Implementation of the Program enhances quality of care by facilitating adherence to regulatory standards. The specific purposes of the Program include organizing CAReS resources to resolve payment discrepancies and detect inaccurate billings as quickly and efficiently as possible, and imposing systematic checks and balances that integrate compliance controls into the structure of CAReS operations. In compliance with New York State Social Services Law § 363d and 18 NYCRR Part 521, this Policy documents the CAReS policies and procedures for detecting and preventing fraud, waste and abuse in federally funded health care programs.

This Program, with a Code of Conduct at its core, encompasses the eight compliance program components mandated by Chapter 442 of the Laws of 2006 and regulations promulgated by the New York State Office of the Medicaid Inspector General ("OMIG"), found in Part 521 of Title 18 of the New York Code of Rules and Regulations ("NYCRR"). In addition, the Program reflects compliance program recommendations issued by the United States Department of Health and Human Services, Office of Inspector General ("OIG") in its Compliance Program Guidance for health care organizations. The Program also reflects consideration of authoritative guidance as to best practices and effectiveness review.

Although it is modeled in conformity with the New York State statute and regulations, OMIG publications, and OIG Guidance, this Program is specifically tailored to CAReS. It is designed to meet the internal needs and specific risks particular to CAReS, and it takes into account characteristics of CAReS such as culture, size, structure, clinical setting, and operational processes.

Many aspects of the Program, including the Code of Conduct, have been in effect since before the inception of a formal compliance program. Existing policies, procedures, and standards have been reviewed, revised, and brought under the umbrella of a coordinated compliance program.

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The Program is an evolving document, reflecting an ongoing process of continuous quality improvement. Accordingly, the Program will be amended and supplemented from time to time to conform to changes in laws, regulations, guidance, and best practices.

Adherence to the Program is a condition of employment for all employees of CAReS.

A. ELEMENTS OF PROGRAM

The Corporate Compliance Program has eight elements. The elements are listed immediately below, and each element is discussed at greater length in the following pages.

1. Implementation of written policies and procedures that

    a. Describe compliance expectations, as embodied in the Code of Conduct;
    b. Implement the operation of the Program; Provide guidance to employees and others on dealing with compliance issues;
    c. Identify ways of communicating compliance issues to appropriate personnel; and
    d. Describe how potential compliance problems are investigated and resolved.

2. Designation of a compliance officer as the individual vested with responsibility for the day-to-day operation of the compliance program.

3. Training and education of all affected employees, executives, directors, and other persons associated with CAReS on compliance issues, expectations, and Program operation.

4. Establishment of communication lines to the compliance officer that are accessible to all employees, executives, and persons associated with CAReS, to allow compliance issues to be reported.

5. Fair and firmly enforced disciplinary policies, to encourage good faith participation in the Program by all affected individuals, and to outline sanctions for:

    a. Failure to report suspected problems;
    b. Participation in non-compliant behavior; and
    c. Encouraging, directing, facilitating, or permitting non-compliant behavior.

6. Systems for routine identification of compliance risk areas specific to clinical practice and residential services for substance use disorder agencies for self-evaluation of such risk areas, including internal audits and, as appropriate, external audits, and for evaluation of potential or actual non-compliance identified in such self-evaluations and audits.

7. Implementation of systems for:

    a. Responding to compliance issues as they are raised;
    b. Investigating potential compliance problems, including compliance concerns that are reported through the available reporting mechanisms and compliance issues that are identified in the course of reviews and audits;
    c. Responding to compliance problems identified in reports, investigations, self-evaluations and audits;
    d. Correcting such problems promptly and thoroughly, and implementing procedures, policies and systems as necessary to reduce the potential for recurrence;
    e. Identifying and reporting compliance issues to the appropriate office (OIG, OMIG the NYS DOH, NYS OASAS) and when required;
    f. Reporting and refunding overpayments within 60 days of identification.

8. Non-intimidation and non-retaliation for good faith participation in the Program, including but not limited to:

    a. Reporting and investigating potential compliance issues;
    b. Participating in self-evaluations, audits, and remedial actions; and
    c. Reporting health care fraud to government officials.

ELEMENT 1: WRITTEN POLICIES AND PROCEDURES

CODE OF CONDUCT

The Code of Conduct sets out the principles that employees and others are expected to follow as they perform their duties with regard to CAReS. Copies of the Code of Conduct are posted in every CAReS building, and additional copies are available upon request from the Compliance Officer.

CAReS is committed to providing a holistic approach to the care of our clients to promote maximum functioning and independence in all aspects of their life. CAReS, its Board of Directors, and its employees are bound by the following commitments:

1. To the community, CAReS is committed to the promotion of health and well-being of its clients. Its best effort will be taken to meet these needs while operating the agency in a fiscally responsible manner.
2. To its employees, CAReS will implement and maintain employment standards that comply with all applicable federal and state laws.

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3. To CAReS clients, the agency is committed to providing an appropriate quality of care that is responsive to clients' needs and complies with government laws.
4. To third-party payors, both private and public, the agency is committed to submitting bills for services in a timely and accurate fashion and reporting all reimbursable costs to the Medicare/Medicaid program and to any other third party in a legally appropriate manner.
5. To CAReS vendors, the facility stresses a sense of responsibility to be a good customer. When the facility feels that its best interest would be to utilize a competitive bidding process, then this process will be completed.
6. To all who do business with CAReS, it is our policy to conduct ourselves in an appropriate manner consistent with tax-exempt status and all other applicable laws and regulations. We expect those who do business with CAReS to be committed to compliance in relation to all work that they perform for us.
7. Specific Code Of Conduct Procedures:
    a. Proper Billing for Health Care and Other Services
        i. CAReS receives reimbursement from government programs (primarily Medicaid) for health care services provided to its clients. The agency also receives payment from state and local government agencies for the provision of other items and services. The submission of accurate bills to government payors is one of CAReS key legal obligations.
        ii. All employees involved in documenting and billing any governmental entity for health care or other services must ensure that they follow all applicable laws, rules, conditions of participation and interpretive guidance relating to the billing process. Among other things, employees must ensure that CAReS does not participate in any of the following activities:
            1. Bill for clients not actually served by the agency;
            2. Bill for services that are not medically necessary;
            3. Bill more than once for the same service in a single day;
            4. Bill at a rate in excess of the rate permitted under the applicable program;
            5. Bill for services provided by unlicensed personnel where prohibited; or
            6. Bill the Medicaid program as the primary payor when the client has other public or private health insurance coverage.
        iii. It is critical that all health care services rendered to clients are appropriately documented in CAReS record, including retrievable hardcopy and electronic files as necessary for the specific service and/or client. Such documentation is necessary to ensure that the agency can demonstrate that it has delivered such services in the event of a government audit or investigation.
        iv. The failure of an employee to adhere to all applicable billing rules may subject CAReS to substantial liability.

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1. Among other things, it is a violation of the False Claims Act of 1986 and Fraud Enforcement and Recovery Act of 2009.
2. Relative to activities at CAReS, these laws pertain to an employee or contractor who knowingly submits a false or fraudulent claim for payment to a federal program such as Medicaid or Medicare.
3. CAReS may be subjected to treble damages (i.e. three times the amount of the false claims) and civil monetary penalties up to $11,000 per claim under the False Claims Act.
4. In 2007, the New York State legislature enacted a comparable state False Claims Act that imposes additional penalties for knowingly submitting false claims to either state or local governments. Under the state law, false claims can result in the imposition of civil penalties up to $12,000 plus treble damages. Other state and federal laws impose civil and criminal penalties on CAReS and its employees for improper billing activity.

v. If CAReS retains a vendor to submit bills on its behalf, CAReS may still be responsible for improper billing activity by the vendor.
   1. Accordingly, employees involved in delegating this function must provide clear direction to vendors on proper billing procedures and carefully monitor their performance. In other words, monitoring of compliance related activities are inherent in all associated positions and job descriptions.
   2. Although this might appear to be a management level decision, this is not solely the responsibility of administration, management, or the Corporate Compliance Officer.

b. Providing Access to Necessary Services
   i. CAReS is committed to ensuring that all clients under its care receive prompt access to full range of medically necessary health care services to which the client is entitled under the applicable government program.
   ii. All services must be ordered and/or delivered by appropriately licensed or qualified personnel. CAReS seeks to provide or arrange for high-quality care at all times.

c. Submitting Complete and Accurate Reports to Government Agencies
   i. Under certain programs, CAReS reimbursement from the government may be based, in whole or in part, on the agency's costs. This is particularly true relative to many of its grant funded programs.
   ii. In these programs, CAReS is usually required to submit regular cost reports (including but not limited to vouchers); which are used by the government for rate-setting and reimbursement purposes.

iii. All employees involved in the process of preparing and submitting cost reports must strive to ensure that these reports are accurate and complete.
iv. Expenses reflected on cost reports must have been actually incurred and properly allocated in accordance with program guidelines.
v. All expenses must also be supported by proper documentation (invoices, paycheck stubs, receipts, etc.)
vi. The same standards of accuracy and completeness apply to any other reports or data regarding the agency's operations submitted to government agencies or private funding sources.

d. Avoiding Kickbacks and Referral Fees
   i. Under the federal Anti-Kickback Statute, it is illegal for any employee or contractor to knowingly and willfully solicit, receive, offer or pay anything of value to another person in return for the referral of a client, or in return for the purchasing, leasing, ordering or arranging for any item or service reimbursed by federal health care programs such as Medicaid.
   ii. Penalties for violating the Anti-Kickback Statute include imprisonment, criminal fines, civil monetary penalties and exclusion from government health care programs. A similar New York law prohibits the exchanges of remuneration for referrals for items or services covered by the state's Medicaid program.
   iii. CAReS has adopted an Anti-Kickback Protocol that describes the restrictions imposed under the Anti-Kickback Statute in greater detail. All employees involved in purchasing items or services from vendors, or managing relationships or conducting business transactions with sources or recipients of client referrals, should familiarize themselves with this protocol.

e. Avoiding Conflicts of Interest

   i. Employees are required to act solely in the best interests of CAReS when carrying out their job responsibilities and must avoid all activities that constitute or create the appearance of a conflict of interest.

      1. Employees are prohibited from using their position with The CAReS for personal benefit. For example, employees are prohibited from accepting gifts of any value from vendors of the agency or facilitating contracts between CAReS and companies in which they have a financial interest.

      2. CAReS Board of Directors are also required to avoid conflicts of interest. Among other things, they are prohibited from voting on or otherwise influencing the implementation of business

arrangements between CAReS and the director/officer or a company in which the director/officer has a financial interest.

f. Using CAReS Resources for Agency Business

i. Employees may not use their affiliation with the CAReS to promote any business, charity or political cause.
ii. Employees shall seek reimbursement for expense only to the extent such expenses have been incurred in the course of carrying out their job duties and in accordance with CAReS expense reimbursement protocols.

g. Using CAReS Resources Exclusively for Charitable Purposes

i. CAReS is a tax-exempt organization under Section 501(c)(3) of the Internal Revenue Code. This status generally requires the agency to engage in only those activities that are within its approved charitable purpose.

ii. CAReS primary charitable purpose is the care of persons with substance use disorders and related behavioral issues. Employees may not use the agency's resources to engage in any business activity that is outside the scope of the agency's charitable purpose without the express written opinion of the agency's legal counsel.

h. Ensuring Equal Opportunity for all Clients, Employees and Contractors

i. CAReS is committed to serving all clients on an equal basis without regard to race, creed, color, national origin, sexual orientation, gender identity or expression, military status, sex, age, disability, religion, familial status; marital status or any other personal characteristic with respect to which discrimination is barred by law.

1. Discrimination on these grounds is also prohibited in connection with the hiring and treatment of employees and contractors. In addition, sexual harassment of employees or clients will not be tolerated.
2. CAReS seeks to create an environment in which the dignity of each individual is fully respected.

i. Maintaining the Confidentiality of Client Records

i. All client records must be kept confidential in accordance with applicable privacy laws and regulations.

1. CAReS is subject to 42 CFR Part II, which governs drug and alcohol records and related issues.
2. CAReS is subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), which limits the use of disclosure of protected health information.
3. CAReS must also comply with special state confidentiality laws governing mental health records and HIV-related information.
4. CAReS has adopted a comprehensive privacy compliance program governing the use and disclosure of client records.
5. All employees who have access to such records must familiarize themselves with this program's protocols and procedures, and adhere to their terms.

j. Conducting all Business with Honesty and Integrity

i. CAReS is committed to conducting all of its activities with honesty and integrity. Employees are expected to act in a manner that promotes the agency's reputation as an organization that exceeds the strict requirements of the law and operated in accordance with the highest ethical standards.

k. CAReS Employees are required to have knowledge of, and comply with, the agency Code of Conduct (see CAReS Code of Conduct, revised 112013)

The Code of Conduct is not intended to address every potential compliance issue that may arise in the course of our agency's business. CAReS has adopted more detailed written policies / procedures and protocols governing key aspects of its operations. Some of these policies are referenced in the Program; others, particularly those specific to job descriptions and inherent duties, may be provided to employees by their supervisors. Employees are required to review and carry out their duties in accordance with the policies applicable to their job junctions. The Code of Conducts' standards is set forth below.

ELEMENT 2: COMPLIANCE OVERSIGHT PERSONNEL

1. Corporate Compliance Committee

a. Membership:

i. The Compliance Committee is compromised of the Corporate Compliance Officer, Chief Executive Officer, Chief Financial Officer, CAReS Medical Director or designee, the agency's legal counsel (ad hoc), the Clinic

Director, the Prevention Director, the Human Resources Director, a member of the Board of Directors, as well as any other employees designated by the CEO/Corporate Compliance Officer. The CEO seeks to appoint members to the Compliance Committee with varying backgrounds and experience to ensure that the Compliance Committee has the expertise to handle the full range of clinical, administrative, operational and legal issues relevant to the Program.

b. Functions

   i. The Compliance Officer will provide a monthly reports, partly of findings, to the CEO, and a quarterly report to the Governance Committee of the Board of Directors. The Committee will provide guidance regarding the operation of the Program;
   ii. Approving the internal auditing plan carried out under the Program;
   iii. Approving the compliance training program provided to all staff, contractors, and Board members;
   iv. Reviewing and confirming the adequacy of all investigations of suspected non-compliance and any corrective action taken as a result of such investigations;
   v. Reviewing policies and procedures related to compliance; and
   vi. Recommending and approving any changes to the program.

c. The Compliance Committee is chaired by the Compliance Officer.

d. The Compliance Committee meets quarterly.

2. The Board of Directors

   a. The Board of Directors has the ultimate responsibility for oversight of the Program. The Board considers compliance-related matters on a periodic basis and whenever warranted by circumstances. The Compliance Committee, appointed by the CEO and the Board and chaired by the Compliance Officer, includes appropriate representation from various CAReS departments, as determined by the Board.

3. Corporate Compliance Officer

   a. The responsibilities of the Compliance Officer include, but are not limited to:
      i. Overseeing and monitoring the implementation of the Program;
      ii. Establishing methods, such as periodic audits and ongoing monitoring, to reduce CAReS' vulnerability to fraud and abuse;

iii. Periodically reviewing and revising the Program in light of significant changes in the needs of CAReS or changes in the law and in the standards and payor procedures;
iv. Developing, coordinating and participating in training programs;
v. Maintaining records of Compliance Program activities;
vi. Ensuring that the OIG's and the OMIG's lists of excluded individuals and entities and the General Services Administration's list of parties debarred from federal programs, have been checked with respect to all employees and contractors; and
vii. Coordinating the investigation of any report or allegation concerning possible violations of the Program, and monitoring subsequent corrective action and/or compliance in accordance with CAReS' policy.
viii. The Compliance Officer will report directly to the Chief Executive Officer or another senior administrator designated by the Chief Executive Officer, and shall periodically report directly to the Governance Committee of the Board of Directors on the activities governed by the Program.

b. The Compliance Officer may designate other individuals to perform compliance-related tasks or to assist in the evaluation or resolution of specific issues from time to time.

ELEMENT 3: CONDUCTING EFFECTIVE TRAINING AND EDUCATION

Education is essential to maintaining compliance. Educational programs will be tailored to the needs of CAReS on an ongoing basis. Training objectives will be established periodically by the Compliance Officer, based on auditing and monitoring results and the Compliance Officer's assessment of risk areas. The Compliance Officer will determine:

1. Individual training needs; and
2. The types of training that best suit the needs of CAReS, and that accomplish training objectives effectively and efficiently.

Training will be provided on an as-needed basis to respond to identified risk areas, but at least annually, and in compliance with any changes in Medicaid coding or billing procedures.

A record of training and educational activities related to compliance will be maintained, under the direction of the Compliance Officer.

3.1. Compliance Training

CAReS employees, executives, Board members, and Compliance Committee members will undergo compliance-related training pertinent to their responsibilities, as part of their orientation

to those roles and responsibilities. Board members will receive training as to the role of the Board in oversight of the Program and as to governance issues identified by OMIG. Topics which may be included in employee compliance training include, for example:

1. The operation and importance of the Program;
2. The Program as a condition of continued employment;
3. The consequences of violating compliance standards and procedures, including disciplinary measures; and
4. The role of each employee in the operation of the Program.

Training may be internal or external, as appropriate. When considering outside training sources, the Compliance Officer will consider: offerings of professional organizations; programs offered by carriers; third-party billing company seminars; the services of an outside consultant; and other resources as available and appropriate. Topics for training may be drawn from publications such as OMIG publications; DOH Medicaid Updates; the OIG's Special Fraud Alerts; OIG Advisory Opinions; and NYS OASAS.

To underscore our commitment to compliance training for employees, the CAReS' employee handbook includes a specific discussion of this Program. The employee handbook also includes a specific discussion of state and federal laws on false claims and the rights of employees to be protected as whistleblowers. A summary of those laws is set out in pages 16 – 26 of this Policy.

3.2. Coding and Billing Training

It is the responsibility of each practitioner to properly document his or her services and to accurately code his or her services for billing purposes. Any newly employed practitioner who is responsible for coding of his or her own services will be trained as part of orientation, which shall occur as soon as possible after assuming duties.

CAReS recognizes that non-clinical personnel who are directly involved with billing, coding or other aspects of the federal health care programs may also require coding and billing education specific to that individual's responsibilities. Examples of topics that may be pertinent to the individual's responsibilities include:

1. Coding requirements and methodology, including proper use of CAReS medical record documentation forms;
2. General understanding of the claim development and submission processes;
3. Proper billing standards and procedures and submission of accurate bills to payors and patients; and
4. Legal sanctions for submitting deliberately or recklessly false billings.

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The failure of an employee to adhere to all applicable billing rules may subject CAReS to substantial liability. Among other things, it is a violation of the False Claims Act of 1986 and Fraud Enforcement and Recovery Act of 2009.

1. Relative to activities at CAReS, these laws pertain to an employee or contractor who knowingly submits a false or fraudulent claim for payment to a federal program such as Medicaid or Medicare.
2. CAReS may be subjected to treble damages (i.e. three times the amount of the false claims) and civil monetary penalties up to $11,000 per claim under the False Claims Act.
3. In 2007, the New York State legislature enacted a comparable state False Claims Act that imposes additional penalties for knowingly submitting false claims to either state or local governments. Under the state law, false claims can result in the imposition of civil penalties up to $12,000 plus treble damages. Other state and federal laws impose civil and criminal penalties on CAReS and its employees for improper billing activity.

If CAReS retains a vendor to submit bills on its behalf, CAReS may still be responsible for improper billing activity by the vendor. Accordingly, employees involved in delegating this function must provide clear direction to vendors on proper billing procedures and carefully monitor their performance. In other words, monitoring of compliance related activities are inherent in all associated positions and job descriptions. This is not solely the responsibility of Administration, Management, or the Corporate Compliance Officer.

3.3. Dissemination of Compliance Information to Certain Contractors

Under the New York State Social Services Law § 363d and 18 NYCRR Part 521, CAReS is required to disseminate information on Corporate Compliance to all contractors and agents who, on behalf of CAReS, furnish or authorize the furnishing of Medicaid health care items or services; perform billing or coding functions; or are involved in the monitoring of health care provided by CAReS. New York State Social Services Law § 363d and 18 NYCRR Part 521, requires that all such contractors and agents adopt and abide this Policy in relation to all work performed for the CAReS; train their employees who are involved in performing work for the CAReS to comply with applicable laws; and make this Policy available to those employees.

To facilitate our contractors' and agents' compliance training and education, this Policy is posted on the CAReS website.

ELEMENT 4: COMMUNICATION LINES

CAReS staff, management, and Board members are encouraged to discuss any billing or compliance concerns with the Compliance Officer, either formally or informally. Formal and informal communication channels are intended to implement an "open door" policy.

Adherence to the Program, including the obligation to report potential non-compliance, is a condition of employment for all employees of CAReS. Employees can report compliance complaints directly to the Compliance Officer by filling out a Compliance Complaint Report and turning it in within 24 hours of the reported compliance incident. Although employees are encouraged to contact the Compliance Officer directly to report concerns, potential compliance concerns may also be reported confidentially. This can be done by submitting a written report to the Compliance Officer on an anonymous basis, or by placing written compliance concerns in the designated lock boxes located in every facility throughout the agency, calling the Compliance Officer at (716) 373 – 4303, x503, or 24 hours per day, 7 days per week at (866) 851-5034. An employee who does not wish to report a compliance concern directly to the Compliance Officer may report the concern through his or her supervisor or to a member of the Compliance Committee, who will then become responsible for ensuring making a report to the Compliance Officer or another member of team.

ELEMENT 5: ENFORCEMENT THROUGH DISCIPLINARY POLICIES

When non-compliant conduct at any level of CAReS has been identified, corrective actions will be undertaken. Non-compliant conduct on the part of an employee of CAReS will be documented in the employee's personnel or credentialing file. Violations of CAReS compliance policies, including failure to report potential violations, participating in non-compliant conduct, or actively or passively encouraging, directing, facilitating, or permitting non-compliant conduct, will result in disciplinary action, in proportion to the seriousness of the violation, in accordance with Human Resources policies and procedures. Sanctions may include oral warnings; written reprimands; demotion; suspension; or termination.

ELEMENT 6: EFFECTIVE SYSTEM FOR ROUTINE AUDITING AND MONITORING

The objective of the auditing and monitoring component of the Program is to ensure that individuals are properly carrying out their responsibilities and that claims are being submitted appropriately. CAReS will utilize audit tools as a means of ascertaining what, if any, problems exist and focus on the risk areas that are associated with those problems. Auditing will include, but will not be limited to, Medicaid claims.

CAReS seeks to identify compliance issues at an early stage before they develop into high risk issues. One of the key methods of achieving this goal is the performance of regular internal audits, risk analysis, and compliance reviews.

The Compliance Officer will develop a work plan setting a schedule of internal audits in January of each year. The work plan is reviewed by the Compliance Committee in the February Compliance Committee meeting. Upon approval, the work plan will be implemented. The audits cover aspects of the agency's operations that pose a heightened risk of non-compliance, including but not limited to, Medicaid billing, cost reporting and access to medical care. A

written report is prepared summarizing the findings of each audit and recommending any appropriate corrective action.

All employees are required to participate in and cooperate with internal audits as requested by the Compliance Officer. This includes assisting in the production of documents, explaining program operations or rules to auditors and implementing any corrective action plans.

6.1. Standards and Procedures Review

The Compliance Officer or designee will periodically review CAReS' current standards, policies and procedures, for example, mandatory reporting, governance and quality of care, to determine if they are current and complete, in accordance with currently applicable standards, regulations, and other authoritative guidance.

Among the standards and materials the Compliance Officer will utilize are the Medicaid Provider Manuals. Relevant CMS Medicaid Updates and other authoritative guidance that bears upon coding and billing will be distributed to staff and incorporated into staff training as appropriate to their responsibilities. The Compliance Officer or designee will alert staff members to pertinent changes on an as-needed basis.

As required by the circumstances, CAReS will seek the advice of consultants for assistance in coding questions, and will consult with legal counsel for assistance in interpreting federal and state regulations and guidance as needed.

6.2. Claims Submission Audit

The Compliance Officer will be responsible for the processes for reviewing bills and medical records for compliance with applicable coding, billing, and documentation requirements. A representative sampling of claims will be periodically reviewed prior to submission, and any identified defects will be corrected.

Self-audits will be used to review such matters as:

1. Whether bills are properly coded and accurately reflect the services provided and documented in the medical record;
2. Whether documentation is completed correctly;
3. Whether the services or items provided were medically reasonable and necessary;
4. Whether the services were provided by appropriately credentialed individuals; and
5. Whether there were any incentives for unnecessary services.

Internal audits will involve routine review of appropriate samplings of charts on a regularly scheduled basis. In addition, focused audits will be performed to verify implementation of any recommended corrective actions.

Risk areas identified by internal or outside audits will be examined in subsequent internal audits as warranted. Where an audit reveals the need for additional education of employees and clinical staff, the Compliance Officer will determine the means by which additional training and education will be implemented.

In addition to internal monitoring and auditing, the Compliance Officer will be responsible for procedures to review denied, rejected, and down-coded claims. Any rejection or down-coding patterns that are identified will be promptly addressed, with additional training and education as needed.

6.3. Identification of Risk Areas

As necessary, CAReS will develop written policies and procedures that address identified risk areas. These written policies and procedures will be communicated to staff members as necessary and pertinent. Risk areas, including risk areas that are identified in the course of quality improvement and credentialing processes, will be addressed as appropriate in periodic and special audits.

Risk areas identified from time to time by OASAS, OIG, OMIG or other authorities will be addressed in CAReS auditing activities as appropriate.

The OIG Guidance has identified the following as areas of potential risk:

1. Coding;
2. Medical necessity;
3. Non-covered services;
4. Documentation, including legibility;
5. Billing for services of physician extenders; and
6. Improper inducements, kickbacks and self-referrals.

Risk areas identified by OMIG include:

1. Overpayments
2. Base year cost calculations;
3. Review of ancillary services included in the Medicaid rate;
4. Property/capital cost allocations;
5. Temporary staffing costs;

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ELEMENT 7: RESPONDING TO DETECTED ERRORS AND OFFENSES

Concerns identified by the Compliance Officer, staff members, payors, or other sources will be reviewed by the Compliance Officer. Under the direction of the Compliance Officer, such concerns will be prioritized, investigations will be undertaken as warranted, and appropriate corrective action programs will be implemented. Response to a detected error may include coordination with quality improvement processes and programs, where pertinent and appropriate.

Depending upon the nature of the concern, the Compliance Officer may consult with legal counsel to determine whether a significant and or reportable violation of applicable law may have occurred, and, if so, the appropriate measures to take.

As appropriate, corrective actions may include one or more of the following:

1. Discipline of an employee up to and including termination;
2. Retraining;
3. Reporting and return of overpayments within 60 days of identification;
4. Self-disclosure to the carrier intermediary or the OIG or OMIG;
5. Revision of a CAReS policy;
6. Implementation of procedures, policies, or systems to reduce the potential for recurrence; or
7. Modification of a relationship with an outside party, such as a billing company.

Depending on the circumstances, the Compliance Officer may also consider whether the Program failed to anticipate or detect a problem, or whether CAReS compliance procedures failed to prevent the violation. If such a Program failure or deficiency identified, the Program will be revised to minimize the risk of future failures.

ELEMENT 8: POLICY OF NON-INTIMIDATION AND NON-RETALIATION

No individual who participates in good faith in the Program will be subject to any form of intimidation or retaliation by CAReS as a result of such participation. Protected activities include reporting and investigating potential compliance issues; participating in self-evaluations, audits, and remedial actions; and reporting health care fraud to government officials.

Any employee who has a concern about potential intimidation or retaliation is encouraged to contact the Compliance Officer. All allegations of intimidation or retaliation will be promptly and fully investigated.

A summary of federal and New York State laws on false claims and whistleblower protections, as prepared and provided by the OMIG, is set out in Appendix A.

B. PROGRAM REVISIONS AND UPDATES

This Program will be revised and updated from periodically to reflect ongoing Program assessment, current compliance guidance, the requirements of regulatory agencies, and considerations of best practices.

This document is not intended to serve as an express or implied employment contract. Its objective is to communicate current policies. The Board of Directors of the CAReS reserves the right to change, modify, or waive all provisions herein. Any questions or concerns should be forwarded to the Compliance Officer or any member of the Compliance Committee.

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FEDERAL & NEW YORK STATUTES RELATING TO FILING FALSE CLAIMS

I. FEDERAL LAWS

1) Federal False Claims Act (31 USC §§3729-3733)

II. NEW YORK STATE LAWS

A. CIVIL AND ADMINISTRATIVE LAWS

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

2) Social Services Law, Section 145-b - False Statements

3) Social Services Law, Section 145-c - Sanctions

B. CRIMINAL LAWS

1) Social Services Law, Section 145 - Penalties

2) Social Services Law, Section 366-b - Penalties for Fraudulent Practices.

3) Social Services Law, Section 145-c - Sanctions

4) Penal Law Article 175 - False Written Statements

5) Penal Law Article 176 - Insurance Fraud

6) Penal Law Article 177 - Health Care Fraud

III. WHISTLEBLOWER PROTECTION

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

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

3) New York State Labor Law, Section 740

4) New York State Labor Law, Section 741

I. FEDERAL LAWS

1) Federal False Claims Act (31 USC §§3729-3733)

The False Claims Act ("FCA") provides, in pertinent part, as follows: § 3729. False claims

(a) Liability for certain acts.--

2) In general. -- Subject to paragraph (2), any person who--

(A) Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

(B) Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;

(C) Conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G);

(D) Has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;

(E) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(F) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; or

(G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government, is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461) note; Public Law 104-410, plus 3 times the amount of damages which the Government sustains because of the act of that person.

(2) Reduced damages.--If the court finds that--

(A) the person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information;

(B) Such person fully cooperated with any Government investigation of such violation; and

(C) at the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation, the court may assess not less than 2 times the amount of damages which the Government sustains because of the act of that person.

(3) Costs of civil actions.--A person violating this subsection shall also be liable to the United States Government for the costs of a civil action brought to recover any such penalty or damages.

(b) Definitions.--For purposes of this section--

(1) The terms “knowing” and “knowingly” --

(A) Mean that a person, with respect to information--

(i) have actual knowledge of the information;

(ii) Acts in deliberate ignorance of the truth or falsity of the information; or

(iii) Acts in reckless disregard of the truth or falsity of the information; and

(B) Require no proof of specific intent to defraud;

(2) The term “claim”--

(A) Means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that--

(i) Is presented to an officer, employee, or agent of the United States; or

(ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government-

(I) provides or has provided any portion of the money or property requested or demanded; or

(II) Will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and

(B) Does not include requests or demands for money or property that the Government has paid to an individual as compensation for Federal employment or as an income subsidy with no restrictions on that individual's use of the money or property;

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

(4) The term "material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

(d) Exclusion.--This section does not apply to claims, records, or statements made under the Internal Revenue Code of 1986.

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

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

throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare or Medicaid program.

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

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

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

This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false or contains false information, or omits material information, the agency receiving the claim may impose a penalty of up to $5,000 for each claim. The agency may also recover twice the amount of the claim.

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

II. NEW YORK STATE LAWS

New York State False Claim Laws fall under the jurisdiction of both New York's civil and administrative laws as well as its criminal laws. Some apply to recipient false claims and some apply to provider false claims. The majority of these statutes are specific to healthcare or Medicaid. Yet some of the "common law" crimes apply to areas of interaction with the government and so are applicable to health care fraud and will be listed in this section.

A. CIVIL AND ADMINISTRATIVE LAWS

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

The New York False Claims Act is similar to the Federal False Claims Act. It imposes penalties and fines upon individuals and entities who knowingly file false or fraudulent claims for

payment from any state or local government, including health care programs such as Medicaid. It also has a provision regarding reverse false claims similar to the federal FCA such that a person or entity will be liable in those instances in which the person obtains money from a state or local government to which he may not be entitled, and then uses false statements or records in order to retain the money.

The penalty for filing a false claim is six to twelve thousand dollars per claim plus three times the amount of the damages which the state or local government sustains because of the act of that person. In addition, a person who violates this act is liable for costs, including attorneys' fees, of a civil action brought to recover any such penalty.

The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties, subject to various possible limitations imposed by the NYS Attorney General or a local government. If the suit eventually concludes with payments back to the government, the person who started the case can recover twenty-five to thirty percent of the proceeds if the government did not participate in the suit, or fifteen to twenty-five percent if the government did participate in the suit.

2) Social Services Law, Section 145-b - False Statements

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

3) Social Services Law, Section 145-c - Sanctions

If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the needs of the individual or that of his family shall not be taken into account for the purpose of determining his or her needs or that of his family for six months if a first offense, for twelve months if a second offense (or if benefits wrongfully received are at least one thousand dollars but not more than three thousand nine hundred dollars), for eighteen months if a third offense (or if benefits wrongfully received are in excess of three thousand nine hundred dollars), and five years for any subsequent occasion of any such offense.

B. CRIMINAL LAWS

CAReS Corporate Compliance Policy

1) Social Services Law, Section 145 - Penalties

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

2) Social Services Law, Section 366-b - Penalties for Fraudulent Practices.

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

3) Penal Law Article 155 - Larceny

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

1. Fourth degree grand larceny involves property valued over $1,000. It is a class E felony.
2. Third degree grand larceny involves property valued over $3,000. It is a class D felony.
3. Second degree grand larceny involves property valued over $50,000. It is a class C felony.
4. First degree grand larceny involves property valued over $1 million. It is a class B felony.

4) Penal Law Article 175 - False Written Statements

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

§ 175.05 - Falsifying business records involves entering false information, omitting material information or altering an enterprise's business records with the intent to defraud. It is a class A misdemeanor.§ 175.10 - Falsifying business records in the first degree includes the elements of the § 175.05 offense and includes the intent to commit another crime or conceal its commission. It is a class E felony.§ 175.30 - Offering a false instrument for filing in the second degree involves presenting a written instrument, including a claim for payment, to a public office knowing that it contains false information. It is a class A misdemeanor.§175.35 - Offering a false instrument for filing

in the first degree includes the elements of the second degree offense and must include an intent to defraud the state or a political subdivision. It is a class E felony.

5) Penal Law Article 176 - Insurance Fraud

This law applies to claims for insurance payments, including Medicaid or other health insurance, and contains six crimes

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

1. Insurance fraud in the 4th degree is filing a false insurance claim for over $1,000. It is a class E felony.
2. Insurance fraud in the 3rd degree is filing a false insurance claim for over $3,000. It is a class D felony.
3. Insurance fraud in the 2nd degree is filing a false insurance claim for over $50,000. It is a class C felony.
4. Insurance fraud in the 1st degree is filing a false insurance claim for over $1 million. It is a class B felony.
5. Aggravated insurance fraud is committing insurance fraud more than once. It is a class D felony.

6) Penal Law Article 177 - Health Care Fraud

This statute, enacted in 2006, applies to health care fraud crimes. It was designed to address the specific conduct by health care providers who defraud the system including any publicly or privately funded health insurance or managed care plan or contract, under which any health care item or service is provided. Medicaid is considered to be a single health plan under this statute.

This law primarily applies to claims by providers for insurance payment, including Medicaid payment, and it includes six crimes.

Health care fraud in the 5th degree — a person is guilty of this crime when, with intent to defraud a health plan, he or she knowingly and willfully provides materially false information or omits material information for the purpose of requesting payment from a health plan. This is a class A misdemeanor.

1. Health care fraud in the 4th degree — a person is guilty of this crime upon filing such false claims on more than one occasion and annually receives more than three thousand dollars. This is a class E felony.

2. Health care fraud in the 3rd degree — a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over ten thousand dollars. This is a class D felony.
3. Health care fraud in the 2nd degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over fifty thousand dollars. This is a class C felony.
4. Health care fraud in the 1st degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over one million dollars. This is a class B felony.

III. WHISTLEBLOWER PROTECTION

1) Federal False Claims Act (31 U.S.C. 43730(h))

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

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

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

3) New York State Labor Law, Section 740

An employer may not take any retaliatory action against an employee if the employee discloses information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that the employer is in violation of a law that creates a substantial and specific danger to the public health and safety or which constitutes health care fraud under Penal Law § 177

(knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions). The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of $10,000 on the employer.

4) New York State Labor Law, Section 741

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