The Osborne Association

Transforming Lives, Communities and the Criminal Justice System

Corporate Compliance Program

Prepared With Assistance Of
Grassi Healthcare Consulting

GRASSI & CO.
ACCOUNTANTS & SUCCESS CONSULTANTS®

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Provider Information

Name of Medicaid Provider: **Osborne Treatment Services, Inc.**

Provider Address: **809 Westchester Avenue, Bronx, NY, 10455**

Chief Compliance Officer: **Patricia Ritchings 718-637-6590 pritchings@osborneny.org**

Anonymous Ethics Hotline: 866-594-0655 ***http://osbornehotline.ethicspoint.com***

Preamble

MISSION STATEMENT

The Osborne Association, Inc. and affiliates ("Osborne" or the "organization") offers opportunities for individuals who have been in conflict with the law to transform their lives through innovative, effective, and replicable programs that serve the community by reducing crime and its human and economic costs. Since 1931, Osborne has offered opportunities for reform and rehabilitation through public education, advocacy, and alternatives to incarceration that respect the dignity of people and honor their capacity to change as they achieve self-efficiency, adopt healthy lifestyles, enter the workforce, form and rebuild families, and rejoin their communities.

PURPOSE

Osborne is committed to conducting its business activities in full compliance with all federal, state and local laws and regulations, and recognizes that failure to comply could threaten the organization's continuing participation in government health care programs. Therefore, the Audit/Finance Committee of the Board directs the Chief Compliance Officer to undertake this Compliance Program in order to continue its commitment to high standards of conduct, honesty and reliability in its business practices.

This Corporate Compliance Program is intended to provide reasonable assurance that we conduct business activity in a compliant manner while exhibiting our commitment to promoting prevention and detection of health care fraud and resolution of instances of potential misconduct within our day-to-day operations.

The Goals of Osborne's Corporate Compliance Program include:

- Ensuring that federal and state regulations are enforced and third party guidelines are followed, including those from health insurance companies;
- Avoiding coding or billing which violates Medicaid rules or regulations or other federal rules or regulations;
- Avoiding intentionally or knowingly making false or erroneous entries on reports, participant charts or other relevant records;
- Reporting known or suspected violations of law, regulation, Osborne's organizational policy or Code of Conduct to the Compliance Officer;
- Providing a common understanding of expectations for proper conduct;
- Providing an effective process for Employees to ask about compliance related concerns and for management to address those concerns;
- Providing a framework for dealing with difficult, complex, or confusing issues such as interpretation of regulations or ethical concerns;
- Ensuring that appropriate individuals will participate in investigations and provide solutions to prevent future occurrences of alleged violations;
- Providing for annual Compliance training as required;
- Avoiding unauthorized alteration or destruction of the records of participants or the organization;

- Avoiding behavior detrimental to the operation of the organization.

Applicability. The Compliance Program is intended to be a routine part of the organization's operations. All Affected Individuals are required to comply with the Code of Conduct contained in this manual and all other policies included in the Compliance Program. All Affected Individuals are further expected to use their best efforts to prevent, detect and correct any fraud, abuse or waste in connection with federally funded health care programs and private health plans. The Corporate Compliance Program Manual will be accessible to all Affected Individuals via Osborne's website and agency intranet.

Hiring Package. All new Employees shall be provided a Compliance Program package by the Human Resources Department containing, at a minimum, a summary of their responsibility to be personally and professionally responsible for understanding and carrying out the Code of Conduct and the policies contained within the Compliance Program. All new Employees are required to complete the attached form acknowledging receipt of these materials.

Board Approval

At a regular meeting of the Board of Directors of The Osborne Association, Inc. on March 15, 2017, after proper notice and upon motion duly made, seconded, and passed, this updated Corporate Compliance Program was adopted. (A copy of Osborne Board Meeting minutes for the March 15, 2017 meeting is on file with Osborne's Compliance Office).

Compliance Program

Required Elements of the Compliance Program

Osborne's Compliance Program ("Compliance Program") shall have, at minimum, the following eight elements:

1. **Written Policies and Procedures.**
    a. The Compliance Program shall include a set of written policies and procedures that describe compliance expectations in a code of conduct or code of ethics.
    b. The Compliance Program shall include or reference the formal resolution of the Board documenting that Compliance Program has been adopted and implemented.
    c. The policies contained within the Compliance Program shall provide direction to Employees and other Affected Individual with regard to potential compliance issues.
    d. The policies contained within the Compliance Program shall provide direction on how to communicate compliance issues to appropriate compliance personnel.
    e. The policies contained within the Compliance Program shall provide direction on how potential compliance problems are investigated and resolved.

2. **Designated Employee with Vested Compliance Responsibility.**
    a. The Compliance Program shall designate an Employee vested with responsibility for day-to-day operation of the Compliance Program ("Compliance Officer").
    b. The Compliance Program shall require the Compliance Officer to report directly to the organization's chief executive or other senior administrator.
    c. The Compliance Program shall require the Compliance Officer to report to the governing body about the activities of the Compliance Program, and shall define the frequency of such required reporting.

3. **Training and Education.**
    a. The Compliance Program shall require training and education to be provided on compliance issues, expectations and the compliance program operation.
    b. Compliance training and education will be provided to:
        i. All employees
        ii. All executives
        iii. All governing body members
    c. The Compliance Program shall require this training to recur periodically, and shall define the frequency of recurring training
    d. The Compliance Program shall require this training to be part of orientation for the following:
        i. New employees
        ii. Executives
        iii. Governing body members

4. **Communication With Compliance Officer**
    a. The Compliance Program shall include policies that establish lines of communication to the Compliance Officer that allow for compliance issues to be reported.
    b. The lines of communication established by (a) shall be accessible to:

i. All employees
ii. Vendors and volunteers
iii. All executives
iv. All governing body members

c. The Compliance Program shall establish a method for *anonymous* and *confidential* good faith reporting of potential compliance issues as they are identified for each group identified in (b) above.

5. Disciplinary Policies to Encourage Good Faith Participation

a. The Compliance Program shall establish disciplinary policies to encourage good faith participation in the compliance program by all Affected Individuals, as appropriate based on their role.
b. The disciplinary policies established pursuant to (a) above shall include the following with respect to all Affected Individuals, as appropriate based on their role:
    i. Expectations for reporting compliance issues
    ii. Expectations for assisting in the resolution of compliance issues
    iii. Sanctions for failing to report suspected problems
    iv. Sanctions for participating in non-compliant behavior
    v. Sanctions for encouraging, directing, facilitating or permitting non-compliant behavior.
c. The Compliance Program shall require the fair and firm enforcement of these disciplinary policies.

6. Routine Identification of Compliance Risk Areas

a. The Compliance Program shall establish a system for routine identification of compliance risk areas specific to the organization.
b. The Compliance Program shall establish a system for self-evaluation of the risk areas identified by the risk identification process, including internal audits and, as appropriate, external audits.
c. The Compliance Program shall establish a system for evaluation of potential or actual non-compliance as a result of these self-evaluations and audits.

7. Responding To Compliance Issues

a. The Compliance Program shall establish a system for responding to compliance issues as they are raised, including:
    i. Investigating potential compliance problems
    ii. Responding to compliance problems as identified in the course of self-evaluations and audits
    iii. Correcting compliance problems promptly and thoroughly
    iv. Implementing procedures, policies and systems as necessary to reduce the potential for recurrence
b. The Compliance Program shall establish a system for identifying and reporting compliance issues to the NYS Department of Health or the NYS Office of Medicaid Inspector General, including the refunding of Medicaid overpayments.

8. Non-Intimidation and Non-Retaliation Policies

a. The Compliance Program shall include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to:

i. Reporting potential issues
ii. Investigating issues
iii. Self-evaluations, audits and remedial actions
iv. Reporting to appropriate officials as provided in Sections 740 and 741 of the New York State Labor Law (see section entitled **Relevant Law**later in this Manual).

Definitions

Affected Individuals	Executives, officers and governing body members and other employees. This includes the President/CEO, executive management, program directors and managers, supervisors and any other persons or individuals hired by and in the paid service of the organization. Also included are temporary and contract employees and, where practical, independent contractors doing business with the organization.
Compliance Office	The Chief Compliance Officer, together with any Deputy Compliance Officer that may be appointed
Employees	All full-time and part time employees, including executive management, program directors, supervisory, managerial and administrative personnel.
Executives	Employees with the ability to make decisions and set policy for the organization
Financial Interest	A person has a financial interest if the person has, directly or indirectly, through business, investment, or family relationship: a. an ownership or investment interest in any entity with which the Corporation Organization has a transaction or arrangement, b. a compensation arrangement with the Corporation Organization or with any entity or individual with which the Corporation has a transaction or arrangement, or c. a potential ownership or investment interest in, or compensation arrangement with, any entity or individual with which the Corporation Organization is negotiating a transaction or arrangement. *Compensation* includes direct and indirect remuneration as well as gifts or favors that are not substantial in nature. A financial interest is not necessarily a *conflict of interest*. A person who has a financial interest may have a conflict of interest only if the appropriate Board or committee decides that a conflict of interest exists.
Governing Body Members	All Board members
Ineligible Person	An individual or entity who/which has been excluded, suspended, debarred or otherwise deemed ineligible to participate in a federally funded healthcare program and has not been reinstated after a period of exclusion, suspension, debarment or ineligibility.
Interested Person	Any director, principal officer, or member of a committee with Board delegated powers who has a direct or indirect financial interest, as defined below, is an interested person.

Designated Employees with Vested Compliance Responsibility

The following personnel have been designated as employees with vested responsibility for the implementation and operation of the Compliance Program at the organization.

The responsibilities of the designated employees are described in the **Policy** section of this manual under **Compliance Responsibilities.**

Chief Compliance Officer: Patricia Ritchings

Acknowledgement: _____, Chief Compliance Officer

Date: _____

Deputy Compliance Officer:

Acknowledgement: _____, Deputy Compliance Officer

Date: _____

Code of Conduct

A. Introduction

Osborne's compliance program embodies its commitment to conducting business in compliance with all applicable laws, rules, regulations and other directives of the federal, state and local governments and agencies. Our commitment is to adhere to the code of conduct ("Code of Conduct") set forth below, which is applicable to all Affected Individuals.

The Code of Conduct is intended to provide general guidelines to assist employees to understand and appreciate the manner in which Osborne wishes to conduct business. Although the Code of Conduct can neither cover every situation in the daily conduct of our many varied activities nor substitute for common sense, individual judgment or personal integrity, it is the duty of every Staff Member to adhere, without exception, to the principles set forth herein. More complex aspects of the Code may require additional guidance and direction (See Section V. of Osborne Employee Handbook).

The Code of Conduct shall be distributed upon hire, to all employees. Employees are responsible for ensuring that their behavior and activity is consistent with this Code of Conduct. This Code is not intended to cover every situation which may be encountered and employees should comply with all applicable laws and regulations whether or not specifically addressed in the Code.

B. Compliance with Laws and Regulations

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

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

C. Fraud and Abuse

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

These laws generally prohibit: (1) the transfer of anything of value in order to induce the referral of participants or any government program business (i.e., Medicare, Medicaid and other federal or state health care programs); and (2) the making of false representations or the submission of false, fraudulent or misleading claims to any government entity or third party payer, including claims for services not rendered, claims which characterize the service

differently than the service actually rendered, or claims which do not otherwise comply with applicable program or contractual requirements.

More specific guidance with respect to laws and regulations applicable to fraud and abuse can be found elsewhere in this manual under the section entitled **Relevant Law**.

D. Professional and Ethical Standards

As professionals, all employees have a duty to support **Osborne's** goals to provide services of the highest quality that respond to the needs of our participants. The services provided must be reasonable and necessary for the care of each participant, and such care must be provided by properly qualified individuals. All such care must be properly documented as required by law and regulation, payer requirements, professional standards and Osborne's policies and procedures.

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

E. Confidentiality

Osborne and its employees are in possession of, or have access to, a wide variety of confidential and sensitive information.

Participant records, including those that contain Protected Health Information (PHI) are the property of the organization and shall be maintained to serve the participant, necessary health care providers, the organization, payers such as Medicare/Medicaid and other third party payers in accordance with legal, accrediting and regulatory organization requirements. The information contained in the health care record belongs to the participant and the participant is entitled to the protection of that information. All participant care information is regarded as confidential and available only to authorized users and employees who may be providing participant care and to third party payers in order to facilitate reimbursement. The operations, activities, business affairs and finances of the organization should also be kept confidential and discussed or made available only to authorized individuals.

It is the duty of the organization and its employees to protect the privacy rights of the participants. The organization and its employees shall maintain the confidentiality of participant medical records and information, as well as proprietary information, by actively protecting and safeguarding such information in a manner designed to prevent the unauthorized disclosure of such information. Any use of confidential information must be preceded by appropriately documented consent from the participant. Additional information on safeguarding patient information may be found in Osborne's HIPAA Policy.

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

F. Business Practices

Osborne's business practices must be conducted with honesty and integrity and in a manner that upholds the organization's reputation with participants, payers, vendors, competitors and the community. The organization expects its employees to be loyal to the Osborne's interests. Employees should not use their positions to profit personally or to assist others in profiting in any way at the expense of the organization. Employees must refrain from activities which create conflicts of interest with **Osborne** or which give the appearance of impropriety.

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

When **Osborne** decides to enter into an agreement or arrangement with any entity or practitioner to provide goods or services, that decision must be free of any improper influence. Thus, any employee involved in the decision-making process with respect to such transactions who believes that s/he or a family member may have a significant financial interest in any entity that (i) engages in business or maintains a relationship with the organization, (ii) provides to, or receives from the organization participant referrals, or (iii) competes with the organization, must notify their immediate supervisor and the Compliance Officer so the potential conflict can be reviewed. In this way, the organization can be assured that our business relationships are free from improper influences. For more information, see **Conflicts of Interest** in the **Policy** section of this manual*.*

G. Employment Practices

Non-discrimination - **Osborne** provides equal opportunity for employment and advancement to all employees and applicants for employment. **Osborne** does not discriminate against any individual based on race, creed, ancestry, citizenship status, religion, color, age, national origin, political belief, sexual orientation, gender, gender identity or self-image, gender appearance, behavior or expression, transgender status, marital status, veteran status, disability, prior arrest or conviction history or any other characteristic or status protected by law in employment decisions including recruitment, hiring, compensation, fringe benefits, staff development and training, promotion or transfer, lay-off or termination, or any other condition of employment. **Osborne** is committed to fostering diversity at all levels. The organization is committed to providing participant care and a workplace environment which emphasizes the dignity and respect of every individual. In that regard, harassment and/or other types of prohibited discrimination in any form or context will not be tolerated.

Environmental Laws - It is the policy of **Osborne** to comply with all environmental laws and regulations as they apply to the organization's services and operations. Osborne will operate each facility with the necessary permits, approvals and controls and employ proper procedures for handling and disposing hazardous and bio-hazardous waste, including but not limited to medical waste.

Drug-free, Smoke-free Workplace - Osborne is committed to providing an efficient, healthy, and safe workplace. Osborne maintains a drug and alcohol free workplace and will not tolerate on its premises the manufacture, dispensation, possession, distribution, or use of illicit drugs or alcohol, or an employee being under the influence of illicit drugs or alcohol. The **Osborne** workplace must also be one that is free of the effects of smoke-contaminated air; **Osborne** does not permit smoking anywhere inside its facilities.

Violence-free Workplace – Osborne and its employees will comply with federal, state and local laws and regulations that promote the protection of health and safety. Violence in the workplace will not be tolerated and such behavior will result in immediate disciplinary action. Employees are expected to report workplace injuries or any situation presenting a danger of injury immediately to their supervisors.

For further details concerning the Osborne Freedom from Harassment Policy, Drug-free Workplace Policy, Alcohol Abuse Policy, Smoke-free Workplace Policy and Workplace Violence Prevention Policy see the Osborne Employee Handbook.

H. Reimbursement

Osborne and its employees have a duty to create and keep records and documentation which conform to legal, professional and ethical standards. Employees involved in delivering reimbursable services, or in billing and reimbursement for services, shall ensure that billings for reimbursement for care are reasonable, necessary and appropriate, that services are provided by properly qualified persons, and that services are billed correctly and supported by adequate documentation.

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

I. Administration and Application of this Code of Conduct

Osborne expects that the Code of Conduct will be integrated into the daily activities of its employees. The Code of Conduct is in addition to, and does not limit, specific policies and procedures of the organization. Employees must perform their duties in accordance with all such policies and procedures.

It is the duty of all Affected Individuals to uphold the standards set forth in the Code of Conduct and to report violations by following the reporting procedures outlined in the Compliance Manual. Alleged violations of the Code of Conduct or other policies or procedures of the organization will be investigated in accordance with the organization's Compliance Program Policy entitled "Investigating Compliance Concerns" in this manual. The organization will make efforts to maintain the confidentiality of the identity of any individual who reports perceived or actual violations. However, confidentiality of identity cannot be guaranteed.

J. Non- Retaliation

It is the duty of all employees to report, in good faith, concerns about actual or potential violations of the Code of Conduct or Compliance Program. Supervisors, managers, and employees are not permitted to engage in retaliation, retribution, intimidation, or any form of harassment directed against an employee who reports a compliance concern. Anyone who is involved in any act of retaliation, retribution or intimidation against an employee that has reported suspected misconduct in good faith will be subject to disciplinary action as described in the Policy section of this manual under **Disciplinary Action**. For more information, also see the **Non-Retaliation, Non-Retribution, and Non-Intimidation for Reporting** policy in this manual.

K. Violations of the Code of Conduct

Adherence to and promotion of the Code of Conduct and Compliance Program will be a factor in evaluating the performance of employees, including supervisory, managerial and administrative personnel. Failure to abide by the Code of Conduct or the guidelines for behavior which the Code of Conduct represents may lead to disciplinary action. Disciplinary action will be determined on a case-by-case basis and may, in the discretion of the organization, range from a warning to termination. If **Osborne** determines that a violation may have included criminal violations of law or regulation, the organization will seek the advice of counsel and cooperate with law enforcement authorities in connection with any investigation and prosecution of the offender. For more information see **Disciplinary Action** under the **Policy** section of this manual.

L. **Reporting a Violation of the Code of Conduct**

Employees should report any violation of the Code of Conduct to their immediate supervisor, the Compliance Office, a member of the Compliance Committee and/or via the Ethics Hotline. The Hotline is particularly helpful if you prefer not to report such matter to your supervisor because you believe s/he may be involved in the actual or perceived violation, if you prefer to remain anonymous, if you have a legitimate reason to be concerned about reprisal, or if your previous reports have not been acted upon, but you may use it for any reason. The number of **the Ethics Hotline is 866-594-0655.** A compliance report may also be reported to the Hotline via the internet at http://osbornehotline.ethicspoint.com. Hotline reports may be made anonymously, however, supplying your name may assist in the investigation of your report but you are under no obligation to do so. Please note that it is an explicit violation of the policy to

retaliate in any way against an employee who, in good faith, reports an actual or potential violation of applicable laws, rules, regulations, or the Code of Conduct.

For details on how to report a violation, please refer to the **Compliance Communication** in the **Policy** section of this manual.

Please note that nothing in this Code of Conduct is intended to, nor shall be construed as providing, any additional employment or contract right to employees or other persons.
Osborne will generally attempt to communicate changes to the Code of Conduct prior to the implementation of such changes. However, the organization reserves the right to modify, amend or alter the Code of Conduct and its policies and procedures without prior notice to any person.

Policies

The following policies are part of the Compliance Program of the organization, and are applicable to all Employees (and other Affected Individuals, as indicated in each policy).

Policy – Compliance Responsibilities

PURPOSE
To explain the roles and responsibilities associated with Osborne's Compliance Program.

POLICY
It is Osborne's the to maintain a Corporate Compliance Office vested with the duties described herein as well as a Corporate Compliance Committee made up of 5-9 members who work closely with the Compliance Office to determine and implement Osborne's compliance strategy and workplan**.** All Osborne program directors and managers are expected to support the compliance program by setting and enforcing standards within their respective departments and ensuring that staff are trained in Osborne's Code of Conduct and Compliance Program.

Compliance Committee

The Compliance Committee shall consist of approximately 5-9 members of the organization, appointed by the President/CEO or Chief Compliance Officer, meeting at least semi-annually and shall include:

- Chief Compliance Officer and any other members of the Compliance Office
- Member(s) of Management
- Member(s) of the Human Resources Department
- Member(s) of the Quality Review/Grants Management Department
- Members of the Program Operations Departments
- Member(s) of the Finance Department

Duties

1. Advise the Compliance Office and assist in the implementation and maintenance of the Compliance Program;

2. Determine the appropriate strategy and/or approach to promote adherence to the Compliance Program and the detection of potential violations;

3. Maintain a system to solicit, evaluate, and respond to complaints and problems;

4. Oversee the education and training of employees and systems for communication with and by employees;

5. Establish confidentiality standards and requirements for committee members and those persons requested to provide assistance to the committee.

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

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

A summary of the activities of the Committee shall be reported to the Board of Directors at least annually.

Corporate Compliance Office

The President/CEO shall appoint the Chief Compliance Officer who shall report to the President/CEO and the Board of Directors. The Chief Compliance Officer may also appoint one or more Deputy Compliance Officers who shall report to the Chief Compliance Officer. The

Chief Compliance Officer and any Deputy Compliance Officers will constitute the "Compliance Office". The Chief Compliance Officer will be responsible for overseeing the administration and implementation of the Compliance Program and will report at least annually to Board of Directors about Compliance Program operations. The Chief Compliance Office will seek advice from outside legal counsel when appropriate.

The Chief Compliance Officer shall be the Designated Employee with Vested Compliance Responsibility as per the section **Required Elements of the Compliance Program,** above in this Manual.

The Chief Compliance Officer acts as staff to the President/CEO and Board of Directors by monitoring and reporting results of the compliance and ethics efforts of the organization and in providing guidance for the Board and senior management team on matters relating to compliance. The Chief Compliance Officer, together with the Compliance Committee, are authorized to implement all necessary actions to ensure achievement of the objectives of an effective compliance program.

The Compliance Office shall have access to all documents and information relevant to compliance activities including but not limited to participant records, billing records, human resources records, marketing records, and contracts and written arrangements or agreements with others.

Primary Responsibilities of the Chief Compliance Officer (assisted by the Deputy Compliance Officer, if applicable):

1. Serve as chairperson of the Compliance Committee and supervise the implementation and day-to-day operations of the Compliance Program (or delegate this role to a Deputy Compliance Officer under supervision of the Chief Compliance Officer);

2. Develop, implement, and periodically update an effective Code of Conduct and Compliance Program, at intervals determined by the Chief Compliance Officer, to prevent illegal, unethical, or improper conduct. The policies therein shall establish standards of conduct, clearly identify prohibited conduct, provide for monitoring of compliance activities, and establish mechanisms by which prohibited conduct will be reported to the Compliance Office.

3. Develop such new policies and procedures as may be required to address areas of high risk of noncompliance.

4. Establish and coordinate a regular compliance training process about relevant compliance issues; develop subject-specific training on regulatory requirements related to department functions if necessary and document the training

administered to ensure that all appropriate employees are knowledgeable about the compliance issues that pertain to them.

5. Assist supervisory staff to establish multi-level mechanisms (including periodic audits) to monitor compliance with the standards set forth in Compliance Policies and document implementation and results.

6. Implement and oversee the development of a confidential system for employees and others to seek guidance on business conduct and to report suspected violations of law, compliance standards or other policies and procedures.

7. Independently investigate and act on matters related to compliance, including the design and coordination of internal investigations that respond to reports of problems or suspected violations.

8. Implement and monitor an anonymous hotline as a mechanism to receive concerns without fear of retaliation and review problem areas identified by callers.

9. Consistently enforce policies and procedures through appropriate interventions and/or disciplinary or other corrective action in conjunction with legal counsel when appropriate.

10. Propose modifications to the Compliance Program, as necessary, to prevent recurrence of problem

11. Conduct a regular review of the Compliance Program's functioning and prepare periodic and annual reports for the Board of Directors describing the compliance efforts undertaken during the preceding year, identifying any changes necessary to improve the Compliance Program.

12. Prepare evaluation reports on compliance activities, including reports or complaints received from employees, investigations, and audits and monitoring, to be presented to the Board, President/CEO, and the Compliance Committee on a regular basis, at intervals determined by the Compliance Office. Reporting to the Board shall be done at least annually.

13. Report all financial, operational and compliance related investigations, at least semi-annually, to the organization's Chief Executive Officer.

14. Coordinate reviews and audits under the Corporate Compliance Plan utilizing the Office of the Medicaid Inspector General's Compliance Program Work Plan Guidance, including a risk assessment of areas by departments and incorporation of risks identified into a work plan, periodically, at intervals determined by the Chief Compliance Officer.

15. Respond, in conjunction with Legal counsel where necessary, to external organizations' requests regarding compliance issues.

Program Directors and Managers

Each program director or manager shall be responsible for the following aspects of the Compliance Program:

1. Implementing and maintaining compliance standards and policies and procedures specific to their program or department and such additional compliance measures as necessary for the business units they oversee, consistent with the Compliance Program and subject to the approval of the Compliance Office.

2. Ensuring that all employees have received training as prescribed by the Compliance Program, including compliance standards, policies, procedures, laws and regulations applicable to employees of the department as directed by the Compliance Office;

3. Enforcing this Compliance Program and the Code of Conduct, the organization's policies and procedures, and applicable laws and regulations as directed by the Compliance Office;

4. Cooperating with any investigation initiated under the Compliance Program as directed by the Compliance Office consistent with the **Policy** entitled **Investigating Compliance Concerns;**

5. Reporting to the Compliance Office any reports or reasonable indication of violations of applicable law or regulation by any employee;

6. Initiating and/or implementing corrective or disciplinary action as determined by the Chief Compliance Officer, in consultation with HR if deemed appropriate, following an Investigation initiated pursuant to the Compliance Program or otherwise appropriate and as necessary for the operation of the department; and

7. Taking all measures reasonably necessary to ensure compliance with this Program and applicable laws and regulations as directed by the Compliance Office.

Policy – Compliance Training and Education

PURPOSE

To provide guidance on the training of all Affected Individuals about their duties and obligations under the Compliance Program and Code of Conduct. Training shall include compliance issues, expectations and the operation of the compliance program.

Training is required to provide all Affected Individuals with the knowledge and skills to carry out their responsibilities in compliance with all requirements, including those relating to the delivery of healthcare and billing for services, in a manner consistent with applicable laws and regulations.

POLICY

A. Initial Training. All new employees will receive a hiring package that includes, at a minimum, an overview of fraud and abuse laws, a presentation on the importance of coding and billing issues (if relevant to their position), a summary of the standards of conduct highlighting the agency commitment to integrity in its business operations and compliance with applicable laws and regulations, and an explanation of the elements of the Compliance Program, including the complaint or reporting process. All new members of the governing body will receive an overview of the Compliance Program that is appropriate for their role.

B. Ongoing Training. All employees and members of the governing body will be trained in the following areas at least every two years:

i. the organization's Compliance Program;

ii. the consequences both to the organization and to individuals of failing to comply with applicable laws and regulations. Such training must emphasize the importance of the Compliance Program and the commitment to honesty and integrity in its business dealings.

C. Substantive Rules. All individuals involved in the delivery of or billing for the organization's health related services, will be trained and, as necessary, retrained in the specific federal and other health care program rules (e.g. Medicare/Medicaid) that relate to their particular job functions. This training will include, but not be limited to the following types of training:

i. ***Intake Staff*** will receive training regarding their role in obtaining the necessary demographic, insurance and other information to support proper authorization for services.

ii. ***Billing Staff*** will receive training in the fraud and abuse laws as they relate to the claim development and submission process and business relationships, as well as relevant Medicare and Medicaid other federal and state requirements.

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

iv. ***Financial and other administrative management personnel*** will receive training applicable to their role.

D. <u>Tailoring of Training To Role</u>.

i. All employees and members of the governing body shall receive minimum training sufficient for compliance with the Compliance Program and Code of Conduct, as determined by the Chief Compliance Officer.

ii. Additional tailored training shall be given to employees as necessary to perform their job functions in a manner consistent with the Compliance Program. The contents of such additional training shall be determined based on the risk areas or areas of concern associated with each job function, subject to approval by the Compliance Officer.

E. Methods of Training. Training and education may occur in sessions with individual employees, in mandatory in-service meetings, via webinar, or incorporated into special or regular departmental meetings or in some other effective manner. Training may consist of live presentations, videos, question and answer sessions and written material and may occur in-house or through attendance at external workshops and seminars, through online webinars or other means determined appropriate by the Chief Compliance Officer.

F. Frequency of Training. Training shall occur for all employees at orientation and at least every two years thereafter. Following any incident or violation of the Compliance Program, additional training may be provided at the discretion of the Chief Compliance Officer.

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

H. Failure to Attend. Failure to comply with training requirements or to attend scheduled training sessions of the agency or required trainings of any department may result in disciplinary action.

I. Evaluation. The Compliance Office shall conduct informal debriefs/evaluations of training and education programs to determine, and if necessary improve, the value, effectiveness and appropriateness of any such program

Policy – Compliance Communication

PURPOSE

To provide guidance on the open communication necessary to maintain an effective compliance program and reduce any potential for fraud, abuse and waste. Any actual or perceived communication problem should be reported to Management, Human Resources, or the Compliance Office.

POLICY

A. Questions. At any time any Affected Individual may seek clarification or advice from the Compliance Office in the event of any confusion or question with regard to this Program or any element of this Program or any organizational policy or procedure related to this Program. Questions and responses should be documented and, if appropriate, shared with employees or other Affected Individuals as appropriate for informational and educational purposes. To facilitate such communication, the Compliance Office and Compliance Committee shall make publicly available their contact information, including names, locations, phone numbers and e-mail addresses.

B. Reporting. All Affected Individuals are required to report violations of the Compliance Program, or acts of fraud, abuse, or waste of which they are aware or reasonably suspect. An employee who for any reason is uncomfortable reporting a suspected violation to any of the above-referenced individuals may do so confidentially or anonymously using the Ethics Hotline. All reports of suspected violations will be treated confidentially. The organization will promptly and thoroughly investigate any suspected violation in as confidential manner as possible, and take appropriate disciplinary action if warranted.

C. Reporting Lines Of Communication for Compliance Questions and Reports

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

2. **To Compliance Personnel.** All Affected Individuals may report directly to the Compliance Office or to a member of the Compliance Committee.

3. **Via Hotline or Website.** All Affected Individuals may anonymously file reports on Osborne's anonymous Ethics Hotline using one of the following methods at any time:

    i. Via the web at ***http://osbornehotline.ethicspoint.com***
    ii. Via toll-free telephone call at **(866) 594-0655**

The above anonymous reporting methods shall be posted in various locations throughout the organization's facility. All Affected Individuals will be made aware of their duty to report violations and the availability of these anonymous reporting methods.

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

D. Confidentiality. Reports received will be treated confidentially to the extent possible under applicable law. However, there may be instances when an individual's identity may become known or must be revealed. For example, if governmental authorities become involved, in response to subpoena or other legal proceeding, or if the matter cannot be fully investigated without the possibility of identifying information about the reporter.

E. Non-Intimidation and Non-Retaliation. All disclosures under this policy are subject to Osborne's **Policy** on **Non-Retaliation, Non-Retribution and Non Intimidation for Reporting**, contained in this manual.

F. Documentation. The Chief Compliance Officer and Deputy Compliance Officer shall maintain a record of reports of violation of this Program, or of the standards of conduct, or of relevant law or regulations, received by the Compliance Officer. The Chief Compliance Officer and Deputy Compliance Officer shall periodically, at intervals determined by the Chief Compliance Officer, furnish a summary of such reports to the President/CEO, the Compliance Committee and the Audit/Finance Committee of the Board of Directors.

Policy – Identifying & Investigating Compliance Concerns

PURPOSE
To provide guidance on the requirements for identifying, and investigating alleged fraud, waste, or abuse, and other compliance concerns. To describe the activities that should be performed to ensure proper investigation of any reported and non-reported concerns. This policy also articulates the expectations for assisting in the resolution of compliance issues for all Affected Individuals.

POLICY
Osborne's Compliance Program shall include routine self-evaluation, risk assessment, internal audit and other activities designed to identify compliance risk areas specific to the organization as well as a process for investigating and addressing potential or actual non-compliance as a result of these self-evaluations and audits.

Routine Identification of Risk Areas
Regardless of whether a complaint or other concern has been received, the following Compliance Investigation activities shall occur on an annual basis except where noted below:

- Completion of OMIG Assessment form;
- Certifying at year-end to the Office of the Medicaid Inspector General;
- Practitioner Credentialing;
- Risk Assessment (at intervals determined by the Chief Compliance Officer);
- Annual completion of the Medicaid Billing Self-Assessment tool for a random sample of Medicaid claims
- Review of a random sample of Medicaid claims at least quarterly using Federal OIG guidelines
- Updating of the Medicaid Compliance Work Plan.

Investigations. Investigations conducted pursuant to the Compliance Program shall be conducted with the following goals:

- To identify situations in which there is reasonable cause to believe applicable federal and state laws, including those related to Medicare and Medicaid programs, or Osborne policies, may not have been followed;
- To identify individuals who may have knowingly or inadvertently violated the law or the Osborne policies;
- To facilitate the correction of any violations or misconduct;
- To implement procedures necessary to ensure future compliance;
- To protect the organization in the event of civil or criminal enforcement actions; and/or
- To preserve and protect the assets of the organization.

A. **Requirement for Program Directors and Managers to Report Violations.** Each manager and program director is responsible for promptly reporting any incident reasonably believed to be a violation of the Compliance Program, Code of Conduct, other policy of

the organization, or any violation of applicable law or regulation by employees or others within his or her supervision. Any report or reasonable indication of a violation of the Compliance Program, applicable law, or regulations must be reported to the Compliance Office prior to initiation of any investigation. In the case of other violations, managers and program directors should consult with the Human Resources. Serious or otherwise sensitive matters or investigations shall be conducted by, or under the direction of, legal counsel in coordination with the Compliance Office.

B. Requirement of Investigation. The Compliance Office shall have an obligation to investigate any report or reasonable indication of a violation of the Compliance Program, Code of Conduct, or any applicable laws or regulations.

C. Requirement of Cooperation. The Compliance Office may utilize other organization employees (consistent with appropriate confidentiality), outside attorneys, outside accountants and auditors or other consultants or experts for assistance or advice. All Affected Individuals are expected to assist in the investigation and resolution of compliance issues at the request of the Compliance Office.

D. Relationship of Compliance Investigations to General Disciplinary Procedures. The investigation by the Compliance Office shall be preliminary to the initiation of disciplinary proceedings under government regulations. In the event there is reasonable cause to believe a violation exists, the Compliance Office or respective manager or program director shall coordinate with the Human Resources Department regarding the appropriate action to be taken in accordance with the applicable policies and procedures of the organization.

E. Access to Information. The Compliance Office (or designee), may conduct interviews with any employee or other person who may possess relevant information, and may review any document relevant to the investigation, including but not limited to those related to claim development and claim submission, participant records, e-mail, and other paper or electronic records in whatever form.

F. Documentation. Upon the completion of any investigation initiated pursuant to the Compliance Program, the Compliance Office shall prepare a report which includes the following:

1. Defines the nature of the situation or problem;
2. Summarizes the investigation process, findings, and corrective action taken;
3. Identifies any person whom the investigator believes to have acted deliberately or with reckless disregard or intentional indifference, particularly toward the Medicare/Medicaid laws, regulations and policies,
4. If there is a potential overpayment, estimates the nature and extent of the resulting overpayment by the government or another entity, if possible.

RESPONSE TO VIOLATIONS

Discipline. If an investigation initiated pursuant to the Compliance Program results in a determination that a violation and/or criminal activity has occurred, appropriate disciplinary action shall be recommended by the Compliance Office.. Such disciplinary action shall be consistent with the **Policy** in this manual entitled **Disciplinary Action.**

Policy Review. Following any investigation initiated pursuant to the Compliance Program, the Compliance Office may determine whether a review of applicable portions of the Compliance Program is appropriate and if so, whether revisions to existing policies or the development of new policies and/or procedures are needed to minimize future risk of noncompliance.

Billing. If the conduct underlying the investigation was related to billing, all affected billing shall be reviewed for correctness by the Compliance Office or designee and remediated as soon as possible. Such remediation may include, as necessary:

1. Discontinuance of fraudulent billing practices;
2. Correction of a defective practice or procedure; and/or
3. Repayment of duplicate or improper payments to the appropriate payor or fiscal intermediary;

Additional education will be undertaken with appropriate employees to prevent future similar problems.

All investigations shall be conducted in accordance with this policy and the **Policy** on **Non-Retaliation, Non-Retribution, and Non-Intimidation for Reporting,** below.

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

PURPOSE

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

The purpose of this policy is to reassure employees who wish to report concerns through any of the methods established by the Compliance Program that a non-retaliation, non-retribution, and non-intimidation policy has been established and pertains to reporting of concerns, *including, but not limited to, reporting potential issues, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials as provided in the New York State Labor Law §§ 740 and 741.*

POLICY

Supervisors, managers, and employees are not permitted to engage in retaliation, retribution, intimidation, or any form of harassment directed against an employee who reports a Compliance concern. Likewise, supervisors, managers, and employees are prohibited from engaging in any such conduct that would discourage any employee from reporting a compliance concern.

Employees have the responsibility to report, in good faith, concerns about actual or potential violations of the Code of Conduct or Compliance Program to their supervisor and upward to the Chief Compliance Officer or Deputy. The organization is committed to a policy that encourages timely disclosure of such concerns and prohibits any action directed against an employee, manager or supervisor or volunteer for making a good faith report of a concern.

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

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

Policy – Disciplinary Action and Sanctions

POLICY

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

The commitment to compliance applies to all personnel levels within the organization. All disciplinary actions will be implemented in accordance with Osborne's system of performance management and progressive discipline. See Disciplinary Procedures in Osborne Employee Handbook.

As noted in the Employee Handbook, the organization has a progressive discipline policy under which sanctions become more severe for repeated infractions. This policy, however, does not mandate the use of a lesser sanction before the organization terminates an employee. In the discretion of management, the organization may terminate an employee for the first breach of the organization's or individual policies and standards if the seriousness of the offense warrants such action.

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

Policy – Credit Balances and Overpayment

PURPOSE

To provide a process for identification, remediation, and prevention of overpayments and credit balances in connection with federal and state-funded healthcare claims.

POLICY

Accurate Bills and Records

Bills for federally funded health care programs, as well as to other payers, must be true, accurate, complete, and ordered by a physician or other appropriately licensed person for services believed to be medically necessary.

It is particularly important that coding, billing and submission of claims to Medicaid and other third party payers, be appropriate, accurate and in compliance with applicable laws and regulations.

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

- Billing for services not rendered
- Misrepresenting services provided (inappropriate coding, inflating units of service)
- Billing for services rendered to participants who do not meet admission criteria
- Duplicate billing for the same service
- Falsifying billing or medical records in any way
- Entering into business agreements that pose a conflict of interest
- Billing for services that are not medically necessary
- Participation in any kickback schemes as prohibited by law
- Participation in any Self-Referrals as prohibited by law

Documentation of Claims

All professional services should be documented timely, correctly and properly. Participant records and other documentation which support the bills should also be true, accurate and complete in accordance with professional standards and available for audit and review. All claims submitted to Medicare, Medicaid and other third party payers shall be supported by signed orders or service plans from the treating physician or other authorized person and valid authorization by the referral source. Any overpayments received from a healthcare program for services in excess of the amount due are returned to the payer, and the participant if applicable, in compliance with federal laws, regulations and standards.

Reporting of Overpayments

Overpayments will be reported and returned by the date which is 60 calendar days after the date on which the fact and amount of the overpayment was identified. An overpayment has

not been "identified" under the 60-day rule until a provider has or should have, "through reasonable diligence, quantified the overpayment".

Definition of Overpayments

Overpayments are funds which the provider receives or obtains but which it is not entitled to under applicable Medicaid or Medicare regulations. Such overpayments may be the result of criminal, civil or administrative law. They may also be the result of billing errors, inadequate internal controls, fraud perpetrated by employees and/or participants, inadequate administrative procedures, etc.

Self-Disclosure of Overpayment

It is the policy of organization to self-disclose all inappropriate payments that warrant disclosure. The OMIG has defined the threshold for such self-disclosure as claims which aggregate to more than $5,000. Claims which aggregate to less than $5,000 can be handled through administrative billing processes such as voiding. Each incident must be considered on an individual basis. It is up to management to decide whether an overpayment should be self-disclosed to the OMIG or handled through administrative processes. Management may not, however, make the determination about whether initial identified overpayment is less than $5,000.

Any identified overpayment must be investigated to make sure that it is not part of a pattern of:

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

The OMIG has stated that it monitors the number and dollar value of voids and/or adjustments to assess whether a provider has such problems. Thus it is imperative for management to ensure that none of these conditions exist.

PROCEDURE

1. Upon identification of an overpayment through internal audit or monitoring activities or through a report from outside sources, the staff member discovering such overpayment must notify his supervisor and the Compliance Office which will ensure that a preliminary review is conducted.

2. If the Compliance Office finds that the overpayment in aggregate does not exceed $5,000 **and that the overpayment is not part of a pattern**, the overpayment should be handled through normal administrative procedures. However, if the claim in aggregate exceeds $5,000 or is part of pattern of activity designed to obtain unauthorized payment, then the Compliance Office will consult with the President/CEO, the CFO and and legal counsel to prepare to self-disclose.

3. Once the decision to self-disclose has been made, the Compliance Office will prepare the following information:
    a. Agency name, type of provider (i.e. LHCSA) and Medicaid ID#
    b. Service provided including the participant ID and dates of service
    c. The methodology of documenting and billing the service
    d. The nature of the improper payment or other violation
    e. How the improper payment/violation was identified
    f. Amount of overpayment by Medicaid
    g. Identify the time period the payments encompass and why the search was not expanded beyond that period
    h. Actions taken to stop the conduct and prevent reoccurrence
    i. Personnel involved in the improper payment, personnel who found the problem and the personnel involved in rectifying the problem.
    j. If known, statutes or regulations implicated
    k. Name, phone number, correspondence address, e mail address of the disclosure contact person
    l. A CD containing an Excel file of the overpayment claims billed to Medicaid
    m. Attestation of accuracy and completeness

4. The President/CEO and/or Chief Compliance Officer will then, under guidance from legal counsel, contact the OIG and/or the OMIG in accordance with OIG or OMIG disclosure protocols, as appropriate.

5. Staff must then be prepared to respond promptly to any additional requests from the OMIG regarding this issue.

Restitution

Any self-disclosure is subject to a thorough OMIG review to determine whether the amount identified is accurate. Following the review, OMIG staff will consult with the State oversight agency to establish a repayment amount and schedule and explore the need to pursue any further administrative action. According to the OMIG, this determination will be based on factors including the nature of the problem, the effectiveness of compliance program, the dollar amounts involved, the time period, thoroughness and timing of disclosure, any potential harm to the health and safety to clients and efforts to prevent the problem from recurring.

Once a repayment amount has been established, the organization may reimburse the State of New York for the full amount or enter into a repayment agreement, based on its negotiations with the State of New York.

Policy – Response to Governmental Inquiry

PURPOSE

To provide guidance to the organization's Compliance Officers and Committee about how to respond to all governmental inquiries and investigations relating to Medicare or Medicaid, as well as the procedure that is to be followed and expectations for the proper handling of documents.

POLICY

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

B. **Process.**

i. **In General.** Employees should not disclose any documents to an unidentified individual or respond to an investigation request without first being directed to do so by the Compliance Officer.

ii. **Notices Received**. Employees who receive a search warrant, subpoena, demand, or request for investigation, should immediately notify their supervisor and the Compliance Officer or, in that Officer's absence, the CEO and/or CFO.

iii. **In-Person Requests.** Employees who are approached by a government representative in person or by phone should politely request identification from the representative, then request that the representative wait until the Compliance Officer or his or her designee arrives before conducting any interview or reviewing documents.

iv. **Response.** The Compliance Officer, in consultation with outside legal counsel, is responsible for coordinating the organization's response to warrants, subpoenas, inquiries and other inquiries and investigations by federal agencies with respect to compliance matters.

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

Policy – Prohibition Against Employing or Contracting with Ineligible Persons

POLICY

This policy incorporates the requirements of the Federal Office of the Inspector General and the Office of the Medicaid Inspector General, Corporate Compliance Programs. In order to avoid the imposition of civil monetary penalties we must ensure compliance with regulations applicable to the federal programs. Therefore it is the policy of the organization:

- Not to employ any individual who is an Ineligible Person in any role associated with the Medicaid/Medicare program;
- Not to contract or do business with any individual or entity who is an Ineligible Person;
- Not to appoint or reappoint to the Medical Director position any physician or allied health professional who is an Ineligible Person, and
- To comply with all reporting requirements governing Ineligible Persons.

Restriction on hiring. The organization will not hire or retain an employee in a position which has or will have discretionary authority to make decisions or whose job functions may materially impact the Medicare/Medicaid claim development and submission if such prospect or employee has been convicted of a crime related to health care or has been excluded.

Restriction on contracting. The organization will not contract with any person or entity to have discretionary authority to make decisions or whose functions may materially impact the Medicare/Medicaid claim development and submission which has been so convicted or excluded or disbarred and will attempt to terminate its contract arrangements with any such person or entity, subject to legal constraints such as damages for breach of contract. The organization will make reasonable and prudent effort not to submit any claim for service ordered or furnished by any person or entity excluded from participation.

Exclusion Review. It is the policy of the organization to conduct on a periodic basis, subsequent to hire and or contracting for services a background check on those staff and contractors whose work is directly related to the provision or billing of Medicaid/Medicare reimburseable services. The background check will include a review for exclusion from the Medicare and Medicaid programs. Employing or working with contractors that have an unfavorable status with government agencies with respect to services that are reimbursable by a federal healthcare program can result in the removal from the Medicare and Medicaid programs.

REFERENCES

OMIG Work Plan	http://www.omig.state.ny.us
Federal OIG List	http://oig.hhs.gov/fraud/exclusions.asp

GSA Exclusion List **http://www.sams.gov**

PROCEDURE

- The **Human Resources Department** shall have the responsibility of performing all initial exclusion checks prior to hiring or rehiring of staff, in addition to normal hiring procedures.

- The **Human Resources Department** shall have the responsibility for:
  - Performing monthly exclusion checks for all employees.
  - Notifying the Compliance Office upon learning of an employee who is an Ineligible Person.

- The **Finance Department** shall have the responsibility for:
  - Performing exclusion checks for prospective vendors bidding to provide goods or services related to the Medicaid/Medicare program;
  - Performing monthly exclusion checks for all current vendors who provide goods or services related to the Medicaid/Medicare program;
  - Working with counsel to terminate the contract of a vendor who becomes an Ineligible Person.

- All **candidates for employment** are required to disclose on the employment application whether he/she is an Ineligible Person. Staff may not be appointed unless confirmed that the individual is not an Ineligible Person.

- All **current employees and contractors** have a responsibility to disclose if they become an Ineligible Person and are subject to dismissal regardless of whether the employee discloses such fact. Human Resources will conduct on a periodic basis a search on ALL the above web sites for any exclusion that may warrant the termination of employment or contract with outside vendors.

- **Requests for Proposals** shall require disclosure statement regarding status as an Ineligible Person. See **Notice of Compliance To Vendors Form**.

DOCUMENTATION

All materials printed regarding the background search of Ineligible Persons must be accessible to the Compliance Office. Human Resources will maintain documentation of their reviews and report to the Compliance Office the status of these reviews and any adverse outcomes.

Policy – Conflicts of Interest

PURPOSE
The purpose of the Conflicts of Interest Policy is to protect Osborne's mission and purpose when it is contemplating entering into a transaction or arrangement that might benefit the private interest or give the appearance of impropriety of an officer, director or employee (see Osborne Conflicts of Interest Policy in the Employee Handbook). Osborne also maintains a Conflicts of Interest Policy that applies specifically to Board Members, Officers and Key Employees which is on file in the Compliance Office.

IN GENERAL
In order to perform their duties with honesty and fairness and in the best interest of the organization, all Affected Individuals must avoid conflicts of interest in their employment.

Personal Benefit. Each employee, for as long as he or she remains an employee of Osborne, is expected to conduct the business of Osborne to the best of his or her ability for the benefit of and in the best interest of the organization. No employee may become involved in any manner with competitors, contractors, customers, suppliers, consumers or their families served by Osborne if such involvement would result in improper personal gain or the appearance of improper personal gain. Such involvement may include the purchase, sale or lease of any goods or services, serving as an officer, director, or in any other management or consulting capacity with competitors, contractors, customers or suppliers.

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

Osborne staff should be alert to potential situations where it may not be appropriate to participate in discussions regarding prohibited subjects with other agencies. Prohibited subjects include any aspect of rate setting of key costs such as employee salaries and services. If anyone outside the agency raises a prohibited subject, end the conversation immediately. Employee will document his or her refusal to participate in the conversation.

Employees should not respond to any inquiry or survey from a competitor that requires information on rates, wages, service activity, or other information pertinent to The Osborne Association business operations.

Financial inducements. All Affected Individuals shall not offer any financial inducement, gift, payoff, kickback, or bribe intended to induce, influence, or reward favorable decisions of any government personnel or representative, any participant, contractor, or vendor in a commercial transaction or any person in a position to benefit the organization or the employee

in any way. Employees are strictly prohibited from engaging in any corrupt business practice either directly or indirectly. No employee shall make or offer to make any payment or provide any other thing of value to another person with the understanding or intention that such payment or other thing of value is to be used for an unlawful or improper purpose. Except for gifts of nominal value, or meals and social invitations that are in keeping with good business ethics and do not obligate the recipient or the employee, it is unacceptable for any Osborne Association employee, or member of his or her immediate family, to accept, give, or offer commissions, gifts, payments, entertainment, services, loans, or promises of future benefits to or from suppliers, governments, or anyone in connection with Osborne Association activities.

Political Participation. Law limits the organization's political participation. Osborne funds or resources are not to be used to contribute to political campaigns or for gifts or payments to any political party or any of their affiliated organizations. Osborne's resources include financial and non-financial donations such as using work time and telephones to solicit for a political cause or candidate.

PROCEDURES

Duty to Disclose

Any employee who thinks that a conflict of interest may exist with his or her own work or that of a family member is expected to immediately report the situation to his/her supervisor or manager or to the Compliance Office. Any employee who thinks that a potential conflict of interest may have gone unreported by a fellow employee is expected to bring the situation to the attention of his/her supervisor or manager or to the Compliance Office or report the situation through Osborne's Ethics Hotline.

Supervisors and Managers who receive such reports will consult with the Compliance Office to determine whether an actual conflict of interest exists and to determine appropriate steps to be taken.

Policy – Acceptable Use of Agency Assets and Social Media

Acceptable Use of the Organization's Assets. The organization will make available to employees assets and equipment necessary to conduct organization business including computer hardware and software, billing and medical records, fax machines, office supplies, and other equipment. Employees should strive to use organizational assets in a prudent and effective manner. The organization's property should not be used for personal reasons or be removed without prior approval from a departmental manager.

Acceptable Use of Social Media. Osborne maintains a policy on the appropriate use of technology assets and social media detailing the appropriate use of social media in the workplace. See **Social Media Policy** in Osborne's Employee Handbook..

Policy – Retention of Certain Records

PURPOSE

State and federal laws require that providers and others within the organization keep certain records for specified periods of time. It is the policy of the organization to keep records for as long as the law requires. Before any documentation is discarded, employees shall verify the standard with his/her supervisor or department head. Records to be retained include, but are not limited to:

(1) clinical and medical records and claims documentation required by federal or state law for participation in federal health care programs
(2) records relating to the Compliance Program such as documentation related to employee training, reports from the hotline, the nature and results of any investigations, and results of the organization auditing and monitoring efforts.

When retention is no longer required, confidential records should be destroyed such that the information contained in the document is not legible or identifiable. Any third party engaged to destroy such documents shall agree to maintain the confidentiality of such records during the destruction process.

Case Notes and Billing files shall be maintained for 7 years following the payment received in accordance with NYS and Federal guidelines.

Forms

COMPLIANCE PROGRAM ACKNOWLEDGEMENT OF RECEIPT

Employee's Name (Print) _____

Title: _____

Department _____

I acknowledge that I have received and read The Osborne Association Corporate Compliance Program Manual including the **Code of Conduct and Conflict of Interest Policy.**

I further acknowledge that I will abide by the Osborne Association Compliance Program and Code of Conduct and will refrain from any behavior that may result in a conflict of interest regarding the organization's established ethical standards**.**

_____ _____

Employee Signature Date

Return this signed acknowledgement to Human Resources.

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

STANDARD COMPLAINT FORM

Date received: _____

Complaint filed by: _____

Address: _____

Telephone: _____ E-mail _____

Is the individual filing the complaint a participant: **[ ] YES** **[ ] NO**

If not: Participant name: _____

Relationship to participant _____

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

_____

_____

_____

_____

Follow up and disposition:

_____

Date complaint closed: _____ was the complainant satisfied ___Yes ___ No

If "No", explain: _____

_____

_____

_____

Person responsible for receiving the complaint: _____

Handling the complaint _____

Employee Name: _____

Title: _____

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

COMPLIANCE PROGRAM - REPORTING FORM

Date _____
How was complaint filed: _____
Name of Facility: _____
Name of Individual Reporting if known: _____
Address: _____
_____
Telephone: _____
E-mail: _____
Is the individual filing the complaint a participant: [ ] Yes [ ] No
Relationship to the organization: _____

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

*Date complaint closed: _____ Complaint satisfied? [ ] Yes [ ] No

If "No", Explain:

Disposition or Action Taken

Investigation conducted by: _____

Reviewed by: CCO _____ DCO _____ Unit Mgr _____

ANONYMOUS REPORTING FORM

THE OSBORNE ASSOCIATION continually strives to provide high quality care to our clients. **THE OSBORNE ASSOCIATION** maintains high standards of integrity in our dealings with our client's families, as well as our own staff members and those with whom we do business. It is our philosophy that we provide all of our services in full compliance with all laws and regulations. This requires the highest standard of conduct from all of our staff members.

If there is reasonable doubt as to the appropriateness of an activity, staff members or any concerned participant or member of the public are encourage to report such activity to the Chief Compliance Office/ Deputy, or to anyone in **THE OSBORNE ASSOCIATION** chain of command.

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

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

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

Describe your concern and give example(s):

_____
_____
_____
_____

Have you already spoken to anyone about your complaint? **[ ] YES** **[ ] NO**

If yes, to whom? _____ (Name & Title)

THE FOLLOWING QUESTIONS ARE OPTIONAL

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

Title: _____
First Name _____
Last Name _____
Address: _____
City: _____
State: _____
Zip Code: _____
Daytime Phone Number _____
Cell Phone Number: _____
What are the best hours to contact you? _____

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

COMPLIANCE PROGRAM - INVESTIGATION FORM

Date _____
Name of Individual Reporting _____
Department _____ Title _____
Contact # _____ Complaint Filing Method _____
Relationship to the organization: _____
Person leading investigation:: _____

Complaint

Summary of Investigation (documents reviewed, persons interviewed) **Attach witness statements to this form.**

Conclusion

Recommended Action

Reviewed by: Exec. Director _____ C.O. _____ Unit Mgr _____

NOTICE OF COMPLIANCE TO VENDORS

To Whom It May Concern:

As part of The Osborne Association's efforts to comply with the Deficit Reduction Act of 2005 and our Corporate Compliance Policy - Prohibition Against Employing or Contracting with Ineligible Persons (attached) hereby requests the following:

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

I confirm that neither I, _____, individually nor the organization I represent, _____ have been deemed ineligible to participate in a federally funded healthcare program.

_____ _____ _____

NAME TITLE DATE

LETTER TO CLIENTS ON FRAUD AND ABUSE

_____, 2016

Dear Participant/Resident:

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

How consumers can help fight fraud and abuse in the Medicaid program:

Examples Of Fraud Or Abuse By Health Care Providers	Examples Of Fraud Or Abuse By Other Consumers
• Billing for Medicare/Medicaid services when you did not get all the services you were supposed to get • Giving out or selling prescriptions when you do not need them • ordering tests that you do not need • Giving money or presents to consumers in return for agreeing to get medical care from someone	• Getting medical help that is not needed • Getting paid by a doctor for receiving medical services • Using someone else's Medicaid card • Forging a prescription • Bribing a Health Care Worker (Aide)

If you hear of any of these actions please call _____ and investigation and report will be performed. All conversations will be confidential. If we are approached by one of our aides who suspects fraudulent actions by you the beneficiary we are required to notify the NYS Office of Medicaid Inspector General.

Please help us to keep Fraud and Abuse out of Healthcare.

Thank You,

_____
President/CEO

Relevant Law

The following section is intended to provide an outline of statutes relating to the filing of false claims. The list is not intended to be exhaustive, nor is the text of each statute quoted in full.

All Employees have a duty to act in compliance with all laws that are applicable to the practice of the organization at all times and to report any known violation of said laws to the Compliance Officer or Deputy Compliance Officer as soon as possible.

Confidentiality and HIPAA requirements and HITECH rule

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

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

Any Employee who observes or suspects any violation of the confidentiality policy or a HIPAA violation should report their concerns to the Chief Compliance Officer and Deputy or a member of the organization's Compliance Committee.
Privacy & Security Compliance

Confidentiality of Participant Information
The organization's Employees have access to highly private and confidential individually identifiable information. Organizational Employees shall conduct themselves in a manner that will maintain the confidentiality of participant information. The Employees shall not disclose any participant specific information unless it is done pursuant to the participant's written authorization or for purposes of treatment, payment or healthcare operations. Upon employment, all agencies' Employees shall sign a confidentiality statement to assure participant confidentiality.
Privacy Rights of Participants

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

- The Right to Inspect and Copy
- The Right to Amend
- The Right to an Accounting of Disclosure
- The Right to Request Restrictions
- The Right to Request Confidential Communications
- The Right to a Paper Copy of the Notice of Privacy Practices

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

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

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

Summary

The Federal False Claims Act provides for penalties for false claims and statements and whistle blower protections under such laws. Any person who knowingly presents, uses, conspires to defraud, is in the possession, custody or control of information and uses that information for the inappropriate benefit of oneself or the organization is liable to the United States Government for a civil penalty of not less than $$10,781 and not more than $$21,563 plus 3 times the amount of damages which the Government sustains because of the act of that person as of August 1, 2016. The Court may assess not less than 2 times the amount of damages the Government sustains because of the act of the person. Such persons will be subject to the disciplinary policies.

Except if:

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

Statutory Language

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

(a) Any person who (1) knowingly presents, or causes to be presented, to an officer or Employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government; . . or (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government, is liable to the United States Government for a civil penalty of not less than $$10,781 and not more than $$21,563, plus 3 times the amount of damages which the Government sustains because of the act of that person…

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

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

In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The False

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

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

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

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

This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false or contains false information, or omits material information, then the agency receiving the claim may impose a penalty of up to $10,781 for each claim. The agency may also recover twice the amount of the claim.

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

New York State Laws

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

A. CIVIL AND ADMINISTRATIVE LAWS

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

The NY False Claims Act closely tracts the federal False Claims Act. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. The penalty for filing a false claim is

$6,000 -$12,000 per claim and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false claim filer may have to pay the government's legal fees.

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

Social Services Law §145-b False Statements

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

Social Services Law §145-c Sanctions

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

B. CRIMINAL LAWS

Social Services Law §145, Penalties

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

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

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

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

Penal Law Article 155, Larceny.

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

a. Fourth degree grand larceny involves property valued over $1,000. It is a Class E felony.
b. Third degree grand larceny involves property valued over $3,000. It is a Class D felony.
c. Second degree grand larceny involves property valued over $50,000. It is a Class C felony.
d. First degree grand larceny involves property valued over $1 million. It is a Class B felony.

Penal Law Article 175, False Written Statements.

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

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

Penal Law Article 176, Insurance Fraud

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

a. Insurance Fraud in the 5th degree involves intentionally filing a health insurance claim knowing that it is false. It is a Class A misdemeanor.
b. Insurance fraud in the 4th degree is filing a false insurance claim for over $1,000. It is a Class E felony.
c. Insurance fraud in the 3rd degree is filing a false insurance claim for over $3,000. It is a Class D felony.
d. Insurance fraud in the 2nd degree is filing a false insurance claim for over $50,000. It is a Class C felony.
e. Insurance fraud in the 1st degree is filing a false insurance claim for over $1 million. It is a Class B felony.
f. Aggravated insurance fraud is committing insurance fraud more than once. It is a Class D felony.

Penal Law Article 177, Health Care Fraud

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

a. Health care fraud in the 5th degree is knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions. It is a Class A misdemeanor.
b. Health cam fraud in the 4th degree is filing false claims and annually receiving over $3,000 in aggregate. It is a Class E felony.
c. Health care fraud in the 3rd degree is filing false claims and annually receiving over $10,000 in the aggregate. It is a Class D felony.

d. Health care fraud in the 2nd degree is filing false claims and annually receiving over $50,000 in the aggregate. It is a Class C felony.
e. Health care fraud in the 1st degree is filing false claims and annually receiving over $1 million in the aggregate. It is a Class B felony.

Whistleblower Protection

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

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

NY False Claim Act (State Finance Law §191)

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

New York Labor Law §740

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

New York Labor Law §741

A health care employer may not take any retaliatory action against an Employee if the Employee discloses certain information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that, in good faith, the Employee believes constitute improper quality of participant 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 participant 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.