ATTENTIVE CARE of Albany, INC. And ATTENTIVE CARE, INC.

Corporate Compliance Program

Updated April, 2025

Index

Section 1:

Key Definitions and Relevant Statues and Standards 04-08

Section 2:

Seven Elements of an Effective Compliance Program 09-11

Section 3:

Corporate Compliance Officer Job Description & Responsibilities 12-14

Section 4:

Compliance Program 15-39

Section 5:

Standards of Conduct and Acknowledgment Form 40-49

Section 6:

Compliance Policies

- Response to Government Inquires 50-51
- Compliance Responsibilities of Management and Directors 52-53
- Code of Ethics 54-57
- Compliance Training and Education 58-60
- Compliance Communication 61-62
- Prohibition against Contracting with Ineligible Persons 63-65
- Federal False Claims Act 66-71
- Red Flag Rule 72-74
- Non-Retaliation and Non-Retribution for Reporting 75-76

Detecting and Reporting Fraud, Waste and Abuse (Self-Disclosure) 77-85

Conflict of Interest and acknowledgement form 86-88

Billing 89-90

Credit Balances 91

Excluded Check of Affected Individuals 92-93

Electronic Visit Verification (EVV) 94-96

Electronic Visit Verification (EVV) Aggregation and Compliance Checks 97-98

Disciplinary Procedures 99-100

Audit/Monitoring 101-104

Section 7:

Attentive Care 2024 Compliance Work Plan 105

KEY DEFENITIONS

Key Definitions; the terms listed, unless otherwise defined in the Compliance Manual have the following meanings:

(1) "Compliance Committee" means the group established by the Agency to coordinate with the Compliance Officer to ensure that the Agency is conducting its business in an ethical and responsible manner, consistent with our Compliance Program.

(2) "Corporate Compliance Officer" means the individual designated by the Agency with responsibility for the day-to-day operation of the Compliance Program. The Corporate Compliance Officer is the focal point for our Compliance Program. Kelly Ottinger is the Compliance Officer for the Agency. The Corporate Compliance Officer reports directly to, and is accountable to, the Agency's Chief Executive Officer.

(3) "Human Resources Compliance Officer" (HR Compliance Officer) means individual designated by the Agency responsible for credentialing of new medical staff. The HR Compliance Officer also oversees compliance with staff Criminal History Record Checks (CHRC), initial and on-going physical requirements, and in-service requirements.

(4) "Governing Authority", referred to as "Authority" means the agencies' Chief Operating Officer (CEO) and Board of Directors. The Corporate Compliance Officer shall have direct access to the CEO and, as required, to the Board of Directors.

(5) "The Agency" means Attentive Care of Albany, Inc. and or Attentive Care Inc.

(6) "Direct care workers" are workers who provide home care services, such as home health aides, personal care aides, caregivers, companions, and Consumer Direct Personal Assistants.

(7) "Good faith participation in the Compliance Program" includes, but is not limited to, the following actions when taken in good faith: (a) reporting potential compliance issues to appropriate personnel; (b) participating in investigation of potential compliance issues; (c) self-evaluations; (d) audits; (e) remedial actions; (f) reporting instances of intimidation or retaliation; and (g) reporting potential fraud, waste or abuse to the appropriate State or Federal entities.

(8) "OMIG" Office of the Medicaid Inspector General (OMIG) is an independent entity created within the New York State Department of Health to promote and protect the integrity of the Medicaid program in New York State.

(9) "Federal health care program" means any plan or program that provides health benefits whether directly, through insurance or otherwise, which is funded directly, in whole or in part, by the United States Government, including certain State health care programs. Examples Include; Medicare, Medicaid, and programs funded through Medicaid including Managed Long Term Care (MLTC) and Medicaid Managed Care Organizations (MMCO).

(10) "Kickback" kickback is the improper payment of anything of value for the referral of a patient or the use of medical products. Kickbacks can also appear as designated health services, the cost of which is reimbursed through Medicare, Medicaid, or another taxpayer funded program.

(11) "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.

(12) "Affected Individuals" means all persons who are affected by the Agency's "risk areas," including our employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers.

(13) "Effective compliance program" means a compliance program adopted and implemented that, at a minimum, satisfies the requirements of 18 NYCRR Subpart 521-1 and that is designed to be compatible with our characteristics (i.e., our size, complexity, resources, and culture). Our Compliance Program is designed to ensure that it: (i) is well-integrated into our operations and supported by the highest levels of the organization, including the chief executive, senior management, and the governing body; (ii) promotes adherence to our legal and ethical obligations; and (iii) is reasonably designed and implemented to prevent, detect, and correct noncompliance with applicable Federal health care program requirements (including but not limited to Medicaid and Medicaid funded programs), including fraud, waste, and abuse most likely to occur for the Agency's "risk areas" and "organizational experience."

(14) "Organizational experience" means the Agency's: (i) knowledge, skill, Agency and understanding in operating our Compliance Program; (ii) identification of any issues or risk areas in the course of our internal monitoring and auditing activities; (iii) experience, knowledge, skill, practice and understanding of our participation in Federal health care programs (including but not limited to Medicaid and Medicaid funded programs) and

the results of any audits, investigations, or reviews we have been the subject of; and (iv) awareness of any issues we should have reasonably become aware of for our category or categories of service.

(15) "Risk areas" are those areas to which the Agency's Compliance Program applies. This includes those areas of operation affected by the Compliance Program and applies to: (i) billings; (ii) payments; (iii) ordered services; (iv) medical necessity; (v) quality of care; (vi) governance; (vii) mandatory reporting; (viii) credentialing; (ix) contractor, subcontractor, agent or independent contract oversight; and (x) other risk areas that are or should reasonably be identified through our organizational experience.

(16) "Contractors" means contractors, agents, subcontractors, and/or independent contractors who are affected by the Agency's risk areas.

(17) "Fraud" is defined as the wrongful or criminal deception intended to result in financial or personal gain. Fraud includes false representation of fact, making false statements, or by concealment of information.

(18) "Waste" is defined as the thoughtless or careless expenditure, mismanagement, or abuse of resources to the detriment (or potential detriment) of the U.S. government. Waste also includes incurring unnecessary costs resulting from inefficient or ineffective practices, systems, or controls.

(19) "Abuse" is defined as excessive or improper use of a thing, or to use something in a manner contrary to the natural or legal rules for its use. Abuse can occur in financial or non-financial settings.

(20) "Standard" is defined as Agency's Standards of Conduct.

Relevant Statutes and Standards can be found in at: https://omig.ny.gov/information-resources/laws-and-regulation and https://dol.ny.gov/labor-standards-0 please reference these links for additional information regarding the laws listed below and the associated civil and criminal penalties that apply.

New York State Social Services Law §363-d
New York State Social Services Law §366-b
18 NYCRR Part 521
42 USC §1396(a)(68) (Federal Deficit Reduction Act) 31
U.S.C. 3729-3733 et seq. (Federal False Claims Act)
New York State Finance Law §§187-194 (State False Claims Act)
New York State Labor Laws §§740, 741
New York State Penal Law §175 (False Written Statements)
New York State Penal Law §176 (Insurance Fraud)
New York State Penal Law §177 (Health Care Fraud)

SEVEN ELEMENTS OF AN EFFECTIVE COMPLIANCE PROGRAM

The following elements comprise the Compliance Program's Structure and Guidelines. Each element governs a different and important aspect of the Compliance Program. The Structure and Guidelines are intended to provide you with an overview of the Compliance Program's framework that supports its day-to-day operations. The framework is designed to allow room for continuous improvement in, and evolution of, the Compliance Program so as to ensure that we continue to conduct business in a manner that supports integrity and ethics in our operations and compliance with the laws, rules, regulations and requirements to which we are subject.

ELEMENT 1:

Written Policies and Procedure

- Reference Section 6 of manual pages 49-95

ELEMENT 2:

Designation of Compliance Officer and the Compliance Committee

- Reference section 3 of manual pages 11-13 and section 4 of manual page 14-38

ELEMENT 3:

Training and Education

- Reference Training policy located in Section 6 of Manual pages 57-59

ELEMENT 4:

Effective Lines of Communication

- Reference Compliance Communication policy located in section 6 pages 60-61

ELEMENT 5:

Disciplinary Standards to Encourage Good Faith Participation in the Compliance Program

- Reference Non-Retaliation and Non-Retribution for Reporting policy located in section 6 pages 70-71 and Detecting and Reporting Fraud, Waste and Abuse (Self Disclosure) policy section 6 pages 72-79, and Disciplinary Procedures located in section 6 pages 93-95

ELEMENT 6:

The System for Routine Monitoring and Identification of Compliance Risk Areas; Annual Compliance Program Reviews; Excluded Provider Checks Program

- Prohibition against Contracting with Ineligible Persons Section 6 pages 62-64, Detecting and Reporting Fraud Waste and Abuse (Self Disclosure) policy section 6 pages 72-79, Excluded Check of Employees and Contractors policy section 6 pages 86-87, and audit policy section 6 pages 93-95

ELEMENT 7:

The System for Promptly Responding to Compliance Issues

- Reference Compliance Communication Policy located in section 6 pages 60-61 and Detecting and Reporting Fraud, Waste and Abuse (Self Disclosure) policy located in Section 6 pages 72-79

CORPORATE COMPLIANCE OFFICER

Position Title: Corporate Compliance Officer

Immediate Supervisor: CEO

General Purpose: The Compliance Officer establishes and implements an effective compliance program to prevent illegal, unethical, or improper conduct. The Compliance Officer acts as staff to the CEO and Governing Board by monitoring and reporting results of the compliance and ethics efforts of the company and in providing guidance for the Board and senior management team on matters relating to compliance. The Corporate Compliance Officer, together with the Compliance Committee, is authorized to implement all necessary actions to ensure achievement of the objectives of an effective compliance program. The Corporate Compliance officer and Compliance Committee shall have access to all documents and information relevant to compliance activities including but not limited to patient records, billing records, marketing records and contracts.

Responsibilities:

- Develops, initiates, maintains, and revises policies and procedures for the general operation of the compliance program and its related activities to prevent illegal, unethical, or improper conduct. Manages day-to-day operation of the Program.
- Develops and periodically reviews and updates Standards of Conduct to ensure continuing currency and relevance in providing guidance to management, employees and other affected individuals.
- Collaborates with other departments (for example, Human Resources, Accounting Manager, and so on) to direct compliance issues to appropriate existing channels for investigation and resolution.
- Consults with General Counsel as needed to resolve difficult legal compliance issues.

- Responds to alleged violations of rules, regulations, policies, procedures, and Standards of Conduct by evaluating or recommending the initiation of investigative procedures.
- Develops and oversees a system for uniform handling of such violations.
- Acts as an independent review and evaluation body to ensure that compliance issues and concerns within the organization are being appropriately evaluated, investigated, and resolved.
- Monitors, and as necessary, coordinates compliance activities of other departments to remain abreast of the status of all compliance activities and to identify trends.
- Identifies potential areas of compliance vulnerability and risk, including (i) billings; (ii) payments; (iii) ordered services; (iv) medical necessity; (v) quality of care; (vi) governance; (vii) mandatory reporting; (viii) credentialing; (ix) contractor, subcontractor, agent or independent contract oversight; and (x) other risk areas that are or should reasonably identified through our organizational experience.
- Develops and implements corrective action plans for resolution of problematic issues, and provides general guidance on how to avoid or deal with similar situations in the future.
- Provides reports on a regular basis, and as directed or requested, keeps the Compliance Committee of the Board and senior management informed of the operation and progress of compliance efforts.
- Ensures proper reporting of violations or potential violations to duly authorized enforcement agencies as appropriate or required.
- Establishes and provides direction and management of the compliance hotline.
- Institutes and maintains an effective compliance communication program for the organization, including promoting:

(a) use of the compliance hotline;

(b) heightened awareness of Standards of Conduct, and

(c) understanding of new and existing compliance issues and related policies and procedures. Measuring success of effectiveness through audits, reports, surveys, compliance meetings and yearly review of compliance program.

- Works with the Human Resources Department and others as appropriate to develop an effective compliance training program, including appropriate introductory training for new employees and ongoing training for all employees and managers.
- Oversees Compliance Program Committee meetings, which will meet quarterly at minimum. Monitoring the performance of the Compliance Program and relates activities on a continuing basis, taking appropriate steps to improve its effectiveness.
- Initiates and oversees annual compliance program review, incorporating all new policies and regulations.
- Implements, and oversees agencies' annual compliance program work plan and reviews with compliance committee.

COMPLIANCE PROGRAM

I. INTRODUCTION

Agencies and departments of the U.S. Government have publicized a number of instances of fraud, abuse and waste in federally funded health care programs including Medicaid. The management of the ATTENTIVE CARE OF ALBANY, INC. AND ATTENTIVE CARE, INC. (the agency) recognizes the seriousness of the issues raised by the Government and recognizes that failure to comply with applicable laws and regulations could threaten the agency's continuing participation in these health care programs.

The agency, therefore, has directed that the Corporate Compliance Officer undertake an integrity program in order to continue the commitment to high standards of conduct, honesty and reliability in its business practices. This integrity program is called a Compliance Program. The purpose of the Compliance Program is to promote understanding of and adherence to applicable federal and state laws and regulations and to make a sincere effort to prevent, detect and correct any fraud, abuse or waste in connection with federally funded health care programs and private health plans. There are several parts to the Compliance Program, each of which is important. The Program applies to all affected individuals. "Affected Individuals" means all persons who are affected by the Agency's "risk areas," including our employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers. This includes any persons or individuals hired by and in the paid service of the agency.

II. STANDARDS OF CONDUCT

All of the agency business affairs must be conducted in accordance with federal, state and local laws, professional standards, applicable federally funded health care program regulations and policies and with honesty, fairness and integrity. Employees should perform their duties in good faith, in a manner that he or she reasonably believes to be in the best interest of the agency and its patients and with the same care that a reasonably prudent person in the same position would use under similar circumstances.

To further these overall goals, a number of policies or standards of conduct have been adopted by the agency. See the separate standards of conduct policy and employee acknowledgement.

Employee handbook: The handbook given to each employee, sets out several types of conduct which are unacceptable. These include:

1. Intentionally or knowingly making false or erroneous entries on reports, patient charts or other agency records.

2. Dishonesty.

3. Unauthorized alteration or destruction of Agency records including patients' charts.

4. Coding or billing which violates Medicaid rules or regulations or other federal rules or regulations.

5. Behavior detrimental to the operation of the Agency. Other unacceptable conduct may be found in the handbook.

Conflict of interest: In order to perform their duties with honesty and fairness and in the best interest of the agency and employees must avoid conflicts of

interest in their employment. Conflicts of interest may arise from having a position or interest in or furnishing managerial or consultative services to any concern or business from which the agency obtains goods or services or with which it competes or does business, from soliciting or accepting gifts, excessive entertainment or gratuities from any person or entity that does or is seeking to do business with the agency and from using agency property for personal or private purposes. Conflicts also may arise in other ways. If an employee has any doubt or any question about any of his or her proposed activities, guidance or advice should be obtained from the Department of Human Resources. The agency has a policy on and prohibiting conflicts of interest. A copy may be obtained from the Department of Human Resources.

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

Workplace administrative searches: To assist in providing a reliable, efficient and productive work force for the proper care of patients, to assist in providing employees with a safe working environment, and to assist in the effective operation of the Compliance Program, supervisors may conduct unannounced administrative searches of agency premises, offices, work areas, property and equipment and the contents of such property and equipment. No employee should have any expectation of privacy on agency property or in their offices or

work areas including lockers, desks, cabinets, drawers, shelves or trash cans or in folders, envelopes or packages located on agency premises. In addition, searches of temporary space of live in aides at clients of the Agency may be subject to search at the discretion of the Agency as a result of a complaint of a patient whose property is occupied. Personal possessions or materials should not be brought to work if they are of a sensitive or confidential nature. The agency policy on Workplace Administrative Searches is attached to code of conduct. A copy may be obtained from the Department of Human Resources. Other policies permit monitoring of and access to computers by supervisors. The use of computers, e-mail and access to the Internet must be reasonable and responsible.

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

Business ethics: Employees must accurately and honestly represent the agency and should not engage in any activity or scheme intended to defraud anyone of money, property or honest services.

Financial reporting: All financial reports, accounting records, research reports, expense accounts, time sheets and other documents must accurately and clearly represent the relevant facts or the true nature of a transaction. Improper or fraudulent accounting, documentation or financial reporting is not only contrary to

agency policy, it may be in violation of applicable laws. Sufficient and competent evidential matter or documentation shall support all cost reports.

Protection of assets: The agency will make available to employees assets and equipment necessary to conduct agency business including such items as computer hardware and software, billing and medical records, both hardcopy and in electronic format, fax machines, office supplies and various types of medical equipment.

Employees should strive to use agency assets in a prudent and effective manner. Agency property should not be used for personal reasons or be removed from the agency without approval from a departmental manager. An employee who believes that any medical equipment is not operating properly nor has an inaccurate calibration should immediately report the problem to his or her supervisor.

Anti-competitive conduct: The agency will not engage in anticompetitive conduct that could produce an unreasonable restraint of trade or a substantial lessening of competition. Evaluation of anti-competitive conduct requires legal guidance.

Communication by employees with competitors about matters that could be perceived to have the effect of lessening competition or could be considered as collusion or an attempt to fix prices should take place only after consultation with legal counsel.

Financial inducements: No employee shall offer any financial inducement, gift, payoff, kickback, or bribe intended to induce, influence or reward favorable decisions of any government personnel or representative, any customer, contractor or vendor in a commercial transaction or any person in a position to benefit the agency or the employee in any way. Employees are strictly prohibited from engaging in any corrupt business practice either directly or indirectly. No

employee shall make or offer to make any payment or provide any other thing of value to another person with the understanding or intention that such payment or other thing of value is to be used for an unlawful or improper purpose. Appropriate commissions, rebates, discounts and allowances are customary and acceptable business inducements provided that they are approved by Administration and that they do not constitute illegal or unethical payments. Any such payments must be reasonable in value, competitively justified, properly documented, and made to the business entity to which the original agreement or invoice was made or issued. Such payments should not be made to individual employees, agents of business entities or other affected individuals.

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

Accurate Bills and Records: Bills for federally funded health care programs, as well as to other payors, must be true, accurate and complete and for services believed to be medically necessary, and that were ordered by a physician or other appropriately licensed person. All professional services should be

documented timely, correctly and properly. Patient records and other documentation which support the bills should also be true, accurate and complete in accordance with professional standards and available for audit and review. The diagnoses and procedures reported on the reimbursement claim must be based on the patient record and other relevant documentation as per the Real-Time Web based Time and Attendant System.

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

Cost Reports: The Accounting Manager shall prepare or cause to be prepared policies and procedures ensuring against submission of false or inaccurate cost reports and ensuring that:

1. Costs are not claimed unless based on appropriate and accurate documentation;

2. Allocation of costs to various cost centers are accurately made and supportable by verifiable and auditable data;

3. Unallowable costs are not claimed for reimbursement;

4. Accounts containing both allowable and unallowable costs are analyzed to determine the unallowable amount that should not be claimed for reimbursement;

5. Costs are properly classified;

6. Fiscal intermediary prior year audit adjustments are implemented and are either not claimed for reimbursement or claimed for reimbursement and clearly identified as protested amounts on the cost report;

7. All related parties are identified and submitted with the cost report and all related party charges are reduced to cost;

8. The agency procedures for reporting of bad debts on the cost report are in accordance with federal statutes, regulations, guidelines and policies;

9. Procedures are in place and documented for notifying promptly any applicable payor, e.g. Medicaid of errors discovered after the submission of the cost report.

Bad Debts: The Accounting Manager shall develop or cause to be developed a mechanism to review, at least annually: (i) whether agency is properly reporting bad debts and (ii) all bad debt expenses claimed, to ensure that agency procedures are in accordance with applicable federal and state statutes, regulations, guidelines and policies. In addition, such a review should ensure that the agency has appropriate and reasonable mechanisms in place regarding beneficiary deductible or co-payment collection efforts and has not claimed as bad debts any routinely waived co-payments and deductibles, which waiver also constitutes a violation of the anti-kickback statute. The Accounting Manager or his or her designee may consult with the appropriate fiscal intermediary if there are questions relating to bad debt reporting requirements.

Credit Balances: The agency will comply with Federal and state laws and regulations governing credit balance reporting and refund all overpayments in a timely manner.

Timely as defined by the Patient Protection and Affordable Care Act of 2010 is the reporting and returns within 60 days of discovery to avoid substantial liability under the False Claims Act. The Accounting Manager shall develop or cause to be developed policies and procedures providing for timely reporting and other federal health care program credit balances. The Accounting Manager shall designate appropriate employees to (i) review reports of credit balances and reimbursements or adjustments on a monthly basis and (ii) be responsible for

tracking, recording and reporting credit balances.

Retention of Records: The Agency Manager shall prepare or cause to be prepared policies and procedures regarding the creation, distribution, retention, storage, retrieval, disclosure and destruction of records and documents. Such records and documents shall include: (i) clinical and medical records and claims documentation required by federal or state law for participation in federal health care programs; and (ii) records relating to the Compliance Program such as documentation related to employee training, reports from the hotline, the nature and results of any investigations, and results of the agency auditing and monitoring efforts. All documents will be kept for the length of time required of by state, federal and contractual regulations, but no less than six (6) years.

III. CORPORATE COMPLIANCE OFFICER AND COMPLIANCE COMMITTEE

A. Corporate Compliance Officer: The CEO shall appoint a high-level employee as Corporate Compliance Officer. The Accounting Manager of Finance shall not be appointed.

B. Duties: The Corporate Compliance Officer and the Compliance Committee shall prepare, and revise as necessary, a job description for the Corporate Compliance Officer. The Corporate Compliance Officer's primary responsibilities set out in the job description shall include:

1. Overseeing and monitoring the implementation of the Compliance Program;

2. Reporting on a regular basis (no less than quarterly) to the Board of Directors, the CEO and the Compliance Committee on the progress of implementation, and assisting the Board, the CEO and the committee in establishing methods to improve the agency efficiency and quality of services, and to reduce the agency vulnerability to fraud, abuse and waste;

3. Periodically (no less than annually) reviewing and revising the Compliance

Program Manual as required by changes in the law, and policies and procedures of government and private payor health plans;

4. Developing, coordinating, and participating in an educational and training program that focuses on the elements of the Compliance Program, and seeks to ensure that all appropriate affected individuals are knowledgeable of, and comply with, pertinent federal and state standards;

5. Ensuring that independent contractors and agents who furnish medical services to the agency are aware of the requirements of the Compliance Program with respect to coding, billing and marketing, among other things;

6. Coordinating personnel issues with the Director of Human Resources.

7. Assisting in coordinating internal compliance review and monitoring activities, including annual or periodic reviews of departments and audits;

8. Independently investigating and acting on matters related to compliance, including the flexibility to design and coordinate internal investigations (e.g., responding to reports of problems or suspected violations) and any resulting corrective action with all agency departments, providers and sub-providers, agents and, if appropriate, independent contractors;

9. Developing policies and programs that encourage affected individuals to report suspected fraud and other improprieties without fear of retaliation

Authority: The Corporate Compliance Officer shall have direct access to the CEO and, as required, to the Board of Directors. The Corporate Compliance Officer shall have access to all documents and information relevant to compliance activities including but not limited to patient records, billing records, marketing records and contracts and written arrangements or agreements with others. The Corporate Compliance Officer may seek advice of legal counsel and with consent of the Compliance Committee, may retain necessary consultants or

experts.

Reports: The Corporate Compliance Officer shall report to the Board at least annually on the status of compliance in the agency. Such reports may be written or oral.

Compliance Committee: The Compliance Committee shall consist of 3 to 5 members and shall include representatives from Finance, Human Resources, Health Information Management, the Business Office and Nursing. Any vacancy on the committee, whether by resignation, illness, death or otherwise, shall be promptly filled by appointment by the CEO and each such appointee shall serve for the remainder of the unexpired term of his or her predecessor.

Duties: The duties of the Compliance Committee shall include:

1. Advising the Corporate Compliance Officer and assisting in the implementation and maintenance of the Compliance Program;

2. Working with appropriate departments of the agency to develop standards of conduct and policies and procedures to promote adherence to the Compliance Program.

3. Recommending and monitoring, in conjunction with the relevant departments, the development of internal systems and controls to carry out the agency standards, policies and procedures;

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

5. developing a system to solicit, evaluate and respond to complaints and problems;

6. Overseeing the education and training and systems for communication with

and by affected individuals;

7. Analyzing the legal requirements with which the agency must comply and locating and analyzing specific risk areas within the agency; and

8. Establishing confidentiality standards and requirements for committee members and those persons requested to provide assistance to the committee.

9. Assist the Corporate Compliance Officer in establishing an annual Compliance Work Plan that addresses the areas of risk identified by the organization and combined with the Work Plans of the OIG and OMIG constitute a monitoring tool that is reportable to governance.

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

IV. TRAINING AND EDUCATION

A. Necessity: It is imperative that coding and billing of federal health care claims be truthful and accurate and within appropriate guidelines. Not only are severe penalties available to the government but honesty and integrity in agency operations are right and proper. However, sometimes conduct undertaken without wrongful intent but with inadequate knowledge may violate applicable laws and regulations. Proper and continuing training and education of affected individuals at all levels is, therefore, a significant element of an effective compliance program.

B. Initial Education: Mandatory initial education and training for all affected individuals will provide an overview of fraud and abuse laws, a summary of the standards of conduct, an explanation of the elements of the Compliance Program, including the complaint or reporting process and highlight the agency commitment to integrity in its business operations and compliance with applicable laws and regulations.

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

D. Substantive Rules: Involved affected individuals will be trained and retrained in the specific federal health care program rules (e.g. Medicaid) that relate to their particular job function. By way of example:

1. Coding personnel will be taught current reimbursement principles, proper coding, the impact of coding and how to avoid the areas of concern applicable to the coding process.

2. Patient care personnel will be instructed in charge entry and coding, and the importance of documenting services and supplies which will later be billed to Medicaid.

3. Billing personnel will be instructed in requirements applicable to the preparation of claims for services, the distinction between covered and non-covered services and the importance of listing those services in the proper section of the CMS-1500 and how to avoid the areas of concern applicable to the billing process. Such affected individuals may be trained individually or as a group.

E. Department Training and Education: Each department director or manager shall periodically identify and advise the Corporate Compliance Officer of training and education necessary or advisable for all or any employees of his or her department. The Corporate Compliance Officer and the director or manager shall

promptly arrange for such training and education.

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

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

H. Documentation: The training provided to each affected individual shall be documented. The documentation shall include the date and a brief description of the subject matter of the training activity or program. Documentation is important.

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

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

V. COMMUNICATION

A. Reason: Open communications between affected individuals and the

Corporate Compliance Officer or Compliance Committee are important to the success of this Compliance Program and to the reduction of any potential for fraud, abuse and waste. Without help from affected individuals it may be difficult to learn of possible compliance problems and make necessary corrections.

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

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

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

2. An affected individual may report directly to the Corporate Compliance Officer or to a member of the committee.

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

prominent locations in the agency.

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

E. Non-Retaliation: There will be no reprisals or retaliation against any affected individual who in good faith reports acts or suspected acts of fraud, abuse or waste or violations or suspected violations of the Standards of Conduct or other wrongdoing or misconduct. However, an affected individual who makes an intentional false report or a report not in good faith may be subject to disciplinary action.

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

VI. SCREENING

A. New Employees: The agency will conduct a reasonable background investigation of all new direct care employees, and or at the discretion of the agency, applicants for employment, who have or will have discretionary authority to make decisions that or whose job function may materially impact the Medicaid claim development and submission process. The purpose of the background investigation is to determine whether any such employee or applicant has been convicted of a criminal offense related to health care. Under PPACA exclusion checks will be performed every 30 days utilizing OIG, OMIG and GSA websites. Refer to separate policy on exclusion checks of employees and contractors.

B. Vendors and Contractors: Reasonable background investigations will be conducted for vendors and contractors to determine if any such vendor or contractor has a criminal conviction related to health care or has been disbarred or excluded by a federal agency. Under PPACA exclusion checks will be performed every 30 days utilizing OIG, OMIG and GSA websites. Refer to separate policy on exclusion checks of employees and contractors.

C. Process: The Human Resources Manager, in consultation as necessary with the Corporate Compliance Officer, Human Resources Manager, and other employees, will implement and maintain policies and procedures for developing relevant applications for employment and for conducting such background investigations. The application for employment should require the applicant to disclose any criminal conviction related to health care programs or exclusion action. The background investigations can utilize the OIG Cumulative Sanction Report.

D. Prohibition: The agency will not hire or retain an affected individual in a position which has or will have discretionary authority to make decisions or whose job functions may materially impact the Medicaid claim development and submission process or the agency's relations with its staff if such prospect or affected individual has been convicted of a crime related to health care or has been excluded. The agency will not contract with any person or entity which has been so convicted or excluded or debarred 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 agency will make reasonable and prudent effort not to submit any claim for service ordered or furnished by any person or entity excluded from participation.

VII. Privacy & Security Compliance

Confidentiality of Patient Information

As providers of healthcare, agency employees have access to highly private and confidential individually identifiable information concerning the patients we serve.

All agency employees shall conduct themselves in a manner that will maintain the confidentiality of patient information. Agency employees shall not disclose any patient specific information unless it is done pursuant to the patient's written authorization or for purposes of treatment, payment or healthcare operations. Upon employment, all agency employees shall sign a confidentiality statement to assure patient confidentiality. Any observers, students, or vendors who come into contact with patient information shall sign the Pledge of Confidentiality.

Privacy Rights of Patients Contained within regulations for the Health Insurance Portability and Accountability Act (HIPAA) are specific rights that patients have regarding the privacy of their protected health information. As an agency, we will comply with all HIPAA privacy regulations. The following rights must be complied with upon the patient's request:

- **Right to Inspect and Copy:** At any time, a patient may request to inspect or obtain a copy of their protected health information that is contained within an agency entity's designated record set for as long as we maintain the protected health information. A written authorization must be obtained from the patient prior to disclosing the information. If a copy is requested, a reasonable fee may be charged for the costs of copying, mailing or other supplies associated with the request. The agency may deny a request to inspect or copy based only on the federal laws which apply.
- **Right to Amend:** If the patient feels that the protected health information in their record is incorrect or incomplete, the patient has the right to request an amendment of the information. The patient has the right to

request an amendment for as long as the information is kept by the agency in the designated record set. The request must be made in writing and must also contain a reason that supports the request. The agency may deny the request if we did not create the information, if the information is not part of the designed record set, or if the information is determined to be accurate and complete by the person who created the information. All requests for an amendment must be submitted to the Privacy Site Coordinator at the corresponding facility.

- **Right to an Accounting of Disclosure:** The patient has the right to receive an accounting of disclosures of their protected health information made by the agency during the six (6) years prior to the date of the request. This is a list of any disclosures made for purposes other than treatment, payment or healthcare operations as described in the Notice of Privacy Practices. Among other things, the list will exclude disclosures made to the patient, disclosures made pursuant to an authorization, disclosures made for facility directory purposes, disclosures made to family members or friends, and disclosures made for notification purposes. The request from the patient must be in writing and must be submitted to the Privacy Site Coordinator at the corresponding facility.
- **Right to Request Restrictions:** The patient has the right to request a restriction on the use and disclosure of his/her protected health information for purposes of treatment, payment or healthcare operations, for facility directories, and to persons involved in the patient's care. The agency is not required to comply with the request. All requests must be made in writing and submitted to the Privacy Site Coordinator at the corresponding facility.
- **Right to Request Confidential Communications:** The patient has the right to request that his/her protected health information is communicated to the patient in a certain way or at a certain location. No explanation for the request need be given, although only reasonable requests must be

accommodated. The request must be in writing and submitted to the Privacy Site Coordinator at the corresponding facility.

- **Right to a Paper Copy of the Notice of Privacy Practices:** Upon the patient's first receipt of services from an agency entity after April 14, 2003, the patient will receive a Notice of Privacy Practices. This Notice contains all the information a patient needs to know regarding the privacy of their protected health information within the agency. Upon receiving the Notice, we will make a good faith effort to get the patient's acknowledgement of receiving the Notice on our Consent for Treatment form. The patient will only receive this Notice once, unless significant changes are made. A patient has the right to request a copy of this Notice at anytime, which must be provided upon request. If there are any questions regarding the Privacy requirements, an employee may contact the Privacy Site Coordinator at the applicable facility.

Retention & Disposal of Documents & Records

State and federal laws require that providers and others within the agency keep certain records for specified periods of time. It is the policy of the agency to keep records for as long as the law requires, the minimum of time being six (6) years. Due to the legal requirements for documents varying, before documentation is discarded, the employee shall verify the standard with their manager or supervisor. All confidential records must be destroyed in a manner so that the information contained in the document is not legible or identifiable. Any third party engaged to destroy such documents shall agree to maintain the confidentiality of such records during the destruction process.

Use of Electronic Systems

Many affected individuals will be provided with access to one or more of the agency's computer systems. Computer access codes are the equivalent of a signature. Identification codes and passwords provided to access computer

systems must never be disclosed to another. Affected individuals must not attempt to learn another's access code or attempt to access a computer system with an access code other than their own. Compromised access codes must be reported to your supervisor immediately. Affected individuals must not use any agency provided computer outside the scope of their job responsibilities. Using the computer to browse patient records out of curiosity or for any other reason not specific to the affected individual's job duties is strictly prohibited.

The Internet, electronic mail, voice mail and facsimile machines are also used throughout the agency. These electronic messaging systems are for business purposes only. Highly sensitive information must only be transmitted on these systems with caution as per policy. Specific policies have been developed for the use of computers, the Internet and electronic messaging systems.

IX. NON-RETALIATION AND NON-RETRIBUTION FOR REPORTING

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

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

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

The agency is committed to a policy that encourages timely disclosure of such concerns and prohibits any action directed against an affected individual for making a good faith report of a concern. Any manager, supervisor or employee who engages in retribution, retaliation or harassment against a reporting affected individual is subject to discipline up to and including dismissal on first offense.

All instances of retaliation, retribution or harassment against reporting affected individuals will be brought to the attention of the Corporate Compliance Officer who will, in conjunction with Legal and Human Resources, investigate and determine the appropriate discipline, if any. If an affected individual reports a concern regarding his/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 affected individual, even if the error constitutes inappropriate or inadequate performance, will be considered a positive constructive action by the affected individual.

X: THE FALSE CLAIMS ACT

The Federal False Claims Act is a law that prohibits a person or entity, such as the agency from "knowingly" presenting or causing to be presented a false or fraudulent claim for payment or approval to the Federal Government and from "knowingly" making, using or causing to be made a false record or statement to get a false or fraudulent claim paid or approved by the Federal Government. These prohibitions extend to claims submitted to federal health care programs, such as Medicaid. The terms "knowing "and knowingly" is having knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information and acts in reckless disregard of the truth or falsity of the information. A person or entity found guilty of violation can be obligated to civil penalty up to $11,000 plus three times the amount of actual damages.

A person or entity can also find themselves excluded from the Medicaid programs if found in violation. New York State law makes it unlawful to knowingly make a false statement or representation (or deliberate concealment of any material fact or other fraudulent scheme or device) to attempt to obtain Medicaid payments for services or supplies furnished under the New York State Medical Assistance Program. A violation of this Act can result in civil damages three times overstated amount or $5,000 whichever is greater. The agency or individual may also be required to pay civil monetary penalty to the Medicaid program if it was known that the services or supplies were not medically necessary, not provided as claimed, if the person requesting such was excluded from the program or the services or supplies for which payment was received were not provided. New York State may also impose the threat of criminal prosecution who had the intent to defraud the State program a Class A misdemeanor punished in accordance with the penalties fixed by such law.

XI. REPORTS

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

XII. DEPARTMENTS

A. General. Each director or manager of an affected department is responsible for implementing and maintaining compliance standards and policies and procedures and manuals specific to their departments and reasonably necessary to ensure compliance with this Program and applicable laws and regulations.

B. Contents. The compliance standards for each affected department shall contain a statement of compliance policy for that department and shall define and assign responsibility for updating the compliance standards, the department compliance manual, training and education, record keeping and the completion of audit work plans requested by the Corporate Compliance Officer. The department compliance manuals may contain such other matters as the director or manager deems necessary or appropriate so long as it does not conflict with this Program.

C. Resource. The department compliance manuals shall be a resource for the affected individuals of each affected department to enhance the ability of affected individuals to perform their jobs in compliance with this Program and applicable laws and regulations. Affected individuals should be encouraged to periodically review their departmental compliance manuals and to discuss any compliance issue with their supervisor or director or manager. Directors and managers are encouraged to involve affected individual in the preparation of such department manuals.

D. Approval. Department compliance manuals must be approved by the Corporate Compliance Officer. The Corporate Compliance Officer may assist in the preparation and maintenance of any such manual upon request.

XIII. RESPONSE TO GOVERNMENTAL INQUIRIES

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

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

C. Documents. The agency response to any warrant, subpoena, investigation or inquiry must be complete and accurate. No affected individual shall alter, destroy or mutilate any document or record or alter, delete or download any material from any computer, word processor, disk or tape. Documents and records must be preserved in their original form.

STANDARDS OF CONDUCT

I. STANDARDS OF CONDUCT

All of the Attentive Care of Albany, Inc. and Attentive Care, Inc. (the agency) business affairs must be conducted in accordance with federal, state and local laws, professional standards, applicable federally funded health care program regulations and policies and with honesty, fairness and integrity. Affected individuals should perform their duties in good faith, in a manner that he or she reasonably believes to be in the best interest of the agency and its patients and with the same care that a reasonably prudent person in the same position would use under similar circumstances. To further these overall goals, a number of policies or standards of conduct have been adopted by the agency.

A. UNACCEPTABLE BEHAVIOR.

These include:

1. Intentionally or knowingly making false or erroneous entries on reports, patient charts or other agency records.

2. Dishonesty.

3. Unauthorized alteration or destruction of agency records including patients' charts.

4. Coding or billing which violates Medicaid rules or regulations or other federal rules or regulations.

5. Behavior detrimental to the operation. Other unacceptable conduct may be defined in the agency's Policies and Procedures.

8. CONFLICT OF INTEREST.

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

B. CONFIDENTIALITY OF INFORMATION.

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

C. WORKPLACE ADMINISTRATIVE SEARCHES.

To assist in providing a reliable, efficient and productive work force for the proper care of patients, to assist in providing affected individuals with a safe

working environment, and to assist in the effective operation of the Compliance Program, supervisors may conduct unannounced administrative searches of agency premises, offices, work areas, property and equipment and the contents of such property and equipment. No affected individual should have any expectation of privacy on the agency property or in their offices or work areas including lockers, desks, cabinets, drawers, shelves or trash cans or in folders, envelopes or packages located on agency premises. In addition, searches of temporary space of live in aides at clients of the Agency may be subject to search at the discretion of the Agency as a result of a complaint of a patient whose property is occupied.

Personal possessions or materials should not be brought to work if they are of a sensitive or confidential nature. The agency policy on Workplace Administrative Searches may be obtained from the Department of Human Resources or designee. Other policies permit monitoring of and access to computers by supervisors. The use of computers, e-mail and access to the Internet must be reasonable and responsible.

D. FRAUD AND ABUSE.

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

E. BUSINESS ETHICS.

Internal employees must accurately and honestly represent the agency and should not engage in any activity or scheme intended to defraud anyone of money, property or honest services.

F. 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 agency policy, it may be in violation of applicable laws. Sufficient and competent evidential matter or documentation shall support all cost reports.

G. PROTECTION OF ASSETS.

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

I. ANTI-COMPETITIVE CONDUCT.

The agency will not engage in anticompetitive conduct that could produce an unreasonable restraint of trade or a substantial lessening of competition. Evaluation of anti-competitive conduct requires legal guidance.

Communication by affected individuals 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.

J. CREDIT BALANCES.

The agency will comply with Federal and state laws and regulations governing credit balance reporting and refund all overpayments in a timely manner.

K. FINANCIAL INDUCEMENTS.

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

L. ADDITIONAL STANDARDS.

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

Questions about the existence, interpretation or application of any law, regulation, policy or standard should be directed, without hesitation, to an internal employee's supervisor, manager or director or to the Corporate Compliance Officer mentioned in a later section of this Program. Because laws, regulations and policies are constantly evolving, this Compliance Program will be revised and updated as needed. Revisions will be communicated timely to agency affected individuals. Failure to comply with the Standards of Conduct or to conduct business in an honest, ethical, reliable manner can result in civil fines or criminal penalties against the agency and its affected individuals or disciplinary action by the agency, including termination. Supervisors are responsible for ensuring that their affected individuals receive a copy of this Program and participate in mandatory training related to the Program.

M. False Claims Act

The Federal False Claims Act is a law that prohibits a person or entity, such as the agency from "knowingly" presenting or causing to be presented a false or fraudulent claim for payment or approval to the Federal Government and from "knowingly" making, using or causing to be made a false record or statement to get a false or fraudulent claim paid or approved by the Federal Government. These prohibitions extend to claims submitted to federal health care programs, such as Medicaid. The terms "knowing "and knowingly" is having knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information and acts in reckless disregard of the truth or falsity of the information.

A person or entity found guilty of violation can be obligated to civil penalty up to $11,000 plus three times the amount of actual damages. A person or entity can also find themselves excluded from the Medicaid programs if found in violation.

Note: A private person who brings civil actions for violations to the False Claims Act is entitled to receive percentages of monies obtained through settlements and is protected by the Non-Retaliation and Non-Retribution for Reporting Policy of the Compliance program.

New York State False Claims Act makes it unlawful to knowingly make a false statement or representation (or deliberate concealment of any material fact or other fraudulent scheme or device) to attempt to obtain Medicaid payments for services or supplies furnished under the New York State Medical Assistance Program. A violation of this Act can result in civil damages three times overstated amount or $5,000 whichever is greater. The Agency or individual may also be required to pay civil monetary penalty to the Medicaid program if it was known that the services or supplies were not medically necessary, not provided as claimed, if the person requesting such was

excluded from the program or the services or supplies for which payment was received were not provided.

New York State may also impose the threat of criminal prosecution who had the intent to defraud the State program a Class A misdemeanor punished in accordance with the penalties fixed by such law.

N. Non-Retaliation and Non-Retribution for Reporting

The agency understands that affected individuals may not report concerns if they feel that they will be subject to retaliation or retribution or harassment for reporting the concern. To reassure affected individuals who wish to report concerns through the Compliance Line, or Page 34 of 63 January 1, 2007 directly to the Compliance Department, a non- retaliation/non-retribution policy has been established. Supervisors, managers or employees are not permitted to engage in retaliation, retribution or any form of harassment directed against an affected individual who reports a Compliance concern.

Anyone who is involved in any act of retaliation or retribution against an affected individual that has reported suspected misconduct in good faith will be subject to disciplinary action. Affected individuals have the responsibility to report, in good faith, concerns about actual or potential wrongdoing.

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

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

All instances of retaliation, retribution or harassment against reporting

affected individuals will be brought to the attention of the Corporate Compliance Officer who will, in conjunction with Legal and Human Resources, investigate and determine the appropriate discipline, if any. If an affected individual 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 affected individual, even if the error constitutes inappropriate or inadequate performance, will be considered a positive constructive action by the affected individual.

Compliance with and the promotion of the Standards of Conduct will be a factor in evaluating the performance of agency affected individuals. Following the Standards of Conduct is not hard to do. Affected individuals should not be apprehensive or frightened.

Affected individuals may stop by in person and speak to Kelly Ottinger the Compliance Officer at 5 Computer Drive West, Albany, New York 12205, or call the Corporate Compliance hotline at 518-482-2273.

STANDARDS OF CONDUCT ACKNOWLEDGEMENT

_______________have received the ATTENTIVE CARE INC. Standards of Conduct and acknowledge that I will comply with such standards as presented. This form will be maintained in my personnel file and updated as warranted.

Employee Name: ___________________________

Date: ______________________

RESPONSE TO GOVERNMENTAL INQUIRIES

PURPOSE:

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

POLICY:

A. Cooperation.

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

B. Process.

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

C. Documents.

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

COMPLIANCE RESPONSIBLITIES OF MANAGEMENT AND DIRECTORS

PURPOSE:

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

POLICY:

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

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

2. Providing training to all his or her affected individuals in compliance standards, policies, procedures, laws and regulations applicable to affected individuals of the department in consultation with the Corporate Compliance officer;

3. Enforcing this Program, the Code of Ethical Conduct, agency policies and procedures, and applicable laws and regulations;

4. Investigating reports or reasonable indications of violations of this Program, the Code of Ethical Conduct, agency policies or procedures;

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

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

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

CODE OF ETHICS

PURPOSE:

To inform and educate Attentive Care staff of the agency's commitment to the application of ethical principles to client care and business practices. To provide a mechanism for the identification and resolution of ethical conflicts and issues as they occur.

POLICY:

1. Attentive Care believes that the application of ethical principles is fundamental to the provision of quality health care services to clients. The client, client's medical practitioner and the client's home care providers should participate in the consideration of ethical issues that arise in the client's care.

2. All staff are to comply with the ethical guidelines established by Attentive Care some of which are, but not limited to:

- All staff are obligated to respect the voice of the client or his/her designee in the consideration of ethical issues that arise during the client's care;

- client admission, transfers and discharges are to be conducted according to agency policy and in an ethical manner;

- clients are to be billed only for services rendered; and

- clients are to be made aware of any financial benefit to the organization resulting from referral to another health care provider.

GENERAL INFORMATION:

Ethical questions may arise that are complex and vary in nature throughout the provision of client services. These may include but are not limited to:

• conflicts involving respect for the client's choices;

• respecting the rights of the care providers;

• reducing client suffering; and

• unequal distribution of costs and benefits of medical care for clients.

The following have been identified as areas of ethical issues and issues prone to conflict:

1. Maintaining the agency's financial operating status without denying care to clients who lack financial resources.

2. Providing services to clients whose families may be abusive or neglectful.

3. Ensuring the safety of all affected individuals who may be providing health care services in an unstable client environment.

4. Clients living in unsafe environments.

5. Decisions about the treatment of the terminally ill. Client decisions/choices involved in withholding/withdrawal of life-sustaining support.

6. Clients unable to make or participate in major care or treatment decisions due to incompetence and/or inability.

7. Clients who are non-compliant regarding prescribed therapies; including self-neglect.

8. Noncompliance of affected individuals.

9. Abandonment of clients.

10. Difficulties in complying with regulations.

11. Ensuring safe and appropriate discharge for the client.

12. Appropriate documentation by caregivers in a home environment.

13. Differences between the proposed plan of care and the client or family's wishes or between the proposed plan of care created by the authorized medical practitioner and the client's needs as assessed by the agency's professional staff.

PROCEDURE:

I. CLIENT/CAREGIVER ISSUES

1. Identify the ethical issue and gather all information pertinent to the decision to be made.

2. Identify who should be involved in the decision-making process. Some issues may be addressed between staff members and client/caregiver directly. However, if this strategy is utilized, the situation must be reported to the nursing supervisor. Any issue that is not resolved should be referred to a team conference with the supervisor and /or agency manager.

3. If the issue remains unresolved it is to be referred to the agency's Compliance Committee appointed by the Governing Authority. Additional participants may include, but not be limited to; Attentive Care's Director of Patient Services, Attentive Care Nursing Supervisors, the client's primary physician, clergy, community agency representatives and legal counsel.

4. An outcome of the case conference should include:

A. Consideration of a broad range of possible courses of action;

B. determination of acceptable courses of action;

C. presentation of courses of action to clients/family for consideration and choice; and

D. decision of Attentive Care

5. The staff will document all findings and interventions in the client's clinical record.

II. CAREGIVER ISSUES

1. Coordination of care or service during times of ethical concerns will be managed by the Nursing Supervisor, or designee, who will arrange for alternate staffing to assure service provision by willing and able caregivers in the event an caregiver may have a conflict with cultural values or religious beliefs.

III. BUSINESS AND MARKETING

1. The support of ethical business practices will assure:

A. Clients will be billed for only the services or products provided to the client;

B. marketing materials will reflect only the products and services provided by Attentive Care either directly or through written agreement;

C. When a client is referred to another agency, organization, service or individual, the client is informed of any financial benefit to the referring organization.

COMPLIANCE TRAINING AND EDUCATION

PURPOSE:

To provide guidance on the training required of faculty and staff within the agency, including initial training, training on general compliance rules, and training on substantive rules.

POLICY:

A. Necessity.

Training is required in order to provide all affected individuals with the knowledge and skills to carry out their responsibilities in compliance with all requirements. Proper and continuing training and education of employees at all levels is, therefore, a significant element of an effective compliance program.

Rules and regulations relating to delivery of healthcare and the conduct of research are complex. The consequences of failure to comply with these requirements, particularly in the areas of coding and billing of federal health care claims and federal research grant claims, can be severe. Sometimes conduct undertaken with good intentions but with inadequate knowledge may violate applicable laws and regulations.

B. Initial Education.

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

C. General Rules.

Annually and as necessary, appropriate affected individuals will be retrained (i) in the agency Compliance Program; (ii) the fraud and abuse laws as they relate to the claim development and submission process and agency business relationships.

(iii) relevant Medicaid and other federal and state requirements; and (iv) the consequences both to the agency and to individuals of failing to comply with applicable laws and regulations. Such training must emphasize the importance of the Compliance Program and the agency's commitment to honesty and integrity in its business dealings.

D. Substantive Rules.

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

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

2. Providers of Patient Care (nurses, home health, social workers, etc.) will receive training that includes clinical documentation requirements, medical necessity considerations, and confidentiality of patient information and other training regarding their activities affecting the claim submission process.

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

duplicate billing.

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

5. Contracts, Vendors and any additional affected individuals will receive training material documenting compliance programs and applicable anti-fraud, abuse and waste laws, rules and regulations, including federal and state false claims act provisions, penalties and protections.

E. Amount of Training.

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

F. Documentation and Tracking.

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

COMPLIANCE COMMUNCATION

PURPOSE:

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

POLICY:

A. Questions.

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

B. Reporting.

Affected Individuals who are aware of or suspect acts of fraud, abuse or waste or violations of the standards of conduct are required to report such acts or violations. Several independent reporting paths are available:

1. 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 Corporate Compliance Officer or member

of the Compliance Committee.

2. An affected individual may report directly to the Corporate Compliance Officer or to a member of the Compliance Committee.

3. 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 Compliance Officer will post this number in one or more prominent locations in the agency.

C. Confidentiality.

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

D. Non-Retaliation.

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

E. Documentation.

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

PROHIBITION AGAINST EMPLOYING OR CONTRACTING WITH INELIGIBLE PERSONS

POLICY:

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

1. Not to employ any individual who is an Ineligible Person;

2. Not to contract or do business with any individual or entity who is an Ineligible Person;

3. Not to appoint or reappoint an allied health professional who is an Ineligible Person, and

4. To comply with all reporting requirements governing Ineligible Persons. The policy covers all personnel, employees and candidates for employment; physicians and allied health professionals; current vendors and consultants and entities/individuals seeking to become vendors or consultants (which are also referred to as affected individuals).

DEFINITIONS:

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

PROCEDURE:

All affected individuals are required to disclose whether he/she is an Ineligible

Person subsequent to hire and or contracting for services.

1. Staff Members may not be appointed unless confirmed that the individual is not an Ineligible Person.

2. Employee responsibility to disclose if they become an Ineligible Person and is subject to dismissal regardless of whether the employee discloses such fact.

3. Preliminary exclusion check applies to vendors and consultants.

4. Requests for Proposals will specifically ask about disclosure as an Ineligible Person.

RESPONSIBILITES:

1. Human Resources Compliance Coordinator: is responsible for performing the initial exclusion checks upon hiring or rehiring of staff.

2. Corporate Compliance Officer with assistance from the Accounting Manager is responsible for:

a. Performing exclusion checks on all affected individuals including office Staff, Direct Care Workers, and staff who provide facility staff relief through Attentive Care every 30 days.

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

c. Performing exclusion checks for prospective vendors.

d. Performing exclusion checks for all current vendors every 30 days.

e. Notifies the Corporate Compliance Office and Human Resources Manager upon learning of a vendor who becomes an Ineligible Person.

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

DOCUMENTATION:

All materials printed regarding the search of the Ineligible Person list must be maintained by the Corporate Compliance Officer for a minimum of six (6) years.

THE FALSE CLAIMS ACT

POLICY:

To establish a policy for all affected individuals of Attentive Care of Albany, Inc, and Attentive Care, Inc. the agency including management and for any contractor or agent of the agency. This policy provides detailed information about the Federal False Claims Act established under sections 3729 through 3733 of title 31, United States Code and any New York State laws pertaining to civil or criminal penalties for false claims and statements and whistle blower protections under such laws.

SCOPE: All affected individuals, including the Board of Directors, Management, Employees and Parties who do business with the agency.

FORMS: Conflict of Interest

DEFINITIONS:

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

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

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

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

PROCEDURE:

Any person who knowingly presents, uses, conspires to defraud, is in the possession, custody or control of information and uses that information for the inappropriate benefit of oneself or the organization is liable to the United States Government for a civil penalty of not less than $5,500 and not more than $11,000 plus 3 times the amount of damages which the Government sustains because of the act of that person. Except if:

-the person committing the violation furnishes information within 30 days of the violation the defendant first obtained the information.

-such person fully cooperated with the Government investigation of such violation.

-at the time such person furnished the information no criminal prosecution, civil action or administrative action had commenced. The court may assess not less than 2 times the amount of damages the Government sustains because of the act of the person. Such persons will be subject to disciplinary policies.

To better educate affected individuals on the False Claims Act (as well as the associated civil and criminal penalties), Attentive Care created the below handout, which is given to on-boarding staff and can also be viewed on Attentive Care's employee portal. (see form to follow, pages 67-70)

FALSE CLAIMS ACT HANDOUT

WHAT IS THE DEFICIT REDUCTION ACT?

The Deficit Reduction Act (DRA) is one of the most pressing compliance laws of 2006.

Medicaid compliance has traditionally played a backseat role to Medicare compliance—but times have changed, dramatically.

The DRA expands the government's oversight of Medicaid compliance and boosts the number of federal Medicaid inspectors from eight to more than 100.

New government focus in relationship to Home Health Care agencies are to strictly enforce that agencies conduct business in an ethical, moral and legal manner.

WHAT IS THE FALSE CLAIMS ACT?

The Federal False Claims Act is a law that prohibits a person, or entity, such as a Hospital, from "knowingly" presenting, or causing to be presented a false or fraudulent claim for payment or approval to the Federal Government, and from "knowingly" making, using or causing to be made a false record or statement to get a false or fraudulent claim paid or approved by the Federal Government. These prohibitions extend to claims submitted to federal health care programs, such as Medicare or Medicaid. The Federal False Claims Act broadly defines the terms "knowing" and "knowingly." Specifically, knowledge will have been proven for purposes of the Federal False Claims Act if the person or entity: (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. The law specifically provides that a specific intent to defraud is not required in order to prove that the law has been violated.

A person or entity found guilty of violating this law is obligated to repay all of the mistakenly obtained reimbursement and will be liable for a civil penalty of up to $11,000, plus three times the amount of actual damages sustained by the Government as a result of the prohibited conduct for each violation of the Act. In addition to being liable for damages and civil penalties, violating the Federal False Claims Acts can subject a person or entity to exclusion from participation in federal health care programs, such as Medicare and Medicaid. Intentionally making a false statement or intentionally submitting a single false claim to the Government can also subject the person or entity violating the law to criminal prosecution under a separate criminal false claims law for a felony punishable by up to five years imprisonment and a fine to the federal Government of up to $25,000.

Private persons are permitted to bring civil actions for violations of the Federal False Claims Act on behalf of the United States (also known as "qui tam" actions) and are entitled to receive percentages of monies obtained through settlements, penalties and/or fines collected. Persons bringing these claims (also known as "relaters" or "whistleblowers") are granted protection under the law. Specifically, any whistleblower who is

discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against by his or her employer because of reporting violations of the federal False Claims Act will be entitled to reinstatement with seniority, double back pay, interest, special damages sustained as a result of discriminatory treatment, and attorneys' fees and costs.

New York State law makes it unlawful to knowingly make a false statement or representation (or by deliberate concealment of any material fact or other fraudulent scheme or device) to attempt to obtain, or to obtain, Medicaid payments for services or supplies furnished under the New York State Medical Assistance Program. A violation of this Act can subject the Hospital or individual to civil damages equal to three times the amount falsely overstated (or in the case of non-monetary false statements or representations, three times the amount of damages which the state, political subdivision of the state, or entity performing services under contract to the state or political subdivision of the state sustain as a result of the violation) or $5,000, whichever is greater. In addition, the Hospital or individual may be required to pay a civil monetary penalty as restitution to the Medical Assistance Program if the Hospital or individual knew, or had reason to know that:

a. the payment involved the providing or ordering of care, services, or supplies that were medically improper, unnecessary or in excess of the documented medical needs of the person to whom they were furnished;
b. the care, services, or supplies were not provided as claimed;
c. the person who ordered or prescribed care, services, or supplies which were medically improper, unnecessary, or in excess of the documented medical need of the person to whom they were furnished was suspended or excluded from the medical assistance program at the time the care, services, or supplies were furnished; or
d. the services or supplies for which payment was received were not, in fact, provided.

New York State law further imposes the threat of criminal prosecution against any person who, with intent to defraud, presents for payment any false or fraudulent claim for furnishing services or merchandise, knowingly submits false information for the purpose of obtaining greater compensation than otherwise permitted, or knowingly submits false information for the purpose of obtaining authorization for furnishing services or merchandise under the New York State Medical Assistance Program. Such person may be guilty of a Class A misdemeanor, unless that act constitutes a violation of a provision of the Penal Law, in which case he or she must be punished in accordance with the penalties fixed by such law.

WHAT IS ATTENTIVE CARE'S ORGANIZATIONAL EXPERIENCE? Locally Owned and operated, Attentive Care was established in 1977. As a Licensed Home Care Agency through the NYS Department of Health, we have a long-standing track record of compliance through the Office of the Medicaid Inspector General's office. Our agency receives federal, state and local funding from contracts including, but not limited to, Medicaid, Department of Social Services and Managed Long Term Care Organizations.

REQUIREMENTS OF OUR AGENCY: The DRA requires our agency to:

- Develop open lines of communication between Affected Individuals and our office.
- Perform internal monitoring and auditing
- Enforce disciplinary action
- Develop Policies and Procedures
- Provide Annual Trainings and Education
- Respond to detected deficiencies
- Designate a Corporate "Compliance Officer"
- Designate a Corporate "Compliance Committee"

WHO ARE THE AFFECTED INDIVIDUALS? Affected Individuals are all persons who may be affected by the agency's "risk areas". Examples may include our employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors and governing body and corporate offices

HOW DOES THIS RELATE TO YOU AS AN AFFECTED INDIVIDUAL? Attentive Care has a large volume of patients whose services are paid for by the New York State Department of Medicaid. Any unethical behavior (listed below) including error in billing or false signature may be found in an audit. Activity Records, Timeslips and Electronically Verified Visits generate our billing. Precise, accurate documentation is crucial. Any false statement or documentation on an Activity Record, Timeslip or Electronically Verified Visit is considered fraud.

WHAT ARE ATTENTIVE CARE'S IDENTIFIED RISK AREAS? Through our organizational experience, Attentive Care identified risk areas include, but are not limited to, the following:

****Billings** ****Payments** ****Ordered Services**
****Medical Necessity** ****Quality of Care** ****Governance**
****Mandatory Reporting** ****Credentialing** ****Contract Oversight**
****HIPPA Breeches**

WHO IS ATTENTIVE CARE'S CORPORATE COMPLIANCE OFFICER? Kelly Ottinger is Attentive Care's Compliance Officer. Kelly is the Agency Manager of Attentive Care and has been working with the company for over 17 years. You can reach her at 518-482-2273.

WHEN SHOULD I CALL THE CORPORATE COMPLIANCE OFFICER? The following items are areas that the DRA focuses on.

If you become aware of these actions that relate to any affected individual, it is required that you call immediately. Attentive Care practices a Non-Retaliation/Non Retribution policy for all reporting's done in good faith.

****Breeches of confidentiality** ****Unethical staff behavior** ****Bribes or kickbacks**
****Unethical relationships** ****Fraudulent or false actions** **** Improper billing practices**
****Unethical/Improper care**

WHAT ARE ATTENTIVE CARE'S DISCIPLINARY STANDARDS? Disciplinary action may be taken against any affected individual that result in a violation of a standard, or whom is aware of actions which violate a standard but fails to take appropriate corrective action. Disciplinary action will be taken on a fair, equitable and consistent basis. Disciplinary action will be appropriate to the affected individual's culpable conduct, that is, the more serious the level of culpable conduct (i.e.: intentional conduct or reckless non-compliance) will result in more significant disciplinary action.
Disciplinary action may include, but are not limited to, the following:

****Verbal and Written Warnings** ****Probation** ****Suspension**
****Demotion** ****Compliance Retraining** ****Termination of Contract**
****Termination of privileges** ****Termination of Employment** ****Termination of Services**

For more information detailing the laws, regulations and penalties enforced by the Office of the Medicaid Inspector General, please visit the following link:
https://omig.ny.gov/information-resources/laws-and-regulations

The Corporate Compliance Officer and Compliance Committee are responsible for the following:

• Develop, initiate, maintain, and revises policies and procedures for the general operation of the compliance

program and its related activities to prevent illegal, unethical, or improper conduct. Manages day-to-day operation of the Program.

• Develops and periodically reviews and updates Standards of Conduct to ensure continuing accuracy and relevance in providing guidance to management and employees.

• Collaborates with other departments.

• Consults with General Council as needed to resolve difficult legal compliance issues.

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

• Develops and oversees a system for uniform handling of such violations.

Acts as an independent review and evaluation body to ensure that compliance issues and concerns within the organization are being appropriately evaluated, investigated, and resolved.

• Monitors, and as necessary, coordinates compliance activities of other departments to remain abreast of the status of all compliance activities and to identify trends.

• Identifies potential areas of compliance vulnerability and risk, develops and implements corrective action plans for resolution of problematic issues and provides general guidance on how to avoid or deal with similar situations in the future.

• Ensures proper reporting of violations or potential violations to duly authorized enforcement agencies as appropriate or required.

• Works with the Human Resources Department and others as appropriate to develop an effective compliance training program, including appropriate introductory and ongoing training for all affected individuals.

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

Additional Resources and updates regarding Medicaid Compliance Programs may be found on the Office of Medicaid Inspector General's compliance website: https://omig.ny.gov/compliance/compliance

Additional details regarding NYS Labor laws and standards may be found on the NYS Department of Labor website: https://dol.ny.gov/labor-standards-0

For more information on Attentive Care's full written compliance policies, please visit our website: www.attentivecareservices.com

If you have any questions regarding the above items or any questions about this program contact the Compliance Officer for clarification at our Corporate Compliance Hotline 518-482-2273.

RED FLAG RULE

PURPOSE:

To comply with the Federal Trade Commission's Red Flags Rule, effective 12/31/2010.

POLICY:

Attentive Care will comply with the Federal Trade Commission's Identity Theft Prevention Program known as the Red Flags Rule.

PROCEDURE:

1) Attentive Care has conducted a risk assessment and identified that we are at low risk for identity theft. The reasons for this identification are 1) that we usually provide services at our customer's homes and 2) we have never had a reported incident of identity theft. We have identified the following red flags that may signal that potential clients are attempting to obtain services from us in a fraudulent manner:

    a) Identification presented by a potential client to an admitting nurse that looks altered or forged.

    b) The photo ID that is presented by a potential client does not appear to match the identity of the potential client.

c) Notice from a customer, a victim of identity theft, a law enforcement agency, or someone else that services have been provided to a client who has been fraudulent in providing their correct identity.

d) A Social Security or Medicaid ID number that is provided to us by a potential client that has been used by a previous client to receive services.

2) Attentive Care has established the following procedures to detect the red flags that we have identified:

a) Potential clients must present a photo ID to the RN Supervisor/designee at the time of case opening for all case managed cases. It will be considered acceptable for Birth Certificates to be presented for children under the age of 18 if they do not have photo ID.

b) Prior to billing a client the accounting department will ensure that billing does not previously exist for a client with a different name, yet same Social Security or Medicaid number.

3) Attentive Care will respond to red flags in the following manner:

a) If it is determined that the photo ID presented by the potential client identifies another person other than the one presenting the ID, the case will not be opened unless a valid ID can be produced.

b) If it is determined that the Social Security number or Medicaid ID number has been used previously by a current or past client, a call will be made to the client to determine if an error has been made prior to billing. If necessary, appropriate authorities will be notified. Examples of appropriate authorities include law enforcement and DSS Supervisors.

4) Prior to administering this program it was approved by the Attentive Care Board of Directors. The Board of Directors has designated the Attentive Services Accounting Manager to administer this program.

5) Training will occur for all in house employees as follows:

    a) Initial in-service to all current staff who are employed as of December 31, 2010 will be completed prior to January 15, 2011.

    b) At time of hire for all staff hired after December 31, 2010.

6) Annually, Attentive Care's Red Flag Identity Theft Program will be evaluated by the Program Administrator to ensure that it remains current.

NON-RETALIATION AND NON-RETRIBUTION FOR REPORTING

PURPOSE:

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

POLICY:

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

PROCEDURE:

Affected individuals have the responsibility to report, in good faith, concerns about actual or potential wrongdoing. The agency is committed to a policy that encourages timely disclosure of such concerns and prohibits any action directed against an affected individual for making a good faith report of a concern. Any manager, supervisor or employee who engages in retribution, retaliation or harassment against a reporting affected individuals is subject to discipline up to and including dismissal on first offense. All instances of retaliation, retribution or harassment against reporting affected individuals will be brought to the attention of the Corporate Compliance Officer who will, in conjunction with Legal and

Human Resources, investigate and determine the appropriate discipline, if any. If an affected individual 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 affected individual, even if the error constitutes inappropriate or inadequate performance, will be considered a positive constructive action by the affected individual.

DETECTING AND PREVENTING FRAUD, WASTE AND ABUSE (SELF-DISCOLOSURE)

PURPOSE:

To outline the Agency's response to a report of fraud, waste, or abuse and to provide guidance on the requirements for investigating and reporting compliance concerns.

POLICY:

This policy sets forth the procedures used by the Agency to respond to a report that any affected individual is engaging in activity that may be contrary to applicable federal or state law or the requirements of the Agency's policies. Attentive Care will use the guidance provided on the Office of the Medicaid Inspector General (OMIG) website https://omig.ny.gov/self-disclosure-submission-information-and-instructions to report overpayments and Self-Disclosures.

The Self-Disclosure Program is the mechanism providers must use to self-report Medicaid Program matters that involve possible fraud, waste, abuse, or inappropriate payment of funds which they have identified through self-review, compliance programs, or internal controls. Providers are required to report, return, and explain any overpayments received by them to OMIG within sixty (60) days of identification, or by the date any corresponding cost report was due, whichever is later. See Social Services Law (SOS) section 363-d.

Additionally, the Self-Disclosure Program accepts provider reports of damaged, lost, or destroyed records. Pursuant to Title 18 of the New York Codes, Rules and Regulations, Section 504.3, providers are required to prepare and maintain contemporaneous records demonstrating their right to receive payment under the

medical assistance program and furnish the records, upon request. If a provider becomes aware that their records have been damaged, lost or destroyed, they are required to report that information as soon as practicable, but no later than thirty (30) calendar days after discovery.

Overview of Self-Disclosure Reporting Per OMIG guidance:

- Any Medicaid billing issues that are determined by the provider to be of a fraudulent nature (no matter what the contract, DSS, MLTC etc.) must be reported within 60 days through the full Self-Disclosure process.
- Routine provider billing errors, for Medicaid client's must be adjusted or voided and reported within 60 days through the abbreviated Self-Disclosure process.
- Routine provider billing errors made for Managed Long-Term Care (MLTC) contracts, must be adjusted or voided within 60 days and reported to the MLTC contract only.

IMPLEMENTATION:

1. Investigation.

A. Purpose of Investigation.

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

B. Conduct of Investigations.

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

C. Investigation Process.

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

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

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

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

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

    b. Identification and review of relevant documentation, including, where applicable, representative bills or claims submitted to the

Medicare/Medicaid programs, to determine the specific nature and scope of the violation and its frequency, duration, and potential financial magnitude.

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

i. The person's understanding of the applicable laws, rules and standards;

ii. Identification of relevant supervisors or managers;

iii. Training that the person received;

iv. The extent to which the person may have acted knowingly or with reckless disregard or intentional indifference of applicable laws;

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

4. For all investigations in which the Agency's legal counsel is not involved determine whether legal counsel should be contacted.

5. Establish a due date for the summary report or otherwise ensure that the investigation is completed in a reasonable and timely fashion and that the

appropriate disciplinary or corrective action is taken, if warranted.

D. Organizational Response.

Misconduct or Suspected Criminal Activity. In the event the investigation identifies misconduct or suspected criminal activity, the Agency will undertake the following steps:

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

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

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

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

5. Where the affected individual or individuals are not terminated, promptly undertake appropriate actions and education to prevent a recurrence of

the misconduct.

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

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

E. Relationship of Compliance Investigations to the agency general disciplinary procedures:

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

F. Process.

The Corporate Compliance Officer, or his or her designee, may conduct interviews with any agency affected individuals and may review any agency document including but not limited to those related to the claim development and submission process, patient records, e-mail and the contents of computers and word processors, and may undertake other processes and methods as the Corporate Compliance Officer deems necessary.

G. Documentation.

The Corporate Compliance Officer may prepare a report which

1. Defines the nature of the situation or problem

2. Summarizes the investigation process

3. identifies any person whom the investigator believes to have acted deliberately or with reckless disregard or intentional indifference, particularly toward the Medicaid laws, regulations and policies,

4. Estimates the nature and extent of the resulting overpayment by the government or another entity, if this is possible.

H. Response.

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

1. Possible Criminal Activity. In the event the investigation reveals or uncovers what appears to be criminal activity on the part of any affected individual, the following action will be taken:

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

   b. A summary of the results of the investigation shall be sent for appropriate disciplinary action to the department director or manager (or the appropriate assistant or associate administrator if the director or manager is implicated) of any affected individual whose conduct appears to have been intentional, willfully indifferent or with reckless disregard for Medicaid or other applicable laws and regulations. Pending disciplinary action, any such affected

individual may be removed from any position with oversight of or impact upon the claims development and submission process.

c. State and federal agencies will be notified as deemed appropriate by legal counsel, the Administrator and the Board. The agency may attempt to negotiate a voluntary disclosure agreement prior to the disclosure.

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

a. If duplicate payments have been made by Medicaid or other health care program or excessive payments made because of coding or other agency errors or mistakes (i) the defective practice or procedure will be corrected as quickly as possible; (ii) the duplicate or improper payments will be calculated and repaid to the appropriate payor or fiscal intermediary; and (iii) a program of education will be undertaken with appropriate affected individuals to prevent future similar problems.

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

c. A summary of the results of the investigation shall be sent for appropriate disciplinary action, if any, to the department

director or manager (or the appropriate assistant or associate administrator if the director or manager is implicated) of any affected individual whose conduct may be wrongful or inappropriate under the circumstances.

I. Voluntary Disclosures.

All voluntary self-disclosures will be guided by the OIG's Provider Self-Disclosure Protocol 63 Fed. Reg. 58399.

J. Reports by Corporate Compliance Officer.

The Corporate Compliance Officer periodically shall furnish information (bearing in mind issues of confidentiality) about such investigations to the CEO, and the Compliance Committee at its regular meetings or as necessary.

CONFLICT OF INTEREST

POLICY:

All members of the Board of Directors, Governing Body/Management Team, office staff and nurses will sign a Conflict of Interest Statement. These Statements will be kept in a file in the President's office. All board members and management personnel will disclose any existing or potential conflict of interest.

PURPOSE:

To ensure no conflict of interest. The Agency defines "conflict of interest" as those activities or actions which:

- Conflict with the mission, philosophy or objection of the Agency
- Violate local, state or federal regulations
- Place the Agency, personnel, clients or their families at risk ethically, financially or legally.
- To protect the Agency's assets, both material, concepts and publications, as well as to include:

a. Confidentiality of patient diagnosis

b. Financial matters

c. Staff salaries

d. Nursing or executive plans that can go to unauthorized agencies

e. Anything given to staff (e.g., forms, systems, equipment) that go to unauthorized people.

PROCEDURE:

1. A signed statement from Governing Body/Management members to assure compliance with privacy of company policies.

2. The Board of Directors will review relationships with other agencies, organizations, educational organizations, health care providers and payers, in order to ensure that these relationships comply with local, state and federal regulations, as well as promote Agency's mission and philosophy.

3. The Board members and staff upon hire will sign the Conflict of Interest form attached, during orientation. Forms are filed in the administrative office.

4. The Agency has coordinated its Conflict of Interest Statement with company attorney and financial officers for legality and appropriateness.

5. Conflict of Interest includes:

a. Double billing

b. Patients referral to agency you also work for

c. Kickbacks

CONFLICT OF INTEREST STATEMENT

I hereby affirm that I am not currently engaging in any activity or activities that present a conflict of interest with Attentive Care of Albany, Inc. I also agree to disclose any future activities that may present a conflict. In addition, I will not remove/take any materials belonging to Attentive Care of Albany, Inc. This includes printed materials, policies and procedures, equipment and clientele.

____

Printed Name

__________________________ __________________________

Signature Date

____

Title

BILLING REVIEW

POLICY:

The agency staff members responsible to bill client accounts will assess client validation of services rendered to ensure that client accounts are properly charged for authorized services rendered and false claims are avoided.

Definition: Direct care providers refers to any individual whose work time and performance are recorded, reported and charged by the agency as services rendered

PROCEDURES:

1. The agency staff member(s) responsible for scheduling client care will revise work schedules and client care schedules as often as necessary to ensure that the agency records of care are accurate and complete. Coordinators will ensure the service authorizations for all scheduled care.

2. Agency staff members responsible for this duty include Staff Coordinator(s) and Nursing Supervisor(s).

3. The agency staff members responsible to check reported work time by direct care providers and compare reported work time to authorizations for service must ensure that that all discrepancies are investigated, documented and reported to supervisory staff. Staff members assigned to this duty includes:

4. Any staff members responsible for recording and transmitting charges for services rendered are prohibited from performing or participating in the performance of the review of direct care work time reported compared to the agency schedule and authorization for care.

5. All claims for agency services must be properly coded, accurately validated,

include the provider identity, patient identity, date and time of service. All billing codes are to be reviewed by billing staff to ensure accuracy. Any questions or concerns regarding billing codes should be brought to the attention of the Compliance Officer who will guide staff in keeping with the compliance plan.

6. Staff members responsible for billing agency services must immediately report discrepancies between documented direct care work time and agency schedules for care to the agency compliance officer. Staff members assigned to perform this duty must charge payers for only those services properly authorized and performed.

7. Staff members responsible for retrospective comparison of claims made for services and services authorized and performed must perform such a review at least weekly and report the findings to the agency compliance officer. Staff members assigned to this responsibility includes:

8. Such staff members will document, investigate and report all concerns or questionable findings to the agency compliance officer weekly. Questionable findings include: inability to determine if work time is actually validated by the client and inability to match the authorized services with actual service rendered.

CREDIT BALANCES

POLICY:

The President/ CEO will ensure that any adjustments, changes, refunds or remittances sent to clients or due to clients are promptly and accurately documented, reported and remitted within 30 days of the any adjustments, changes, positive balances or remittance discovered due.

PROCEDURE:

1. The staff members responsible for posting charges and credits to agency patient accounts will report all adjustments, changes in charges, refunds, remittances or positive balances to the compliance officer for investigation and resolution.

2. The Corporate Compliance Officer will investigate the report to make sure that each change is in accordance with agency policy for fraud and abuse of patient services and ethical business practices.

3. Any findings of potential fraud and abuse of patient services will be documented, investigated, and reported to the President/ CEO and the agency fraud and abuse prevention committee for determination of all actions

EXCLUSION CHECK FOR AFFECTED INDIVUALS

PURPOSE:

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

POLICY:

It is the policy of Attentive Care, Inc. to conduct a check for exclusion from the Medicare and Medicaid program, including OMIG and LEIE Exclusion lists, on all affected individuals, both subsequent to hire and or contracting for services and, at minimum, every 30 days.. Employing or working with contractors (or any other affected individuals) that have an unfavorable status with government agencies can result in the removal from the Medicare and Medicaid programs.

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

PROCEDURE:

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

Current Employees, Contractors and all other affected individuals. Attentive Care will conduct on a monthly basis a search on the above web sites for any exclusion that may warrant the termination of employment or contract with outside vendors.

In addition: for any new contract with contractors, Attentive Care will require that verbiage is in the contract that they will check the OMIG and LEIE Exclusion lists every 30 days for all their Affected individuals.

DOCUMENTATION AND REPORTING

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

ELECTRONIC VISIT VERIFICATION (EVV)

PURPOSE:

In order to comply with the New York State Law and the Department of Health's requirement for Licensed Agencies and Consumer Direct Personal Assistant Program (CDPAP) Fiscal Intermediary's (FI's), to implement an Electronic Visit Verification (EVV) System. Electronic Visit Verification (EVV); is an electronic system that verifies when a provider visit occurs and captures the date and time of the visit, the location of the visit, the person who received the services, the person who provided the services, and the services provided. Attentive Care has partnered with HHAeXchange (an EVV vender).

POLICY:

Section 12006(a) of the 21st Century Cures Act mandates that states implement EVV for all Medicaid personal care services (PCS) and home health services (HHCS) that require an in-home visit by a provider.

PROCEDURE:

All Direct Care Workers will be trained on EVV at hire and then annually via in-services video, tracked by the compliance designee. It will be the responsibility of the person conducting the orientation to include an informative EVV video as well as distributing HHAeXchange Application instructions and the New York State Department of Health Electronic Visit Verification (EVV) Facts sheet.

The person conducting orientation is also responsible for giving the Direct Care Worker a personal pin number that is connected to a background personnel identifier. Both numbers are created by the EVV Vendor when direct care worker's information is entered into the EVV system.

Direct Care Workers will be instructed to download the EVV Vendor Application

to an IPhone or Smartphone device or use the toll-free number to call in/out from the Client or Consumer's home phone if they are unable to us a Smartphone device.

Direct Care Workers must enter their Time & Attendance PIN to verify their identity whenever placing an EVV calls (using an approved phone number). This allows the system to match up their call with the proper visit.

It will be the responsibility of the Field Staff Supervisors (FSS) to ensure all Direct Care Workers are using the clocking in or out by EVV application or the Direct Care Worker must dial the Agency's time and attendance toll free phone number from the client's home phone.

When the call is placed, the system reviews the number the call originates from and matches it with an accepted Client/Consumer phone number entered into Client/Consumer's electronic chart. If the system cannot match the number from the Caller ID, the call is sent to the Call Maintenance Dashboard, maintained by the Homecare and Consumer Direct Field Staff Supervisors. Manual punch time entries can only be entered by Field Staff Supervisors/office staff, if appropriate confirmation has been received form both the Direct Care Worker who completed the shift and Client/Consumer (or family member/designated representative if applicable). Documentation of manual entries must be entered into Client/Consumer electronic chart as back up and must include information on why the manual entry occurred, how the information was verified and what retaining was completed (if applicable).

The Mobile Application may be used to place EVV punch times with the GPS functionality.

The Mobile ID is generated when the Direct Care Worker signs up for the Mobile Application. This Mobile ID is provided from the Direct Care Worker and entered in the Direct Care Worker Profile in HHAeXchange. It is the responsibility of the

FSS to assist Direct Care Workers with linking the mobile ID.

The EVV Application uses Google Maps to determine the GPS coordinates of the address entered in the Address 1 field entered into HHA eXchange.

- An informational EVV video has been added to the orientation video and annual in-services video for Direct Care Workers.
- In-service Certificates have been updated. Direct Care Workers will be given HHAeXchange App/EVV Instructions Sheet at orientation.
- The employee and personal assistant signature sheets were updated to include verbiage that employees and personal assistants have received and reviewed Electronic Visit Verification (EVV) instructions and the New York State Department of Health Electronic Visit Verification (EVV) Facts sheet.

ELECTONIC VISIT VERIFICATION (EVV) AGGREGATION AND COMPLIANCE CHECKS

PURPOSE:

To ensure the aggregation of electronic visit verification EVV transactions for personal care services and/or home health care services reimbursed by Medicaid or Medicaid Managed Care Organizations are properly submitted through our EVV system HHAeXchange and transmitted to the electronic New York State Medicaid system eMeDNY.

POLICY:

As a licensed home care service Agency (LHCSA) and Fiscal Intermediary (FI), Attentive Care of Albany, Inc. will comply with all state and federal regulations, which include DOH's EVV program expectations, as outlined in the April 14, 2022, guidance document entitled "New York State Electronic Visit Verification Program Guidelines and Requirements" and Section 12006(a) of the 21st Century Cures Act mandates that States implement EVV for all Medicaid personal care services (PCS) and home health services (HHCS) that require an in home visit by the provider.

PROCEDURE:

Attentive Care's Operations Manager or designee will be responsible to ensure the aggregation of EVV transactions for personal care services and/or home health care services reimbursed by Medicaid or Medicaid Managed Care Organizations are properly being submitted through our EVV system HHAeXchange. Aggregation reports will be run a minimum of once per week for the prior week's billing cycle. Any issues resulting in "failed transactions" will be corrected. Any transactions that cannot be corrected by the Operations Manager or Designee will be reported to Attentive Care's Corporate Compliance Officer,

who will try to resolve the issue and will reach out to HHAeXchange, DOH or OMIG for further direction if necessary.

Non-Compliant EVV Methods:

Attentive Care will continue to provide initial and on-going training to caregivers providing personal care services and/or home health care services; to discourage and limit non-compliant EVV methods such as paper time sheets. In any circumstances where EVV is not properly captured, Attentive Care's Staff will document reasons why the information is missing, how the information was verified, and any re-education or corrective action to prevent future issues.

Attentive Care's Agency Manager or Designee will run weekly visit verification compliance reports from HHAeXchange and work with the scheduling supervisors of the Homecare and Fiscal Intermediary departments to make corrective actions to decrease use us of any manual entries including use of non-compliant EVV methods such as paper time sheets. Continual failure of refusal of EVV compliance will be reported to the Corporate Compliance officer for further corrective action, which may include termination when necessary.

DISCIPLINARY PROCEDURES

PURPOSE:

All affected individuals are required to comply with applicable state and federal law, ethical standards and Agency's policies, including the Standards of Conduct contained in this Manual. Any affected individual who violates any of the foregoing Standards of Conduct (referred to below as "Standard") will be subject to disciplinary action, up to and including termination.

The Agency's disciplinary policies will be structured to encourage good faith reporting, employees are not permitted to engage in retaliation, retribution or any form of harassment directed against an affected individual who reports a Compliance concern. Anyone who is involved in any act of retaliation or retribution against an affected individual that has reported suspected misconduct in good faith will be subject to disciplinary action.

POLICY:

In accordance with OMIG regulation section 521-1.4(f) for providers to clarify the requirements for the publication and enforcement of the Required Provider's disciplinary procedures, and the requirement that such procedures be enforced fairly and consistently.

PROCEDURE:

Disciplinary action will be taken against any affected individual who:

- Authorizes or participates directly in a violation of a Standard;
- Deliberately fails to report a violation of a Standard;
- Deliberately withholds relevant and material information concerning a violation of a Standard;
- Deliberately fails to cooperate in an investigation of a suspected violation

of a Standard;

- Retaliates or seeks or causes retribution against any individual who has either reported a suspected violation of a Standard or participated in an investigation of a suspected violation of a Standard;
- Encourages, directs, facilitates or permits either actively or passively non-compliant behavior; and
- Fails to participate in required training programs.

Disciplinary action may also be taken against any supervisory personnel who direct or approve an affected individual's actions which result in a violation of a Standard, is aware that an affected individual's actions which violate a Standard but fails to take appropriate corrective action or who otherwise fails to exercise appropriate supervision.

Disciplinary action may include oral or written warning, probation, suspension, demotion, termination from employment or suspension or termination of staff privileges. Disciplinary action will be taken in accordance with Agency personnel policies and procedures. Disciplinary action will be taken on a fair, equitable and consistent basis. Disciplinary action will be appropriate to the level of the affected individual's culpable conduct, that is, the more serious the level of culpable conduct (intentional conduct or reckless non-compliance) will result in more significant disciplinary action. Notwithstanding the foregoing, this statement is not a guaranty of progressive discipline and the Agency reserves the right to terminate an affected individual at any time for any lawful reason.

AUDITING/MONITORY POLICY

PURPOSE: The Agency has implemented policies for internal and external audits performed to comply with Sate Federal and Contractual agreements. Results of each audit are reported and tracked by the Compliance Committee and Corporate Compliance Officer to measure potential areas of compliance vulnerability and risk, including (i) billings; (ii) payments; (iii) ordered services; (iv) medical necessity; (v) quality of care; (vi) governance; (vii) mandatory reporting; (viii) credentialing; (ix) contractor, subcontractor, agent or independent contract oversight; and (x) other risk areas that are or should reasonably identified through our organizational experience.

POLICY: Section 521-1.4(g)(1) Ongoing audits are performed by internal or external auditors who have expertise in Medicaid program requirements or the subject area of the audit. Audits or investigations conducted by state or federal governmental entities are not considered external audits. This section identifies specific requirements for ongoing audits.

PROCEDURE:

External Audits:

- **BST:** Accounting firm engaged by Attentive Care to complete yearly review of all financial records.
- **KPMG:** Accounting firm engaged by Attentive Care for annual financial audit of submitted information for New York State Department of Health (DOH) cost report.

Internal Audits and Monitoring:

- **Corporate Compliance Office and Compliance Committee:**
  - The Corporate Compliance Office and or Compliance Committee will meet a minimum of quarterly to discuss and review compliance issues and perform quarterly audits and or compliance checks, that will be reported in the meeting minutes.
  - The Compliance Meetings will review any audits conducted each quarter and any adverse determinations or corrective actions implemented.
  - The Corporate Compliance Officer and Compliance Committee will suggest, initiate, oversee and implement periodic internal auditing for each department to measure the effectiveness of the Compliance program, or as part of a plan of corrective action. The Corporate Compliance officer and Compliance Committee shall have access to all documents and information relevant to compliance activities including but not limited to patient records, billing records, marketing records and contracts.
  - The Corporate Compliance Officer and Compliance Committee will Conduct Annual Review and update of Agency's Compliance Program and Manual.
    - Results will be reported quarterly and reviewed annually with the CEO/Governing Authority.
  - The Corporate Compliance Officer and Committee will Review and update they Agency's Annual Compliance Work Plan
    - The Agency's compliance work plan will be discussed in quarterly meeting to measure that goals and effectiveness are being met.
    - Results will be reported quarterly and reviewed annually with the CEO/Governing Authority.
  - The Corporate Compliance Officer and Committee will review,

evaluate and update the Corporate Compliance Training Program, using identified risk areas to improve training in key areas of concern.

- **Continuous Quality Improvement (CQI):**
  - Performed quarterly by designated representatives from Attentive Care's Nursing department, Homecare department and Agency Manager.
    - Results reviewed by CQI committee which includes a Consumer and Physician and reported to Governing authority or designated representative.
    - A minimum of 10 % of client charts (including active, on hold and discharged clients) are pulled for the audit.
      - The charts of any client who had a complaint during the quarter, will be included in this audit if applicable.
    - CQI audits review areas of risk for:
      - Services ordered
      - Medical Necessity
      - Quality of Care
- **Contract Audits:**
  - Attentive Care maintains contractual agreements with various programs including but not limited to the Expanded In-home Services for the Elderly Program (EISEP), Department of Social Services (DSS), Medicaid Long Term Care (MLTC), MMCOs and Programs of All-Inclusive Care for the Elderly (PACE). Information on services rendered and agency policies are submitted as requested.
    - Results of audits with contracts are reported to the Compliance Officer and the Compliance Committee and are reviewed quarterly in Compliance Committee Meetings and yearly during the yearly Compliance Review.

      - A plan of correction will be implemented in the time frame director or as soon as practicable if there are any areas of deficiency or negative determinations.

- **Financial Audits:**
  - Accounts receivable and payable are reconciled monthly and reviewed quarterly by the accounting department and Accounting Manager.
  - The Accounting department and Accounting Manager will provide financial reports to the Governing Authority, Chief Operating Officer and Corporate Compliance Officer quarterly and as requested.
- **Electronic Visit Verification (EVV):**
  - System utilized by Attentive Care in which direct care staff clock in and out from their client's homes, which initiates payroll and billing.
    - Reviewed by assigned office staff a minimum of weekly for pay/billing purposes.
    - EVV is recognized monthly by Attentive Care's Accounting Department.
- **HHAeXchange Electronic Visit Verification (EVV) Conflict Report:**
  - Report Generated by HHAeXchange which reflects and overlapping time or duplicate billing with another Agency utilizing the HHAeXchange Visit Verification System