Community Home Care Referral Services, Inc., D/B/A
Helping Hands Attendant Services

STANDARDS OF CONDUCT

The Agency relies on the good faith of its directors, officers, employees and agents to comply with all laws applicable to Community Home Care Referral Services, Inc., D/B/A Helping Hands Attendant Services' business. In particular, the Agency requires all of its officers, directors, employees and agents to comply with the letter and spirit of all state as well as federal health care fraud and abuse laws applicable to Medicare and Medicaid Providers, including Medicare certified home health agencies and licensed home care agencies. This section of the Compliance Program will describe the policies, standards and legal requirements that the Agency has adopted as its "Standard of Conduct", but it is not limited to the items listed. Additional policies and procedures are incorporated into the Policy and Procedure Manual as necessary.

It is the agency's policy to fully comply with the intent and spirit of the laws and regulations governing the organization. The agency will now record (attest to) their annual "Certification Statement for Provider Billing Medicaid." This annual certification shall occur on the anniversary date of the provider's enrollment in Medicaid.

The Agency will maintain an open line of communication between the Compliance Officer and the Agency employees, agents and officers. The laws, rules and regulations governing Medicare, Medicaid, commercial insurance, and managed care programs are complex and ever changing. Accordingly, individuals are encouraged not to guess whether certain conduct is improper, but rather are encouraged to ask the Compliance Officer/designee when there is any confusion or question. As applicable, legal counsel may be engaged by the agency to clarify questions.

A. FRAUD

The Agency specifically prohibits any officer, director, employee or agent from committing fraud related to Agency business. Fraud is defined as intentional deception or misrepresentation that could result in some unauthorized benefit to the provider, contractor, subcontractor, an another agency representative. These individuals know

the deception or misrepresentation to be false, or may be the effect of reckless or ignorant behaviors or attitudes regarding financial/billing issues of the agency. Fraud can be committed by not telling someone a fact that should be told to avoid misinterpretation. This is fraud by omission, or constructive fraud. If for example, a nurse knows a key piece of information and intentionally withholds it in her documentation, the law says that withholding key information may be the same thing as misrepresentation.

Abuse is defined as incidents or provider practices that are inconsistent with sound fiscal, business, medical or professional practices, and may result in unnecessary costs to Medicare, Medicaid or commercial insurance programs, as well as improper payment and/or payment for services that may fail to meet recognized professional standards of care or are medically not necessary. It also includes enrollee practices that result in unnecessary costs to the Medicaid program. There is a fine line between what constitutes outright fraud and what constitutes abuse. This distinction is determined by the evidence necessary to establish whether acts have been committed intentionally, or knowingly and willfully, nor merely committed out of simple negligence.

Several types of fraudulent conduct have been identified in the home health industry:

1. <u>FALSE OR FRAUDULENT CLAIMS RELATING TO THE PROVISION OF SERVICES</u>

   <u>Examples of these practices may include:</u>

   a) Submitting claims for treatment not rendered or visits not made;
   b) Submitting duplicate claims for the same service;
   c) Falsifying patient signatures on documents such as daily itinerary sheet (charting sheets) or physician signatures on plans of care and doctor's orders;
   d) Services were not ordered by a qualified practitioner in a timely manner;
   e) Not adequately documented;
   f) Third-party coverage was not pursued;

g) Personnel did not meet all regulatory requirements such as certification, licensure, or any other necessary training;
h) Misrepresenting or misusing federal symbols such as Medicare and/or Social Security in marketing or billing practices:
i) Supervision of personnel;
j) Spend down reviews if applicable;
k) And home health aide overlapping payments.

To avoid allegations of fraudulent claims, employees and agents must accurately and completely document clinical and financial / billing information. Employees and agents shall not document patient or financial / billing information in a manner that is misleading, inaccurate or untrue. All employees and agents shall produce clinical records in a timely manner to ensure accuracy and completeness of clinical information. Clinical records must provide objective data supporting the progress and status of the patient, as well as the need for skilled professional services. Corrections on clinical records shall be made within the relevant standards of practice so as to avoid misleading or deceptive record keeping.

The agency will bill only for services that are medically necessary. We will bill Medicaid or other third party payers for services, which it believes, are reasonable, and ordered by an authorizing practitioner or a managed long term care provider. The authorizing practitioner will be kept informed, as appropriate, about any changes in the condition, or course of a treatment, of a client.

We will bill only for services based on a signed plan of care. A home care plan of care/treatment must be established, dated and signed by a professional registered nurse before any claims are submitted. This is not applicable for companion, housekeeper and homemaker services.

All services will be properly documented in a clear manner that complies with all local, state and federal regulations. Unintentional errors will have exception report

documentation explaining the circumstances surrounding the error. This documentation will be kept in a log in the billing office.

1. FRAUD IN ANNUAL COST REPORT CLAIMS

In addition to submitting claims for specific services, the Agency is required to submit annual cost reports to Medicare and Medicaid for reimbursement of administrative overhead and other general costs. Such costs must be:

a) reasonable,
b) necessary for the maintenance of the health care entity, and
c) related to patient care.

It is Agency policy that only allowable costs will be submitted for reimbursement on its cost reports.

2. PROMOTION OF NON-COVERED OR UNNEEDED SERVICES TO PATIENTS

Any educational or community activities related to Agency business shall be conducted in an honest, straightforward, fully informative and non-deceptive manner.

Patients or prospective patients must not be encouraged to seek non-covered or unneeded medical services.

3. UTILIZATION OF SERVICES

Patients who receive services from the agency shall receive:

a) only those services that are safe and appropriate, and
b) only those services that meet the applicable coverage guidelines for Medicare, Medicaid, commercial managed care coverage or insurance, if such third-party payors will be billed for the services.

Clinical records should be current and include information to support the level of utilization. The Plan of Care shall reflect the patient's needs and condition.

To avoid allegations of fraud, the general rule for all Agency officers, directors, employees, and agents is always to tell the truth in agency related documents and do not omit any material facts.

B. BRIBERY

The Agency prohibits any employee, agent, officer, or director from offering, soliciting, promising, or giving anything of value for the purpose of, or concerning business with, Community Home Care Referral Services, Inc., D/B/A Helping Hands Attendant Services. State and federal surveyors, auditors, inspectors and investigators are likely to be considered public officials for the purpose of bribery. Any actions that would constitute bribery are strictly prohibited by the Agency and will subject the violator to discipline, up to and including termination.

C. KICKBACKS

Federal and state law prohibit any agency employee to offer or provide something of value for the purpose of improperly obtaining or rewarding a referral, a contract or any other business. This value can be received or accepted directly or indirectly. The Agency prohibits any conduct that could be construed to be an illegal kickback. It is against Agency policy for any employee, agent, officer or director to give or receive, offer or solicit any remuneration, directly or indirectly, in exchange for or to induce the referral of patients. Paying a person or entity; that is prohibited by law to do so, to recommend or arrange for referrals of patients to a health care provider is also prohibited by the Agency.

The concept of improper remuneration includes the giving of anything of value, not just money. Remuneration may include cash payments, free services, and certain discounts. Merely because certain activities are customary in a particular location or particular area of business activity does not indicate that such an activity is legal. Before

any payments are made to, or oral or written agreements are made with, referral sources, the Compliance Officer must be consulted.

Practices in the home health industry that the government may consider to be kickbacks include the following:

A. Payment of a fee to a physician for each plan of care certified by the physician on behalf of the home care agency.
B. Disguising referral fees as salaries by paying referring physicians for services not rendered, or in excess of fair market value for services rendered.
C. Offering free services to patients, including transportation and meals.
D. Providing payments or free services, such as nursing coverage, to retirement homes or assisted living facilities, in return for referrals.
E. Subcontracting with retirement homes or assisted living facilities for the provision of home health services, to induce the facility to make referrals to the home care agency.

Community Home Care Referral Services, Inc., D/B/A Helping Hands Attendant Services does not accept nor give any form of remuneration, directly or indirectly, covertly, or overtly, in return for referring patients to or from us.

D. SELF-REFERRAL PROHIBITIONS

Certain state and federal laws prohibit physicians from referring patients for home care services if such physicians have a compensation or investment relationship with the home care agency (i.e. contract or ownership). While there are certain exceptions to the state and federal self-referral prohibitions, Agency employees, officers, directors, and agents should be mindful of relationships between the Agency and physician referral sources. Before any compensation or ownership relationships are established between physicians and the Agency, the Compliance Officer must be consulted.

E. OBSTRUCTION OF JUSTICE

Community Home Care Referral Services, Inc., D/B/A Helping Hands Attendant Services prohibits any conduct that obstructs or impedes the administration of justice.

The general term “obstruction of justice” includes attempts to influence or silence any witness or informer in a government investigation or to destroy or alter records during an investigation, with the intent to obstruct the investigation. The risk of liability for obstruction of justice in the health care context most commonly arises during visits to the provider by law enforcement agents, such as the Federal Bureau of Investigation or State Medicare or Medicaid Fraud Control Units. If any federal or state law enforcement officers, investigators or representatives visit the Agency officers or any site where the Agency provides services or a subpoena or search warrant is received by an employee, officer, director or agent, the Compliance Officer must be notified immediately.

F. PATIENT ABUSE / EXPLOITATION

The Agency strictly prohibits any conduct that could be construed to be patient abuse, neglect and exploitation. Any Agency employee or agent who engages in such activity will be subject to discipline by the Agency and, as required by the law, reported to the appropriate governmental authorities.

The Agency also supports appropriate, good faith reports of known or suspected patient abuse, neglect or exploitation to the appropriate state or federal agencies designated with regulatory authority over such matters.

G. CONTRACT/SUBCONTRACT/SUPPLIER SERVICES

The Agency’s standards of conduct apply not just to employees, but also to all affiliated providers including those that are operating under or on behalf of the agency as it may provide some of its services through arrangements with independent contractors rather than through direct employees of the Agency. Agency policy requires that where the Agency contracts to have another organization provide services on its behalf, the Agency will remain professionally responsible for, and will monitor, the services to the extent required by the New York State Department of Health. A written contract will be in place when services are provided to the Agency by independent contractors.

If any officer, director, employee, or agent has any questions in this regard, the Compliance Officer should be consulted. All those who provide services for or on behalf of the agency will receive a copy of the corporate compliance plan and are subject to all compliance program requirements within their scope of contracted authority and affected risk areas. All contracts with contractors, agents, subcontractors and independent contractors will include termination provisions for failure to adhere to the required agency's compliance program requirements. The agency will maintain honest and straightforward relationships with all suppliers, contractors, and subcontractors. Any incidence of pressure to conduct business or participate in potential improper behavior shall be reported to the corporate compliance officer. Non-adherence to the Agency's compliance program requirements may result in a termination of contractual services with the designated agent and/or contractor.

H. CONFIDENTIALITY OF PATIENT INFORMATION

All Agency employees, officers, directors, and agents shall protect the confidentiality of patient clinical information and records. Employees and agents must not engage in discussions or leave patient records in places where confidential patient information could be disclosed. Agency policy prohibits the unauthorized release of patient clinical records unless permitted by law. The release of any patient records will be coordinated by the Director of Patient Services / designee and will be handled in accordance with HIPAA Privacy Standards and relevant state law.

It is the agency's responsibility to safeguard and maintain confidentiality of all patient information. Our corporate compliance plan also requires employees to follow all policies and procedures related to maintaining the confidentiality of patient information. The agency is bound not only by HIPAA but also by any local and state statues and regulations such an HYSDOH HIV-related information protection, NYS Department of Mental Hygiene Laws and regulations.

The protection of patient information is also considered in the storage and retention of records. Only those employees authorized will be permitted to have access to patient information. Documents and discussions related to patient care should be in an area

that is properly secured. Computer terminals will be password protected. Any agency employee who discloses unauthorized patient information may be terminated immediately and subject to possible civil and criminal sanctions.

NYS Information Security Breach and Notification Act

The NYS Information Security Breach and Notification Act is comprised of section 208 of the State Technology Law and section 899-aa of the General Business Law. The statutes can be searched and viewed at the New York State Legislature Site.

State entities and persons or businesses conducting business who own or license computerized data which includes private information must disclose any breach of the data to New York residents whose private information was exposed.

A cybersecurity incident is defined by the notice as “the attempted or successful unauthorized access, use, disclosure, modification, or destruction of data or interference with an information system operation”. Therefore, even if a healthcare provider is aware of an unsuccessful attempt of a breach (*e.g.* by a disgruntled employee), that incident should be reported to the Department. Within 24 hours of receiving confirmation that a credible cybersecurity incident has occurred the agency will:

a. Follow the Cybersecurity Incident Reporting Protocol to call the, NYSDOH Regional Office that covers your geographic location and report any cybersecurity incidents that meet the above definition.
b. The NYSDOH Regional Office will then provide instructions to the provider regarding any follow-up activities.

I. DISCRIMINATION

The Agency provides equal employment opportunities for all employees and applicants for employment. The Agency will not discriminate in its employment or patient care practices in any respect on the basis of age, ethnicity, gender, marital status, veteran status, disability / medical condition, race, religion, sexual orientation or national origin.

J. CONFLICTS OF INTEREST

A conflict of interest is any interest (business, financial, or personal) held directly by an officer, director, or employee that would or might affect his or her decisions or actions with respect to business transactions and other affairs of the Agency, or would in any way be adverse to, or in competition with the interests of the Agency. Examples of conflict of interest situations include, but are not limited to:

a) an employee has an interest that materially affects the amount of time or attention that is to be devoted to his or her Agency job duties, or
b) an employee, director or officer has a business interest in an organization or with individuals who have a relationship, or are in competition, with the Agency.

Outside employment may constitute a conflict of interest if it places an employee in a position of appearing to represent the Agency, involves services substantially similar to those the Agency provides or is considering making available, or lessens the efficiency, alertness or productivity normally expected of employees on their jobs. Outside employment may also constitute a conflict of interest if employees perform services either for:

i. individuals or entities (e.g., physicians), whose services are employed by the Agency or who may refer patients to the Agency, or for any individuals or entities that provide services for or employ such individuals or entities, or
ii. individuals or entities to which Agency patients may be referred (e.g., providers of ancillary services), or
iii. Patients of the Agency.

All outside employment that raises any question in this regard must be disclosed to the Agency and be approved in advance by the Compliance Officer.

Agency directors, officers and employees will avoid situations in which conflicts of interest, including potential or perceived conflicts of interest can occur. All conflicts of interest, potential conflicts of interest and situations that give the appearance of conflicts of interest must be immediately disclosed to the Compliance Officer.

K. REFRAINING FROM SUBSTANCE ABUSE

It is the policy of the Agency to provide employees and patients with a working environment that is free of the issues associated with the use and abuse of controlled substances and the abuse of alcohol.

L. BILLING AND REIMBURSEMENT

The Agency is committed to ensuring that its billing and reimbursement practices comply with all federal and state laws, regulations, guidelines and policies and that all bills are accurate and reflects current payment methodologies. The Agency is committed further to ensuring that, as applicable, all patients and payors receive timely bills and that all questions regarding billing are answered. Add-ons such as the worker recruitment and retention, recruitment, training and retention, and any and all accessibility, quality, and efficiency adjustments are compliant with the regulatory requirements in Public Health Law 3614.

The agency will ensure that all staff meet regulatory, educational, medical and experience requirements for billing of services.

In addition our agency is committed to ensuring that:

- patient care plans are created and approved by designated professional staff, forming the basis of authorized services;
- consistency exists between plans deemed necessary, services rendered and hours billed as authorized;
- services are adequately documented, the required supervision has been conducted, and all personnel requirements have been met;
- participate in pre-claim verification, if required;

- no duplication of billing or services has occurred, i.e. while patient has been hospitalized.

Duty sheets and any other types of records must be completed honestly. No false records of patient services will occur. An employee risks personal sanctions under local, state and federal statutes. Deliberate misrepresentation will lead to termination from the agency.

Electronic Visit Verification

New York State Department of Health (NYSDOH) required providers of Medicaid-funded PCS to select and implement EVV systems that meet the requirements of the 21st Century Cures Act by January 1, 2021. Providers of Medicaid-funded HHCS will be required to select and implement compliant EVV systems by January 1, 2023.

The agency's EVV is used to:

- Verify visits on a real-time basis, including date, location, type of service,
- individual(s) providing and receiving services, and duration of service(s)
- Validate hours of work for home health employees.
- Eliminate billing data entry mistakes
- Reduce costs related to paper billing and payroll
- Help combat fraud, waste, and abuse.

M. RECEIVING BUSINESS COURTESIES FROM VENDORS

It is the policy of the Agency that its employees are not to solicit gifts of any kind or amount and are not to accept gifts other than those having strictly nominal value. As a general rule, all payments, benefits, or gifts provided to any member of the Agency's staff or their family members by a vendor must be reported to the Compliance Officer.

N. ACCURATE BOOKS AND ACCOUNTS

All of the Agency's payments and other transactions must be properly authorized by management and be accurately and completely recorded on the Agency's books and records in accordance with generally accepted accounting principles and established corporate accounting policies. No false, incomplete or unrecorded corporate entries shall be made. No undisclosed or unrecorded corporate funds shall be established for any purpose, nor shall the Agency's funds be placed in any personal or non-corporate account.

It is the responsibility of the agency to exercise caution in all claims submitted for payment. Medicaid billing will be reviewed periodically for any possible situation of overpayment. If there is a repayment to be made, the agency will follow regulatory guidance documents, give notice of overpayment and make a timely repayment.

O. SAFEGUARDING THE AGENCY'S RESTRICTED INFORMATION

It is the Agency's policy to control closely the dissemination of the Agency's proprietary information. Except as specifically authorized by management pursuant to established policy and procedure, do not disclose to any outside party any non-public business, financial, personal commercial or technological information, plans or data acquired during employment at the Agency. During the term of employment at the Agency, an employee should disseminate these types of information only after checking with the Compliance Officer and should protect these types of information from access by unauthorized personnel. Upon termination of employment, an individual may not copy, take, or retain any documents containing the Agency's restricted information.

The prohibition against disclosing the Agency's restricted information extends beyond the period of employment as long as the information is not in the public domain. An individual's agreement to continue to protect the confidentiality of such information after the term of employment ends is considered an important part of that person's obligations to the Agency. The agency will conform to HIPAA.

P. COMPLIANCE WITH ALL LAWS AND REGULATIONS

All of the Agency's employees must perform their duties in good faith and to the best of their abilities and must scrupulously comply with all federal, state and local laws and government regulations related to the Agency's business and must immediately and directly report to the Agency's Compliance Officer any actual or perceived violation of this Code of Conduct, the Compliance Program or any other Agency policy. The Agency further expects all employees to comply with all certification rules, licensure laws and regulations

1. Healthcare Worker Bonus

As part of the Fiscal Year 2022-23 Budget, Governor Kathy Hochul announced the launch of the Health Care and Mental Hygiene Worker Bonus (HWB) Program, which allocated $1.3 billion for the payment of recruitment and retention bonuses to certain health care and mental hygiene workers. OMIG staff, in consultation with DOH through a dedicated work group, developed processes to ensure that these bonuses are appropriately distributed.

Beginning in 2023, OMIG began managing the New York State hotline and dedicated email box for inquiries and complaints related to the HWB program. OMIG communicates with employees and employers to ensure all information is available so a complete review of HWB claims and payments can be conducted. The final vesting period for the HWB ends on March 31, 2024.

Q. COMPLIANCE WITH ALL AGENCY POLICIES AND PROCEDURES

All of the Agency's employees must also scrupulously comply with all Agency

policies and procedures. It is management's responsibility not only to keep apprised of whether Agency policies and procedures are being followed, but also to determine whether employees or agents are complying with the Code of Conduct and Compliance Program. Any employee is required to report any known or suspected violations of the Code of Conduct and Compliance Program to the Corporate Compliance Officer. Failure to do so will result in disciplinary action.

R. COMPLIANCE WITH THE AGENCY'S PATIENTS' RIGHTS STATEMENTS

All of the Agency's employees must comply with all standards set forth in the Agency's Patients' Rights Statements. Agency employees must also comply with all policies governing patient care.

The Agency reserves the right to amend the Code of Conduct, in whole or in part, at any time and solely at its discretion.