Code of Conduct

This Code of Conduct sets forth the standards of conduct that all Affected Individuals must adhere to and follow.

I. CODE OF CONDUCT: COMMITMENT TO COMPLIANCE

- The Agency's goal is to provide comprehensive at-home services to enhance our clients and their families' lives. We strive to be home health care leaders in the communities that we serve and will continue to do so by being focused on quality, service, and technology.
- The Agency strives to provide high quality services to our clients without regard to age, race, color, sexual orientation, marital status, religion, sex, or national origin. We have a commitment to conduct our business in compliance with all applicable laws, rules and regulations and in accordance with ethical principles. The Agency expects the same from all Affected Individuals. We do not and will not tolerate any form of unlawful or unethical behavior by anyone associated with the Agency. We will follow the letter and spirit of applicable laws, rules and regulations, conduct our business ethically and honestly, and act in a manner that enhances our standing in the community.

II. CODE OF CONDUCT: SCOPE OF APPLICATION TO AFFECTED INDIVIDUALS

- The Compliance Program - and specifically this Code of Conduct - applies to all Affected Individuals. The term Affected Individuals is defined in this Compliance Manual.
- All Affected Individuals have a responsibility to help create and maintain a work environment in which compliance concerns may be openly raised, and promptly reviewed, discussed and addressed.

III. CODE OF CONDUCT: STANDARDS

☐ General Standards

- You must be honest and lawful in all of your business dealings and avoid doing anything that could create even the appearance of impropriety.
- You must: comply with the Code of Conduct; refuse to participate in any action you think may be possibly unethical, illegal or in violation of the Code of Conduct, a Compliance Policy and Procedure or the Compliance Program; report compliance issues and any unethical or illegal conduct to the Compliance Officer; cooperate with compliance inquiries and investigations; and work to correct any improper practices that are identified. The Agency expects and requires your good faith participation in the Compliance Program.
- Acts of retaliation or intimidation for good faith reporting of any suspected violation of, or for other good faith participation in, the Compliance Program will not be tolerated and are themselves a violation of the Compliance Program. ***For more information,*** see the

Non-Retaliation, Non-Intimidation for Good Faith Participation in the Compliance Program Policy.

☐ **Standards Related to Quality of Care/Credentialing/Medical Necessity**

- You are required to protect and promote the rights of all patients, including but not limited to, the right to participate in all decisions about their own care and treatment.

- You must ensure that patient care conforms to acceptable clinical and safety standards.

- All personal care and home care services provided to our patients are furnished by Personnel who have been appropriately trained and are qualified to furnish such services. Documentation of such qualifications (e.g., certificate of completion from a State Department of Health approved training program) will be maintained. The Agency will take steps on a regular basis to monitor and ensure such compliance.

- The Agency also appropriately accesses the Home Care Worker's Registry information prior to the worker beginning to provide home care services on the Agency's behalf. The Agency also conducts criminal history record checks pursuant to federal and state law on Personnel involved in providing care.

- In addition to the general credentialing process, the Agency will confirm the identity and determine the exclusion status of all Affected Individuals. In doing so, we will review the following State and Federal databases at least every thirty (30) days: (a) the OMIG Exclusion List; (b) the U.S Department of Health and Human Services Office of Inspector General's (the "OIG") List of Excluded Individuals and Entities (c) the General Services Administration's System for Award Management. Our Contractors are also required to comply with these requirements. The results of such checks will be promptly shared with the Compliance Officer and other appropriate compliance personnel. For more information, see our Compliance Reviews for Excluded or Ineligible Individuals/Entities Policy.

- If you have been found to have violated the law or receive notification of exclusion from Medicare, Medicaid or any Federal health care program, you must report such information, in writing, to the Compliance Officer within two (2) business days. Upon receipt of any conviction or exclusion report, Compliance Counsel, the Compliance Officer, and the Director of Human Resources will assess whether your conviction or exclusion violates the Compliance Program.

- The Agency has strict standards in place regarding quality of care. The Quality Assurance Director will be responsible for overseeing quality of care issues. The Agency has established processes by which quality assurance reviews are conducted, issues are addressed, and corrective actions are implemented. In addition, the Agency has established protocols for reviewing complaints from patients and third parties and addressing issues which may arise.

- The Agency is committed to protecting and promoting the rights of all patients, including, but not limited to, patients' rights to respect, privacy, to participate in the planning of their own care and to submit complaints about care and services. The Agency will provide all patients with written notice of their rights prior to the initiation of care.

- Health care services will only be provided after a determination has been made by a registered nurse (or by an individual directly supervised by a registered nurse) indicating that the patient's health and safety needs can be met safely and adequately at home by the Agency.

- Home Care services will be provided consistent with the services ordered by a physician and authorized by the Managed Long Term Care ("MLTC") Plan (as applicable) for the patient.

- Personal care and home health aide services will be furnished under the appropriate supervision of a registered nurse, licensed practical nurse or professional therapist (if the aide carries out simple procedures as an extension of physical therapy, occupational therapy or speech language pathology) and documentation evidencing such supervision will be maintained. The required frequency of nursing supervision visits should be stated in the Plan of Care. The individual responsible for supervising the aide is required to prepare patient-specific written instructions for the aide based on the patient's assessed individualized needs.

- The Agency will only provide rehabilitative services, such as physical therapy, occupational therapy, and speech language pathology, pursuant to a written care plan and a physician order. Orders must include the specific procedures and modalities to be used and the amount, frequency and duration of such services. Services must be reasonable and necessary for treatment of the patient, based on the patient's actual clinical condition. The provision of these services, including session length, will be accurately documented.

- The Agency will only submit claims for payment to payers for services that are medically necessary or that otherwise constitute a covered service and are consistent with the payer's applicable policies and requirements.

☐ **Standards Related to Coding, Billing and Documenting Services**

- The Agency will comply with the coding, billing, documentation and submission rules and requirements of all of its payers, including government payers such as Medicare and Medicaid, and commercial payers, as well as all applicable Federal and State laws, rules and regulations governing the coding, billing, documentation and submission of claims. ***For more information,*** see our Billing, Coding and Documentation Policy.

- The Agency is committed to preparing accurate claims, consistent with such requirements. All coding, billing and documentation of services must be accurate and truthful.

- Specifically, among other rules, we follow 18 NYCRR § 521-1.3(d):

- **Risk areas.** The compliance program shall apply to the required provider's risk areas, which are those areas of operation affected by the compliance program and shall apply to: (1) billings; (2) payments; (3) ordered services; (4) medical necessity; (5) quality of care; (6) governance; (7) mandatory reporting; (8) credentialing; (9) contractor, subcontractor, agent or independent contract oversight; (10) other risk areas that are or should reasonably be identified by the provider through its organizational experience.

- You may never misrepresent charges or services to or on behalf of the government, a patient or a payer. False statements, intentional omissions or deliberate and reckless misstatements to government agencies, payers or others will expose those involved to disciplinary action. As but one example, no Affected Individual will knowingly engage in any form of upcoding of any service in violation of any law, rule, regulation or requirement. Among other things, any Affected Individual involved in such activities is subject to potential termination of employment or contract, and potential criminal and civil liability.

- Billing codes - including CPT, HCPCS and ICD diagnostic codes - should never be selected on the basis of whether the given code guarantees or enhances payment. Rather, only those codes that correspond to the actual service rendered and documented should be selected.

- Only those services that are consistent with accepted standards of care may be billed. In this regard, billing and coding must always be based on adequate documentation of the justification for the service provided and for the bill submitted, and this documentation must comply with all applicable requirements.

- We also comply with all associated and applicable Federal and State laws, rules and regulations that relate to the coding, billing and documentation of services including, but not limited to those concerning: the ordering of services; waiving coinsurance or other patient financial responsibility amounts; providing professional courtesy to physicians or their families; obtaining Advance Beneficiary Notices from Medicare patients for non-covered services; and gathering insurance information from patients.

- In accordance with **Federal and New York State law**,[1] the Agency provides to all Affected Individuals a detailed description of: (i) the Federal False Claims Act; (ii) the Federal Program Fraud Civil Remedies Act; (iii) State civil and criminal laws pertaining to false claims; and (iv) the whistleblower protections afforded under such laws. The Agency also provides Affected Individuals with detailed provisions regarding our policies and procedures for detecting and preventing fraud, waste, and abuse. The employee handbook also includes specific discussion of the laws described above, the rights of employees to be protected as whistleblowers, and the Agency's policies and procedures for detecting and preventing fraud, waste and abuse.

[1] See 42 USC § 1396a(a)(68); 18 NYCRR § 521-1.4(2)(ix).

- The Agency does not retain any payments to which it is not entitled. The Agency will timely report, return and explain any identified overpayments in accordance with applicable law, rules, regulations and requirements. ***For more information,*** see "Mandatory and Other Reporting" below; and

  For more information, see the Billing, Coding and Documentation Policy; the Waiving/Reducing Coinsurance, Copayment and Deductible Amounts Policy; the Compliance with Anti-Referral Laws Policy; and the Compliance with Federal and State False Claims Laws (Overview of the Laws Regarding False Claims and Whistleblower Protections/Policy.

- Although the Agency does not directly submit claims to Federal health care programs, the services we provide pursuant to contracts with certified home health agencies are submitted for such payment. Those claims are based on our documentation of services and our compliance with applicable law and regulations. All Personnel providing services through the Agency must do so in accordance with regulatory standards as to quality of care, frequency of care and level of care. Additionally, such Personnel must be qualified to provide the service and receive adequate supervision.

- Although the Agency's documentation of service may be submitted to an outside company to perform the billing function, the Agency remains responsible for the accuracy of all claims submitted to private and government payers. The Agency will ensure that the billing company has implemented its own Compliance Program and, among other things, performs regular audits of claims submitted on the Agency's behalf. If any claims submitted are found to have been improper, the Agency will work with the billing company to resolve the issue(s) and refund any overpayments received or take other corrective action, as necessary and appropriate.

- Documentation of patient care must be accurate and truthful, with no misrepresentations regarding services provided. If the entity responsible for submitting claims has any question as to the accuracy of the documentation of services provided or if the medical record is unclear, the Agency Personnel must cooperate with any request for clarification or additional information.

- Personnel must take the necessary steps to prevent the submission of claims for payment and reimbursement that are fraudulent, abusive, and inaccurate or for medically unnecessary services. The following practices are prohibited:

  1. Falsifying the amount of time spent providing care to a patient;

  2. Failing to provide services as required by the plan of care/medical orders;

  3. Falsely or inaccurately documenting services in the progress notes or plan of care;

  4. Providing misleading information about a patient's medical condition;

  5. Failing to meet the standard of supervision required;

6. Forging a health care professional's or patient's signature on documents.

   Personnel involved in such activities are subject to termination of employment or contract, and potential criminal and civil liability.

- The Agency will comply with all Federal and State laws relating to matters including, but not limited to: obtaining Advance Beneficiary Notices from Medicare patients for non-covered services; gathering insurance information from patients; and the retention of billing and medical records.

☐ **Standards Relating to Business Practices**

- All business records must be accurate, truthful and complete, with no material omissions.

- The Agency will forego any business transaction or opportunity that can only be obtained by improper or illegal means and will not make any unethical or illegal payments to induce or reward the use of our services.

- No Affected Individuals will engage, either directly or indirectly, in any corrupt business practices intended to influence the manner in which the Agency performs services, or otherwise engages in business practices.

- 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. Sufficient and competent evidential matter or documentation shall support all cost reports.

- The Agency will not engage in anti-competitive conduct that could produce an unreasonable restraint of trade of a substantial lessening of competition. 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.

  For more information, see the Billing, Coding and Documentation Policy; the Compliance with Anti-Referral Laws Policy; the Compliance with Federal and State False Claims Laws (Overview of the Laws Regarding False Claims and Whistleblower Protections/Policy; the Gifts and Benefits Policy; and the Conflict of Interest Policy.

☐ **Standards Relating to Record Retention and Access to Records**

- The Agency will comply with all applicable laws, rules, regulations and requirements relating to the retention of billing and medical records.

- The Agency will make available to the New York State Department of Health ("DOH"), the OMIG and the MFCU, upon request, all records demonstrating that we have adopted, implemented and operate an effective compliance program and have satisfied the requirements of 18 NYCRR Subpart 521. Such records will be retained by the Agency

for a period not less than six (6) years from the date the program was implemented, or any amendments thereto were made, in accordance with 18 NYCRR § 521-1.3(b), or for such longer period of time as may be required by applicable laws, rules, regulations or contractual requirement.

- In order to help ensure the effectiveness of the Compliance Program, the Compliance Officer and appropriate compliance personnel will have access to all records, documents, information, facilities and Affected Individuals that are relevant to carrying out their Compliance Program responsibilities.

☐ **Standards Relating to Conflicts of Interest**

- All members of the Covered Group must avoid any and all activities that conflict with their responsibilities and obligations to the Agency and its Patients.

  i. Members of the Covered Group must not have an interest in or serve as director, officer, manager, or member of an entity in competition with the Agency, without permission.

  ii. Any members of the Covered Group who performs work or renders service for any competitor of the Agency or for any organization which does business with or seeks to do business with the Agency outside the normal course of his or her employment or other engagement with the Agency must notify the Compliance Officer or the Administrator.

  iii. Engaging in business with any Agency vendor, supplier, contractor, or agency of any of their officers or employees that is not conducted on behalf of the Agency is prohibited, unless previously authorized by the Compliance Officer or the Administrator.

  iv. Staff members may not permit their names to be used in any fashion that would tend to indicate a business connection with any organization which does business with or seeks to do business with the Agency without the prior approval of the Compliance Officer or the Administrator.

  v. The Agency may not be represented by a member, manager, officer, director, or employee, contractor or agent in any transaction in which he or a relative has a personal or financial interest.

- In accordance with the Agency's Conflict of Interest and Related Party Transactions Policy, members of the Covered Group are required to disclose actual and potential conflicts of interest involving themselves or their relatives to the Compliance Officer using the Agency's "Conflict of Interest Disclosure Statement."

☐ **Patient Referrals/Marketing Activities**

- In general, Federal and State anti-kickback laws prohibit offering, paying, soliciting or receiving any remuneration to induce or reward referrals of items or services that are reimbursed by a Federal health care program (including, but not limited to, Medicare and Medicaid). This includes the giving of any form of remuneration, including virtually anything of value, in return for a referral. The decision to refer patients is a separate and independent clinical decision made by physicians or other appropriate licensed practitioners. In certain situations, there may be exceptions and/or "safe harbors" to the anti-kickback laws. The Agency does not offer, pay, solicit or receive remuneration to or from physicians, or anyone else, either directly or indirectly, for patient referrals, in violation of applicable laws, rules and/or regulations. ***For more information,*** see our Compliance with Anti-Referral Laws Policy; and our Compliance with Federal and State False Claims Laws (Overview of the Laws Regarding False Claims and Whistleblower Protections) Policy.

- All marketing activities and advertising by Affected Individuals must be truthful and not misleading, must be supported by evidence to substantiate any claims made and must otherwise be in accordance with applicable laws, rules and regulations. In this regard, our best "advertisement" is the quality of the services we provide. You should never disparage the service or business of a competitor through the use of false or misleading representations.

- You may not offer, pay, solicit or receive any gifts or benefits to or from any person or entity that would compromise the Agency's integrity (or even create an appearance that the Agency's integrity is compromised), or under circumstances where the gift or benefit is offered, paid, solicited or received with a purpose of inducing or rewarding referrals or other business between the parties, in violation of applicable laws, rules, regulations or requirements. The guiding principle is simple: Affected Individuals may not be involved with gifts or benefits that are undertaken to influence any business decision in a manner that violates the law. Cash or cash equivalents may not be given or accepted under any circumstances. ***For more information,*** see our Gifts and Benefits Policy; and our Compliance with Anti-Referral Laws Policy.

☐ **Mandatory and Other Reporting**

- As part of its commitment to providing high quality care and services, the Agency complies with all applicable Federal and State mandatory reporting laws, rules and regulations. To this end, the Agency will ensure that all incidents and events that are required to be reported are reported in a timely manner and will monitor compliance with such requirements. This includes required reporting to appropriate government agencies or parties.

- The Agency will also ensure its compliance with the requirement that, upon enrollment and annually thereafter, it certifies that it has met the requirements of New York Social Services Law (*i.e.*, N.Y. Social Services Law § 363-d and 18 NYCRR Subpart 521-1).

Further, the Agency will provide a copy of the certification required by 18 NYCRR § 521-1.3 to each Medicaid Managed Care Organization (including managed care providers and managed long term care plans) (collectively, "MMCO") for which it is a participating provider upon signing the participating provider agreement with the MMCO, and annually thereafter. As applicable, the Agency will also comply with other State and Federal certification requirements that are or may become applicable to it.

- The Agency will ensure that all identified overpayments are timely reported, returned and explained in accordance with applicable laws, rules, regulations and requirements. For example, it is our policy to exercise reasonable diligence in identifying overpayments, not to knowingly retain any funds which are received as a result of overpayments and to report, return and explain any overpayments received from Federal health care programs (including, for example, but not limited to, Medicare and Medicaid) within 60 days from the date the overpayment is identified (or within such time as is otherwise required by law or contract). Any such monies that are improperly collected will be refunded, in accordance with applicable laws, rules, regulations and requirements, to the appropriate party at the correct address. ***For more information,*** see our Protocols for Investigation and Implementing Corrective Action, Including Discipline Policy.

- Moreover, in appropriate circumstances (e.g., after an internal investigation confirms possible fraud, waste, abuse or inappropriate claims), the Agency will utilize the appropriate self-disclosure process and report, as necessary and appropriate, to the OMIG, OIG, the Centers for Medicare and Medicaid Services, or other appropriate payer/agency. In such circumstances, the Agency may consult with legal counsel or other experts, as needed. **For more information,** see our Protocols for Investigation and Implementing Corrective Action, Including Discipline Policy.

☐ **Standards Relating to Confidentiality and Security**

- In compliance with Federal and State privacy laws, all Affected Individuals will keep patient information confidential and secure.

- The posting of any Agency patient's information or picture to social media is strictly prohibited.

- The Agency has also implemented and maintains a HIPAA Compliance Program that addresses privacy and security. All Affected Individuals must adhere to the standards of the HIPAA Compliance Program.

- Confidential information acquired by Affected Individuals about the business of the Agency must also be held in confidence and not used for personal gain, either directly or indirectly, or in any manner that violates applicable laws, rules, regulations or requirements.

☐ **Government Inquiries**

- It is the Agency's policy to comply with applicable laws, rules, regulations and requirements, and to cooperate with legitimate government investigations or inquiries. All responses to requests for information must be accurate and complete and must not omit any material information. Any action by Affected Individuals to destroy, alter, or change any of the Agency's records in response to a request for such records is strictly prohibited and will subject them to immediate termination of employment or contract and possible criminal prosecution, among other things.

- You may speak voluntarily with government agents, and the Agency will not attempt to obstruct such communication. It is recommended, however, that you contact the Compliance Officer before speaking with any government agents.

- You must receive authorization from the Compliance Officer before responding to any request to disclose the Agency's documents to any outside party.

- It is the Agency's policy to comply with applicable laws, rules, regulations and requirements, and to cooperate with legitimate government investigations or inquiries. All responses to requests for information must be accurate and complete and must not omit any material information. Any action by Affected Individuals to destroy, alter, or change any of the Agency's records in response to a request for such records is strictly prohibited and will subject them to immediate termination of employment or contract and possible criminal prosecution, among other things.

- It also is our policy to comply with all lawful directives of the DOH, OMIG or other appropriate government agencies with respect to the adoption, implementation, and maintenance of our Compliance Programs pursuant to applicable laws, rules and regulations, including, but not necessarily limited to, 18 NYCRR Subpart 521-1.

  For more information, see our Responding to Government Inquires Policy.

☐ **Specific Compliance Provisions for Agreements with Contractors**

- It is the policy of the Agency to ensure that all contracts with our Contractors specify that the Contractor is subject to our Compliance Program, to the extent that the Contractor is affected by our risk areas (within the scope of the contracted authority and affected risk areas). We will follow OMIG's guidance regarding agreements in place prior to the effective date of OMIG's updated compliance regulations. ***For more information,*** see our Contractor Requirements Policy.

- In addition, such contracts will also include termination provisions for the failure to adhere to our Compliance Program requirements.