



Revival Home Health Care Corporate Compliance Program

Revival Home Health Care is committed to the prevention and detection of fraud, waste and abuse of federal and state resources and takes all appropriate action to assure compliance with all applicable laws and regulations and to promote honest and ethical behavior in all work-related activities. The Agency is committed to high standards of professionalism, conduct, honesty, and reliability in its business practices.

The Agency recognizes the importance of adhering to all rules of the federal and state agencies overseeing the use of Medicare and Medicaid resources, and follows all regulations and requirements established by the federal Office of the Inspector General and the NYS Office of the Medicaid Inspector General. In accordance, all Agency business affairs must be conducted in compliance with federal, state, and local laws and professional standards with honesty, fairness and integrity.

All staff are educated at the time of hire and on an annual basis to refrain from conduct which may violate federal and state fraud, waste, and abuse laws. These laws prohibit the submission of false, fraudulent or misleading claims to any government entity or third-party payer, including claims for services not rendered, claims which characterize the service differently than the service rendered or claims which do not otherwise comply with applicable program or contractual requirements.

The Agency's Code of Conduct provides guidance to ensure that the Agency promotes an environment of honest and responsible behavior. All personnel employed by or associated with Revival Home Health Care are required to adhere to the standards of conduct outlined in the code and to avoid any conduct that might reflect adversely upon the integrity or reputation of the Agency.

CODE OF CONDUCT

In general, all Agency business should be conducted with regard to:

Honesty. All personnel must be honest and truthful in all of their dealings, both within and outside of the Agency.

Lawful Conduct. All personnel must avoid doing anything that is, or might be, against the law. If personnel are unsure whether an action is lawful, then they should not do it until they have checked with their manager, director or the Compliance Officer.

Cooperation with the Compliance Program. All personnel must cooperate fully with all inquiries concerning possible compliance issues and actively work to correct any improper practices that are identified. This includes bringing compliance issues to the attention of Agency administration.

Respect: All personnel must show respect towards co-workers, management, patients and their families and other outside parties in the course of doing business. This includes respecting the rights and view of other and treating other with fairness, courtesy and good faith.



Professionalism: All personnel must conduct themselves in a professional manner encompassing professional appearance, behavior, punctuality and diligence to complete work assignments in an efficient, timely and accurate manner.

The following business practices and standards will be maintained by all personnel:

1. Standards Relating to Business Practices

General Business Practices. Revival will forego any business transactions or opportunities that can only be obtained by improper and illegal means and will not make any unethical or illegal payments to anyone to induce the use of our services.

- All business records must be accurate and truthful, with no material omissions.
- The assets and liabilities of the Agency must be accounted for properly in compliance with all tax and financial reporting requirements.
- All information submitted to governmental agencies, insurance carriers, or other entities will be accurate and honest.
- The institutional cost report will be prepared in compliance with all applicable state and federal regulations.

Payments and Gifts. No personnel or associated entity will make or offer to make any payment or provide any other item of value to another person with the understanding or intention that such payment is to be used for an unlawful or improper purpose. Nor may personnel accept any gifts, gratuities, loans, or other favors from any patient, client, vendor, contractor, individual or entity that does (or is seeking to do) business with, or is a competitor of Revival under circumstances from which it could be inferred that the personnel's action was for their own benefit, and not solely for the benefit of Revival.

- Cash gifts are strictly prohibited.
- Personnel may provide or receive social amenities or business courtesies of nominal value, consistent with good taste and mature judgment. Such gifts, however, cannot be given for the purpose of influencing the business behavior of the recipient.
- Gifts of even nominal value may not be offered to any governmental official.

Any questions regarding whether an item or situation falls within the scope of this section must be raised immediately with the Compliance Officer.

Purchasing and Competitive Bidding. All purchasing decisions must be made with the purpose of obtaining the highest quality product or service for Revival at the most reasonable price. No purchasing decision may be made based on considerations that any personnel, or family member or friend of personnel, will benefit.

Conflict of Interest. All personnel owe a duty of loyalty to Revival, and any potential conflict of interest must be disclosed to ensure that an appearance of impropriety is not created and that the integrity of our operations is not compromised. All personnel must, therefore, disclose to the Compliance Officer any financial interest they or a member of their family have in any enterprise that does business or competes with Revival in any manner.



Marketing and Patient Referrals. In marketing Revival services, personnel must be truthful and honest in all representations they make about the Agency and never agree to offer anything of value in return for referrals. Revival does not pay anyone, either directly or indirectly, for referrals; nor does the Agency accept any form of remuneration in return for referring to other health care providers, individuals who have been under our care.

Relationships with Physicians and Other Providers. Revival is committed to maintaining ethical relationships with physicians and other providers. The Agency will not in any way pay or offer other inducements to physicians or any other entities to refer patients to the Agency. All relationships with physicians (and with any other medical providers who have a referral relationship with Revival) will not be based on the volume or value of referrals of Medicare or Medicaid business between the parties. Nor will free services or items be accepted or provided in return for referrals.

Relationships with Patients: Revival will only accept patients to our services based on the reasonable expectation that the patient's health care needs can be met in the patient's home by the services the Agency provides. Once patients are accepted, care will be provided under the direction of the patient's physician or other permitted non-physician practitioner. A proper discharge plan will be formulated considering patient's long-term needs. Abandonment of the patient is prohibited.

Grants. The receipt and use of all grant money at Revival must be pre-approved by appropriate senior management. The receipt, or continued receipt, of grant money must occur under conditions which do not create an appearance that the judgment of Agency personnel will be adversely affected, so as to place their own interest, or that of an outside concern, above that of Revival and its patients. Grant money should not be accepted in return for the promise or expectation that Revival or any of its staff will obtain specific services or supplies from a particular company.

Requests for Information. While staff may speak voluntarily with government agents, it is recommended that, before doing so, they contact their managers, directors and the Compliance Officer first. In no event, however, may any personnel respond to a request to disclose Agency documents without first speaking with their manager and the Quality Management/Compliance Department. If it is appropriate to give a response to a request for information, the response given must be accurate and complete. Revival personnel are not to destroy, alter or change any Agency records in response to a request for such records.

Confidential Information. All personnel will keep patient information in the strictest of confidence and will abide by Revival's HIPAA Compliance Program. Disclosure of PHI may only be provided according to applicable Revival policy and procedures governing patient confidentiality. Personnel may not disclose or release without the prior authorization of the appropriate administrator any confidential information relating to Agency operations, pending or contemplated business transactions, payroll and other personnel records. All confidential information pertaining to the Agency is to be used for the benefit of the Agency and its patients and is not to be used for personal benefit.

Credit Balances/Overpayments. On a regular basis, Revival will generate reports of the status of any credit balances or refunds owing to Medicare, Medicaid and other third-party payors. Such refunds will then be given to the appropriate payor in a timely manner.

2. Standards Relating To Billing, Coding, and Providing Services

Billing: All federal and state regulations governing billing procedures will be meticulously followed for all services billed by the Agency.

- All billing documents must be accurate and truthful. This includes visit documentation maintained in the patient's clinical record.
- Personnel should never misrepresent charges to, or on behalf of, a patient or third-party payor. Deliberate or reckless misstatements to government agencies or other payors will expose the employee involved to termination and criminal penalties.
- Only those services provided to patients that are consistent with acceptable standards of care may be billed.
- Billing procedures must always be based on accurate documentation of the service provided and for the bill submitted, in compliance with all applicable regulations including procurement of signed practitioner's orders.

Coding: All coding must be based upon the appropriate documentation in the clinical record and upon the appropriate and most current coding guidelines.

- No "defaults" to a particular billing code can ever be used. Billing codes should never be selected on the basis of whether the given code enhances payment. Only those codes that correspond to the service rendered and documented should be selected.
- All coding personnel will be fully trained in how to read, review and appropriately code clinical records. Coders will also be informed of all updates and modifications to the home health coding conventions and all other relevant coding guidelines.

Other Billing Practices:

- **Coinsurance.** Revival will not waive coinsurance unless the patient has an actual and appropriately documented financial need.
- **Patient Liability.** The Agency must follow Medicare rules regarding the appropriateness of services and complete Advance Beneficiary Notices (ABN) when Medicare is likely to find a service to be non-covered under its standards and thus not reimbursable, making the patient personally liable for payment through either another payer or personally. ABNs may not be given out to patients on a routine basis but only provided when appropriate.

3. Scope and Application of Standards to Personnel and Others

Personnel Covered. The standards set forth in this Code of Conduct apply to all employees, the Agency's administration, the Board of Directors and others associated with Revival.

Contractors. To the extent practicable, all persons and entities with which Revival contracts will be asked to cooperate with the Agency's Compliance Program.

Directors, Supervisors and Managers. All directors, supervisors and managers have the responsibility to help create and maintain a work environment in which ethical concerns can be raised and openly discussed. They are also responsible to ensure that



the personnel they supervise understand the importance of this Code of Conduct and the Compliance Program.

Departmental Compliance Protocols. In addition to the Code of Conduct and Compliance Procedures set forth in this Summary and the Agency's Policy and Procedure manual, departments within the Agency may have department-specific compliance procedures and practices. These additional procedures and practices are an integral part of the Compliance Program and are designed to complement the procedures and standards set forth in the Policy and Procedure manual.

Responsibility of All Employees. Each employee has a significant role in maintaining the integrity of the Agency. All employees are expected to comply and be familiar with all federal and state laws, rules, and regulations that govern their job within the Agency. All employees are also expected to comply with the standards set forth in this Code of Conduct and with any applicable departmental compliance protocols. Strict compliance with these legal and compliance standards is a condition of employment, and violation of any of these standards of conduct will result in disciplinary action. Agency assets, including company time, materials, supplies, equipment and information are to be used only for Agency goals and purposes. Observations of any compliance issues or improper use of Agency resources should be reported to the supervisor, director or Compliance Officer. Retaliation against such disclosures is strictly prohibited

Responsibility of the Organization to Employees. Revival is committed to providing effective orientation and on-going education to all employees. The Agency is committed to providing a fair and equal opportunity work environment in compliance with Federal, State and local laws. Harassment or discrimination will not be tolerated, and any known or suspected harassment or discrimination should be reported to the Director of Human Resources, to the Compliance Officer and/or appropriate supervisor or director immediately.

Revival has developed effective lines of communication between the Chief Compliance Officer and the organization's employees, contractors, agents, directors, and patients to support the reporting of potential misconduct. These lines of communication are confidential, easily accessible, and include in-person, telephone, email, hotline, and online reporting. Any Revival employee, patient, contractor, or agent who has concerns or questions about unethical practices, improper employee conduct, fraud or other illegal activities must report these concerns.

Anyone who has questions about compliance standards or who suspects that any person associated with this Agency has engaged in any fraud or other questionable activity can anonymously report it by calling the Agency's Compliance Hotline at 718-663-4911 or by calling the Agency's Compliance Officer directly at 718-629-1000.



COMPLIANCE PROGRAM POLICIES AND PROCEDURES

The following Policies and Procedures Provide additional information regarding the Agency's Corporate Compliance Program:

CORPORATE COMPLIANCE POLICY

PURPOSE:

The purpose of the Compliance Plan is to establish guidelines and procedures to ensure that the Agency engages in lawful and ethical practices that comply with all federal and state laws and regulations; and to make a sincere effort to prevent, detect, and correct any fraud, abuse, or waste.

POLICY:

Revival Home Health Care is committed to the prevention and detection of fraud, abuse, and waste of federal and state resources and to taking all appropriate action to assure compliance with all legal and regulatory statutes and to promote honest and ethical behavior in all work-related activities. The Agency is committed to high standards of conduct, honesty, and reliability in its business practices.

The Ownership and Administration of the Agency recognize the seriousness of the issues raised by federal and state agencies overseeing the use of Medicare and Medicaid resources namely the federal Office of the Inspector General (OIG) and the NYS Office of the Medicaid Inspector General (OMIG) and recognize that failure to comply with applicable laws and regulations could threaten the Agency's continuing participation in these health care programs.

The Plan applies to all employees. "Employees" mean the administrators, directors, managers, supervisors, field staff and any other persons or individuals hired by and in the paid service of the Agency including employees of contracted vendors.

PROCEDURE:

A. STANDARDS OF COMPLIANCE

All of the Agency's business affairs must be conducted in accordance with federal, state, and local laws, professional standards, applicable federally and state funded health care program regulations and policies 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, the following practices or standards have been adopted by the Agency.

1. **CODE OF CONDUCT.** Upon hire, every employee is given the Agency's Code of Conduct. The Employee Handbook is also given and includes a summary of the Code and the Compliance Program. Specifically, employees are made aware of unacceptable conduct that includes:
 - Intentionally or knowingly making false or erroneous entries on reports, patient charts or other records.



- Dishonesty.
- Unauthorized alteration of records
- Coding or billing which violates Medicare or Medicaid rules or regulations or other federal or state rules or regulations.
- Behavior detrimental to the operation of Revival Home Health Care

Both acceptable and unacceptable conduct may be found in the Code of Conduct (see Addendum 4-022-A) and the Employee Handbook.

- 2. CONFLICT OF INTEREST.** To perform their duties with honesty and fairness and in the best interest of the Agency, 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 Revival 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 company and from using company 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 Compliance Officer, Director of Human Resources, or the employee's manager.

- 3. FRAUD, WASTE AND ABUSE.** Employees must refrain from conduct, which may violate federal and state fraud, waste, 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 payer, including claims for services not rendered, claims which characterize the service differently than the service actually rendered or claims which do not otherwise comply with applicable program or contractual requirements; 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.
- 4. BUSINESS ETHICS.** Employees must accurately and honestly represent Revival Home Health Care and should not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.
- 5. 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, but it may also be in violation of applicable laws. Sufficient and competent evidential matter or documentation shall support all cost reports.
- 6. 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.

- 7. ADDITIONAL STANDARDS.** Revival Home Health Care has adopted a number of other policies and procedures. Additional standards and policies may be applicable only to particular departments and copies may be obtained from the Director of Quality Management, the Corporate Compliance Officer, and from the managers and directors in those departments. It is particularly important that coding, billing, and submission of claims to Medicare, Medicaid, and other third-party payers be appropriate, accurate and in compliance with applicable laws and regulations. Standards relating to billing will be found in a later section of this document.

8. ADMINISTRATION AND APPLICATION OF STANDARDS

These Standards apply to *all* employees, including supervisors, managers, directors, and administrators. They also apply to temporary and contracted employees, as well as independent contractors doing business with the Agency.

These Standards are not intended to cover every situation which may be encountered, and employees should comply with all applicable laws and regulations whether specifically addressed in these Standards or the Code of Conduct. Questions about the existence, interpretation or application of any law, regulation, policy, or standard should be directed, without hesitation, to the Compliance Officer.

Because laws, regulations and policies are constantly evolving, this Compliance Program will be revised and updated as needed. Substantial revisions will be communicated timely to Agency employees through an administrative notification process.

Failure to comply with the Standards in the Compliance Program and Code of Conduct or failure to conduct business in an honest, ethical, reliable manner can result in civil fines or criminal penalties against the Agency and its employees or disciplinary action by the Agency, including termination. Compliance with the Standards of the Compliance Program will be a factor in evaluating the performance of Agency employees.

B. RISK AREAS

- 1. BILLING PRACTICES.** Generally, federal and state laws and regulations provide civil and criminal penalties for individuals and institutions that submit claims for services which were: (1) not provided; (2) billed in a manner other than as actually provided; (3) not medically necessary; or (4) billed in a manner that did not comply with applicable government requirements. This applies to the intentional submission of such claims but may also be levied for unintentional false claims. Lack of knowledge is not necessarily a valid excuse.

Home Health Aide service claims are particularly vulnerable. As required by NYS Medicaid participation, the Agency must contract with a NYS approved Verification Organization (VO) when annual Medicaid revenue exceeds \$15 million. The VO identifies erroneous HHA billing through a daily "Conflict" report and other available reports.

2. **NON-COVERED SERVICES.** Some services are not covered under Medicare and claims for payment should not be submitted. Services would not be covered when:
 - Face to Face Physician Encounter 90 days prior to or 30 days after home care admission has not been documented.
 - Services are medically unnecessary. That is, items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve function or which are not medically necessary for the health of the patient
 - Services are provided to patients who are not homebound.
 - Services provided are not skilled according to Medicare criteria.

When a Medicare patient requests that a known non-covered service be billed, an Advanced Beneficiary Notice should be obtained from the patient explaining that the service is not covered and will be the patient's responsibility. The patient may request that a claim be submitted to Medicare to get an official determination or request that claims be submitted to another payer source.

3. **KICKBACKS.** Federal law prohibits the Agency from paying a physician or anyone else for the referral of a patient for services which might be covered by Medicare or Medicaid or any other payor.
4. **ACCURATE BILLS/RECORDS.** Bills to Medicare, and other federally funded health care programs such as Medicaid, as well as to other payers, must be true, accurate and complete and for services believed to be necessary, and that were ordered by a physician (or an authorized non-physician practitioner). Provision of all services should be documented timely, correctly, and accurately according to Agency and industry standards and regulatory requirements. Patient records and other documentation which support the bills must 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.
5. **CODING OF CLAIMS AND RECORDS.** Training, education, and documents necessary for accurate code assignment is and will continue to be made available to employees involved in coding. Clinical Reimbursement Specialists, Billing Department coders and billing and coding consultants will not be provided any financial incentive to improperly up code claims or otherwise improperly increase the Agency's revenue.

C. COMPLIANCE OFFICER AND COMPLIANCE COMMITTEE

1. **COMPLIANCE OFFICER.** The Governing Authority shall appoint a high-level employee as Compliance Officer.
 - a. The Compliance Committee shall prepare, and revise as necessary, a job description for the Compliance Officer. The Compliance Officer's primary responsibilities set out in the job description shall include:

- Overseeing and monitoring the implementation of the Compliance Program.
 - Reporting on a regular basis to the Governing Authority/Owner, the Administrator, and the Compliance Committee on the progress of implementation, and assisting the Governing Authority, the Administrator and the Committee in establishing methods to improve the company's efficiency and quality of services, and to reduce the company's vulnerability to fraud, waste and abuse.
 - Periodically revising the Compliance Program as required by changes in the law and policies and procedures of government and private payer health plans.
 - 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 employees are knowledgeable of, and comply with, pertinent federal and state standards as appropriate to their position.
 - Ensuring that independent contractors and agents who furnish health care services to the Agency are aware of the requirements of the company's Compliance Program with respect to coding, billing and marketing, among other things.
 - Coordinating personnel issues with the Director of Human Resources to ensure that the National Practitioner Data Bank and Cumulative Sanction Report have been checked with respect to all employees, medical staff, and independent contractors.
 - Assisting in coordinating internal compliance review and monitoring activities, including annual or periodic reviews of departments and audits.
 - 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; and
 - Developing policies and programs that encourage management and employees to report suspected fraud and other improprieties without fear of retaliation.
- b. The Compliance Officer shall have direct access to the Administrator who is a member of the Governing Authority. The 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 Compliance Officer may seek the advice of legal counsel and with the consent of the Compliance Committee may retain necessary consultants or experts.

- c. The Compliance Officer shall report to the Governing Authority/~~Owner~~ at least annually on the status of compliance in the company. Such reports may be written or oral.
2. **COMPLIANCE COMMITTEE CHARTER.** The Compliance Committee will include representatives from Billing/Finance, Human Resources, Information Technology, Business Operations, Clinical and Paraprofessional Services, and Quality Management. The Chairperson of the Compliance Committee shall be the Corporate Compliance Officer. The Committee will meet quarterly.

The duties of the Compliance Committee shall include:

- Advising the Compliance Officer and assisting in the implementation and maintenance of the Compliance Program.
- Working with appropriate Agency departments to develop up to date standards of conduct and policies and procedures to promote adherence to the Compliance Program.
- Recommending and monitoring, in conjunction with the relevant departments, the development of internal systems and controls to carry out the company's standards, policies and procedures.
- Determining the appropriate strategy and/or approach to promote adherence to the Compliance Program and the detection of potential violations.
- Developing a system to solicit, evaluate and respond to complaints and problems.
- Overseeing the education and training of employees and systems for communication with and by employees.
- Analyzing the legal requirements with which the company must comply and locating and analyzing specific risk areas within the organization.
- Establishing confidentiality standards and requirements for committee members and those persons requested to provide assistance to the committee.
- Advocating for the allocation of sufficient funding, resources and staff for the compliance officer to fully perform their responsibilities.
- Advocating for adoption and implementation of required modifications to the compliance program.
- Reviewing and updating this Compliance Committee Charter at least annually.

D. TRAINING AND EDUCATION

It is imperative that coding and billing of federal and state health care claims be truthful and accurate and within appropriate guidelines. Not only are severe penalties possible but honesty and integrity in health care operations are right and proper. Sometimes, however, conduct undertaken without wrongful intent but with inadequate knowledge may lead to violation of applicable laws and regulations. Proper and continuing training and education of employees at all levels is, therefore, a significant element of an effective compliance program.

1. **Initial Education.** Mandatory new employee orientation and the Employee Handbook given at the time of hire will provide an overview of fraud and abuse laws, the Code of Conduct, an explanation of the elements of the Compliance Program, including the complaint or reporting process. The Agency's commitment to integrity in its business operations and compliance with applicable laws and regulations is emphasized.

- 2. Ongoing Education.** On an annual basis, and more frequently as necessary, appropriate employees, including the administrator who is a member of the governing authority, will be retrained (1) in the Compliance Program; (2) in fraud and abuse laws as they relate to the claim development and submission process and Revival Home Health Care business relationships; (3) relevant Medicare and other federal and state requirements; and (4) the consequences both to the company and 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.

Annual training may be incorporated into the Annual Mandatory In-service Program.

- 3. Departmental Specific Training and Education.** Each department director or manager shall periodically identify and advise the Compliance Officer of training and education necessary or advisable for all or any employees in their department. The Compliance Officer and the director or manager shall promptly arrange for such training and education.
- 4. Training Venues.** Training and education may occur in sessions with individual employees, 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, online training, question and answer sessions and written material.
- 5. Training Content and Intensity.** All employees need not have the identical amount of training and education, nor will the focus of training and educational efforts be the same for all employees. All employees will, however, receive the core training at the time of hire and once annually.

Targeted training and education may be provided to employees 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 Revival Home Health Care or the Office of the Inspector General (OIG) or the Office of the Medicaid Inspector General (OMIG), Revival Home Health Care's compliance experience and the results of periodic audits or monitoring.

- 6. Documentation of Training.** The training provided to each employee shall be documented. The documentation shall include the date and a brief description of the subject matter of the training activity or program.
- 7. Evaluation of the Effectiveness of the Training Program.** Periodic evaluations of training and education programs should occur to determine, and if necessary, improve the value, effectiveness, and appropriateness of any such program.

E. COMMUNICATION OF COMPLIANCE MATTERS

1. Open communication between employees, contractors, patients and their representative, and the Compliance Officer or the Compliance Committee is important to the success of the Agency's Compliance Program and to the reduction of any potential for fraud, waste, and abuse. Without help from employees and others it may be difficult to learn of possible compliance problems and make necessary corrections.

2. At any time, any employee, contractor, patient/representative may seek clarification or advice from the Compliance Officer in the event of any confusion or question with regard to this Program, any element of the Program or any Agency policy or procedure related to Compliance. Questions and answers, if appropriate, will be shared with others for informational and educational purposes. Employees and others mentioned are encouraged to contact the Compliance Officer or any member of the Compliance Committee. For this purpose, the Compliance Officer's name, location, and contact information will be provided to all employees, contractors and patients/representatives. The names of members of the Committee and their location and email address will be made known by the Compliance Officer if requested.
3. **Reporting.** Anyone working with the Agency who becomes aware of or suspects acts of fraud, abuse or waste or violations of the Compliance Standards, Code of Conduct or applicable law or regulations should report such acts or violations. Several independent reporting paths are available:
 - Employees may, but are not required to, report to their department director, manager, or supervisor. Supervisors and managers will promptly pass on the report to the Compliance Officer.
 - Reporting directly to the Compliance Officer.
 - The Agency operates a 24-hour, 365 day per year telephone reporting system known as the "Corporate Compliance Hotline". This hotline may be used anonymously at any time, day, or night. The phone number of the Hotline has been posted on the Agency's website, provided to patients in the Agency's admission information packet, provided to employees during orientation and appears on the back of the employee's ID Card with a statement regarding their duty to report actual or suspected wrongdoing.
 - Exit interviews of resigning employees may be utilized as another means to identify compliance problems.
4. **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 must be revealed if governmental authorities become involved or in response to a subpoena or other legal proceeding.
5. **Non-Retaliation/Non-Intimidation.** There will be no intimidation, reprisals or retaliation against any individual who in good faith reports acts or suspected acts of fraud, abuse or waste or violations or suspected violations of the Compliance Standards or Code of Conduct or other wrongdoing or misconduct. However, an employee who makes an intentional false report or a report not in good faith may be subject to disciplinary action. (See Policy 4-030 Non-Intimidation/Non-Retaliation).
6. **Documentation.** Reports that suggest substantial violation of this Program, violation of the Compliance Standards or Code of Conduct or violation of relevant law or regulation should be documented by the Compliance Officer. Information about such reports should be furnished periodically to the Administrator as a member of the Governing Authority and to the Compliance Committee at its regular meetings.

F. INVESTIGATION

1. **Requirement and Purpose.** Reasonable indications of fraud, abuse or waste, violations of the Compliance Standards, violations of the Code of Conduct, violations of Revival compliance policy or procedure or violations of applicable law or regulation will be promptly investigated. The purpose of the investigation shall be to (1) identify those situations involving fraud, abuse or waste or relevant violations or unacceptable conduct; (2) to identify individuals who may have knowingly or inadvertently caused or participated in such situations or may need further training and education; (3) to facilitate corrective action; and (4) to implement procedures necessary to ensure future compliance.
2. **Control of Investigation.** The Compliance Office shall be responsible for directing the investigation of the alleged situation or problem. In undertaking investigations, the Compliance Officer may utilize other employees (consistent with appropriate confidentiality), outside attorneys, outside accountants and auditors or other consultants or experts for assistance or advice.
3. **Process of Investigation.** Because of the many situations or problems which are possible, the process and method of investigation is left to the sound judgment and discretion of the Compliance Officer. However, the Compliance Officer or his or her designee, may conduct interviews with any Revival Home Health Care employee and with other persons and may review any document including but not limited to those related to claim development and submission process; patient records; e-mails; and the contents of computers.
4. **Documentation of an Investigation.** The Compliance Officer shall prepare a report which (1) defines the nature of the situation or problem; (2) summarizes the investigation findings; (3) identifies any person whom the investigator believes to have acted deliberately or with reckless disregard or intentional indifference, particularly toward Medicare/Medicaid laws, regulations, and policies; and (4) if possible, estimate the nature and extent of the resulting overpayment by the government.
5. **Response.**
 - All billing involved in the situation or problem will be discontinued until such time as appropriate corrections are made.
 - A summary of the results of the investigation shall be sent for appropriate disciplinary action to the department director or manager (or the appropriate administrator if the director or manager is implicated) of any employee whose conduct appears to have been intentional, willfully indifferent or with reckless disregard for Medicare/Medicaid or other applicable laws and regulations. Pending disciplinary action, any such employee may be removed from any position with oversight of or impact upon the claim's development and submission process, including field staff.
 - State and federal agencies will be notified as deemed appropriate by legal counsel, the Administration/Governing Authority. The Agency may attempt to negotiate a voluntary disclosure agreement prior to the disclosure.

- **Other non-compliance.** In the event the investigation reveals claims development and submission problems, which do not appear to be the result of criminal activity on the part of any employee, the case will be evaluated for the need for and level of corrective action and/or further education.
- All voluntary self-disclosures will be guided by the OIG's and OMIG's Provider Self-Disclosure Protocols.
- **Reports by Compliance Officer.** The Compliance Officer periodically shall furnish information (bearing in mind issues of confidentiality) about such investigations to the Administrator/Governing Authority and to the Compliance Committee at its regular meetings.

G. AUDITS

1. Periodic audits will be undertaken to identify deficiencies in the claim development and submission process and other risk areas such as the quality of services provided. The Agency will devote such resources as are reasonably necessary to ensure that audits are adequately staffed by persons with appropriate knowledge and experience.
2. The Compliance Committee or the Administrator shall designate when audits should be performed and the departments and functions to be audited.
3. It is the responsibility of each department manager to ensure that employees who are new to a position, which has a direct impact on the claim development and submission process, are provided adequate and appropriate training and education. To verify that each new employee understands the essential elements of his or her job function, the work of such new employees should be reviewed until the director or manager is satisfied that the accuracy of the employee's work is adequate to justify cessation of review. Directors or managers may rely on other competent and experienced employees to assist in such reviews. New employees whose work does not meet the necessary quality or standard within a reasonable time after employment may be transferred to another job in or out of the department and such transfer shall not be considered disciplinary action for any purpose or reason.
4. **Periodic Tests and Audits.** The Agency, under the direction of the Compliance Officer, will facilitate periodic tests of claims submitted to Medicare, Medicaid and other federal health care plan and audits of the claim's development and submission process. The audits shall include reviewing the work of coders, billers, ancillary departments, and risk areas identified by the OIG, OMIG or fiscal intermediaries. Audits shall also cover the Agency's relationship with third party contractors

The Compliance Office may request that the director or manager of each affected department prepare and submit testing, audit, and monitoring plans for his or her department.

5. Auditors and reviewers shall have access to all necessary documents including those related to claim development and submission, patient records, e-mail and the contents of computers and other electronic devices. Auditors and reviewers shall always bear in mind confidentiality requirements.



6. The Compliance Officer will be notified of the results of all audits. Further action, if any, by the Compliance Officer with respect to any deviation or discrepancy revealed by an audit will be taken under the provisions of Section F.
7. **Documents.** All audits shall be documented. Such documents shall be maintained in the permanent files of the Compliance Officer and adequately secured.

H. SCREENING

1. **Employees.** Revival Home Health Care will conduct a reasonable background investigation of all new employees, or applicants for employment, who have or will have discretionary authority to make decisions that or whose job function may materially impact the Medicare/Medicaid claim development and submission process. This includes but is not limited to all field staff. The purpose of the background investigation is to determine whether any such employee or applicant has been:
(1) convicted of a criminal offense related to health care or (2) listed by a federal or state agency as debarred, excluded or otherwise ineligible for federal or state program participation.

After hire, employees will be screened periodically for exclusions.

2. **Providers.** A similar reasonable background investigation will be undertaken for providers, such as physicians or other allowed non-physician practitioner ordering home care services, who possess an individual Medicare or Medicaid provider number. Such providers also should be periodically screened.
3. **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 or state agency.
4. **Process.** The Compliance Officer, in consultation as necessary with the Director of Human Resources, 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 should utilize the OIG/OMIG Sanction Reports, the General Services Administration list of debarred contractors, the National Practitioner Data Bank and/or the Office of the Professions administered by the state.
5. The Agency will not hire for or retain an excluded or convicted employee in a position which has or will have discretionary authority to make decisions or whose job functions may materially impact the Medicare/Medicaid claim development and submission process. Revival 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, including physicians, excluded from participation.



I. EVALUATION OF EMPLOYEES' PERFORMANCE IN RELATION TO COMPLIANCE

Adherence to Compliance Standards and promotion of the Compliance Program will be a factor in evaluating the performance of employees, including the evaluation of supervisory, managerial, and administrative personnel.

J. REPORTS TO THE GOVERNING AUTHORITY, ADMINISTRATOR AND COMPLIANCE COMMITTEE

The Compliance Officer shall make reports on compliance activities, including reports by or complaints received from employees; reports of investigations, audits, and monitoring, to the Administrator/Governing Authority, and members of the Compliance Committee on a regular basis. Reports to the Governing Authority shall be at least annually or more often as necessary or advisable.

K. RESPONSE TO GOVERNMENTAL INQUIRIES

1. **Cooperation.** Federal agencies have available several investigation tools including search warrants, subpoenas and civil investigation demands. Actions also may be brought against the Agency to exclude it from participating in Medicare/Medicaid if the Agency fails to grant immediate access to agencies conducting surveys or reviews. It is, therefore, the policy of Revival Home Health Care to cooperate with and properly respond to all governmental inquiries and investigations.
2. Employees 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, and immediately notify the Compliance Officer or in that Officer's absence, a member of the Compliance Committee or the employee's department director or manager. Employees should request the government representative to wait until the Compliance Officer, or their designee arrives before conducting any interview or reviewing documents. The Compliance Officer in consultation with outside legal counsel is responsible for coordinating the Agency's response to warrants, subpoenas, inquiries, and investigations by federal and state agencies. If appropriate, the Agency may also provide legal counsel to employees.
3. The Agency's response to any warrant, subpoena, investigation or inquiry must be complete and accurate. No employee shall alter, destroy, or mutilate any document or record or alter, delete, or download any material from any computer, word processor, disk or tape. Documents and records must be preserved in their original form.

L. DISCIPLINE AND DISCLAIMER

1. In addition to possible disciplinary action mentioned elsewhere in the Compliance Plan employees may be subject to disciplinary action for:
 - Failure to perform any obligation or duty required of employees relating to compliance with this Program or applicable laws or regulations.
 - Failure of supervisory or management personnel to detect non-compliance with applicable policies and legal requirements and this Program where reasonable diligence on the part of the manager or supervisor would have led to the discovery of any violations or problems.



2. Disciplinary action will follow the Agency's existing disciplinary procedures.

See Policy 4-029 Disciplinary Action for Failure to Adhere to the Compliance Program Policies and Procedures.

Disclaimer

Nothing in this Program shall (1) constitute a contract of or agreement for employment; or (2) modify or alter in any manner any employee's at-will employment status.

Any part of this Program may be changed or amended at any time without notice to any employee. Employees will, however, be notified of any substantial change.

Effective: 2009; Revised: 3/6/14, 12/10/19, 3/25/25, 3/17/26



CORPORATE COMPLIANCE: ETHICAL RESPONSIBILITY FOR PREVENTING FRAUD, ABUSE AND WASTE

Agency Policy:

Revival Home Health Care is committed to its role in preventing health care fraud and abuse and complying with applicable State and federal law related to health care fraud and abuse. The Deficit Reduction Act of 2005 requires dissemination of information about both the federal False Claims Act (“FCA”) and other laws, including State laws, dealing with fraud, waste, and abuse and whistleblower protections for reporting those issues. The Agency supports the efforts of government authorities in identifying incidents of fraud and abuse.

This policy sets forth the Agency’s policies and procedures for detecting and preventing fraud, waste, and abuse and an overview of the federal and state Civil False Claims and Program Fraud Civil Remedies Acts.

If an employee discovers an event that may be a violation of the False Claims Act or any other Medicare or Medicaid law, the employee is encouraged to communicate with the Agency’s Compliance Officer for further investigation. The Agency will not retaliate against any employee for informing the Agency or an applicable government authority of a possible violation of these laws. An employee with any questions concerning the application of these laws should communicate with the Agency’s Compliance Officer. This policy is intended to detect and prevent fraud, abuse and waste in federal health care programs.

The Agency takes health care fraud and abuse very seriously. It is the Agency’s policy to provide information to all employees, contractors and agents about the federal False Claims Act, remedies available under these provisions and how employees and others can use them, and about whistleblower protections available to anyone who claims a violation of the federal False Claims Act. The Agency will also advise employees, contractors, and agents of the steps the Agency has in place to detect health care fraud and abuse.

Federal False Claims Laws

The Agency, for Medicare and Medicaid Services (“CMS”), defines “fraud” as the intentional deception or misrepresentation that an individual knows to be false (or does not believe to be true) and makes, knowing that the deception could result in an unauthorized benefit to himself or another person. CMS defines “abuse” as incidents or practices of providers that are inconsistent with sound medical/health care practice and may result in unnecessary costs, improper payment, or the payment for services that either fail to meet professionally recognized standards of care or are medically unnecessary.

The federal government has enacted criminal and civil laws pertaining to the submission of false or fraudulent claims for payment or approval to the federal and State governments and to private payers. These false claims laws, which provide for criminal, civil, and administrative penalties, provide governmental authorities with broad authority to investigate and prosecute potentially fraudulent activities, and provide anti-retaliation provisions for individuals who make good faith reports of waste, fraud, and abuse.

The Federal Civil False Claims and Program Fraud Civil Remedies Acts and anti-retaliation provisions are summarized below.



Federal Civil False Claims Act, 31 U.S.C. § 3729 et seq.

The FCA is a statute that imposes civil liability on any person who knowingly presents, or causes to be presented, a false or fraudulent claim, record or statement for payment or approval.

The term “knowingly” as defined in the FCA includes a person who has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information.

The term “claim” includes any request or demand for money or property if the United States Government provides any portion of the money requested or demanded.

Potential civil liability under the FCA includes monetary penalties per claim, treble damages, and the costs of any civil action brought to recover such penalties or damages.

The Attorney General of the United States is required to diligently investigate violations of the FCA and may bring a civil action against a person. Before filing suit, the Attorney General may issue an investigative demand requiring production of documents and written answers and oral testimony.

The FCA also provides for actions by private persons (*qui tam* lawsuits) who can bring a civil action in the name of the government for a violation of the FCA. Generally, the action may not be brought if more than six years after the violation, but in no event, more than ten years. The United States Government may choose to intervene in the lawsuit and assume primary responsibility for prosecuting, dismissing, or settling the action. If the government chooses not to intervene, the private party who initiated the lawsuit has the right to continue the action and may have a right to share in recovery if certain conditions are met.

If the civil action is frivolous, clearly vexatious, or brought primarily for harassment, the plaintiff may have to pay the defendant its fees and costs. If the plaintiff planned or initiated the violation, the share of proceeds may be reduced and, if found guilty of a crime associated with the violation, no share will be awarded the plaintiff.

The FCA also provides employees protection from retaliation. An employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in terms and conditions of employment because of lawful acts conducted in furtherance of an action under the FCA may bring an action in Federal District Court and may be entitled to reinstatement, back pay, and other costs, damages, and fees.

Federal Program Fraud Civil Remedies Act of 1986, 31 U.S.C. § 3801 et seq.

The Program Fraud Civil Remedies Act of 1986 (“1986 Act”) is a statute that establishes an administrative penalty against any person who presents or causes to be presented a claim or written statement that the person knows or has reason to know is false, fictitious, or fraudulent due to an assertion or omission of a material fact.

The term “knows or has reason to know” is defined in the 1986 Act means having actual knowledge of the information, acting in deliberate ignorance of the truth or falsity of the information, or acting in reckless disregard of the truth or falsity of the information.



The term “claim” includes any request or demand for property or money, e.g., grants, loans, insurance, or benefits, when the United States Government provides or will reimburse any portion of the money.

The 1986 Act allows for civil monetary sanctions to be imposed in administrative hearings, including penalties of \$5,000 per claim and an assessment, in lieu of damages, of not more than twice the amount of the original claim.

New York State False Claims Laws

On April 9, 2007, the New York State government enacted the New York False Claims Act (“NYFCA”), which imposes civil penalties on anyone who submits false or fraudulent claims for payment or approval to the State governments and to private payors. This false claim law provides state and local governmental authorities with broad authority to investigate and prosecute potentially fraudulent activities and provides anti-retaliation provisions for individuals who make good faith reports of fraud, abuse, and waste. The NYFCA is closely modeled after the FCA described above and contains nearly identical language.

The New York False Claims Act and anti-retaliation provisions are summarized below.

New York False Claims Act, Bill No. S02108C, Art. 13, § 187 et seq. of the State Finance Law

The NYFCA is a statute that imposes civil liability on any person who knowingly presents, or causes to be presented, a false or fraudulent claim, record or statement for payment or approval.

The term “knowingly” as defined in the NYFCA includes a person who has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information.

The term “claim” includes any request or demand for money or property if the State or a Local Government provides any portion of the money requested or demanded.

Potential civil liability under the NYFCA includes penalties that are currently between \$6,000 and \$12,000 per claim, treble damages, and the costs of any civil action brought to recover such penalties or damages.

The Attorney General of the State of New York is required to diligently investigate violations of the NYFCA and may bring a civil action against a person. Before filing suit, the Attorney General may issue an investigative demand requiring production of documents and written answers and oral testimony.

The NYFCA also provides for actions by private persons (*qui tam* lawsuits) who can bring a civil action in the name of the government for a violation of the NYFCA. Generally, the action may not be brought if more than six years after the violation, but in no event, more than ten years. The State or Local Government may choose to intervene in the lawsuit and assume primary responsibility for prosecuting, dismissing, or settling the action. If the government chooses not to intervene, the private party who initiated the lawsuit right to continue the action and may have a right to share in recovery if certain conditions are met.



The NYFCA also includes a whistleblower provision, which provides employees protection from retaliation. An employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in terms and conditions of employment because of lawful acts conducted in furtherance of an action under the NYFCA may bring an action in the appropriate New York State Supreme Court and may be entitled to reinstatement, back pay, and other costs, damages, and fees.

Any questions regarding this policy should be directed to the Agency's Corporate Compliance Officer.

Effective: 2009; Revised: 3/6/14. 12/10/19, 3/25/25, 3/17/26



DISCIPLINARY ACTION FOR FAILURE TO ADHERE TO COMPLIANCE PROGRAM POLICIES AND PROCEDURES

PURPOSE

To establish consistent enforcement standards/disciplinary action when non-adherence of the Corporate Compliance Program is discovered.

POLICY

The leadership of Revival Home Health Care is committed to the attainment of ethical and professional standards and prevention of fraud, waste and abuse as established in the Corporate Compliance Plan and the Code of Conduct.

The Agency's disciplinary policy embodies the expectation that all affected Individuals act in accordance with the Plan and Code of Conduct and will refuse to participate in unethical, illegal or non-compliant conduct. Appropriate discipline will be imposed, if after an appropriate investigation, it is concluded that an affected individual has failed to comply with the written policies and procedures of Revival's Compliance Plan, Code of Conduct, or applicable laws and regulations.

Definitions

For the purpose of this policy, affected individuals are defined as any employees, officers, contractors, vendors, agents, representatives, or governing authority of the Agency.

PROCEDURE

1. Implementation of discipline may be imposed based on but not limited to:
 - An unlawful or unethical action
 - Negligent or reckless conduct
 - Deliberate ignorance of Agency policy, including the Code of Conduct and all applicable compliance policies and procedures, laws and regulations.
 - Condoning or not reporting unlawful actions by others
 - Retaliation or intimidation against those who report suspected wrongdoing or violations.

2. Disciplinary actions in response to non-compliance or violations of the Agency's Compliance Plan or Code of Conduct include the following depending on the nature, frequency and impact of the offense as well as mitigating and/or aggravating factors and based on a thorough and impartial investigation:
 - Verbal Warnings
 - Written Warnings
 - Retraining
 - Probation

- Demotion
- Denial of promotion
- Temporary suspension
- Termination from employment,
- Removal from the Governing Authority and/or removal as an officer, as applicable
- Termination of contract or agreement for entities under contract.
- Referral for appropriate sanctioning by regulatory agencies and/or criminal prosecution.

Disciplinary actions are subject to escalation based on the severity or history of behavior. Intentional or reckless violations and repeated violations will require more severe disciplinary actions among those identified above.

3. The Agency's disciplinary policy will be fairly and uniformly enforced in a timely manner. Disciplinary actions may be taken against, and sanctions imposed upon, any affected Individual, regardless of an individual's position within the Agency. While uniformity and evenhandedness are valued, the disciplinary actions taken may vary based on the individual's responsibilities and relationship to the Agency.
4. Senior management may be held to a higher standard for failure to detect or address legal or compliance issues in proportion to the expectations of their role within the Agency. All senior managers, executives, officers and members of the Governing Authority are expected to exemplify and embody the Agency's compliance expectations, and such Individuals may have specific responsibilities related to the implementation and oversight of the Compliance Program based on their job description.
5. Disciplinary action shall be in accordance with Agency policy set forth in the Employee Handbook.
6. Every stage of the disciplinary process is documented and written counselling of employees included in their personnel file.
7. Disciplinary action taken by the Agency is strictly in addition to, and does not depend on, nor mitigate or preempt, the ability of federal or state enforcement agencies to impose civil or criminal fines, program exclusion, imprisonment, and other sanctions or punishment available under the law.

Approved 3/17/26



NON-INTIMIDATION AND NON-RETALIATION POLICY

PURPOSE

To create a solid foundation for effective lines of communication to promote good faith reporting of conduct that is fraudulent or noncompliant with the Code of Conduct or the Corporate Compliance Plan.

POLICY

Revival Home Health Care recognizes that the authenticity and reliability of its Compliance Program rest upon the obligation of affected individuals, as a condition of employment or of having a working relationship with the Agency, to report compliance concerns, including but not limited to potential fraud, waste or abuse. To encourage reporting, the Agency is committed to the protection of employees, contractors, patients or their representatives, and others who come forward in good faith and report known or suspected compliance issues. As such, the Agency endeavors to protect these individuals from retaliation and intimidation.

To create the foundation for effective lines of communication to identify and to detect non-compliance, the Agency maintains this policy of Non-Intimidation and Non-Retaliation. The Agency's goal is to create a safe environment to promote individuals to come forward with reports and concerns, to candidly participate in investigations and resolutions, or to seek guidance about questionable circumstances or legal requirements.

Intimidation and retaliation against an individual who in good faith reports actual or potential compliance concerns and participates in an investigation and resolution is strictly prohibited and is itself a violation of this policy, the Compliance Program and the Code of Conduct.

Definitions

Intimidation: generally, means any action that is reasonably likely to manipulate an individual or intentionally cause feelings of fear or inadequacy.

Retaliation: generally, means any adverse action against an individual because of the individual's good faith report of a compliance concern, participation in the Compliance Program or other report of suspected improper conduct.

Affected Individuals are defined as any employees, officers, contractors, vendors, agents, representatives, patients or their representatives, or governing authority of the Agency.

Good Faith: protection applies when an individual honestly believes a concern is true, based on the information known at the time, even if it is later proven to be mistaken.

PROCEDURE

1. The Agency affirmatively requires employees and other affected individuals to seek direction and report known or suspected violations, or other genuine misgivings.



2. Anyone who participates in good faith reporting of compliance concerns is guaranteed complete protection from any harm, adverse action, and/or intimidation. When participating in good faith with the following compliance activities, an individual will be free of any intimidation or retaliation in any form:
 - Reporting known or potential compliance issues to appropriate personnel.
 - Participating in the investigation of known or potential compliance issues.
 - Participating in self-evaluations.
 - Participating in audits.
 - Participating in remedial actions.
 - Reporting instances of intimidation or retaliation.
 - Reporting potential fraud, waste, or abuse to the appropriate State or Federal entities; and
 - Any action or reporting protected under the Agency Deficit Reduction Act Policy 4-027.
3. Those who attempt to intimidate or retaliate against others for engaging in Compliance Activities, such as termination, suspension, demotion, threats or discrimination are subject to Agency's Disciplinary Policy (4-028). Disciplinary action may include termination of employment or contract, or any other action pursuant to the Disciplinary Policy specifically related to the Corporate Compliance Plan.
4. Any individual who fears retribution or feels uncomfortable openly sharing information or who believes that they have been subject to intimidation or retaliation for good faith participation in the Agency's Compliance Program should immediately report such concerns, intimidation or retaliation to the Compliance Officer either directly in person, by mail, by email or by phone or by reporting the situation anonymously by calling the Compliance Hotline.
5. Confidentiality will be maintained to the extent possible when Individuals openly report their concerns in good faith.
6. Allegations of intimidation or retaliation will be investigated promptly by the Compliance Officer or their designee; Violations may lead to severe disciplinary action against the offender.

Approved 3/17/26

