

<b>CARDINAL HAYES HOME  POLICY AND PROCEDURE</b>	<b>Date Issued</b> 04/24/2023	<b>Date Revised</b>	<b>Date of Last Review</b> 3/27/2023	<b>Date Approved</b> 04/24/2023	<b>Section Number</b> CC-01
	<b>Subject</b>  Corporate Compliance				
	<b>Topic</b>  Policy Development, Approval and Maintenance				

**I. PURPOSE:**

The Policy and Procedure provides clear direction for the process of developing and maintaining policies and establishes a process that promotes effective and timely policy development and review.

**II. STATEMENT OF POLICY:**

It is the policy of Cardinal Hayes Home for Children (sometimes referred to as “Cardinal Hayes Home”) (CHH) to express policies in writing where appropriate. Policies explain how goals will be achieved and serve as guides that define the general scope of activities permissible for goal accomplishments.

Procedures, distinct from policies, are guides for action to be taken in the implementation of policies. When applicable, each CHH policy will include a prescribed procedure to be followed for proper implementation.

The Corporate Compliance Officer is responsible for the overall coordination and implementation of any new or revised policy. The Executive Director and the Executive Administration will be consulted as needed throughout the process of developing or revising any policy.

The CCO maintains the CHH policy manual, which is stored in the CHH Agency Shared Folder (policy & procedures). The CCO will also maintain a Policy Catalogue Database. The office is responsible for formulating statements of policy and for making recommendations as to implementation to the Executive Director. Prior to recommendations of approval to the Executive Administration, all policies will be referred to the Corporate Compliance Committee for review to ensure compliance with the legal and regulatory requirements and other Cardinal Hayes Policies and approval. When applicable, policies will also be forwarded to the Board of Directors for approval.

All policies and procedures must be reviewed annually by the Policy Owner or designee to update and incorporate changes in applicable laws, regulations and departmental processes as needed. If there are necessary revisions to the policy, the responsible person will follow the workflow provided below for approval.

All policies and accompanying procedures prepared will follow a standardized process for policy development, approval, revision, and implementation to promote high quality service and assist in improved decision-making.

All Cardinal Hayes Home policies will contain the required header information:

- a) **Date Format:** 00/00/0000
- b) **Subject:** Name of Department
- c) **Topic:** Exact name of the policy.
- d) **Section Number:** The prefix represents the department and is an alphabetical abbreviation of 2 or 3 letters. Next is a hyphen, followed by the 2-digit policy number. This Section Number must match what is on the CHH Policy Manual and Database. All Section Numbers will be issued by the CCO.
- e) **Date Issued:** The date the policy was originally put into effect.
- f) **Date Revised:** The date when any changes are made to the policy.
- g) **Date of Last Review:** Date approved by Compliance Committee.
- h) **Date Approved:** Date when the policy is approved by the Executive Administration and Bd of Directors (when applicable).

All **CARDINAL HAYES HOME** policies will include the following components:

- a) Purpose – A brief description of why the Policy is being promulgated and/or what it seeks to accomplish.
- b) Statement of Policy - A brief description of the policy.
- c) Owner of Policy- The Policy Owner is the department/program administrator or individual responsible for the policy implementation and oversight. The Policy Owner shall be responsible for recommending the timely development, review, revision, and implementation of new and existing policies relating to their respective areas of accountability.
- d) Scope- Affected departments or employees.
- e) Procedure – Detailed procedure to be followed to implement the policy appropriately.
- f) Sanction Statement- Non-compliance with this policy may result in disciplinary action, up to and including termination.
- g) Compliance Statement
- h) Record Retention Statement

**III. POLICY OWNER**

Corporate Compliance Officer or designee

**IV. SCOPE**

This policy applies to all operations at Cardinal Hayes Home for Children & Cardinal Hayes School for Special Children.

**V. PROCEDURES**

**1. Procedure for New Policy Initiation**

<b>Responsible Staff</b>	<b>Actions Taken</b>
Executive Director or Executive Administration	1. Requests that a policy be initiated in draft and assigns this task to a responsible person.
All Staff	1. Policies may be drafted by any CHH staff when such a statement seems appropriate and will serve a useful purpose.
Responsible Person for drafting the policy	<ol style="list-style-type: none"> <li>1. Type the policy accessing the form via the template in the forms catalog in the agency shared folder (policy &amp; procedures).</li> <li>2. Using the format described in the policy statement, draft the policy and label it DRAFT.</li> <li>3. Draft policy statements specific to the unit/department/disciplines are submitted to the appropriate Director or Policy Owner for review and consideration.</li> <li>4. Create post-training test questions for policies related to the care of individuals.</li> <li>5. Submit the draft policy to the Corporate Compliance Officer.</li> </ol>
Corporate Compliance Office	<ol style="list-style-type: none"> <li>1. Receives the draft policy statement for review.</li> <li>2. The Corporate Compliance Officer in collaboration with the Compliance Committee will review new policies and provide feedback to the Policy Owner and/or appropriate administrator.</li> <li>3. Incorporates the revisions and changes suggested by the CC into the policy.</li> <li>4. Forwards all policies to the Executive Administration for final approval. When applicable, will send to Bd of Directors for their approval.</li> <li>5. Once approved, remove all editing fonts, and assign a policy number.</li> <li>6. Approved policies will be cataloged and posted in the CHH agency shared folder (policy &amp; procedures).</li> <li>7. The effective date of the policy shall be the date of final approval.</li> <li>8. Notifies via email, the Board of Directors, the Executive Director, and all staff, and, if applicable, independent contractors and agents within 10 business days of final approval.</li> <li>9. Updates the CHH Policy database.</li> </ol>
Policy Owner	1. Within 10 days of posting in the agency shared folder (policy & procedures), the policy owner must inform all Affected Departments and Staff Development.
Staff Development	1. Must enroll all Affected staff for new policies in Relias.

## 2. Procedure for Revision of Existing Policies

Responsible Staff	Actions Taken
Responsible Person/Department or designee For Revising Policy	<ol style="list-style-type: none"> <li>1. Policy owner or designee, as specified in the policy and procedure, must review the policy annually by the Review Date on the policy (request the Word version of existing policy from the Corporate Compliance Office).</li> <li>2. Revise the policy and procedure as needed to include updates.</li> <li>3. Using the Track Changes feature in Microsoft Word, edit the policy including the revision date. The policy should be marked DRAFT.</li> <li>4. Submit the revised policy to the appropriate Director or Policy Owner for review and consideration.</li> <li>5. Update post-training questions for policies related to the care of individuals as needed.</li> <li>6. Submit the revised policy to the Corporate Compliance Officer.</li> </ol>
Corporate Compliance Office	<ol style="list-style-type: none"> <li>1. Receives the revised policy statement for review.</li> <li>2. The Corporate Compliance Officer in collaboration with the Compliance Committee will review revised policies and provide feedback to the Policy Owner and/or appropriate administrator.</li> <li>3. Incorporates the revisions and changes suggested by the CC into the policy.</li> <li>4. Forwards all policies to the Executive Administration for final approval and Bd of Directors when applicable.</li> <li>5. Once approved, remove all editing fonts.</li> <li>6. Approved policies will be posted in the CHH agency shared folder (policy &amp; procedures).</li> <li>7. The effective date of the policy shall be the date final approval.</li> <li>8. Notifies the Board of Directors, the Executive Director, and all staff, and, if applicable, independent contractors and agents within 10 business days of final approval, that revised/approved policies have been posted in the agency shared folder (policy &amp; procedures).</li> <li>9. Updates the CHH Policy database.</li> </ol>
Staff Development	<ol style="list-style-type: none"> <li>1. Must enroll all Affected staff for approved revised policies in Relias.</li> </ol>

## 3. Department Specific Standard Operating Procedures

Responsible Staff	Actions Taken
Department Head or Discipline Head	<ol style="list-style-type: none"> <li>1. Determine the need to establish a department or discipline specific standard operating procedures which are not based on any specific CHH policy.</li> <li>2. Develops required department or discipline specific standard operating procedures.</li> <li>3. Reviews all developed standard operating procedures on an on-going basis to assure review/revision as indicated and at least annually.</li> <li>4. Department and Discipline Heads are responsible for distributing approved department or discipline standard operating procedures to all appropriate staff and for maintaining all such in a centrally maintained department or discipline operating manual.</li> </ol>

**VI. SANCTION STATEMENT**

Non-compliance with this policy may result in disciplinary action, up to and including termination.

**VII. COMPLIANCE STATEMENT**

As part of its ongoing auditing and monitoring process in its Compliance Program, CHH will review this policy based on changes in the law or regulations, as CHH's practices change, and, at minimum, on an annual basis. Additionally, this policy will be tested for effectiveness on an annual basis or more frequently as identified in accordance with CHH's Compliance Program. Testing will include but is not limited to ensuring that the policy is appropriately followed; the policy is effective; the policy has been disseminated to all affected individuals, as well as notified of any updates or changes.

Tracking of the criteria above and results of this testing will be completed by the Compliance Officer, or designee. Additionally, results will be reported to the Compliance Committee and Governing Body on a regular basis.

**VIII. RECORD RETENTION STATEMENT**

CHH will retain this policy and all subsequent revisions, and any related documentation will be retained for a period of, at minimum, six years.

<b>CARDINAL HAYES HOME  POLICY AND PROCEDURE</b>	<b>Date Issued</b> 04/24/2023	<b>Date Revised</b>	<b>Date of Last Review</b> 03/27/2023	<b>Date Approved</b> 04/24/2023	<b>Section Number</b> CC-02
	<b>Subject</b>  Corporate Compliance				
	<b>Topic</b>  Compliance Plan				

**I. PURPOSE:**

Cardinal Hayes Home for Children (sometimes referred to as “Cardinal Hayes Home”) (CHH) is committed to providing services of the highest quality and to being in full compliance with all federal, state, and local laws and regulations. As part of that commitment, CHH has adopted this Compliance Plan and the Standards of Conduct as the basis of its efforts in fostering an organizational culture that promotes responsible and honest conduct, transparency in all business transactions, and adherence to the laws and regulations of the government oversight agencies and funders.

For purposes of this Policy, the term “Affected Individuals” includes all persons who are affected by the required risk areas including all employees, the Executive Director and other senior administrators, supervisors, contractors, agents, interns, and the Board of Directors (hereafter referred to as “Affected Individuals”).

**II. STATEMENT OF POLICY:**

It has been and continues to be the policy of CHH to comply with all applicable Federal, State, and local laws and regulations, and payer requirements. It is also the CHH’s policy to facilitate the prevention of improper or illegal activities, to provide mechanisms to detect any violations of laws and regulations and work to prevent, detect, and investigate issues related to fraud, waste, and abuse. To ensure this, CHH has established a Compliance Plan and commits to maintaining an effective Compliance Program.

CHH is, and will remain, committed to our responsibility to conduct our business affairs with integrity based on sound ethical and moral standards. We will hold all Affected Individuals to these same standards.

CHH is committed to maintaining and measuring the effectiveness of our Compliance Program and Standards of Conduct through monitoring and auditing systems reasonably designed to detect noncompliance by Affected Individuals.

CHH is committed to the prevention of improper or illegal activities and to provide mechanisms to detect noncompliance, including but not limited to, any violations of laws and regulations, healthcare program requirements, the Standards of Conduct and CHH’s policies and procedures. The CHH is committed to the prompt investigation and resolution of reported or detected noncompliance.

CHH is committed to the performance of regular, periodic compliance audits by internal and/or external auditors who have expertise in Federal and State healthcare statutes, regulations, and healthcare program requirements.

**III. POLICY OWNER**

Corporate Compliance Officer or designee

**IV. SCOPE**

This policy applies to all Affected individuals at Cardinal Hayes Home for Children & Cardinal Hayes School for Special Children.

**V. POLICIES AND PROCEDURES AND STANDARDS OF CONDUCT**

All Affected Individuals shall acknowledge that it is their responsibility to report any instances of suspected or known noncompliance to their immediate supervisor, the Executive Director, or the Compliance Officer without fear of retaliation, retribution, or intimidation.

CHH will communicate its compliance standards and policies through required training and communication initiatives and distribution of the Compliance Plan and the Standards of Conduct to all Affected Individuals.

- **Compliance Officer and Compliance Committee**
  - CHH has appointed a Compliance Officer who is responsible for the overall operation of the Compliance Program. A Compliance Committee works with the Compliance Officer to implement and maintain an effective Compliance Program.
  
- **Discipline/Enforcement**
  - The Compliance Plan will be consistently enforced through appropriate disciplinary mechanisms including, if appropriate, discipline of Affected Individuals responsible for failure to report known noncompliance or making reports that are not in good faith. Not reporting will be grounds for disciplinary action, up to and including termination of employment, contract, assignment, or appointment. Reports related to harassment or other workplace-oriented issues will be referred to Human Resources.
  
- **CHH Response**
  - Detected noncompliance, discovered through any mechanism, such as compliance auditing procedures and/or confidential reporting of noncompliance, will be responded to in an expedient manner. CHH is dedicated to the resolution of such matters and will take all reasonable steps to prevent further similar violations, including any necessary modifications to the Compliance Plan and policies and procedures.
  
- **Due Diligence**
  - CHH will, at all times, exercise due diligence with regard to background and professional license investigations for all Affected Individuals.
  
- **Non-Retaliation, Non-Intimidation, and Whistleblower Protections**
  - CHH will not take any retaliatory action against an Affected Individual who, in good faith, reports actual or suspected noncompliance or illegal activities or for good faith participation in the Compliance Program.
  - CHH will not take any retaliatory action against an employee if the employee discloses certain information about the CHH's policies, practices, or activities to a regulatory, law enforcement, or other similar agency or public official. Protected disclosures are those that assert that the CHH is in violation of a law that creates a substantial and specific danger to the public health and safety; or that constitute healthcare fraud under the law; or that assert that the employee, in good faith, believes constitutes improper quality of care.

#### **VI. SANCTION STATEMENT**

Non-compliance with this policy may result in disciplinary action, up to and including termination.

#### **VII. COMPLIANCE STATEMENT**

As part of its ongoing auditing and monitoring process in its Compliance Program, CHH will review this policy based on changes in the law or regulations, as CHH's practices change, and, at minimum, on an annual basis. Additionally, this policy will be tested for effectiveness on an annual basis or more frequently as identified in accordance with CHH's Compliance Program. Testing will include but is not limited to ensuring that the policy is appropriately followed; the policy is effective; the policy has been disseminated to all affected individuals, as well as notified of any updates or changes.

Tracking of the criteria above and results of this testing will be completed by the Compliance Officer, or designee.

Additionally, results will be reported to the Compliance Committee and Governing Body on a regular basis.

#### **VIII. RECORD RETENTION STATEMENT**

CHH will retain this policy and all subsequent revisions, and any related documentation will be retained for a period of, at minimum, six years.

<b>CARDINAL HAYES HOME  POLICY AND PROCEDURE</b>	<b>Date Issued</b> 12/14/2020	<b>Date Revised</b> 03/20/2023	<b>Date of Last Review</b> 03/27/2023	<b>Date Approved</b> 04/24/2023	<b>Section Number</b> CC-03
	<b>Subject</b>  Corporate Compliance				
	<b>Topic</b>  Roles and Responsibilities of the Compliance Committee				

**I. PURPOSE:**

Cardinal Hayes Home for Children (sometimes referred to as “Cardinal Hayes Home”) (CHH) is committed to the operation of an effective Compliance Program. Therefore, CHH established the Compliance Committee to monitor results of the compliance functions and determine the CHH’s strategy for promoting compliance.

For purposes of this Policy, the term “Affected Individuals” includes all persons who are affected by the required risk areas including all employees, the Executive Director and other senior administrators, supervisors, contractors, agents, interns, and the Board of Directors (hereafter referred to as “Affected Individuals”).

**II. STATEMENT OF POLICY:**

It is the Policy of CHH to ensure that the organization maintains an effective Compliance Program in compliance with regulatory standards. This Policy defines the roles and responsibilities of the Compliance Committee and their duty to help ensure that CHH has an effective Compliance Program.

**III. POLICY OWNER**

Corporate Compliance Officer or designee

**IV. SCOPE**

This policy applies to all Affected individuals at Cardinal Hayes Home for Children & Cardinal Hayes School for Special Children

**V. POLICIES AND PROCEDURES AND STANDARDS OF CONDUCT**

1. The Compliance Committee is appointed by the President of the Board of Directors and Executive Director to advise and assist the Compliance Officer with the implementation of the Compliance Program. The Compliance Committee will report directly to the Executive Director and Board of Directors.
2. The Compliance Committee will be comprised of Senior Leadership, at minimum.
3. The Compliance Committee will meet on a regular and routine basis, but at minimum quarterly. Meeting minutes will be recorded. The Compliance Officer will maintain the minutes of all meetings.
4. The CHH will develop and implement a Compliance Committee Charter. The Charter will outline the Compliance Committee’s duties and responsibilities, membership, designation of a chairperson, and frequency of meetings.
5. The Compliance Committee will review and update the Compliance Committee Charter at least annually.

6. Affected Individuals will be introduced to the role and responsibilities of the Compliance Committee as part of the Compliance Program education and training.
7. The Compliance Committee is responsible for the following:
  - Analyzing the regulatory environment where CHH does business, including legal requirements with which it must comply.
  - Reviewing and assessing existing policies and procedures that address risk areas for possible incorporation into the Compliance Program.
  - Reviewing and monitoring Compliance Program training and education to ensure that they are effective and completed in a timely manner.
  - Ensuring that the CHH has effective systems and processes in place to identify Compliance Program risks, overpayments, and other issues and has effective policies and procedures for correcting and reporting such issues.
  - Working with departments to develop standards and policies and procedures that address specific risk areas and to encourage compliance according to legal and ethical requirements.
  - Coordinating with the Compliance Officer to ensure that the written policies and procedures and Standards of Conduct are current, accurate, and complete.
  - Developing internal systems and controls to carry out compliance standards, Standards of Conduct, and policies and procedures.
  - Coordinating with the Compliance Officer to ensure communication and cooperation by Affected Individuals on compliance-related issues, internal or external audits, or any other function or activity.
  - Developing a process to solicit, evaluate, and respond to complaints and problems.
  - Monitoring internal and external audits to identify issues related to non-compliance.
  - Implementing corrective and preventative action plans and follow-up to determine effectiveness.
  - Ensuring the development and implementation of an annual Compliance Work Plan.
  - Advocating for sufficient funding, staff, and resources to be allocated to the Compliance Officer to carry out duties related to the Compliance Program.
  - Ensuring that the CHH has appropriate systems and policies in place that effectively identify risks, overpayments, and other areas of concerns including fraud, waste, and abuse.
  - Monitoring and evaluating the CHH's Compliance Program for effectiveness at least annually and making recommendations for necessary modifications to the Compliance Program as applicable.
  - Developing and implementing a Compliance Committee Charter. The Charter will outline the Compliance Committee's duties and responsibilities, membership, designation of a chairperson and frequency of meetings. The Charter will be reviewed and updated annually.



**VI. SANCTION STATEMENT**

Non-compliance with this policy may result in disciplinary action, up to and including termination.

**VII. COMPLIANCE STATEMENT**

As part of its ongoing auditing and monitoring process in its Compliance Program, CHH will review this policy based on changes in the law or regulations, as CHH's practices change, and, at minimum, on an annual basis. Additionally, this policy will be tested for effectiveness on an annual basis or more frequently as identified in accordance with CHH's Compliance Program. Testing will include but is not limited to ensuring that the policy is appropriately followed; the policy is effective; the policy has been disseminated to all affected individuals, as well as notified of any updates or changes.

Tracking of the criteria above and results of this testing will be completed by the Compliance Officer, or designee. Additionally, results will be reported to the Compliance Committee and Governing Body on a regular basis.

**VIII. RECORD RETENTION STATEMENT**

CHH will retain this policy and all subsequent revisions, and any related documentation will be retained for a period of, at minimum, six years.

12/14/2020 update: HVR; reviewed 4-1-2022,

Revised 3/20/2023

<b>CARDINAL HAYES HOME  POLICY AND PROCEDURE</b>	<b>Date Issued</b> 12/31/2020	<b>Date Revised</b> 03/31/2023	<b>Date of Last Review</b> 04/03/2023	<b>Date Approved</b> 04/24/2023	<b>Section Number</b> CC-04
	<b>Subject</b>				
	<b>Corporate Compliance</b>				
<b>Topic</b>					
<b>Compliance Education &amp; Training</b>					

**I. PURPOSE:**

The development and implementation of regular, effective education and training seminars is an integral part of the Compliance Program. Compliance education is divided into two general components. First, all Affected Individuals must receive an introduction to the Compliance Program. Second, those parties whose work is linked to identified risk areas should receive specialized compliance education pertaining to their function and responsibilities.

For purposes of this Policy, the term “Affected Individuals” includes all persons who are affected by the required risk areas including all employees, the Executive Director and other senior administrators, supervisors, contractors, agents, interns and the Board of Directors (hereafter referred to as “Affected Individuals”).

**II. STATEMENT OF POLICY:**

It is the Policy of Cardinal Hayes Home for Children (sometimes referred to as “Cardinal Hayes Home”) (CHH) to ensure that all Affected Individuals receive formal training relating to the Agency’s Compliance Program. The Agency will ensure that all trainings are provided in a way that is accessible to all Affected Individuals and that they are in alignment with the required State and Federal laws, rules, and regulations.

It is the Policy of the Agency to ensure that Affected Individuals in identified risk areas, and members of the Board of Directors and Management, receive more detailed education related to their function and responsibilities.

This Policy applies to all Affected Individuals. Successful completion of the training sessions is mandatory and a condition of continued employment, contract, appointment, or assignment with the Agency.

**III. POLICY OWNER**

Corporate Compliance Officer or designee

**IV. SCOPE**

This policy applies to all Affected individuals at Cardinal Hayes Home for Children & Cardinal Hayes School for Special Children.

**V. POLICIES AND PROCEDURES AND STANDARDS OF CONDUCT**

1. The Compliance Officer is responsible for developing the compliance education curriculum and monitoring and ensuring that compliance training and orientation meet the Policy standards on this subject.
2. Compliance education and training seminars must include an explanation of the structure and operation of the Compliance Program. They will introduce the Compliance Officer and the roles and responsibilities of the Compliance Committee to Affected Individuals.

3. Compliance education and training seminars will include, at a minimum, information on the following aspects of the Compliance Program:

- CHH's Compliance Plan;
- Standards of Conduct and other related written guidance;
- Federal False Claims Act;
- New York False Claims Act;
- Whistleblower Protections;
- Risk areas and organizational experience;
- The role and responsibilities of the Compliance Officer and the Compliance Committee;
- Communication channels (name of Compliance Officer, reporting mechanisms, anonymous reporting mechanism);
- CHH's expectations for reporting known or suspected fraud, waste, and abuse; illegal or unethical acts; actual or suspected violations of Federal or State laws and regulations; actual or suspected violations of the Standards of Conduct, the Compliance Program, and CHH's policies and procedures; improper acts in the delivery or billing of services; and other wrongdoing (collectively referred to as "compliance concerns" for purposes of this Policy);
- How the Agency responds to reports of compliance concerns, including the investigation process and corrective actions;
- CHH's disciplinary policy and standards;
- Prevention of fraud, waste, and abuse; and
- Non-retaliation and non-intimidation policy.

Specialized areas for education will include, but not be limited to, the following risk areas:

- Improper or fraudulent billing for services;
- Preparation of inaccurate or incorrect cost reports;
- Misuse of CHH funds;
- Payment or receipt of remuneration or gifts in return for referrals of service recipients or business contracts;
- Medicaid requirements specific to CHH's services and programs;
- Coding and billing requirements and best practices, if applicable;
- Claim development and the submission process, if applicable;
- Government and private payor reimbursement principles; and
- Government initiatives related to the services provided by the Agency, if applicable.

4. Comprehensive education materials will be developed to facilitate the compliance sessions and ensure that a consistent message is delivered to all Affected Individuals. Education protocols and materials must be standardized, so as to evidence that everyone attending a seminar receives the same instruction.

5. As part of their initial orientation, each employee, including the Executive Director and other senior administrators, and Board members shall receive a training session within the first 30 days of employment or association with the Agency. Each party will receive an introduction to CHH's Compliance Program and objectives, and written copies of the Standards of Conduct and Compliance Plan and be provided access to Compliance Program policies and procedures. Each party will sign an acknowledgement form (attached to this Policy), or equivalent, that they are aware of and will abide by the Compliance Plan and Standards of Conduct.

6. All Affected Individuals will receive training and/or education at least once per year that includes a review of the existing Compliance Plan, the Standards of Conduct, and any applicable policies and procedures. The session will also focus on any changes in Federal or State laws and regulations.

7. All education and training relating to the Compliance Program will be verified by attendance and a signed acknowledgement of receipt of training. Training records will include the date, start and end time of the training, and the content of the material presented. The Compliance Officer will maintain records of attendance for all training sessions.
8. Only properly trained individuals will be used to provide compliance education and training seminars. Compliance Program trainers must be knowledgeable of the (a) Compliance Plan; (b) applicable Federal laws and regulations; (d) relevant CHH policies/procedures; (e) operations of the Compliance Program; and (f) content of the Standards of Conduct.
9. The Compliance Officer is responsible for coordinating with Management to ensure that specialized compliance education occurs in identified risk areas.
10. The Compliance Officer will ensure that all contractors and vendors meeting the criteria below are provided with a copy of the Compliance Plan and the False Claims Act and Whistleblower Protections Policy upon entering into a contractual agreement with CHH. For purposes of this Procedure, contractor and vendor are defined as:
  - Any independent contractor, contractor, subcontractor, or other person who, on behalf of the Agency, furnishes or otherwise authorizes the furnishing of Medicare, Medicaid, or other federally-funded healthcare items or services, or performs billing or coding functions; or
  - Any independent contractor, contractor, subcontractor, or other person who provides administrative or consultative services, goods, or services that are significant and material, are directly related to healthcare provision, and/or are included in or are a necessary component of providing items or services reimbursed by Medicare, Medicaid, or other federally funded healthcare program; or
  - Any independent, contractor, subcontractor, or other person who is involved in the monitoring of healthcare provided by the Agency.
11. CHH will ensure that the Compliance Officer has sufficient opportunities to receive training on compliance issues. Compliance training will be secured and made available to new Compliance Officers as part of the orientation to the role.
12. The Compliance Officer is responsible for submitting periodic reports to the Compliance Committee and Board of Directors on all education seminars related to the Compliance Program. This information will be trended and analyzed to evaluate and ensure that the Agency has an effective Compliance Program.
13. All education and/or training related to the Compliance Program will be incorporated into the Agency's training plan. The training plan shall, at a minimum, outline the subjects or topics for training and education, the timing and frequency of the training, which Affected Individuals are required to attend, how attendance will be tracked, and how the effectiveness of the training will be periodically evaluated. The training plan will be reviewed by the Compliance Officer and Compliance Committee and updated as needed, but at minimum on an annual basis.

## **VI. SANCTION STATEMENT**

Non-compliance with this policy may result in disciplinary action, up to and including termination.

## **VII. COMPLIANCE STATEMENT**

As part of its ongoing auditing and monitoring process in its Compliance Program, CHH will review this policy based on changes in the law or regulations, as CHH's practices change, and, at minimum, on an annual basis. Additionally, this policy will be tested for effectiveness on an annual basis or more frequently as identified in accordance with CHH's Compliance Program. Testing will include but is not limited to ensuring that the policy is appropriately followed; the policy is effective; the policy has been disseminated to all affected individuals, as well as notified of any updates or changes.

Tracking of the criteria above and results of this testing will be completed by the Compliance Officer, or designee. Additionally, results will be reported to the Compliance Committee and Governing Body on a regular basis.

**VIII. RECORD RETENTION STATEMENT**

CARDINAL HAYES HOME will retain this policy and all subsequent revisions, and any related documentation will be retained for a period of, at minimum, six years.

History:

Issued 12/31/2020

Revised 3/31/2023

Reviewed 4/3/2023

**Appendix A  
CARDINAL HAYES  
Attestation Form – Compliance Training and Education**

**Date of Training:** \_\_\_\_\_

**Time of Training:** \_\_\_\_\_

Location: \_\_\_\_\_

Instructor: \_\_\_\_\_

**Contents**

- Cardinal Hayes Home’s (CHH) Compliance Plan
- Standards of Conduct
- Prevention of Fraud, Waste, and Abuse
- Federal False Claims Act
- NY False Claims Act
- Whistleblower Protections
- Non-retaliation and Non-intimidation Policy
- The Role of the Compliance Officer and the Compliance Committee
- Reporting and Investigation of Compliance Concerns
- Disciplinary Standards
- Communication Channels (including name of Compliance Officer and methods to report)

- ✓ I acknowledge that I have attended Compliance training on this date. I have been provided with the opportunity to ask any questions that I may have.
- ✓ I acknowledge that I have received and read a copy of the Compliance Plan and the Standards of Conduct.
- ✓ I understand that I must comply with the Compliance Program, the Standards of Conduct, all laws, regulations, policies and procedures, and guidance provided.
- ✓ I understand that I must report any instances of known or suspected fraud, waste, and abuse; illegal or unethical acts; actual or suspected violations of Federal or State laws and regulations; actual or suspected violations of the Standards of Conduct, the Compliance Program, and CHH’s policies and procedures; improper acts in the delivery or billing of services; and other wrongdoing (collectively referred to as “compliance concerns”) to a member of Management or the Compliance Officer.
- ✓ I understand that CHH maintains a hotline (845-245-2417) for confidential or anonymous reporting of compliance concerns.
- ✓ I understand that my failure to comply with the Compliance Program, the Standards of Conduct, laws, regulations, and CHH’s policies and procedures or to report possible violations may result in disciplinary action, up to and including termination of employment, contract, assignment or association with the Agency.

Print Name \_\_\_\_\_

Title \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Appendix B**  
**CARDINAL HAYES**  
**Compliance Training – Attendance**

Date of Training: \_\_\_\_\_

Time of Training: Start: \_\_\_\_\_ End: \_\_\_\_\_

Location: \_\_\_\_\_

Instructor: \_\_\_\_\_

Contents

- Cardinal Hayes Home’s Compliance Plan
- Standards of Conduct
- Prevention of Fraud, Waste, and Abuse
- False Claims Act
- NY False Claims Act
- Whistleblower Protections and Non-retaliation Policy
- The Role of the Compliance Officer and the Compliance Committee
- Reporting and Investigations of Compliance Concerns
- Disciplinary Standards
- Communication Channels (including name of Compliance Officer and methods to report)
- Questions and Answers

Attendance

**Note: Each attendee/participant must also sign an acknowledgement of attendance.**

Print Name

Title

Signature

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<b>CARDINAL HAYES HOME  POLICY AND PROCEDURE</b>	<b>Date Issued</b> 3/31/2021	<b>Date Revised</b> 3/28/2023	<b>Date of Last Review</b> 04/13/2023	<b>Date Approved</b> 04/24/2023	<b>Section Number</b> CC-05
	<b>Subject</b>  Corporate Compliance				
	<b>Topic</b>  Conflict of Interest				

**I. PURPOSE:**

All employees and Board members of Cardinal Hayes Home (CHH) have an obligation to conduct business within guidelines that prohibit actual or potential conflicts of interest. This policy is established to ensure that services and business activities are conducted in an objective manner and are not motivated by a desire for personal or financial gain. The Board of Directors is responsible for the implementation of the Conflict of Interest Policy.

For purposes of this Policy, the term “Affected Individuals” includes all persons who are affected by the required risk areas including all employees, the Executive Director and other senior administrators, supervisors, contractors, agents, interns, and the Board of Directors (hereafter referred to as “Affected Individuals”).

**II. STATEMENT OF POLICY:**

It is the Policy of CHH to ensure that decisions about CHH’s operations are made to benefit the organization when contemplating a transaction or arrangement that could benefit an officer, director, or employee.

1. Employees, officers, and Board members are required to disclose any actual or potential conflict of interest and seek guidance on how to handle the situation.
- *Conflict of Interest:* Any situation in which financial or other personal considerations may compromise or appear to compromise (1) an employee’s or Board member’s business judgment; (2) delivery of services; or (3) ability for an employee to do his or her job. An actual or potential conflict of interest occurs when an employee or Board member is in a position to influence a decision that may result in a personal gain for that employee, Board member, or for an immediate family member as a result of business dealings. For the purpose of this Policy, an immediate family member is any person who is related by blood or marriage, or whose relationship with the employee or Board member is similar to that of persons who are related by blood or marriage. An immediate family member of a person includes:
    - The person’s spouse;
    - Natural or adoptive parent, child, or sibling;
    - Stepparent, stepchild, stepbrother, or stepsister;
    - Father-in-law, mother-in-law; son-in-law; daughter-in-law; brother-in-law; or sister-in-law;
    - Grandparent or grandchild; and
    - Spouse of a grandparent or grandchild.

Immediate family members will not be allowed to work together at the same program area on a permanent basis. In the case of a workplace crisis, special consideration may be given to staff to work together on a temporary basis. In addition, staff will not be allowed to directly supervise immediate family members or employees whose relationship is similar to that of persons who are related by blood or marriage. Immediate family members will recuse themselves when staff compensation is considered.



2. Business dealings with outside entities should not result in unusual gain for those entities, CHH, a Board member, or an employee. Unusual gain refers to gifts, bribes, product bonuses, special fringe benefits, unusual price breaks, and other windfalls designed to ultimately benefit the employer, the employee, or both or that would reasonably be determined to influence the employer, employee, or both.
3. The materials, products, designs, plans, ideas, and data are the property of the agency and should never be given to an outside firm or individual without appropriate prior authorization from the Executive Director. Any improper transfer of material or disclosure of information, even though it is not apparent that an employee has personally gained by such action, is prohibited.
4. CHH will not enter into a related party transaction unless the Board affirmatively determines that the transaction is fair, reasonable, and in the best interest of the agency. A related party transaction means any transaction, agreement, or arrangement in which a related party has a financial interest. A related party is defined as: (i) any director, officer, or key employee (e.g., members of senior leadership) of CHH or its related entities; (ii) any relative of any director, officer, or key employee of CHH or its related entities; or (iii) an entity in which any individual described in (i) or (ii) has a 35% or greater ownership or beneficial interest, or in the case of a partnership or professional corporation, a direct ownership interest in excess of 5%.

### **III. POLICY OWNER**

Corporate Compliance Officer or designee

### **IV. SCOPE**

This policy applies to all Affected individuals at Cardinal Hayes Home for Children & Cardinal Hayes School for Special Children.

### **V. PROCEDURES**

1. Each employee will be provided with CHH's Conflict of Interest Policy as part of the new hire orientation process. Each employee shall sign a statement that affirms that the employee:
  - Has received a copy of the Conflict of Interest Policy,
  - Has read and understands the Policy, and
  - Has agreed to comply with the Policy.
2. Each Board member, officer, key employee, and member of a committee with Governing Board-delegated powers will be provided with CHH's Conflict of Interest Policy and shall sign a statement at the time of hire, assignment, and/or Board approval that affirms that such person:
  - Has received a copy of the Conflict of Interest Policy,
  - Has read and understands the Policy, and
  - Has agreed to comply with the Policy.
3. Employees must disclose any potential conflicts of interest upon hire and when a potential conflict arises. The Employee completes the Conflict of Interest Disclosure Statement form (attached to this Policy) to record an actual or potential conflict of interest upon hire and when a potential conflict arises. Completed forms are to be forwarded to and retained by the Compliance Officer.
4. Key employees (members of senior leadership), the Executive Director, officers, and Board members must complete a Conflict of Interest Disclosure Statement upon hire or prior to being seated (voted on for approval) and annually thereafter in order to report any actual or potential conflict of interest. Such annual statement shall not exempt any key employee, officer, or Board member from

disclosing a potential conflict of interest pursuant to Procedure #11 below. The Compliance Officer shall provide copies of all completed Conflict of Interest Disclosure Statements by key employees, the Executive Director, officers, and Board members to the President of the Board.

5. An employee or Board member with questions or concerns about a potential conflict of interest will promptly address the issue with appropriate Management staff and/or the Compliance Officer. Management staff will consult with the Compliance Officer before responding to a concern or question about a potential conflict of interest.
6. Board Members, Officers, the Executive Director, and Management personnel are expected to avoid actions that could be perceived or interpreted as being in conflict with the best interest of the agency .
7. Actual or potential conflicts of interest must be disclosed to appropriate management personnel and the Compliance Officer. Employees who may be involved in any CHH's business transaction in which there is an actual or potential conflict of interest will promptly notify their immediate supervisor and Compliance Officer; the Compliance Officer will promptly notify the Executive Director and the President of the Board.
8. The completed Conflict of Interest Disclosure Statements are reviewed by the Compliance Officer and Executive Director and, if necessary, appropriate actions and adjustments are made to avoid possible conflicts of interest. The Compliance Officer will report significant concerns regarding the Conflict of Interest Disclosure Statements to the Compliance Committee and the President of the Board.
9. The Compliance Officer will maintain a written record of any report of potential conflict of interest and of any adjustments made to avoid potential conflicts of interest.
10. The President of the Board, after receiving information about a potential conflict of interest, will take such action as is necessary to ensure that the transaction is completed in the best interest of CHH without the substantive involvement or influence of the person with the potential conflict of interest.
11. Key employees, officers, and Board members who have a direct or indirect interest in a related party transaction must disclose, in good faith, such interest to the Board or Committee considering the transaction and the material facts concerning such interest.
12. Key employees, officers, and Board members who have a direct or indirect interest in a related party transaction may not be present or otherwise participate in any Board or Committee deliberations or voting concerning the transaction; however, such individuals may present information concerning a related party transaction prior to the commencement of deliberations or voting.
13. Prior to entering into a related party transaction, the Board or Committee must consider alternatives, to the extent available, that would not be a related party transaction.
14. The Board or Committee must approve the related party transaction by not less than a majority vote of those present at the meeting.
15. The Board or Committee must contemporaneously document, in writing, the basis for its approval of the related party transaction, including its consideration of alternatives to the related party transaction.

16. Board members with conflicts will absent themselves from the discussion/deliberation and vote on the item/circumstance that the Board member has identified as a conflict. The meeting minutes shall indicate when the member left the room, that the discussion and vote, if any, occurred, and then that the member was invited to return to the meeting. If any member with a conflict does not excuse themselves from the meeting, the President of the Board shall ask the member to leave the room. The existence and resolution of the conflict, if any, must be documented.
17. Board members are strictly prohibited from any attempt to influence the discussion, deliberations, or vote on any subject that relates to the member's conflict.
18. Employees must seek guidance and approval from appropriate Management personnel prior to pursuing any business or personal activity that may constitute a conflict of interest.
19. Outside employment may not interfere with the employee's ability to perform their job with CHH. In addition, CHH employees may not have any ownership interest in a competitor.
20. The Compliance Officer shall document the existence and resolution of any conflict in the agency's records, including putting in the minutes of any meeting at which a conflict was discussed and voted upon.
21. The Compliance Officer will investigate any violations of this Policy.

**VI. Sanction Statement:**

Non-compliance with this policy may result in disciplinary action, up to and including termination.

**VII. Compliance Statement:**

As part of its ongoing auditing and monitoring process in its Compliance Program, CHH will review this policy based on changes in the law or regulations, as CHH's practices change, and, at minimum, on an annual basis. Additionally, this policy will be tested for effectiveness on an annual basis or more frequently as identified in accordance with CHH's Compliance Program. Testing will include but is not limited to ensuring that the policy is appropriately followed; the policy is effective; the policy has been disseminated to all affected individuals, as well as notified of any updates or changes.

Tracking of the criteria above and results of this testing will be completed by the Compliance Officer, or designee. Additionally, results will be reported to the Compliance Committee and Governing Body on a regular basis.

**VIII. Record Retention Statement:**

CHH will retain this policy and all subsequent revisions, and any related documentation will be retained for a period of, at minimum, six years.

History

3.2021- updated

4.2022- reviewed

3.31.2023- revised, Approved 4.24.2023

**Appendix-A**  
**CARDINAL HAYES HOME**  
**Conflict of Interest Disclosure Statement**

The Conflict-of-Interest Policy includes a provision that sets forth standards of conduct expected and requiring Board members, Management, and employees to disclose all interests that could result in an actual or potential conflict of interest.

In accordance with **Cardinal Hayes Home's** (CHH) Conflict of Interest Policy, a conflict of interest is defined as any situation in which financial or other personal considerations may compromise or appear to compromise (1) an employee's or Board member's business judgment; (2) delivery of services; or (3) ability for an employee to do their job. An actual or potential conflict of interest occurs when an employee or Board member is in a position to influence a decision that may result in a personal gain for that employee, Board member, or for an immediate family member as a result of business dealings.

Please complete and return this Conflict of Interest Disclosure Statement. Please be assured that the disclosure requirements are intended to provide the Board and Management with a systematic and ongoing method of disclosing and ethically resolving potential conflicts of interest. Although it is impossible to list every circumstance giving rise to a possible conflict of interest, the following will serve as a guide to the types of activities that might cause conflicts and that should be fully reported:

**A. Outside Interests**

- a. To hold, directly or indirectly, a position or a financial interest in any outside concern from which the individual has reason to believe the agency secures goods or services (including the services of buying or selling stocks, bonds, or other securities), or that provides services that compete with the agency.
- b. To compete, directly or indirectly, with the agency in the purchase or sale of property or property rights, interests, or services.

**B. Outside Activities**

To render directive, managerial, or consultative services to any outside concern that does business with the agency, or competes with the services of the agency, or to render other services in competition with the agency.

**C. Inside Information**

To disclose or use information relating to the agency's business for the personal profit or advantage of the individual or their immediate family.

**D. Gifts, Gratuities, and Entertainment**

To accept gifts, excessive entertainment, or other favors from any outside concern that does, or is seeking to do, business with, or is a competitor of, the CHH – under circumstances from which it might be inferred that such action was intended to influence or possibly would influence the individual in the performance of their duties.

- ✓ I have been provided with a copy of CHH's Conflict of Interest Policy.
- ✓ I hereby state that I, or members of my immediate family, have the following affiliations or interest and have taken part in the following transactions that, when considered in conjunction with the position with or relation to the agency, might possibly constitute a conflict of interest. (Check "None" where applicable)

1. Outside Interests

Identify any interests, other than investments, of yourself or your immediate family, as described in paragraph A (Outside Interests) above.

( ) None

2. Investments

List and describe, with respect to yourself or your immediate family, all investments that might be within the category of "financial interest", as described in paragraph A (Outside Interests) above.

( ) None

3. Outside Activities

Identify any outside activities, of yourself or your immediate family, as described in paragraph B (Outside Activities) above.

( ) None

4. Other

List any other activities in which you or your immediate family are engaged that may be regarded as constituting a conflict of interest, giving particular attention to paragraphs B (Outside Activities) and C (Inside Information) above.

( ) None

5. I hereby certify that neither I nor any member of my immediate family have accepted gifts, gratuities, or entertainment that might influence my judgment or actions concerning the business of the agency, except as listed below:

( ) None

6. The following circumstances may possibly violate the Standards of Conduct:

( ) None

7. List any family members employed by **CHH** or serving as a member of **CHH's** Board of Directors.

NAME	RELATIONSHIP

By signing below, I affirm that:

1. I have received and read a copy of **CHH's** Conflict of Interest Policy.
2. I agree to comply with the Policy.
3. I have no actual or potential conflicts as defined by the Policy or if I do, I have previously disclosed them as required by the Policy or am disclosing them on this form.
4. I hereby agree to report to Management or the Compliance Officer any future situation that may result in a conflict of interest.

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Name (Printed or typed)

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Title

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Signature

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Date

**Reviewed by:**

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Name (Printed or typed)

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Title

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Signature

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Date

<b>CARDINAL HAYES HOME  POLICY AND PROCEDURE</b>	<b>Date Issued</b> 03/2021	<b>Date Revised</b> 3/20/2023	<b>Date of Last Review</b> 04/03/2023	<b>Date Approved</b> 04/24/2023	<b>Section Number</b> CC-06
	<b>Subject</b>  Corporate Compliance				
	<b>Topic</b>  Standards of Conduct				

**I. PURPOSE:**

Cardinal Hayes Home for Children (sometimes referred to as “Cardinal Hayes Home”) (CHH) is committed to conducting its business ethically and in conformance with all Federal and State laws, regulations, interpretations thereof, and its Standards of Conduct. To support this commitment, CHH will maintain and update as appropriate, written Standards of Conduct to provide guidance on employee and agency responsibilities related to compliance. The Standards of Conduct document serves as a foundational document that describes the CHH’s fundamental principles, values, and commitment to conduct its business in an ethical manner.

For the purposes of this and all CHH policies, the agency has changed terminology from Code of Conduct to Standards of Conduct. Any policies and documents created before January 1, 2023, will retain the use of the terminology Code of Conduct. After January 1, 2023, all policies and documents will be updated to use the new terminology of ‘Standards of Conduct’ where appropriate.

For purposes of this Policy, the term “Affected Individuals” includes all persons who are affected by the required risk areas including all employees, the Executive Director and other senior administrators, supervisors, contractors, agents, interns, and the Board of Directors (hereafter referred to as “Affected Individuals”).

**II. STATEMENT OF POLICY:**

It is the Policy of CHH to develop, maintain, and update as appropriate written Standards of Conduct to provide Affected Individuals with guidance on requirements for conduct related to employment, contract, association, or appointment by CHH.

**III. POLICY OWNER**

Corporate Compliance Officer or designee

**IV. SCOPE**

This policy applies to all Affected individuals at Cardinal Hayes Home for Children & Cardinal Hayes School for Special Children.

**V. POLICIES AND PROCEDURES AND STANDARDS OF CONDUCT**

1. The Compliance Officer is responsible for the development and periodic update of CHH’s Standards of Conduct.
2. The Standards of Conduct will be reviewed at least annually as part of the review of the Compliance Plan and Compliance Program Policies and Procedures.
3. The Compliance Committee and the Board of Directors will be responsible for oversight and final approval of the Standards of Conduct.

4. The Standards of Conduct will be written at a basic reading level, avoiding complex language and legal terminology.
5. The Standards of Conduct will communicate the expectation that all Affected Individuals will act in accordance with the Standards of Conduct, that they must refuse to participate in unethical or illegal conduct, and that they must report any unethical or illegal conduct to the Compliance Officer.
6. The Standards of Conduct will address specific areas of potential fraud or similar wrongdoing (e.g., claims development, submission processes, and coding).
7. The Standards of Conduct will address critical areas such as compliance with laws and regulations, key human resource practices, conflicts of interest, proprietary rights, confidentiality, recordkeeping, service provision, reimbursement practices, fair dealing, gifts, and kickbacks, the CHH's risk areas, and its measures to prevent fraud, waste, and abuse.
8. The Standards of Conduct will communicate the responsibility of Affected Individuals to report suspected fraud, waste, and abuse; illegal or unethical acts; actual or suspected violations of Federal or State laws and regulations; actual or suspected violations of the Standards of Conduct, the Compliance Program and CHH's policies and procedures; improper acts in the delivery or billing of services; and other wrongdoing (collectively referred to as "compliance concerns" for purposes of this Policy) directly to the Compliance Officer or other management personnel.
9. The CHH's confidential reporting and non-retaliation/non-intimidation policies will be referenced and included as part of the Standards of Conduct for the purpose of encouraging communication and the reporting of potential non-compliance.
10. The Standards of Conduct will provide written guidance on how Affected Individuals may report actual or suspected compliance concerns without fear of retribution, retaliation, or intimidation to the Compliance Officer through a confidential and/or anonymous mechanism that bypasses Management.
11. The Standards of Conduct will include a description of disciplinary mechanisms utilized by the CHH and the procedures for addressing disciplinary actions.
12. CHH's Standards of Conduct and Compliance Plan will be provided to all Affected Individuals as defined by this Policy.
13. CHH's Standards of Conduct and Compliance Plan will be posted on its website.
14. The Compliance Officer will ensure that all Affected Individuals, as defined by this Policy, are provided with a copy of the Compliance Plan and Standards of Conduct as part of their orientation to the CHH.
15. The Compliance Officer will ensure that each Board member is provided with a copy of the Compliance Plan and Standards of Conduct at the time of Board orientation.



16. All Affected Individuals will sign and date an Acknowledgement Form (attached to this Policy) (or similar format) that acknowledges: (a) receiving a copy of the Compliance Plan and Standards of Conduct, (b) reading and understanding the contents, and (c) agreeing to abide by the provisions of the documents.
17. The Compliance Officer will ensure that all Affected Individuals, as defined by this Policy, receive training annually related to the contents of the Standards of Conduct to help them understand how it applies to everyday situations. The Compliance Officer will ensure that records are maintained to document the receipt of training.
18. The Compliance Officer will include in their report to the Compliance Committee and Board of Directors the status of training, along with any recommendations for updating or improving the contents of the Standards of Conduct and/or training.
19. The Compliance Officer is responsible for investigations of possible violations of the Standards of Conduct and Compliance Program and ensuring that appropriate disciplinary action has been taken when necessary.

**VI. SANCTION STATEMENT**

Non-compliance with this policy may result in disciplinary action, up to and including termination.

**VII. COMPLIANCE STATEMENT**

As part of its ongoing auditing and monitoring process in its Compliance Program, CHH will review this policy based on changes in the law or regulations, as CHH's practices change, and, at minimum, on an annual basis. Additionally, this policy will be tested for effectiveness on an annual basis or more frequently as identified in accordance with CHH's Compliance Program. Testing will include but is not limited to ensuring that the policy is appropriately followed; the policy is effective; the policy has been disseminated to all affected individuals, as well as notified of any updates or changes.

Tracking of the criteria above and results of this testing will be completed by the Compliance Officer, or designee. Additionally, results will be reported to the Compliance Committee and Governing Body on a regular basis.

**VIII. RECORD RETENTION STATEMENT**

CARDINAL HAYES HOME will retain this policy and all subsequent revisions, and any related documentation will be retained for a period of, at minimum, six years.

Updated 3/2021, reviewed 4/2022,  
Revised 3/20/2023, Reviewed 4/3/2023

**Appendix A –  
CARDINAL HAYES HOME  
Acknowledgement Form**

**Compliance Plan and Standards of Conduct**

- I acknowledge that I have received and read, and that I understand, Cardinal Hayes Home’s (CHH) Compliance Plan and Standards of Conduct.
  
- I understand that I must comply with CHH’s Compliance Plan, the Standards of Conduct, and all laws, regulations, policies, procedures, and other guidance applicable to the responsibilities of my position.
  
- I understand that my failure to report any suspected fraud, waste, and abuse; illegal or unethical acts; actual or suspected violations of Federal or State laws and regulations; actual or suspected violations of the Standards of Conduct, the Compliance Program and CHH’s policies and procedures; improper acts in the delivery or billing of services; and other wrongdoing (collectively referred to as “compliance concerns”) may result in disciplinary action, up to and including termination of employment, contract, assignment or engagement with CHH.

**By placing a checkmark in the boxes above, I acknowledge that I have read and understand each statement.**

Signature

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Print Name

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Title

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Date

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<b>CARDINAL HAYES HOME POLICY AND PROCEDURE</b>	<b>Date Issued</b> 3/31/2021	<b>Date Revised</b> 4/12/2023	<b>Date of Last Review</b> 04/13/2023	<b>Date Approved</b> 04/24/2023	<b>Section Number</b> CC-07
	<b>Subject</b>  Corporate Compliance				
	<b>Topic</b>  Reporting and Investigation of Compliance Concerns				

**I. PURPOSE:**

Cardinal Hayes Home for Children (sometimes referred to as “Cardinal Hayes Home”) (CHH) recognizes that a critical aspect of its Compliance Program is the establishment of a culture that promotes prevention, detection, and resolution of instances of conduct that do not conform to Federal and State requirements, the agency’s ethical and business policies, and fraud, waste, and abuse prevention.

To promote this culture, CHH has established processes to encourage effective communication and the reporting of compliance questions, issues, concerns, or events that will result in a thorough investigation and appropriate remedial actions.

For purposes of this Policy, the term “Affected Individuals” includes all persons who are affected by the required risk areas including all employees, the Executive Director and other senior administrators, supervisors, contractors, agents, interns and the Board of Directors (hereafter referred to as “Affected Individuals”).

**II. STATEMENT OF POLICY:**

It is the Policy of CHH to maintain a formal confidential and anonymous compliance reporting process to encourage the reporting of any known or suspected fraud, waste, and abuse; illegal or unethical acts; actual or suspected violations of Federal or State laws and regulations; actual or suspected violations of the Standards of Conduct, the Compliance Program, and CHH’s policies and procedures; improper acts in the delivery or billing of services; and other wrongdoing (collectively referred to as “compliance concerns” for purposes of this Policy).

It is the Policy of CHH to fully and promptly investigate all reports of any compliance concerns and take appropriate remedial and/or disciplinary action upon completion of the investigation.

**III. POLICY OWNER**

Corporate Compliance Officer or designee

**IV. SCOPE**

This policy applies to all Affected individuals at Cardinal Hayes Home for Children & Cardinal Hayes School for Special Children.

**V. PROCEDURES**

**Reporting Process:**

1. All Affected Individuals have an affirmative duty and responsibility to promptly report any compliance concerns.
2. An “open-door policy” will be maintained at all levels of Management to encourage the reporting of problems and compliance concerns through normal business channels and appropriate levels of the agency for timely and effective resolution. The agency recognizes there may be situations where such

reporting is impractical or inappropriate. In those instances, direct access to various levels of Management may be more appropriate.

3. CHH encourages all Affected Individuals, service recipients, vendors, and any party conducting business with it to promptly communicate questions, issues, or compliance concerns through any one of the following means:
  - Direct written or oral communication by fax, mail, email, telephone, or personal contact to the immediate supervisor, a member of Management, the Executive Director, a member of the Compliance Committee, or the Compliance Officer.
  - Confidentially or anonymously to the Compliance Officer through the Compliance Hotline. If the reporter elects to make the report anonymously to the Compliance Officer, no attempt will be made to trace the source of the report or identify the person making the report.
4. If the compliance concern is about the Compliance Officer, the Executive Director is to be notified.
5. If the Compliance Officer receives a concern related to the Executive Director, the Compliance Officer shall report such information to the President of the Board of Directors.
6. If a Board member has knowledge of a compliance concern as defined by this Policy, the Compliance Officer and the Executive Director are to be notified. If there is a concern about the Executive Director, the Compliance Officer and the President of the Board of Directors are to be notified.
7. Employees have the same obligations for reporting suspected compliance concerns committed by the agency's vendors or contractors.
8. Affected Individuals cannot exempt themselves from the consequences of their own misconduct by reporting the issue, although self-reporting may be considered in determining the appropriate course of action.
9. Strict confidentiality regarding the reporting of compliance concerns will be maintained unless the matter is subject to a disciplinary proceeding, referred to or under investigation by Federal, State, or local law enforcement, or should the disclosure be required during a legal proceeding. Those staff assigned to complete any investigation of a compliance concern shall treat the investigation as entirely confidential and shall reveal no details or discuss the content or status of the investigation with CHH staff or any other party except as may be directed by the Compliance Officer or legal counsel. Failure of staff to respect the confidentiality of any investigation of a compliance concern may be grounds for disciplinary action up to and including termination of employment.
10. The Compliance Officer will ensure that all reports of compliance concerns as defined by this Policy are recorded on the Compliance Concern Report Form (attached to this Policy) and tracked on the Compliance Concern and Investigation Log (attached to this Policy).
11. Any member of Management who receives a report of a compliance concern will immediately notify the Compliance Officer and complete a Compliance Concern Report Form. The completed Form will be promptly forwarded to the Compliance Officer.

12. Knowledge of a violation or potential violation of this Policy must be reported directly to the Compliance Officer or the Compliance Hotline.
13. Affected Individuals who report issues or concerns that are unrelated to the Compliance Program shall be redirected to the appropriate department or party. In instances where the Affected Individual seeks confidentiality or reports anonymously, the Compliance Officer shall redirect the report to the appropriate department or party while maintaining the request for confidentiality/anonymity.
14. CHH strictly prohibits its Management, employees, and Board members from engaging in any act, conduct, or behavior that results in, or is intended to result in, retribution, retaliation or intimidation (hereafter, collectively referred to as “retaliation”) against any party for reporting compliance concerns as defined by this Policy.
15. If an Affected Individual believes in good faith that they have been retaliated against for reporting a compliance concern or for participating in any investigation of such a report, the retaliation should be immediately reported to the Compliance Officer or the Compliance Hotline. The report should include a thorough account of the incident(s) and should include the names, dates, specific events, the names of any witnesses, and the location or name of any document that supports the alleged retaliation.
16. The Compliance Officer will ensure that the means for reporting actual or suspected compliance concerns to the Compliance Officer are communicated to all Affected Individuals and service recipients. The Compliance Officer’s contact information and Compliance Hotline number will be published on the agency’s website and visibly posted in a manner consistent with employee notification in locations frequented by CHH employees.
17. The Compliance Officer’s contact information and the Compliance Hotline number shall be provided to all Medicaid recipients of service.

**Investigation and Resolution:**

1. It is the responsibility of the Compliance Officer to conduct or oversee the conduction of all internal investigations involving compliance concerns and shall have the authority to engage legal counsel or other consultants, as needed. The Compliance Officer, in conjunction with the Executive Director and legal counsel, will consider whether the investigation should be conducted under attorney privilege.
2. Before conducting an investigation of any compliance concern as defined by this Policy, the Compliance Officer shall ensure a full understanding of the relevant laws, regulations, and government issuances. If a reported violation is related to improper billing, the Compliance Officer will consider the need for an audit of billing practices and determine the scope of interviews.
3. If deemed appropriate, the Compliance Officer will recommend the cessation of internal activities that may be the cause of, or contribute to, the alleged non-compliance.
4. The Compliance Officer will determine the scope of the reported compliance concern and make a determination regarding the course of action, including the investigation process and notifications to be made.

5. Upon report notice or discovery of an alleged compliance concern, the Compliance Officer will conduct an initial inquiry into the alleged situation. The purpose of the initial inquiry is to determine whether there is sufficient evidence of possible non-compliance to warrant further investigation. The initial inquiry may include documentation review, interviews, audit, or other investigative techniques. The Compliance Officer should: (a) conduct a fair impartial review of all relevant facts; (b) restrict the inquiry to those necessary to resolve the issues; and (c) conduct the inquiry with as little visibility as possible while gathering pertinent facts relating to the issue.
6. If, during the initial inquiry, the Compliance Officer determines that there is sufficient evidence of possible noncompliance with any criminal, civil, or administrative law to warrant further investigation, the issue should be turned over to legal counsel. A memorandum to this effect should be directed to legal counsel with a copy to the Executive Director. The Compliance Officer or Executive Director will immediately make arrangements to retain legal counsel and no further internal discussion or investigative activity shall take place regarding the report except as directed by legal counsel. Once legal counsel is retained, it will be determined whether legal counsel or the Compliance Officer will be leading the investigation.
7. All documents produced during the investigation by or under legal counsel to be possibly protected from disclosure should include the notation: "Privileged and Confidential Document; Subject to Attorney-Client Privileges; Attorney Directed Work Product."
8. For investigations that do not involve legal counsel, the Compliance Officer will determine which personnel possess the requisite skills to examine the particular issue(s) and will assemble a team of investigators, as needed. The Compliance Officer shall work with the investigation team to develop a strategy for reviewing and examining the facts surrounding the possible violation. The Compliance Officer will also decide whether the agency has sufficient internal resources to conduct the investigation or whether external resources are necessary. If it is determined that additional resources are needed, the Compliance Officer will work with the Executive Director to secure such resources.
9. The Compliance Officer will be responsible for the investigation of and follow-up on any reported retaliation against a party for reporting a compliance concern or participating in the investigation of a compliance concern. The Compliance Officer will report the results of an investigation into suspected retaliation to the Executive Director, the Compliance Committee, and the Board of Directors.
10. If at any time, during an investigation, it is determined that the situation warrants the retention of legal counsel, the Compliance Officer will immediately suspend the investigation and follow the process in Procedure #6 (Investigations and Resolution) above.
11. The Compliance Officer, in consultation with the Compliance Committee and, where appropriate, the Board, may undertake measures during an investigation of a compliance concern to protect the integrity of the investigation, prevent the destruction of documents or other evidence relevant to the investigation, and respect the due process rights of involved parties. Measures may include, but are not limited to, reassignment or placement on administrative leave until the investigation is complete.

12. The Compliance Officer will track the investigation, responsible parties, and due dates. The resolution of the investigation will be recorded on the Compliance Concern and Investigation Log (attached to this Policy).
13. The Compliance Officer should ensure that the following objectives are accomplished for each investigation:
  - The complainant or reporter, if known, is fully debriefed;
  - Appropriate internal parties are notified;
  - The cause of problem, desired outcome, affected parties, applicable guidelines, and possible regulatory or financial impact are identified;
  - A complete list of findings and recommendations are provided;
  - The necessary corrective action measures (e.g., policy changes, operational changes, system changes, personnel changes, discipline, training/education) are identified; and
  - The investigation is documented.
14. Upon receipt of the results of the investigation, depending upon the scope and severity of the identified violations, the Compliance Officer may consult with legal counsel, the Executive Director, and/or the Compliance Committee to determine: (a) the results of the investigation and the adequacy of recommendations for corrective actions; (b) the completeness, objectivity, and adequacy of recommendations for corrective actions; and/or (c) further actions to be taken as necessary and appropriate.
15. Upon conclusion of the investigation, the Compliance Officer will organize the information in a manner that enables the agency to determine if an infraction did, in fact, occur. The Compliance Officer will maintain all notes of the interviews, all evidence and documents as part of the investigation file. The investigation file will be securely maintained by the Compliance Officer.
16. If the Compliance Officer, in consultation with legal counsel, identifies credible evidence or credibly believes that a State or Federal law, rule, or regulation has been violated, the Compliance Officer will promptly report such violation to the appropriate governmental entity, where such reporting is otherwise required by law, rule or regulation. The Compliance Officer will receive and maintain copies of any reports submitted to governmental entities.
17. The Compliance Officer, in consultation with legal counsel, the Executive Director, and the Compliance Committee, will evaluate any confirmed violation to determine if a voluntary self-disclosure of the violation is appropriate. In the event that voluntary disclosure is appropriate or required, the Compliance Officer will consult with legal counsel on the notification of appropriate government officials, private payors, or other entities. Notification shall be made within a reasonable time period from date of discovery and may include restitution of monies paid by the applicable Federal or State agency, payer, or other entity. The Compliance Officer will ensure that all overpayments are reported and refunded to the appropriate payer within 60 days of the identification of the overpayment and in accordance with the Billing Errors, Overpayments, and Self-Disclosure Policy and Procedure.
18. The Compliance Officer will be responsible for reporting the results of all investigations to the Executive Director, Compliance Committee, and the Board.

19. The Compliance Officer or appropriate member of Management will inform the reporter, if known, of the conclusion of the investigation and the outcome, if appropriate.

**VI. Sanction Statement:**

Non-compliance with this policy may result in disciplinary action, up to and including termination.

**VII. Compliance Statement:**

As part of its ongoing auditing and monitoring process in its Compliance Program, CHH will review this policy based on changes in the law or regulations, as CHH's practices change, and, at minimum, on an annual basis. Additionally, this policy will be tested for effectiveness on an annual basis or more frequently as identified in accordance with CHH's Compliance Program. Testing will include but is not limited to ensuring that the policy is appropriately followed; the policy is effective; the policy has been disseminated to all affected individuals, as well as notified of any updates or changes.

Tracking of the criteria above and results of this testing will be completed by the Compliance Officer, or designee. Additionally, results will be reported to the Compliance Committee and Governing Body on a regular basis.

**VIII. Record Retention Statement:**

CHH will retain this policy and all subsequent revisions, and any related documentation will be retained for a period of, at minimum, six years.

History

3.2021- updated

4.2022- reviewed

4.13.2023- revised



**Appendix-A**  
**CARDINAL HAYES HOME**  
**Compliance Concern Report Form**

Today's date (date report filed): /\_\_\_\_/\_\_\_\_/\_\_\_\_

Your name: \_\_\_\_\_ Title/Position: \_\_\_\_\_

Department/Program \_\_\_\_\_

**Mode of Contact:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Report to Supervisor                  | <input type="checkbox"/> Hotline             | <input type="checkbox"/> Email                  |
| <input type="checkbox"/> Compliance Officer (Direct contact)   | <input type="checkbox"/> Walk-In             | <input type="checkbox"/> Organization phoneline |
| <input type="checkbox"/> Letter or Note                        | <input type="checkbox"/> Staff Meeting       | <input type="checkbox"/> Other _____            |
| <input type="checkbox"/> Letter to Board or Executive Director | <input type="checkbox"/> Compliance Training |   |

**Source of Report:**

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> Employee, Independent Contractor | <input type="checkbox"/> Vendor/Subcontractor | <input type="checkbox"/> Board Member |
| <input type="checkbox"/> Service Recipient/Family Member  | <input type="checkbox"/> Other Provider       | <input type="checkbox"/> Other _____  |

**Contact Confidentiality Status:**

- |                                    |   |                                     |
|------------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Anonymous | <input type="checkbox"/> Confidential (Identified self) | <input type="checkbox"/> Name _____ |
|                                    | Phone _____   |                                     |

**Type of Report:**

- Suspected Violation/Misconduct    Regulatory Inquiry    Organization P&P Inquiry    Ethical Business Practice

**Is this a question about the Compliance Program?** Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, indicate question here:

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**Is this a suspected violation of the Compliance Program?** Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, answer the questions below:      **(Attach additional sheets if necessary.)**

Please describe in as much detail as possible, the violation: *(Please be specific where the violation may have occurred)* \_\_\_\_\_

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When did this occur? \_\_\_\_/\_\_\_\_/\_\_\_\_      Were you directly involved? \_\_\_\_

If yes, describe what you did: \_\_\_\_\_

---

Who else was directly involved? *(Names and positions, if known):*

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Is there any documentation or other evidence of the alleged violation? *Please describe/list or attach:*

---

Has the reporter discussed this issue with anyone else within the agency? *Please list by name and position:*

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Has the reporter discussed this with others outside the agency? *Please identify by name and relationship:*

\_\_\_\_\_

Completed by: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Forward completed form to Compliance Officer

### For Use by Compliance Officer:

#### Follow Up:

Reported to Compliance Officer: \_\_\_\_\_ By: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Reported to Executive Director: \_\_\_\_\_ Date: \_\_\_\_\_

Reported to Compliance Committee: \_\_\_\_\_ Date: \_\_\_\_\_

Reported to Board: \_\_\_\_\_ Date: \_\_\_\_\_

#### Actions Taken:

Immediate Response Provided  Internal investigation initiated; assigned to: \_\_\_\_\_

Researched regulations  External investigation; Entity \_\_\_\_\_ Date \_\_\_\_\_

Researched CHH P&P  Referred to legal counsel \_\_\_\_\_ Date: \_\_\_\_\_

Responded to reporter; date \_\_\_\_\_

#### Summary of Action Taken:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Final Disposition by Compliance Officer: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Classification: \_\_\_\_\_

Compliance Report and Investigation Log Number: \_\_\_\_\_

Completed by:

\_\_\_\_\_  
Compliance Officer Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Appendix-B  
CARDINAL HAYES HOME  
Compliance Concern and Investigation Log**

<b>Number</b>	<b>Date Received</b>	<b>Source</b>	<b>Type</b>	<b>Program/ Department</b>	<b>Summary</b>	<b>Date Investigation Completed</b>	<b>Disposition/Outcome</b>	<b>Date of Committee Review</b>

**Type of Report:**

- Question
- Documentation Issue
- Billing Issue
- Violation of Standards of Conduct
- Missing Funds/Misuse of Funds
- Confidentiality/HIPAA
- Human Resource Issue
- Alleged Retaliation
- Violation of Policy & Procedure
- Other

**Source:**

- Employee, Contractor (Direct to Compliance Officer)
- Supervisor
- Contractor, Vendor
- Hotline
- Other Provider
- Service Recipient/Family
- Anonymous letter
- Other

<b>CARDINAL HAYES HOME  POLICY AND PROCEDURE</b>	<b>Date Issued</b> 3/31/2021	<b>Date Revised</b> 4/13/2023	<b>Date of Last Review</b> 04/13/2023	<b>Date Approved</b> 04/24/2023	<b>Section Number</b> CC-08
	<b>Subject</b>  Corporate Compliance				
	<b>Topic</b>  Discipline - Enforcement of Compliance Standards				

**I. PURPOSE:**

Cardinal Hayes Home for Children (sometimes referred to as “Cardinal Hayes Home”) (CHH) is committed to conducting its business ethically and in conformance with all Federal and State laws, regulations, interpretations thereof, and the agency’s Standards of Conduct. To support this commitment, CHH has developed procedures for disciplinary actions to be taken for illegal or unethical acts; violations of Federal or State laws and regulations; violations of the Standards of Conduct, the Compliance Program, and CHH’s policies and procedures; improper acts in the delivery or billing of services; and other wrongdoing (collectively referred to as “compliance violations” for purposes of this Policy) by Affected Individuals.

For purposes of this Policy, the term “Affected Individuals” includes all persons who are affected by the required risk areas including all employees, the Executive Director and other senior administrators, supervisors, contractors, agents, interns and the Board of Directors (hereafter referred to as “Affected Individuals”).

**II. STATEMENT OF POLICY:**

It is the Policy of CHH to ensure that:

1. Affected Individuals who, upon investigation, are found to have committed compliance violations will be subject to appropriate disciplinary action, up to and including termination of employment, contract, assignment, or appointment with CHH.
2. The following actions shall result in disciplinary action:
  - Authorization of or participation in actions that violate Federal or State laws, regulations, the Compliance Program, Standards of Conduct, or any related policies and procedures;
  - Failure to comply with the agency’s policies governing the prevention, detection, or reporting of fraud and abuse;
  - Falsification of records;
  - Submitting or causing to submit a false claim;
  - Failure to report a violation by a peer or subordinate;
  - Failure to cooperate in an investigation; and
  - Retribution, retaliation, or intimidation against a person for reporting a possible compliance violation or participating in an investigation.
3. The agency will apply progressive discipline consistent with the violation. Examples of the disciplinary action that may be taken in accordance with the nature and scope of the infraction include but are not limited to: (a) verbal counseling or warning; (b) counseling with written warning; (c) retraining; (d) reassignment or demotion; (e) suspension without pay; and (f) termination of employment, contract, assignment, or appointment. The agency will consider intentional or reckless behavior as being subject to more significant disciplinary action.

4. The Compliance Officer will be responsible for assuring that disciplinary actions related to compliance violations are consistent with actions taken in similar instances of non-compliance and that the same disciplinary action applies to all levels of Affected Individuals.

### **III. POLICY OWNER**

Corporate Compliance Officer or designee

### **IV. SCOPE**

This policy applies to all Affected individuals at Cardinal Hayes Home for Children & Cardinal Hayes School for Special Children.

### **V. PROCEDURES**

1. All reports of compliance violations are to be reported to the Compliance Officer in accordance with the Reporting and Investigation of Compliance Concerns Policy and Procedure.
2. To the extent possible, disciplinary action for employees will be taken in accordance with the agency's Human Resource Manual.
3. When the determination is made that a compliance violation by an Affected Individual has occurred, the Compliance Officer will notify the Executive Director, the appropriate department/program administrator, and the employee's supervisor.
4. When the determination is made that a compliance violation by a Board member or a corporate officer has occurred, the Compliance Officer will notify the Executive Director and the President of the Board. If the President of the Board is implicated in the violation, the Compliance Officer and Executive Director will work with the Executive Committee of the Board (President to be recused) to determine and execute appropriate disciplinary action.
5. When the determination is made that a compliance violation by the Executive Director has occurred, the Compliance Officer will notify the President of the Board in order to determine and execute appropriate disciplinary action. Legal counsel may be consulted, as appropriate.
6. When the determination is made that a compliance violation occurred involving a contractor or vendor, the Compliance Officer will notify the Executive Director and work collaboratively to determine and execute the appropriate corrective action.
7. If appropriate, the Compliance Officer may notify the Board or the Compliance Committee prior to the next regularly scheduled meeting when a full report of compliance-related disciplinary actions would normally be presented.
8. The Compliance Officer and Director of Human Resources will work in collaboration with the appropriate supervisor/manager in determining and executing the disciplinary action related to a compliance violation by an employee. The Compliance Officer shall have the discretion to recommend a disciplinary process other than the normal procedure.
9. The Compliance Officer and/or Director of Human Resources shall consult with the Compliance Committee, the Executive Director, and legal counsel, as necessary to determine the appropriate disciplinary action to be taken.
10. Discipline will be appropriately documented in the disciplined employee's personnel file, along with a written statement of reason(s) for imposing such discipline. Such documentation will be considered during the employees' regular and promotional evaluations.

11. The Compliance Officer will maintain a written record of all disciplinary actions taken against Affected Individuals, including verbal warnings, and will reference these records when necessary to ensure consistency in the application of disciplinary measures.
12. The Compliance Officer shall maintain a record of all disciplinary actions, including verbal warnings, taken against Affected Individuals related to compliance violations and report regularly to the Compliance Committee and not less than annually to the Board of Directors, regarding such actions.
13. The Compliance Officer will reference the record of disciplinary actions as necessary to ensure consistency in the application of disciplinary measures related to compliance violations.
14. The Compliance Officer will ensure that the disciplinary procedures are disseminated to all Affected Individuals and that these individuals have received relevant training in accordance with the agency's training plan.

**VI. Sanction Statement:**

Non-compliance with this policy may result in disciplinary action, up to and including termination.

**VII. Compliance Statement:**

As part of its ongoing auditing and monitoring process in its Compliance Program, CHH will review this policy based on changes in the law or regulations, as CHH's practices change, and, at minimum, on an annual basis. Additionally, this policy will be tested for effectiveness on an annual basis or more frequently as identified in accordance with CHH's Compliance Program. Testing will include but is not limited to ensuring that the policy is appropriately followed; the policy is effective; the policy has been disseminated to all affected individuals, as well as notified of any updates or changes.

Tracking of the criteria above and results of this testing will be completed by the Compliance Officer, or a designee. Additionally, results will be reported to the Compliance Committee and Governing Body on a regular basis.

**VIII. Record Retention Statement:**

CHH will retain this policy and all subsequent revisions, and any related documentation will be retained for a period of, at minimum, six years.

History

3.2021- updated

4.2022- reviewed

4.13.2023- revised

<b>CARDINAL HAYES HOME  POLICY AND PROCEDURE</b>	<b>Date Issued</b> 04/2021	<b>Date Revised</b> 03/31/2023	<b>Date of Last Review</b> 04/13/2023	<b>Date Approved</b> 04/24/2023	<b>Section Number</b> CC-13
	<b>Subject</b>				
	<b>Corporate Compliance</b>				
<b>Topic</b>					
<b>Antikickback – Business Courtesies, Gifts, and Entertainment</b>					

**I. PURPOSE:**

Cardinal Hayes Home for Children (sometimes referred to as “Cardinal Hayes Home”) (CHH) recognizes that there are legitimate and lawful reasons to accept or provide reasonable business courtesies. However, in healthcare, business courtesies pose a risk for conflict of interest or fraud and/or abuse related to anti-kickback laws and regulations. The Federal Anti-Kickback law prohibits the offer of payment, solicitation, or receipt of anything of value to induce or reward the referral of Federal health care program recipients, such as Medicare and Medicaid recipients. The Federal Anti-Kickback statute also prohibits the payment or receipt of any remuneration that is intended to induce the purchasing, leasing, or ordering of any item or service that may be reimbursed, in whole or in part, under a federal health care program. It also prohibits the payment or receipt of any remuneration that is intended to induce the recommendation of the purchasing, leasing, or ordering of any such item or service.

The purpose of this policy is to assure that the agency complies with Federal Anti-Kickback laws. The policy provides guidance for providing business courtesies.

For the purpose of this policy, the following definitions apply:

- **Affected Individuals:** all persons who are affected by the required risk areas including all employees, the Executive Director and other senior administrators, supervisors, contractors, agents, interns and the Board of Directors (hereafter referred to as “Affected Individuals”)
- **Business Courtesies:** A business courtesy is anything of value, a favor, or a benefit provided free of charge or at a charge less than fair market value in the context of a business relationship. The Policy applies to gifts, entertainment, and hospitality involving the agency’s employees or Board members and its referral sources and business partners intended to enhance business relationships and/or further their mutual business interests. Examples include gifts, entertainment, or hospitality for the purposes of inducing:
  - Referrals for the agency’s services or treatment;
  - The purchasing, leasing, or ordering of any item or service; or
  - The recommendation of the purchasing, leasing, or ordering of any such item or service.
- **Immediate Family Member:** For the purpose of this policy, an immediate family member is any person who is related by blood or marriage, or whose relationship with the employee or Board member is similar to that of persons who are related by blood or marriage. An immediate family member of a person includes:
  - The person’s spouse;
  - Natural or adoptive parent, child, or sibling;
  - Stepparent, stepchild, stepbrother, or stepsister;
  - Father-in-law, mother-in-law; son-in-law; daughter-in-law; brother-in-law; or sister-in-law;
  - Grandparent or grandchild; and

- Spouse of a grandparent or grandchild.
- Nominal Value: CHH has determined that items with a value of \$ 322.00 or less to be of nominal value
- Potential Referral Source: A potential referral source includes a physician, other healthcare provider, or party who could reasonably be a source of referral of individuals or patients to the agency for services or treatment.
- Remuneration: Any type of direct or indirect payment, bribe, rebate, or other type of inducement.

## **II. STATEMENT OF POLICY:**

1. Any business courtesy intended to induce or reward referrals or result in the purchase of goods or services is strictly prohibited.
2. It is the policy of CHH that gifts, entertainment, and other benefits will not be provided to a potential referral source, except as permitted by this policy.
3. Any business courtesies involving physicians or other individuals or entities in a position to refer individuals or patients to CHH for services must strictly follow CHH's policies and be in conformance with all Federal and State laws, regulations, and rules regarding these practices.

## **III. POLICY OWNER**

Corporate Compliance Officer or designee

## **IV. SCOPE**

This policy applies to all Affected individuals at Cardinal Hayes Home for Children & Cardinal Hayes School for Special Children.

## **V. POLICIES AND PROCEDURES AND STANDARDS OF CONDUCT**

1. CHH's employees and Board members may not offer a potential referral source business courtesy unless the following criteria are met:
  - The business courtesy is not based, directly or indirectly, on the volume or value of referrals or other business generated by the potential referral source;
  - The business courtesy is not solicited by the potential referral source or the referral source's employees;
  - The business courtesy does not consist of cash or the equivalent of cash; and
  - The business courtesy does not violate the Federal Anti-Kickback statute or any state or Federal law governing claims submission.
2. All employees and Board members must receive prior approval from the Compliance Officer before extending business courtesies to potential referral sources and business partners. The Compliance Officer will record any business courtesy extended to potential referral sources and business partners on the Gifts and Entertainment Recording Log attached to this Policy. The Compliance Officer will ensure that business courtesies are of nominal value.
3. Employees, Board members, and their Immediate Family Members are prohibited from receiving and/or accepting business courtesies from CHH's business partners or potential business partners as an inducement to purchase or lease goods or services.



4. Employees, Board members, and their Immediate Family Members shall not accept or solicit excessive gifts, meals, expensive entertainment, or other offers of goods or services that have more than a nominal value from vendors, suppliers, contractors, or other persons.
5. Employees and Board members may only retain gifts from vendors that have a nominal value. Gifts from vendors must be reported to the Compliance Officer and recorded on the Gifts and Entertainment Recording Log. If an employee or Board member has any concern as to whether a gift should be accepted, the Compliance Officer should be consulted. To the extent possible, these gifts should be shared with other individuals/employees at the agency.

**VI. SANCTION STATEMENT**

Non-compliance with this policy may result in disciplinary action, up to and including termination.

**VII. COMPLIANCE STATEMENT**

As part of its ongoing auditing and monitoring process in its Compliance Program, CHH will review this policy based on changes in the law or regulations, as CHH's practices change, and, at minimum, on an annual basis. Additionally, this policy will be tested for effectiveness on an annual basis or more frequently as identified in accordance with CHH's Compliance Program. Testing will include but is not limited to ensuring that the policy is appropriately followed; the policy is effective; the policy has been disseminated to all affected individuals, as well as notified of any updates or changes.

Tracking of the criteria above and results of this testing will be completed by the Compliance Officer, or designee. Additionally, results will be reported to the Compliance Committee and Governing Body on a regular basis.

**VIII. RECORD RETENTION STATEMENT**

CARDINAL HAYES HOME will retain this policy and all subsequent revisions, and any related documentation will be retained for a period of, at minimum, six years.

History

Implemented 4.2021

Reviewed 4.1.2022

Revised: 3.31.2023

Reviewed: 4.3.2023

Effective: 4.24.2023

**Appendix A –  
CARDINAL HAYES HOME  
Gifts and Entertainment Recording Log**

**For the period 1/1/20\_\_ to 12/31/20\_\_**

Potential Referral Source, Business Partner or Vendor	Authorized By	Date of Gift/ Entertainment	Type of Gift/ Entertainment	Gift/Entertainment Amount	Reason for Gift/ Entertainment

<b>CARDINAL HAYES HOME</b>  <b>&amp;</b>  <b>CARDINAL HAYES DAY</b> <b>SCHOOL</b>  <b>POLICY AND PROCEDURE</b>	<b>Date Issued</b> <b>03/16/2018</b>	<b>Date Revised</b> <b>10/02/2023</b>	<b>Date of Last Review</b> <b>10/19/2023</b>	<b>Date Approved</b> <b>11/10/2023</b>	<b>Section Number</b> <b>CC-15</b>
	<b>Subject</b>  <b>Billing Errors, Overpayments &amp; Self Disclosure</b>				
	<b>Topic</b>  <b>Compliance Plan</b>				

**I. PURPOSE:**

Cardinal Hayes Home for Children (sometimes referred to as “Cardinal Hayes Home”) (CHH) is committed to adopting and implementing an effective Compliance Program that includes ensuring the ability to detect, correct, and resolve payment and billing errors as quickly and as efficiently as possible.

For purposes of this Policy, the term “Affected Individuals” includes all persons who are affected by the required risk areas including all employees, the Executive Director and other senior administrators, supervisors, contractors, agents, and the Board of Directors (hereafter referred to as “Affected Individuals”).

**II. STATEMENT OF POLICY:**

It is the policy of CHH that any overpayments or inaccurate billing of claims be detected, reported, and returned in a timely manner following all rules, regulations, and laws.

CHH is committed to ensuring that in the event that the Agency has received an overpayment under the Medicaid Assistance Program (Medicaid), Medicare, or another third-party payer, the Agency shall report and return the overpayment, notify the appropriate payer, and comply with all Federal and State laws, regulations, guidelines, and policies.

**III. POLICY OWNER**

Chief Quality & Corporate Compliance Officer or designee.

**IV. SCOPE**

This policy applies to all Affected individuals at Cardinal Hayes Home for Children & Cardinal Hayes School for Special Children.

**V. POLICIES AND PROCEDURES**

**A. Billing Practices**

- a) All employees and affected individuals will receive compliance training upon hire and annually thereafter on the Cardinal Hayes Home Compliance Program Plan and Standards of Conduct which includes, but is not limited to information on reimbursement practices, contemporaneous and accurate documentation of medically necessary services, reporting of compliance concerns and non-intimidation/retaliation protection, and enforcement of noncompliance.
- b) All claims submitted to Fiscal for reimbursement submission will be reviewed and verified as per agency policies and practices. For the ICF programs, the attendance records will be submitted the Monday of each week. For HCBS residential and day habilitation programs, the service documents will be submitted twice during the month with the monthly note attached to the last submission for the month.
- c) Internal monitoring and auditing will be conducted as per agency policies and procedures.

**B. Identification of Billing Errors and Overpayments**

- a) The Compliance Officer must be promptly notified of all potential or actual billing errors and suspected overpayments. Examples of billing errors or reasons for overpayment may include, but are not limited to, the following:
  - Coding errors;
  - Errors in rate or unit;
  - Keying or inputting errors;
  - Provision of unauthorized services;
  - Services are not medically necessary, or necessity is not documented in the record;
  - Absence of one or more required elements of documentation;
  - Service was not rendered;
  - Falsification of service or billing documents;
  - Duplicate payments;
  - Fraudulent behavior by employees or others;
  - Discovery of an employee or contractor on the Federal or State exclusion lists; and
  - Damaged, lost, or destroyed records.
- b) The Compliance Officer will notify the Executive Director and the Chief Financial Officer of potential billing issues and overpayments. The preliminary circumstances will be reviewed to determine if a suspension of billing is to be initiated.
- c) The Compliance Officer or designee will investigate the issue; review any underlying facts; quantify and identify the amount of overpayment; ensure that any errors are corrected; and ensure that any refunds are made to the appropriate governmental agency or third-party payer. The investigation will be conducted in accordance with the Reporting and Investigation of Compliance Concerns Policy and Procedure. The Compliance Officer may engage outside legal counsel, auditors, or other consultants to help determine whether an overpayment has occurred and/or to quantify the overpayment.
- d) An overpayment is deemed “identified” when it is determined or should have been determined through the exercise of reasonable diligence, that an overpayment was received, and the amount of the overpayment has been quantified.
- e) The Compliance Officer is responsible for ensuring that the Agency properly discloses all overpayments to the appropriate payer and makes any reports and refunds that are necessary within the required timeframe for the payer.
- f) Medicaid and Medicare overpayments must be reported and returned:
  - no later than 60 days after the date the overpayment was identified; or
  - by the date that any corresponding cost report is due, if applicable.
- g) Medicaid overpayments must be reported and returned in accordance with the Office of Medicaid Inspector General’s (OMIG) Self-Disclosure Protocol. The Protocol is available on OMIG’s website at <https://omig.ny.gov/>. (For further information, refer to the Medicaid Self-Disclosure section below.)
- h) Medicare overpayments are reported and refunded to the Medicare Administrative Contractor (MAC) or through the Office of Inspector General’s Voluntary Self Disclosure program.
- i) Overpayments to other third-party payers will be made in accordance with the contractual agreement.
- j) Any overpayments retained by the Agency after the deadline for reporting and returning the overpayment may be subject to a monetary penalty.
- k) The Compliance Officer must approve the overpayment and self-disclosure procedures and/or any revisions to procedures or forms before implementation.

- l) Failure to report a potential reimbursement and billing issue or suspected overpayment will result in disciplinary action, up to and including termination of employment or contract.
- m) The Compliance Officer will maintain a file for each overpayment and self-disclosure. All interview notes, evidence, claims data, and written communication to and from the government agency or third-party payer will be maintained in the file in a secure location.
- n) The Compliance Officer will maintain a log of all overpayments that have been disclosed to governmental authorities and third-party payers. The following information will be recorded on the Overpayment and Disclosure Log (attached to this Policy):
  - The date that the overpayment was identified/quantified;
  - The date that the overpayment was disclosed;
  - The date that the overpayment was refunded;
  - The cause of the overpayment;
  - The department, program, or service;
  - The amount of the overpayment; and
  - The corrective action(s) to prevent the overpayment from recurring.
- o) A report of overpayments, the results of investigations, and remedial actions will be reported to the Compliance Committee on a quarterly basis, and to the Board of Directors at least annually

**C. Medicaid Self-Disclosure**

- a) The Agency will participate in the OMIG's self-disclosure program under the following eligible conditions as required:
  - The Agency is not currently under audit, investigation, or review by the Medicaid Inspector General, unless the overpayment and the related conduct being disclosed does not relate to the OMIG audit, investigation, or review;
  - The Agency is disclosing an overpayment and related conduct that at the time is not being determined, calculated, researched, or identified by OMIG;
  - The overpayment and related conduct will be reported by the deadline previously specified, i.e., within 60 days of identification and the overpayment is quantified, or the date any corresponding cost report is due; and
  - The Agency is not a party to any criminal investigation being conducted by the deputy attorney general for the Medicaid Fraud Control Unit or any agency of the US government or any political subdivision thereof.
- b) The Agency will pay the overpayment amount determined by OMIG within 15 days of OMIG notifying the Agency of the amount due, unless the OMIG permits the Agency to repay the overpayment and interest due in installments.
- c) The Agency will enter into a self-disclosure compliance agreement with the Medicaid Inspector General that will be executed within 15 days of receiving said agreement from the Medicaid Inspector General or other time frame permitted by OMIG, but not less than 15 days.
- d) Any false material information or omitted material information when submitting a self-disclosure, any attempts to evade an overpayment due, or any failure to comply with the terms of a self-disclosure and compliance agreement will not be tolerated and will be subject to disciplinary action up to and including termination.

**VI. SANCTION STATEMENT**

Non-compliance with this policy may result in disciplinary action, up to and including termination.

**VII. COMPLIANCE STATEMENT**

As part of its ongoing auditing and monitoring process in its Compliance Program, CHH will review this policy based on changes in the law or regulations, as CHH's practices change, and, at minimum, on an annual basis. Additionally, this policy will be tested for effectiveness on an annual basis or more frequently as identified in accordance with CHH's Compliance Program. Testing will include but is not limited to ensuring that the policy is appropriately followed; the policy is effective; the policy has been disseminated to all affected individuals, as well as notified of any updates or changes.

Tracking of the criteria above and results of this testing will be completed by the Compliance Officer, or designee. Additionally, results will be reported to the Compliance Committee and Governing Body on a regular basis.

**VIII. RECORD RETENTION STATEMENT**

CARDINAL HAYES HOME will retain this policy and all subsequent revisions, and any related documentation will be retained for a period of, at minimum, six years.

History

**Implemented:** 3/16/18, rev. 4/8/2021; reviewed 4/2022

Revised 10/2/2023: Changed title from 'Billing Practice & Billing Errors' to '**Billing Practice, Billing Errors, Overpayments & Self-Disclosure.**'

**CARDINAL HAYES HOME FOR CHILDREN**  
**Overpayment and Disclosure Log**

<b>Date Overpayment Identified/ Quantified</b>	<b>Date Overpayment Disclosed</b>	<b>Date Overpayment Refunded</b>	<b>Cause of Overpayment</b>	<b>Amount of Overpayment</b>	<b>Department/ Program/ Service</b>	<b>Corrective Action(s)</b>

<b>CARDINAL HAYES HOME  POLICY AND PROCEDURE</b>	<b>Date Issued</b> 04/2021	<b>Date Revised</b> 03/31/2023	<b>Date of Last Review</b> 04/03/2023	<b>Date Approved</b> 04/24/2023	<b>Section Number</b> CC-17
	<b>Subject</b>				
	<b>Corporate Compliance</b>				
<b>Topic</b>					
<b>False Claims Act and Whistleblower Protections</b>					

**I. PURPOSE:**

Cardinal Hayes Home for Children (sometimes referred to as “Cardinal Hayes Home”) (CHH) is committed to prompt, complete, and accurate billing of all services provided to service recipients. CHH and its employees and contractors shall not make or submit any false or misleading entries on any claim forms. No employee or contractor shall engage in any arrangement or participate in such arrangement at the direction of another person, including any supervisor or manager, that results in the submission of a false or misleading entry on claims forms or documentation of services that result in the submission of a false claim.

For purpose of this Policy, a contractor is defined as:

- Any independent contractor, contractor, subcontractor, or other person who, on behalf of the agency, furnishes or otherwise authorizes the furnishing of Medicare and/or Medicaid healthcare items or services, or performs billing or coding functions;
- Any independent contractor, contractor, subcontractor, or other person who provides administrative or consultative services, goods, or services that are significant and material, are directly related to healthcare provision, and/or are included in or are a necessary component of providing items or services reimbursed by Medicare, Medicaid, or another federally-funded healthcare program; or
- Any independent, contractor, subcontractor, or other person who is involved in the monitoring of healthcare provided by the agency.

**II. STATEMENT OF POLICY:**

It is the policy of CHH to detect and prevent fraud, waste, and abuse in Federal and State healthcare programs. This Policy explains the Federal False Claims Act, the Administrative Remedies For False Claims, the New York State False Claims Act, and other New York State laws concerning false statements or claims and employee protections against retaliation for reporting. This policy also sets forth the procedures that CHH has put into place to prevent any violations of Federal or New York State laws regarding fraud, waste, or abuse in its healthcare programs. (Refer to the appendix entitled “Overview of Relevant Laws” for further information.)

**III. POLICY OWNER**

Corporate Compliance Officer or designee

**IV. SCOPE**

This policy applies to all Affected individuals at Cardinal Hayes Home for Children & Cardinal Hayes School for Special Children.



## **V. POLICIES AND PROCEDURES AND STANDARDS OF CONDUCT**

1. CHH will provide training and/or education in this policy and procedure to all Board members, all employees including Executive Director and senior leadership, and contractors, as defined by this Policy.
2. Training and/or education in this Policy will be provided to all employees as part of the new employee orientation.
3. Training and/or education in this Policy will be provided to all Board members and to new Board members as part of Board orientation.
4. The Compliance Officer will ensure that all Board members, all employees including Executive Director and senior leadership, and contractors receive training and/or education related to the contents of this Policy and the False Claims Act. The Compliance Officer will ensure that records are maintained to document the receipt of training.
5. The Compliance Officer will ensure that this Policy is attached to any contract with a contractor as defined by this Policy.
6. The prevention of fraud, waste and abuse, CHH requires compliance with the following requirements related to the provision of service(s) and claims for reimbursement:
  - a. All service documentation, records, and reports are prepared timely, accurately, and honestly;
  - b. All documentation supporting claims for service is complete and maintained in accordance with regulatory requirements and the agency's policies;
  - c. All claims submitted to any government or private healthcare program are accurate and comply with all Federal and State laws and regulations and payer requirements;
  - d. Claims are only submitted for medically necessary services provided by eligible providers;
  - e. All claims are properly documented and accurately coded; and
  - f. Billing errors are promptly identified, and any payments received in error are promptly returned to the payer.
7. Any employee or contractor who has any reason to believe that anyone is engaging in false billing practices, false documentation of services, and other non-compliance related to service provision and billing is expected to report the practice to the Compliance Officer in accordance with the Reporting and Investigation of Compliance Concerns Policy.
8. Any form of retribution, intimidation, and/or retaliation against any party who reports, in good faith, a perceived problem or concern regarding the provision or billing of services is strictly prohibited.
9. Any employee or contractor who commits or condones any form of retribution, intimidation, or retaliation will be subject to discipline up to, and including, termination of employment or contract.
10. CHH will perform billing activities in a manner consistent with the regulations and requirements of third-party payers, including Medicaid, Medicare, and other Federal healthcare programs.
11. CHH will conduct regular auditing and monitoring procedures as part of its efforts to ensure compliance with applicable regulations.
12. CHH will report and refund all overpayments to Medicaid and Medicare within 60 days of identification of the overpayment in accordance with the Billing Errors, Overpayments, and Self-Disclosure Policy.

## **VI. SANCTION STATEMENT**

Non-compliance with this policy may result in disciplinary action, up to and including termination.

## **VII. COMPLIANCE STATEMENT**

As part of its ongoing auditing and monitoring process in its Compliance Program, CHH will review this policy based on changes in the law or regulations, as CHH's practices change, and, at minimum, on an annual basis. Additionally, this policy will be tested for effectiveness on an annual basis or more frequently as identified in accordance with CHH's Compliance Program. Testing will include but is not limited to ensuring that the policy is

appropriately followed; the policy is effective; the policy has been disseminated to all affected individuals, as well as notified of any updates or changes.

Tracking of the criteria above and results of this testing will be completed by the Compliance Officer, or designee. Additionally, results will be reported to the Compliance Committee and Governing Body on a regular basis.

#### **VIII. RECORD RETENTION STATEMENT**

CARDINAL HAYES HOME will retain this policy and all subsequent revisions, and any related documentation will be retained for a period of, at minimum, six years.

#### History

Implemented 4.2021

Reviewed 4.2022

Revised: 3.31.2023, Approved 4.24.2023

## **Appendix A – Overview of Relevant Laws**

### **The False Claims Act (31 USC Chapter 37, §§ 3729-3733)**

The False Claims Act is a Federal law designed to prevent and detect fraud, waste, and abuse in Federal healthcare programs, including Medicaid and Medicare. Under the False Claims Act, anyone who “knowingly” submits false claims to the Federal Government is liable for damages up to three times the amount of the erroneous payment plus mandatory penalties of approximately \$12,000 to \$25,000<sup>1</sup> for each false claim submitted.

The law was revised in 1986 to expand the definition of “knowingly” to include a person who:

- Has actual knowledge of falsity of information in the claim;
- Acts in deliberate ignorance of the truth or falsity of the information in the claim; and
- Acts in reckless disregard of the truth or falsity of the information in a claim.

False Claims suits can be brought against individuals and entities. The False Claims Act does not require proof of a specific intent to defraud the Government. Providers can be prosecuted for a wide variety of conduct that leads to the submission of a false claim.

Examples include, but are not limited to, the following:

- Knowingly making false statements;
- Falsifying records;
- Submitting claims for services never performed or items never furnished;
- Double-billing for items or services;
- Upcoding;
- Using false records or statements to avoid paying the Government;
- Falsifying time records used to bill Medicaid; or
- Otherwise causing a false claim to be submitted.

### Whistleblower or “Qui Tam” Protections

In order to encourage individuals to come forward and report misconduct involving false claims, the False Claims Act contains a “Qui Tam” or whistleblower protection.

The United States Government, or an individual citizen acting on behalf of the United States Government, can bring actions under the False Claims Act. An individual citizen, referred to as a whistleblower or “Relator,” who has actual knowledge of allegedly false claims may file a lawsuit on behalf of the United States Government. If the lawsuit is successful, and provided certain legal requirements are met, the whistleblower may receive an award ranging from 15% - 30% of the amount recovered.

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<sup>1</sup> The penalties are updated regularly; the provider should refer to the Federal False Claims Act for current amounts.

## Employee Protections

The False Claims Act prohibits discrimination by an organization against any employee for taking lawful actions under the False Claims Act. Any employee who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts by the employee in False Claims actions is entitled to all relief necessary to make the employee whole. Such relief may include reinstatement, double back pay, and compensation for any special damages, including litigation costs and reasonable attorney fees.

### **Administrative Remedies for False Claims (31 USC Chapter 38, §§3801-3812)**

The Federal False Claims Act allows for administrative recoveries by Federal agencies including the Department of Health and Human Services, which operates the Medicare and Medicaid Programs. The law prohibits the submission of a claim or written statement that the person knows or has reason to know is false, contains false information, or omits material information. The Federal agency receiving the claim may impose a monetary penalty of up to \$5,500 per claim and damages of twice the amount of the original claim.

Unlike the False Claims Act, a violation of this law occurs when a false claim is submitted, not when it is paid.

### **New York State Laws**

#### A. Civil and Administrative Laws

#### New York State False Claims Act (State Finance Law §§187-194)

The New York State False Claims Act closely tracks the Federal False Claims Act. It imposes fines on individuals and entities that file false or fraudulent claims for payment from any State or local government, including healthcare programs such as Medicaid. The penalty for filing a false claim is \$6,000 - \$12,000<sup>2</sup> per claim and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false claim filer may be responsible for the government's legal fees.

The New York State Government, or an individual citizen acting on behalf of the Government (a "Relator"), can bring actions under the New York State False Claims Act. If the suit eventually concludes with payments back to the government, the party who initiated the case can recover 15% - 30% of the proceeds, depending upon whether the government participated in the suit.

The New York State False Claims Act prohibits discrimination against an employee for taking lawful actions in furtherance of an action under the False Claims Act. Any employee who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts by the employee in furtherance of an action under the False Claims Act is entitled to all relief necessary to make the employee whole.

#### Social Service Law §145-b False Statements

It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment, or other fraudulent scheme or device. The State or the local Social Services district may recover up to three times the amount of the incorrectly paid claim. In the case of non-monetary false statements, the local Social Service district or State may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to \$2,000 per violation. If repeat violations occur within five years, a penalty up to \$7,500 may be imposed if they involve more serious violations of the Medicaid rules, billing for services not rendered, or providing excessive services.

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<sup>2</sup> The penalties are updated regularly; the provider should refer to the Federal False Claims Act for current amounts.

### Social Service Law §145-c Sanctions

If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the person's and the person's family needs are not taken into account for a period of six months to five years, depending upon the number of offenses.

## **B. Criminal Laws**

### Social Service Law §145 Penalties

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

### Social Service Law § 366-b, Penalties for Fraudulent Practices

Any person who, with intent to defraud, presents for payment any false or fraudulent claim for furnishing services or merchandise, knowingly submits false information for the purpose of obtaining Medicaid compensation greater than that to which they are legally entitled to, or knowingly submits false information in order to obtain authorization to provide items or services shall be guilty of a Class A misdemeanor.

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

### Penal Law Article 155, Larceny

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

### Penal Law Article 175, Written False Statements

There are four crimes in this Article that relate to filing false information or claims. Actions include falsifying business records, entering false information, omitting material information, altering an organization's business records, or providing a written instrument (including a claim for payment) knowing that it contains false information. Depending upon the action and the intent, a person may be guilty of a Class E felony.

### Penal Law Article 177, Health Care Fraud

This Article establishes the crime of Health Care Fraud. A person commits such a crime when, with the intent to defraud Medicaid (or other health plans, including non-governmental plans), they knowingly provide false information or omits material information for the purpose of requesting payment for a healthcare item or service and, as a result of the false information or omission, receives such a payment in an amount to which they are not entitled. Prosecution under Health Care Fraud is determined by the amount of payment inappropriately received.

### New York Labor Law §740

An employer may not take any retaliatory personnel action against an employee if the employee discloses information about the employer's policies, practices, or activities to a regulatory, law enforcement, or other similar agency or public official.

This law offers protection to an employee who:

- Discloses, or threatens to disclose, to a supervisor or to a public body an activity, policy, or practice of the employer that is in violation of law, rule, or regulation that presents a substantial and specific danger to the public health or safety;
- Provides information to, or testifies before, any public body conducting an investigation, hearing, or inquiry into any such violation of a law, rule, or regulation by the employer; or
- Objects to, or refuses to participate in, any such activity, policy, or practice in violation of a law, rule, or regulation.

The employee's disclosure is protected under this law only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation, with certain exceptions. The law allows employees who are the subject of a retaliatory action to bring a suit in State court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees.

### New York Labor Law §741

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

This law offers protection to an employee who:

- Discloses or threatens to disclose to a supervisor, to a public body, to a news media outlet, or to a social media forum available to the public at large, an activity, policy, or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety; or
- Objects to, or refuses to participate in any activity, policy, or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety.

The employee's disclosure is protected under this law only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation, unless the danger is imminent to the public or patient and the employee believes in good faith that reporting to a supervisor would not result in corrective action. Certain exceptions apply. If the employer takes a retaliatory action against the employee, the employee may sue in State court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a healthcare provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of \$10,000 on the employer.

<b>CARDINAL HAYES HOME  POLICY AND PROCEDURE</b>	<b>Date Issued</b> 04/2021	<b>Date Revised</b> 03/31/2023	<b>Date of Last Review</b> 04/03/2023	<b>Date Approved</b> 04/24/2023	<b>Section Number</b> CC-18
	<b>Subject</b>				
	<b>Corporate Compliance</b>				
<b>Topic</b>					
<b>Whistleblowers Protection &amp; Non-Retaliation</b>					

**I. PURPOSE:**

Cardinal Hayes Home for Children (sometimes referred to as “Cardinal Hayes Home”) (CHH) is committed to promoting an environment where concerns regarding known or suspected fraud, waste, and abuse; illegal or unethical acts; actual or suspected violations of Federal or State laws and regulations; actual or suspected violations of the Standards of Conduct, the Compliance Program, and CHH’s policies and procedures; improper acts in the delivery or billing of services; and other wrongdoing (collectively referred to as “compliance concerns” for purposes of this Policy) are reported and addressed without fear of retaliation, intimidation, retribution or harassment for good faith reporting of such concerns. To reinforce this commitment, CHH maintains a policy of non-intimidation and non-retaliation for good faith participation in the Compliance Program, including but not limited to reporting potential issues and compliance concerns, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials as provided in the Labor Law.

For purposes of this Policy, the term “Affected Individuals” includes all persons who are affected by the required risk areas including all employees, the Executive Director and other senior administrators, supervisors, contractors, agents, interns, and the Board of Directors (hereafter referred to as “Affected Individuals”).

**II. STATEMENT OF POLICY:**

It is the policy of CHH to strictly prohibit any form of retaliation or intimidation against Affected Individuals or entities, for reporting compliance concerns.

CHH strictly prohibits Affected Individuals from engaging in any act, conduct, or behavior that results in, or is intended to result in, retribution, intimidation, or retaliation against any individual or entity for reporting compliance concerns to the agency or government agency.

No CHH supervisor, manager, or employee is permitted to discharge, demote, suspend, threaten, harass, or in any other manner discriminate against an employee, vendor, contractor, or other individual or CHH (all such activity collectively referred to as “retaliation”) who in good faith participates in the Compliance Program, including but not limited to reporting potential compliance concerns, investigating or participating in an investigation, self-evaluations, audits, and reporting to the appropriate officials.

**III. POLICY OWNER**

Corporate Compliance Officer or designee

**IV. SCOPE**

This policy applies to all Board members, all employees including Executive Director and senior leadership, and contractors.

## **V. POLICIES AND PROCEDURES AND STANDARDS OF CONDUCT**

1. If an Affected Individual, vendor, or service recipient believes in good faith that they have been retaliated against for reporting a compliance concern or for participating in any investigation of such a report, the retaliation should be immediately reported to the Compliance Officer or the Compliance Hotline. The report should include a thorough account of the incident(s) and should include the names, dates, specific events, the names of any witnesses, and the location or name of any document that supports the alleged retaliation.
2. Knowledge of a violation or potential violation of this Policy must be reported directly to the Compliance Officer or the Compliance Hotline.
3. Any employee who believes they are subjected to retaliation, intimidation, harassment, discrimination, or an adverse employment consequence must immediately report the actions to the Compliance Officer or Human Resource Director.
4. The Compliance Officer will implement this Policy and take appropriate actions in response to the whistleblower's complaint of retaliation based on the nature of the report. Legal counsel will be consulted, if appropriate.
5. The Compliance Officer will investigate all reports of retaliation in accordance with the Reporting and Investigation of Compliance Concerns Policy and report results to the Director of Human Resources and the Executive Director.
6. The Executive Director or designee will investigate any report that the Compliance Officer is engaging in intimidation or retaliation.
7. The Compliance Officer will provide information on each report of retaliation and any actions taken to the Compliance Committee and the Board of Directors.
8. The right of the reporter to protection against retaliation does not include immunity for any personal wrongdoing that is alleged and investigated.
9. Any Affected Individual who commits or condones any form of retaliation will be subject to discipline up to, and including, termination.
10. The Compliance Officer will ensure this Policy is disseminated to all Affected Individuals and that these individuals have received relevant training in accordance with the agency's training plan.



## Further Information Regarding Employee Protections

### New York Labor Law §740

An employer may not take any retaliatory personnel action against an employee if the employee discloses information about the employer's policies, practices, or activities to a regulatory, law enforcement, or other similar agency or public official.

This law offers protection to an employee who:

- Discloses, or threatens to disclose, to a supervisor or to a public body an activity, policy, or practice of the employer that is in violation of law, rule, or regulation that presents a substantial and specific danger to the public health or safety;
- Provides information to, or testifies before, any public body conducting an investigation, hearing, or inquiry into any such violation of a law, rule, or regulation by the employer; or
- Objects to, or refuses to participate in, any such activity, policy, or practice in violation of a law, rule, or regulation.

The employee's disclosure is protected under this law only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation, with certain exceptions. The law allows employees who are the subject of a retaliatory action to bring a suit in State court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees.

More information can be found at <http://public.leginfo.state.ny.us/lawssrch.cgi?NVLWO%20>: under LAB-Labor.

### New York Labor Law §741

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

This law offers protection to an employee who:

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**VII. COMPLIANCE STATEMENT**

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**VIII. RECORD RETENTION STATEMENT**

CARDINAL HAYES HOME will retain this policy and all subsequent revisions, and any related documentation will be retained for a period of, at minimum, six years.

History

Implemented 4.2021

Reviewed 4.2022

Revised: 3.31.2023

Approved 4.24.2023